

VA MEDICAL CARE BUDGET FOR FY 2000

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
FIRST SESSION

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FEBRUARY 24, 1999
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VA MEDICAL CARE BUDGET FOR FY 2000

WEDNESDAY, FEBRUARY 24, 1999

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

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Honorable Cliff Stearns (chairman of the subcommittee), presiding.

Present: Representatives Stearns, Smith, Chenoweth, Simpson, Doyle, Peterson, Snyder, Rodriguez, and Shows.

Also Present: Representative Hayworth.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning.

The Veterans' Affairs Subcommittee on Health will come to order. I would like to welcome all of you, and I want to thank you for being here this morning. I particularly want to thank our witnesses who have traveled some distance to attend this important hearing.

As Chairman of the Health Subcommittee, I have closely studied the proposed VA medical budget for fiscal year 2000. It is a concern. It concerns me that this VA budget appears to be the most troubling I have seen in my tenure in Congress. It is a concern that this budget requires more than \$1 billion in cuts.

We have heard the Secretary defend this budget as providing for "better and more accessible service to veterans." But, to many of us, and I think it is true on both sides of the aisle, we have a different view, and I think that Department officials have a different view. We need to be clear that the VA health care system can no longer do more with less. To quote the Non Commissioned Officers Association, "Less is less."

I regret that we did not get more candor from Secretary West in his testimony here on February 11. We heard the Secretary express "confidence" that this is a workable budget, yet only 3 days earlier the Under Secretary for Health had warned him that this budget would place VA in a "precarious situation." Some weeks ago, we wrote to the Secretary and asked whether there was a plan to achieve the more than \$1 billion in savings proposed in this budget.

The response from him made it clear there is no such plan. Instead, we were told, "Because of VHA's decentralized decision structure the specific management initiatives will be decided by the VISN." To us, one thing is clear. If we are going to understand how

VA would cope with this budget we need to hear from the network directors, since they are the ones that are going to have to deal with it.

It has become clear that this budget will pose huge problems for VAs throughout the country, so we have asked network directors from widely differing regions to testify today. To avoid having OMB write their testimony, they were not asked to prepare formal opening statements. However, I would like each one of the network directors at the outset to provide us informally a perspective on this budget.

We are all working together. We are all trying to come up with a solution. I'd like each of you to take 4 or 5 minutes, tell us the kind of steps that you believe should be taken to get through the next fiscal year with this budget. We earnestly need your input. We need to put to rest the fiction that the VA can keep doing more with less. We need to make it clear that the VA cannot cut more than \$1 billion from its budget without cutting services to veterans.

In short, I'd like to challenge the Administration to resubmit this budget, because the budget we see today is not acceptable and we think we can do better.

I certainly look forward to hearing from our witnesses on this critical subject, but before inviting our first panel to come up this morning I would like to welcome our Ranking Minority member, Mr. Doyle from Pennsylvania, to provide his perspective.

OPENING STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Thank you very much.

I want to thank my friend, Subcommittee Chairman Stearns, for convening today's hearing to further examine the VA Medical Care Budget for fiscal year 2000 as proposed by the Administration. I also want to welcome all of my fellow colleagues who are present here this morning.

In addition, I want to thank those of you who are here to testify before the subcommittee for taking the time to share your expertise and insight on VA medical care and related funding issues. Your efforts are greatly appreciated and will assist members of this Committee in our work to fashion budget recommendations that accurately reflect and meet the needs of all veterans.

Before I begin my remarks, I ask unanimous consent that the testimony which was prepared and submitted by the American Federation of Government Employees be included as part of the record.

Mr. STEARNS. Without objection.

[The statement of Bobby L. Harnage appears on p. 57.]

Mr. DOYLE. Thank you.

In the interest of time, I will keep my opening comments brief and to-the-point. I think it is safe to say that there is not a whole lot to like about the Administration's overall budget for the Department of Veterans Affairs. And there's even less to like—if that is possible—about the woefully inadequate funding levels specified for medical care. As was made clearly evident in the full Committee's February 11 hearing on the overall budget, members on both sides of the aisle are particularly concerned about VA medical care programs.

Unlike committee dynamics you may observe elsewhere on the Hill, the concern that members of our committee have does not stem from internal bickering over obscure matters, but from our real doubts about whether we are fulfilling our commitment to our nation's veterans. And I am not talking about fulfilling our commitment in valiant terms as outlined recently by the report of the Congressional Commission on Service Members and Veterans Transition Assistance. I am talking about fulfilling the most basic of our commitments—the right of a veteran to have access to high-quality health care and to receive treatment in a timely manner.

No matter how you look at it, the Administration's Medical Care Budget does not add up—not in terms of funding new initiatives such as treatment of Hepatitis C or even maintaining existing programs.

In fact, it falls \$1.1 billion short in terms of keeping up with the inflation and paying the salaries of hard working VA employees. I could go on in more detail, but I will reserve some of my more specific concerns for the upcoming rounds of questions.

In good conscience, we must do everything we can to prevent the proposed funding for medical care from going unaltered. The Medical Care Budget is not just simply inadequate, but seriously compromises the professional integrity of the VA system in regards to the level of quality care that is being delivered and adequate staffing positions in various sectors. Without major overhaul, fiscal year 2000 funding levels also pose a significant danger to the long-term viability of the system.

It is my hope that the subcommittee members will not only emerge from today's proceedings more informed about the funding levels for the Medical Care Budget and their potential implications—but more energized about the need to clearly articulate to those whose decisions will greatly affect their day-to-day lives our concern about the vets back home.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Doyle appears on p. 55.]

