H.R. 3808, TO PRESERVE VA'S FLEXIBILITY IN MEETING ITS MEDICAL WORKFORCE NEEDS, AND DRAFT LEGISLATION TO AUTHORIZE A PILOT PROGRAM FOR VA PARTICIPATION IN STATE HEALTH REFORMS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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H.R. 3808, TO PRESERVE VA'S FLEXIBILITY IN MEETING ITS MEDICAL WORKFORCE NEEDS, AND DRAFT LEGISLATION TO AUTHORIZE A PILOT PROGRAM FOR VA PARTICIPATION IN STATE HEALTH REFORMS

TUESDAY, MARCH 8, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9:33 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland (chairman of the subcommittee) presiding.

Present: Representatives Rowland, Long, Baesler, Kreidler, Brown, and Smith.

OPENING STATEMENT OF CHAIRMAN ROWLAND

Mr. ROWLAND. This morning, we will hear testimony on two pieces of legislation. These bills respond to some very critical problems and challenges facing the VA health care system.

Our veterans, the Congress, and this administration have all looked to VA to launch changes in its health care system. We have urged the department to develop the capacity to provide primary care services to improve service delivery and generally to reinvent itself.

These are not unreasonable goals, but as VA has moved to meet the challenges, the Office of Management and Budget has directed that it do so without the most basic of resources: people. The fiscal year 1995 budget tells the story. It tells VA to cut 5,000 positions and find some way to get the job done.

Veterans have been offered the promise of an improved health care system which would be an enrollment option under a national health care reform. But veterans' hopes will be thwarted if OMB employment numbers rather than veterans' enrollment choices dictate VA staffing levels. We have surveyed VA medical facilities. The survey data illustrates what the OMB directive would mean for the next fiscal year: Bed closures at more than 100 facilities; elimination of programs at up to 91 facilities; 200,000 fewer outpatient visits and 9,000 fewer episodes of hospitalization; increased costs at virtually every facility, totalling at least $88 million; cutbacks on sharing agreements resulting in lost savings of more than $38 million.

Those officials have also been active participants in ongoing efforts to develop a VA role in some of the States which have taken the lead in developing health reform programs. Substantial reforms have advanced in a number of States. Because of the far-reaching impact those reforms would have on VA operations if VA is shut out, I have had subcommittee staff develop draft legislation to permit the department's participation. As many of our witnesses have suggested in their testimony, such legislation is critical.

The extensive line up of service organizations and employee groups who have appeared to testify today attests to the importance of the issues under discussion. And we certainly look forward to their testimony.

Let me just recognize the gentlelady from Indiana. If she has any comments.

Ms. LONG. Thank you, Mr. Chairman. I don't have an opening statement, but I do want to commend you for holding this hearing, and I think that given the cuts in real dollars that we have seen in the Department of Veterans Affairs over the past number of years, I think that this hearing is a very important hearing, and I commend you for holding it.

Mr. ROWLAND. Thank you.

Dr. Kreidler.

OPENING STATEMENT OF HON. MICHAEL KREIDLER

Mr. KREIDLER. Thank you, Mr. Chairman.

I want to also commend you for holding this hearing and comment specifically on the second bill that is before us which is the pilot program. This is particularly germane to the State of Washington because we have enacted health care reform of a comprehensive nature with an employer mandate, broad benefits package, and universal coverage.

If legislation is not enacted, the VA in the State of Washington will be left out of health care reform and will not be able to participate in a meaningful way by the time Federal legislation essentially brings it into the ball game. This is of particular concern to the veterans in my State who are eager to not see the VA system go away; that they will be able to preserve it. And here is an opportunity with this proposal before us to address this issue with this pilot program. And hopefully our State will be one of those that is selected for that process.

The panel before us today are individuals who are particularly knowledgeable in how the VA will be able to participate in a program like this, and I would like to particularly note Mr. Joe Manley from the Seattle VA who is here and on the panel. His background and knowledge in this issue, particularly understanding the State of Washington's program is important.

All of the four VA Medical Centers in the State of Washington are eager and desirous to see that we at the Federal level will assist them in being able to participate before the VA system is left out of reform in the State of Washington.

Thank you, Mr. Chairman.

Mr. ROWLAND. The gentleman from Kentucky.

Mr. BAESLER. No statement.

Mr. ROWLAND. No opening statement.

STATEMENT OF ELWOOD HEADLEY, M.D., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL; PATRICIA O'NEIL, SPECIAL ASSISTANT TO THE ASSISTANT SECRETARY FOR POLICY AND PLANNING AND STATES' HEALTH CARE REFORM CLUSTER LEADER; AND SANFORD GARFUNKEL, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR OPERATIONS

Mr. ROWLAND. Let me welcome, then, Dr. Elwood Headley, who is Acting Deputy Under Secretary for Health. Dr. Headley, would you introduce the people who accompany you this morning and proceed with your testimony.

I am going to ask that everyone who testifies this morning limit their statement to 5 minutes, and your entire statement will be made a part of the record.

Dr. HEADLEY. Thank you, Mr. Chairman.

Mr. Chairman, and Members of the Committee, we have submitted written testimony and I will be presenting just a summary of that. First, I would like to introduce Ms. Mary Lou Keener, VA General Counsel, Mr. Sanford Garfunkel, Associate Chief Medical Director for Operations, and Ms. Pat O'Neil, Special Assistant to the Assistant Secretary for Policy and Planning and the Director of our States' Health Care Reform Project.

I am pleased to be here this morning to present the Administration's views on two important pieces of legislation before the subcommittee. The first measure is your draft bill to allow VA to participate on a pilot basis in State health reform activities. The second, H.R. 3808, would limit the Administration's efforts to trim the Federal workforce in VA over the next 5 fiscal years.

The Nation is focused on the need for reform of our health care system. Last fall the President submitted legislation to Congress which embodies his vision of a system which will ensure all Americans access to affordable health care.

Congress is now considering that legislation; however, many States are proceeding to enact their own health care reform measures in advance of national health care reform. We in VA plan to move with the States as partners in developing better ways to meet veterans' health care needs, reduce costs, and maintain the highest levels of quality service.

We are focusing presently on nine States and the Commonwealth of Puerto Rico that have already enacted State health care reform legislation or have received or requested waivers permitting medicaid demonstration projects. We are also closely monitoring States in which we expect significant health care reform legislation to be enacted in 1994.

Generally, the States are working first to provide poor and uninsured citizens with health care coverage through managed care plans. While it is still too early to fully determine the actual effect on VA of State-based health care reforms, some veterans who currently use the VA system may elect to enroll in State approved health care plans rather than seek care from VA.

This may be particularly true in States like Tennessee where the basic benefits package is richer than what VA is now statutorily permitted to provide most veterans. To respond to the challenges

of State health care reform, the VA has developed a unified vision for VA's role in national health care reform.

We have designated a VA Medical Center director within each State as lead director and started a State-based strategic planning initiative to develop a unified plan for providing health care services to veteran customers and to identify actions required at the local and national levels to ensure VA participation.

Also, we are now educating State officials on the role of VA in their communities and we are providing information to State legislatures in a variety of forums to ensure that VA is considered in State health care reform deliberations.

We have initiated a relationship with the Health Care Finance Administration, HCFA, to ensure appropriate consideration of VA and veterans in their review and approval process of State requests for medicaid waivers. We want to ensure that VA is a player and holds a place in reformed State health care markets.

Mr. Chairman, you have asked us to comment on a draft bill which has not yet been introduced and which we understand is still in a somewhat evolutionary stage. Your bill has much in common with an administration bill which we are planning to submit to Congress in the very near future.

Both your bill and the administration bill would allow us to gain the kind of valuable experience we will need to compete in the health care marketplace we anticipate will result with the enactment of national health care reform.

My formal statement discusses major aspects of your bill and areas that cause us some concern. We would appreciate working with your staff to resolve these concerns.

Mr. Chairman, the second bill on your agenda, H.R. 3808, would effectively immunize the Veterans' Health Administration from government-wide efforts to reduce the number of Federal employees. While we appreciate the objective of this bill to assure our ability to effectively participate in the new health reform process, we believe the approach taken may deprive us of the opportunity to pursue some efficiencies.

In an effort to meet the goals identified in the President's budget, we have already identified ways to streamline VA operations and are actively exploring additional ways to deliver services more efficiently. This includes consideration of new approaches to the provision of health care under health reform.

Until we have more experience with this process, we cannot say that the employment reductions that could flow from current efforts to streamline or right size the various governmental entities, including VA, would have an adverse impact on our ability to effectively participate in the various health initiatives now under consideration.

For that reason, we do not support the enactment of H.R. 3808.

In conclusion, Mr. Chairman, national health care reform represents an unprecedented opportunity for the VA health care system to become a key player in State and regional health care systems.

We know that we must move ahead now with the States and we appreciate your efforts to support this.

This concludes my remarks. I and the other members of this panel will be pleased to respond to any questions from the committee.

[The prepared statement of Dr. Headley appears on p. 49.]

Mr. ROWLAND. Thank you very much.

I do have some questions to ask. I intend to enforce the 5-minute rule and if there are additional questions if a Member's time has expired, we will have another round and additional rounds in order to answer those questions. I will do that so that everyone will have an opportunity.

Mr. Garfunkel, let me ask you this question: Assuming the VA has four more budgets with FTE reductions of 5,000 each year, like this one, and assuming further that sweeping national health care reform has not been enacted, what in your personal opinion, will the VA health care system look like in terms of quality of service delivered, the number of facilities that might have to be closed and so forth.

Can you give me two scenarios what you think is the worst case and whatever you think is the most likely picture.

Mr. GARFUNKEL. I am not sure, Congressman, that I can give both scenarios. Obviously, there is concern on the part of the field as to what will happen under these scenarios involving a loss of FTE. However, we don't really know at this point what impact it is going to have on us.

We have been spending a good deal of time with a field-based group, as well as in Central Office, taking a look at what reductions can be made without having any impact on the quality of care or the services we provide.

Such things as consolidation of services, and elimination of some administrative programs may add up to a lot of FTEs as well as efforts to contract out various services that we now do within our own facilities, and in some cases contracting out may in fact be cheaper than it is to provide services in-house.

I think it remains to be seen what happens under national health care reform. The Secretary has testified that if national health care reform is passed, then as far as the VA is concerned, we need to take another look at any potential FTE cuts, but for the current year and in fiscal year 1995, we think we can develop a plan that will allow us to cut the FTEs required without diminishing the quality of services we provide.

Mr. ROWLAND. Dr. Headley, let me be clear on what you said. I understood you to say that these cuts would not significantly affect the quality of care that would be able to work within those parameters, did I misunderstand?

Dr. HEADLEY. What I said is we are working to ensure that quality of care will not suffer from any cuts. We are exploring, as Mr. Garfunkel mentioned, cuts in areas not directly related to patient care, cuts in FTE that would be realized by consolidating administrative services amongst facilities, and contracting out when in our estimation it is cost-effective and in keeping with good quality of care to our patients.

Mr. ROWLAND. It seems to me that cuts of the magnitude that are being proposed would be very difficult to adjust the delivery

system in the VA to those cuts so that it would be competitive with whatever might be put in place.

I am really concerned that we might find the VA losing veterans to whatever other system there may be out there.

Dr. HEADLEY. I appreciate that concern. All I can respond is that we are currently looking at how we would approach the delivery of a continuum of health care services in various markets and in some areas, it may make sense to contract out various parts of care delivery on a cost-effective basis, and we anticipate that the private sector will be doing very similar sort of things.

I just—I think that we can't know at this point in time how this will play out.

Mr. ROWLAND. Since H.R. 3808 does dictate a specific employment level, how would the bill in your words deprive you of opportunities to streamline?

Dr. HEADLEY. It may remove the incentive for us to look at some of the opportunities to streamline that we are now considering, which Mr. Garfunkel touched on in his answer to the question.

We are looking at ways to consolidate administrative services and so forth and so on.

Mr. ROWLAND. It seems to me that the competition that you would face in the VA from whatever system is out there would certainly be an incentive to streamline and to better prepare for delivering services.

Dr. HEADLEY. I think that all of health care is going to be streamlining and looking at ways to better deliver health care services, both in the Federal sector as well as the private sector.

Mr. ROWLAND. Mr. Garfunkel, let me ask you one question: It is our understanding that the number of VA facilities designated as reinvention laboratories will be exempted from workforce reduction requirements in fiscal year 1995. Would you please explain such exemption in the face of your testimony regarding the benefits of the workforce reduction policy?

Mr. GARFUNKEL. I am not sure that I testified for the benefits of the workforce reduction policy. There are two facilities in the VA that have been designated as reinvention laboratories and they will be exempt for the most part from these reductions because we want to give them every freedom they can have to institute whatever programs they feel they need to institute.

They are exempt from most provisions that we have for most of our Medical Centers, most policies. However, we are trying to see how creative they can be in instituting various programs. Again, I don't—I hope I didn't testify to the benefits of the workforce reductions only that we are not sure if there really will be a detriment at all to the quantity of care we provide.

Mr. ROWLAND. Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman. Mr. Chairman I would ask that my opening comments be made a part of the record at this point.

Mr. ROWLAND. Without objection.

[The prepared statement of Congressman Smith follows:]

PREPARED STATEMENT OF HON. CHRIS SMITH

Good Morning Mr. Chairman. It is a pleasure to be here this morning as the subcommittee continues its series of hearings regarding the role of VA in national health reform efforts. Today we will address the VA's ability to participate in various State reform initiatives.

Specifically, we will address draft legislation which gives VA flexibility to waive certain aspects of current law that would bar their full participation in State health reform programs. Let me be perfectly clear, I am only interested in allowing VA flexibility to waive current requirements in situations where if VA did not, there would almost certainly be no incentive left in those States for veterans to stay with the VA system. It is my understanding that there are about five States that are near completion of reform plans so that implementation is imminent. The goal of this hearing therefore is to design legislation which enhances VA's survivability under State reform.

Although the draft legislation only allows VA to pilot such waivers in up to five States, such authority is of monumental importance in helping this subcommittee gauge the ability of VA to compete. Since the advent of national health reform, there has been a wide range of differing opinions regarding VA's ability to compete. Some believe that forced competition will spell the demise of the VA system as we now know it. This pilot will allow the subcommittee to test the concept without putting the entire VA system at risk.

The draft bill contains language which requires VA to provide a comprehensive report to Congress prior to actual VA participation in any State plan. Such oversight is important for many reasons as VA ventures into what is essentially uncharted waters. There are many aspects of this bill which give me concern, but specifically however, many of my colleagues, myself included, would attempt to block VA from participating in any plan which attempts to shift the cost of care for service-connected veterans to employers. While some of the State plans call for employer mandates, none of them require employers to bear the cost of care for veterans. I would support VA participation in these states but only if the obligation for the cost of care for service-connected veterans be maintained as a federal obligation. There are other issues as well Mr. Chairman which warrant this subcommittee's intense oversight.

Secondly, we will examine H.R. 3808 a bill introduced by the Chairman of the full committee, Mr. Montgomery. This bill would ban any FTEE reductions in the Veterans Health Administration other than those specifically required by law or by the availability of funds. This legislation was introduced in response to arbitrary across-the-board reductions in VA health personnel as requested by the administration. In this era of health reform, at a time when VA is attempting to prepare itself to meet the challenge of reforms, it is a sad commentary that the administration would make such nonsensical requests. None the less, this subcommittee will examine ways in which to once again, protect the VA from OMB budget slashers.

Mr. Chairman, I want to thank in particular the panel of VA hospital representatives who will enlighten us on VA reform in their individual States. Mr. Chairman, I thank you for holding these hearings and I look forward to the testimony of the witnesses.

Mr. SMITH. Dr. Headley, under the pilot program how could Congress be assured that the level of services provided at other VA Medical Centers would not decline in order to fund the five pilot sites?

Dr. HEADLEY. I think this is going to be a challenge to our system. I think that, first off, we would not necessarily have five pilot sites. It would be up to five pilot sites, and I think that financial availability of the pilots would have to be one of the factors considered in determining how many pilots we could have.

Secondly, I think that there would be some savings realized in the pilots as we explored new ways of doing business, as we had more flexibility to deliver outpatient care instead of inpatient care, as we tried to provide care closer to where people lived rather than having them travel great distances and having to be admitted and so forth. So I think there would be economies realized as well.

And finally, I think that we would have to be aware of this as an issue and be prepared to deal with it in our development of pilots.

Mr. SMITH. Dr. Headley, are there any aspects to the Administration's bill that you might want to share with this committee that is not in the Chairman's bill? You said it was very similar, but not the same.

Dr. HEADLEY. It is very similar. I would defer to general counsel to answer that question as she has been most intimately involved.

Ms. KEENER. Yes, sir. Essentially we are in the process of finalizing the bill with the Administration so none of these particular points have been locked into stone as of this time. But I think that some of the differences were mentioned in Dr. Headley's written testimony that has been submitted, and I can briefly review those for you if you like.

First is in the area of funding, and I think the main difference is that the Administration bill would not provide authority to transfer appropriated funds into a major or general revolving fund that would be used for the projects.

Second, in the area of sharing, the bill you are considering, has a very broad sharing component. We believe the Administration bill might be a little narrower and limit sharing only to the pilot projects.

It is our understanding that this particular bill provides expanded sharing authority beyond the pilot projects themselves.

And the third area, of course, would be in the area of contracting. This particular bill provides a very broad exception to the statutory constraints in the area of contracting authority that we have now. We are looking at some particular provisions or contracting requirements we might want to maintain in statute.

We are basically going to look at those particular contracting authorities that impede our ability to compete, but we would not propose to eliminate the Clean Air and Water Act and other provisions that we feel are important to maintain.

Mr. SMITH. Thank you. I yield back.

Mr. ROWLAND. Ms. Long.

Ms. LONG. Thank you, Mr. Chairman. I have a question for Mr. Garfunkel. In your personal opinion, would a policy that tells directors over the next 5 years that they have to reduce staffing by 2 percent or more each year and use those employment dollars to obtain services in some other manner represent a sound management policy?

Mr. GARFUNKEL. Well, as a former hospital director, it is very difficult to accept personnel cuts when we face the need to prepare for national health care and all other reforms.

But again, I think if the VA is going to streamline itself, I think the American people have spoken pretty clearly that they want government to streamline itself, then we need to at least take a real hard look at what we can do to streamline the VA to make the changes necessary.

We have a proposal, for example, to convert to a system of VSAs as opposed to regions. That will save us FTE, but more importantly, it will give us close management on the scene of the delivery of health care and allow us to make the decisions that need to

be made to consolidate services, have mission changes, various other things to allow us to get ready for national health care.

So again I think from a director's point of view, an FTE reduction is difficult to take. From a systemwide point of view, it does at least afford us an opportunity to take a look at these various issues and make the changes that perhaps we need to make.

Ms. LONG. Okay. Now, would you answer my question? Is it a sound management policy?

Mr. GARFUNKEL. I am not sure if it is—I am not sure at this time whether it is or isn't a sound management policy. I think it is difficult to tell at this time. We would have to play it out and see what happens.

Ms. LONG. Thank you.

Dr. Headley, I have a question for you, would you for the committee describe the major component elements of establishing a VA health plan in a State and comment on the magnitude of costs associated with the start-up efforts of doing that?

Dr. HEADLEY. Yes. This is a very complex question, as you can well imagine, and one that we have spent a great deal of time thinking about. The—and I am not sure that I can answer it in precise detail relative to the magnitude of expenditures that will be incurred, but perhaps relatively speaking.

First, it is necessary for the State to develop a comprehensive plan to look at what is being offered in the State health plan and to dissect out from that the things that will be necessary for VA to do in order to offer care in that State that will be comparable to other care offered in that State.

And this is perhaps the most important and most difficult part of the process. We have already started this process in some five or six States that have already had health care legislation and they are developing their strategic plan and vision at the present time.

Based on this, it is necessary, then, for the State facilities acting as a unit to begin to look at marketing issues, to begin to—and by this I don't mean advertising, but I mean marketing in the larger sense—to begin to look at the market research questions of who would use VA, what services would make VA attractive, who won't use VA, and what sorts of services do we need to develop in order to make VA an attractive provider in this health care system.

The final part of the development of a plan in a State is to go about instituting those things that VA doesn't currently have. Setting up the managed care system to deliver the continuum of health care; defining how provider networks are going to be established; defining how primary care is going to be put into the community so that the VA plan reads, if you will, like other plans in the community.

Now, the planning efforts, we feel, while they are extensive and difficult, can be done within existing resources. We see no real challenge here in the development of the plan. The marketing issues we are exploring initially as a part of our national health care reform efforts and hopefully we can achieve some economies of scale. While all health care is local and while there will have to be local market research and local decisions made, we can develop processes on a national level that can be applied at a local level.

So we feel that this probably can be managed without much in the way of additional resources.

The part that begins to get into resource utilization has to do with the development of primary care networks and managed care systems and as these will differ from State to State, it is very difficult to give a global response.

We presently have begun work on how to think about these initiatives in terms of costs.

Mr. ROWLAND. Dr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Headley, one of the issues that I have wondered about is that when it comes to the Department of Veterans Affairs, you have a system that has been pretty well defined.

Some people would call it a rigid type of administration, fairly straightforward.

You can use the same rules in one place in the country as you use in another place. You have your own schools to train your administrators as I understand it. How do you make an adjustment internally in leadership for a system where you are obviously going to be trying to mimic what has been going on in the private sector for some time?

Dr. HEADLEY. Yes. And I think this is one of the challenges that is going to face us as a system. I think that we are going to have to be more responsive to local market needs and concerns, to what veterans want in their States, what veterans want in terms of health care in the facility they use, and so one of the major thrusts that we have throughout health care reform is a concern about customer service orientation and access, finding out what veterans want from our system and how we will go about delivering this to them.

And this will really be a national approach. While there will be individual variations, there will be a national approach to making health care more palatable for veterans, more in keeping with what they want, and more accessible.

In addition, we are emphasizing the fact that VA and veterans' health care is a national resource. It is something that will exist all over the country. When veterans are traveling, they will be able to go to a veteran health plan in another State and their care will be covered.

In addition, we will still have an emphasis on the national programs that we hold so important, such as spinal cord injury and rehabilitation and chronic mental illness and so forth and so on. The thing that VA uniquely has to offer, and to date the private sector has not really paid as much attention to, we will continue to offer as nationally organized, nationally comprehensive health care pieces.

Mr. KREIDLER. Do you envision the possibility of seeing some major inroads into the civil service system as it is presently constituted in the administration of your Medical Centers?

Dr. HEADLEY. Well, one of the things that H.R. 3600 ultimately will provide us is some flexibility in how we manage personnel issues and one of the things that we are hoping to achieve in some of our pilots is ways to manage human resources that allow us more flexibility at the local level for managing care delivery.

One of the things that we have learned in looking at customer service orientation is that it is a very complex issue. It requires more than a quick fix. It requires a fundamental change in the way we approach and do business. It requires a focus on our consumers. It also requires a focus on the personnel who deliver care.

And very likely we will need some changes in these areas.

Mr. KREIDLER. Can you identify which States are ahead of Federal legislation in developing their own health care reform initiatives?

Dr. HEADLEY. Yes. The nine States that currently are the most active and that either have health care legislation already in effect or have applied for medicaid waivers are Arizona, Florida, Hawaii, Maryland, Minnesota, Puerto Rico, Oregon, Rhode Island, Tennessee, and Washington. These are the States that we have been tracking most closely.

In addition, there are five other States that are very active and we expect to see some legislative activity within the next year. These are California, Montana, Vermont, Colorado, and Pennsylvania.

We are also—well, we are monitoring all of the States for activity, but there are also 20 additional States that may be coming on line within a year or two. So there is a lot of activity out there. But as I mentioned, the first nine States are the States that are leading the pack at this point in time.

Mr. KREIDLER. Of those nine States, would you put them in a priority as to their potential impact on the VA?

Dr. HEADLEY. We haven't done this yet. But we are working with the States at this point in time to develop their strategic plan and part of their strategic plan includes an analysis of the State legislation and its impact on VA.

And so I think that down the road as we begin to look at these strategic plans, we will be able to prioritize the States as to the impact on VA of the legislation in the State.

Mr. KREIDLER. Thank you, very much.

Thank you, Mr. Chairman.

Mr. ROWLAND. Mr. Baesler.

Mr. BAESLER. Doctor, if we don't adopt a national health plan, do you anticipate there would be more or less demand on your system than is present?

Dr. HEADLEY. If we do not?

Mr. BAESLER. The great possibility that we will not, yes.

Dr. HEADLEY. I think it is difficult to say whether there would be an increase, a decrease, or whether demand would remain the same. We are hoping to see national health care reform to keep us from having to go through the process in each of the individual States that we are currently having to do.

Also, in H.R. 3600 we have most of their things that we need to compete successfully I think.

Mr. BAESLER. The reason for the question is that you are recommending, or at least the Administration is recommending, a cutback in the FTE or the personnel; I think that is correct. Isn't that correct?

Dr. HEADLEY. Yes.

Mr. BAESLER. And I assume from your earlier remarks that seems to be made on the premise that we are going to have a national health plan—it is not made on that premise?

Dr. HEADLEY. No, not entirely. It was also made on the premise that there are things that we can do at the present time in terms of consolidation of administrative functions at various Medical Centers, in terms of reconfiguring our regions into VSAs or some other configuration and we would save FTE in doing this.

In terms of looking at contracting out certain things that we can contract out even without health care reform, some of the support functions that we now have, so there are things that we could do without health care reform that might conserve FTE.

Mr. BAESLER. In your high-level discussions, does it take place that maybe the Department of Veterans Affairs has an ability to integrate part of the need of the new health care needs or is it just sort of thrown aside like the other plans in the national health program?

Dr. HEADLEY. I am sorry?

Mr. BAESLER. You call it a national resource, which I agree with you.

Dr. HEADLEY. Right.

Mr. BAESLER. Let me rephrase it. Are we trying to maximize the national resource? Are we trying to subordinate it to the national health plan or a little bit of both?

Dr. HEADLEY. I think we are trying to maximize the national resource. I think that we are looking at improved ways of delivering health care. Most of the things that we have looked at in our planning for national health care reform are things that VA needs to do anyway.

We are looking at emphasizing managed care with a continuum of health care, including primary care services which we haven't always emphasized in the past. We are looking at developing customer service orientation and involving veterans and veterans' service organizations more in the decision-making about how our health care services are presented.

So I think that we are trying to strengthen VA and its health care delivery capabilities as a national resource.

Mr. BAESLER. My concern is that I would have to assume from your—from the Administration's desire to cut FTEs, that we are not efficient, number one. I mean, that is their assumption.

Number two, I have to assume that we—even after we cut those FTEs, and they are all not going to be administrative I wouldn't think, but maybe they are—that we are now going to have to find a way to address the increasing needs that previous to this year or last year were not there.

For instance, we just passed or are getting ready to pass an expansion of the women's health services available to women veterans which we haven't done previously. And with the new statistics demonstrating that over 24 percent of the new enlistees in the military will be women, it seems like it is safe to assume that there is going to be more need for services women veterans than there has been in the past.

And then with the possible inclusion of other illnesses or things that previously, with the Agent Orange or whatever, it seems like

we are going to have a larger demand than we have had up to 1990 this way. But over here we are saying we are so inefficient, we are going to cut down this waste.

I am having problems understanding how the hospital is going to operate unless we have been terribly inefficient to meet the demand, that is going to be increased, that you haven't heretofore addressed and without enough people to do it in.

Dr. HEADLEY. Maybe I could ask Mr. Garfunkel to help me a bit on this one because he has done a lot of thinking and has been working with several groups that have been looking at possibilities for efficiencies in VA.

Mr. GARFUNKEL. Thank you.

I don't think we have a definitive answer to that. It is obviously a challenge for us. We feel there is a good deal of consolidations and changes that we can make to meet the mandated FTE reductions and without in any way being detrimental to patient care at this point.

How we can grow at the same time we are cutting back on FTE, I don't really know for sure. But we certainly can make a good effort and, as I have said before, we have had a field based group working intently on coming up with areas where we can make changes and consolidations and we get into VSAs and they can look at mission changes.

We feel there is a good deal of efficiencies to be gained. Whether we can do it all and still meet additional mandates, I really don't know.

Mr. BAESLER. Mr. Garfunkel, my reasons for my questions is I am finding it very hard to understand why the Administration wants to just include the Department of Veterans Affairs, as they do all other parts of government when everybody says the number one issue we have in our country is health care, so we just take an ax and slice out the health care portion of veterans as if we don't have this national resource you are talking about.

I just find it inconceivable that when we are trying to establish a national health care program, that we take a national resource and lessen its importance and suggest it has been so insufficient in the past that we can consult out all these people and still take care of all the needs we are going to have in the future which we haven't addressed yet.

To me it doesn't give much credibility to the Administration's proposal.

Mr. ROWLAND. I thank the gentleman. I have some additional questions that I will submit for the record I would like for you to answer.

(See p. 103.)

Mr. ROWLAND. Mr. Smith, do you have questions?

Mr. SMITH. I too have some questions, but for the interests of the remaining panels, I will submit mine for the record as well.

(See p. 105.)

Mr. ROWLAND. Thank you.

Mr. KREIDLER. Mr. Chairman, I would also like to submit questions for the record.

Mr. ROWLAND. Okay. That is fine.

(See p. 107.)

Mr. ROWLAND. Thank you. We all thank you very much for your testimony here this morning and we look forward to the answers to our questions that are submitted.

Dr. HEADLEY. Thank you.

Mr. ROWLAND. Our next panel consists of Dr. Robert Petzel, who is Chief of Staff at the VA Medical Center in Minneapolis, Mr. Malcom Randall the Director of the VA Medical Center in Gainesville, FL, Mr. Gary De Gasta, who is the Director of the White River Junction VA Medical and Regional Office Center, and Mr. Joseph Manley, Acting Director of the VA Medical Center in Seattle.

STATEMENTS OF ROBERT PETZEL, M.D., CHIEF OF STAFF, VAMC, MINNEAPOLIS, MN; MALCOM RANDALL, DIRECTOR, VAMC, GAINESVILLE, FL; GARY DE GASTA, DIRECTOR, VAMROC, WHITE RIVER JUNCTION, VT; AND JOSEPH MANLEY, ACTING DIRECTOR, VAMC, SEATTLE, WA

Mr. ROWLAND. Gentlemen, thank you very much for being here. Mr. Randall, it is nice to see you again.

Mr. RANDALL. Thank you, Mr. Chairman. Good seeing you.

Mr. ROWLAND. I understand that you may not have opening statements; is that correct? Does anyone there have an opening statement that you wish to make?

Mr. RANDALL. No.

Mr. ROWLAND. Very well. We will go directly to questioning, and I have a question that I would like for each of you to answer because each of you is in a State that has embarked on some sort of health care reform effort.

I would like for you to describe, if you will, the planning work done by your facility regarding its possible participation in your State's reform plan and the impact of anticipated FTE reductions for fiscal year 1995 and the subsequent 4 fiscal years as they relate both to your current mission operations and your ability to participate under a State reform plan.

If you would do that, I would be most grateful. Dr. Petzel.

Dr. PETZEL. Mr. Chairman, thank you on behalf of all of us and the veterans of Minnesota. We want to thank you for the opportunity to talk to you about health care reform in our State.

Minnesota Care was enacted in 1992 and the principles of the reform were basically managed competition, mandated universal coverage, and global expenditure ceilings. Already Minnesota Care is covering a segment of the population, about 90,000 people, and it is expected to be extended to a larger number on July 1st of 1994.

The veteran in the short term may have more options available to them under Minnesota Care with increased access to State programs. However, in the long term, if these State programs continue to attract veterans from our system, we anticipate that it will erode our patient base and our ability to provide those special programs to veterans which make the VA a unique health care deliverer.

In Minnesota our strategies have included the following: first of all, we wish to implement a primary care system. This would provide accessible primary care sites to veterans throughout the State by contractual arrangements with other providers.

Secondary and tertiary care would be provided at the VA Medical Center for those veterans.

We would anticipate setting up a partnership with providers where they provide care to the family and we provide care to the veteran, and the primary care is provided by the contractor in the veteran's local community.

Major systems in our infrastructure would have to obviously be overhauled in order to implement this primary care system.

It would require communication with a large number of providers about patient data, billing data, and other important health care information. These data systems would include a medical record, and the appropriate computer technology for transmitting the information.

We would also need to hire a consultant to perform actuarial market research surveys and cost surveys so we would be able to accurately predict the cost of contracting for care and provide a potential contractor with adequate information about our patient population to allow them to make an appropriate bid.

The second effort involves a managed care institute. Minneapolis VAMC is currently acquiring a lease to construct an outpatient clinic or other facilities to serve its members under the VA's enhanced use program.

The Veterans Administration Medical Center and the health care provider would then enter into a joint partnership to develop an institute dedicated to the study and teaching of managed care. This partnership would enable the VA to expand health care services for veterans at no additional cost to the government.

We are involved in a number of internal strategies. Minneapolis VA Medical Center needs to enhance its ambulatory care area to provide easy access and customer-driven services; processes need to be established to enhance customer service and accessibility, and these include concurrent review of every admission, pre-admission screening, streamlining our discharge process, and reducing waiting times both within a clinic when the patient has arrived and waiting times between clinic appointments.

Fourthly, our VAMC is involved in joint efforts with the State looking at the delivery of research and education in the State which is also a part of health care reform in Minnesota. This will ensure that the VA will continue to be a major provider and participant in policy development for medical education and research.

We have had meetings with the Commissioner of Health in Minnesota, key legislators, executives in the health care industry in Minnesota, and the community in general. The State is actively interested in maintaining the $200 million plus which the VA spends in the State of Minnesota.

All of these efforts have resulted in the State's desire to make it possible for the VA to participate in Minnesota Care. We now need Federal changes in order to make it possible for the VA to participate in health care reform in our State.

Regarding the second question, the impact that the FTE reductions may have on our ability to cope with our present circumstance in health care reform, it is very difficult to predict accurately. We presently do need flexibility both in terms of budget and FTE if we are going to adapt to the changes that Minnesota health care reform is foisting on us.

I believe that the long-term goals of the Administration and our long-term goals are compatible. That is, a reduction of FTE is not something that we could—that would be incompatible with our complying with health care reform.

However, in the next 3 to 5 years we would definitely need to have flexibility in terms of FTE and hiring. There are a number of things that we wish to do and need to do immediately that our present employment situation just won't allow us to do.

Thank you.

Mr. ROWLAND. Thank you, Mr. Randall.

Mr. RANDALL. Mr. Chairman, may I also express my appreciation on behalf of the hospitals in the State of Florida for the opportunity to appear before this distinguished committee.

Florida is one of the first States to enact legislation beginning the health care reform process and the Florida plan was developed to approach health care reform in a comprehensive manner, reforming all aspects of health care financing, delivery, purchasing, and regulation.

In the fall of 1991, the governor of Florida requested that Dr. Leighton Cluff, of the Gainesville VA, distinguished physician, chair the Florida health care work group to develop recommendations for the governor and for the Florida legislature regarding the principles of health care reform.

The Florida legislature then passed the Health Care Reform Act of 1992. Florida's health plan utilizes a market based approach to managed competition to provide universal access, basic coverage, and contained costs. Similar to the President's plan, Florida is community health purchasing alliances and accountable health plans are the operational framework for the program.

In addition to Dr. Cluff's role, the VA has been heavily involved in the Florida health care reform process. With the passage of the State legislation, I began working with the director of the Agency for Health Care Administration, which was created by the new legislation, to define the role that the VA might play in a reformed health care market.

Ms. Kathy Jurado, who is the Assistant Secretary for Public and Intergovernmental Affairs, and I testified in January of this year before both the Florida House/Senate Committees on Health to discuss and outline the contributions that VA was currently making to the health care to the citizens of Florida.

And in my role as the lead director for Florida, I initiated strategic planning efforts to integrate the VA health care program with the Florida health care reform program. In January I appointed a strategic planning committee that was made up of representatives of each of the Medical Centers in the State of Florida, the District Counsel, representatives of the State veterans' service organizations, and the executive director of the State Department of Veterans Affairs so that from day one we would have the involvement of these key people in the planning process. We have already completed our first step in the strategic plan that we are developing.

Your second question about FTE reductions, I agree with Dr. Petzel that we are looking at a short term and a long-term situation here. Over the long haul this reduction might be consistent with where we would wind up as we move to compete effectively.

Over the short term, for the next approximately 5 years, this could be a problem. I do know that the Department of Veterans Affairs is working on this issue. They are attempting to identify new approaches to eliminate FTE without affecting the Medical Centers, the use of contracts such as contracts with medical schools to pay for residents rather than placing them on the VA FTE roles.

In fact we have done this successfully at Gainesville for approximately 15 years and it has not had any impact on health care at all.

But if I were to speak from a hypothetical point of view in view of my lack of knowledge as to how these FTE figures are finally going to come out. I would have to say that if these reductions come, they would have a marked impact on the operation of our Medical Centers and additional FTE reductions over the next 5 years would only further reduce our ability to operate effectively, and it could be necessary to make vertical program cuts.

We realize that VA is not being singled out and that FTE reduction is a part of the government-wide effort to deal with budget realities. On the other hand, if I am going to attempt to respond honestly to your question, then I need to give you at least a hypothetical scenario of what might happen.

And in Florida, for example, the majority of the VA Medical Centers would have to look at decreasing the numbers of acute medical and surgical operating beds. They would have to look at programs that they might consider eliminating.

Florida is in a peculiar situation because over the years, due to the rapid migration of veterans into the State and the relentless increase in health care costs, which incidentally, is one of the reasons why the country cries out for health care reform, health care reform efforts in Florida are going to mean that we need to attempt to take care of an ever increasing population that we in many cases are not adequately taking care of now because of funding.

We, the directors and Chiefs of Staff in Florida, believe that we can compete successfully in a new health care environment. We have the ability to compete based on the excellence of our staff and overall quality of our hospitals, as based on the recent joint commission scores where the VA out scored the private sector.

We can compete on cost. We can compete based on our experience in working with the local global budget and most of all, we feel that the future is now and that we must make health care reform work if the viability of the VA system is going to be maintained. But in order to compete successfully, we need to start expanding our services now and stop reducing our operating capacity and that is why I am concerned about the next 5 years.

Mr. ROWLAND. I guess my time has long since expired. I will come back, Mr. De Gasta to you and Mr. Manley and we will repeat the question if necessary.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman. And Mr. Randall, just to pick up on your ending remarks, both the Chairman and I as well as Members on both sides of this subcommittee are very, very concerned about what those cuts in FTE will actually do when and if they are indeed enacted into law.

The Administration I think has a very misguided policy when it comes to veterans health care, and it is kind of forcing VA into a position where it could over time cease to exist. I think we have to be very cognizant of that. I would ask all of you if you could respond.

As you know, this committee did a very comprehensive study of 154 hospitals and Medical Centers and found that 99 percent said either it would make it impossible for them to compete for patients or would severely restrict their ability to compete under national health care reform, with the cuts and the anticipated 5,000 FTEE in fiscal year 1995.

Is that your sense as well?

Mr. RANDALL. I really don't know right now because I don't know how successful Central Office's efforts to cut in other areas. I know that there are efforts to keep the cuts away, if they can, from the Medical Centers.

I don't know how successful our contracting out is going to be. For example, the example I gave of contracting for residents. We have been doing that as I said for over 15 years at Gainesville, and it has sharply reduced the number of FTE we require. We have got the same number of residents, and it has not cut the quality of service so I don't know how successful that is going to be across the country. I think much depends on how successful their efforts are to take away the impact directly on hospitals, and I think when we finally know how successful those efforts are going to be, then we are going to be in a better position to know just precisely how we are going to have to deal with it.

Mr. SMITH. Would you other gentlemen want to comment on it?

Mr. MANLEY. I and the other VA directors in Washington State appreciated the opportunity to respond to the committee's survey. We don't know how the other Medical Centers in the country replied, but we concluded that given the current restrictions on contracting out for services and the limitations that the Federal personnel system place on us, it would be very difficult for us to adjust to the rapidly changing health care environment in Washington State if we had to reduce staff at this time.

The Washington State legislation requires us to expand services to veterans and to deliver care nearer their homes. It is very hard to do that while at the same time reducing FTE.

We also recognize that the VA is a very large and complex organization, and it is possible that the VA could carry out the administration's FTE reduction mandate in such a way as to minimize the impact on our local operations.

Mr. SMITH. How? Would you enlighten us?

Mr. MANLEY. We do not know how the cuts could be made but, as I say, it is a very big system and our leadership may have ideas that haven't occurred to us.

Mr. SMITH. Very diplomatic answer.

Mr. De Gasta.

Mr. DE GASTA. I think I agree with my panelists. To prepare for health care reform we require flexibility. Flexibility is absolutely essential. We have got to have both legislative and statutory relief to allow us to function somewhat more independently than we have

in the past. I think flexibility is imperative if we are going to be successful.

Mr. SMITH. But the cuts—what impact would they have in your locale?

Mr. DE GASTA. I will try to respond very briefly about the impact. Over the last several years my particular facility, the White River Junction VA, a small rural facility located in northern New England, crafted its budget to develop its ability to favorably position us to deal with health care reform.

Initially our actions were accomplished within existing resources, but with little regard to FTE. The VA has entered a new era of FTE constraint and we are addressing various alternatives to provide quality care to our veterans.

We think we know what is right for us in terms of health care reform within Vermont. We have begun reorganizing our health care delivery system through community outreach—part of a vision which I can talk about if you are interested.

Each of our initiatives, however, requires us to have flexibility. We either have to have VA people, or people purchased by us in the community, to provide services either on a continuing basis or to expand services.

Mr. SMITH. Doctor, did you want to comment?

Dr. PETZEL. Yes. The immediate problem would be great for us in terms of trying to deal with health care reform in Minnesota. We need the flexibility to be able to hire people to do different kinds of jobs than we are doing now.

There are a number of things we need to do I think and I would like to reiterate. In the long term, I think this is something we can cope with. The long term as Mr. Randall mentioned is 5 years. In the short term, we need to have some sort of relief, some sort of flexibility to use our funds in the fashion that we deem best to cope with health care reform.

Mr. SMITH. Thank you.

Mr. ROWLAND. Dr. Kreidler.

Mr. KREIDLER. Mr. Manley, you didn't have an opportunity to comment on just exactly how the State of Washington would integrate the State's health care reform with the VA system.

Would you care to elaborate more on the challenges you face in the State of Washington relative to taking the VA system into the reform that has been passed last year by the legislature?

Mr. MANLEY. Yes, sir. As Congressman Kreidler mentioned, Washington State has enacted very comprehensive health care reform legislation. It is similar to what has been proposed by President Clinton for national health care.

The Washington State law provides universal coverage in a managed competition plan with premium and payment caps. It creates a uniform benefit package, provides subsidies for low-income enrollees, and provides skilled nursing facility, home health, and hospice services.

Beginning in February of next year, the health plans will be certified and they will begin enrolling citizens. Over time, every State resident, including all veterans, will be required to obtain the uniform benefit package from a certified health plan.

The management officials from all of the VA Medical Centers in Washington State have been working together for several months to develop plans and proposals for VA's participation in the reform effort. One of the results of our planning efforts is a draft strategic plan which is currently being reviewed by VA Central Office.

We have concluded that the VA will have to change significantly to be competitive in the new environment and it will take the support of all of our staff to be successful. For example, the VA has traditionally focused on hospital care for those veterans who physically come to our health care facilities.

Under the Washington State reform law, all certified health care providers will be required to provide preventative and family practice care near the patient's home. That is a significant change for VA and will require us to contract with a lot of private family doctors throughout the State.

Mr. KREIDLER. Am I correct in assuming that you have looked at what other States are doing in conjunction with your study and how other VA systems are contemplating integration.

Do you know of any other State that is even close to having a system that is going to guarantee universal coverage employing something like an employer mandate as the State of Washington does? What I am really wondering here aren't you in many respects more under the gun than perhaps other States?

Mr. MANLEY. We believe we are. The States that Dr. Headley mentioned are taking different approaches to resolving their health care difficulties. Most are trying to expand health care to the disadvantaged and are not creating systems that affect the greater population.

Washington and Minnesota are taking comprehensive reform actions that will affect all of their citizenry. For VA in Washington State it means 100 percent of our veterans could be drawn away into the private sector if we are not a full participant.

Mr. KREIDLER. Have you estimated what the impact would be if the VA in the State of Washington remained unchanged and health care reform proceeds unfettered in the State of Washington?

Mr. MANLEY. As in if we were not chosen as a pilot, sir?

Mr. KREIDLER. Correct. Presuming let's say national reform does not take place. The State of Washington like Minnesota and some of the other States were given the authority to continue and the VA system tried to stay as it is presently.

Mr. MANLEY. It is difficult to speculate. What we do know is that in order to enroll veterans, or any citizens in a health plan, we must first be certified by the State.

We need pilot status in order to have the basic tools to become certified. So if we aren't selected as a pilot, we believe that we would not be eligible for certification and would end up being a secondary provider for those veterans who either don't like the care they are getting from their primary system or who are in need of services not included in the primary benefit package.

We would likely become a long-term care and rehab type provider because those services are not part of the uniform benefit package. Our acute care medical and surgical missions and the teaching programs that go along with those missions would be in jeopardy.

Mr. KREIDLER. What kind of support are you getting from the veterans' organizations in the State of Washington?

Mr. MANLEY. I am glad you asked that question. I have personally discussed our strategic plan with the leadership of all the major veterans' service organizations in the State, and they are very supportive of our efforts to make the VA a fully functioning certified health plan.

All of the groups that I have talked with have endorsed our candidacy to become a pilot program and all of them were comfortable with dependents enrolling in the VA plan so long as the dependents do not receive their care in existing VA facilities.

I have received letters from the State commanders of The American Legion and the Veterans of Foreign Wars and the director of the Washington State Department of Veterans Affairs documenting their support of our effort. The leadership of the Paralyzed Veterans of America and the Disabled American Veterans have told me that they are sending similar letters to express their support of our efforts.

Mr. KREIDLER. Thank you, very much, Mr. Manley, and Mr. Chairman may I ask those letters be entered into the record.

[The information follows:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

DEPARTMENT OF WASHINGTON

GEORGE "CORKY" BERTHIAUME
State Commander

BLAINE TEACHMAN, *Senior Vice Commander*
CHUCK VITIRITTI, *Junior Vice Commander*
DON BRACKEN, *Adjutant/Quartermaster*

JANE ADAMSON, *Judge Advocate*
MILES IRVINE, *Surgeon*
LYLE KELL, *Chaplain*

Director
VA Medical Center
1660 Columbia Way South
Seattle, Washington 98108

Dear Sir:

The Veterans of Foreign Wars of the United States, Department of Washington, is extremely interested in lending its full support to your efforts, working with the Federal V.A., to create a viable Health Care Plan for the Veterans of the State of Washington. We also recognize the value, and heartily endorse the concept of having the State of Washington designated as one of the pilot program States at the onset of the Veterans Health Care Plan.

Several members of our staff have reviewed your Strategic Health Care Plan for Washington and our organization endorses your plan as it is presently written. We recognize that substantial additional planning will be necessary to adequately provide for wives and families through contract negotiations with other medical facilities outside of our present V.A. Hospitals.

We understand that your Strategic Plan is the initial basic document for planning purposes, and is subject to revision and modification as circumstances change. We certainly appreciate your invitation to provide input as the process evolves. Our nationally accredited service officers, who represent thousands of Veterans and their families in the State of Washington, are available to provide you any assistance you may request.

Yours in comradeship,

George C. Berthiaume

George Berthiaume, Commander
Veterans of Foreign Wars
Department of Washington

STATE OF WASHINGTON
DEPARTMENT OF VETERAN AFFAIRS
P.O. Box 41150 • M.S. 1150 • Olympia, Washington 98504-1150 • (206) 753-5586

February 24, 1994

Joe Manley, Acting Director
Seattle V.A. Medical Center
1660 S. Columbia Way
Seattle, WA 98108

Dear Mr. Manley: Joe

We are delighted that the USDVA will be a key participant in national as well as state health care reform efforts. This is an essential effort which must be done well to ensure quality care for veterans and their families.

As the advocate for veterans in Washington state, our department fully supports the VA as an integral part of the Washington Health Services Act. Our state's pioneering efforts in health care have received national attention. As a result, we certainly think that Washington is an ideal candidate for pilot study status. It is difficult to conceive a state better suited to accomplish this key task. The empirical data this yields will allow VA to compete as a viable participant in national as well as state health care reform. Every veteran leader we have discussed this with is enthusiastic about this process.

We remain fully committed, supportive and involved with health care reform efforts relating to veterans and family members. We have discussed a number of the "fixes" which must be accomplished. Working together, I am convinced we can do that.

We appreciate our inclusion in the planning process and are committed to working with you on this opportunity and to serving our state's veterans and their families.

Sincerely,

Beau

W.J. "Beau" Bergeron
Director

THE AMERICAN LEGION
DEPARTMENT of WASHINGTON

DEPARTMENT HEADQUARTERS
(206) 491-4373
FAX (206) 491-7442

P.O. Box 3917
Lacey, Washington 98503-0917

TRUCK SHIPPING ONLY
3600 Ruddell Road S.E.
Lacey, Washington 98503-0917

February 10, 1994

Joe Manley
Acting Director
VA Medical Center
1660 Columbia Way South
Seattle, WA 98108

Dear Mr. Manley:

The American Legion, Department of Washington at this time is in support of the VA in their effort to remain a full service health care provider under both the National Health Care reform and the Washington State Health Care Plan. We know that to assure the survival of this very important resource for the veterans we represent, a change in necessary, without a change we risk losing the entire VA medical care system.

We are in the process of reviewing the VA Health Care plan for Washington State. At this time we have no objections to the plan as long as the enrollment of non-veterans under a VA Certified Health Care Plan does not include treatment of these enrolles in VA Medical Centers.

It is understood that the strategic plan is a dynamic document subject to revision with changing circumstances. We intend to take full advantage of your invitation to provide input as the process of adapting to a new and competitive environment unfolds.

Sincerely yours,

Derald Robertson
Department Commander

DR/fl

Mr. ROWLAND. Without objection that—we will come back for further questioning, too, if you have some more.

Mr. Baesler.

Mr. BAESLER. Yes, sir. I understood you all, I think, to say that in the next 5 years if the FTEs—if we were to follow through with the cut in FTEs, your ability to provide the service that you now provide, and your ability to provide the service the States may require, and your ability to provide the services that might—new services for women or for other programs that have been brought forth from this committee and from Congress, might be jeopardized; is that right?

Mr. RANDALL. I think both Dr. Petzel and I said similar things. I am reminded of the old saying that when you are buying a house there are three important things that you must consider: Location, location, location.

And for VA to be able to compete successfully, there are three important things that must be considered: Access, access, access. As it now stands, we have many hospitals and veterans must get in a car and drive 50 miles or 60 miles or ride 100 miles on a bus in order to get to care.

If we are going to compete, we have got to locate around the primary service areas of each single hospital points of access and one of the best ways of doing that is through contracting. If there are providers already in place that we can contract with to provide the initial access, the primary care, and then direct the patient into the tertiary hospital if he needs care.

So over the long haul, we may through this contracting out, which we will be doing in order to improve our access, we may need less FTE than we now have. But I think both Dr. Petzel and I are concerned about the short term. For example, if we are able to contract out all the residents, the house staff salaries that will amount to according to my best estimates about 2,000 positions that FTE can be eliminated right away in the first year.

But then that is a herculean job for our Washington office to pick up those other FTEs over the short haul. But I think long range, we may come out someplace in the same position that—

Mr. BAESLER. The question was in 5 years, yes or no, folks. Five years is all I asked about.

Dr. PETZEL. It would certainly seriously impair our ability with one caveat, we don't know what Central Office is going to do to buffer us from those cuts, but if they distribute the cuts to the hospitals directly without anything else happening, it would seriously impair our ability, correct.

Mr. BAESLER. Thank you.

Mr. ROWLAND. Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

First of all, I want to thank Mr. Randall for being here today. He is a national supporter of veterans' needs, not just Florida, but throughout the country, but I do have a question about Florida.

Florida has one of the most complex VA systems in the country. We have five hospitals, nine satellite clinics, the fastest growing veterans population, and the second largest veterans population over 65. We rank 43rd in per capita in VA funding. I can think of no other State better situated for a pilot program.

Can you give us an idea of how Florida can prepare for a national health care reform without the trial period of a pilot program?

Mr. RANDALL. Well it certainly would be helpful. As you know, Congresswoman Brown, the Florida plan, Florida law looks an awful lot like the President's plan. And so it would be an ideal setting to test the national plan.

And with the complexities that Florida has, if anything is going to go wrong in trying to develop a pilot, it will go wrong in a complex situation such as Florida. So there would be real opportunity to explore ways of doing a better job in delivering health care under health care reform.

Ms. BROWN. Mr. Chairman, I would just like to submit the rest of my statement to the record.

Mr. ROWLAND. Without objection.

[The prepared statement of Congresswoman Brown follows:]

PREPARED STATEMENT OF HON. CORRINE BROWN

Mr. Chairman, thank you for holding this important hearing, and for introducing H.R. 3808, which I am proud to cosponsor.

I would like to welcome Malcom Randall, Mr. Chairman. Mr. Randall as director of the VAMC in Gainesville is enormously knowledgeable about the needs and concerns of our veterans. And I am glad he is here today.

The VA system currently serves 2.7 million veterans, our Nation's veteran population is 27 million. H.R. 3808 is a major step in the right direction, but it will not increase the number of personnel at VA facilities it will only keep it at the current level. Florida veterans already suffer 6 hour waiting periods to receive medical attention. Only through this pilot program proposed here today—and H.R.3808—can Florida adequately care for its veterans.

Let me come back to the question that I had posed earlier that was answered by two members there and, Mr. Manley, I believe that you partially answered my question in responding to Dr. Kreidler, but let me ask you the second part of that question, the impact of anticipated FTE reductions for fiscal year 1995 and the subsequent 4 years. How will that relate to your current mission and to your operations as they might apply to any State reform plan?

Mr. MANLEY. With regards to participating in the State reform effort, it would severely hinder our efforts to adjust to the rapidly changing health care environment. We must create a State-wide umbrella organization this year in order to bring all of the facilities' functions under one roof and to initiate actions like the enrollment of veterans, advertising and conducting actuarial studies.

Any one of these actions would strain our existing FTE ceiling to try to accomplish this new nontraditional work.

If we don't act this year, we are faced with not being a provider in the new environment. If State health care reform were not happening in the State, we could probably deal with the FTE reductions. It is that difference from the rest of the Nation that is hindering us in Washington.

Mr. ROWLAND. It is really an unknown for you?

Mr. MANLEY. Yes, sir.

Mr. ROWLAND. Very well. Mr. De Gasta, shall I repeat the question?

Mr. DE GASTA. I think I understand the question, Mr. Chairman.

Mr. ROWLAND. Very well.

Mr. DE GASTA. Let me comment about where we are in State health care reform in Vermont, a very small rural State. Our initial activities in White River Junction actually began with the State of Vermont back in 1988.

For all intents and purposes active participation with the State of Vermont began in March 1991, when the governor of Vermont appointed a blue ribbon commission on health care reform.

He then charged the Health Policy Council, where we had a VA physician representative, with crafting a health care resources management plans for the State of Vermont. In 1992 with the passage of the Health Care Reform Act 160, the Vermont legislature established a Health Care Authority and charged that authority with submitting a plan for universal access to health care under a global budget to the 1994 legislature, the current legislature.

The charge by the governor was to develop both a single payer and multiple payer plan. In the 1992 meeting with the governor's staff we, the staff of the White River Junction VA, were informed that our traditional VA organizational structure—having all our patient care facilities and services concentrated in a single campus—was totally incompatible with the State models of universal access and access to primary care within 30 minutes.

We quickly realized that if we were going to formally position ourselves with health care reform in Vermont, we needed to develop veterans' access points to the White River Junction VA in various locations throughout our primary service area which also includes the State of New Hampshire.

Over the next 2 years we responded and created a satellite clinic in Burlington, VT, some hundred miles from our parent facility and secured a mobile health van. Working with county mental health agencies within Vermont and New Hampshire, we outbased VA psychiatric providers through sharing agreements with these mental health facilities—securing space in exchange for services provided by our providers. We also created sharing agreements for after hours alcohol counseling. We accomplished all this within existing resources and existing FTE, and through medical resource sharing agreements.

In 1993, the Health Care Authority began to use the Health Policy Council, where we had a VA member, to get involved in the Vermont health care plan. In April we met with the governor and were challenged by him to earn a place in the Vermont health care plan by offering quality and cost-effective services to Vermont veterans.

In November the report of the Health Policy Council included language referencing the White River Junction VA. We were very, very pleased to see that bill go forward to the Vermont legislature for debate. However, the governor chose to submit his own draft of the health care reform legislation which did not include the VA.

In January 1994, members of our staff, including a representative from the VA Central Office, gave testimony on the VA before the Vermont Special Committee on Health. Other members of our professional staff were invited to testify before the State Health and Welfare Committee on the topic of geriatrics.

This past February, our VA veterans service organizations and their dependents gave testimony to the House Special Commission

on Health Care during a standing room only hearing at the State house in Montpelier, VT. In March 1994, the revised version of H–645, the governor's Universal Access to Health Care Bill, was submitted to the legislature for debate. The bill contained special language requiring the Vermont Health Care Authority to submit recommendations integrating the VA Medical and Regional Office Centers and the Vermont health care system. We are very, very pleased with that legislation.

The issue I raised earlier was about our vision. Let me share with you just for one moment, if I may, what our vision for health care in the State of Vermont might look like. The White River Junction vision for health care delivery in Vermont, and our State health care strategic plan, was recently submitted to the VA Central Office. It is very comprehensive, but relatively simple.

We want to become an independent health care plan for Vermont veterans. We would like to create primary access points to the VA health care system throughout our primary service area through establishing community-based outpatient clinics. We propose to optimize utilization of our existing White River Junction programs—our mobile health van, our Burlington based outreach facility and our psychiatric program. We want VA psychiatric providers out based in local mental health facilities to continue their role and we want to expand that role to include medical activities.

Local arrangements would entail primary care providers referring veterans to the White River Junction campus for secondary and high tech care. The VA White River Junction campus would provide all the services possible. Where services were unavailable at White River Junction, they would be secured from the VA system, as we currently do, or through our affiliate or non-VA facilities, or in our local community. If authorized, the Department of Veterans Affairs overall plan for caring for VA dependents could be provided within, or outside the VA system, by using VA salaried employees or by using contract people. We envision doing pretty much what we are doing now with the flexibility of purchasing additional services within the community and having those resources available to accomplish that care.

I might add one final comment. The Vermont health plan includes the following: the overarching principles of universal coverage, global budget, portability of service, uniform benefits, control of capitated expenditures, binding caps on expenditures and of course access to primary care within 30 minutes.

Thank you, Mr. Chairman.

Mr. ROWLAND. Thank you, Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

If you would all consider answering this question: If waiver authority is granted to allow the VA participation in your State, what assurances do we have that you will continue to provide services to veterans which may be outside the basic benefits package. Perhaps put another way, is it possible that in the quest to be competitive that this might lead to a diminution of services for the treatment of blindness, blind rehabilitation, prosthetics, spinal cord, and the like?

Mr. MANLEY. Do you want to begin with me?

Mr. SMITH. Yes.

Mr. MANLEY. Yes. We would not allow that to occur. Those programs are something that VA does best and we would be foolish to jeopardize those.

Mr. SMITH. Thank you.

Mr. DE GASTA. I think we would have to set our priorities and provide those services which our patients, our veterans, our customers demand and require.

Mr. RANDALL. I think probably VA would be the only setting in many places where those services could be provided and therefore I think it is a moral responsibility to provide them. However, I think that in 5 years, we are going to be competing well enough and gathering enough money from people who are not now using our system. Of the over 27 million veterans, only 2 million of them are using the VA system.

I think we can compete well enough to attract a lot of those people into our system, start collecting money through the health alliances so that we won't have to make those kind of choices. I look down the road where we can be expanding services and offering better and additional services.

Dr. PETZEL. I think those services in our institution—traumatic injuries are an example—are things that define us as being unique and better in the community. There are going to be services that we think are going to be desirable. Oh, no, I think that it will not happen. I think contrarily, that some of those that we see as being unique service for veterans are going to become assets in the community.

Mr. SMITH. Thank you very much.

Mr. ROWLAND. Thank you. I have just one additional question. Maybe we will have some to submit for the record. There seems to be a belief out there that large companies like IBM or Kodak, or even the Housing and Urban Development, are able to cut thousands of employees. Well, why can't the veterans' centers do that as well? I think medical care is a little different from those, though. What kind of judgments do you have to make when you are told you are going to cut your employment by 2 percent each year for the next 5 years? Everyone want to pitch an answer on that? Dr. Petzel.

Dr. PETZEL. First of all, I hope that isn't going to come to pass. It would be a very difficult thing to do and I think if we were asked to cut 2 percent, again speaking hypothetically, of our employees per year over the next several years we would have to reduce services and we would have to make choices as to what types of services we did or didn't want to provide or we would have to contract out as an alternative. If the money didn't disappear, if we would still have the money, we would have to quickly look at ways to contract for services.

Mr. RANDALL. First of all, Mr. Chairman, I agree with you that we are not the same as IBM and Xerox. It is different but I also think that VA is extremely efficient as it is right now. And I don't think we have got all those many jobs around that are surplus to our needs. If, however, that should come to pass and, as Dr. Petzel says, if the money doesn't go away we are going to have to look at alternatives to providing the service.

Right now, for example, in Gainesville, our strategic planning committee, which is composed chiefly of clinicians, are looking at options of what we might do, how we might deal with this eventuality if it really comes about. We are going to have to make the hard choices about what are the services that are the most important.

Mr. ROWLAND. Very well. I want to thank all of you.

Do you have any additional questions?

I want to thank all of you very much for being here. It seems to me I am hearing you say that these FTE cuts are going to be very difficult to contend with in any health reform that is coming insofar as the ability to compete is concerned. And that it won't just be streamlining that will take place but we will actually lose the ability to provide services to veterans. Thank you very much, gentlemen. I appreciate your testimony.

Mr. ROWLAND. The next panel will consist of Frank Buxton, who is Deputy Director of the National Veterans Affairs and Rehabilitation Commission, The American Legion; Dave Gorman, Deputy National Legislative Director, Disabled American Veterans; James Magill, Director, National Legislative Service, Veterans of Foreign Wars; Michael Brinck, National Legislative Director, AMVETS; Russell Mank, Legislative Director, Paralyzed Veterans of America; Paul Egan, Executive Director, Vietnam Veterans of America; Tom Miller, the Director of Governmental Relations, Blinded Veterans Association.

Gentlemen, I want to thank all of you very much for being here. I would ask that you limit your oral presentation for 5 minutes. Your entire statement will be made a part of the record.

STATEMENTS OF FRANK BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; DAVE GORMAN, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; JAMES MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; MICHAEL BRINCK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; RUSSELL W. MANK, LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; PAUL EGAN, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA; AND TOM MILLER, DIRECTOR OF GOVERNMENTAL RELATIONS, BLINDED VETERANS ASSOCIATION

STATEMENT OF FRANK BUXTON

Mr. BUXTON. Good morning, Mr. Chairman and subcommittee Members. The American Legion appreciates this opportunity to comment on H.R. 3808, the legislation to preserve the VA's flexibility in meeting its medical workforce needs, and on the draft legislation entitled "The Veterans' Health Care Pilot Program of 1994."

I am going to go away from my prepared text for a moment, Mr. Chairman, to express my amazement at the complacency that we have heard from the Department of Veterans Affairs this morning in regard to cutting 25,000 of their employees over the next 5 years.

I am sitting here in amazement. I have never been speechless before this subcommittee before but I am working on it. I would like to know what this committee and these VSO representatives have been fighting for all these years to keep the VA viable. Contracting out services only allows the VA to divest itself of the FTE; it doesn't do anything to decrease their cost. In fact, it might even increase it.

With that being said, I will go back to my text.

At a time when the VA anticipates implementing the most radical change in VA health care delivery system in its history, the next several years will be crucial to the viability of this most valuable resource. The Veterans' Health Administration will be required to reshape itself in a way so as to attract veteran enrollees and to deliver services and competition with the private sector. This is certainly not the time to be cutting personnel or funding resources. The VHA's delivery system must be given every opportunity to thrive and to survive.

Although the National Performance Review, with its emphasis on streamlining and reengineering and simplification, the Federal Government must be taken seriously. To impose personnel cuts on a health care system which has, at best, the personnel capacity to serve veterans at a current level of care, let alone any increases in types and amendments of services under health care reform, defies logic.

On the one hand, there is an express commitment to strengthen the VA health care system to operate in a competitive environment while on the other hand diminishing the very resources which will allow that to happen. If that occurs, it is simply tilting the playing field in a direction which would cause the VA to fail in its new mission. Mr. Chairman, the VA must be exempt from the resource cuts imposed by the NPR.

We wish to put forth our comments on the draft legislation entitled "The Veterans Health Care Pilot Program of 1994." The legislation would allow VA to be a participant and a competitor in States which have enacted State health care reform legislation in anticipation of, and prior to, national health care reform. Failure to remove the administrative encumbrances which would cripple VA's ability to survive in a competitive environment would be a disaster.

With a few changes, Mr. Chairman, The American Legion could support this legislation. We believe, however, that the legislation should: One, permit the creation of a revolving fund seeded by appropriate dollars separate and distinct from normal appropriations and allow such a fund to exist on a no-year limitation basis and also to allow the funds collected for health care delivery to be deposited in such a fund. We have concerns about tapping regular medical care or construction account appropriations. This mixing of disbursements and receipts could cloud the determination of the true program costs. However constructed, the ability to determine the costs versus expenditures for such a program must continue to exist.

Number two, the application of a pilot program to all VA facilities within the State affected, without limitation on the number of States involved, by selecting only certain facilities within certain

States we would fragment the delivery of care—confuse our veteran beneficiaries and create unequal levels of care for veterans that may be affected. And, third, that the caveat that the Secretary of Veterans Affairs should have the discretion to determine in which States the pilot program would be initiated must remain.

Mr. Chairman, The American Legion would reiterate its concerns that certain veterans might be disenfranchised by the provision which allows families of veterans to enroll and receive benefits in VA plans. We agree that there is a chance that some veterans may not choose the VA as their health care plan if their families can't enroll as well. However, since all persons who wish to receive care in the VA must enroll in the program, and the fact that all veterans are entitled to enroll, the opportunities for disenfranchisment seem greatly diminished. That notwithstanding, the Secretary's assurance that nonveteran care will be contracted to other plans or providers until the capacity and the demand for services in VA have been determined must prevail.

The VA must move quickly to define benefit packages to be offered, the cost of the premiums and the co-pays as soon as State health care reform programs are enacted.

Mr. Chairman, we conclude with our statement of trust in this committee and this subcommittee and in VA and in the veterans' organizations that VA's transition to an efficient, cost-effective and competitive force in this amazing time of change will receive the needed support every step of the way.

Thank you, Mr. Chairman. That concludes our statement.

Mr. ROWLAND. Thank you. I think we will just move down the line from your left to your right.

[The prepared statement of Mr. Buxton appears on p. 56.]

STATEMENT OF DAVE GORMAN

Mr. GORMAN. Thank you, Mr. Chairman. Good morning.

I would say at the outset, Mr. Chairman, that it is the DAV's belief that the series of hearings over the years regarding the status of the VA health care delivery system and its need for reform have now laid a solid foundation and in many ways have set the stage for this morning's hearing. We believe that the draft legislation, which is before the committee today, when put in final form and if enacted would represent the first genuinely tangible effort, from the legislative viewpoint, toward moving the VA into an era of health care reform.

Mr. Chairman, the DAV believes it absolutely critical that VA be given broad innovative authority and flexibility for the dual purpose of launching mini reform pilot projects in those States that have enacted their own version of health care reform in advance of any national reform package being put in place.

Also, we believe VA must be allowed to move in tandem with the States in their varied reform efforts. VA will, in our view, gain a great deal of experience from these pilots which may be extrapolated then throughout the rest of their health care delivery system.

We feel it crucial to the long-term successes of the VA, and therefore to the pilot program, to have a board of directors at each facility participating in a plan for the purpose of continued dialogue and participation with VA in the delivery of health care services

and the conduct of the pilot programs. We would, therefore, suggest perhaps clarifying language be inserted in Section 3 of the draft legislation that would direct the creation of such a board or advisory committee to the facility directors for the express purpose of establishing a firm collaborative partnership providing ongoing dialogue between the facility management, providers, veterans and other interested consumer groups.

Mr. Chairman, as we understand it, veterans defined in Section 1710(a) of Title 38, who now receive health care services from VA would incur no liability for the payment of premiums, deductibles or co-payments in conjunction with the pilot programs.

Also, VA would maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord injuries, blindness and mental illness.

Again, we feel some clarifying language or report language is necessary to better define and strengthen the intent of this provision. The intent, we believe, is to assure those veterans afflicted with serious disabilities and/or disabilities in which VA possesses expertise to continue to be able to provide those services to veterans.

In addition to the conditions listed, we would add to that list disabilities in situations involving veterans suffering from conditions or maladies such as posttraumatic stress disorder, homelessness, the broad category of veterans utilizing the services of the VA Prosthetic and Sensory Aid Service and other areas where VA has a demonstrated level or degree of expertise.

To simply have VA say they will continue those programs gives us little comfort, Mr. Chairman. Section 4 of the draft legislation would establish in the Treasury a revolving fund for the conduct of the pilot programs. Additionally, the Secretary would be authorized to transfer funds from the medical care appropriation and construction accounts to the revolving fund which are determined necessary to carry out the programs.

Mr. Chairman, as we understand the proposal, funds received by VA by reason of furnishing health care under the pilot programs from an individual, other agency or department of the government, or State or local governments, or health care provider, health care plan, or other entity would be deposited in the revolving fund. Those funds would then be made available for the continuing use in providing care under the pilot program.

While we are generally supportive of the basic concepts and intent of the pilot programs, we would offer a note of concern and caution regarding the transfer of medical care funds. Certainly, we urge diligence on the part of VA and the appropriate oversight to ensure any transferred funds be used prudently and only for the express purpose of successfully conducting the pilot programs.

Mr. Chairman, in regard to the other piece of legislation on the agenda, H.R. 3808, we believe the bill has as its intended purpose providing VA with increased flexibility in meeting the workforce needs of their health care delivery system. Section 2 would prohibit, during the five year period beginning October 1 of 1994, the reduction of full-time equivalent employees in VHA other than as specifically required by law or the availability of funds.

Also, and importantly, we believe, VHA would be managed on the basis of needs of eligible veterans and the availability of funds. Mr. Chairman, we are supportive of this provision.

As we stated earlier, Mr. Chairman, while we agree and are supportive of the need for reform of the VA health care system, we do nevertheless have concern regarding Section 3 of H.R. 3808. Quite frankly, as adopted by the delegates to our most recent national convention, DAV resolution number 222, by which we are bound, opposes further contracting out of services currently performed by Federal employees. I would add, however, Mr. Chairman, that the genesis of that resolution was to oppose the concepts embodied in OMB circular A–76 which has as its intent the privatization of much of government. In tandem with such intent, it would, of course, mean the loss of Federal employment of countless disabled veterans.

Mr. Chairman, that concludes my oral remarks.

[The prepared statement of Mr. Gorman appears on p. 60.]

Mr. ROWLAND. Thank you very much.

Mr. Mank.

STATEMENT OF RUSSELL W. MANK

Mr. MANK. Mr. Chairman and Members of the subcommittee, the Paralyzed Veterans of America appreciate this opportunity to testify with regard to H.R. 3808, legislation to preserve VA's flexibility to maintain its medical care workforce, and draft legislation to authorize a pilot program for VA participation in State health reforms.

Mr. Chairman, PVA strongly supports H.R. 3808. This bill would prevent a devastating loss of personnel from the Veterans' Health Administration at the very time VA is attempting to marshal all of its resources to compete and survive in a reformed national health care system.

Due to budget shortfalls and subsequent loss of staff over the past 12 years, the VA health care system has already sustained a major erosion in its infrastructure, equipment base and service delivery capacity.

In essence, we offer our full support behind the eventual passage of this bill. In the interest of time, Mr. Chairman, I would like to spend the rest of it discussing the pilot program.

PVA supports the concept of establishing a pilot program. However, Mr. Chairman, PVA has identified three areas of concern in the process of designing pilot programs to allow VA to interact successfully and survive under individual State health care reform initiatives. These areas of concern are: (1) Designing an adequate benefit/eligibility package, while at the same time maintaining the VA's ability and willingness in those States to provide the traditional additional benefits, such as care for spinal cord injury and dysfunction that have been unique in the VA system; (2) Determining how the service area of the facility will be drawn in order to establish who will obtain benefits; and (3) Defining how and from what source these pilot programs will be funded.

I would like to address, for the rest of my time, the first point of providing authority for VA facilities under these circumstances.

To offer a basic benefit package will, for many veterans, grant services they had not previously been eligible to receive. But basic benefit packages, whether under a State reform plan or under a national reform scenario, will also set limits on the amount of services VA facilities can provide. Various reimbursement scenarios from third parties, State or Federal entities, will drive individual facilities to provide services only up to the authorized level. Appropriations, under any reform plan, would still be used to cover the additional benefits, over and above the basic package.

Such services include specialized rehabilitation, prosthetics, sustaining and long-term care for veterans with spinal cord injury and dysfunction, specialized care for other veterans with severe disabilities, blinded veterans, and extended mental health services that are unique to the VA system.

PVA is concerned that the drive for costs containment and competitiveness, coupled with an erosion in the availability of the appropriated dollar, will entice individual VA Medical Centers to shrink their benefit package to the lowest common denominator and to abandon and discard these additional services, viewing them as a burden and not a traditional obligation of the VA mission.

Over the years, the VA has established a comprehensive network of centers for the treatment of veterans with spinal cord injury and dysfunction. The centers have forged a cadre of health professionals trained in specialized care. Abandoning such a system would be a catastrophe for the VA as well as a tragedy for the veterans who look to the system to receive this specialized care.

We are aware that the eventual demise of the SCI system was raised in positive tones more than once at the recent VA health care reform task force meeting in Washington. Abandoning these and other specialized services, which would be over and above any State or Federal basic benefit package, seems to PVA to be an alluring temptation for any VA Medical Center director looking to cut costs and become more "competitive."

There is no mention or authorization in Title 38, USC, for care for veterans with spinal cord injury or dysfunction nor is there any reference to the existence of the VA SCI centers. We firmly believe these and other specialized programs are in danger under any health care reform scenario.

PVA strongly recommends that the committee include a specific mandate for the continuation of these specialized services in both the legislation that authorizes the State pilot programs as well as the final version of the national health care reform bill.

Mr. Chairman, I could address the other two topics but in the interest of time, that concludes my statement. Thank you.

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

Mr. ROWLAND. Thank you very much.

Mr. Brinck.

STATEMENT OF MICHAEL BRINCK

Mr. BRINCK. Good morning, Mr. Chairman.

As you know, AMVETS has indicated its general support to the President's health plan, and that support was based largely on its accomplishments of the eligibility reform requirement. That is what we have been speaking to for years.

But what we didn't sign on to was the across-the-board personnel cut that the Administration is now proposing that we think will put VA in a position to fail in its transition to a competitive marketplace. Chairman Montgomery could not have been more correct when he said that it was ironic that the President's bill would give VA more flexibility in personnel management decisions but OMB on the other hand would cut the workforce by over 20,000 in 5 years. To us, it seems the only flexibility being given to managers will be to make it easy to fire, not hire.

At the risk of oversimplifying the cuts, VHA currently employs about 1,400 personnel for each Medical Center in the system. A 20,000 cut in staff means that, without increased contracting to offset those losses, VA will experience a drop in treatment capacity equivalent to about 15 nominal hospitals.

Chairman Montgomery has introduced H.R. 3808 to exempt VHA from personnel cuts during the national health care reform transition and we enthusiastically support the bill because VA faces sufficient challenges without significantly downsizing the workforce at the same time.

While the bill will not prevent the Administration from slashing VA payrolls as required by law or budget, it will require VA contractors to give some priority to former department employees as well as directing VA to assist displaced employees in obtaining other Federal positions or retraining programs.

AMVETS understand that the bill in no way intends to place nonveteran VA employees on an advantageous or level footing with its veterans who may be displaced by contracting. Therefore, to clarify the intent of the bill, we suggest the additional of language that would reiterate the need for businesses with Federal contracts worth $10,000 or more to comply with the requirements of USC 38 4212 to "take affirmative action to employ and advance the employment qualified special disabled veterans and veterans of the Vietnam era."

Further, all Federal agencies, especially VA, bear some responsibility towards monitoring contractor compliance with veterans' hiring priority law. Therefore, we ask that the bill be modified to require VA to submit annually to Congress a list of contractors meeting the $10,000 threshold, along with VA-certified copies of the contractors' VETS 100 reports. It is time to take the requirements of 4212 seriously and VA must take the lead.

While contracted care certainly has its place in regions where VA has no presence, or as a transitional method to provide care while VA expands its internal primary care network, or for scarce medical specialty services, it must not be allowed to largely replace the VA system. Keep in mind that beyond its primary mission to care for veterans, VA's secondary missions of DOD backup, national disaster response, research and development and education all require a critical mass of personnel and facilities to retain any credible capability in those areas.

For instance, VA treated over 20,000 people following the Los Angeles earthquake. Outside of DOD, what Federal resources could have been mustered if VA did not exist? We also understand that VA's experience in fee-for-service treatment of veterans is significantly costlier than in-house treatment. Therefore, we support a ju-

dicious use of an integrated network of VA facilities as well as contracted services to increase the treatment capacity of the new VA system.

The draft bill does not appear to place geographic limits on catchment areas and we support that concept because many centers have traditionally treated veterans from many States. Obviously, that will cause funding issues and we urge VA to find a way to accommodate its traditional catchment areas or catchment veterans under the same rules, if at all possible.

We also support the provisions that require the Secretary to include consideration of his sharing agreement authority when making the determination of the competitive damage to VA care.

We support the appropriation of an amount to establish a revolving fund for the pilot program. Additional costs for the pilot program should not come from an already strapped baseline. While we support the concept of a central revolving fund, local facilities must be allowed to retain some portion to test the effect of those additional funds on local operations.

And we fully support Section 5 provisions to ease contracting requirements, as well as allowing VA to help carry out traditional private sector functions like advertising and marketing.

Mr. Chairman, once again AMVETS would like to thank the committee and its staff for holding this hearing and that concludes our statement.

[The prepared statement of Mr. Brinck appears on p. 71.]

Mr. ROWLAND. Thank you.

Mr. Magill.

STATEMENT OF JAMES MAGILL

Mr. MAGILL. Thank you, Mr. Chairman.

H.R. 3808 introduced by Chairman Montgomery would provide VA flexibility in meeting the workforce needs of its health care system. This legislation, unfortunately, was prompted due to the fact that the Administration is proposing a reduction of 4,000 employees in the VA health care delivery system during fiscal year 1995.

We believe such a drastic employee cut would undermine VA's ability to fulfill its anticipated role in health care reform and the treatment of veterans in general. Now is the time that VA should be increasing its workforce to meet its increasing work load. Especially so if VA is to be competitive in national health care. It is now, however, being asked to do just the opposite and do more with less.

I would also like to share comments of my colleagues with respect to VA's response to this question. VA stated that most of the cuts would come from nonhands-on health care personnel. VFW is totally committed to a uniform team working at VA and certainly support staff are just as important as the physicians and nurses who treat our Nation's veterans. We do, of course, support H.R. 3808, applaud the Chairman for its introduction, and urge its quick enactment.

In your letter of invitation to this morning's hearing, we were also asked to offer our comments on the draft proposal that would authorize a pilot program for VA participation in State health reforms. VFW has long maintained that VA must be encouraged and

allowed to be as competitive as possible with other health care systems at the same time keeping with its traditional role of caring for our Nation's veterans. This is particularly true if VA expects to be the health care provider of choice for our Nation's veterans.

As national health care reform is being debated here in Washington, many States have not waited to see the final product but have instead implemented their own health care reform plans. While the draft proposal before us today does appear to allow VA to be competitive in five States which have their own health care reform plans, there are several areas of concern that VFW has with this pilot project.

VFW is particularly concerned with the potential problem that may arise with respect to the catchment area of a VA pilot project facility. There is the distinct possibility that a VA medical facility, which is participating in the State health care reform program, will be able to offer enhanced medical care to veterans who live within that State. And in many cases, certain VAMCs draw veterans from other States where there is no VA Medical Center within a reasonable traveling distance.

For example, as we heard today, the White River Junction, VT, VAMC also treats veterans residing in New Hampshire. In this particular case, identically service-disconnected disabled veterans being treated in the same VA Medical Center could receive varying degrees of treatment.