Mr. STEARNS. I thank the Ranking Member for his supportive comments.

We will go to the panels, unless any member feels that he or she would like to offer a particular statement.

Mr. STEARNS. If not, we will have Panel 1 come forward, if you would.

We have Doctor Thomas Garthwaite; Doctor Ted Galey; Mr. James Farsetta; and Ms. Laura Miller; and Mr. Thomas Trujillo. I think what we'll do is have Dr. Garthwaite first, and then I'll have Mr. Hayworth introduce Mr. Trujillo.

STATEMENT OF THOMAS L. GARTHWAITE, MD, DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WILLIAM (TED) GALEY, MD, DIRECTOR, VISN 20; JAMES FARSETTA, DIRECTOR VISN 3; LAURA MILLER, DIRECTOR, VISN 10; THOMAS TRUJILLO

STATEMENT OF THOMAS L. GARTHWAITE

Dr. GARTHWAITE. Thank you, Mr. Chairman. I have only brief remarks and have submitted a formal statement for the record.

Just in the way of introduction, Doctor Ted Galey, is our Network Director in Portland, OR, is the neophyte of the group, appointed a little over a year ago, I believe, but has been a Chief of Staff and a Medical Center Director there in Portland. Laura Miller is our Network Director is VISN 10, which is centered in Cincinnati, Ohio, and joined the network structure when we first formed it, as did Jim Farsetta on my right, who is the Director in New York City VISN 3. Tom Trujillo you can introduce, but I know him well because he was Network Director in VISN 18, centered in Phoenix, AZ. They represent a good cross section, not only of the geography of America, but also some of the changes in the private sector, such as penetration of managed care, variation in practice patterns, as seen by analysis of Medicare data and other reasons.

Mr. Chairman, with your help we have made dramatic progress in transforming the Veterans Health Administration. We have been able to see more patients with documented improved quality, despite diminished budgetary buying power. The 30/20/10 goals that we labeled as stretch goals 2 years ago are in sight if we get aggressive Medicare subvention legislation soon. This budget keeps our part of the Balanced Budget Agreement.

However, many of the assumptions on which we based our 5-year budget have changed. The external and internal pressures to avoid changing the way we do business are building and the systems remaining to engineer are fewer than when we started.

We have been able to see more patients with improved quality, despite diminished buying power in our budget for a simple reason. We have changed how we do business. More difficult changes in how we do business will be necessary in the future.

I will make one final point. The veterans health care system is, and has been, resource constrained. That is, there is more demand for care than resources to provide it. Within the constraints of the budget, we have attempted to give high-quality care to the maximum number of veterans in priority as defined in law. This concept is simple to state, but enormously complex to understand and difficult to administer.

Mr. Chairman, we welcome the dialogue on some of the specific changes that might be necessary if this budget is adopted unchanged and welcome your questions at this time.

[The prepared statement of Dr. Garthwaite appears on p. 61.]

Mr. STEARNS. Okay. Before we go further, I would like my colleague from Arizona, Mr. Hayworth, to introduce our VISN Director.

J.D.?

OPENING STATEMENT OF HON. J.D. HAYWORTH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. HAYWORTH. Mr. Chairman, I thank you very much, and members of the subcommittee, I thank you for the courtesy and the indulgence.

I would simply say again, as has been demonstrated by both the Chairman and the Ranking Minority Member this morning, that we should emphasize that the mission of our overall committee, as well as the various subcommittees, is truly non-partisan in nature, as we work to obtain the very best for those who have worn the uniform of our country.

It is in that tradition that I am honored to introduce one of the very best, who coincidentally is a constituent of mine, who makes his home in Gilbert, AZ, and who recently retired after 33 years of service to the Department of Veterans Affairs.

And, let me simply quote from a letter signed by both our Senior Senator John McCain and the Chairman of our committee here, Bob Stump, quoting now, "For 33 years you have been one of the best advocates veterans ever had, and veterans have witnessed public service at its best." I speak of Tom Trujillo, who has been Director of VISN 18, who is retiring now after 33 years of service. Under his direction, VISN 18 has increased the outpatient clinics from 17 in 1996 to 27 today, three of them opening in the 6th Congressional District alone. He assisted in establishing a vet center in Cheney, AZ, the very heart of the Navajo nation, an area basically the size of the State of West Virginia. He increased health care services to Native Americans by also providing access to traditional medicine, installing telemedicine and video conferencing equipment at all facilities and several of the out-based clinics, and lest you think this is some sort of spending extravaganza, I would point out that my good friend, Tom Trujillo, received the Scissor Award for developing a process that saved approximately \$400,000.00 in capital equipment funding. So, he has found consistently better ways, more effective ways, to deliver health care services to our veterans, and certainly it is no disrespect intended to other members of the panel, who also have their accomplishments that they can cite, but I do appreciate the indulgence again of the Chair, and it is my honor to introduce to you my friend, my constituent, and an effective spokesman for the veterans of this country, Tom Trujillo.

Mr. STEARNS. Mr. Trujillo, we are pleased and honored to hear your testimony. If you will begin.

STATEMENT OF THOMAS TRUJILLO

Mr. TRUJILLO. Thank you, Mr. Chairman. It is, indeed, an honor and a privilege to be here with you this morning.

I did start my career in hospital finance many years ago, and I have extensive experience in medical care budgets, hospital budgets, as a financial manager and in this area as Associate Director, Director and Network Director.

And, first of all, it is my honor to be here this morning, and I thank you so very much.