One other area that I would like to comment on of concern is with respect to the treatment of dependents. The delegates to our most recent national convention adopted VFW Resolution No. 633, which supports the Secretary's decision to oppose the treatment of dependents in VA Medical Centers for whatever reason when veterans are being turned away. Therefore, we cannot support this provision of the draft bill.

As stated previously, the VFW maintains and encourages VA to be as competitive as possible in its participation of health care reform. We have stated this on a national level and certainly believe it holds true on the State level as well. We look forward to working with you in the drafting of final legislation on this issue.

This concludes my statement. I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Magill appears on p. 75.]

Mr. SMITH (presiding). Thank you very much, Mr. Magill.

Our next panelist will be Tom Miller.

STATEMENT OF TOM MILLER

Mr. MILLER. Thank you, Mr. Chairman, and good morning to the subcommittee.

The Blinded Veterans Association appreciates the invitation to participate in this hearing this morning to present our views on the legislation under consideration, H.R. 3808, a bill that would provide increased flexibility for VA to meet its medical workforce needs, the health care delivery system, and the draft legislation prepared by Representative Rowland and his staff that would establish the Health Care Pilot Programs Act of 1994.

Frequently in the past, Mr. Chairman, organizations like ours have come before this committee and others urging enactment of

certain legislation. Seldom, however, has there been the urgency that I think is present today regarding the future of the VA and its ability to participate in a competitive health care environment.

As we know, national health care reform has taken center stage here on Capitol Hill, but as Mr. Magill just indicated, many of the States have already moved past that phase and are about to implement or are in implementation stages of their own health care reform.

The VA must be allowed the flexibility to be an active participant in these State health care plans. We believe that involvement in those State plans would be excellent laboratories for the VA to gain the necessary experience to be a viable competitor in any national health care reform plan that should eventually be adopted.

Fundamental to this certainly is the VA be retained as the health care delivery system for an independent health care delivery system for our Nation's veterans. BVA supports passage of H.R. 3808.

I was equally amazed, as Mr. Buxton this morning, listening to the VA witnesses regarding the potential impact of FTE reductions in the coming fiscal year and over the next 5 years. It occurred to me that as the VA is preparing for national health care reform, and indeed local or State health care reform, any reductions in staffing levels, it would be devastating to them. And arbitrary reductions in FTE, and then developing a plan to fit within those, is all too typical of how the VA has operated in the past. Arbitrary ceilings and floors have been established and then they have got to develop some kind of a program to fit within those.

Needs should be driving the FTE level, the workforce level rather than numbers. Health care reform, I think, provides an excellent opportunity for VA as they become competitive and they should not need someone standing with a club over their head to encourage them to be competitive. They will be forced to make management efficiencies and take steps to become and to continue to be competitive if they wish to survive.

Certainly BVA strongly supports passage of H.R. 3808. Failure to exempt the VA from the NPR requirements would be devastating and certainly a prescription for the rather rapid phase out of the VA health care system, as we know.

BVA is also supportive of the draft legislation for the Health Care Pilot Programs Act of 1994 in concept. We have several concerns as have been indicated by several of my colleagues already here this morning related to funding in service areas, and I would particularly like to identify with the concerns raised by PVA over the future of the special disability programs.

Again, I heard mixed messages this morning from the panel of VA representatives from the various States and at one point during the questioning, one or more of the directors indicated that reductions could indeed force them to reduce or eliminate special programs. Later in their testimony they talked about how great the special programs were and they showcased them as being what the VA does best and that they would not in any way consider eliminating those programs.

Obviously, you can't have it both ways. We feel strongly, as PVA does, that there needs to be a strong mandate in any legislation to

ensure the continued viability of these special disability programs. While blindness is a low incidence disability, it is interesting to note that the blinded veteran population is increasing at a time when the overall population of veterans is decreasing. VA cannot manage their existing work load for blinded veterans in terms of providing blind rehabilitation and any further constraints on their staffing levels is only going to exacerbate an unacceptable situation that currently exists.

In terms of the funding concerns related to funding, we believe that some of the revenues that are collected at the local level, be it State or local facilities, should be retained at that level while the remainder would go into a revolving fund. We have serious concern about providing discretionary authority to transfer funds from the medical care account or construction accounts. There aren't sufficient funds there to manage the system as it is currently configured and my time just ran out.

Thank you, Mr. Chairman.

Mr. SMITH. Mr. Miller, you want to continue just to conclude? Please do.

Mr. MILLER. I was right at the end anyway, that generally we certainly enthusiastically support passage of H.R. 3808 and would eagerly look forward to working with this subcommittee and the VA to polish the pilot draft, and I think it is incumbent that that be done yesterday; as we heard from the director from the State of Washington, they have to have a comprehensive plan ready to go by February 1 of next year. That doesn't leave them much time to take care of the things they need to do to get ready to participate in the competitive environment.

Thank you, Mr. Chairman.

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

Mr. SMITH. Thank you for your testimony.

Our next speaker, Mr. Paul Egan, Executive Director, Vietnam Veterans of America.

STATEMENT OF PAUL EGAN

Mr. EGAN. Thank you very much, Mr. Smith.

I think it is important to place both of these bills, both H.R. 3808 as well as the draft bill, in some sort of context. On one hand, we have a proposal from the President for health security that offers, unlike any other plan that is floating around Capitol Hill, the VA an opportunity to remain an independent agency; offers the opportunity to remove a variety of complicated and extremely troublesome eligibility criteria. It recognizes the importance of competition and asks the VA, in essence, in order to survive, to take care where the veteran is, which necessarily means contracting for health services.

On the other hand you have got an OMB that inserts into the fiscal year 1995 budget proposals to drastically cut back on VA health care personnel. H.R. 3808, I think, properly authorizes the Secretary as he deems appropriate to maintain current staffing levels.

The provisions within the bill that relax regulations on contract authority I suppose have to be read in a couple of different ways. I think if I were OMB I would read that to mean that we can just

willy-nilly cut back on VA health personnel. However, from a policy standpoint, and it might be well to modify this bill in some way to more specifically identify what kind of contracting we are talking about, it is important with or without national health reform that VA affirmatively begin to contract, begin to engage in sharing arrangements so that the care can be made available where the veteran is. Someone earlier identified the problem with VA as access, access, access. That couldn't be more true.

It would seem to us with the draft bill that it is self-evidently necessary to give the VA in those States flexibility in creating pilot projects that will permit it to compete in those States where reform is already in place.

We would comment, however, on the part of the bill that discusses the funding mechanism, the revenue that is generated in these pilots. We think that what is appropriate in these pilots is also appropriate at the national level and that is that the lion's share of revenues generated by people choosing to get their care at the VA ought to be kept at the level of the pilot or the level of the plan.

Certainly, some amount of it ought to be used for marketing and perhaps some other things, but making sure that the funding stays with the entity that is competing successfully makes sense to us and in the process avoids the possibility of political monkeying around with these funds and avoids the possibility of rewarding plans that are losers.

It is disappointing to look at the proposal in the 1995 budget on VA health care personnel because the promise from our perspective of the President's plan is great. It is hard to think of a time that was more exciting than the weeks that several of us spent with over 200 VA employees that were brought into town and divided up into 19 different work groups essentially attempting to come up with a plan using the Clinton proposal as an assumption as to how the VA can find a way to survive in a competitive environment.

The spectacle of watching VA employees embrace the idea of competition, embrace the idea of being cut loose from some of the regulatory constraints, but then the proposal in the budget comes that essentially says, well, in spite of what we said about you being an independent agency, in spite of what we said about your ability to compete and how we are going to help you, we are going to cut your personnel.

And that is at least one reason why in our testimony we have articulated a position, a proposal, if you will, calling upon the VA in the national health environment to compete not only for middle income paying customers but also for the service disabled that the system was created to serve.

The question has to be asked and an answer has to be given, what happens in a national health environment if VA doesn't make it? Once a program goes through the congressional meat grinder it isn't at all clear what it is going to look like. It isn't at all clear whether the VA is in fact going to be part of this plan. It isn't entirely clear whether VA is going to be placed in a competitive position on a level playing field. That being so, we think that it is especially important as part of whatever develops in national health,

what program, that we look to the future in order to protect the availability of free care for the service disables.

That concludes my testimony.

[The prepared statement of Mr. Egan appears on p. 82.]

Mr. ROWLAND. I want to thank you very much. We have some additional questions that we will want submitted for the record and we would like to have you answer.

(See p. 162.)

Mr. ROWLAND. I guess what I am hearing from you as well is that the VA is not going to be competitive if these kinds of cuts do take place. Is that what I am hearing from you, all of you?

Mr. MAGILL. Yes, sir.

Mr. EGAN. Yes, sir.

Mr. ROWLAND. Does anyone disagree with that statement. Very well. I just wanted to get that as part of the record. I thank all of you very much for being here.

Mr. SMITH. Mr. Chairman, I have a question.

Mr. ROWLAND. I am sorry.

Mr. SMITH. I will just ask one and submit the others for the record as well.

As you know, Mr. Chairman, during reconciliation last year, the veterans' service organizations very adamantly and very wisely opposed shifting the costs of service-connected care to insurers. My question is, do you believe that employers should now bear the cost of that care? We are talking about service-connected—disabled veterans being paid for, or their care being paid for by way of an employer mandate. Do you agree with that or disagree with that?

Mr. BUXTON. Mr. Smith, we certainly can say that the government has a responsibility. The United States Government has the responsibility for the service-connected care for the disabilities. We would think that would be improper to transfer that responsibility to somebody in the private sector.

Mr. GORMAN. IBM or Kodak or General Motors doesn't make veterans. The Federal Government and its policies created veterans and therefore the Federal Government has the responsibility to continue to fund the cost of care for service-connected disabilities.

Mr. MANK. PVA concurs with both of those statements.

Mr. BRINCK. So would AMVETS.

Mr. EGAN. Well, the short answer is the Vietnam Veterans of America concur as well. It is important to point out for the record, after all, despite the fact there are a variety of different classes of individuals in this country laying some claim to Federal resources, there is no other class besides disabled veterans who can more squarely lay the reason for their disabilities at the foot of the Federal Government, and so the care of those individuals must be paid by the Federal Government and that, we believe, is true whether they were treated in the VA or in the private sector.

Mr. MILLER. Mr. Chairman, the Blinded Veterans Association concurs with all the other organizational comments and that the Federal Government or national health care reform cannot be a vehicle for relieving the Federal Government of the moral and financial responsibility for the care of service-connected disabled veterans and that is unacceptable, and I am afraid that there are those

that may view that as a way of reducing that $38 billion appropriation.

Mr. MAGILL. The Veterans of Foreign Wars concurs.

Mr. SMITH. Thank you. I just want to thank this panel again for your excellent testimony. It is helpful to us to hear such unity as well as very well reasoned arguments as you made today. I think it is also important, too, and I say this not in a partisan way, but there has been an attempt to try to roll a lot of organizations, groups, providers, and the like by saying, if you don't play you are not going to be there at the table and you are going to be left out. It is being done with members individually. It is being done with organizations and thankfully the VSOs have said, wait a minute, this is not good for our membership, it is not good for veterans at large. You have been able to speak out with clear and well reasoned arguments, so I just want to thank you for that.

It is not a sure bet, as you well know, that the President's plan will pass and survive. I find in my own district, and most recent polling shows, that since the first time polling has been done on the President's plan, the majority does not now favor it. And the more you look at details, the more one becomes concerned and perhaps even vexed by some of the problems it will unleash, including rationing. The people to get hit when rationing kicks in are the ones that need it: the catastrophic care people, the people with spinal cord injuries, the preemies.

Obviously, that is not a mandate for the veterans' organizations, but they are expensive, especially trying to take care of a premature child when you have cost savings and ceilings on what can be spent. Those groups of people will fall by the wayside, so I thank you so much for your testimony.

Mr. GORMAN. Mr. Smith, may I make a comment please, and I don't necessarily disagree with anything you have said. But I think it needs to be clear that at least in the DAV's viewpoint we are embracing the concept of the Clinton plan, that includes the Department of Veterans Affairs health care system.

For years—as someone made the comment up here at the table—for years the VSO by means of Independent Budgets and hearings such as this have come in and said time and time again VA needs to take care of itself, it is broken, it is fragmented, it needs to be fixed. And this is really the one vehicle that is on the table right now to at least try to address that issue, and I don't think anybody is necessarily locked into any binding precepts about what plan is out there to deal with the VA but there is no other discussion going on, and certainly no other legislation introduced. So I just wanted to make that comment, but it is good for the debate that this is happening now. It is good for the debate. I see you don't necessarily disagree with me.

Mr. SMITH. I would like to respond briefly. I support the concept as well, although there are parts of that concept when it was reduced on paper into legislative language that causes one to say, I think the devil is in the detail. And I just want to say that we do need reform, that is a given. Whether or not this is the reform that will lead to more problems or actually resolve the question is an open question. Thank you.

Mr. ROWLAND. Mr. Magill.

Mr. MAGILL. What I would just like to add, to expand on what Dave said, right now the only health care plan that addresses veterans is the administration plan, and I think that is important, that the rest of the plans don't even mention VA and certainly we are at the VFW, and I think I share this with the rest of the panel up here that we are concerned about that and I just wanted to make that point.

Mr. ROWLAND. Thank you.

Mr. ROWLAND. The next panel will be Dr. John Burton, Secretary-Treasurer, National Association of VA Physicians and Dentists; Bette Davis, President, The Nurses' Organization of the VA; and Chapin Wilson, Legislative Representative with the American Federation of Government Employees.

We would ask that you limit your oral presentation to 5 minutes and your entire statement will be made a part of the record.

Dr. Burton.

STATEMENTS OF JOHN BURTON, D.D.S., SECRETARY-TREASURER, NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS; BETTE DAVIS, PRESIDENT, THE NURSES' ORGANIZATION OF THE VA; AND CHAPIN E. WILSON, JR., LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES (AFL-CIO)

STATEMENT OF JOHN BURTON, D.D.S.

Dr. BURTON. Thank you, Mr. Chairman. Good morning. My name is Dr. John F. Burton. Although I am employed as the Chief of the Dental Service at the William Jennings Bryan Dorn VA Hospital in Columbia, South Carolina, I am here today as an officer of the National Association of VA Physicians and Dentists (NAVAPD), the professional organization of the 14,000 dedicated doctors of the VA.

As a member of the VA system for over 20 years, having served in national and local positions in five different Medical Centers, I have observed the doctors of the VA and know of the personal sacrifices they make to provide the highest quality of patient care. They believe that the VA health care system is a national resource that should be an integral part of any national health care system.

The VA health care system provides high quality health care at costs that are significantly lower than in the private sector. For example, VA Central Office just last week released estimates that showed that VA dental services provided in fiscal 1993 would have cost 26 percent more if contracted out. The VA health care system provides clinical experience to 65 percent of the medical students in this country. It provides residency training for over 50 percent of the practicing physicians in this country. And the VA medical system provides unique opportunities for research.

Despite years of negligent and chronic underfunding, the VA system is, to a great extent, a monument to what is right about this Nation's health care system. VA doctors want to provide the quality of patient care which has led the JCAHO to score VA hospitals higher than average in recent overall ratings. At the same time, we do understand the need to cut spending.

If we are given a level playing field, we are supportive of the kind of accountability that is envisioned under reform. However,

every surgeon knows there are cuts that can be fatal and I see signs that we are reaching a point in the VA medical system where even the most dedicated doctor and health care provider will not be able to overcome the lack of equipment and support personnel at today's patient levels.

Even the increase of $500 million in this year's budget request is approximately $2.3 billion less than the amount specified by the Independent Budget. Of relevance to these hearings is the fact that the $41 million decrease in medical prosthetic research will effectively cripple that program with decreases equal to 830 positions.

This is just one area of patient impact under consideration today. Medical care is scheduled to lose more than 3,600 FTEE, of which 73 percent are estimated to be direct patient care positions.

I see no way we can sustain such a loss without having additional impact on the quality of care. For this reason, we strongly support H.R. 3808 to provide VA flexibility and stop the bleeding of our workforce. In fact, our workforce is so thin in some areas that I could give you examples where the loss of a single critical employee can cause a major disruption of health care services.

We are supportive of efficiency measures and even downsizing that are justified within the context of our mission today and the broader mission contemplated under reform. But we are saddened to see arbitrary cuts that sap morale and frustrate our efforts to provide proper care for our patients.

In addition, we feel there should be a higher level of concern than has been evidenced for the defense mission of the VA as a backup system to handle active duty casualties in the case of conflict. A system that is dismantled cannot be put back together overnight.

We are even more concerned at the kind of chaos that could be wrought by health care reform plans that do not fully consider the impact on the VA health care system and make that system a full partner in their efforts. For that reason, we also fully support the Veterans Health Care Pilot Programs Act to set up pilot programs in those States that are already instituting health care reform.

We ask that you help us in our quest to maintain the quality of patient care in the VA health care system by approving H.R. 3808 to preserve VA's flexibility in meeting the medical workforce needs and the Veterans Health Care Pilot Act of 1994.

We are proud of the system we have helped create and want to help in bringing it into a new era of success in serving the Nation. Thank you.

[The prepared statement of Dr. Burton appears on p. 90.]

Mr. ROWLAND. Thank you.

Ms. Davis.

STATEMENT OF BETTE DAVIS

Ms. DAVIS. Mr. Chairman and Members, thank you for inviting NOVA to testify today. NOVA applauds the introduction of H.R. 3808, legislation that would put off any health care staff reductions until the VA can more realistically determine its workforce needs.

The Secretary must have this option if VA health care facilities are to be viable partners in offering VA health plans for veterans.

At a time when VA is preparing to meet an additional demand in its services, both by veterans already in the private sector and from a present downsizing of the Defense Department, we are now being asked to decrease an already lowered, yearly lowered FTE ceiling just to provide current care.

Right now in most VA facilities it is difficult for VA nurses to function on the FTE ceilings assigned to nursing each fiscal year. Among the obvious telling signs is the necessary amount of dollars used for overtime and for RN pools established for additional nursing coverage. Now, more than ever, is the time to recognize the need for adequate staffing numbers and use budget dollars for official FTE positions. Health and lifesaving care cannot be ignored, postponed or sacrificed.

NOVA is concerned that workplace restructuring, the impact of mandated employee cuts as proposed for Federal agencies would essentially halt any attempts for comprehensive health care reform legislation, just as the VA is on the brink of something beneficial happening. OMB's proposed reduction would prevent VA from becoming a competitive participant.

VA's registered nurses' contribution as frontline providers of health care to the Nation's veterans is extraordinary. Failing to fill vacancies and reducing RN staff could pose serious problems of quality and safety in patient care. Patients who are hospitalized are more seriously ill and require an even higher RN-to-patient ratio than in the past for delivering more complex care.

The cost effectiveness and quality of care of using RNs in all settings has been demonstrated but NOVA fears that attempts to lower costs immediately will shift more direct patient care to lesser trained health care workers and aides. Published research shows that hospital mortality rates, patient complications, readmission rates, and patient lengths of stay all decrease as the number of RNs caring for patients increases. Adequate RN nursing care saves money, ensures quality care, and contributes to positive patient outcomes.

Demand for RNs will even be greater. Opening doors for expanded care for veterans who have already delayed or deferred care takes appropriately prepared nurses and other professionals to ensure a successful transition into more comprehensive care and for implementation of programs already proposed and under way.

NOVA also supports legislation that would provide authority for the Secretary to establish and operate pilot programs in up to five States which have enacted a State health reform plan.

Pilot programs would provide VA an early opportunity to test its ability to compete for enrollment in VA health care plans and provide transition models for the future.

A reorganization of VA under health care reform must take place at the local Medical Center level. Thus, NOVA endorses VA's participation in pilot programs as outlined in the draft legislation. Factors of health coverage include consideration of benefits afforded State residents, the cost of financially supporting a viable plan, assurances of no-cost care for service-connected veterans, and the continuation of access for specialized treatment programs of disabled veterans.

Establishment of a revolving fund for conduct of the pilot programs without fiscal year limitation for expenses and for other means to receive funds from State plans are imperative to carry out the purposes of the pilot program. Such an approach increases flexibility and assurance of positive results.

For VA to give comparable health care in a State which has enacted a State reform plan, it is important that VA Medical Centers be able to function more autonomously and enter agreements with health care plans' insurers and other health care providers. NOVA believes veteran clients would actively participate in establishing health care priorities, governance and future direction of each Medical Center, if enlisted.

Mr. Chairman, thank you for the opportunity to share with you nursing concerns related to health care staff reduction and the VA's participation in State health reforms.

[The prepared statement of Ms. Davis appears on p. 93.]

Mr. ROWLAND. Thank you.

Mr. Wilson.

STATEMENT OF CHAPIN E. WILSON, JR.

Mr. WILSON. Thank you, Mr. Chairman, for asking AFGE here today. I am here on behalf of Bobby Harnage, the National Secretary-Treasurer. He wasn't able to be here this morning. I will be very brief because, most of what I might say is in our testimony in terms of our concerns, so it would be redundant. I won't unnecessarily take the committee's time.

I would like to say we represent about 125,000 VA employees nationwide. We don't think we have enough staff to carry out the services that are needed now. We are very much supportive of the major thrust of H.R. 3808, which is to basically stop the downsizing of the VA. We believe that agencies ought to be right sized, not downsized, and what I would like to do is just give a little perspective here about where the Administration and the OMB particularly appear to be coming from.

The cuts throughout government are basically arbitrary and capricious. It has been established in testimony before Congresswoman Eleanor Holmes Norton's subcommittee of the Post Office Civil Service Committee that the administration witness could in no way justify or define or point to any studies or any kind or any review which would support the across-the-board downsizing in the departments.

Of the 252,000 FTEs that are to be cut in the outyears, 118,300 are to be cut this year. The VA simply has been allotted its pro rata share without regard to anything. I think it would be incumbent upon this committee to ask the VA and the OMB where is your study; where is your review to justify these cuts in FTEs?

AFGE is supporting the President's plan for reinvention. We are not opposed to efficiencies. We are not opposed certainly to giving better and more efficient care to the VA population. We are opposed to things that are arbitrary and capricious and without foundation, and we think with respect to these cuts they are without foundation.

H.R. 3808 will do a great deal to remedy these problems. We would very much like to see a very close look at all contracting out. We take great exception to it generally.

There is a recent study by the GAO which was asked for by Senator Pryor on the Governmental Affairs Committee which has been published which basically says that it is cheaper generally to do things in-house in the government rather than contract them out.

There are massive problems generally—cost overruns, et cetera, et cetera. I would encourage the committee to look at all of that before offering either in H.R. 3808 and certainly in the pilot project broad, broad sweeping authority to contract services out.

I would be happy to answer any questions. Thank you very much.

[The prepared statement of American Federation of Government Employees appears on p. 97.]

Mr. ROWLAND. Thank you. Please give my best regards to Bobby Harnage. He is a good friend.

Mr. WILSON. I will. I know that he is.

Mr. ROWLAND. We do have some questions but I was late and we will just submit those questions to you and ask that you respond for the record. Thank you very much for being here this morning.

[Whereupon, at 12:04 p.m., the subcommittee was adjourned.]

APPENDIX

STATEMENT OF
ELWOOD J. HEADLEY, M.D.
ACTING DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MARCH 8, 1994

Mr. Chairman and Members of the Committee:

I am pleased to be here this morning to discuss two important pieces of legislation before the Subcommittee. The first measure is your draft bill to allow VA to participate, on a pilot basis, in state health reform activities. The second bill, H.R. 3808, would limit the Administration's efforts to trim the Federal work force over the next five fiscal years.

STATE HEALTH REFORM DRAFT BILL

The Nation is focused on the need for reform of our health care system. Last Fall the President submitted legislation to the Congress which will ensure all Americans of access to affordable health care. Congress is now considering that legislation. However, many states are not waiting for national health reform. They are proceeding to enact their own health care reform measures now.

As a result, one of our first activities was an initiative to ensure and enable VA participation in State health care reform activities. We in VA plan to move with the States as partners in developing better ways to meet veterans' health care needs, reduce costs and maintain the highest levels of quality service.

The VA has compiled extensive data on state-based health care reform activities occurring throughout the country. We have reviewed State legislative proposals, State health care commission reports and other materials to assess the extent to which we can anticipate some effect on veterans' health care delivery. As a result of our review, we are focusing on nine (9) States and the Commonwealth of Puerto Rico that have already enacted State health care reform legislation or have received or requested waivers permitting Medicaid demonstration projects. The States are: Arizona, Florida, Hawaii, Maryland, Minnesota, Oregon, Rhode Island, Tennessee and Washington. In addition, we are closely monitoring States in which we expect significant health care reform legislation to be enacted in 1994. These include California, Colorado, Montana, New York, and Vermont, as well as the Commonwealth of Pennsylvania. We also recognize that nearly twenty (20) States have special commissions or task forces preparing reports to present to their legislatures, so we can foresee an increase in the number of States with health care reform plans in the coming months. We continue to monitor these reports and the activities of the respective State legislatures.

We continue to monitor these reports and the activities of the respective State legislatures.

With respect to the State legislation that has already been enacted, our review indicates that generally the States are first working to provide poor and uninsured citizens with health care coverage through managed care plans. They may also plan to phase-in additional categories of residents over a period of years. States, such as Washington, that have adopted universal coverage still require Federal waivers from ERISA (Employee Retirement Income Security Act), Medicare and Medicaid restrictions before they may achieve full implementation

Now, let me address some specific concerns about VA and our participation in State health care reform:

While it is still too early to fully determine the actual effect on VA of state-based health care reforms, we do know that some veterans who currently use the VA system will gain increased access to other non-VA health care services. These veterans may elect to enroll in State-approved health care plans, rather than seek care from VA. This may be particularly true in States like Tennessee where the basic benefits package is richer than what VA is now statutorily permitted to provide to most veterans, especially with regard to outpatient and preventive care services.

The number of veterans who will become eligible for State health care coverage under States' reform varies. For instance, Oregon's reform sets the threshold at all citizens below the Federal poverty level. Of the over 38,000 veterans treated at VA facilities in Oregon, approximately 4,500 - or 12% of the patients - would meet this requirement. The State of Florida sets 250% of the Federal poverty level as the income threshold for their "MedAccess" program. This could effect an estimated 21,000 of the 153,000 veterans treated by VA facilities in Florida - or a potential 14% of VA patients.

There are several challenges posed to VA with State health care reform:

We are a public health care system and lack experience in participating in a competitive business environment. We do not currently have all of the financial, information, and other necessary systems and structures in place to operate like a business. While we have gained some experience in recent years such as billing third party payers through the Medical Care Cost Recovery (MCCR) program, we still have a long way to go in this arena.

We are a Federal health care system and lack experience in dealing with State governments. Most of the State health care reform legislation that has passed to date has not considered the VA as a participant, primarily because the States are not aware of the significant role that VA plays in community health care. Although we have for years enjoyed effective working relationships with the State Directors of Veterans Affairs, we have generally not had a

must change and are working toward that end as you will hear later.

We are a National health care system and, as such, have requirements including eligibility criteria that apply system-wide. Therefore, we currently lack the flexibility to tailor services to meet the diverse requirements imposed by each individual State's legislation.

VA has responded to the challenges of State health care reform in several ways.

First, the Department has developed a unified vision for VA's role in national health care reform. We have a system-wide commitment to participation in State health care reform as a key first step to meeting our vision.

Second, we designated one or more VA medical center Directors within each State as "Lead Director." These individuals are responsible for coordinating the State's plans for VA participation in State health care reform with an eye toward National health care reform. The Lead Director is expected to ensure that State and private sector officials are aware of VA's current role in the State and our interest in participating as plans are being made for State reform. Further, we are encouraging our managers throughout the country to become more involved in their State's health care reform activities.

Third, we have begun a state-based strategic planning initiative that brings together VA facilities in a State to develop a unified plan for providing health care services to veteran customers and identify actions required at the local and national levels to ensure VA participation. We started this strategic planning activity with VA facilities in six States that have implemented (or are implementing) significant state-based health care reforms. These states are Washington, Oregon, Tennessee, Florida, Vermont and Minnesota. However, this effort will be expanded shortly to incorporate facilities in additional priority States.

Fourth, we have initiated a relationship with the Health Care Finance Administration (HCFA) to ensure appropriate consideration of VA and veterans in their review and approval processes of State requests for Medicaid waivers.

Fifth, we are now educating State officials on the role of VA in their communities. VA is an important national health care resource that enhances the health care capabilities of the State and also contributes significantly to the economic vitality of local communities. Last year VA spent $5.2 billion on goods and services for its medical centers while a labor force of 237,000 individuals substantially affected local economies. In addition, VA contributed $85 million to construction and acquisition of State veteran homes, and provided clinical training to over 100,000 students in the health professions.

Sixth, we are providing information to State legislatures in a variety of forums to ensure that VA is considered in State

health care reform deliberations. We also are attending meetings with Governors' Veterans Advisory Committees and working closely with representatives of Veterans' Service Organizations at the State level.

The different state reform initiatives vary in detail, but they generally include the common theme of increasing access to care. Additionally, they often ensure that citizens will receive a standard benefits package containing a wider array of services than we can now furnish to veterans. In that situation, many veterans who now obtain care from VA might choose to seek services in another setting. To ensure that VA is able to continue providing veterans with the care and services they need and deserve, we must be allowed to participate in the new health care marketplace that is emerging in these States. Further, we want to ensure that VA is a player and holds a place in State reformed health care markets which are forming now and which will probably remain in place under a reformed national system. That requires Federal legislation.

You have asked us to comment on the draft of a bill which, we understand, is still in a somewhat evolutionary stage. Accordingly, our comments on the draft you provided us will address the major issues covered by the bill, rather than any specific language. The bill would permit VA to establish pilot programs in up five states which have undertaken health reform. At the pilot sites, we would provide health care on the same or similar basis as care is furnished by other health care providers in the State.

Your bill has much in common with an Administration bill which we plan to submit to Congress in the very near future. Both your bill, and the Administration bill, would allow us to continue serving veterans in those States where significant expansions in access and coverage to residents of that State could jeopardize our patient base. Also, both bills would allow us to gain the kind of valuable experience we will need to be competitive in the health care marketplace we anticipate will result with enactment of national health reform.

Your draft bill would provide us with broad authority to enter into sharing arrangements with health care plans, insurers, health care providers, or with any entity or individual to either furnish or obtain any health-care resource. We could enter into such an agreement without regard to any other law, but only if necessary to maintain an acceptable level and quality of service to veterans. We believe that some expansion of the current VA sharing authority contained in 38 U.S.C. § 8153 is desirable in the States with reformed health care systems where pilots would be established. The Health Security Act contemplates expanded sharing as one of many ways to assist VA in competing under health reform. The House draft bill would expand sharing far beyond the policies of the health Security Act by providing expanded authority to facilities not competing in State health reform, i.e., as part of a State pilot. Our bill will provide needed sharing authority

while maintaining policies consistent with the Health Security Act.

If we are unable to meet the needs of veterans through expanded sharing, the bill provides another mechanism which will facilitate our participation in state health care reforms. Like the bill we plan to submit to Congress, it would authorize the conduct of pilot programs in up to five states. At the pilot sites, we would establish health plans to furnish veterans and their dependents with care on the same or similar basis as care would be mandated for other citizens under State law.

Further, the Secretary could authorize a pilot in a state only after determining that failure to do so would result in a decline in VA workload to the extent that it would threaten a facility's mission, or result in serious deterioration in the quality of care provided. We have some concern with respect to this condition; potential decline in workload should not be the only reason for establishing pilot projects. As we said earlier, another reason for our participation in these pilot projects is to permit us to obtain the valuable experience we will need to compete in the health care marketplace we anticipate will result with enactment of national health reform. There is, however, nothing in the house draft bill that would preclude us from considering this factor in selecting pilot States. We are raising this point simply to make the Committee aware of this issue.

The bill also provides that under any pilot program, veterans who now have mandatory eligibility for care, (so-called category A veterans) would have to be able to receive care without incurring liability for any premium, deductible, or copayment. At least 30 days before actually initiating a program, the Secretary would have to submit a report to the Congress fully describing how the pilots would work. We support both of these provisions and intend to include them in the Administration's own bill.

Under the draft bill we would also have to ensure that we maintain a capacity to provide the specialized treatment and rehabilitation we now provide even if the state plan does not provide for that. Included would be care for blind and spinal cord injured veterans, and those with mental illness. We support those provisions.

To facilitate financial management of the pilot programs, the draft bill would establish a revolving fund. It would authorize an appropriation to the fund for each fiscal year from 1995 through 2000, and would permit the Secretary to transfer funds from the Medical Care Appropriation Account and the Construction Appropriation Accounts into the Fund. Additionally, funds collected from 3rd party insurance carriers that are in excess of amounts CBO estimates we would collect under current law for the years the pilot would operate, would be added to the fund. Amounts in the fund would be available until expended for all purposes of carrying out the pilot programs, except they could not be used for major facility construction or leasing. Several of

the revolving fund provisions of the bill are similar to provisions which will be included in the Administration's bill, and are essential to the success of pilot programs. We would suggest, however, that the bill not include authority to transfer funds from appropriated accounts. These funds are already available to the facilities at levels determined by the Secretary. We also recommend that the bill be modified to limit appropriations to the period of Fiscal Years 95-97, to be consistent with the implementation assumptions underlying the Health Security Act.

Additionally, the House bill would authorize the Secretary to establish checking and savings accounts. We are currently discussing with the Department of the Treasury whether this is necessary. The outcome of these discussions will be reflected in our bill.

Other provisions in the bill would provide specific authority for us to conduct market and consumer surveys, and promote and advertise our health plans. It would also ease current restrictions on our ability to reorganize our facilities when necessary for the success of the pilot. We support these provisions which we anticipate including in our own bill.
We cannot support, however, the provision to grant the Secretary authority to enter into contracts for health care services without regard to any law or regulation. We believe this authority is too broad. This would exempt VA from criminal and revolving door statutes, the Anti-deficiency Act, and the Clean Water and Air Acts. Our own bill will include a more limited version of the contracting authority provision.

As I indicated previously Mr. Chairman, we will soon be sending a bill to the Congress which would accomplish many of the things that this bill is intended to accomplish. We urge you to give consideration to the provisions of our bill when it is complete.

H.R. 3808 -- WORK FORCE REDUCTIONS

As you know Mr. Chairman, Vice President Gore undertook the National Performance Review process in an effort to streamline the way the Government does its business. One result of that effort was a determination that substantial reductions are needed in the number of Federal employees. The Administration anticipates that reductions will take place in our Department as well as other departments throughout the Government.

H.R. 3808 would make it impossible for the Veterans Health Administration (VHA) to participate in proposed reductions. It would also ease restrictions on our ability to contract for services now provided by Federal employees. The bill provides that during Fiscal Years 1995 through 1999, no reduction could be made in the number of full-time equivalent employees (FTEE) working in VHA unless specifically authorized by law, or required by the unavailability of funds. It provides that VHA personnel

should be managed on the basis of the needs of eligible veterans and the availability of funds. The bill would also lift the restrictions on contracting imposed by 38 U.S.C. § 8110(c) for the same five year period.

Mr. Chairman, while we can appreciate the objective of this bill -- to assure our ability to effectively participate in the new health reform process -- we believe the approach taken is premature and unnecessary. In an effort to meet the goals identified in the President's budget, we have already identified ways to streamline VA operations. For example, we are eliminating the supply depots because they are no longer cost-effective. We are reorganizing VHA's field operations into veterans service areas, which will significantly reduce the number of staff in our regional offices. We are also evaluating the desirability of consolidating personnel, procurement, and other administrative offices now located in each hospital. Throughout the Department we are exploring ways to deliver services more efficiently. This includes consideration of new approaches to the provision of health care under health reform. As these examples illustrate, there are real opportunities for savings in VA.

I want to assure you that in the President's efforts to reduce Federal employment, VHA has not been held to a formula-driven, across the board reduction. As you know, with 212,657 full-time equivalent employees, the VA medical care system is by far the largest Federal civilian agency employer on budget -- larger than the Departments of Health and Human Services, Treasury, and Justice individually, and six other cabinet agencies combined. Its sheer size and the necessity of being competitive suggest that VA can participate in meeting the President's goal. We believe there are still more steps we can take to improve VA's efficiency and delivery of service. For that reason, we do not support the enactment of H.R. 3808.

In conclusion, Mr. Chairman, let me say that the Department of Veterans Affairs has set forth its vision to become a successful participant in the reformed National health care delivery system that this country will soon enjoy. We will offer a full range of services, enhanced by education and research, benefiting veterans and their families, and the Nation as a whole. Successful participation in State health care reform will further our goals. National health care reform represents an unprecedented opportunity for the VA health care system to become a key player in State and regional health care systems. We know that we must move ahead now with the States as partners and we want to ensure that VA has an effective role in the health care activities that are quickly moving forward in the States.

I thank you for this opportunity to speak with you and look forward to your questions.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
MARCH 8, 1994

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to comment on H.R. 3808, legislation to preserve VA's flexibility in meeting its medical work force needs, and draft legislation to authorize a pilot program for VA participation in state health care reform initiatives.

H.R. 3808 would provide VA the requisite authority and flexibility to provide staffing levels for the Veterans Health Administration (VHA) of the Department of Veterans Affairs as necessary to meet its responsibility to provide health care services to eligible veterans and to permit implementation of national health care reform by VA.

The Office of Management and Budget (OMB), as part of the announced plan to require a reduction over five years of 252,000 full-time employee (FTE) positions in the executive branch, proposes to reduce VA medical care by 25,000 FTE positions over a five-year period. Even though VHA received a waiver for more than 4,500 positions for Fiscal Year 1995, beginning October 1, 1994, VHA is forecast to still lose nearly 5,000 FTE during FY 1995.

Section 2 of H.R. 3808, would amend Chapter 7 of title 38, United States Code, to place a limit on the reduction of full-time employees within VHA. The measure will require that during the five-year period beginning on October 1, 1994, no reduction may be made in the number of FTE in the Veterans Health Administration other than as specifically required by law or by the availability of funds. The measure also specifies that the personnel levels of VHA shall be managed on the basis of the needs of eligible veterans and the availability of funds.

Section 3 of H.R. 3808, would amend section 8110(c) of title 38, United States Code, to ease limitations in current law on contracting for services currently being performed by employees at VA health care facilities. During Fiscal Years 1995 through 1999, any contractor of the Federal government must give priority in hiring to any displaced VA employee, and provide such displaced employees with all possible assistance in obtaining Federal employment or entrance into job training and retraining programs.

Mr. Chairman, The American Legion wholeheartedly supports the provisions contained in H.R. 3808. At a time when VA anticipates implementing the greatest health care delivery changes in its history, the next several years will require

VHA to consolidate and reinforce its present capabilities, and not be required to incur debilitating personnel or funding reductions. It is important to the future success of the VA health care system, in regard to health care reform legislation, that the VA medical care system be provided every opportunity to survive and thrive in a reformed health care environment. Although National Performance Review, with its emphasis on streamlining, re-engineering and simplifying the Federal Government must be taken seriously, to impose its personnel mandates on a health care system which presently cannot accommodate its workload demand or provide care in a timely manner, let alone any increased workload under health care reform, simply defies logic.

The 25,000 personnel reduction specified for VA under the National Performance Review will offset any gains realized by VA under the President's Health Care Investment Fund, contained in Title 8 of the Health Security Act (H.R. 3600). On the one hand, the Administration has expressed a commitment to strengthening the VA health care program to enable VA to successfully compete under health care reform. To have the National Performance Review employment reductions proposal apply to the VA medical care system, contradicts all assurances made by the Administration to Veterans Service Organizations that VA will be able to compete on a "level playing field" under the Health Security Act.

It is important that the Administration rededicate its commitment to the veteran community and establish that their special needs will not become victim to misdirected cost-cutting proposals. The veterans of this nation have earned the right to have a fully functional health care system dedicated to serving their health care needs.

Mr. Chairman, we also wish to comment today on the draft legislation entitled "The Veterans Health-Care Pilot Program of 1994." This legislation would allow VA to provide, under a pilot program, health care services to veterans and their family members in states which have enacted health care reform legislation which has not embraced the facilities of VA in such legislation or in those states which make VA competition an essential element of survival.

Failure to include VA in state health care reform or to enact enabling national legislation removing the encumbrances which shackle VA today would cripple its ability to survive in a competitive environment. Simply put, VA must be in a position to do all the things a private sector competitor must do to attract patients: provide quality accessible care, market and advertise services, network, contract and make service decisions based on local need and create an attractive, comfortable environment in which to deliver those services. The cliche that

the competitive game must be played on a level playing field holds true more than ever in this situation.