Secondly, I am very concerned with the subject that I am being asked to comment on, and that is the fiscal year 2000 budget. Be-

fore I talk about the 2000 budget, if I may, I must mention the situation with the current year budget. Because of this increase in number of veterans being cared for by—and I am going to talk basically about our network, which, basically, also multiplies into 22 other networks, I am sure, in some form or fashion.

The increased usage and cost of materials and supplies, the current funding level will be short by approximately \$15 million in my network alone this year. However, we are taking actions to meet the budget if we, indeed, have to, which I always assume that we will. This is after having squeezed almost every efficiency we can out of VISN 18.

We have established many economies and systems in our network, standardized pharmaceutical formularies to make sure the dollars we spend are appropriate, and maximized, we have realigned programs from inpatient to outpatient. We have consolidated procurement. We have realigned organizational structures at each facility, and we have developed a patient referral process to provide specialized services in the most efficient and effective manner.

Network 18 has the lowest bed base of care per 1,000 patients. Some surgical procedures are now done routinely on an ambulatory care basis. Last year alone, we treated 167,000 veterans at a cost of \$3,600.00 each, the lowest in the country.

As a quick observation, with Senior Care, the name of the Medicare provider in our area, the cost is over \$6,000.00. We, in Network 18, as well as across the Veterans Health Administration, have stretched ourselves way too thin from my perspective, like the proverbial rubber band, we are, indeed, ready to snap, as has been mentioned before. And, snap we probably will in the year 2000 with the proposed budget in VISN 18, we will experience approximately a \$30 million shortfall if VERA continues to move money into our network. If VERA does not continue to move money into our network, as it has in the last 2 or 3 years, and we get a straight line budget with no decrease, we will experience an approximate shortfall of \$45 million in our network alone.

And, quite frankly, Mr. Chairman, I tried to come up with a word that would be descriptive, and the only thing I could come up with is, it stinks. With \$45 million, we can operate an entire medical center, such as Big Spring, AZ—I mean, Prescott, AZ, or Big Spring, TX, for an entire year.

Because of what we have already done to economize, we can in no way come up with the arbitrary "efficiencies" required by the proposed budget. I would anticipate a required reduction of somewhere in the neighborhood of 600 full-time employee equivalents in our network alone, and this is without even taking into consideration the impact of required new services, such as long-term care, extended long-term care programs, emergency care, Hepatitis C, homeless programs, et cetera.

So, what is the proposed budget 2000 going to do to the system that I have spent my life working for? I read somewhere where Congressman Evans said that this budget is like a house of cards which may work for a while, but eventually will fall. I would go even further and say that from the view of a VISN Director that

administering this budget will be like trying to build that house of cards in an Oklahoma tornado.

Gentlemen and ladies, I would like to close with a plea to you to take care of our nation's veterans in their time of need. I am often amazed at how destiny and coincidence converge to make strong statements that seem to transcend our normal perception of life's events. In one corner of the world, American forces, once again, stand ready prepared to enforce the international community's sanctions against Iraq and preclude their ability to rebuild an arsenal of mass destruction, while at the same time it is necessary that I stand before you with my hat in hand, more or less, pleading that adequate resources be directed to preserving the health care structure to care for these veterans when they need it, and I would extend that expression to those individuals responsible for preparing or submitting the year 2000 budget.

And, I appear before you today, as was mentioned while ago, as a private citizen. It is no longer a daily concern to my livelihood what the VA budget is. It is, however, of daily concern to my heart and my conscience, as it should be for every American.

Throughout the century, each time the freedom and security of our shores, or that of our allies, has been endangered, America's Armed Forces have risen to the challenge and served with courage and honor. Those men and women did not stop to ask for justification, but immediately stepped into the line of battle and gave all to assure our country's freedom. The very least that we owe them in return is the assurance that when they need our help, when they need health care or social services, there will be facilities and staff ready and able to provide the best our nation has to offer. To do anything less, Mr. Chairman, would bring dishonor to the United States of America, and that is exactly what I think the country is doing with the proposed budget for veterans health care in the year 2000. We are, indeed, bringing little attention and little respect to the veterans of this country.

I thank you for the opportunity to testify before you, and I would certainly welcome any questions.

Mr. STEARNS. I thank you for your candid comments, and I think you set the tone.

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

Mr. STEARNS. Doctor Galey, you are next.

STATEMENT OF WILLIAM GALEY

Dr. GALEY. Thank you. It's a pleasure to be here, thank you for offering me the opportunity.

From my perspective as a Physician Manager, and as a Director, and then as a VISN Director, the guidepost of 30/20/10 I found to be the first time that I had a clear vision of what it was as an organization we were trying to accomplish, I believe that it has guided us toward more efficiency, more effectiveness, more accountability, and certainly toward more patient focus.

Under the VERA model, VISN 20 in the first 3 years of the VERA model was a so-called "winner." We got increased resources and were fortunate to have those resources to do things that needed to be done for veterans in the Northwest.

However, 2000 will be a different year. That will be the first year when we will experience significant shortfalls that I will be very glad to talk about the specifics of, but suffice it to say will be in the range of \$30 to \$50 million in the year 2000. If we continue, over the next several years, on the budgetary path that we have outlined in front of us, I believe we will see even larger budgetary shortfalls in VISN 20.

The cause of this I do not believe are related to 30/20/10. I think they mostly are due to things such as unfunded mandates, a remarkable acceptance and valuing of our product with more veterans than we ever expected to see asking for our services, and the ongoing increase of inflation and the costs that are associated with new technologies, new drugs, new therapeutic interventions, which I believe veterans have every right to expect and deserve.

So, therefore, I'm very pleased to have the opportunity to talk today about what I see are going to be the impacts for 2000, and certainly into the future if the budgetary line is maintained.