There is something basically flawed about the idea that there is any consistency or fairness about the way VA is being prepared for survival in a Clinton-like competitive health care environment. We have discussed the inequity of making strong expectations of VA and then removing the very tools with which it must fight the competitive battle such as dollars and personnel in our comments on H.R. 3808.

The American Legion can support this draft legislation with a few minor adjustments. We agree, Mr. Chairman, with the creation of a revolving fund to conduct the pilot program. The establishment of such a fund would enable VA to gather accurate cost and reimbursement data and apply this information toward future system wide application of the President's health reform initiative. We believe the program should have a flexible funding mechanism and a source of identified additional funding.

The ideal situation would be to appropriate sufficient funds on a no-year limitation basis, separate and distinct from normal appropriations. We favor the idea that all funds received by VA by reason of the furnishing of health care under a pilot program shall be deposited to the revolving fund. We have some concern that using normal Medical Care Account and Construction Account appropriations to fund the pilot program could impede the program's intended objectives.

We support the application of a pilot program to all VA facilities located in a state chosen to conduct a pilot initiative. Selecting only certain facilities within a state to participate would fragment VA services and promote confusion among veteran beneficiaries. Also, we have some concern about the effect of limiting the pilot program to no more than five states. Currently, up to eight states may soon enact some configuration of health care reform, in addition to Tennessee, which implemented Tenn-Care on January 1, 1994. By limiting the pilot program to a predetermined number of states, other VA medical facilities could become seriously deficient in promoting and conducting competitive health care plans upon enactment of health reform by particular states. It would be self-defeating to limit the scope of the pilot program for fiscal reasons. The American Legion favors a provision of the draft bill that would enable the Secretary to determine the number and location of pilot programs.

In addition, the designation of specific catchment areas for each VA facility must be made to assure that we do not create different and separate health benefits for veterans who presently fall within the existing catchment area but do not reside in the state which is undergoing reform.

The American Legion would support legislation which would lend improvement to the appallingly complicated and unfair eligibility regulations and the serious funding limitations which encumber and cripple VA today. This type of legislation is essential to the survival of the VA medical care system as well as enabling VA to step into the competitive arena with the assurance that they can compete well and are playing on that "level playing field."

The American Legion would reiterate our concern that certain veterans might be disenfranchised because of the provision which allows families of veterans to enroll and receive benefits under VA health care plans. We agree that there is a chance that some veterans may not choose VA as their health care plan if their families cannot enroll as well. Related to the fact that all recipients of care under VA plans must enroll to receive benefits, the likelihood of such disenfranchisement would be greatly diminished. The Secretary's assurance that non-veteran care will be contracted to other plans or providers until VA capacity to treat is established must be continued.

The American Legion believes VA needs to be ready to define its basic and supplemental benefits package, and its premium and coinsurance costs for each state health care plan, as determined by the marketplace. We think that many of the promising suppositions of VA health care reform can be tested through the proposed pilot program. Therefore, it is consequential to the future shape of the Veterans Health Administration that this pilot program is structured in such a manner that the test data provides some insight to the future application of VA health care in a reformed market environment.

Mr. Chairman, that concludes our statement.

STATEMENT OF
DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 8, 1994

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.2 million members of the Disabled American Veterans, I want to say how very much we appreciate the opportunity to appear before the Subcommittee this morning to offer our views on draft legislation to authorize a pilot program which would permit the Department of Veterans Affairs (VA) to participate in state health care reform efforts; and H.R. 3808, a bill aimed at preserving VA's flexibility in meeting the workforce needs of its health care delivery system.

At the outset, Mr. Chairman, it is our belief that the series of hearings, over the years regarding the status of the VA health care delivery system and its need for reform, have laid a solid foundation and, in many ways, set the stage for today's hearing. We believe the draft legislation which, when put in final form and if enacted, would represent the first genuinely tangible effort -- from the legislative viewpoint -- toward moving the VA into an era of health care reform.

Said another way, Mr. Chairman, DAV believes it absolutely critical VA be given broad, innovative authority and flexibility for the dual purpose of launching "mini reform" pilot projects in those states that have enacted their own versions of health care reform in advance of any national reform package being put in place. Also, VA must be allowed to move in tandem with the states in their varied reform efforts. VA will, in our view, gain a great deal of experience from these pilots that may then be extrapolated throughout the rest of the VA health care delivery system.

Mr. Chairman, Section 2 of the draft legislation proposes to create, beginning in Fiscal Year 1995 and through Fiscal Year 2000, authority for the Secretary of the VA to operate pilot programs in up to five states which have enacted legislation intended, at a minimum, to give residents of those states who lack, or have inadequate health insurance coverage access to health care services.

In creating and operating such pilot programs, the Secretary may:

* provide health care services in the same or similar manner as the state reform plan mandates to veterans, members of the family of any veteran who participates in the pilot program, and individuals participating in the CHAMPVA program (as defined in Section 1713(a), Title 38, USC);

* comply with such state requirements pertaining to the establishment and operation of a health plan or to function as a participant in, member of, or contractor to such a health plan;

* conduct pilot programs in some or all VA health care facilities located in a state; and

* establish such catchment areas as deemed appropriate.

Section 3 of the draft legislation would authorize VA facilities to participate in the pilot programs only under circumstances where:

* The Secretary has determined, based on very defined and specified factors, the projected workload in one or more VA health care facilities in the affected state would decline to a level that would:

  - threaten to impair the capability of VA to meet one or more assigned missions of the facility; or

  - result in a deterioration in the quality of care or services to a degree it would not be determined reasonable to continue to provide such care or services.

Additionally, the Secretary would be required to submit a report to appropriate Congressional committees that would include:

* the rationale for VA's proposed participation in a state reform plan;

* the extent to which applicable provisions of State law accommodates and facilitates participation by VA in a state reform plan;

* a detailed business plan for VA's participation in a state reform plan; and

* a description of VA's actions taken to consult with veterans regarding VA's proposed participation.

Mr. Chairman, we feel it crucial to the long term success of the VA and, therefore, the pilot programs to have a "Board of Directors" at each facility participating in a plan for the purpose of continued dialogue and participation with VA in the delivery of health care services and conduct of the pilot program. We suggest, clarifying language that would direct the creation of such a "board" or advisory committee, to the facility director for the expressed purpose of establishing a firm collaborative partnership providing ongoing dialogue between the facility management, providers, veterans and other consumer groups.

As we understand, veterans defined in Section 1710(a)(1), Title 38, USC who receive health care services from VA would incur no liability for the payment of premiums, deductibles or copayments in conjunction with the pilot program.

Also, VA would maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans described in Section 1710(a), Title 38, USC, including veterans with spinal cord injuries, blindness and mental illness.

Mr. Chairman, again we feel clarifying language necessary to better define and strengthen the intent of this provision. The intent, we believe, is to assure those veterans afflicted with serious disabilities and/or disabilities in which VA possesses expertise to continue to be able to provide those services to veterans.

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In addition to the conditions listed, we would add to that list disabilities in situations involving veterans suffering conditions or maladies such as Post-Traumatic Stress Disorder, homelessness, the broad category of veterans utilizing the services of the VA's Prosthetic and Sensory Aids Service and other areas where VA has a demonstrated level or degree of expertise.

Mr. Chairman, VA must not be permitted to lose, by design or otherwise, their capabilities in providing such specialized services to a cohort of veterans who so desperately require them for their day-to-day existence.

Finally, Mr. Chairman, Section 3 contains the caveat that the pilot programs may not be entered into until the Secretary has fully considered the feasibility of utilizing the expanded sharing authority (Title II) contained in the draft legislation.

Section 4 of the draft legislation would establish, in the Treasury of the United States, a revolving fund for the conduct of the pilot programs.

There would be authorized specific funding for each of the Fiscal Years 1995-2000. Additionally, the Secretary would be authorized to transfer funds from the medical care appropriation and construction accounts to the revolving fund, which are determined necessary to carry out the pilot program.

Disbursements from the revolving fund would be made when deemed necessary to carry out the pilot program for the furnishing of medical care and services, or for the acquisition, construction, repair, or renovation of facilities necessary for the successful completion of the program. Also, disbursements could be made for the conduct of consumer surveys, marketing, advertising, printing and other related issues.

Funds in the revolving fund would not be available for a major medical facility project or lease, as defined in Section 8104(a)(3), Title 38, USC.

Mr. Chairman, as we understand the proposal, funds received by VA, by reason of furnishing health care under the pilot program from an individual, another agency or department of the United States, or state or local government, a health care provider, health care plan, insurer or other entity, would be deposited in the revolving fund. Those funds would be made available for the continuing use in providing care under the pilot program.

Importantly, funds collected and attributable to the pilot programs, which are in excess of the applicable Congressional Budget Office baseline, shall not be subject to the current restrictions in Section 1729(g)(2).

Mr. Chairman, the Secretary would be authorized to establish and maintain checking and saving accounts in such places and in such a manner as determined appropriate and disbursements from such accounts would be made when determined necessary to carry out the purposes of the pilot programs.

Mr. Chairman, while we are generally supportive of the basic concepts and intent of the pilot programs, we offer a note of concern and caution regarding the transfer of medical care funds. Certainly, we urge diligence on the part of VA and appropriate oversight to ensure any transferred funds be used prudently and only for the express purpose of successfully conducting the pilot programs.

Mr. Chairman, Section 5 of the draft legislation would grant the Secretary broad administrative and personnel flexibility in order that VA may:

* carry out administrative re-organizations without regard to Section 510(b); and

* enter into contracts for provision of health care services, the procurement of commercially available items, under a cost of $100,000 without regard to competitive procedures or source of supply; and

* without regard to the provisions of Section 8110(c).

Additionally, VA would have authority to carry out consumer surveys, promotional, advertising and other related marketing activities related to the operation of the health plan.

Mr. Chairman, Title II of the draft legislation proposes an expanded and enhanced sharing authority permitting the director of a participating VA health care facility to enter into agreements with health care plans, insurers, health care providers, or with any other entity or individual to furnish or obtain any health care resource necessary for the conduct of such plans.

Finally, Mr. Chairman, reimbursements to VA would be based on a methodology that provides appropriate flexibility to establish an appropriate reimbursement rate. Proceeds to the government would be credited to the applicable department medical appropriation into funds having been allotted to the facility that furnished the resource involved.

H.R. 3808

Introduced by Chairman Montgomery, H.R. 3808 has, as its intended purpose, provided the VA with increased flexibility in meeting the workforce needs of their healthcare delivery system.

Mr. Chairman, the DAV applauds the recognition of gross contradictions between H.R. 3600 -- the Health Security Act -- and the seemingly mindless requested reduction of some 25,000 full-time employee positions over a five year period.

Clearly, in an era of health care reform where on the one hand H.R. 3600 would remove the many constraints on VA management and empower VA managers to manage in an effective way, it is ironic that a corresponding reduction of critical VA health care personnel would be mandated by the Fiscal Year 1995 budget request.

At this point Mr. Chairman, I would offer the DAV's appreciation to the full committee for its recent action restoring $390 million and 2,047 employees to the medical care account.

Section 2 of H.R. 3808 would, as we understand it, prohibit, during the five year period beginning October 1, 1994, the reduction of full-time equivalent employees in the Veterans' Health Administration (VHA) other than as specifically required by law or the availability of funds. Also, and importantly, VHA would be managed on the basis of needs of eligible veterans and the availability of funds. Mr. Chairman, DAV is in agreement with and supportive of this provision.

As we understand it, Mr. Chairman, Section 3 would materially alter the manner in which VA would possess authority

to contract out activities currently being performed by VA employees at VA health care facilities. Specifically, we view this measure as providing very broad authority for VA to contract out services now performed by VA employees.

Mr. Chairman, we completely understand the need for flexibility within VA in their quest to provide health care services to veterans in a timely and efficient manner. VA will be entering an era of health care reform wherein they will be forced to compete with other health care providers.

As concerns VA, competition translates into a retooling of not only their method of delivering health care but also in the administration of health care and a major cultural transition that will focus on an atmosphere of putting the veteran patient first.

Mr. Chairman, while the DAV is unequivocally supportive of the need for reform of the VA health care system, we do, nevertheless, have concern regarding Section 3. Quite frankly, as adopted by the delegates to our most recent national convention, DAV resolution number 222, by which we are bound, opposes further contracting out of services currently performed by federal employees.

The genesis of our resolution was to oppose the concepts embodied in OMB circular A-76 which had as its intent the privatization of much of government. In tandem with such intent would, of course, be the loss of federal employment of countless disabled veterans.

Mr. Chairman, once again, I want to thank you for allowing us to share our views with you on this timely and most important issue concerning the future of the VA health care delivery system. I would be pleased to respond to any questions you or members of the Subcommittee may have.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF
RUSSELL W. MANK, NATIONAL LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
H.R. 3808, LEGISLATION TO PRESERVE THE
DEPARTMENT OF VETERANS AFFAIRS'S (VA) FLEXIBILITY IN MEETING
ITS MEDICAL WORKFORCE NEEDS
AND
DRAFT LEGISLATION TO AUTHORIZE A PILOT PROGRAM FOR
VA PARTICIPATION IN STATE HEALTH REFORMS
MARCH 8, 1994

Mr. Chairman and members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to express our views on H.R. 3808, legislation to preserve VA's flexibility to maintain its medical care workforce, and draft legislation to authorize a pilot program for VA participation in state health reforms.

Mr. Chairman, PVA strongly supports H.R. 3808. This bill would prevent a devastating loss of personnel from the Veterans Health Administration (VHA) at the very time VA is attempting to marshall all its resources to compete and survive in a reformed national health care system. Due to budget shortfalls and subsequent loss of staff over the past twelve years, the VA health care system has already sustained a major erosion in its infrastructure, equipment base and service delivery capability. The Department has already witnessed a FY 1995 budget request from the Administration that is the lowest in three years. In addition to this budget request the Administration is proposing under its "Report of the National Performance Review" (Reinventing Government) a 12 percent reduction in VA personnel amounting to a loss of 25,080 full time employees (FTEs) from VA health care over five years. This reduction in health care staffing is intolerable. The proposal completely contradicts the Administration's pledge that VA would be dealt a strong hand in the process of gearing up for health care reform.

The legislation introduced by Chairman Montgomery would shield VHA from these federal work force reductions for a period of five years, while providing the Secretary of Veterans Affairs (VA) wide latitude in contracting out activities currently being performed by VA employees. Reductions could only occur if specifically required by law or because of the availability of funds.

Section 3 of H.R. 3808 would allow VA to contract out for the services by providing that the section of title 38 restricting most contracting (Section 8110 (C)) not be in effect during Fiscal Years 1995 - 1999. If activities are contracted out then preference must be given to former VA employees, and all possible assistance must be given to all displaced VA employees. Mr. Chairman, PVA greatly appreciates your concern in designing and introducing this legislation. We offer our full support behind eventual passage of the bill.

Mr. Chairman, national health care reform legislation, currently pending in the Congress, will have a profound effect on the structure and the provision of services within the national VA system. To a certain degree, the tools that the VA needs to help ease that transition are contained in the reform plan itself. In the meantime, several states have decided to move ahead of the federal government to implement their own unique reform plans. These state governments have almost completely ignored the contribution VA makes to health care in their state. They have also ignored the fact that VA should be a full partner in the provision of health care under those reforms. Likewise, up until recently, VA has been slow to realize the peril VA facilities in those states would find themselves in trying to compete over patients and cost with other private and public health systems while still restrained by current outdated eligibility criteria and restrictive administrative regulations unique to the federal government.

Five years ago, PVA realized that the states, frustrated by the lack of movement on the part of the federal government, would address the growing national health care crisis unilaterally by moving ahead with their own reforms. We realized that VA medical facilities could be in imminent danger if reforms in the state either enticed veterans out of the VA into state programs to receive enhanced benefits, or precluded veterans from the state system on the assumption (most often false) that all veterans could receive all the care they needed through VA. On the one hand the VA patient base would be decimated and facilities would be closed, as was the case with the Canadian veteran health care system after Canada implemented universal coverage. Under the other scenario, VA health care facilities could be swamped with veteran patients without the resources to care for them properly. And, those veterans would continue to be blocked from the full continuum of care due to existing fragmented VA eligibility criteria.

This misunderstanding on the part of the states arises as much from their desire to reduce the cost of reforms by automatically excluding veterans from state programs in the same fashion as they exclude other federal beneficiaries - Medicare and DoD, for instance. It also comes from the false perception that all veterans are eligible for care through the VA, and once they arrive on the VA doorstep all veterans can receive all the care they need. The PVA response to this issue was to heighten awareness within the states of the nature and importance of the VA health system, to correct misunderstandings over VA eligibility, and to point out the importance of VA being an equal, interactive partner in the development and implementation of state reforms.

PVA established its State Health Care Reform Project to monitor state reform activity. Through the work of the Project, PVA has raised the concern of potential conflicts with veteran health care through direct negotiations with the Commonwealth of Massachusetts during the late 1980's in the context of their now-stalled health care reform effort. PVA has also helped to resolve veteran eligibility conflicts in the reform efforts of both Hawaii and Tennessee. At the present time the project routinely collects and updates health care reform data on all 50 states, the District of Columbia and the territories. The objective is to identify and help resolve conflicts between VA and the state before they happen. This is more important than trying to create appropriate interfaces after reforms are in place.

In January 1994, PVA published the first edition of its summary and status of state health care reform initiatives. This matrix indicates whether a state has included, or even made reference to, the VA health care system in its planning and legislative efforts. A copy of this document has been made available to

every member of the Committee. Sadly, within this review of the reform literature, only two states have even mentioned that VA is a provider within their borders or a potential participant in their reform efforts. These omissions need to be corrected.

Over the past year PVA has communicated its concerns through a media campaign in state legislative periodicals, with the governors and top health reform planners in all 50 states, the members of appropriate Congressional committees, delegations and staff, and senior VA leadership (As an example we are attaching a letter dated November 12, 1993, which was sent to Secretary Jesse Brown). Our
purpose is to create an awareness of how the state benefits from the contribution VA makes.

> VA provides care to a large number of medically indigent veterans relieving the state of extensive additional Medicaid costs, uncompensated care and public health care costs.
>
> VA provides a training resource for health manpower and a medical research base within the state.
>
> VA, through sharing agreements and affiliations with health professions schools, is an integral part of the state's health infrastructure.
>
> VA is a large employer in every state.

From our review of state reform activity there are five states that have either enacted partial reforms or are in the process of imminent major reform implementation: Florida, Minnesota, Oregon, Tennessee, and Washington. Of these, Florida, Minnesota, and Washington will offer the most comprehensive reform and the most direct challenge to the VA system in their state. A summary of each state reform plan is attached to this testimony. In each instance, reforms enacted by these states, both large and small, already have, or most probably will, go into effect prior to implementation of national health care reform. VA must have the tools to interact and compete successfully with these proposals if it is to survive and maintain its existing comprehensive mission.

The Congress and the Administration must agree to give VA facilities in those states the flexibility to offer comparable benefits and the relief from regulation necessary to become an equal partner within the state system. This flexibility must be provided in the form of pilot programs involving VA facilities in those states listed above. The pilot programs will give VA in those states the opportunity to become a full participant in the health care system. It will also provide valuable experience to draw upon when the full VA system faces the same challenges in the context of national health care reform.

Congressional action is necessary to allow VA to:
1) Offer a comprehensive set of benefits to veterans using VA medical facilities within a state.
Unfortunately, VA would not be facing this difficulty if the Congress and the Administration had agreed to enact veterans health care eligibility reform providing a standard benefit package containing the full continuum of care last year. However, that option still remains with regard to benefit packages designed for the pilot programs. As a second option, the pilot programs could offer a benefit package similar to the basic benefits in H.R. 3600, the Administration's "Health Security Act." As a third option, (not without hazard as we will discuss later) each VA facility could be authorized to offer benefits at a level no less than the level of benefits authorized under the state plan.

2) Allow VA to establish needed community-based outreach clinics necessary to attract and serve its enrollees.
The biggest adjustment for the VA system under any health care reform proposal will come in its ability to shift and expand out of its traditional role as an inpatient, tertiary provider to a health system offering the full spectrum of care including expanded primary services. VA should have additional authority and resources to lease space in the community to bring primary care services to its patient population in the same way as would any other provider in the private sector. VA facilities should also
have the authority to augment their community-based operations through contracts and sharing agreements with other providers.

3) Allow VA to contract for services.
VA facilities in these situations should not be forced to become "all things to all veteran patients." Within available resources, VA facilities should maximize those things it does best and most efficiently and send the other services elsewhere, either under contract or sharing agreement basis.

4) Allow VA to provide services to the family members of veterans, either in-house or on a contract basis.
Such authority will allow VA to match and compete with the benefit packages offered by other providers in the state in order to attract and retain veterans in the VA plan. It will also provide an additional source of revenue for the system. There is certainly nothing inconsistent with the traditional role of the VA in being able to provide or manage services to the families of those who have served in defense of this nation, as long as the needs of eligible veterans retain the primary focus of the system.

The pilot program should ensure that VA facilities have the ability to create VA-state working relationships. These relationships are essential to enhance the use of existing health care resources available within a state to contain costs and make services optimally accessible. These working relationships should include:

1) Sharing excess VA resources within the state on a sharing agreements basis.

2) Establishing formal relationships between health plans operating within a state.

3) Strengthening the relationships between VA and affiliated health professions schools regarding the number and types of manpower needed to best serve the needs of VA patients.

4) Expanding opportunities for cooperative medical and health services research.

Mr. Chairman, PVA has identified three areas of concern in the process of designing pilot programs to allow VA to interact successfully and survive under individual state health care reform initiatives. These areas of concern are:

1) Designing an adequate benefit/eligibility package, while at the same time maintaining the VA's ability and willingness in those states to provide the traditional additional benefits, such as care for spinal cord injury and dysfunction, that have been unique to the VA system.

Providing authority for VA facilities under these circumstances to offer a basic benefit package will, for many veterans, grant services they had not previously been eligible to receive. But basic benefit packages, whether under a state reform plan or under a national reform scenario, will also set limits on the amount of services VA facilities can provide. Various reimbursement scenarios from third parties, state or federal

entities will drive individual facilities to provide services only up to the authorized level. Appropriations, under any reform plan would still be used to cover the cost of additional benefits, over and above the basic state or eventual federal package, that VA has traditionally provided. Such services include specialized rehabilitation, prosthetics, sustaining and long-term care for veterans with spinal cord injury and dysfunction, specialized care for other veterans with severe disabilities, blinded veterans, and extended mental health services that are unique to the VA system.

PVA is concerned that the drive for cost containment and competitiveness, coupled with an erosion in the availability of the appropriated dollar, will entice individual VA medical facilities to shrink their benefit package to the lowest common denominator and abandon or discard these additional services viewing them as a burden and not a traditional obligation of the VA mission. Over the years, VA has established a comprehensive network of centers for the treatment of veterans with spinal cord injury and dysfunction. The centers have forged a cadre of health pro- fessionals trained in the specialized care of these veterans and developed a system of sustaining and extended care, rehabilitation, research, prosthetics and orthotics for spinal cord injured veterans that is unique in the United States. Abandoning such a system would be a catastrophe for VA as well as a tragedy for veterans who look to the system to receive this specialized treatment.

We are aware that the eventual demise of the SCI system was raised in positive tones more than once at the recent VA health care reform task force meeting in Washington. Abandoning these and other specialized services, which would be over and above any state or federal basic benefit package, seems to PVA to be an alluring temptation for any VA medical center director looking to cut costs and become more "competitive." There is no mention or authorization in title 38, U.S.C. for care for veterans with spinal cord injury or dysfunction, nor is there any reference to the existence of the VA SCI centers. We firmly believe these and other specialized programs are in danger under any health care reform scenario.

PVA strongly recommends that the Committee include a specific mandate for the continuation of these specialized services, in both the legislation that authorizes the state pilot programs as well as the final version of the national health care reform bill.

2) Determining how the service area of the facility will be drawn in order to establish who will be eligible for benefits.

Under the state reform pilot program VA will be creating islands of unique standing and eligibility within the VA system. Individual VA medical centers in certain states will have unusual freedom from regulation, unique funding sources and administrative latitude unknown in the rest of the VA system.

However, at least until national health care reform is enacted, the greatest difference between facilities in these states and other VA medical centers will rest in the enhanced benefit package they will be authorized to offer. PVA sees this situation, as an acceptable anomaly in order to respond to the state health care reform process to protect those VA facilities in those states. While it is not necessarily right, and despite mandates in title 38, there already are major differences in the availability of services from one VA to another throughout the country. These variations are the result of the density of the veteran population, availability of resources, degree of patient load, and the lack of uniform entitlement to care for all veterans.

PVA does see major problems, however, in determining how eligibility for expanded benefits within the service areas of the facilities under the pilot program will be established. One option would be to limit expanded eligibility only to those veterans residing in the state that has enacted the reforms. This would limit all out of state veterans, even those who might have the identical current eligibility for care under title 38, to a lesser benefit from the same medical facility. Such a scenario completely ignores the often regional or interstate mission many VA medical centers have, particularly in the provision of specialized services such as care for spinal cord injury or dysfunction. It establishes a gross inequity between veterans based solely on their place of residence. It also would skew the results of the pilot study by artificially limiting the pool of VA users who would naturally be in the service area of that facility.

PVA believes that the only way to proceed in this matter is to ignore the state boundaries and establish eligibility based on the traditional service area of the facility. The financial impact on the VA to cover the additional benefits for these out of state veterans can be contained through an enrollment process and might even be offset completely by the loss of previous VA users who decide to enroll in non VA plans within the state once reforms are enacted. In any case, PVA believes that service area enrollment versus limitations on state boundaries are the only logical option in determining benefit eligibility.

3) Defining how, and from what source, these pilot programs will be funded.
Preliminary discussions on funding for the pilot programs call for VA to utilize existing funds from the medical care or construction account. PVA objects strongly to this concept.

The Administration's FY 1995 budget proposal will not contain enough funds to adequately support the VA system as a whole, let alone provide additional funding to support an expansion of benefits and services in a handful of areas throughout the country. In our opinion, the pilot programs are being designed to respond to a unique, near emergency situation where, without immediate action, the viability of existing VA facilities in those states would come under immediate question.

PVA urges that funding for the pilot programs come from separate appropriations in the nature of a grant program. Along these lines, the Independent Budget for FY 1995 has designed an outline for such a grant program. We would be happy to make that proposal available to the committee.

Mr. Chairman, PVA congratulates you and the members of the Subcommittee for holding this hearing and making these issues a matter of immediate concern at the beginning of this session of the Congress.

Thank you again for your invitation to be here today. I will be happy to answer any questions that I can.

SERVING
WITH
PRIDE

Testimony of

Michael F. Brinck

AMVETS National Legislative Director

before the

House Veterans Affairs Subcommittee
on
Hospitals and Healthcare

regarding

H.R. 3808
and a

Discussion Draft for a VA Pilot Healthcare Program
in
Various States

March 8, 1994

AMVETS

NATIONAL
HEADQUARTERS
4647 Forbes Boulevard
Lanham, Maryland
20706-4380
TELEPHONE 301-459-9600
FAX 301-459-7924
FTS 8-344-3552

Mr. Chairman, AMVETS would like to thank you for holding this hearing to discuss important issues that will affect the Department of Veterans Affairs health care system.

AMVETS has indicated its general support for the president's healthcare reform plan as it applies to VA. That support is based largely on two major provisions in H.R. 3600. That is, eligibility reform that would entitle all Category A veterans to the standard inpatient and outpatient benefits package at no cost and make all other veterans eligible for VA care through a buy-in program.

What we did not sign on to was an across-the-board personnel cut that offers the distinct possibility of putting VA in the position to fail in its transition to a competitive marketplace. Chairman Montgomery could not have been more correct when he said that it was ironic that H.R. 3600 would give VA broad flexibility in personnel management decisions, while the Office of Management and Budget would cut the workforce by over 20,000 in five years. It seems the only flexibility given to managers will be to make it easy to fire, not hire.

AMVETS hopes that Congress will provide VA the ability to choose a scalpel, not a cleaver to cut personnel. VA has an opportunity to rid itself of those employees who have not been customer-focused and the source of much frustration on the part of veterans and the VA system over the years.

To put this in more simplistic terms, VHA currently employs about 1400 personnel for each medical center in the system. A 20,000 cut in staff means that, without increased contracting to offset those losses, VA will experience a drop in treatment capacity equivalent to about 15 nominal hospitals. What conclusion is possible other than the administration is backing away from the federal government's commitment to veterans?

Chairman Montgomery has introduced H.R. 3808 to exempt the Veterans Health Administration from personnel cuts during the national healthcare reform transition and we enthusiastically support the bill because VA faces sufficient challenges without significantly downsizing the workforce. While the bill will not prevent the administration from slashing VA payrolls as required by law or budget, it will also require VA contractors to give some hiring priority to former department employees as well as directing VA to assist displaced employees in obtaining other federal positions or retraining programs.

AMVETS understand that the bill in no way intends to place non-veteran VA employees on an advantageous or level footing with its VA employees who may be displaced by contracting. Therefore, to clarify the intent of the bill, we suggest the addition of language that would reiterate the need for businesses with federal contracts worth $10,000 or more to comply with the requirements of USC 38 4212 to "take affirmative action to employ and advance in employment qualified special disabled veterans and veterans of the Vietnam era." Further, federal agencies - especially VA - bear some responsibility towards monitoring contractor compliance with veterans hiring priority law. Therefore, we ask that the bill be modified to require VA to submit annually to Congress, a list of all contractors meeting the $10,000 threshold, along with VA-certified copies of the contractors' VETS 100 reports. It is time to take the requirements of Section 4212 seriously, and VA must take the lead.

H.R. 3808 will also make it much easier for VA to contract out services during the healthcare reform transition. Naturally, AMVETS is concerned that this may be viewed by some as a means to significantly downsize the VA infrastructure and replace it with contracted care. While contracted care certainly has its place in regions where VA has no presence, or as a transitional method to provide care while VA expands its internal primary care network, or for scarce medical specialty services, it must not be allowed to largely replace the VA system. Keep in mind that beyond its primary mission to care for veterans, VA's secondary missions of DoD backup, national disaster response, research and development and education all require a critical mass of personnel and facilities to retain any credible capability in those functional areas. For instance, VA treated over 20,000 people following the Los Angeles earthquake. Outside of DoD, what federal resources could have been mustered if VA did not exist? We also understand that VA's experience with fee-for-service treatment of veterans is significantly costlier than in-house treatment. Therefore, we support a judicious use of an integrated network of VA facilities as well as contracted services to increase the treatment capacity of the new VA system.

Finally, in accordance with our national resolutions, we ask that Section 4212 be modified to change the terms "special disabled and Vietnam era veterans" to "qualified veterans with special affirmative action for disabled veterans."

Mr. Chairman, the discussion draft pilot program bill is an excellent start. Title I will

allow VA to mirror inpatient and outpatient benefits packages provided under state programs where the Secretary determines that delays will put VA at significant competitive disadvantage. The draft does not appear to place geographic limits on catchment areas, and we support that concept because many VA medical centers treat veterans from several states. Obviously, that will cause funding issues, but we urge VA to find a way to accommodate its traditional catchment veterans under the same rules if at all possible. One small suggestion would be to add some specificity as to in and outpatient care being available to core veterans at no cost.

We also support provisions that require the Secretary to include consideration of his sharing agreement authority when making the determination of the competitive damage to VA care.

Veterans with spinal cord injuries, blind veterans and the mentally ill all deserve our special support and we are glad to see the draft give them specific consideration.

We support the appropriation of an amount to establish a revolving fund for the pilot program. Additional costs should not come from an already-strapped baseline. While we support the concept of a central revolving fund, local facilities should be allowed to retain some portion to test the effect of those additional funds on operations.

We fully support Section 5 provisions to ease contracting requirements, as well as allowing VA to carry out private sector functions like advertising and marketing functions.

Mr. Chairman, AMVETS once again thanks the committee and staff for taking these proactive measures to improve VA's position in a competitive healthcare market, and we look forward to participating in VA's reform. That completes our testimony.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 3808 and
DRAFT LEGISLATION TO AUTHORIZE A PILOT PROGRAM FOR VA PARTICIPATION IN STATE HEALTH REFORMS

WASHINGTON, D.C. MARCH 8, 1994

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the men and women of the Veterans of Foreign Wars of the United States, I wish to thank you for inviting the VFW to participate in today's important hearing. The VFW is appreciative of this subcommittee for its continued concern that our veterans receive the best health care possible. We also commend your commitment to ensure that the Department of Veterans Affairs be able to provide that care.

H.R. 3808 introduced by the Honorable G. V. "Sonny" Montgomery, chairman of the full House Veterans' Affairs Committee, would provide VA flexibility in meeting the work force needs of its health care system. This bill would also give the Secretary the necessary flexibility to meet his responsibilities in providing medical care under a national health care plan. This legislation, unfortunately, was necessitated due to the fact that the Clinton Administration is proposing a reduction of 4,000 employees in the VA Health Care Delivery System during Fiscal Year (FY) 1995. We believe such a drastic employee cut, would undermine VA's ability to fulfill its anticipated role in health care reform. Now is the time VA should be increasing its work force to meet its increasing work load. Especially so if VA is to be competitive in national health care. It is now, however, being asked to do just the opposite and to do more with less.

Chairman Montgomery's bill provides that during the period of October 1994 through 1999, no reduction be made in the number of employees in the Veterans Health Administration other than as specifically required by law or by the unavailability of funds. It would also ease limitations in current law on contract activities currently being performed by employees at VA health care facilities. The chairman's legislation would free VA to carry out its critical health care mission basing its work force needs on veterans use of VA health care services either under existing law or under health care reform. The VFW applauds Chairman Montgomery for introducing this important legislation and urges its quick enactment.

Mr. Chairman, in your letter of invitation to this morning's hearing, we were also asked to offer our comments on a draft proposal that would authorize a pilot program for VA participation in state health reforms. The VFW has long maintained that VA must be encouraged and allowed to be as competitive as possible with other health care systems at the same time keeping with its traditional mission of caring for our nation's veterans. This is particularly true if VA expects to be the health care provider of choice for our nation's veterans. As national health care reform is being debated here in Washington, many states have not waited to see the final product but have

instead implemented their own health care reform initiatives. For many states with VA medical facilities within their borders, a direct line of competition has emerged between the VA health care system and the private sector. Under current law, VA does not have the authority to participate in state health reform plans.

While the draft proposal before us today does allow VA to be competitive in up to five states, which have their own health reform plans, there are several areas of concern the VFW has with this pilot program.

While the pilot program does grant authority in up to five states, the VFW questions this limitation. We believe that VA should be allowed to be competitive in any state that develops its own health care plan. We also believe that if a state implements such a health care reform plan and it also happens to have more than one VA medical center then all VA facilities be allowed to participate in the pilot project.

Mr. Chairman, the VFW is particularly concerned with a potential problem that may arise with respect to the catchment area of a VA pilot project facility. There is the distinct possibility that a VA medical facility, which is participating in the State Health Reform Program, will be able to offer enhanced medical care to veterans who live within that state. In many cases, certain VA medical centers (VAMCs) draw veterans from other states where there is no VA medical center within a reasonable travelling distance. For example: the White River Junction, Vermont VAMC also treats veterans residing in New Hampshire. In this particular case identically service-connected disabled veterans being treated in the same VA medical center could receive varying degrees of treatment. This gross disparity is not only unacceptable to the VFW but, in our opinion, poses legal questions as to a federal entitlement or benefit being unequally disbursed in a federal facility.

With respect to funding, Mr. Chairman, we are concerned that without new money and additional funding for this pilot project, the rest of the VA hospital system will be forced to foot the bill. The VA hospital care system cannot and should not be scavenged to support this or any other pilot project.

One other concern the VFW has is with the provision of allowing dependents to be treated in VA medical facilities. We will oppose dependent treatment in VA medical centers until all veterans -- every one -- are guaranteed access to VA. Delegates to our most recent National Convention adopted VFW Resolution No. 633 opposing the treatment of non-veterans so long as veterans themselves, for whatever reason, are being turned away. Therefore, we oppose this provision in the draft bill.

As stated previously, the VFW maintains and encourages VA to be as competitive as possible in its participation of health care reform. We have stated this on a national level and certainly believe it holds true on the state level as well. We look forward to working with you in the drafting of final legislation on this issue.

This concludes my statement, I will be happy to respond to any questions you may have.

BLINDED VETERANS ASSOCIATION

477 H STREET, NORTHWEST • WASHINGTON D.C. 20001-2694 • (202) 371-8880

TESTIMONY

PRESENTED BY

THOMAS H. MILLER

ON BEHALF OF THE

BLINDED VETERANS ASSOCIATION

BEFORE THE

HOUSE VETERANS' AFFAIRS

SUBCOMMITTEE ON

HOSPITALS AND HEALTH CARE

MARCH 8, 1994

Mr. Chairman and members of the subcommittee, on behalf of the Blinded Veterans Association (BVA) I want to express our appreciation for the invitation to present our views on H.R. 3808 and draft legislation that would authorize VA to establish pilot programs enabling VA to participate in state health care reform. BVA commends the Chairman of the full committee and this subcommittee for introducing H.R. 3808, a bill that preserves VA's flexibility to meet medical workload needs and you Mr. Chairman, for developing the draft legislation providing VA with special authority to establish pilot programs. Both of these pieces of legislation are urgently needed if VA is to have a reasonable opportunity to survive as an independent health care provider for veterans and their families. Time is of the essence if VA is to position itself for National Health Care Reform (NHCR), and even more critical in terms of becoming active participants in these states who are already enacting health care reform. We are painfully aware of the obstacles confronting VA that could threaten its ability to operate effectively under a managed competition system of health care delivery. First, VA is currently a facility based system accustomed to providing care on an inpatient basis not preventive or ambulatory care. This demands VA dramatically change the way it delivers medical care services in order to compete. Second, current eligibility rules could effectively limit VA participation in any individual state health care plan resulting in substantial drops in VA work load endangering continued operation of one or more VA facilities in that state. The legislation under consideration this morning is therefore critical if VA is to have a realistic opportunity to compete.

H.R. 3808

BVA strongly supports adoption of this vital legislative initiative. This bill as introduced by Chairman Montgomery would preserve VA's flexibility to meet medical work force needs for its health care delivery system. Last fall, the Administration introduced its health care reform initiative, H.R. 3600, the Health Security Act (HSA), in which a clearly defined role for an independent VA health care delivery system was outlined. Health care reform, whether in the form recommended by the HSA or some other legislation that may ultimately be adopted, will require VA to radically change the way it currently delivers health care. Consequently, re-invention of the VA health care system is imperative.

The Veterans Health Administration (VHA) has aggressively begun the re-invention process and a plan is nearly ready for submission to the Secretary of DVA for his review and approval. This has been a massive project involving people from within and outside VHA. In fact, this plan has been largely designed by VHA employees in the field with input and expertise from VACO officials as well as Veterans Service Organizations (VSOs). BVA is proud to have been an active participant in the process and therefore is keenly aware of the problems facing VHA as it attempts to position itself for HCR. The final product of this project has been created in the context of HSA and is dependent on adequate appropriations for VHA in addition to the Investment Fund described in the legislation.

Ironically, several initiatives eagerly pursued by the Administration are complicating VA's efforts to position itself for HCR. The President's FY 95 budget request for DVA is

totally inadequate, severely limiting VHA's ability to even meet current services levels of FY 94. VHA will be hard pressed to move new initiatives forward related to HCR with such a sparse appropriation request. Further, the Administration's National Performance Review (NPR) requires a total federal work force reduction of 252,000 FTEE over the next five years. The VHA's share of this reduction will be over 20,000. At a time when VHA is attempting to reinvent itself, analyze what role it will have under NHCR, and what enrollment levels it can expect, VHA cannot be required to make significant reductions in the medical work force. The budget shortfall and required reductions of over 3600 FTEE contained in the VHA FY 95 budget will be absolutely devastating if enacted.

The policies established in H.R. 3808, preventing any reduction in FTEE for VHA until the year 2000 and expanding contracting authority for the provision of services not currently being provided by VHA are badly needed. Once VHA can accurately assess work loads based on enrollments and services required and has completed the necessary reorganization to best accomplish its missions, it will be in a position to realistically assess work force needs. FTEE reductions could naturally result from this process without adversely impacting the VHA. While arbitrarily reducing FTEE may be politically beneficial, when they are unrelated to operational missions the consequences may be disastrous. BVA also endorses the protection for the FTE employees that might be displaced by expanded contracting authority. Every effort should be made, however, to insure essential medical personnel are not arbitrarily displaced as the result of some hastily perceived cost savings.