You asked about some specific things that I thought were going to be important for us to think about in dealing with that. One of those things is, is that we have about an \$800 million a year cost that is related only to inflation and the increased cost of pay raises. That's expected, and I think it was integrated into the thinking about 30/20/10, but things like Hepatitis C, drugs like Viagra, the new treatments for a number of cancers and other therapeutic interventions that we can now bring to bear on the many maladies the veterans have, the aging population and their increased needs, are all things that are mandates for care for which 30/20/10 I do not believe covers the monetary need.

I ask that this group and the Administration support us in the management changes that we need to make, that are going to be very difficult for us all, change is difficult for us all, and understand that we are trying to do the very best that we can for veterans in making those changes, hoping to keep them focused on patient care and patient needs, but at the same time taking advantage of every opportunity that we have to be as competitive and as efficient as any other organization.

And, understanding that medical care technology, therapeutics are increasing rapidly, they are very effective and they are very expensive, and veterans, I believe, have the right and an expectation that we will provide those services and therapeutics, and I believe we have an obligation to provide them.

I appreciate the opportunity and I am glad to talk about any specifics relative to budget that you would like to ask me on VISN 20.

Mr. STEARNS. Thank you.

We'll go to Mr. Farsetta for 5 minutes.

STATEMENT OF JAMES FARSETTA

Mr. FARSETTA. Thank you for the opportunity of being here today.

Just from a historical perspective, Network 3 has never been a network that has shied away from dealing with budgetary reductions. Under the VERA methodology, we sustained the largest net reduction of any network. We've already achieved in real dollars about \$150 million worth of reductions. We have reduced our unit

costs by about 20 percent. We have eliminated almost 2,700 employees.

So, the idea of budgetary reduction is not something that is necessarily particularly troubling to Network 3. To this date, I have never been before this committee making a plea that dollars were necessary for me to maintain my operation. But, that really is not the case as we approach the year 2000.

I think that the things that we have done in our network to be more efficient are things that have actually improved service to veterans, have actually improved the quality of service to veterans, but I am really out of what I call "across the board" options that we can continue to utilize. I have too much infrastructure. What I mean by infrastructure is that I question institutional viability when you down size a hospital to a point where you have very few beds and yet you must support the infrastructure to keep that institution open.

For next year, my network is looking at a reduction in the range of about \$100 million. That would probably put my total reduction over the course of 4 years at about maybe \$220 or \$225 million, which is probably a little bit more than 25 percent of my budget. I do not believe it is achievable without some fairly draconian things. In fact, I could not present a plan to you right now of how I would come up with \$100 million. I think the idea of continuing to cut every medical center by a percent, without adversely impacting patient care, is simply not a viable solution.

I do not believe that I have enough management efficiencies that I can derive \$50, or \$60, or \$70 million in the area of management efficiencies. (I think not, in all probability, of proposing facility closure, and I think the reality of the time frame that is allotted, perhaps, furloughs would be the only option that I might have available to deal with budgetary shortfalls that I think I am going to be confronting.)

I have a whole series of other items that I could address, but I would prefer to do that in the questioning portion of the session.

Mr. STEARNS. Thank you.

And, the best for the last. Ms. Miller.

STATEMENT OF LAURA MILLER

Ms. MILLER. Thank you, I appreciate the opportunity to be here and to make some informal comments.

Like my colleagues, over the last 3 years I think we have made significant improvements in our network. We have established 14 community-based outpatient clinics. We are treating more veterans. We are doing 70 percent of our surgery on an outpatient basis. We started at somewhere around 20 percent. We have reduced bed days of care from over 3,600 per thousand to around 1,200 per thousand, and we have managed to operate more efficiently while increasing services and the numbers of veterans that we treat. We employ 500 less staff than in fiscal year 1996, and expect to continue reducing staff.

Like some networks, we have managed to fare well under VERA because of the productivity and the low unit costs that we have had, and so this year, while we did not achieve a level of budget that was equivalent to inflation and our salary increases and so on,

we are managing and will obviously continue to manage within the dollars allocated.

However, the horizon for fiscal year 2000 begins to reflect some of the same kinds of problems you have heard from my colleagues, I expect that, even though our concerns and issues with managing in 2000 will not be as significant as those in Network 3, as we move forward into 2001 and 2002, we will have the same kinds of problems that Mr. Farsetta is facing.

In our network, we anticipate that we will have a significant shortfall in prosthetics dollars that I will somehow have to support in 2000, that the money funded will be short of need by around \$5 million. We expect the pharmacy budget to increase from its present budgeted amount of \$55 million to over \$63 million. We expect personal services to increase from their present \$362 to over \$371 million. I expect a utilities increase of 5.7 percent that I have no control over, and a subsistence increase of around another 3 percent. In addition, using a prevalence of 10 percent as a marker for Hepatitis C, as we begin that screening, and at an annual cost of \$15,000.00 per patient, there is a bill of potentially \$21 million for Hepatitis C treatment.

Given all these things we anticipate a \$21.8 million shortfall, just without Hepatitis C or emergency services. Given that shortfall I have begun discussions with the directors in our network about holding off on opening more clinics, about the numbers of wards that we may have to reduce, about the numbers of FTE that we will have to reduce, about the need for targeted RIFs in some instances, and about the possibility of curtailing our contracted services for inpatients in Columbus, which is the largest city in the country without an inpatient VA presence.

I would be most happy to answer any questions from the Committee.

Thank you.

Mr. STEARNS. Thank you, Ms. Miller.

Mr. STEARNS. Doctor Garthwaite, you are probably the only one at the table that can really implement changes and be a forceful advocate here, so let me start with my questions to you.

You have heard the VISN Directors talk here, you know how the Paralyzed Veterans of America feel. In their testimony they imply that the VA budget has already detailed a national plan that is going to hurt the system, and they don't think you are going to right size the system. We know that Doctor Kizer has had a memo talking about how precarious the budget is. Let me just say, in the face of that criticism we are all working together for the same purpose, to try and help veterans. We are trying to come up with a budget, and we made the Secretary of Veterans Affairs a Cabinet position because we wanted to see from that position a strong advocate, somebody who is going to go out and make the case to the Administration. We don't feel it up here. You could be one of those people, you could go back to the Secretary and make the case, but in light of that criticism do you agree with Doctor Kizer's memo, do you think the veterans budget is a precarious situation?

Dr. GARTHWAITE. Yes, I think that this budget has significant financial challenges ahead of us. I think that you hear from people in the field that they are not comfortable. I do not think we heard

the same thing when we embarked on the dramatic changes we have made in the Veterans Health Administration during the last 4 years. So, to answer to the questions—Is this an easy budget to live with? Are there hard choices ahead? When the total prioritization of the entire federal budget chooses to provide this amount for veterans health care, it is for us to reconfigure our system to provide maximum care to veterans with that amount of money. Significantly hard changes are ahead, and I tried to allude to those in my brief remarks.

Mr. STEARNS. The VVA states in their testimony that it is their understanding that one of the reasons for OMB's rejection of VA's funding request is that the VHA finished fiscal year 1998 with some \$600 million in savings. Could you explain that to us?

Dr. GARTHWAITE. Well, I think that there are several reasons why we finished the fiscal year that we went through with some carryover. For the first time we were allowed, because of the MCCF funding legislative change in the Medical Care Cost Recovery Fund, we are allowed to take some dollars forward.

There was an additional quarter of MCCF collections that were put into that fund. Probably most significantly, we did not know the impact of enrollment and eligibility reform, because we were just beginning to do enrollment for the first time. Our managers responded to these uncertainties and without a long-term sense of our budget, without much understanding of where eligibility reform and enrollment were going to take us, by bringing some additional dollars forward for this year. In addition, we knew, because of the 5-year budget projections, that we were going to have to make up for inflation as well, and so, with all those factors ahead we had the opportunity, and I think appropriately so, brought forward some money. We do not see that the picture is rosy at the end of 1999, there are significant challenges ahead in this particular year, including paying for the Hepatitis C treatment, so we have deferred some things that the other witnesses have already outlined.

Mr. STEARNS. Let me talk to the rest of the panel.

In the budget, they are talking about opening 89 new outpatient clinics to treat 54,000 new veterans. Let me ask you folks, can you do that with a flat budget? I mean, is that possible, anyone who would like to answer that.

Mr. FARSETTA. I am not sure it is possible. I think, at least for me, it has got to be put in the context of what my actual budget is going to be. It would make little sense to me to continue expanding services, for example, if I am looking at maybe a day a month that all of my employees will not be paid.

At some point, we need to make a decision, in terms of what segment of the veteran population can we continue to treat with the resources that we have available, and I'm not sure what message we are sending, you know, to veterans, that if we do not have the resources to provide all the care that we need to provide should we continue to expand in that area.

Mr. STEARNS. Yes, Doctor Galey.

Dr. GALEY. As you know, when the legislation about the CBOCs was discussed, there was an agreement that they were not being put out there to increase numbers of new veterans coming through

the door, they were to provide increased access to the existent veterans.

The CBOCs, in our vision, are in locations which I believe do provide remarkably increased access, which is very favorable for veterans. Often times you have to travel several hundred miles to get to VA medical centers that exist right now.

However, those veterans do have access to services in other ways within those communities, which I think in some instances is a hardship for them, but it is available. So then, what we have to do is to make a decision about what are we going to take out of one area to fund CBOCs if we make that choice, and since we believe that we are going to be hard pressed to maintain the ongoing critical services that we have in the centers that we now operate, we are putting CBOCs on hold. We believe that that, in Oregon alone, will save us about \$1.6 million, when we are looking at that budgetary shortfall of \$30 to \$50 million we believe that that is something which to maintain the other services balances out, but it's certainly not good for the veterans and their access to care.

Mr. STEARNS. Okay. Mr. Trujillo.

Mr. TRUJILLO. In Network 18, we had budgeted about 43 total community-based clinics through the year 2000, but in view of the budget that we are looking at, and because we have opened the community-based clinics with dollars that we had within our system, and efficiencies that we have implemented in our system, and no additional dollars have been made available for that, we will—well, they will be taking the position of retreating and looking at those very critically and doubt that we will make any further progress in opening community-based clinics.

Mr. STEARNS. Ms. Miller?

Ms. MILLER. We have been tracking utilization of our clinics and find that about two thirds of the patients in our community-based clinics are not new to the system, but have been utilizing the system. We are able, in the community-based clinics, to offer those services at a lower per unit cost than we typically experience when we provide service in a tertiary care setting. So, we believe that it is a more efficient way to deliver the primary care services, and it is part of the reason that we have been able to expand the number of veterans we treat.

However, you get to a certain point, where taking the utilization of the resources out of the tertiary centers and the long-term care programs has to come to a standstill. Once we have reached a point where we can longer shrink utilization in these areas, and I believe by the end of this year we will be at that point then I have some concern about whether or not we can continue with the few more clinics that we have scheduled or without reductions.