Mr. Chairman, from a more parochial perspective, the combination of inadequate funding request in FY 95 for VHA and the NPR forced employee reductions would virtually eliminate any possibility for VHA to make meaningful improvements in the unacceptably long waiting times and lists for admission to VA blind rehab centers and clinics. Further provision of additional essential resources such as more full time Visual Impairment Services Team (VIST) Coordinator positions and the addition of Outpatient blind rehab specialists to act as an integral element of the VIST could not be provided. Whether from a parochial or global perspective, the passage of H. R, 3808 is crucial to the future of VHA

Draft Legislation

Even more urgent to VHA than NHCR is the initiatives currently underway in an increasing number of states who are implementing their own health care reform. BVA supports the draft legislation under discussion this morning Mr. Chairman. VA must have an opportunity to participate in these state programs or risk loosing significant work load endangering the existence of existing facilities within those states. Based on available information, it would appear that health care benefits packages offered in these state plans could be much richer than benefits veterans of the state may currently be eligible for through VA. Without meaningful relief from outdated eligibility rules, VA will certainly loose customers.

This draft legislation entitled Health Care Pilot Programs Act of 1994, authorizes VA to establish up to five Pilot Programs to permit VA the flexibility to participate in these state

programs. BVA believes it is absolutely essential for VA to participate in these state health care reform initiatives to protect the integrity of the VA health care delivery system in any individual states. Failure to provide VA with special authority enabling participation would possibly cause irreparable damage.

Confusing and unnecessarily complicated eligibility rules place VA at a distinct disadvantage in terms of providing a comprehensive health care benefit package. Certainly, the states will be endeavoring to provide comprehensive packages to residents of the state who are either uninsured or under insured. Veterans should not be driven away from VA because benefits packages offered under the states plans are richer.

BVA believes the pilot programs offer VA a laboratory to test delivery of health care services as envisioned under national health care reform. The strategies composed by VHA and contained in their new VHA health care plan can be tested and valuable experience can be gained from participation in these pilots. VA has no experience in operating in a managed care environment, marketing its services or managing a customer driven system. Unquestionably, VHA cannot afford to miss out on such a valuable opportunity to gain badly need experience. Mr. Chairman, BVA recommends consideration be given to removing the limitations on the pilot programs. As many as 19 states are considering health care reform and VA must have the opportunity to actively participate in any individual state reform plans.

Several aspects of establishing such pilot programs concern us however. Will veterans residing in neighboring states but receiving VA health care be eligible in the reform state? Will they receive the same package of benefits? How will these pilots be funded? All of these questions seem to complicate the implementation of pilot programs. While we along with many others raise these questions, we do not necessarily believe they in any way preclude implementation of pilot programs unless in the latter, the system were to go bankrupt in the process of trying to fund the pilot programs.

Section 2 of Title 1 of this bill does provide the Secretary of DVA the authority to establish catchment areas he deems appropriate which seems to offer the potential for providing care to vets residing outside the actual state in which the pilot is operating. Difficult decisions would then have to be made regarding what benefits would be provided to out-of-state residents and how they would be paid for. Such decisions could dramatically affect existing work loads at individual facilities, particularly if the benefits offered were richer than currently available. Many additional out-of-state vets might wish to take advantage of such packages. This could prove very costly to VA if they would not be reimbursed for provision of such benefits. Establishing catchment areas will be a very sensitive task for VA and will take excellent communications with the VSOs and the local veteran constituency regarding the pilot nature of these programs and benefits contained there in. There may be no perfect solution to this issue that will leave all veterans satisfied. BVA believes however, the pilots are critical to VA being an active participant in the state plan thus preserving the integrity of VA health care in that state as well as providing invaluable experience to assist VHA in transitioning to NHCR.

Financing these Pilot Programs is another critical issue which presents significant obstacles for VA. Section 4 of title 1 provides for the establishment of a revolving fund in the U.S. Treasury into which income or funding generated from the state plans will be deposited for distribution at the Secretaries discretion to fund the pilot programs. We have some concern about such a plan and question whether the revenues collected at the state level could not just be retained by the VA participating in any state plan. It seems to us additional appropriations will be needed if such transitioning can effectively take place in time for state reforms.

The other provision of Section 4 which authorizes the Secretary to transfer funds from the medical care appropriation account or from the construction appropriations account to the revolving fund to support the pilot programs. The Secretary must be exceptionally careful if exercising this option especially since the medical care and construction accounts have little excess funds available and are constrained even to support current '94 service levels. As important as we believe these pilot programs are to the future success of VA in HCR, we cannot condone bankrupting or further constraints on the remainder of the system.

Mr. Chairman, BVA is obviously pleased that insurances are built into this legislation protecting eligibility for and provision of special disability programs such as Spinal Cord Injury (SCI) and Blind Rehabilitation. Neither of these services are likely to be provided by any state as part of a basic benefits package and absolutely must continue to be available to these disabled veterans in any state by using current referral patterns.

Conclusion

Mr. Chairman, while BVA does not possess special expertise in the Health Care arena nationally or on the state level, we are anxious to work with this committee and the VA to find solutions to the awesome task ahead. Education of our constituents and indeed all veterans will be critical if we are to be successful. BVA has been an active participant in the VHA re-invention effort carried out over the past two months. We are committed to continuing our involvement in the coming months. Mr. Chairman, BVA supports favorable action on both H.R. 3808 and the Pilot Programs Act discussed here this morning. We thank you again for holding this important hearing and certainly would be pleased to answer any questions you might have.

Vietnam Veterans of America, Inc.
1224 M Street, NW
Washington, DC 20005-5183

(202) 628-2700
(202) 628-5880 fax

STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Paul S. Egan
Executive Director

Before The

House Veterans' Affairs Subcommittee On Hospitals and Health Care

On

H.R. 3808 & Draft Legislation for VHA Participation in State Health Reforms

March 8, 1994

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Introduction

Mr. Chairman and members of the Subcommittee, Vietnam Veterans of America (VVA), appreciates the opportunity to present its views on the legislation before the Subcommittee today. Both matters are of very timely concern to veterans and a VA health care system struggling to prepare for health care reform. VVA commends the authors of both bills, as it is imperative that the Veterans Health Administration (VHA) have flexibility in preparing for national health care reform, as well as ongoing state initiatives.

H.R. 3808

H.R. 3808 would appropriately insulate the Veterans Health Administration from cuts contemplated in the Fiscal Year 1995 budget, as well as the federal workforce reduction associated with the National Performance Review. Currently, eligible veterans are either turned away from many VHA facilities or simply become frustrated by excessive wait times and forego needed health services because staffing doesn't allow VHA to meet demand. Further cuts would exacerbate this problem and threaten the survival of the veterans' health system with passage of national health reform legislation.

Contemplating future demand on VHA under a national health reform environment is problematic, at best. The General Accounting Office and Paralyzed Veterans of America estimate a 30 to 50 percent VHA patient-base loss overnight if national health reform provides universal coverage and thereby gives currently VHA-dependent health care consumers an alternative. While very few legislators would publicly suggest closing down the veterans health system, the only legislative proposal to address VA health care and give VHA an impetus to reinvent itself is the Clinton health care proposal.

Trying to predict future demand for VHA services in a national health environment, even under the best of all possible scenarios portrayed by the Clinton bill, is nearly impossible for one very simple reason. Between now and the time veterans have an option to enroll in a VA health plan, many things could change to either entice or drive away potential veteran users. After all, it is the veterans' perception of the quality of care they get at VHA that will determine its use and ultimately its fate.

VVA has participated in the ongoing VA Health Care Reform Project. We are excited as never before by the innovative thought projected, as well as the true commitment of the VHA field staff participating in this planning project, to improve and enhance the health services provided to veterans and their families. If VHA is given all the tools it needs under national health care reform, we are optimistic that VHA's efforts to fashion itself into a desirable health care provider will succeed.

While estimates of future VHA use are uncertain, one thing is certain; cutting back staffing and programs now will force VHA to turn more veterans away, and will ensure that these men and women will not choose to enroll in a comprehensive VA health plan when that choice becomes available. Veterans with a negative VA experience will choose a non-VA health plan because this same experience of VA as a poorer quality provider that denied them needed care will override any recent changes or innovation VHA has undertaken. Unfortunately, many veterans have already made this decision and are likely lost to the system forever. For these reasons, VVA supports the provisions of H.R. 3808, which allow VHA to maintain its current staffing levels, as the Secretary deems appropriate.

H.R. 3808 would also ease the regulations which often inhibit VHA from contracting for health care services. This too is important, as VHA will be able to improve and expand its services to adapt to the changing climate of health care

provision -- that of managed care. Some would argue that VHA has already been practicing managed care; but its "managing" is based upon convoluted eligibility rules and budget limitations -- not the welfare of the patient. Providing VHA with the ability to more easily contract for services will allow VHA to provide better care. In this way, VA may refer patients to the private sector for services it does not currently provide, and make VA-prompted care available where veterans can conveniently access it.

Establishing relationships with private sector providers will benefit VHA as national health system reform is implemented because it won't have to scramble to establish referral networks that the private sector already has in place. This will be particularly important as VHA begins to care for veterans' family members, and thus a need for obstetrical and pediatrics evolves; VHA can use contract relationships now to enhance its services to women veterans and thus make itself more attractive to veterans' families. Also, a broad outpatient network of primary care providers will be required and VHA can utilize its contract relationships to enhance its own outpatient capabilities.

In reflecting upon Chairman Montgomery's statement before the full House upon introducing this bill, his comments regarding the VHA's need for flexibility with an uncertain future demand for services on the horizon are particularly relevant. We too suggest that a better public policy would be to stall the proposed 20,000 FTEE cuts in the Veterans Health Administration until a clearer assessment of the future of the system can be determined.

Draft Bill Regarding State Reforms

Again, in the interest of providing VHA with the flexibility it needs to sustain itself in the face of competition from health care coverage provided to veterans through legislated health system reforms, VVA urges the Subcommittee to pass this legislation as quickly as possible. In order for VA to be able to intervene on its own behalf in certain state jurisdictions where the legislatures are either currently debating or have already passed a state health system reform initiative, federal relief from certain statutes is needed to allow VHA to provide comprehensive care to state residents and to establish relationships with the private sector to provide a full continuum of care to veteran enrollees and their families.

The pilot program contemplated in the draft legislation is exactly what is needed right now to develop a clearer picture of future use of VHA services under a national health care system. If nothing is done to adapt the VHA to these changes, it is very likely that patientload will decrease to a level which threatens facilities' continued viability. The health care coverage offered by these state reform plans will provide for comprehensive care, whereas VHA is currently able to offer only a patchwork of services depending upon eligibility and funding.

In order to attract veteran patients, the VHA must have the flexibility to adapt to the climate in states where health care reform efforts are already underway. This draft bill would provide such flexibility. VVA is particularly pleased to see the following concepts incorporated:

Section 2 allows for establishment of pilot projects in up to 5 states. An earlier draft proposed pilot projects in only 3 states, which was troublesome because of the speed with which 5 state programs are progressing. We would anticipate that the Secretary might choose states such as Minnesota, Tennessee, Vermont and Washington, which have already passed legislation. Given the fact that many other states have pending legislation, or can be expected to address health care reform in 1994 or 1995, we would suggest that the Congress allow VA to expand this pilot project to additional states on an as needed basis.

This section also includes provision for all veterans who choose to use the VHA and their families, similar to the President's "Health Security Act". The Secretary would also be given flexibility in establishing catchment areas, as use of individual facilities generally crosses state boundaries. Absent this provision, the law would allow differentiation of eligibility and treatment of veterans using the same facility, based solely upon the veteran's state residency.

Provisions in Section 3 establish the conditions under which the Secretary may implement the pilot projects, and requires a report to Congress prior to implementation. We suggest that Congress not unnecessarily delay approval of the pilot projects, as time is of the essence in addressing the state situations, because veterans lost to the VA health plan initially are not likely to return.

Section 3 also ensures that category A veterans will not be required to make copayments for services they already receive from the VHA. And it requires the VHA to retain its mission of providing the often costly specialized services to disabled veterans, such as spinal cord injury, prosthetics and blind rehabilitation, which are often unavailable in the private sector.

Section 4 contains perhaps the most important provisions, that of the funding mechanisms. A revolving fund would be established into which appropriations and receipts for services provided are held. Flexibility in spending authority is granted, both where funds go, and on a year to year basis -- funds unused at the end of the fiscal year need not be returned, but can be used to reinvest. No major construction is allowed under this provision, however, which seems a logical step -- its silly to build a large facility if over time it is shown that no one will use it. Receipts do not go to Treasury.

One point we must raise concern with, however, is that the Secretary may determine that excess funds are available, and these resources may be shifted to the VA medical care appropriation. Throughout the VA Health Care Reform Project meetings, we raised the issue that local VA health plans should maintain a significant portion of revenues at the local level, rather than having all funds go into a national revolving fund. This flexibility is needed so the pilot projects can adapt to changes in service demands, and reinvest as appropriate.

Failing to establish some sort of formula by which a percentage of enrollee premiums, deductibles and copayments are maintained at the local level will leave this system open to the possibility of "tinkering with the money", taking funds from competitive plans to uphold VA plans that are not attracting veteran subscribers and are thus not truly viable. Such a practice will discourage innovation and service improvements in a massive bureaucracy such as the Veterans Health Administration, and will encourage the practice of "business as usual".

VVA suggests in both this pilot project and the broader national health care reform legislation, that a formula be developed to direct approximately 2-5 percent of the aforementioned revenues to marketing; 1-2 percent be directed toward research with the caveat that 75 percent of all research conducted be of direct benefit to patient care; perhaps 5 percent of revenues would be directed to a national revolving fund for broad system improvement investments or special projects; and that the remainder stay with the local VA health plan for reinvestment and program improvement.

Finally, VVA would like to comment on the provisions of Section 5, which allows VHA to reorganize itself under the pilot projects. VHA again would be granted flexibility in contracting services and sharing authority in order to be as cost-effective as possible, while ensuring quality of services. VHA can also do marketing activities to attract potential users or enrollees.

What if VA Health Care Ceases to Exist?

Given some of the past characterizations of VVA's position on the VA health system, some may ask why we care about all of this intermediary legislation. Why is VVA concerned about the demise of the VA system in selected states or as a whole, when it has advocated all along that veterans should be able to access the private sector at the government's expense? There is a very simple reason -- we are concerned with ensuring the best possible care for veterans, either within or outside the VA. Our concern is and always has been veterans, rather than the system designed to meet their needs. To that end, there is another matter VVA would like to see this Subcommittee address as national health care reform legislation evolves.

While VVA has strongly endorsed the Clinton health care reform proposal and particularly the VA's service improvements contemplated therein, one particular ambiguity stands out causing fear and trepidation within the VA health user community. What if the VA fails to attract patients and doesn't exist three years from now -- how will the nation's commitment to service-connected disabled veterans be met?

VVA is very optimistic that VA will improve its capabilities and successfully fulfill its mission of caring for the nation's disabled and low-income veterans for years to come. Two scenarios emerge on the horizon, however, which threaten its viability.

First, the rigors of the legislative process in Congress may produce a final national health care reform product that doesn't give VA the necessary tools to survive the transition or the veterans health system is ignored altogether in national reform, leaving it to continue as untenably as it has in the past. The VSOs have broadly associated themselves with the President's Health Security Act because it would give all veterans the option to use VA, and allows VA the means to improve its services and provide a comprehensive continuum of care without complicated eligibility rules.

Other legislative proposals either don't address the VA or wrongly assume it will exist in a reformed health care environment just as it does today. Multiple studies estimate a nearly 50 percent patient-base loss under national health care reform because the VA-dependent population will have an alternative for the first time. As such we cannot assume enough patients to sustain VA's labor and cost-intensive health programs any more than we can assume continued Congressional support for a costly yet dysfunctional and underutilized VA system.

Under the best of circumstances, as proposed in the Clinton Health Security Act, VA has the fight of its life on its hands. In the absence of the Clinton proposal for veterans, the VA health system can be expected to sink like a stone. Unfortunately, the Congressional "rumor mill" indicates that some of these other proposals are gaining steam.

The second scenario is just this -- health care reform legislation is passed and signed into law that does give veterans a choice of where to receive care and provides VA with all necessary survival tools, but it still fails to attract sufficient veteran enrollees to sustain itself. Before long continuing funding support from the Congress erodes and the system collapses.

In either case, whether the VA is dissolved with passage of national reform legislation or disintegrates over time, along with it goes the nation's commitment to service-connected disabled veterans. Not only do the VA Medical Centers disappear, but the "special" VA medical programs uniquely serving veterans go too. This means the VA's expertise in post traumatic stress disorder, substance abuse, spinal cord injury treatment, blind rehabilitation and prosthetics evaporate, with nothing to replace them in the private sector.

If the VA disappears, low-income veterans currently dependent upon the VA will likely be able to obtain comprehensive care in the general health care reform program. On the other hand, service-connected disabled veterans who do not fall into the low-income category will have to fend for themselves in the general program, paying premiums, co-payments and deductibles for all health care, including costly specialized services. Unless...

VVA is working for passage of a "service-connected disabled veterans entitlement" to federally-funded health care. Without such an entitlement, veterans are forced to get care at VA or pay premiums, co-payments and deductibles for private insurance coverage. With no VA, they are definitely stuck with the bill.

Service-connected disabled veterans deserve an entitlement to health care in or out of the VA, as no other population can claim that their health conditions are directly related to federal decision-making. Should the VA fail to compete under the President's plan or simply disappear as a result of another, these veterans will still constitute a legitimate federal responsibility.

Competition represents the essence of the President's plan to improve our nation's health care delivery system, and veterans' choice will force VA to improve and enhance its programs. Unless the VA is forced to compete for service-connected disabled veterans just as it will be required to compete for middle-class paying customers under the Clinton plan, VA will continue to improperly enjoy an artificially engineered dependent patient population. Premiums, co-payments and deductibles will be a heavy cost-factor to weigh in decisions about provider choice for disabled veterans, particularly when many feel the federal government is responsible for their health care. Restricting disabled veterans' health provider choices in this way will force many to use a VA system they feel is undesirable. Under the circumstances, this is not only unfair, but holds service-connected disabled veterans -- the very veterans this system was designed to serve -- hostage to the VA. Failing to account for these individuals' care needs if the VA disappears is just plain wrong.

Some people, both veterans and non-veterans alike, live under the illusion that a veterans entitlement to health care already exists. This is not the case, as any veteran who has jumped through the eligibility hoops for VA care can attest. Federal law and administrative regulation currently govern who can get into the VA for health services -- and the maze of eligibility criteria were established to meet budgetary concerns, not a commitment of fairness to the most deserving veterans.

VVA is fearful that if such a "service-connected disabled veterans entitlement" is not created now and for some reason the VA does disappear in the next few years, service-connected disabled veterans will be forced to bear the financial burden of their health conditions alone. Given the anticipation that the federal budget and deficit reduction concerns will continue many years into the future, it is unlikely that such an "entitlement" can be created without the benefit of health care reform legislation to serve as the vehicle.

VVA's proposal to phase-in a service-connected disabled veterans health care entitlement, regardless of which health reform plan is passed, is as follows.

In the first year of health care reform implementation:

- 50 - 100 percent service-connected disability rating -- receives all health care services at no personal cost either within the VA or outside the VA.
- 0 - 40 percent service-connected disability rating -- receives all health care services at no personal cost within the VA; outside the VA, receives care for service-connected condition at no personal cost, will be required to pay premiums, co-payments and deductibles for non-service connected conditions

In the second year of health care reform implementation:

- 30 - 100 percent service-connected disability rating -- receives all health care services at no personal cost either within the VA or outside the VA.
- 0 - 20 percent service-connected disability rating -- receives all health care services at no personal cost within the VA; outside the VA, receives care for service-connected condition at no personal cost, will be required to pay premiums, co-payments and deductibles for non-service connected conditions

In the third year of health care reform implementation:

- Any veteran with an adjudicated service-connected disability rating from 0 - 100 percent receives all health care services at no personal cost either within or outside the VA.

Under the assumptions of a Clinton-like health reform package, no significant revenues should be required, as an annual federal appropriation already covers health services for these service-connected disabled veterans. The Clinton proposal would accommodate comprehensive care for veterans choosing to obtain it within the VA only. The VVA proposal would offer veterans the additional choice of getting the same cost-free care in the private sector.

VVA proposes a phase-in period for the proposed service-connected disabled veterans health care entitlement in order to provide VA the opportunity to do just what it says it both can and will do -- compete for veteran patients. A three year phase-in period is suggested to coincide with use of the $3.3 billion VA investment fund within the Clinton proposal. After all, if VA is genuinely serious about competing for veteran enrollees, it should not shrink from competition for service-connected disabled veteran enrollees as well. If it does, it is disingenuously engineering a dependent population of disabled veterans just as it always has in the past. The service-connected disabled deserve better than this and must not be used as hostages to prop-up a dysfunctional system. Instead, service-connected disabled veterans must be given the same choices as all other veterans, and in the process further encourage VA to compete aggressively for the sake of its own survival as a health care provider.

No additional bureaucratic mechanisms are anticipated, as the health security cards/electronic medical records issued to all citizens should be coded with service-connected disabled veterans disability rating and conditions. Payment for those veterans getting care outside the VA health plan should be billed to the VA health plan or directly to the federal government, through the local health alliance. (The reverse of such an arrangement is already contemplated for service-connected disabled veteran enrollees of non-VA plans, who choose to get VA care for service-connected conditions normally covered within the basic benefits package.)

Mr. Chairman, this concludes our testimony.

Testimony of Dr. John F. Burton
Subcommittee on Hospitals and Heath Care
March 8, 1994

Good morning Mr. Chairman and members of the Committee. My name is Dr. John F. Burton. Though I am employed as the Chief of the Dental Service at the William Jennings Bryan Dorn VA Hospital in Columbia, South Carolina, I am here today as an officer of the National Association of VA Physicians and Dentists (NAVAPD), the professional organization of the 14,000 dedicated physicians and dentists of the VA Health System.

As a member of the VA system for over 20 years, holding both local and national positions at five different medical centers, I have had a chance to observe the doctors of the VA system and know, first hand, of the personal sacrifices they make to provide the highest quality of patient care. I can tell you that they sincerely believe in the basic premise of the VA Health System: That those who have defended our nation have earned the right to the best medical care our nation can provide.

The physicians and dentists of the VA also believe that the VA health care system, to which they have devoted their lives, is a national resource that should be an integral part of any national health care system.

It provides high quality health care at costs that are significantly lower than in the private sector as has been verified by several independent studies. Just this month VA Central Office completed a study of the cost-effectiveness of dental services. It was shown that, in 1993, VA dentists provided services that by very conservative interpretations of the American Dental Association fee schedules, would have cost the government $264 million. The actual cost was $209 million--a savings of $55 million.

In addition, 65 percent of medical students receive clinical experience in VA facilities and over 50 percent of the practicing physicians in this country received some or all of their residency training at VA facilities. The system also provides unique opportunities for research for many doctors and has been responsible for many important discoveries in medical science such as the CAT scan and advances in prosthetic devices.

As a result of the specialized bodies of knowledge that rest with VA physicians and dentists and the research that they have conducted, VA has established expertise in the management of many conditions that are common in the veteran population. In addition to the advancements in the quality of care this experience provides for veterans, there is another, less concrete but no less important quality that veterans receive in our medical centers. This is the sense of community they feel. Our doctors are their personal doctors and when they come to their VA Medical Center, they are surrounded by other veterans, with whom they share a common culture. There is a great deal of talk about changing the culture of the VA Medical System to make it competitive under health care reform. But this is part of the VA culture we must go to great length to preserve.

Despite years of neglect and chronic underfunding, the VA system is, to a great extent, a monument to what's right about health care in this nation.

VA doctors want to continue to provide the quality of patient care which has led the Joint Commission on Accreditation of Healthcare Organizations to score VA hospitals higher than average in recent overall ratings. At the same time, we are highly cognizant, as a group, of the need to cut government spending.

If we are given a level playing field, we are supportive of the kind of accountability that is envisioned under health care reform, whereby VA Medical Centers would be funded or reimbursed based on their ability to provide a quality of care that would cause patients to choose them over other health care providers.

However, every surgeon knows there are cuts that can be fatal, and I see signs that we are reaching a point in the VA medical system where even the most dedicated doctor will not be able to overcome the lack of equipment and support personnel at today's patient levels, let alone the much higher levels that are theoretically possible under health care reform.

Evidence of this was found in a recent survey conducted by the Veterans Service Organizations of VA hospitals in six states. The survey found prolonged clinic waiting times and appointments commonly delayed for three to nine months.

Even the increase of $500 million in this year's healthcare budget request is approximately $2.3 billion dollars less than the amount specified by the **Independent Budget**, which NAVAPD has endorsed, to provide the same amount of care as FY1988--the last year before the VA Medical Care program suffered major funding shortfalls.

Particularly critical is the $41 million decrease in Medical Prosthetic Research which will result in effectively crippling that program if it stands.

A great deal of the reason that the VA retains such a high level of medical personnel is the opportunity to participate in research and, it will be particularly important to recruit and retain these eminent physicians and dentists as the VA attempts to change its culture and compete under health care reform. Yet the research area is scheduled for decreases equal to 830 positions.

But this is just one area of impact. Medical care is scheduled to lose 3,680 positions, of which 2,668 or 73 percent will be direct patient care positions. For the most part these will not be physicians and dentists, but adequate numbers of support personnel are as important to the maintenance of quality health care as physicians and dentists.

I see no way that we can sustain such a loss without having a direct affect on the quality of patient care. And for this reason, we strongly support H. R. 3808 to provide VA flexibility in meeting the workforce needs of its health care system.

NAVAPD does not support maintenance of the VA Health Care System for its own sake. We are aware that the veteran population is shrinking and that no one can with certainty predict the effect of the massive changes underway in national health care.

We urge a rational approach that will protect our veterans' rights to high quality health care and preserve those contributions the system makes to medicine in the United States, such as research and medical training.

We are supportive of efficiency measures and even downsizing that are justified within the context of our mission today and the broader mission contemplated under healthcare reform. But we are saddened to see arbitrary cuts that sap morale and frustrate our efforts to provide proper care for our patients.

In addition, we feel there should be a higher level of concern than has been evidenced for the defense mission of the VA as a backup system to handle active duties casualties in the case of war. A system that is dismantled cannot be put back together overnight.

We are even more concerned at the kind of chaos that could be wrought by health care reform plans that do not fully consider the impact on the VA healthcare system and make that system a full partner in their efforts. For that reason, we also fully support the Veterans Health Care Pilot Program Act to set up pilot programs in those states that are already instituting bilateral health care reform.

We see this proposal both as a means of providing the VA medical centers in those states with the flexibility to become part of those states' programs and as a way of setting up prototypes for the national systems, to see just what changes will have to be undertaken in the VA system to make it competitive. It will also help us identify unexpected impacts that affect patient volume and prepare the system for them.

Under all the scenarios for health care reform--including the one that envisions no action--the VA Health Care System undergoes significant change. The veteran population is becoming older, creating a greater need for geriatric and long-term care programs. The veteran population is shifting geographically depopulating some centers and overloading others. Health care reform will only add to the changes required.

The very nature of the VA healthcare system is to be responsive to the changes in veteran populations created by the unpredictable conflicts in which this nation has become involved. We strongly believe that the physicians and dentists of that system are equipped to meet the challenge of change, if we are given the flexibility and allowed the time and resources to rationally plan for and deal with the changes called for.

We ask that you help us in our quest to maintain the quality of patient care in the VA healthcare system by approving H.R. 3808 to preserve the VA's flexibility in meeting the medical workforce needs and the Veterans Health-Care Pilot Act of 1994. Further, we ask that you make the doctors of the VA Healthcare System an integral part of the planning for the future under health care reform.

We are proud of the system we have helped create and want to help in bringing it into a new era of success in serving the nation.

Thank you.

NOVA NURSES ORGANIZATION OF VETERANS AFFAIRS
1726 M Street, N.W., Suite 1101
Washington, D.C. 20036
Phone (202) 296-0888
Fax (202) 833-1577

Statement of

Nurses Organization of Veterans Affairs

NOVA

Bette L. Davis, MSN, RN, CS
President

Before the

Subcommittee on Hospitals and Health Care
Committee on Veterans' Affairs
United States House of Representatives

on

H.R. 3808, Legislation to Preserve VA's Flexibility in
Meeting Its Medical Workforce Needs
and
Draft Legislation to Authorize a Pilot Program for VA
Participation in State Health Reforms

March 8, 1994

Mr. Chairman and members of the Subcommittee, I am Bette L. Davis, MSN, RN, CS, a clinical nurse specialist at the Washington, D.C. Veterans Affairs Medical Center and president of the Nurses Organization of Veterans Affairs (NOVA). Thank you for inviting NOVA to testify today on H.R. 3808, legislation to preserve VA's flexibility in meeting its medical workforce needs, and draft legislation to authorize a pilot program for VA participation in State health reforms. We appreciate the opportunity to work with this Subcommittee for the improvement of veterans' health care.

H.R. 3808

Mr. Chairman, NOVA applauds the introduction of bill H.R. 3808, legislation that would put off any health care staff reductions until the DVA Secretary can more realistically determine its workforce needs. In order to implement VA health care under national health care reform, the Secretary must have this option if VA health care facilities are to be viable partners in offering VA health plans for veterans.

At a time when VA is preparing to meet an additional demand in its services, both by veterans already in the private sector and from a present downsizing of the defense department, we are being asked to decrease an already yearly-lowered FTE ceiling just to provide current care. Right now, in most VAMCs, it is difficult for VA nurses to function on FTE ceilings assigned to nursing each fiscal year. Among the obvious, telling signs is the necessary among of dollars used for overtime and VA RN prn pools established for additional nursing coverage. Contracting with outside nursing agencies is even more costly with less control of quality. Now, more than ever, is the time to recognize the need for adequate staffing numbers and use budget dollars for official FTE positions. Health and life-saving care cannot be ignored, postponed or sacrificed.

NOVA supports the two key policies in bill H.R. 3808 that would provide no reduction in number of employees in Veterans Health Administration for fiscal years 1994-1999, unless specifically required by law or by availability of funds; and that would ease limitations in current law on contracting out activities currently being performed by employees at VA health care facilities, as long as priority in hiring or in job training is given to any displaced VA employee.

NOVA is concerned that workplace restructuring, the impact of mandated employee cuts as proposed for federal agencies by the Office of Management and Budget, and a Balanced Budget Amendment would essentially halt any attempts for comprehensive health care reform legislation, just as the VA is on the brink of something beneficial happening. OMB's proposed reduction would prevent VA from becoming a competitive participant. VA's registered nurses' contribution as front line providers of health care to the nation's veterans is extraordinary. Failing to fill vacancies and reducing RN FTEs could pose serious problems of quality and safety in patient care. Patients who are hospitalized are more seriously ill and require an even higher RN to patient ratio than in the past for delivery of more complex care.

The cost effectiveness and quality of care of using RNs in all settings has been demonstrated, but NOVA fears that attempts to lower costs immediately will shift more direct patient care to lesser-trained health care workers and aides. Published research shows that hospital mortality rates, patient complications, readmission rates, and patient lengths of stay all decrease as the number of RNs caring for patient increases. Adequate RN nursing care saves money, ensures quality care and contributes to positive patient outcomes.

NOVA urges Congress to consider education and retraining of nurses and other health professionals for programs now being developed for primary and preventive care. Demand for RNs within hospitals and in the shift toward more ambulatory, home, and community-based care will be even greater. Opening doors for expanded care to veterans who have delayed or deferred care takes appropriately prepared nurses and other professionals to ensure a successful transition into more comprehensive care and for implementation of programs already proposed and underway, such as health care for women veterans, homeless veterans and Gulf War veterans, to name a few.

Draft Legislation to Authorize Pilot Programs for VA Participation in State Health Reforms

NOVA supports legislation that would provide authority for the Secretary of DVA to establish and operate pilot programs in up to five states which have enacted a State health reform plan.

In implementing VA pilot programs, the Secretary would be allowed to

1.) provide health care services on the same or similar basis as the State reform plan to veterans and family members of participating veterans
2.) comply with State law requirements applicable to a State reform health plan
3.) conduct pilot programs in some or all VA health care facilities located in the State, and
4.) establish catchment areas for participation in pilot programs

NOVA believes that establishment of pilot programs would provide VA an early opportunity to test its ability to compete for enrollment in VA health care plans and provide transition models for the future.

A reorganization of VA under health care reform must take place at the local VAMC level. Thus, NOVA endorses the conditions of participation in pilot programs as outlined in the draft legislation. Factors of health coverage include consideration of benefits afforded State residents, the cost of financially supporting a viable plan, a timely reporting mechanism and rationale of the pilot programs, assurances of no-cost

care for SC veterans, and the continuation of access for specialized treatment programs of disabled veterans.

Establishment of a revolving fund for conduct of the pilot programs without fiscal year

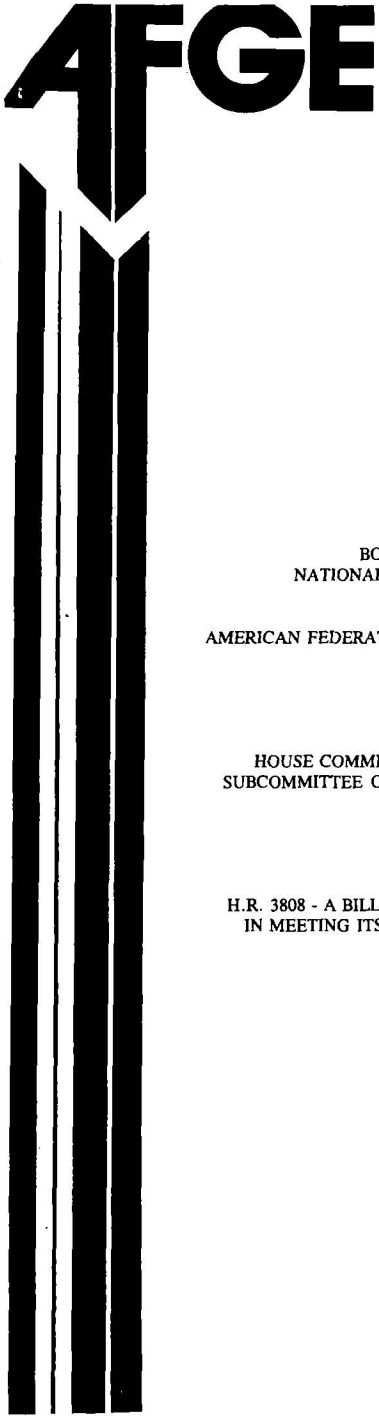
limitation for expenses is imperative to carry out the purposes of the pilot program. Such an approach increases flexibility and assurance of positive results.

NOVA supports Administrative and Personnel flexibility for positioning VAMCs to enter contracts for health care services and for other items or supplies when it is cost-effective or necessary to provide services in a timely manner.

Expanded Sharing Authority

In order for VA to give comparable health care in a State which has enacted a State reform plan, it is important that VAMCs be able to function more autonomously and enter agreements with health care plans, insurors , or other health care providers, etc. NOVA believes veteran clients would actively participate in establishing health care priorities, governance and future direction of each medical center, if enlisted.

Mr. Chairman, thank you for the opportunity to share with you VA nursing's concerns related to health care staff reductions and VA's participation in State health reforms. NOVA looks forward to your ongoing support for VA nursing and veterans health care.



American Federation of
Government Employees, AFL-CIO

80 F Street, N.W.
Washington, D.C. 20001
(202) 737-8700

STATEMENT

BY

BOBBY L. HARNAGE
NATIONAL SECRETARY-TREASURER

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
(AFL-CIO)

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

ON

H.R. 3808 - A BILL TO PRESERVE VA'S FLEXIBILITY
IN MEETING ITS MEDICAL WORKFORCE NEEDS

MARCH 8, 1994

Mr. Chairman and members of the Subcommittee, my name is Bobby L. Harnage and I am the National Secretary-Treasurer of the American Federation of Government Employees, AFL-CIO (AFGE). On behalf of the 125,000 employees of the Department of Veterans' Affairs our union represents, I appreciate the opportunity to present our views on H.R. 3808, the Veterans Health Care Pilot Program Act of 1994.

We share many of the same concerns expressed by you, Mr. Chairman, in your remarks upon introducing H.R. 3808, a bill to provide VA flexibility in meeting the workforce needs of its health care system. Many of the goals this legislation seeks to achieve are, in part, the same goals we have presented to this Subcommittee in previous testimony. However, we have grave and justifiable concerns about this particular proposal and do not believe that it is a viable means to achieve the goals we share.

We agree that the Administration's proposed workforce reductions at the DVA are purely arbitrary and unnecessarily deep. As Vice President Gore's NPR Report found, FTE ceilings are an incredibly poor way to manage agencies. The Government should be, as we have previously testified, "right sized". The mission of each agency should be carefully examined and the most efficient way to carry it out and provide quality services to its consumers, the American public, determined. Once this determination is made, the agency should be staffed accordingly. Simply selecting an arbitrary number of employees to perform work bears no rational relationship to the work to be performed and cannot possibly result in improved service delivery.

Further, the Administration's proposed reduction in the Federal workforce ignores the fact that the total number of people performing the Government's business consists not only of those in Federal service, but a very large number of individuals employed by contractors. It has been well-established that the Government's contracting out program is replete with fraud, abuse and massive cost over-runs. Accordingly, the bloated contractor workforce must not be overlooked when considering overall reductions of government personnel.

A report released January 13, 1994 by Office of Management and Budget Director Leon Panetta, cited "serious" problems in the way the Federal Government contracts for services from the private sector.

As stated in the Government Employee Relations Report of January 24, 1994, the OMB report said that many agencies are being forced to do more with less. Further, agencies often assume that additional Government personnel will not be authorized and, therefore, there is no alternative but to contract for needed services. According to the report, the Government spends over $105 billion annually for all types of services. The OMB report was highly critical of service contracting practices and urged a number of actions be taken to prevent abuse.

It is long past time for the Congress and the Administration to recognize that service contracting is not always the most efficient and cost effective way to perform work. Obviously, in those instances where it is not both efficient and cost effective, it should not be undertaken. It is time for the Congress and the Administration to recognize that any workforce reductions must be made applicable to the entire workforce--those employed directly by the Federal Government, as well as those individuals employed indirectly -- the huge shadow or contractor workforce. H.R. 3808 does not do this. It simply circumvents the proposed reductions by reducing Federal personnel and authorizing increases in the number of contractor personnel.

Mr. Chairman and members of the Committee, if, as we all agree, the Administration's proposed workforce reductions will leave insufficient personnel to carry out the current mission of the DVA, not to mention the personnel needed deliver the services proposed in connection with national health care reform, then you must say no to those irrational cuts. You must, instead, authorize sufficient Federal personnel to provide the quality services deserved and expected by our veterans and their families.

H.R. 3808 would authorize the Secretary of Veterans Affairs to establish and operate pilot programs in up to five states. These

states must have enacted legislation which is intended, at least in part, to give their residents, who lack, or have inadequate, health insurance coverage, access to health care services. In our view, this is putting the cart before the horse. Mr. Chairman, the Administration's Health Security Act is, as you stated, "a serious, meaningful effort to address the needs of our nation's veterans", as well as the needs of all Americans. However, health care reform is not a reality yet. In fact, no one can predict at this time precisely what will be required of each state nor precisely what the Department of Veterans' Affairs' role will be in delivering services under any health care reform measure enacted.

To authorize the Secretary to participate in and to comply with state laws applicable to that state's reform plan without any mention of applicable standards to be met, is simply not acceptable or appropriate. Certainly, if a state plan does not provide for meaningful cost containment measures, if it does not provide a comprehensive range of core benefits, if it does not have quality assurance features, the Federal Government should not be a party to it. While we recognize that prior to the establishment of such a pilot project, the Secretary would be required to submit a report to the appropriate Committees of Congress, we still find that the basic approach of H.R. 3808 is wrong and wholly unwarranted at this time.

Second, the bill provides that funds from the Medical Care Appropriation Account and the Construction Account may be transferred to a revolving fund. It gives the Secretary authority to establish and maintain checking and savings accounts in any Federal Reserve Bank in connection with the revolving fund and to spend that money in any way he determines appropriate in connection with the pilot programs. This unprecedented authority, in our view, is both unwise and of questionable legal authority. We do not believe the provisions can be squared with Article I, Section IX of the United States Constitution. That section requires that "no money shall be drawn from the Treasury but in consequence of appropriations made by law...." It appears that this specifically

enumerated power of the legislature is abrogated under H. R. 3808. What is proposed is that monies appropriated for specific purposes may be transferred at the sole discretion of the Secretary for other purposes which the Secretary, not the Congress, deems appropriate including such things as "conducting consumer surveys, printing, marketing, and advertising". If nothing more, this certainly is so grossly over-broad as to have the appearance of a misuse of taxpayers' monies.