Mr. STEARNS. Now, the budget also includes \$39 million to hire 197 full-time employees to expand the homeless programs. Now, when you talk about a budget, it is easy to promise things. You can promise things to everybody, but the problem is, you may not be able to deliver. Is this an example where the budget cannot deliver, hiring 197 full-time employees, spending an additional \$39 million? Can you folks, under your flat budget, fund this program?

Dr. GARTHWAITE. Certainly one of the expectations would be that if we treat more homeless veterans more comprehensively and get

them out of homelessness, that their total health care needs would diminish. There is evidence in the medical literature that homeless veterans consume more resources, are sicker in general than those who are not homeless, and that by improving their nutrition, improving their exposures and so forth, that we could decrease the costs that we would otherwise have to put into treatment if they just present to our hospitals with illnesses.

Again, we are not curing the homeless problem with this, we are making a small step to address it in a little more aggressive fashion than we have in the past.

Mr. STEARNS. The last question I have, Doctor Garthwaite, deals with the bonuses for VISN Directors. As I understand it, VISN Directors could earn an additional \$80,000.00 in addition to their present salary for doing good work. Is that accurate, and have any one of you got an additional \$80,000.00 bonus?

Dr. GARTHWAITE. No, it is not accurate. It would be good news, I suppose, to the people sitting around me.

Mr. TRUJILLO. Sign me up.

Mr. STEARNS. Are you coming back?

Dr. GARTHWAITE. Mr. Trujillo, it is too late for you. No, there is no truth to that. There are some bonuses. I would point out to you that if you compared the salary structure, certainly of our non-physician leaders, and even our physician leaders, to private sector health care leaders in integrated networks of the budgetary size and complexity that we have, we are paying a half, a third, maybe even a quarter of what the private sector is paying. These are folks making very difficult decisions, and they are doing it, really, on a relatively modest government salary, because as Tom Trujillo put it, for their love of the principle and for service of veterans.

We do give some bonuses, the maximum amount we gave under our structure last year was \$16,000.00. Only a few VISN Directors got that amount. Several got a smaller amount, and a few got Presidential Rank Awards. We have that data available if you would like to see it. For the last couple of years that money is given for demonstrable improvement in the outcomes for veteran patients, and I think that is another key piece. There are relatively few government agencies where managers have to make something change—the access, the courtesy scores, the preventive services and so forth for veterans to be considered for bonuses. Improved service is a significant factor in determining those amounts and not for cutting budgets as has been suggested by some. Of course, our managers get a budget, and they have to live with it. They get a bonus if they are able to make veterans outcomes of care, and access scores and things like that improve.

Mr. STEARNS. Okay.

Let me go to Mr. Doyle, Pennsylvania, the Ranking Member.

Mr. DOYLE. Thank you, Mr. Chairman, and thank you to the panelists for being here. Tom, especially someone like yourself that has been on both sides of the fence now, we appreciate your testimony, and, Laura Miller, good to see you again, we miss you in Pittsburgh.

Ms. MILLER. Thank you.

Mr. DOYLE. A couple questions, and maybe a couple comments first. Nobody on either side of this aisle likes this budget. This

budget does stink. I just do not understand how we can flat line a budget since 1997 to 2004 and expect this system not to collapse. But, I want to remind my colleagues, too, that those of us that were here during the Balanced Budget Act, I would venture to say every member of this committee probably voted for that budget agreement, and in that agreement there are spending caps, and we are looking at some \$30 billion of discretionary spending cuts in that budget, and those of us that sit on this committee that are asking for increases in this budget, and I am one of those people, have to be prepared to also break that budget agreement, because that is what it is going to entail. It is going to entail members of Congress who voted for those spending reductions, back when the Balanced Budget Act was there, be willing to rethink, given the fact that we are in a surplus position and that the economy is doing a lot better than it was back when we made that agreement, whether or not we are willing to bust those budget caps to provide the revenue that sits here.

So, in defense of the Administration, and I do not like anything about this budget, I think I made that clear, but in defense of the Administration they are trying to keep their budget requests in line with the balanced budget agreement that we all voted for, and we are going to have to be willing to break those spending caps. And, I am sure, you know, Mr. Kasich, and other members of the Budget Committee, and the appropriators, are not as willing to do that as maybe some of us are, but I think, you know, in fairness to the Administration that point needs to be made.

Doctor Garthwaite, let me ask you first, and I think my friend, Cliff Stearns, alluded to this earlier, that VHA has requested concurrence on some reductions in force and other right sizing authorities needed to get several VISNs through the current fiscal year, are you aware of where those requests are at this time and when the Secretary will review them?

Dr. GARTHWAITE. I can tell you what I am aware of. I know that following the hearing on February 11, the Secretary and Doctor Kizer met, discussed those budget requests, and that they are undergoing a final review by the Secretary's office. I cannot promise you a date, as it is out of my hands, but I know there has been additional discussion between the Secretary and Doctor Kizer regarding those.

Mr. DOYLE. Does the VA—do you have a plan for managing a zero growth budget for the foreseeable future? I mean, if you could speak to us about the numbers of hospitals that would be closed, the number of patients that you would be able to treat under that scenario, the number of full-time employees that are going to lose their job in order to conform to this no growth budget for 5 consecutive fiscal years, I mean, what is that going to look like and what is your plan? I mean, we were here at a hearing February 11, and Doctor Kizer and Secretary West said that, you wonderful VISN Directors are all going to come up with a plan to implement this budget, I am very curious what your hospitals are going to look like after 5 years of consecutive no growth budgets and what that is going to mean in real terms and real people and services.

Perhaps, each of you can address that a little bit.