Finally, we note that H.R. 3808 waives all current statutory safeguards with respect to administrative reorganizations and competitive contracting for services and the procurement of any item at a cost of less than $100,000. We can think of no need for this. The Department of Veterans Affairs currently has more authority with respect to obtaining the necessary personnel and other resources than almost any other agency of the Federal Government. It has special pay scales and hiring authority provided in order to enable the DVA to recruit qualified medical personnel. It is exempt from many of the provisions of Federal labor law and other personnel laws applicable to employees in other agencies. It currently has contracting authority within certain guidelines. And, it has a host of other options to enable it to carry out its current mission. But, as many reports substantiate, it has been unable to use this broad authority wisely and well. Certainly the solution does not lie in either granting the Secretary more authority or exempting the DVA from more provisions of law.

The problems documented by our title 38 members are legion. DVA employees themselves have brought many of these to the attention of the Committee and we stand ready to work with it to find ways to improve the relationship between the DVA and its workforce, as well as ways to enhance service delivery in a cost efficient manner. And, if the mission of the DVA is changed or expanded as a result of enactment of health care reform, then further authority may be necessary at that time but not now.

In sum, AFGE is of the opinion that it is premature to take

legislative action to meet needs which may or may not be required under national health care reform. We question the legality of giving the Secretary authority to transfer and use appropriated funds for purposes which he, and not the Congress, deems appropriate. And most of all, we do not believe that the way to address a shortfall of personnel necessary to carry out the Department's mission should be by authorizing additional service contracting. In fact, we urge this Committee to take the lead in pointing out that arbitrary FTE ceilings are a poor way to manage agencies. FTE ceilings only focus on a part of the Federal workforce. It ignores the fact that the huge contractor workforce is costing the taxpayers in excess of $105 billion each year. More often than not, the work could be more efficiently performed by Federal personnel at a lower cost. What must be done is to assess the mission of the Department of Veterans' Affairs, determine how that mission can be carried out in the most efficient and cost effective manner and provide for staff accordingly. If this entails more personnel than DVA currently has, then Congress should provide the authorization and funds to hire such additional personnel.

AFGE believes that the President's plans for national health care reform hold the potential to greatly improve both the quality and quantity of health care services the DVA now provides. As we have testified previously, this may require that the DVA change its resource priorities. But, we do not believe H.R. 3808 is the manner in which to do this.

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

HONORABLE J. ROY ROWLAND
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
QUESTIONS SUBMITTED FOR THE RECORD
FOR ELWOOD HEADLEY, M.D.
DEPARTMENT OF VETERANS AFFAIRS
HEARING MARCH 8, 1994

Question 1: How do we avoid a situation where, under broad delegations of authority, a national VA system becomes fragmented as facilities in individual states pursue a state-focused mission rather than a VA system mission?

Answer: State based health care reform and national health care reform share common factors. Both are concerned with controlling cost, improving the quality of care, improving access, and designing a delivery system that is more responsive to their customers. These factors are, and will remain, the national mission of VA.

However, veterans do not live, work, and get sick on a national scale. They live, work, and need health care at or near their home. The most overused but true phrase of health care reform in VA is that "health care is local." It is through the broad delegations of authority, and the decentralization of VA health care, that we will be best able to respond to what veterans want: local health care tailored to their particular needs.

Finally, the VA is an integrated national health care system that will continue to be a national resource for veterans who require a specialized service, such as Spinal Cord Injury (SCI), Post Traumatic Stress Disorder (PTSD), blind rehabilitation services, and substance abuse treatment programs. These services will remain available for veterans along with the comprehensive benefits services provided to every veteran who enrolls in a VA health plan. It is in that respect that we will continue to simultaneously have a national VA system mission while providing health care on a local basis with state-focused planning.

Question 2: With respect to state health reform do you foresee the possibility that even with an authorization of appropriations in law, that the VA health care system as a whole may have to bear the initial costs of VA facilities' participating in a few states? Doesn't that argue for caution in limiting the number of states in which VA participates?

Answer: It certainly does. There are many changes VA must consider if it is to be a full player in health care reform and a successful competitor for new enrollees. That is why we agree with the Subcommittee's view that we should only conduct pilots in up to 5 states. This will give us an opportunity to test ideas on a limited basis and learn what works.

Question 3: Does the literature suggest how large an enrollment pool of a health plan needs in order to develop a managed care system within a framework of managed competition which results in an appropriate case mix and sufficient workload to negotiate discounts on provider contracts?

Answer: The literature suggests that a certain number of enrollees are required to support a certain level of investment in staff, infrastructure, and the spectrum of medical services provided for a successful pre-paid Health Maintenance Organization (HMO). The literature also suggests that it is not just the number of enrollees but the balance and mix of enrollees with certain health status variables, including age, marital status, previous medical history, etc., that influence the financial health of an HMO and the services that can be offered to enrollees.

A January 1993 article in The New England Journal of Medicine suggests that 300,000 enrollees would be necessary to support an HMO that offered all ambulatory services and hospital services with its own panel of providers and a 600 bed hospital, but would need

to contract for some surgical specialties, including cardiothoracic and neurosurgery services. A plan of 120,000 could provide the full complement of acute care hospital services using its own staff, although some specialty services would be at the three person minimum. This size plan could exert substantial influence over one or two other community hospitals and providers of specialty services, but would need to contract for other inpatient facilities with other plans.

HONORABLE CHRIS SMITH
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
QUESTIONS SUBMITTED FOR THE RECORD
FOR ELWOOD HEADLEY, M.D.
DEPARTMENT OF VETERANS AFFAIRS
HEARING MARCH 8, 1994

Question 1: If VA is allowed to establish its own catchment area and it elects to allow veterans of other states to enroll, who would be responsible for payment of the out-of-state veteran's premium?

Answer: This question has received a great deal of debate and will continue to be discussed over the next several months. Eligibility for care at a VAMC is currently based on Title 38 and not state or catchment area boundaries. Therefore, any veteran who is eligible for care will continue to receive care at a VAMC, even if that VAMC is in a pilot state.

Designation of a pilot site should not interfere with existing referral patterns for out-of-state residents. For example, veterans living in Boise, Idaho, often receive primary care in Boise and referral to Seattle for tertiary care. This type of network and referral pattern in VA would not be changed if Washington became a pilot site.

Question 2: Have you considered whether there are any legal implications to the provision of variable benefits packages to similarly eligible veterans depending upon their state of residence? For example, a veteran who resides over the state line but who relies on VA in a state in which reform has taken place, because the veteran is not a resident of the state, he may not be eligible for the same benefits package as those who do reside in the state. How have you or would you resolve this?

Answer: VA facilities will need to consider managing two separate systems of patient benefits (one for state residents and one for non-residents).

Question 3: If VA were to enact comprehensive eligibility reform with a clearly identified veteran population, mandated to receive access to a full continuum of care, would state waiver authority be necessary?

Answer: VA has testified on the need to streamline veteran eligibility requirements in the past. We believe that all necessary revisions to current eligibility requirements are addressed in the President's proposal for health care reform. It offers all veterans, for the first time, the opportunity to enroll in VA health care plans and receive the comprehensive benefits package.

Question 4: How is VA going to track funding at each facility so that Congress will be able to weigh the relative cost per state?

Answer: Proposed state pilot legislation requires VA to establish a revolving fund with a separate account for each separate pilot state. This revolving fund must consist of all appropriated funds for VA facilities in that state, any additional appropriated funds, and any additional funds received by the pilot state from enrollee premiums, Medicare reimbursements, sharing agreements, etc. This should allow VA to better track the costs and revenues for all the facilities in a pilot state.

Question 5: In your opinion, are the proposed FY 1995 FTEE cuts consistent with VA's own planning models for meeting current and future demand for health care services?

Answer: The proposed FTEE cuts are not based on patient workload, but rather on proposed improvements in efficiency. This is addressed through a broad management

improvement initiative which includes: collaboration with community health care providers; decentralization and local delegation of authority; consolidation of support and clinical functions; and mission realignments. This will help eliminate over-control and micro-management while promoting local empowerment and innovation, all of which are compatible with National Performance Review proposals. This effort to "right-size" VA is consistent with private sector activities and will keep us well positioned for national health care reform.

Question 6 : In your opinion, will the proposed FTEE cuts allow VA to provide health care more efficiently to veterans? If so, how?

Answer: Yes. This request reflects a change in the management perspective on federal staffing. In addition to adding to management's flexibility to meet health manpower requirements, VA is also implementing more efficient and streamlined operations which should help reduce overall employment requirements even under health care reform. This is addressed through the management improvement initiative discussed above.

HONORABLE MIKE KRIEDLER
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
QUESTIONS SUBMITTED FOR THE RECORD
FOR ELWOOD HEADLEY, M.D.
DEPARTMENT OF VETERANS AFFAIRS
HEARING MARCH 8, 1994

Question 1: If Congress gives the VA authority to operate pilot programs, how much authority would the VA give local VAMCs to make decisions on how best to operate?

Answer: It is the intention of VA to empower pilot plan management with necessary and appropriate authority. For example, we expect that in most instances general contracting authority will be decentralized to the extent that statute permits.

Question 2: In participating in state health reform, won't VA in effect be guaranteeing that it will provide all needed care covered in the state plan to enrollees at a fixed cost/enrollee? This would be an entirely new undertaking for VA, and miscalculations could be costly, couldn't they?

Answer: Yes. A VA health care plan with a benefits package as defined by the state would be offered to many enrollees for a fixed premium. We may also have the opportunity to sell supplemental benefit packages for services offered by VA and not offered in the state benefit package. It is important to remember that the price of such plans assumes that every offered service will not be used by every enrollee.

The greatest area of concern with respect to possible miscalculations is expected to be associated with our ability to actuarially assess our potential enrollment and to then set our prices accordingly. That is what it will take if VA is to participate effectively as a health plan--on a level playing field with all other health plans. It is the art of assessing future costs and revenues so as to set prices that VA must learn to do well, if it is to succeed in a competitive health care marketplace.

Question 3: Would you describe the major component elements of establishing a VA Plan in a state and comment on the magnitude of costs associated with those start-up efforts?

Answer: We cannot fully answer this question until a solicitation for facility proposals (SFP) is developed and evaluated and until a marketing survey is completed. We hope to have these completed this summer or fall. We can, however, comment on our efforts to date.

Some time ago we asked the lead directors to begin a strategic planning effort involving all VA facilities located in priority states or that provide significant care to veterans who are among that state's residents. It is intended that this effort will ultimately result in a business plan for VA participation in the state's reformed health care environment. The three principal elements of this strategic plan are:

a. Develop a Vision--state in concrete terms relative to programs, services, customers, and organizations.

b. Conduct a Situational Assessment--explore those factors that obstruct or enhance reaching the vision.

c. Identify a Strategy--detail actions necessary to manage issues building on strengths, overcoming weaknesses, exploiting opportunities, blunting threats and including a feasibility assessment that identifies resources needed.

Among the specific activities that lead directors have recently undertaken include the following:

a. analysis of the state health care reform legislation, the market--including current users, potential users and the competition--and the wants and degrees of satisfaction of current and potential customers.

b. design and assessment of VA's approach to statewide participation, including analysis of costs, and exploration of the efficacy and method of sharing and reallocating VA resources to meet customer demands.

c. assessment of strengths and weaknesses in accomplishing plans, including the identification of major obstacles and actions necessary to address deficiencies that can be resolved at various levels of VA.

Question 4: How do we avoid a situation where, under broad delegations of authority, a national VA system becomes fragmented as facilities in individual states pursue a state-focused mission rather than a VA system mission?

Answer: State-based health care reform and national health care reform share common elements. Both are concerned with controlling cost, improving the quality of care, improving access and designing a delivery system that is more responsive to their customers. That is and will remain the national mission of VA.

However, veterans do not live, work, and get sick on a national scale. They live, work, and need health care at or near their home. The most overused but true phrase of health care reform in VA is that "health care is local." It is through the broad delegations of authority, and the decentralization of VA health care, that we will be best able to respond to what veterans want: local health care tailored to their particular needs.

Finally, the VA is an integrated national system that will continue to be a national resource for veterans who require a specialized service, such as Spinal Cord Injury (SCI), Post Traumatic Stress Disorder (PTSD), blind rehabilitation services, and substance abuse treatment programs. These services will remain for veterans along with the comprehensive benefits services provided to every veteran who enrolls in a VA health plan. It is in that respect that we will continue to simultaneously have a national VA system mission while providing health care on a local basis with state-focused planning.

Question 5: One purpose of participating in State reform efforts would seem to be to serve as a laboratory for the larger system. What provision is the Department making for the pilot participants to focus on the "exportability" of their work?

Answer: A major reason for participating in state reform and for having the authority to conduct pilots is so that the pilots may serve as laboratories for VA health care reform as a whole. We expect that we will test many of the nationally-planned elements of our implementation plan for national health care reform and we will learn of locally tried aspects that warrant broader application in VA. The primary reason for conducting pilots is to test ideas and proposed changes on a limited basis before they are implemented on a national scale. There are many issues and lessons to learn for VA to participate in a national, competitive health care environment.

We are in the process of developing a solicitation for facility proposals (SFP) in order to competitively select the most promising sites for VA pilot program participation. This SFP will be sent to states that have already enacted comprehensive health care reform initiatives. The criteria for selection will essentially be based on the potential for the pilot state to serve as a model for VA to learn how best to compete with other health care providers in other states when national health care reform is enacted. VA is specifically interested in the extent to which a proposed pilot state plans to provide or phase in universal coverage and cost controls. We are also interested in the pilot state's proposed scope of benefits offered to residents and the sources of financing.

We plan to closely monitor the progress of pilot states and plan to conduct a research-based evaluation of the pilots. We expect that the results of the evaluation will be disseminated throughout VA and to Congress and will include any statutorily required information and assessments.

Chairman Rowland to Malcom Randall, Director, VA Medical Center, Gainesville, FL

HONORABLE J. ROY ROWLAND
SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE
HEARING ON MARCH 8, 1994
QUESTIONS SUBMITTED FOR THE RECORD
FOR PANEL I

1. The Department's testimony said that VA is evaluating the desirability of consolidating personnel, procurement, and other administrative offices now located in each hospital as a means of reducing staff. Isn't it likely that health reform will significantly increase hospital responsibilities in some of these areas -- requiring more personnel rather than fewer?

Answer: If we are going to compete for veteran patients through Accountable Health Plans (AHPs), it will be necessary for us to establish small clinics in the Primary Service Area of each VAMC. The problem of ready access in terms of distance and miles driven is key to whether or not VA can successfully compete. We must compete for the lower priority patients (i.e., higher-income veterans, nonservice-connected), in addition to service-connected and lower income-veterans, in order to compensate for any loss in patients that might occur because both groups of veterans decide to receive their care in their home communities under the coverage that would be provided through health care reform. The first issue we must deal with, therefore, is the issue of access. Although the access clinics that we would establish would be mini-clinics rather than satellite clinics that VA now has, the number of these clinics would depend on the size of the Primary Service Areas. Thus, VA would be required to either establish these clinics with VA personnel or to contract for the services. If these community clinics bring in veterans we have not been seeing before, it could increase the number of patients that require hospitalization. If this happens, some of the beds that have been closed will need to be reopened, requiring additional personnel. However, it is too early to tell whether implementation of health care reform will require expansion of administrative offices in areas where we are currently seeking to achieve more efficient operations. In any event, the types of organizational changes we are making in order to become more efficient will not be inconsistent with implementation of reform.

2. VA officials have long maintained that there is suppressed veteran demand for VA care. If so,isn't there a likelihood that as some of your patients opt out of the system to obtain care under a new State plan, that others would take their place:

Answer: I agree with the VA officials that there is a suppressed demand for VA care, particularly in Florida. Florida VAMCs have been turning away many patients based on the "space available" concept. Many of these lower priority patients have attempted to access the VA system repeatedly, and then have stopped attempting to access the system because they realize that they probably will not be picked up in a patient care program. If we do a good job of making access available close to their homes and of providing prompt, responsive treatment, I

believe that we have a good chance of having many of these patients who have not been accepted in the past choose the VA Accountable Health Plan.

3. How do we ensure that the start-up work and systems which you develop to establish and operate health plans can be exported to serve national needs? Conversely, how do we guard against your developing or obtaining software, for example, that could not be easily meshed into the development of a uniform, national electronic patient record?

Answer: We can ensure that start-up work and systems in the different states can be exported by establishing pilot states. Out of these pilot states can come practical operating experience which can be used to develop national guidelines for all of the states. As to the second part of this question, if pilot states are established, they can be instructed not to use software that could not be easily meshed into the development of a uniform, national electronic patient record.

4. Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without any impact on veterans' care?

Answer: I do not know the extent to which the VA Central Office can reduce FTEE through mechanisms such as streamlining administrative operations, eliminating certain Central Office functions, and the contracting route. I do know that they are making every attempt to avoid any impact of FTEE reductions on patient care. Reductions in direct care personnel that are applied systemwide could have an adverse impact on our ability to provide care to our patients, but as we change from specialty care to primary care, we may find some personnel reductions may not have a significant effect on patient care.

QUESTIONS SUBMITTED FOR THE RECORD
MALCOM RANDALL, VAMC, GAINESVILLE, FL
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 8, 1994

1. Your state is already in the process of implementing state reform efforts with universal coverage as its goal. What waiver authorities are necessary for VA to become a full participant in state reform?

Answer: There are a number of federal issues which would require waiver for VA to become a full participant in state reform. I will detail a few of the necessary waivers.

Contracting Authority. We need local authority to enter into contracts to form an accountable health partnership (AHP) or to join one. The authority must allow us to enter into other contracts to facilitate AHP formation, such as with consultants. It should also allow us to participate in medical assistance, Medicaid, and other state programs for disadvantaged citizens to the extent compatible with our mission to treat veterans (and perhaps their families).

Ability to Use Appropriated Funds. There is legislation pending in the Florida Legislature authorizing VA to automatically function as an AHP. If the state is unable to pass this legislation, we need authority to use appropriated funds to form an AHP, to capitalize any new organizations, to establish any reserves or deposit required by state law, to market the AHP and to advertise it. This authority must allow us to keep funds in reserve to the extent necessary to comply with state regulatory requirements. The authority should further allow us to agree to indemnification provisions to the extent required by state law.

Eligibility Waivers. The Federal interim legislation should authorize VA to provide the state's comprehensive care package to eligible veterans and their families. The law should allow us to provide obstetrical and emergency care. The law should allow us to provide whatever care may be necessary to meet conversion and continuation of care requirements, to comply with state requirements in case unforeseen circumstances result in loss of coverage. The law should allow us to waive all copayments, deductibles, and premiums so we can structure payments from eligible veterans in accordance with the market.

Submission to State Regulations. The legislation should permit us to use appropriated funds to pay state fees and or state licenses necessary to participate as an AHP, and otherwise agree to follow state regulations if that is necessary to compete in the marketplace.

Pre-emption of State Provisions and Non-Discrimination Clauses. The Clinton plan provides for pre-emption of state provisions and health alliance requirements that are contrary to Federal law or regulation and also provides that alliances may not discriminate against VA plans due to those differences. We need that type of provision immediately. We also need a provision providing that a state may not deny licensure, registration, certification, or whatever regulatory

language is used in that state to VA plans based on the VA plan's refusal to comply with state provisions that are contrary to Federal law, regulation or policy.

Local Control. We need local control to contract and waive specific manual provisions impeding our participation in state health care reform. We also need fiscal waivers to permit us to move funds between control points.

Personnel Issues. In order to respond to the market place, we need waivers of certain Title 5 and Title 38 personnel practices.

Alternative Dispute Resolution. We need authority to enter into binding arbitration to resolve claim disputes, arising from AHP operations including access to the Judgment Fund for payment of medical malpractice claims. We also need to be able to use this process for eligibility claims and other issues that impact on medical care but are now resolved by VBA.

Education Issues. We need broad authority to participate in health professional education programs, such as state-run internships and loan forgiveness programs. We need broad authority to enroll in other Federal programs and state and local programs either as an educational institution, employer of graduates, or employer of current students.

Release of Information. We need an amendment to 38 USC 5701 to allow us to release names and addresses of patients to the state for patient surveys and other information required by state law such as comparative data to enable residents to make more informed choices.

2. Do you believe inclusion of dependents of veterans is essential to successful VA participation in state reform? Why or Why not?

Answer: Yes, to truly compete successfully in the Florida health care reform program, VA will have to include the treatment of the dependents of veterans. Estimates show that 69 percent of the veteran population uses health care services in a given year. Of this number, only 14 percent use VA as their health care provider. A majority (82 percent) of the veterans in Florida have at least one dependent residing in their household. Over 62 percent of Florida's veterans have incomes that exceed $25,000 per year. Normally, families purchase health care coverage as a unit rather than for the individuals members of the family. If VA is going to successfully compete as an accountable health plan (AHP), we need to offer our AHP to the veteran and his/her entire family. We must be able to either provide the veteran and his/her family with treatment in a VA facility or purchase the service through a contractual arrangement. If we do not provide health care coverage for the veteran and his entire family, it likely that the veteran would choose to purchase another AHP to provide health care coverage.

3. How does the uniform basic benefit package provided to those covered in your state compare to the health care services provided by VA? More comprehensive or less comprehensive?

Answer: Although Florida's basic benefit package has not been fully defined by the legislature, the proposed benefits package offered by the state would be slightly less comprehensive than the services the VA currently provides to certain eligible veterans. The VA offers a full continuum of care, including services such as dental, optometry and home health care. The state package includes these services on a very restricted basis. The state plan does, however, emphasize primary and preventive care -- a VA priority.

A major difference between the state package and VA health care is the area of women's services. VA has made tremendous progress in providing quality women's health care services. However, current eligibility restrictions prohibit VA from providing obstetrical services to veterans. Because of these resolutions, the state package does offer more comprehensive benefits for women.

4. If waiver authority is granted to allow VA participation in your state, what assurances do we have that you will continue to provide services to veterans which may be outside the basic benefits package? (i.e., Spinal Cord Injury and Blind Rehabilitation, prosthetics)

Answer: The services VA offers that exceed the state's basic benefits package such as spinal cord injury programs, blind rehabilitation, and prosthetics make the VA benefits package more attractive to veterans who are purchasing an AHP. They will assist us in marketing our AHP as the best plan for veterans. As the providers of these specialized services, VA practitioners have become experts in these highly specialized areas of care. These types of specialized services are normally tied to our affiliations with medical schools. They are what make VA the most appropriate plan for veterans. VA knows the health care needs of veterans and has services to meet these needs. As the veteran population ages, the need for these services, especially prosthetics, will be a major marketing tool for VA. In addition, these services are integral to VA's mission in meeting veterans' specialty needs, and I believe VA will continue to attach a priority to them.

5. Have you studied what effect there will be on veteran workload at your medical center if VA cannot participate in state reform?

Answer: Yes, the possibility exists that VA's workload will decrease unless we participate in state reform. The most significant threat in Florida is the proposed MedAccess program. This program would allow Florida citizens who earn up to 250% of the poverty level to buy in to the Medicaid program. Approximately 14%, or 21,361 of the 153,104 veterans actually treated by the VA would be eligible to receive their health care through the MedAccess program. These conservative estimates place VA's workload at a 14% decrease, if all of veteran patients eligible to buy in to Medicaid did so and discontinued using VA facilities.

6. If VA participation were allowed, please describe briefly how VA would function in your state.

Answer: As part of VA's transition into health care reform, the VA medical centers in Florida are developing a strategic plan to insure successful integration with the state health care reform program. The VA medical centers in Florida would like to participate as full partners in the Florida health care reform program and develop an accountable health plan. The primary goal for the VA Medical Centers in Florida is the development of a health care delivery model that will insure that VA can successfully compete in the reformed health care market. The VA facilities in Florida would operate as an integrated health care network with health care provided either in a VA facility or through contractual arrangements with local health care providers.

7. How optimistic are you that VA could transform itself in your state to become a primary care focused system? Are additional resources necessary to achieve this?

Answer: VA facilities in Florida will be able to make the transformation. Additional resources from revenues from insurers are essential to enable VA to provide access to the substantial numbers of veterans and their dependents who are not now receiving care from VA facilities in Florida to provide access in locations which lack local VA facilities, and to provide access to the wide range of women's and children's services not currently available at VA facilities but which will be essential in order to attract and retain veterans and their dependents. These services need to be local.

8. What effect will VA transformation to a primary care mission have on VA's partnership with affiliated medical schools?

Answer: If we work closely with the affiliated medical schools, it should have minimal effect. The medical schools of the country are already making changes to increase the number of primary care physicians that they produce. They also are emphasizing primary care in the ambulatory care clinics at the medical school. In addition, they are either establishing clinics in communities away from the medical school campus, or are seeking linkages with existing clinics, group practices, preferred provider organizations, and similar settings in order to provide primary care experience for undergraduate medical students and for residents.

9. Is it possible for VA to compete with waiver authority in the various state initiatives and still maintain its research, medical education and backup to DOD missions?

Answer: We will be able to compete in the various state health care reform plans and still be able to maintain our missions of research, medical education and backup to DOD. The current changes in health care are going to accelerate. This finds the medical schools as well as the VA seeking new ways to provide access to care to make the institutions more user friendly and to move toward increased primary care. Thus, if we plan carefully, I can see that VA's ties with the medical schools will strengthen our ability to meet the four missions of the VA health care system. As the medical schools seek to greatly expand their primary care programs, they will certainly maintain their specialty training programs

which would insure that VA patients had access to all the specialty care they might require. Backup to DoD will be unaffected by these changes.

10. If VA were to enact comprehensive eligibility reform with a clearly identified veteran population who would be mandated to receive certain services, would state waiver authority be necessary?

Answer: I have been working closely with the Florida Agency for Health Care Administration (AHCA) concerning the current requirements of the Florida health care reform program and how they affect VA. The Director of the Florida agency has indicated that he recognized the contributions VA makes to the health care of Florida's citizens and that VA is a vital component in Florida's health care program. Recently, the agency requested that I review draft legislation that would specifically waive VA from some of the state requirements under current state legislation. Draft legislation currently before the Florida Legislature removes all restrictive licensing and other technical barriers to VA's participation while leaving intact the regulations relating to performance and services for AHPs.

11. What effect do you believe the Administration's FTEE reduction would have on the ability of your facility to compete if the health security act was enacted?

Answer: It is too early to determine. If we are successful to compete under the health security act, we no doubt will need to enter into some contractual relationships with local hospitals and clinics in order to provide access closer to the homes of veterans.

12. How will inpatient and outpatient workloads at your facilities be impacted as a result of the administration's federal workforce reduction?

Answer: I do not know the extent to which the VA Central Office can reduce FTEE through mechanisms such as streamlining administrative operations, eliminating certain Central Office functions, and the contracting route. I do know that they are making every attempt to avoid any impact of FTEE reductions on patient care.

13. Will you be forced to close beds or wards as a result of the administration's FTEE reduction?

Answer: I do not know the extent to which the VA Central Office can reduce FTEE through mechanisms such as streamlining administrative operations, eliminating certain Central Office functions, and the contracting route. I do know that they are making every attempt to limit the impact of FTEE reductions on patient care.

14. How will sharing agreements with DoD and the private sector be impacted by the administration's FTEE reductions?

Answer: At the present time, I do not know whether or not it will affect any of our DoD or private sector sharing agreements.

15. How many of the veterans treated in your facility reside outside the state?

Answer: Approximately 10 percent of the Gainesville VA Medical Center outpatient visits are for veterans who reside outside the state of Florida. The percent of the inpatients treated who reside outside the state of Florida is approximately the same.

16. Are you funded above or below the mean within your hospital group RPM analysis based on unit of facility work?

Answer: The Gainesville VA Medical Center is funded well below the national average in terms of cost per unit workload. We are one of the lowest funded in the mid-size affiliated hospital category.

17. Please submit the RPM data which explains exactly where your hospital currently falls within your group.

Answer: See Attachment A for RPM data.

Facility: 573 - Gainesville Region: 3 Hospital Group: 3 Mid-Affil

Cost Efficiency

c.1 Data Displayed	c.2 Nat Rnk	c.3 Reg Rnk	c.4 HG Rnk	c.5 Patient Count	c.6 Fac Work	c.7 Pat Care Recurring 01 Cost	c.8 Pat Care Cost	c.9 Cost/ FacWork	c.10 Pct Diff from the HG Mean	c.11 Out	c.12 Diff from the HG Mean	c.13 St Dev from the HG Mean
1a Rec 01 Cost / Fac	116	22	37	36,211	26,111	$92,971,128	$103,353,187	$3,561	-8.71		-$340	-.54
2a AO Cost / FacWork				36,211	26,111	$92,971,128	$23,006,515	$881	-9.44	n/a		

Cost Efficiency - Special Pay Indicator

c.1 Data Displayed	c.2 Nat Rnk	c.3 Reg Rnk	c.4 HG Rnk	c.5 Patient Count	c.6 FTE	c.7 Pat Care Recurring 01 Cost	c.8 Pat Care Cost	c.9 Average Salary	c.10 Pct Diff from the HG Mean	c.11 Out	c.12 Diff from the HG Mean	c.13 St Dev from the HG Mean
3a Average Salary				36,211	1,629.1	$92,971,128	$71,270,575	$43,750	-3.69	n/a		
4a RN Average Salary	107	28	33	36,211	342.1	$92,971,128	$18,332,957	$53,589	-5.12	n/a	-$2,890	-.57

Productivity

c.1 Data Displayed	c.2 Nat Rnk	c.3 Reg Rnk	c.4 HG Rnk	c.5 Patient Count	c.6 Fac Work	c.7 per 1000 FTE	c.8 FTE Fac Work	c.9 Pct Diff from the HG Mean	c.10 Out	c.11 Diff from the HG Mean	c.12 St Dev from the HG Mean
5a Total FTE / FacWo	115	24	37	36,211	26,111	1,629.1	62.39	-8.26		-5.6141	-.74
6a MD FTE / FacWork	101	20	30	36,211	26,111	93.2	3.60	-8.45	n/a	-.3040	-.36
7a RN FTE / FacWork	89	9	28	36,211	26,111	342.1	13.10	-1.97	n/a	-.3006	-.13

Staffing Mix

c.1 Data Displayed	c.2 Nat Rnk	c.3 Reg Rnk	c.4 HG Rnk	c.5 Patient Count	c.6 FTE Numerator	c.7 FTE Denominator	c.8 FTE Ratio	c.9 Pct Diff from the HG Mean	c.10 Out	c.11 Diff from the HG Mean	c.12 St Dev from the HG Mean
8a RN FTE / Nur FTE	53	10	14	36,211	342.1	473.8	.722	7.48	n/a	.0502	.71
9a Ind FTE / Dir FTE	144	37	40	36,211	445.1	1,155.9	.385	-15.35	n/a	-.0698	-.68

Resource Utilization

c.1 Data Displayed	c.2 Nat Rnk	c.3 Reg Rnk	c.4 HG Rnk	c.5 Patient Count	c.6 Pat Care Recurring 01 Cost	c.7 Total Indirect Costs	c.8 Total Direct Costs	c.9 IndCost per DirCost	c.10 Pct Diff from the HG Mean	c.11 Out	c.12 Diff from the HG Mean	c.13 St Dev from the HG Mean
10a IndCst / DirCst	140	33	40	36,211	$92,971,128	$24,048,870	$69,015,321	.348	-17.62	n/a	- 07	-.76

Chairman Rowland to J. M. Manley, Acting Director, VAMC, Seattle, WA

HONORABLE J. ROY ROWLAND

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

HEARING ON MARCH 8, 1994

QUESTIONS SUBMITTED FOR THE RECORD

FOR PANEL I

1. THE DEPARTMENT'S TESTIMONY SAID THAT VA IS EVALUATING THE DESIRABILITY OF CONSOLIDATING PERSONNEL, PROCUREMENT, AND OTHER ADMINISTRATIVE OFFICES NOW LOCATED IN EACH HOSPITAL AS A MEANS OF REDUCING STAFF. ISN'T IT LIKELY THAT HEALTH REFORM WILL SIGNIFICANTLY INCREASE HOSPITAL RESPONSIBILITIES IN SOME OF THESE AREAS -- REQUIRING MORE PERSONNEL RATHER THAN FEWER?

We believe that some consolidations may be possible over the next few years primarily due to advances in ADP technology. It is unknown at this point, what long term staffing adjustments may be possible or what specific impact a significant increase in enrollees may have on our operation.

2. VA OFFICIALS HAVE LONG MAINTAINED THAT THERE IS SUPPRESSED VETERAN DEMAND FOR VA CARE. IF SO, ISN'T THERE A LIKELIHOOD THAT AS SOME OF YOUR PATIENTS OPT OUT OF THE SYSTEM TO OBTAIN CARE UNDER A NEW STATE PLAN, THAT OTHERS WOULD TAKE THEIR PLACE?

When the Washington State health reform law is fully implemented in 1999, all State residents will have universal coverage and will be required to choose a Health Plan. If VA does not compete successfully with the other Health Plans, then we risk losing 100% of our patients. However, if we are successful, the VA Plan may be particularly attractive to service connected and low income veterans, in which case, we would attract additional patients. Historically, the VA has cared for approximately 51,000 of the State's veteran population of 650,000.

3. HOW DO WE ENSURE THAT THE START-UP WORK AND SYSTEMS WHICH YOU DEVELOP TO ESTABLISH AND OPERATE HEALTH PLANS CAN BE EXPORTED TO SERVE NATIONAL NEEDS? CONVERSELY, HOW DO WE GUARD AGAINST YOUR DEVELOPING OR OBTAINING SOFTWARE, FOR EXAMPLE, THAT COULD NOT BE EASILY MESHED INTO THE DEVELOPMENT OF A UNIFORM, NATIONAL ELECTRONIC PATIENT RECORD?

We expect that VACO program offices will be actively involved in development of finance, enrollment, insurance, marketing, and other systems developed or modified to insure that they are compatible and exportable to other VA facilities. On any software or systems development project we will be working closely with the VA's Information Systems Centers (ISCs), who are responsible for DHCP software development. The ISC's will assist us in making certain that

3. DO YOU BELIEVE INCLUSION OF DEPENDENTS OF VETERANS IS ESSENTIAL TO SUCCESSFUL VA PARTICIPATION IN STATE REFORM? WHY OR WHY NOT?

Yes, I believe inclusion of veterans dependents is essential because in most cases health care is a family, not an individual issue/ decision. It is also more efficient and effective for families to get their primary care from one physician who is familiar with the family's circumstances. Without enrollment of families, the VA certified health plan would lack some of the elements of an integrated managed delivery system, which would put it at a competitive disadvantage with other plans.

4. DOES THE UNIFORM BASIC BENEFIT PACKAGE PROVIDED TO THOSE COVERED IN YOUR STATE COMPARE TO THE HEALTH CARE SERVICES PROVIDED BY VA? MORE COMPREHENSIVE OR LESS COMPREHENSIVE?

The Washington State Uniform Benefits Package (UBP) will not be fully defined until December, 1994.

5. WAIVER AUTHORITY IS GRANTED TO ALLOW VA PARTICIPATION IN YOUR STATE, WHAT ASSURANCES DO WE HAVE THAT YOU WILL CONTINUE TO PROVIDE SERVICES TO VETERANS WHICH MAY BE OUTSIDE THE BASIC BENEFITS PACKAGE? (I.E., SPINAL CORD INJURY AND BLIND REHABILITATION, PROSTHETICS)

VA excels in these areas and they may prove to be our niche in the market place. Further, since we expect that no veteran would lose services they are currently entitled to, we will need to continue to provide these special services. The VA has a distinct obligation and mission to serve this valuable and vulnerable group of veteran patients.

6. HAVE YOU STUDIED WHAT EFFECT THERE WILL BE ON VETERAN WORKLOAD AT YOUR MEDICAL CENTER IF VA CANNOT PARTICIPATE IN STATE REFORM?

Although no formal study has been conducted, we believe that we are potentially at risk for losing 100% of our current patients at such time that State Reform is fully implemented. If the VA is not a fully qualified and certified Health Plan, we would most likely be relegated to a secondary provider status in the state.

7. IF VA PARTICIPATION WERE ALLOWED, PLEASE DESCRIBE BRIEFLY HOW VA WOULD FUNCTION IN YOUR STATE.

VA would meet the requirements to become a State-wide Certified Health Plan (CHP), with the ability to enroll veterans and their families, collect premiums, and offer the Uniform Benefits Package (UBP) at community rated premiums.

our development efforts are in line with similar efforts nationally and at other VAMCs so that we do not duplicate the work of others and our finished product is compatible with and exportable to other systems.

4. DO YOU HAVE CONFIDENCE THAT, AS VA'S FORMAL TESTIMONY IMPLIED, IT CAN ACHIEVE A MASSIVE REDUCTION IN ITS WORKFORCE SIMPLY BY STREAMLINING ADMINISTRATIVE OPERATIONS, AND DO THAT WITHOUT ANY IMPACT ON VETERANS' CARE?

As stated in my testimony of March 8, 1994, before the Subcommittee on Hospitals and Health Care, I believe the VA Medical Centers in Washington State may be in the unique position of having to expand services to meet the requirements of the State reform law. VA Central Office is currently developing plans to meet the employment levels proposed in the FY 1995 budget. At this point, I do not know the details of VA's plans and have no basis to judge the potential success of the initiative.

HONORABLE CHRIS SMITH

QUESTIONS SUBMITTED FOR THE RECORD

JOSEPH MANLEY, VAMC, SEATTLE, WA

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

MARCH 8, 1994

1. YOUR STATE IS ALREADY IN THE PROCESS OF IMPLEMENTING STATE REFORM EFFORTS WITH UNIVERSAL COVERAGE AS ITS GOAL. WHAT WAIVER AUTHORITIES ARE NECESSARY FOR VA TO BECOME A FULL PARTICIPANT IN STATE REFORM?

We would need to be exempted from certain contracting and sharing provisions; to reorganize offices without first seeking congressional approval; and to obtain a waiver from state law to allow the VA Health Plan to limit enrollment to veterans and their dependents.

2. CURRENTLY YOUR STATE RECEIVES OVER $250 MILLION IN ANNUAL APPROPRIATIONS IN ORDER TO PROVIDE HEALTH CARE TO VETERANS. HOW MUCH ADDITIONAL RESOURCES WOULD BE NECESSARY IN ORDER FOR VA TO PARTICIPATE AS A VIABLE OPTION UNDER YOUR STATE PLAN?

We do not have the technical means to estimate future needs at this time.

The proposed WA State VA Health Care Plan would:
Offer two health plan choices. One choice will be the UBP. For a higher premium, another choice will include added benefits.

Service connected and low income veterans would be exempt from premiums, copayments or deductibles, if they choose the VA plan.

Ideally, the VA Plan will have contracts with private providers, hospitals, and other health plan providers located throughout the state in order to offer local care to veterans and their families.

8. HOW OPTIMISTIC ARE YOU THAT VA COULD TRANSFORM ITSELF IN YOUR STATE TO BECOME A PRIMARY CARE FOCUSED SYSTEM? ARE ADDITIONAL RESOURCES NECESSARY TO ACHIEVE THIS?

We are very optimistic. Additional resources may be necessary to create a primary care focused system that covers the state, to be competitive with other providers, and to meet state mandates in the areas of finance, insurance, data systems, malpractice, and quality.

9. WHAT EFFECT WILL VA TRANSFORMATION TO A PRIMARY CARE MISSION HAVE ON VA'S PARTNERSHIP WITH AFFILIATED MEDICAL SCHOOLS?

The expanded primary care mission for Washington State VAMC's should strengthen the affiliation with the University of Washington School of Medicine. The UWSM is unique among leading US medical schools in having a strong and successful commitment to supporting rural care in the northwest and in training medical students and residents in primary care.

10. IS IT POSSIBLE FOR VA TO COMPETE WITH WAIVER AUTHORITY IN THE VARIOUS STATE INITIATIVES AND STILL MAINTAIN, ITS RESEARCH, MEDICAL EDUCATION AND BACKUP TO DOD MISSIONS?

Yes. However, it should be recognized that most academic medical centers, are experiencing stress and anxiety because of increasing competition based on cost and the recognition that education and research add to the cost of health care provided in the academic medical centers. Academic medical centers have responded by becoming more cost efficient. The other strategy to help preserve the education and research missions has been to more clearly identify and then separately fund the true costs of these missions. This has been included in the President's plan, and it is likely that the Washington State Legislature will expand the current level of support it provides for postgraduate medical education as part of its Health Care Reform. In the VA, education and research are both clinically based, and to the degree that successful competition by the VA allows for expansion of the clinical work load, these missions would benefit.