Dr. GARTHWAITE. I would just say a few words. If one just looks at the numbers and projects it out a bit, and assumes a usual percentage of our budget for personnel, which is like 76 percent or so, and considers normal inflationary increases guess at how many reductions in personnel would be necessary to live with that sort of fixed rate.

The problem is that there are thousands of other things that are changing simultaneously, Hepatitis C comes in, you pay some more, minimally invasive surgery comes in, you save a little, outpatient drug rehabilitation becomes the standard of care, as opposed to inpatient, a dramatic change in what happens and you save, then total hip arthroplasty, you know, artificial hips comes in and more veterans need those and that costs. So at any given moment there is this continuous flux of things that save money and that cost money.

In addition, every network is different. It is said, all politics is local, we believe all health care is local. That is why we turn to our network directors, why we meet with them on a monthly basis, talk to them on a weekly basis or more often, and are in constant discussion and negotiation about how best to deal with these budgetary challenges.

So, we believe it has to come from below, because it is relatively difficult to see all the nuances and impacts from far away, or to design a policy that if implemented across the entire nation would work just as well in New York City as it would in rural Oregon.

And, for that reason, we do not have the kind of specifics you might talk about, I mean our plans are much more generic and larger in nature. I think I will stop there and let the people on the panel address your question.

Mr. DOYLE. Yes, I would be interested to hear from the VISN Directors, and Tom, just speaking to where they see their VISNs with 5 years, five consecutive years of flat line budgets. I mean, what are your systems going to look like, and how are you going to cope with that?

Mr. FARSETTA. I think there were probably some questions that need to be answered, or at least raised. If we assume that we will be caring for the population that we are currently caring for, I think the facilities would look one way. If we were willing system-wide to make some determinations relative to the various priority categories of veterans, those that we would elect not to provide services to, if we were to look at, for example, whether we will continue to provide long-term care, I think that is clearly going to have an impact on what the network would look like.

But, if I were to look at my network in a 5-year straight line budget and total that up in terms of increased expenditures that I will be incurring in dollars that I will not have, it would probably equate to close to the budgets of three hospitals. So, I would not be able to provide funding for upwards of three medical centers. I'm not saying they would close, but that is what it would come to in dollars.

Now, for my network you have to factor in the impact of VERA, which is roughly \$150 million.

Mr. DOYLE. And, you are a VERA loser, right?

Mr. FARSETTA. I am the VERA loser. I am not a VERA loser. So, it is quite, I believe draconian, and quite honestly without decisions I am not sure how manageable it is, and by the same token I am not sure how honestly you want to talk about things, because when you start discussing closing institutions, it has a whole secondary effect on the veteran community, most importantly, where are they going to be deriving services and on the employees in that area, and there may be other ways of dealing with it that has to do with the fact that we will simply be providing less service to less veterans. So, veterans who otherwise would have been entitled to health care won't be anymore.

I am certainly opposed to that, I think we owe veterans whatever it is that they have done for this country, and that is the reason that we are here, but when it comes to dollars, and it comes to quality of patient care, I think tough decisions are ultimately going to have to be made.

Mr. DOYLE. Anyone else?

Dr. GALEY. Yes. I took the flat line budget to be related to, and in a context with, 30/20/10. My sense is that we will reach all but the 10 goal far ahead of the 2004 time frame, and if, for instance, we are going to continue to see over that time period 7 percent growth in our veterans, on the average per year, or 35 percent rather than the 20 percent we are slated for, that is, in my mind, a change in the landscape that was not expected under that agreement, and, therefore, we would require more funds for it.

In addition to that, it considered the medical care scene as it was at that point in time, and as we know and have heard it has changed dramatically, and is continuing to change, and while we do have the offsets of things that improve our costs and decrease our costs at the same time, I believe the increased costs are winning at this point in time. So, that is a change in the landscape as well.

What will that have as an impact on our network? Well, we are going to see the same impacts that I believe Jim was talking about, perhaps, to a different degree. We have certain control points. We are either going to decrease the number of veterans, we are going to have to decrease the number of services that are within the package, or we are going to have to start closing centers or programs to be able to maintain that budgetary status.

Ms. MILLER. I would basically echo Doctor Galey's comments. I think that over an extended period of flat line budgets, if we continue to have budget decreases under VERA, it would be about equivalent to one of our facility budgets, and I could see that we will have to make some program decisions that will be very unpopular, not only with the veteran community, but also with our affiliates, and I think that that is going to come in this next budget cycle.

I also think that the policy issues regarding where we are going on long-term care need to be addressed because we cannot maintain everything.

Mr. DOYLE. Thank you, Mr. Chairman.

Dr. GARTHWAITE. If I could have one sentence, just to say that I think if you look at our testimony when 30/20/10 was proposed and adopted as a 5-year budget plan, it was with the proviso that

you could not pull it apart, you could not just say we want the 30 and the 20, but you don't get the 10. It was with that explicit testimony.

Thank you.

Mr. STEARNS. Okay.

Mr. Simpson, anything you would like? Any questions?

Okay. Mr. Snyder, I think you are next, and I just have to run to the Floor to give a statement and I will be back, and I will ask my colleague, Mr. Simpson, to take over the chairmanship.

Mr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Mr. SNYDER. Thank you, Mr. Chairman. Before you leave, I want to thank you for this panel. I think this is a very helpful to have these directors where, I do not want to say where the rubber meets the road, but I think that is what we are thinking, and I really appreciate them being here.