Conversely, because increased competition and Health Care Reform is occurring in the State of Washington, if the VA is not allowed to compete it would likely lead to a significant reduction in patient work load and eventually the failure of this VA academic medical center. Thus, we feel that continued success of the missions of education, research and backup for DOD would be best guaranteed by giving us the waivers and support that will give us the best chance to compete successfully.

11. IF VA WERE TO ENACT COMPREHENSIVE ELIGIBILITY REFORM WITH A CLEARLY IDENTIFIED VETERAN POPULATION WHO WOULD BE MANDATED TO RECEIVE CERTAIN SERVICES, WOULD STATE WAIVER AUTHORITY BE NECESSARY?

This is unknown and depends on which services are mandated through the UBP.

12. WHAT EFFECT DO YOU BELIEVE THE ADMINISTRATION'S FTEE REDUCTION WOULD HAVE ON THE ABILITY OF YOUR FACILITY TO COMPETE IF THE HEALTH SECURITY ACT WAS ENACTED?

As stated in my testimony of March 8, 1994, before the Subcommittee on Hospitals and Health Care, I believe the VA Medical Centers in Washington State may be in the unique position of having to expand services to meet the requirements of the State reform law. VA Central Office is currently developing plans to meet the employment levels proposed in the FY 1995 budget. At this point, I do not know the details of VA's plans and have no basis to judge the potential success of the initiative.

13. HOW WILL INPATIENT AND OUTPATIENT WORKLOADS AT YOUR FACILITIES BE IMPACTED AS A RESULT OF THE ADMINISTRATION'S FEDERAL WORKFORCE REDUCTION?

See response to question 12.

14. WILL YOU BE FORCED TO CLOSE BEDS OR WARDS AS A RESULT OF THE ADMINISTRATION'S FTEE REDUCTIONS?

See response to question 12.

15. HOW WILL SHARING AGREEMENTS WITH DOD AND THE PRIVATE SECTOR BE IMPACTED BY THE ADMINISTRATION'S FTEE REDUCTIONS?

See response to question 12.

16. HOW MANY OF THE VETERANS TREATED IN YOUR FACILITY RESIDE OUTSIDE THE STATE?

VAMC Seattle treated 26,410 veterans in fiscal year 1993 of which 22,134 were WA State veterans and 4,276 were from outside the state.

17. ARE YOU FUNDED ABOVE OR BELOW THE MEAN WITHIN YOUR HOSPITAL GROUP RPM ANALYSIS BASED ON UNIT OF FACILITY WORK?

Seattle is below the mean for Hospital Group 3 based on unit of facility work. The mean for Hospital Group 3 (48 facilities) is $3,900; Seattle's is $3,860 which is -1.03 percent below the mean.

18. PLEASE SUBMIT THE RPM DATA WHICH EXPLAINS EXACTLY WHERE YOUR HOSPITAL CURRENTLY FALLS WITHIN YOUR GROUP.

See attached report.

RPM TA — Patient Care Recurring 01 Cost per F — Cost Efficiency) — UCR 1a

c.1 Nat Rnk	c.2 Reg Rnk	c.3 HC Rnk	c.4 Fac	c.5 Facility Name	c.6 Reg	c.7 HC	c.8 Patient Count	c.9 Fac Work	c.10 Pat Care Recurring 01 Cost	c.11 RPM Total Cost	c.12 Rec 01 Cost/ FacWork	c.13 Pct Diff from the HC Mean	c.14 Out	c.15 Diff from HC Mean	c.16 St Dev from HC Mean
1	1	1	512	Martinez	4	3	29,782	10,644	$70,452,328	$88,147,194	$8,619	89.70		$2,718	4.34
6	3	2	526	Bronx	1	3	26,700	20,736	$110,201,874	$120,187,047	$5,314	38.26	Hi*	$1,414	2.26
8	5	3	665	Sepulveda	4	3	18,925	18,834	$97,689,753	$107,588,082	$5,187	32.09	Hi*	$1,287	2.05
18	10	4	642	Philadelph	1	3	27,313	21,909	$102,252,289	$111,438,092	$4,867	19.66	Hi*	$767	1.22
19	11	5	561	East Orang	1	3	28,906	24,426	$112,835,423	$125,005,247	$4,807	18.11		$706	1.13
23	13	6	689	West Haven	1	3	17,860	18,033	$81,842,602	$83,648,186	$4,541	10.42		$441	1.02
32	19	7	523	Boston	1	3	37,109	28,408	$115,963,355	$131,806,284	$4,391	12.58		$490	.78
33	9	8	605	Loma Linda	4	3	25,050	18,621	$81,627,406	$87,322,398	$4,384	12.39		$483	.77
34	10	9	662	San Franci	4	3	24,661	20,726	$90,270,972	$115,742,638	$4,355	11.66		$455	.73
35	6	10	607	Madison	2	3	12,887	11,036	$47,881,942	$54,646,394	$4,338	11.22		$438	.70
39	9	11	535	Chicago (L	2	3	20,976	16,304	$68,736,295	$73,205,877	$4,216	8.10		$316	.50
41	1	12	521	Birmingham	3	3	26,497	17,494	$73,725,435	$83,158,821	$4,214	8.05		$314	.50
51	12	13	583	Indianapol	2	3	25,644	20,756	$84,424,279	$89,278,978	$4,087	4.20		$187	.27
54	24	14	646	Pittsburgh	1	3	24,602	23,182	$92,892,540	$100,218,435	$4,011	2.83		$110	.18
60	16	15	552	Dayton	2	3	19,290	23,238	$93,068,125	$100,391,223	$4,006	2.69		$105	.17
65	8	16	629	New Orlean	3	3	29,713	22,313	$87,997,889	$89,838,884	$3,944	1.12		$43	.07
68	26	17	500	Albany	1	3	21,877	19,984	$78,365,984	$80,328,400	$3,925	.64		$25	.04
75	11	18	534	Charleston	3	3	19,210	14,300	$56,993,076	$61,832,631	$3,865	-.38		-$15	-.02
76	18	19	664	San Diego	4	3	30,957	24,411	$94,483,169	$109,078,128	$3,870	-.76		-$30	-.05
77	32	20	512	Baltimore	1	3	23,487	16,426	$63,524,877	$71,793,023	$3,867	-.85		-$33	-.05
78	17	21	584	Iowa City	2	3	16,713	13,885	$52,841,384	$62,206,237	$3,867	-.86		-$33	-.05
79	16	22	506	Ann Arbor	2	3	25,486	19,639	$75,860,981	$89,171,110	$3,884	-.94		-$37	-.06
80	19	23	663	Seattle	4	3	22,422	24,528	$93,442,512	$113,826,385	$3,880	-1.03		-$40	-.06
83	19	24	589	Kansas Cit	2	3	22,449	16,379	$70,820,728	$81,937,109	$3,993	-1.20		-$47	-.07
84	20	25	537	Chicago (W	2	3	30,048	21,993	$84,700,788	$97,800,819	$3,851	-1.26		-$49	-.08
85	13	26	558	Durham	3	3	21,783	18,931	$72,458,076	$83,096,969	$3,827	-1.87		-$73	-.12
87	34	27	688	Washington	1	3	29,404	25,390	$98,814,358	$112,587,892	$3,813	-2.23		-$87	-.14
88	21	28	596	Lexington	2	3	18,981	24,152	$91,804,088	$98,700,912	$3,793	-2.75		-$107	-.17
89	22	29	539	Cincinnati	2	3	19,987	17,427	$65,783,511	$77,601,929	$3,776	-3.22		-$125	-.20
102	36	30	590	Hampton	1	3	18,710	17,121	$62,454,102	$87,186,713	$3,648	-6.48		-$253	-.40
104	37	31	650	Providence	1	3	16,559	12,526	$45,498,893	$60,695,476	$3,633	-6.86		-$268	-.43
108	22	32	678	Tucson	4	3	20,777	18,068	$65,235,396	$75,174,727	$3,610	-7.43		-$290	-.46
110	40	33	480	Wilmington	1	3	13,123	8,871	$38,558,488	$39,274,855	$3,602	-7.64		-$298	-.48
113	30	34	636	Omaha	2	3	14,106	13,494	$48,521,486	$55,769,201	$3,598	-7.83		-$306	-.49
114	31	35	553	Allen Park	2	3	26,264	21,889	$78,480,680	$87,710,680	$3,684	-8.11		-$316	-.51
115	21	36	667	Shreveport	3	3	19,448	15,539	$55,300,504	$81,648,285	$3,583	-8.65		-$338	-.54
116	22	37	573	Gainesvill	3	3	36,211	28,111	$92,971,128	$103,383,187	$3,561	-8.71		-$340	-.54
118	23	38	660	Salt Lake	4	3	21,054	19,383	$68,700,005	$82,206,607	$3,545	-9.12		-$356	-.57
124	25	39	554	Denver	4	3	29,153	22,259	$77,822,971	$92,793,254	$3,496	-10.36		-$404	-.65
128	39	40	603	Louisville	2	3	20,896	18,214	$62,924,357	$73,438,802	$3,456	-11.43		-$446	-.71
129	43	41	670	Syracuse	1	3	19,003	14,196	$49,040,047	$56,986,753	$3,454	-11.44		-$446	-.71
131	27	42	501	Albuquerqu	4	3	34,120	24,240	$83,480,747	$94,620,118	$3,444	-11.70		-$458	-.73
133	27	43	635	Oklahoma C	3	3	32,531	22,113	$76,581,153	$85,288,981	$3,417	-12.30		-$483	-.77
142	32	44	508	Decatur	3	3	34,862	24,327	$80,644,318	$95,404,851	$3,318	-15.01	Lo*	-$585	-.93
144	34	45	626	Nashville	3	3	28,134	20,233	$67,011,534	$79,476,228	$3,312	-15.08	Lo*	-$588	-.94
149	38	46	586	Jackson	3	3	24,187	22,721	$72,941,142	$81,447,367	$3,210	-17.86		-$690	-1.10
155	41	47	543	Columbia (	2	3	16,187	16,743	$50,470,872	$59,038,881	$3,014	-22.71	Lo*	-$888	-1.41
157	41	48	544	Columbia (	3	3	29,624	21,880	$64,115,845	$74,081,058	$2,933	-24.80	Lo*	-$957	-1.54
				Total			1,149,983	835,066	$3,647,029,940	$4,143,534,691	$3,000				
				Std Dev							$626				

11-Jun-03

Department of Veterans Affairs / Veterans Health Administration
Budget Office (171) / Boston Development Center (171D)

Chairman Rowland to Robert A. Petzel, M.D., Chief of Staff, VAMC, Minneapolis, MN

Answers to the Supplemental Questions

1. The Department's testimony said that VA is evaluating the desirability of consolidating personnel, procurement, and other administrative offices now located in each hospital as a means of reducing staff. Isn't it likely that health reform will significantly increase hospital responsibilities in some of these areas -- requiring more personnel rather than fewer?

The consolidation on a national level will undoubtedly provide some FTEE savings (especially facility consolidations). In the short term, coping with health care reform in Minnesota may require some new and additional personnel. However, over the long term we should be able to cope with our present FTEE.

2. VA officials have long maintained that there is suppressed veteran demand for VA care. If so, isn't there a likelihood that as some of your patients opt out of the system to obtain care under a new State plan, that others would take their place?

All State residents will have universal coverage in 1997 when MinnesotaCare is fully implemented. If the VA does not compete successfully, that is, become a provider that patients will choose when they have a choice, then we risk losing a large portion of our patients. Unless we provide competitive care, we do not think new patients will come to us.

3. How do we ensure that the start-up work and systems which you develop to establish and operate health plans can be exported to serve national needs? Conversely, how do we guard against your developing or obtaining software, for example, that could not be easily meshed into the development of a uniform, national electronic patient record?

We would work with VA Central Office to ensure that what we develop would be exportable. In addition, we would expect to work closely with the other states so that communications systems, records, etc. would be compatible. Finally, entering of the electronic record would be DHCP-based and station-developed (perhaps with the other pilots). There is no system to buy and no one is ahead of the VA on this one.

4. Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without any impact on veterans' care?

I think that with facility consolidations and mission changes it could be done, however, it will take time. In Minnesota we need the flexibility to hire now and to explore how contractual services could be beneficial.

5. Dr. Petzel, in responding to a Committee survey last month, your hospital responded to a question regarding the impact of FTEE reductions on future sharing of resources with the Department of Defense. Your response indicated that required workforce reductions would likely force you to abandon efforts to develop such a sharing agreement, with resulting revenue loss of at least $750 thousand annually. Would you explain how FTEE reductions relate to sharing opportunities?

In order to capitalize on these sharing possibilities, we needed to bring on some new people. While we have excess capacity to share, we would need to add people up front in order to provide acceptable service. Under the present restrictions, we cannot add these people up front and therefore cannot start the sharing project.

Questions submitted for the record
Subcommittee on Hospitals and Health Care
March 8, 1994

1. Your state is already in the process of implementing state reform efforts with universal coverage as its goal. What waiver authorities are necessary for VA to become a full participant in state reform?

In addition to the authority provided under H.R. 4013, the following changes to the law are necessary so the Minneapolis VAMC can effectively compete under Minnesota health care reform.

Federal:

-We need authority to be a Medicare and Medicaid provider, to collect the funds for such care, and to keep the funds at the local facility for providing care that is not funded by the appropriation.

-We need authority to set up new hiring, classification, pay, and other personnel systems for Title 5 and Title 38 employees.

State:

-The state bill allow a federal agency to create an integrated service network (ISN).

-It must allow a federal agency ISN to limit care to veterans and their dependents.

-It must exempt a federal agency ISN from the requirement that it participate in Medicaid and other programs for low-income residents.

-It must encourage state officials to consult with federal officials to find a way to meet state solvency requirements for ISNs.

2. Currently your state receives over $200 million in annual appropriations in order to provide health care to veterans. How much additional resources would be necessary in order for VA to participate as a viable option under MinnesotaCare?

We approach this question from the perspective of becoming a competitive provider, i.e. providing a level of access and satisfaction that will cause veterans with insurance who have a choice to choose us. We would require some non-recurring money over an initial 3-5 year period in order to make those changes and get 80% of our patients into a primary care setting. Over this 3-5 year period, as became more efficient, freed up our inpatient resources, we would be able to cover these costs. Our estimates for this non-recurring cost is $15-20 million/year. After this initial period we would expect that increased work would bring increased revenue via third party billing.

3. Do you believe inclusion of dependents of veterans is essential to successful VA participation in MinnesotaCare? Why or why not?

No, we do not think it is essential to include dependents. Our plan involves contracting in the community for the primary care of veterans. We would hope to do this in partnership with a provider who would also care for the family. Thus the family would be cared for by the same primary care provider. The veteran would come to the VA for secondary and tertiary care. The family would go elsewhere for secondary and tertiary care. The important thing is for families to get primary care at the same location.

4. How does the uniform basic benefit package provided to those covered in your state compare to the health care services provided by VA? More comprehensive or less comprehensive?

The Minnesota benefit package is not as comprehensive as the service provided by the VA to the service connected and low income veterans.

5. If waiver authority is granted to allow VA participation in your state, what assurances do we have that you will continue to provide services to veterans which may be outside the basic benefits package? (i.e. spinal cord injury and blind rehabilitation, prosthetics).

These services will continue to be provided to patients who have care eligibility, i.e. service-connected and low income. We excel in these areas and they are an intrinsic part of our obligation to veterans. While we may slowly become less dependent on appropriation and more dependent on revenue generation, we will not lose our distinct obligations to veterans.

6. Have you studied what effect there will be on veteran workload at your medical center if VA cannot participate in state reform?

We have not studied this formally. However, we are at initial risk of losing 10-20% of our present workload. We think this will slowly increase as our "core" population shrinks. Eventually we would not be able to provide that broad range of services unique to us that the veteran community needs.

7. If VA participation were allowed, please describe briefly how VA would function in your state.

The VA would care for "core" veterans as it has in the past. It would offer the same broad range of service to these veterans as it has done in the past. In addition, the VA would offer two benefit packages to all other veterans. One would be similar to the state-wide mandated package and the other would be a "premium" package. VA would collect insurance monies etc. like any other provider in the state. To make this medical center plan attractive and viable we will have to become more accessible and more accommodating as a provider. Finally, VA will contract with other providers to provide care in specialty services to eligible veterans.

8. How optimistic are you that VA could transform itself in your state to become a primary care focused system? Are additional resources necessary to achieve this?

We are optimistic that the VA can compete in this State. We will need additional non-recurring resources to create our primary care network and improve customer satisfaction.

9. What effect will VA transformation to a primary care mission have on VA's partnership with affiliated medical schools?

We anticipate that the elevation of the VA to a more primary care focused mission (already 40% of our patients have primary care provided) will enhance the relationship with our affiliated medical school. The University of Minnesota has been a national leader in producing primary care physicians and the Minneapolis VA has been the primary training site for this program.

10. Is it possible for VA to compete with waiver authority in the various state initiatives and still maintain, its research, medical education and backup to DOD missions?

Yes, it is possible. However, it will not be easy. All academic medical centers are experiencing tremendous stress and pressure on their academic missions. It is no longer possible to simply bury the costs of research and education in the cost of patient care as the private sector has done in the past. The VA is foremost in that it has clearly delineated and separated those costs since its inception. However, as we become less dependent on appropriation and more dependent on generated revenue, it will be necessary to squeeze education and research money out of patient revenues. If we can not compete and maintain our necessary patient base then our research and education functions will not be maintained.

11. If VA were to enact comprehensive eligibility reform with a clearly identified veteran population who would be mandated to receive certain services, would state waiver authority be necessary?

We believe that we can not survive by taking care of a "mandated" population, however, under almost any imaginable scenario, we think we need to compete for eligible veterans and not just mandated veterans.

12. How will inpatient and outpatient workloads at your facility be impacted as a result of the administration's federal workforce reduction?

Unknown at this time.

13. Will you be forced to close beds or wards as a result of the administration's FTEE reductions?

We will close beds as we become more efficient and move more workload into the outpatient arena.

14. How will sharing agreements with DOD and the private sector be impacted by the administration's FTEE reductions?

The FTEE reductions have reduced the flexibility we need to execute new sharing agreements.

15. How many of the veterans treated in your facility reside outside the state?

We treated approximately 45,000 unique veterans in 1993. Of these about 8,000 were from outside of Minnesota.

16. Are you funded above or below the mean within your hospital group RPM analysis based on unit of facility work?

Minneapolis VAMC is funded below the mean for the 26 medical centers in Group 5. The mean for Group 5 is $3913; Minneapolis is $3661 which is 6.44 percent below the mean.

17. Please submit the RPM data which explains exactly where your hospital currently falls within your group.

Please see attached.

Rank	Reg Ana	HG Rnk	C.# Fac	Facility Name	C.B Reg	C.F HG	Patient Count	Fac Work	Accounting Ol Cost	Total Cost	FacWork	HG Mean Out	Mean	HG Mean
1	3	1	630	New York	1	5	31,327	25,201	$127,610,256	$147,521,005	$5,064	29.40	$1,150	1.69
2	4	2	640	Palo Alto	4	5	25,209	33,146	$165,570,210	$194,938,976	$4,995	27.55 Hi*	$1,082	1.59
3	6	3	525	Brockton/W	1	5	20,437	23,794	$118,374,840	$133,096,708	$4,975	27.13 Hi*	$1,062	1.56
4	5	4	600	Long Beach	4	5	37,871	34,000	$166,916,125	$181,615,507	$4,909	25.45 Hi*	$996	1.46
5	7	5	691	Los Angeles	4	5	36,908	39,319	$197,060,957	$214,659,069	$4,780	22.16	$867	1.27
6	9	6	527	Brooklyn	1	5	31,496	31,369	$148,957,271	$161,358,963	$4,749	21.34	$835	1.22
7	14	7	632	Northport	1	5	19,952	23,005	$104,375,728	$113,914,332	$4,537	15.94	$624	.91
8	3	8	578	Hines	2	5	30,804	35,262	$159,946,385	$173,907,735	$4,523	15.58	$610	.89
9	11	9	648	Portland	4	5	30,549	28,299	$116,676,424	$125,009,397	$4,123	5.18	$210	.31
10	13	10	695	Milwaukee	2	5	27,933	26,904	$109,576,928	$121,767,199	$4,073	4.08	$160	.23
11	15	11	541	Cleveland	2	5	41,422	34,868	$140,385,750	$156,737,449	$4,026	2.88	$113	.17
12	6	12	509	Augusta	3	5	20,679	26,342	$105,694,346	$113,948,644	$4,012	2.63	$99	.15
13	20	13	528	Buffalo	1	5	23,034	23,520	$92,424,922	$101,803,102	$3,928	.22	$15	.02
14	19	14	546	Miami	3	5	44,980	26,403	$142,232,313	$162,087,397	$3,910	-.29	-$3	
15	28	15	618	Minneapolis	2	5	45,688	40,170	$147,069,921	$169,754,074	$3,561	-6.44	-$252	-.37
16	18	16	673	Tampa	3	5	43,552	33,833	$123,524,555	$139,460,104	$3,651	-6.70	-$262	-.38
17	19	17	614	Memphis	3	5	29,211	28,934	$105,297,435	$118,106,531	$3,643	-6.92	-$271	-.40
18	20	18	657	St. Louis	2	5	34,051	31,547	$113,837,207	$128,414,153	$3,509	-7.79	-$305	-.45
19	42	19	652	Richmond	1	5	26,722	31,001	$107,750,116	$121,847,501	$3,476	-11.18	-$438	-.64
20	29	20	598	Little Roc	3	5	40,921	41,061	$139,295,325	$158,691,497	$3,392	-13.31	-$521	-.76
21	23	21	671	San Antoni	3	5	41,749	33,274	$119,573,272	$130,351,236	$3,323	-15.23	-$590	-.87
22	35	22	580	Houston	3	5	53,375	46,116	$152,648,186	$169,489,824	$3,310	-15.41 Lo*	-$603	-.88
23	36	23	549	Dallas	3	5	44,938	34,605	$114,313,003	$131,249,275	$3,303	-15.59	-$610	-.89
24	40	24	516	Bay Pines	3	5	52,277	33,629	$103,605,597	$122,221,957	$3,081	-21.27 Lo*	-$832	-1.22
25	30	25	644	Phoenix	4	5	35,112	25,756	$76,557,851	$88,550,938	$2,972	-24.04 Lo*	-$941	-1.38
26	42	26	672	San Juan	3	5	49,531	38,933	$107,351,729	$123,779,794	$2,757	-29.54 Lo*	-$1,156	-1.69
				Total			919,828	840,402	$3,288,725,312	$3,712,483,262	$3,913			
				Std Dev							$682			

HONORABLE J. ROY ROWLAND
SUBCOMMITTEE ON HOSPITAL AND HEALTH CARE
HEARING ON MARCH 8, 1994
QUESTIONS SUBMITTED FOR THE RECORD
FOR PANEL I

1. The Department's testimony said that VA is evaluating the desirability of consolidating personnel, procurement, and other administrative offices now located in each hospital as a means of reducing staff. Isn't it likely that health reform will significantly increase hospital responsibilities in some of these areas -- requiring more personnel rather than fewer?

Before I can fully answer the question, I need more information on the Departments plan.

Personnel, procurement and other Administrative offices consolidation could facilitate new structures and systems needed for new ways of doing business.

2. VA Officials have long maintained that there is suppressed veteran demand for VA care. If so, isn't there a likelihood that as some of your patients opt out of the system to obtain care under a new State plan, that others would take their place?

Yes, we are planning to attract many veterans who have not been using the VA Medical Center.

3. How do we ensure that the start-up work and systems which you develop to establish and operate health plans can be exported to serve national needs? Conversely, how do we guard against your developing or obtaining software, for example, that could not be easily meshed into the development of a uniform, national electronic patient record?

At this Medical Center we are planning to institute a system of primary managed care clinics located in the community and staffed with local community providers. This initiative can easily be exported to urban as well as rural areas. Additionally, our intent is to use the VA Decentralized Medical Management System (DMMS) and Decentralized Hospital Computer Program (DHCP) which will be phased in nationwide.

4. Do you have confidence that as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without any impact on veterans' care.

Confidence can only come with development of specific plans, which are still under development.

5. Dr. Petzel, in responding to a Committee survey last month, your hospital responded to a question regarding the impact of FTEE reductions on future sharing of resources with the Department of Defense. Your response indicated that required workforce reductions would likely force you to abandon efforts to develop such a sharing agreement, with resulting revenue loss of at least $750 thousand annually. Would you explain how FTEE reductions relate to sharing opportunities?

Response not requested.

HONORABLE CHRIS SMITH
QUESTIONS SUBMITTED FOR THE RECORD
GARY DEGASTA, VAMROC, WHITE RIVER JUNCTION, VT
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 8, 1994

1. Your state is already in the process of implementing State reform efforts with universal coverage as its goal. What waiver authorities are necessary for VA to become a full participant in State Reform?

In addition to the waiver authorities proposed in H.R. 4124 by the Senate and House of Representatives, we believe that release of information to the state or other organizations under state health care reform is necessary, requiring some provision in the nature of an exception under the Privacy Act for such release.

2. Do you believe inclusion of dependents of veterans is essential to successful VA participation in State Reform? Why or Why Not?

Yes. Vermont requires a carrier to offer its plans to all alliances and all members of the alliances (i.e., all Vermont residents). To exclude families of veterans could philosophically and practically have a damaging effect on VA's participation under the Vermont reforms.

3. How does the uniform basic benefit package provided to those covered in your State compare to the Health Care services provided by VA? More comprehensive or less comprehensive?

The State of Vermont has yet to define/legislate the content of the defined benefit package. However, it is anticipated that the VA should not have difficulty matching the State plan.

4. If waiver authority is granted to allow VA participation in your State, what assurances do we have that you will continue to provide services to veterans which may be outside the basic benefits package? (i.e., Spinal Cord injury and Blind Rehabilitation, Prosthetics).

White River Junction recognizes these services as part of VA's obligation and mission. Also, since we excel in these services, they will enhance what VA can provide to health care reform.

5. Have you studied what effect there will be on veteran workload at your medical center if VA cannot participate in State Reform?

While the response to this question has not been specifically studied, we have anticipated this issue and are attempting to obtain data. However, it is predictable that VA will lose a large percentage of users if a State Plan provides community based choice of care, and the VA does not have a presence in the local community.

6. If VA participation were allowed, please describe briefly how VA would function in your State.

VA would offer its own plan as a registered carrier, providing a coordinated plan of common benefits at the WRJ, VAMC facility and through a network of providers under contract with VA throughout the state. VA would coordinate such care as the primary provider, or such care would be coordinated through a primary provider chosen by the patient from among the network of providers established by VA. VA would provide such services for family members on a contract or fee basis.

7. How optimistic are you that VA could transform itself in your State to become a primary care focused system? Are additional resources necessary to achieve this?

VAM&ROC, WRJ is very optimistic. For many years White River Junction has provided primary care/continuity of care for at least half of its enrollees. Case management under a locally driven implementation of FIRMS is now underway. This plan serves to cover every enrollee with a defined provider.

It is not known at this time whether additional resources will be necessary to cover and meet State requirements.

8. What effect will VA transformation to primary care mission have on VA's partnership with affiliated medical schools?

Most medical schools and residency training programs including our affiliate, the Dartmouth Medical School are moving toward providing training and education which is more oriented toward the provision of primary/managed care than was the training provided even 5 years ago. A shift in VA mission toward primary care will likely improve and streamline relationships with affiliates. This VA, as a component member of the Dartmouth Hitchcock Medical Center (DHMC) is a player in the DHMC's long term strategic goal of excellence in the provision, the teaching, and the research of primary care.

Recently, the VAM&ROC initiated a 2B affiliation with the University of Vermont Department of Internal Medicine to support trainees in Ambulatory Care.

9. Is it possible for VA to compete with waiver authority in the various state initiatives and still maintain, its research, medical education and backup to DoD missions?

Yes.

10. If VA were to enact comprehensive eligibility reform with a clearly identified veteran population who would be mandated to receive certain services, would state waiver authority be necessary?

We do not know yet.

11. What effect do you believe the Administration's FTEE reduction would have on the ability of your facility to compete if the Health Security Act were enacted?

As long as we are able to contract for the local provision of primary care for veteran enrollees at a distance from the facility, the effect of limited FTEE reduction under the Health Security Act will encourage this VA to be more creative in effectively addressing enrollee needs.

12. How will inpatient and outpatient workloads at your facilities be impacted as a result of the Administration's Federal Workforce Reductions?

This is unknown as it will depend on the size of the reduction, our flexibility and contracting, etc.

13. Will you be forced to close beds or wards as a result of the Administration's FTEE reductions?

Unknown at this time.

14. How will sharing agreements with DoD and the private sector be impacted by the Administration's FTEE Reductions?

Unknown, but increased sharing may be the means of addressing FTEE reductions.

15. How many of the veterans treated in your facility reside outside the State?

The official VA Primary Service Area for VAM&ROC, White River Junction covers the State of Vermont, four and one-half (4 1/2) counties in New Hampshire and all of Canada.* However in 1992 VAM&ROC, WRJ., VT treated 4,863 veterans residing outside of Vermont.

*VAM&ROC White River Junction has fee basis and claims processing jurisdiction for all of Canada.

16. Are you funded above or below the mean within your hospital group RPM analysis based on unit of facility work?

White River Junction is above the mean for the small-affiliated Hospital Group.

See attached.

17. Please submit the RPM Data which explains exactly where your hospital currently falls within your group.

See attached.

Responses of
Frank C. Buxton, Deputy Director
Veterans Affairs and Rehabilitation Commission
The American Legion
to
Questions Submitted for the Record
by the
Honorable J. Roy Rowland
Subcommittee on Hospitals and Health Care
for the hearing on March 8, 1994

1. Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in it's workforce simply by streamlining administrative operations, and do that without any impact on veteran's care?

Response: No. Aside from the impact of budget cuts to VA, the 25,000 full-time-equivalents which VA could lose under National Performance Review could seriously impair VA's ability to render quality medical care to veterans. The administrative sections have, over the past few fiscal years, been subjected to cuts in FTEE. Additional cuts in personnel can do little but affect the care-givers and, thus, the care patients receive. VA is expected to embark upon a massive change in the way it delivers care. The Veterans Service Area (VSA) concept will impact upon the administrative sections. The Legion believes that if VA could maintain quality care and access to that care, while undergoing major reductions in personnel, they would surely have done that years ago to save resources and avoid restricting entry into the system and the downsizing of some very important medical programs.

The American Legion has listened to a litany of stories about streamlining administrative functions by the use of automated systems. Although there is movement in that area, there has been little visible evidence that the information systems improvements have progressed to the point that they can maintain the effective and efficient workload of thousands of employees. VA needs to utilize their resources to accomplish the tremendous task before them... survival under national health care reform. They should get that job done and then rearrange their administrative chairs.

2. Do you have concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially re-focusing VA care to meet State goals might lead to fragmentation of its focus as a national system?

Response: National and state health care reform goals should not differ immensely in the delivery of health care from that of VA. Quality, cost-effectiveness, access and choice will be goals of VA as well as other plans. Yes, VA may have to compete for patients but each of the other plans would have to do the same. A difference in the basic benefits package under reform would not preclude VA from delivering additional or mandated services to veteran patients with payment by appropriation or cost-sharing. However, no form of cost-sharing should ever occur in the delivery of care for service-connected illness or disability.

In regard to fragmentation because of delegation of authority, such delegation is paramount to VA having the ability to be flexible to deliver services which are reflective of the medical needs of the veteran populations which they serve. VAMCs will remain a integral part of the VA national health care delivery system while serving the needs of the veterans within their catchment areas and having the flexibility to adjust services based upon demands of the local health care market.

Responses of
Frank C. Buxton, Deputy Director
Veterans Affairs and Rehabilitation Commission
The American Legion
to
Questions Submitted for the Record
by the
Honorable Chris Smith
Subcommittee on Hospitals and Health Care
for the hearing on March 8, 1994

1. What effect do you believe the President's FTEE reduction will have on the ability of the VA to compete under national health reform?

Response: FTEE reductions of the magnitude of the National Performance Review expectations will virtually cripple VAs ability to continue the current level of services. Most of the reductions in FTEE will come from the medical care portion of the VA workforce. Continued insults to VA in the form of withholding or reducing resources can only act to precipitate the demise of the largest health care delivery system in the nation and the failure of the nation to uphold the obligation to care for its veterans. VA will not be in a position to compete for patients if FTEE are reduced.

2. Do you believe inclusion of veterans' dependents is essential to successful participation in the various state reform efforts?

Response: The VA health care system's primary mission should continue to be the provision of quality health care to veterans. Most veterans service organizations are mandated by their constituencies to continue opposition to the treatment of non-veterans in VA because of the possibility of disenfranchisement of certain veterans by that move. There is evidence to suggest that, under competitive reform of the health care system, many veterans would prefer to have their dependents in the same care plan. The VA should accept these dependents into the VA health care plan and contract for the care of dependents in community facilities. If the plan requires enrollment of veterans to receive care and proper marketing of the plan occurs, the chance of veterans being disenfranchised would diminish. With that in mind, VA could move to admit dependents with positive assurance that all the medical care needs of the veteran community have been met.

3. Do you believe the draft bill provides adequate assurances that VA services outside of the basic benefits package (i. e. Spinal Cord Injury and blind rehabilitation , prosthetics, etc) will continue to be provided to veterans?

Response: Participation in a state reform program should not and must not abrogate the responsibility of VA to provide services that are required by, or unique to, the needs of the disabled veteran population especially those which provide care to service-connected veterans. The concern should not be with whether VA will continue to provide these special services but where VA could use the provision and expansion of such services to attract additional veteran enrollees.

4. Do you believe VA ought to have greater flexibility in contracting for health care services?

Response: Yes

Why or why not?

Response: In situations where it is not sound fiscal policy to create or add programs to the medical armamentarium of VAMCs, flexibility must be at hand to contract for these services. Such contracting should be negotiated by, and under control of, VA Medical Center or Veteran Service Area directors. Contracts for hard-to-deliver services and services in geographically isolated areas must be put in place. Since the local VA authorities can evaluate local veterans health care needs, they must be accountable for the contracting process with minimal oversight by Central Office.

5. Do you believe VA has in place adequate oversight and control over its contractors?

Response: There are those that contend that the contracting process in VA is subject to so much oversight that the timeliness and the purpose of the contract becomes secondary. The contracting business at VA should be de-centralized to the VSA or facility level. The accountability for service provision should be at that level as well. Diligence on the part of the contracting officer should be tantamount to the assurance that the services are as contracted, that fiscal responsibility and accountability are evident and that the quality of care for contracted services is high.

6a. Do you believe that employers should bear the cost of care for the current mandatory category of veterans?

Response: No. It is the responsibility of the federal government to accept the costs of care for mandatory care veterans.

6b. If VA were to participate in a state where employers are mandated to pay premiums, should the current mandatory category of veterans be exempted and have there premiums paid by VA?

Response: The ideal situation, of course, would be to have VA as a participant in the state plan and to have mandatory category veterans receive all of their care through VA health plans. If VA is not the plan of choice for a mandatory care veteran, VA should be responsible for seeing that payment for that care is made. Service-connected veterans should receive basic benefits packages without co-payment or deductibles as well as care for their service-connected disability or illness. We do not have a problem with "employer mandates" for non-service-connected care.

7a. Inherent in the word "competition" is the concept that there will be a winner and a loser. What happens if VA is the loser?

7b. What safeguards need to be in place to prevent demise of the VA system in the various states?

Responses: First of all, the concept that there will be one winner and one loser is flawed when there may be numerous plans "competing" for patient/enrollees. No one plan would be the "winner." One plan may have more enrollees than another but that doesn't imply that the rest of the plans are "losers." Enrollees will have the opportunity to move from one plan to another annually and the "winner" may be different each year. This whole idea of competing for enrollees is the very reason why VA must be freed from its current restrictions such as constraints in eligibility, contracting and the ability to obtain third party reimbursement for care to non-mandatory veterans. If VA is a "loser" in the sense of not being allowed to compete in a certain state, these types of changes in VA must still happen. The ideas put forward in the publication, "**An American Legion Proposal to Improve Veterans Health Care**", the recommendations of the Commission on the Future Structure of Veterans Health Care and the recommendations of the VA Task Force on VA Health Care Reform spell out the ways VA can continue to serve veterans with or without a competitive health care reform environment. In the cases of state reform, all action possible must be encouraged to assure that VA is a player in both the planning and the implementation of health care reforms. "Seed" money similar to that provided in the Investment Fund of "The Health Security Act" must be available to VA to allow them to upgrade facilities and technology to a competitive level.

8a. Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly from state?

8b. Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibility and benefits.

Response: One variance might be in the election of a state to become a single-payer universal plan rather than a plan which allows consumer choice. This scenario would clearly require strategies on the part of VA to prevent an exodus of veterans from the system. There is a possibility that the benefits provided to a state resident may be different from those provided an out-of-state consumer at VA. However, these differences would only be in certain service provision. It would be up to VA to assure that all services required for the care of the

disabilities and illnesses of service-connected veterans are available and accessible. Since VA is a national system, there is the possibility that contracts and memoranda of understanding may be required to reduce benefit package variations. The bottom line is that VA must be there to care for our nation's veterans with a system which provides quality, accessible, acceptable, available and cost-effective health care.

AMVETS' response to additional questions submitted by the Honorable J. Roy Rowland, March 8, 1994.

1. QUESTION: Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without any impact on veterans' care?

ANSWER: Notably absent from the Secretary's testimony was any outline of how VA would proceed with the reduction in force (RIF). Any RIF of this size is bound to have a negative effect on the morale and production of the workforce. If the RIF concentrates on administrative personnel, sparing hands-on healthcare providers, it will have less effect than if providers are included in the RIF.

If the Secretary's statement that efficiencies are capable of freeing up 4,000 positions is correct, then why not transfer those positions to VBA? The disastrous backlog of 700,000 claims and the pending six-to-seven year wait for an appeal can only be solved with more personnel operating in a radically reformed adjudication system.

2. QUESTION: Do you have concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially refocusing VA care to meet State goals might lead to fragmentation of its focus as a national system?

ANSWER: Delegation of authority and state-centered programs certainly hold the threat of fragmentation of the VA system. However, AMVETS feels that the greater threat to the survival of an improved VA system lies in allowing local healthcare competition to bypass VA. We firmly believe that competition is a healthy thing for VA, and since all healthcare is local, VA must have the flexibility to make the – in all likelihood -- marginal adjustments necessary to compete in a given state.

It then becomes doubly important that VA central office (VACO) play a stronger policing role than they appear to have done in the past. VA seems reluctant to replace poor administrators and hold its senior management accountable, and that practice must stop.

3. QUESTION: Mr. Buxton testified that it would be self-defeating to limit the pilot program for fiscal reasons. Given the likelihood that VA will not get additional appropriations for the pilot program, isn't it prudent to limit its scope now?

ANSWER: Each pilot program is an investment in the future of VA. Each state that proceeds with healthcare reform ahead of the federal government will provide an opportunity for VA to test new eligibility rules, benefit packages, delivery models and networking. VA will have to attempt to provide care in each of those states anyway, and to hinder that transition will only make the catch-up game even costlier.

AMVETS' response to additional questions submitted by the Honorable Chris Smith, March 8, 1994.

1. QUESTION: What effect do you believe the president's FTEE reduction will have on the ability of the VA to compete under national health reform?

ANSWER: AMVETS believes this is the wrong time to do FTEE cuts. If VA can implement efficiencies allowing an FTEE cust of 4,000 in FY95 and 25,000 over the next five years, we believe that the majority of those existing resources should be devoted to other areas of severe service shortfalls within VA – like solving the ridiculous adjudication backlog.

2. QUESTION: Do you believe inclusion of veterans' dependents is essential to successful VA participation in the various state reform efforts?

ANSWER: Yes. All other health plans will accommodate entire families and offer – if nothing else – the convenience of dealing with just one bureaucracy. Inclusion of families within the VA system will also accelerate VA's capability to extend a greater range of services to women veterans – an area in which VA must do better.

3. QUESTION: Do you believe the draft bill provides adequate assurances that VA services outside of the basic benefits package (i.e. spinal cord injury and blind rehabilitation, prosthetics, etc.) will continue to be provided to veterans?

ANSWER: Our major concern with HR 3600 is the lack of a funding mechanism that will truly guarantee sufficient funds to carry out VA's missions – including specialty care areas. That is why AMVETS supports funding VA medical care through mandatory spending accounts instead of yearly appropriations. We are very concerned that care for those with severe disabilities will decrease because of a combination of factors centering around the need for a true entitlement for all service-connected veterans.

4. QUESTION: Do you believe VA ought to have greater flexibility in contracting for healthcare services? Why or why not?

ANSWER: AMVETS believes that VA must have the flexibility necessary to provide access to VA-sponsored care to all veterans through a mix of VA facilities, community-based storefronts operated by VA staff, mobile clinics, and contractual agreements with local providers such as community hospitals and clinics. At a time when change in delivery models is the name of the game, it would seem more cost-effective and more attractive to local veterans to rely on existing community-based facilities as much as possible.

5. QUESTION: Do you believe that VA has adequate control over its contractors?

ANSWER: Increased contracting for services will require increased capability to monitor contractor performance. Since the National Performance Review would cut 25,000

employees and no new FTEE devoted to contractor oversight, VA's ability to conduct appropriate oversight would also diminish. We note that VA – like most government agencies – has a large staff devoted to construction management and oversight. With NPR looming, it would seem appropriate to devote those resources to monitoring the delivery of care rather than providing redundant construction planning and oversight that could be better accomplished by shifting to a "best commercial practices" standard for construction contracting.

6. QUESTION: Do you believe employers should bear the cost of care for the current mandatory category of veterans? If VA were to participate in a state where employers were mandated to pay premiums, should the current mandatory category of veterans be exempted and have their premiums paid by VA? What about service-connected veterans?

ANSWER: AMVETS believes that the cost of care for service-connected veterans is a federal responsibility. The federal government gets its revenue from various sources through mandatory taxes, and, for all practical purposes, mandatory employer contributions amount to a tax. Therefore, we would not object to this method of nation-wide financing. However, to promote the hiring of veterans, especially disabled veterans, we believe that a premium discount equal to any service-connected disability rating should be given to employers.

7. QUESTION: Inherent in the word competition is the concept that there will be a winner and a loser. What happens if VA is the loser? What safeguards need to be in place to prevent demise of the VA system in the various states?

ANSWER: A true entitlement to care for all service-connected veterans would protect at least that group from VA failure to compete.

8. QUESTION: Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly form state to state? Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibility and benefits?

ANSWER: It is possible that eligibility and benefits will vary significantly from state to state. This makes it possible that veterans will see inconsistent care from state to state in terms of scope and access. While we do not support this, and would hope that VA would provide as level a playing field as possible within the law, any test program will cause temporary inequalities. The important point is to learn from the negative effects of a given program and use this knowledge system-wide.

Responses to Questions
Submitted by Honorable J. Roy Rowland
to
Russell Mank, National Legislative Director
Paralyzed Veterans of America
Regarding
Hearings on VA State Health Care Reform Pilot Programs
House Committee on Veterans' Affairs
March 8, 1994

Question 1: Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without any impact on veterans' care?

Response: The VA statement is a contrivance, designed to rationalize support for the Administration's determination to reduce VA FTEE levels by 25,000 over a period of five years in accordance with the recommendations of the National Performance Review. Personnel cuts of this magnitude could not be absorbed by administrative consolidations alone. Cuts of this size would have a severe effect on the quality and quantity of patient care services as well as limit the ability of the system to prepare itself to adapt and survive in a reformed health care environment.

Question 2: Do you have concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially refocusing VA care to meet State goals might lead to fragmentation of its focus as a national system

Response: In most respects, VA medical facilities in the pilot program states are going to have to have a maximum degree of flexibility if they are going to adapt, compete and survive in a new health care environment. Flexibility gives them that opportunity, otherwise the VA national system would begin to loose major components of its national system as one by one these facilities closed their doors.

PVA is concerned that those programs, identified as part of the national mission of the VA system and targeted to meet the specialized needs of the veteran population, ie. spinal cord injury, blind rehabilitation, extended rehabilitation, prosthetics, orthotics, specialized AIDS treatment programs, substance abuse programs, post-traumatic stress disorder treatment and extended mental health services, because of their discretionary funding base, could be in jeopardy if left to "flexible" interpretation and implementation by local VA health care facility managers. In this instance, flexibility to determine what services VA facilities should offer, and how and to what extent those specialized services should be funded, should not be a matter of individual interpretation at the local level. Specialized programs under the state health reform pilots, as well as under national health care reform initiatives, should have mandatory authorization and distinct funding controlled at the national level.

Question 3: Mr. Buxton testified that it would be self-defeating to limit the pilot program for fiscal reasons. Given the likelihood that VA will not get additional appropriations for the pilot program, isn't it prudent to limit its scope for now?

Response: The pilot program serves little purpose, either to protect VA facilities in health care reform states, or to serve as a test program for the edification of the rest of the system facing national health care reform, if results of the pilot are skewed in any way by a limitation of resources. The pilots should be given additional appropriated funds. Funding should not be syphoned from the rest of the VA health care system already in fiscal distress.

Responses to Questions
Submitted by Honorable Chris Smith

Question 1: Your testimony gives overwhelming support for a VA role in state reform. However, you do not state PVA's endorsement of the draft legislation. Do you support the bill?

Response: PVA supports the legislation. We are appreciative that the Committee has chosen to recognize the importance of the specialized programs, including services for veterans with spinal cord dysfunction. PVA believes, however, that the bill could be improved either through the inclusion of report language or amendment in conference with language that would:

1. Require the Secretary to make a clear definition through the design of treatment protocols of those services needed to provide the full continuum of care for veterans with SCI/D.

2. Mandate centralized, clearly identified funding levels to support SCI/D programs.

We strongly urge the committee to include these two concepts in the final version of the VA portion of the national health care reform legislation.

Question 2. What effect do you believe the President's FTEE reduction will have on the ability of the VA to compete under national health care reform?

Response: See response to Representative Rowland's Question 1 above.

Question 3: Do you believe the inclusion of veterans' dependents is essential to successful VA participation in the various state reform efforts.

Response: VA should have as many of the same tools at its disposal as other providers in the state in order to be competitive. Enrollment of non-veterans, including the families of veterans should not be seen as a negative as long as it does not interfere with the primary mission of the VA health care system in providing services for those who have served in defense of this nation.

Question 4: Do you believe the draft bill provides adequate assurance that VA services outside of the basic benefits package (ie. spinal cord injury and blind rehabilitation, prosthetics etc.) will continue to be provided to veterans.

Response: The bill goes part of the way by mandating the provision of these services for the first time. However, we believe these provision could be strengthened as outlined in our response to Question 1 above. PVA will be happy to work with the Committee in this regard.

Question 5: Do you believe VA ought to have greater flexibility in contracting for health care services? Why or why not?

Response: Local VA managers should have as much flexibility as they require to provide health care in the most cost-effective and efficient means possible. Contracting versus the in-house provision of services can be a dollar saving tool. However, VA central office managers should be given the authority to insure that the search for cost-effectiveness does not over stimulate local managers to abandon control and emphasis on the central mission of the VA health care system.

Question 6: Do you believe VA has in place adequate oversight and control over its contractors? If not, what changes need to

be made?

Response: VA currently has adequate monitoring and control ability.

Question 7: Do you believe that employers should bear the cost of care for the current mandatory category of veterans? If VA were to participate in a state where employers were mandated to pay premiums, should the current mandatory category veterans be exempted and have their premiums paid by VA? What about services-connected veterans?

Response: PVA has repeatedly objected to any formula that would wrest the responsibility of the federal government from defraying the costs of health care for veterans with service-connected disabilities. This concern applies to changes that are made at both the state and national level.

Question 8: Inherent in the word competition is the concept that there will be a winner and a loser. What happens if VA is the loser? What safeguards need to be in place to prevent the demise of the VA system in various states?

Response: The state pilot program legislation gives VA facilities in those states the tools they need to manage effectively under state health care reforms if they are given the tools, resources and innovative management. Title 38, U.S.C. provides the safeguards for the maintenance and continuation of health care services for eligible veterans.

Question 9: Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly from state to state. Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibly and benefits.

Response: VA should provide access to inpatient and outpatient care within the framework for the operating system. These benefits may, in some instances, be more or less generous than any given state. However, even without health care reform, certain veterans, service-connected disabled veterans for instance, receive significantly more health care from VA than others. It is also true that independent interpretation of eligibility criteria from facility to facility based on the availability of resources creates great disparities in the provision of services from one region of the country to another at the present time. This latter differential is not necessarily good, but, it stands to represent the fact that disparities in the provision of services exist in the system today and veterans have learned to accept them.

PVA's main concern with differences in eligibility under the legislation authorizing the pilot programs stems from the fact that only veterans residing in the state would be eligible for the enhanced benefits package. Veterans utilizing the VA, but residing out of state and still within the same service area, would not be eligible for the increased benefits even though they have identical eligibility as a veteran who is a state resident.

In the end, however, these differences should be in large part erased through provision of the national comprehensive benefit package provided to veterans who enroll in VA plans in all the states after national health care reform is enacted and implemented.

THE HONORABLE J. ROY ROWLAND
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING ON MARCH 8, 1994
QUESTIONS SUBMITTED FOR THE RECORD
VIETNAM VETERANS OF AMERICA

1. Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce by streamlining administrative operations, and do that without any impact on veterans' care?

No. While some minor efficiencies may be achieved by reorganizing administrative functions, it is not likely that the massive workforce reductions contemplated in the FY 1995 budget can be accomplished without effecting patient care. More important is the fact that VA is at a critical juncture with national health care reform looming on the horizon. No one has any clear idea of future demand on VA health services and it is premature to reduce Veterans Health Administration (VHA) workforce when a very uncertain future lies ahead. VA faces the challenges of surviving in a competitive health provider environment and reducing workforce will exacerbate the negative image VA already suffers, if forced to turn more and more veterans away before reform provides the opportunity to open the VA system.

2. Do you have concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially refocusing VA care to meet State goals might lead to fragmentation of its focus as a national system?

At this point, it is important that local managers be given flexibility to meet the demands of a changing health provider environment. If VA is not allowed to adapt in these areas where state governments are enacting reform measures, it is very likely that VA will become underutilized. State reforms in almost every case provide a more generous package of health care benefits than VA is currently able to offer to its consumers. Just as there is a very real threat that veterans will opt-out of VA if a more attractive option becomes available on the national scale, the programs in these states will likely cause VA to loose patientbase and subsequently funding if adaptations are not made to allow VA to compete. We are not fearful of a fragmented system. We are more concerned that veterans will loose the specialized services so often needed by service-connected disabled veterans, if the VA systems in these states loose their viability.

3. Mr. Buxton testified that it would be self-defeating to limit the pilot program for fiscal reasons. Given the likelihood that VA will not get additional appropriations for the pilot program isn't it prudent to limit its scope for now?

I too think it would be self-defeating to limit the scope of these pilot programs. If these state plans are designed and implemented with a sound business plan, it is conceivable that they could become self-sustaining after an initial start-up investment -- similar to the concept encapsulated within H.R. 3600. Rather than assume defeat on the funding issue, we would suggest that the Committee, along with the organized veterans community, fight to secure appropriate investment in these programs.

THE HONORABLE CHRIS SMITH
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING ON MARCH 8, 1994
QUESTIONS SUBMITTED FOR THE RECORD
PAUL EGAN, VIETNAM VETERANS OF AMERICA

1. Your testimony states that you support the President's Health Security Act but you express concern that the VA may cease to exist under this plan. While you support the cost-shifting of federally funded veterans health care programs to employers, you also call for a federal entitlement. How do you reconcile this inconsistency?

VVA, along with the other major veterans service organizations, has embraced the concepts of the President's Health Security Act because it gives the VA the tools it needs to survive -- flexibility, eligibility expansion, and most importantly additional revenues. Absent these tools that only the Clinton bill contains, we are certain that the VA will cease to exist. This is because no matter how one slices the pie, without some rather extensive system reorganization and the funding that goes with it, the VA will be a less attractive health provider option for most veterans.

VVA, as well as other veterans service organizations, have for some time called for an "entitlement" for health care services for veterans with service-connected disabilities. VVA is content to accept an employer mandate for all other veterans, because we view this as the only method of securing universal coverage for all Americans short of implementing a single-payer system.

It should be noted that health care reform is a veterans issue not only because it threatens to derail the VA health care system, but because veterans are American citizens who are concerned for the health and welfare of their spouses and families as well. Regardless of how attractive the VA can become by reducing waiting times, expanding access, providing comprehensive care and being a consumer-friendly system, there will always be some veterans unwilling to use the VA system because of prior negative experience, pride or any number of other personal issues. We would be derelict in our advocacy if we failed to account for the concerns and health care access of these veterans in addition to those who use VA services.

We have noted with pleasure the Committee legislation H.R. 4124, which uses the framework of H.R. 3600 and improves upon it by securing the ever-requested entitlement and clearing-up certain funding ambiguities in the original language.

2. What effect do you believe the President's FTEE reduction will have on the ability of the VA to compete under national health reform?

The massive workforce reductions contemplated in the FY 1995 budget can hardly be accomplished without effecting patient care. With national health care reform on the horizon, no one has any clear idea of future demand on VA health services and it is thus premature to reduce Veterans Health Administration (VHA) workforce. VA faces many challenges in a competitive health provider environment and reducing workforce will exacerbate the negative image VA already suffers, if it is forced to turn more and more veterans away. The more veterans who become discouraged and dejected with the current VA system, the more likely it is to loose patientbase rather than gain consumers when reform provides the opportunity to open the VA system to a greater population.

3. Do you believe inclusion of veterans' dependents is essential to successful VA participation in the various state reform efforts?

Yes. Health care provider choices are generally made for family units, rather than individuals. These decisions are traditionally made by the female within the household. If VA cannot address the health care needs of women and children, it is likely that potential veteran subscribers will be lost to the VA system before enhanced benefits, cost

factors and specialized programs are even introduced into the health provider choices forum. This is true of both state reform initiatives and national health care reform.

4. Do you believe the draft bill provides adequate assurances that VA services outside of the basic benefits package (ie., spinal cord injury and blind rehabilitation, prosthetics, etc.) will continue to be provided to veterans?

Yes. We are confident that the provisions of Section 3 of the bill will secure the VA's mission of providing these specialized services. The only concern we have regarding this issue, and this is true of national reform as well, is that if general usage diminishes for whatever reason such that it is untenable to maintain the VA health plan in any given area, Congressional support for the whole system may erode and with it goes the funding for these specialized programs -- throwing the baby out with the bath water, in essence. For this reason, we are fearful for the specialized programs.

It is also worth noting that medically it is desirable and cost-effective to provide comprehensive care to those veterans who need VA's specialized programs through a cohesive, managed care provider network. If VA becomes solely a specialized services provider, we are concerned that veterans needing these services will get disjointed, lower-quality care.

5. Do you believe VA ought to have greater flexibility in contracting for health care services? Why or why not?

Yes. There will undoubtedly be services in some areas that VA can provide more cost-effectively by purchasing them from other providers, rather than investing huge sums to develop the in-house capacity. This is particularly true of primary and outpatient care capacity. In many locations across the country where veterans are forced to travel 150 to 200 miles to reach the nearest VAMC, VA could contract for primary care services through several local community providers at a cost much less than building a single outpatient clinic. This would broaden VA's capacity such that it would reach more veterans.

6. Do you believe VA has in place adequate oversight and control over its contractors? If not, what changes need to be made?

I really have no expertise in this area.

7. Do you believe that employers should bear the cost of care for the current mandatory category of veterans? If VA were to participate in a state where employers were mandated to pay premiums, should the current mandatory category veterans be exempted and have their premiums paid by VA? What about service-connected veterans?

The specifics of each state reform plan need to be evaluated to clearly understand what is desirable. While VVA is committed to the concept of federally funded care for service-connected disabled veterans, we are not as troubled by employer mandates as we are concerned with ensuring this population's access to comprehensive care.

The employer mandate issue could be addressed by making this sum a tax credit for the employer. This returns the burden for service-connected disabled veterans to the federal government, and would also serve as a veterans hiring-preference mechanism.

8. Inherent in the word competition is the concept that there will be a winner and a loser. What happens if VA is the loser? What safeguards need to be in place to prevent demise of the VA system in the various states?

In VVA's view, it is not so important that VA be a winner, but that the veterans who use the system come out of the health care reform process as winners. Essentially any legislation that makes private sector insurance more accessible will force VA to compete. As we know, if VA doesn't improve services it will loose patientbase. Competition will be the driving force in making VA improve its consumer-friendliness. Improvement of

VA services and/or access to private sector care will make veterans the winners of the competition of health care reform.

*9. **Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly from state to state. Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibility and benefits?***

Variance of services in VA health plans from state to state may be awkward for a time, but VVA views these pilot projects as just that -- temporary programs which will give us useful information for the implementation of a nation-wide program. In order to have the flexibility to adapt to the state reform initiatives, it may be necessary to have inconsistent eligibility and benefits. If, as is suggested in the language of the bill, the Secretary chooses to implement the pilot programs by catchment areas rather than strictly adhering to state lines, some of the problems associated with this variance can be avoided.

National Association of VA Physicians and Dentists
Responses to Questions From March 8, 1994 Hearing

Questions from the Honorable J. Roy Rowland

1. **Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by focusing on administrative operations, and do that without any impact on care of veterans?**

No. We agree that the VA Medical System is top-heavy with administration. But the system and "culture" of the VA makes it difficult to have confidence that there will be a rational approach to cuts that will focus on the "fat" and not the support personnel that are essential not only to meet today's needs but those of the future under healthcare reform.
In addition, the VA has already cut personnel directly responsible for patient care to a level that is affecting patient care in some areas. Any reductions in administrative personnel slots should be replaced with technicians and other medical professions in the areas where they are desperately needed.

However, it is difficult to make any precise assessment of the needs of the VA healthcare System's when we are in the midst of so much change. The System was facing enormous changes in the veteran patient base prior to the proposal of healthcare reform. The healthcare reform plan has only multiplied those needs. Making any arbitrary reductions now without first assessing the affects of these changes as well as rationalizing eligibility requirements is flying without instruments in the midst of a mountain range.

National Association of VA Physicians and Dentists
Responses to Questions From March 8, 1994 Hearing

Questions from the Honorable Chris Smith

1. **Do you believe the draft bill provides adequate assurances that VA services outside the basic benefits package (i.e., spinal cord injury and blind rehabilitation, prosthetics, etc.) will continue to be provided to veterans?**

I am unsure as to which "draft bill" the Congressman refers. However, NAVAPD strongly supports the concept that the purpose of the VA Healthcare System is to treat veterans with service connected disabilities without qualification. My uncertainty is an indication of the confusion that exists and the number of measures that are pending that impact the system. We urge that ultimately there be a single prioritized approach that will look first at the needs of veterans and assure that their needs are met by providing adequate medical personnel and resources to all VA physicians and dentist to do what they are dedicated to providing: Providing the highest quality of patient care.

2. **In your opinion, if VHA staffing levels are reduced to the proposed level, can VA continue to deliver high quality care? If so, at what point do these FTEE reductions begin to pose serious quality care concerns?**

No. As we indicated in a similar question from Representative Rowland, we agree that the VA Medical System is top-heavy with administration. But the system and "culture" of the VA makes it difficult to have confidence that there will be a rational approach to the cuts that will focus on the "fat" and not the support personnel that are essential not only to meet today's needs but those of the future under healthcare reform. In addition, the VA has already cut personnel directly responsible for patient care to a level that is affecting patient care in some areas. Any reductions in administrative personnel slots should be replaced with technicians and other medical professions in the areas where they are desperately needed.

However, it is difficult to make any precise assessment of the needs of the VA healthcare System when we are in the midst of so much change. The System was facing enormous changes in the veteran patient base prior to the proposal of healthcare reform. The healthcare reform plan has only multiplied those needs. Making any arbitrary reductions now without first assessing the affects of these changes as well as rationalizing eligibility requirements is flying with not instruments in the midst of a mountain range.

3. **What effect do you believe the administration's FTEE reduction would have on the ability of the VA to compete if the health security act was enacted?**

The effect could be devastating. Even before these cuts, we are reaching a point in the VA medical system where even the most dedicated doctor will not be able to overcome the lack of equipment and support personnel at today's patient levels, let alone the much higher levels that are theoretically possible under health care reform.

Evidence of this was found in a recent survey conducted by the Veterans Service Organizations of VA hospitals in six states. The survey found prolonged clinic waiting times and appointments commonly delayed for three to nine months.

Even the increase of $500 million in this year's healthcare budget request is approximately $2.3 billion dollars less than the amount specified by the **Independent Budget,** which NAVAPD has endorsed, to provide the same amount of care as FY1988--the last year before the VA Medical Care program suffered major funding shortfalls.

We cannot be expected to serve veterans' needs, let alone provide the atmosphere and level of service a private hospital provides if the system continues to sustain ever increasing cuts in resources and personnel.

National Association of VA Physicians and Dentists
Responses to Questions From March 8, 1994 Hearing

Questions from the Honorable Chris Smith

4. What effect will VA transformation to a primary care mission have on VA's partnership with affiliated medical schools?

New missions for the VA should not, of themselves, have a negative affect on the medical school affiliation. But we are concerned that the new necessity to compete is being used as an excuse to cut research, as a "frill." This would hurt not only our affiliation, but the quality of patient care and the system's ability to compete.

It is accepted that the reason the VA retains a high level medical personnel and is affiliated with top universities because of the opportunity it offers to participate in research. These affiliations will be particularly important to recruit and retain eminent physicians and dentists as the VA attempts to change its culture and compete under health care reform. Yet the research area is scheduled for decreases equal to 830 positions and the budget has been cut significantly once again.

# # #

ANSWERS TO QUESTIONS SUBMITTED FOR THE RECORD

Questions submitted by the Honorable J. Roy Rowland

1. Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without impact on veterans care?

The BVA response to this question is absolutely not. While we agree streamlining administrative operation could possibly result in some reductions in employees without serious damage to VA health care, the magnitude of the reductions proposed by the President would without question seriously jeopardize VA's capacity to continue to deliver quality services or more importantly position itself for participation in a managed competition environment envisioned under National Health Care Reform (NHCR). We do not believe VA has sufficient resources to carry out new functions for which they have no experience, such as marketing, while at the same time experiencing a significant reduction in workforce.

2. Do you have any concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially refocusing VA care to meet State goals might lead to fragmentation of its focus as a national system?

BVA is concerned that under the proposed Pilot Programs, the delegation of authority could be too great. We have maintained that eligibility reform for VA health care is absolutely essential and should not be held hostage to NHCR. If eligibility reform has to be enacted the need for the State Pilot Programs legislation would probably be less critical. In the absence of eligibility reform, VA must be provided the necessary authority to compete in state plans or risk devastating losses in veteran work load and indeed the viability of VA in those states as a health care provider for veterans. The danger of fragmentation certainly will increase if a NHCR package is not passed and increasing numbers of individual states enact their own HCR. To the extent that state reform plans differ with respect to benefits packages, could lead to fragmentation of focus as a national system.

3. Mr. Buxton testified that it would be self-defeating to limit the pilot program for fiscal reasons. Given the likelihood that VA will not get additional appropriations for the pilot program isn't it prudent to limit its scope now?

Although it may be self-defeating to limit the pilot programs for fiscal reasons, failure to appropriate additional funding for these programs could place the entire system at risk financially should it become necessary to transfer funds from the medical or construction accounts to support these programs. Given your assumption Mr. Chairman, it does seem prudent to limit the scope of the programs.

Questions submitted by the Honorable Chris Smith

1. What effect do you believe the President's FTEE reduction will have on the ability of the VA to compete under National Health Reform?

We believe that VA's ability to compete under National Health Care Reform will be severely impaired by the proposed FTEE reductions proposed by the President. Until VA's role is more clearly defined and enrollment levels have been determined it is totally unreasonable to impose such drastic employment reductions on VA.

2. Do you believe inclusion of veterans' dependents is essential to successful VA participation in the various state reform efforts?

Yes, Mr. Smith we do believe inclusion of veteran dependents is essential for successful VA participation in state plans. At the very least, providing this option will give VA valuable experience regarding just how important the availability of a family plan is to enrollment of veterans. It will also give valuable data regarding the impact on the VA's capacity to provide care to dependents, particularly with regards to contracting for services they are unable to provide in house.

3. Do you believe the draft bill provides adequate assurances that va services outside of the basic benefits package (i.e. spinal cord injury, blind rehabilitation, and prosthetics, etc.) will continue to be provided to veterans?

Mr. Smith, BVA is concerned that greater assurances or requirements be included in the draft legislation. BVA is deeply concerned that adequate funding levels may not be available or that if provided may be used for other purposes if a local manager believes he needs resources for other programs or services to be more competitive in their local market.

4. Do you believe VA ought to have greater flexibility in contracting for health services? Why or why not?

Yes, BVA does believe VA needs greater flexibility in contracting for services. In our view, if VA is to have any chance to compete, access to the system or plan must be substantially improved. In order for VA to achieve greater access, it will be necessary to rely more heavily on contracting for services. This will be especially true with respect to provision of primary care. Additionally, new and creative cooperation and collaborative relationships with other providers will likely be necessary for VA to succeed.

5. Do you believe VA has in place adequate oversight and control over its contractors? If not, what changes need to be made?

BVA is not in a position to respond to this question. We do believe however the task will be much greater with greater flexibility and greatly increased number of contract. Furthermore, oversight will be critical to provision of quality health care services and therefore success as a competitive provider.

6. Do you believe that employers should bear the cost of care for the current mandatory category of veterans? If VA were to participate in a state where employers were mandated to pay premiums, should the current mandatory category veterans be exempted and have their premiums paid by VA? What about service-connected veterans?

BVA does not believe employers should bear the cost of care for Category A veterans. As was stated by the DAV witness during the hearing, employers or in this case states did not make veterans, the federal government did and must bear the responsibility, both moral and financial, for the care of the Category A veterans, especially service-connected disabled vets. If this group is not exempted in state plans, this could certainly lead to shifting this responsibility to employers in any national reform plan that may be adopted.

7. Inherent in the word competition is the concept that there will be a winner and a loser, what happens if VA is the loser? What safeguards need to be in place to prevent the demise of the VA system in the various states?

It seems clear that without eligibility reform for VA health care and adequate appropriation levels, VA is doomed to fail in states enacting reform because they will be unable to compete with respect to attracting veteran enrollment for comparable benefits packages. Veterans must be entitled to receive health care benefits at least as good as other Americans.

8. Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly from state to state. Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibility and benefits?

It is difficult to speculate at this time regarding the differences in veterans services and eligibility from state to state. We do anticipate that services and eligibility will be greater in those states enacting reform than for those not engaging in health care reform. This certainly will be problematic if NHCR is not enacted correcting these differences or inequities.

RESPONSES OF DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
TO THE QUESTIONS OF
THE HONORABLE J. ROY ROLAND
CHAIRMAN, SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
Hearing on March 8, 1994

Question 1: Do you have confidence that, as VA's formal testimony, implies, it can achieve a massive reduction in its work force, simply by streamlining administrative operations, and do that without any impact on veterans care?

Answer: No. The fact of the matter is, VA has already been decimated by what we consider to be arbitrary cuts in real terms, in their work force. VA has been faced with years of new demands and programs placed upon it without corresponding increases in human resources. Although its level of employees has remained somewhat steady and, in fact, may have experienced some increase, VA has not been able to keep up with ever-increasing demands placed on its various programs. As the level of care for veterans is becoming increasingly more complex due to an aging veteran population with multiple, chronically disabling conditions, we believe VA's human resources will continue to be severely strained.

Question 2: Do you have any concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially refocusing VA care to meet State goals might lead to fragmentation of its focus as a national system?

Answer: Mindful of the need to closely monitor any pilot program initiated as a result of the proposed legislation, DAV suggested in our formal testimony the necessity to create a functional "Board of Directors" at each of the affected VA Medical Centers. It is our belief, even with the best of intentions, there is potential under the pilot program to stray from VA's mission of providing care to eligible veterans. We are especially mindful of the absolute need for VA to maintain its focus and responsibility for providing care to those severely disabled veterans afflicted with "special" and catastrophic conditions, such as blindness, amputations, spinal cord injury, etc. We do not envision VA under the pilot programs, refocusing on state goals for the delivery of health care. Rather, being aware of the various states movements toward their own reform efforts, it is absolutely imperative that VA be able to keep pace as best they can. This becomes essential not only to gain valuable experience in operating a reformed VA system, but also, to maintain their critical mass of patients.

Question 3: Mr. Buxton testified that it would be self-defeating to limit the pilot program for fiscal reasons. Given the likelihood that VA will NOT get additional appropriations for the pilot program, isn't it prudent to limit its scope for now?

Answer: We believe it may be prudent, in fact necessary, to confine the number of states that would be allowed to initiate the pilot program. We do not necessarily favor the shifting of resources from VA clinical care programs to support or initiate the creation of other clinical care programs. There may, however, with innovative and creative thinking, be areas in the non-clinical care area that could be looked to for needed resources. We believe, it is imperative that those medical centers participating in any pilot program not have arbitrary

limitations placed upon them as concerns their management flexibilities. VA Medical Center directors need local authority to manage their facilities in a way thought to be best for the patient population served. The exception, of course, would be that no currently eligible service-connected disabled veteran would suffer a reduction in the benefits or services that are now eligible for by-law and/or regulation.

**RESPONSES OF DAVID W. GORMAN,
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
TO THE QUESTIONS OF
THE HONORABLE CHRIS SMITH,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
OF THE HOUSE VETERANS AFFAIRS COMMITTEE,**
Hearing on March 8, 1994.

Question 1: What effect do you believe the President's FTEE reduction will have on the ability of the VA to compete under national health reform?

Answer: If VA were forced to comply with any arbitrarily established employee reduction, the ability to provide needed medical care and services to disabled veterans would be compromised to a point that would be intolerable. We believe VA's human resources have been stretched to and often beyond the limit and have been for some time. The levels of care being required by an aging veteran population suffering with complex, multiple chronically disabling conditions requires a level of care that is labor-intensive. VA cannot absorb the arbitrary FTEE reductions proposed.

Question 2: Do you believe inclusion of veterans' dependents is essential to successful VA participation in the various state reform efforts?

Answer: Yes. As we understand the proposal, veterans will be offered the choice of which health care system they wish to receive their care from. It makes little sense that a veteran would choose to receive care via the VA if their family members were denied that same opportunity. It is illogical to believe that veterans should go to one system -- VA -- for their care, while their spouse and dependents would be precluded from using the same system, and therefore, forced to choose a separate health care provider. Also, if the VA is responsible for dependents' care, then an adequate funding stream to pay for that care must be established and functional. Of course, the inclusion of dependents in the VA system is contingent on the premise that no otherwise eligible veteran would be denied services or have their medical care benefits diminished as a result of dependents' participation.

Question 3: Do you believe the draft bill provides adequate assurances that VA services outside of the basic benefit packages (i.e., spinal cord injury, blind rehabilitation, prosthetics, etc.) will continue to be provided to veterans?

Answer: As we indicated in our written testimony, we believe clarifying language must be included to assure the VA will not abrogate their responsibility to the catastrophically disabled veteran suffering disabilities as mentioned.

Question 4: Do you believe VA ought to have greater flexibility in contracting for health care services? Why or why not?

Answer: Yes. We do not believe that each VA facility has the in-house capability to provide all needed medical care to each veteran who would enroll in a reformed system. Principally, this would be due to the lack of services for certain specialties, based upon the current lack of veteran workload which is retricted by arcane eligibility rules. Conversely, it seems likely that VA, in certain facilities, may have excess services which would allow them to serve as the provider of services, on a contractural basis, to the private sector. We believe VA should, in certain instances, be permitted and encouraged to sell their services to non-VA sources when it is

in the best interests of VA and veteran patients. We would note that these services need not be clinical in nature. Of course, our support for such contracting is contingent upon no otherwise eligible service-connected veteran being denied needed medical care or services or having their medical care diminished in any way.

Question 5: Do you believe VA has in place adequate oversight and control over its contractors? If not, what changes need to be made?

Answer: No. As concerns clinical care, we believe a functional system of case management needs to be initiated and employed by VA. This will help assure that veterans dependent upon VA for their care receive quality timely care from contract providers. Also, we believe medical center directors need to have the authority and flexibility to deal with the entire issue of contracting without total VA Central Office approval. Of course, contracting extends beyond that contemplated by only clinical services.

Question 6: Do you believe that employers should bear the cost of care for the current mandatory category of veterans? If the VA were to participate in a state where employers were mandated to pay premiums, should the current mandatory category of veterans be exempted and have their premiums paid by VA? What about service-connected veterans?

Answer: Clearly, it is the DAV's belief that the federal government continue to bear the total responsibility for the care of service-connected disabled veterans who have incurred their disabilities coincident with military service. As you know, current law requires VA to bill a veteran's private insurance carrier -- often provided for by the employer -- for the reasonable cost of care provided to veterans in VA facilities for non-service-connected disabilities. VA is vigorously complying with that mandate. H.R. 3600 contains relief for the payment of premiums by service-connected disabled veterans who are self-employed and choose VA as their provider of care. Additionally, the bill also exempts, which DAV supports, service-connected disabled veterans from the payment of premiums, deductibles or co-payments when choosing VA as their provider of care.

Question 7: Inherent in the word competition is the concept that there will be a winner and a loser; what happens if VA is the loser? What safeguards need to be in place to prevent demise of the VA system in the various states?

Answer: We would respond to the concept of competition in a somewhat different manner, that being the presence of a health care system that excels in the care delivered versus one which provides but mediocre care and services. We continue to believe VA has the capabilities to excel in the delivery of medical care to veterans. In order to create a VA health care delivery system that is viable, eligibility reform, as proposed by the Veterans Service Organizations, needs to occur as soon as possible.

Question 8: Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly from state to state? Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibility and benefits?

Answer: We do believe, based on demographics that the services provided and required by veterans will vary, however, not greatly. We do not believe that basic eligibility should vary greatly. Particularly, we would oppose anything that has

the potential to reduce benefits already provided for in law or by regulation, manual or otherwise to service-connected disabled veterans. We do believe in order to maintain against an exodus of veterans from the VA system, that VA needs to be, at a minimum, consistent with the basic benefit packages provided by the various states. Otherwise, veterans may have little incentive to choose VA as their provider of care. We do envision Title 38 to be controlling for veterans to, at a minimum, maintain their current eligibility status. We certainly do anticipate problems and situations to arise. We also believe VA totally capable of identifying and proactively addressing these issues as they occur and resolve them via the pilot program. We believe this is preferable to initiating a total, wide-sweeping reform of the VA system all at once. Unless imposed specifically by statute, we are confident VA will be able to succeed in these pilot program initiatives.

HEARING QUESTIONS
Imposed by
The Honorable J. Roy Rowland
(for Panel 2)
on
H.R. 3808 and
Draft Legislation to Authorize A Pilot Program for VA Participation in State Health Reforms
(March 8, 1994)

QUESTION #1: Do you have confidence that, as VA's formal testimony implied, it can achieve a massive reduction in its workforce simply by streamlining administrative operations, and do that without any impact on veterans' care?

RESPONSE to QUESTION #1: No. The VFW has continually brought to this committee's attention, as well as to the attention of the Department of Veterans Affairs, that VA is seriously understaffed. We have attributed ward closings and patient treatment denials and delays as being a direct result of this understaffing dilemma.

QUESTION #2: Do you have concerns that there could be too great a delegation of authority under the proposed pilot program, and that substantially refocusing VA care to meet State goals might lead to fragmentation of its focus as a national system?

RESPONSE to QUESTION #2: Yes. While we agree VA must be as competitive as possible in order to retain patients in this unique situation, VA's mission as a nation-wide health care system for veterans must not be compromised.

QUESTION #3: Mr. Buxton testified that it would be self-defeating to limit the pilot program for fiscal reasons. Given the likelihood that VA will not get additional appropriations for the pilot program isn't it prudent to limit its scope for not?

RESPONSE to QUESTION #3: One of the VFW's primary concerns is the financing mechanism for the pilot project. We agree additional funding will probably not be provided and the fear that the remainder of the VA hospital system will be forced to financially support the pilot project.

HEARING QUESTIONS
Imposed by
The Honorable Christopher H. Smith
on
H.R. 3808 and
Draft Legislation to Authorize A Pilot Program for VA Participation in State Health Reforms
(March 8, 1994)

QUESTION #1: What effect do you believe the President's FTEE reduction will have on the ability of the VA to compete under National Health Reform?

RESPONSE to QUESTION #1: The VA is hard pressed already in terms of caregiver to patient ratios. Additionally, in order for VA to successfully compete for an expanded universe of veteran patients under eligibility reform, as the VFW envisions it, there will have to be considerable expansion of outpatient care facilities to reach out into the communities. Accordingly, more FTEE would be required rather than less . Reduced staffing equals reduced services.

QUESTION #2: Do you believe inclusion of veterans' dependents is essential to successful VA participation in the various state Reform efforts?

RESPONSE to QUESTION #2: The official VFW position is that we feel that non-veterans ought not be treated by VA until eligibility reform has been completed and VA is able to successfully quantify, hopefully, a large number of veterans seeking to access it for services. However, it is only common sense to believe that within families, it is not likely that one member will seek out VA and expect his dependents to be served by another health care provider if he or she has adequate medical insurance to cover costs. Accordingly, at some point in time, VA will definitely have to increase the level of care it provides to dependents.

QUESTION #3: Do you believe the draft bill provides adequate assurances that VA services outside of the basic benefits package (i.e., spinal cord injury and blind rehabilitation, prosthetics, etc.) will continue to be provided to veterans?

RESPONSE to QUESTION #3: The position of the VFW is that any veteran accepted for treatment should be entitled to the full continuum of VA health care. It is our judgment that to date none of the draft legislative proposals equate to that level of care which we envision. This full continuum of care begins with preventive care and continues on through nursing home care to be provided to veteran patients accepted for care by VA.

QUESTION #4: Do you believe VA ought to have greater flexibility in contracting for Health Care Services? Why or Why not?

RESPONSE to QUESTION #4: A consideration here is "mainstreaming". We want to be assured that veteran patients understand that it is VA which is providing their health care and is aggressively monitoring the effectiveness of that health care whenever it contracts out for health care services. We understand the need for contracting out of health care in order to accommodate veterans access. We would expect that VA always remains the primary caregiver.

QUESTION #5: Do you believe VA has in place adequate oversight and control over its contractors? If not, what changes need to be made?

RESPONSE to QUESTION #5: We would hope that VA has adequate oversight and control over its contractors. Our Field Representatives occasionally receive complaints regarding clinical care which is contracted out; i.e., contract nursing home facilities. In most of the latter cases, there has been a failure by VA to adequately visit these facilities and ensure that patients contracted there by VA are appropriately treated.

QUESTION #6: Do you believe that employers should bear the cost of care for the current mandatory category of veterans? If VA were to participate in a state where employers were mandated to pay premiums, should the current mandatory category veterans be exempted and have their premiums paid by VA? What about service-connected veterans?

RESPONSE to QUESTION #6: The Veterans of Foreign Wars does **not** believe that service-connected veterans should reimburse the government for their care. The remaining largest mandatory category of current veteran patients are those who, in most cases, are unable to assume the cost of their care; have no third-party insurance; and, therefore, no employer to bear the cost of their care by VA.

QUESTION #7: Inherent in the word competition is the concept that there will be a winner and a loser, what happens if VA is the loser? What safeguards need to be in place to prevent demise of the VA system in the various states?

RESPONSE to QUESTION #7: The VFW is adamant that VA should receive the investment monies needed to grant it a "level playing field" to make up for years of underfunding of the VA health care delivery system. If VA is provided the necessary funding and staffing to take a stab at competing for an expanded universe of veteran patients and fails, then we would expect that VA would be the loser. We doubt that the system is likely to completely collapse since VA is a leader in such fields as spinal cord injury, long-term psychiatric care, provision of prosthetic devices, and certainly a provider for higher level of nursing home care than can be found in the community.

QUESTION #8: Do you anticipate that within the context of the pilot program that veterans services and eligibility may vary greatly from state to state. Do you anticipate any potential problems with the application of waiver authority which results in inconsistent eligibility and benefits?

RESPONSE to QUESTION #8: The VFW has concerns that the various packages of care provided under these state pilot programs may vary considerably from state to state to include eligibility for accessing them. In addition, VA medical facilities have catchment areas which cross state boundaries and if the VA was somehow constrained by state health care packages, this could impact on VA's ability to deliver appropriate levels of health care to **all** veterans. It is for these reasons that the VFW has some concerns over the concept of the pilot program which was being considered.

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