I wanted to ask Mr. Garthwaite, picking up on what Mr. Doyle said and one of the comments you made, Doc^r - Garthwaite, I am sorry, you and I worked too hard for those fees to give them away that easily, in your statement you referred to our part of the Balanced Budget Agreement, talk about that a moment, if you would. You know, the information we have, I think, is that Secretary West, or actually you all's submission to OMB was for, I think, \$1.3 billion more than was in the President's budget, so you must have foreseen that your part of the Balanced Budget Agreement, at least extended another—that you were entitled to another \$1.37 billion. How do you analyze what you foresee, or what you all see as the Veterans Administration's part of the Balanced Budget Agreement, how do you see that? Or, does somebody come to you and say, after you have submitted it, hey, we have got a balanced budget we have got to do, and you all are going to get cut back?

Dr. GARTHWAITE. I think we started this year with a sense that we had 5-year projections dating back a couple years, and when we began to pull together the budget to meet those projections, I think both Doctor Kizer and Secretary West looked at the challenges that those levels would entail with regards to things that were not on the table when the Balanced Budget Act was passed, such as, the Hepatitis C issue, the sort of consensus was that the additional funds should be requested.

Mr. SNYDER. I understand that, but your submission was for almost \$1.4 billion more.

Dr. GARTHWAITE. Right, I think that is—

Mr. SNYDER. Did you believe that submission, you thought you were still within the constraints of your part of the balanced budget?

Dr. GARTHWAITE. No, I think that we felt as we looked at those additional pieces that we needed to raise that during the Administration budget discussions to put clearly on the table those particular issues and their added costs. I think the stresses envisioned was reflected by the testimony here.

Mr. SNYDER. I have kind of gotten the impression, Doctor Garthwaite, that there are things you would probably rather be doing today than having to deal with this particular issue, carrying

the water you are carrying, but Doctor Kizer's memo, which I guess probably within about 2 hours after he signed it was faxed all over the world, I was going to say the Free World, but, you know—but he actually did not say in there significant challenges, his memo says to Secretary West that there are very serious financial challenges, and the significant challenge to me is figuring out what to do about Hepatitis C for veterans. This is a kind of a different kind of a challenge.

I like what Ms. Miller talked about, you know, the push towards more efficiency, and we always have this challenge, whether it is in business or government, the proper tension between, you know, watching the bucks, recognizing the taxpayer dollars, being as efficient as we can, versus providing the quality of care. I do not know if I want you all, I do not know if I want these, used to be four, now three people going to into this year with a serious financial challenge. I think I want their challenge to be providing quality care to veterans and meet the mandates that we are giving them. I am going to try to give you another one with regard to Hepatitis C, if I can, because I think it is real problem out there.

My question is, I mean would you agree, Doctor Garthwaite, that the challenge that is facing them, a very serious financial challenge is the wrong kind of challenge that we ought to be laying on your staff?

Dr. GARTHWAITE. Well, I think—there is no easy way to do this. Obviously, our job is to take the money we are given and to turn it into the best care possible. The reason I think we brought forward the additional initiatives in the internal process was because these are very difficult management challenges to take on, To undertake a RIF takes time, it has significant repercussions, both personally for the people who are RIFed, it has significant repercussions for the people who have to go through it, and to deal with colleagues who are losing their jobs.

Mr. SNYDER. Let me interrupt, because we, of course, the Chairman is gone, I guess we could just have as much time as we need—oh, no, we have got a new Chairman, you know, you say your job is to take the money you are given and do the best job with it, but Doctor Kizer's memo was not a memo about, we have a rare opportunity to set a model of efficiency for health care in America today. I mean, that's not the tone of the memo. The memo was, he does not say it, is that we have been screwed. I mean, that is the tone of the memo, you know, and we all know it, and you all know it, and Doctor Kizer is a doctor and he's sending word out to his medical administrators, we got screwed in the budget and if we do not work on it we are going to be in precarious difficult times. I mean, that is a different kind of a challenge, is not it not?

Dr. GARTHWAITE. I would think the implication is that these are very serious and difficult challenges, and we cannot wait to take action, to put us into a position to live with the budget. If we wait, the nature of our business is that it will cost more later if you do not take the administrative actions early, and you will have to take more actions later and they will be less effective and helpful, and less reasoned.

Mr. SNYDER. I had several other questions I wanted to ask, but maybe I will just go on a different line here. For our directors,

what has been the impact, as not just this budget, but of what Ms. Miller called, you know, the push towards efficiency? One of the things I have liked about the VA, as somebody who trained at two different VAs, both in Portland and in Little Rock, is that medical education, those kinds of things, what is the potential impact on the research that is being done at these facilities, what is the impact that you see on recruitment of the kinds of physicians that you want at VA facilities?

Dr. GALEY. Let me take a stab at that.

First off, the research budget is a separate line item, I believe that is the correct term for it, and so I do not see an impact directly because of our medical care budget on that budget.

However, I do see that because we are striving for increased efficiencies because we are going to be short of FTE and so forth, that the individuals that do the research, the clinical investigators, are going to certainly feel the impact of a short medical care budget.

Mr. SNYDER. Let me, I mean I think that is an important point there, I mean, what you are telling me is in looking for efficiencies, people that you hire, physicians that you hired to be researchers are being asked to do more clinic work, I mean, they are being asked to see more patients than they were originally told, is that a fair statement?

Dr. GALEY. Yes.

Mr. SNYDER. So, they are doing less research.

Dr. GALEY. Yes, that is true to an extent, and let me explain what I mean. There are some good things about that as well. First off, in the past we did not pay a whole lot of attention to the research accountability, the value of having the budgetary constraints is that now we do, and I can tell you a lot better now that our investigators are every successful at what they are doing. They are very efficient at what they do. They manage their time very well, and our research is better because of it.

Our clinical care activities, all of our researchers in our VISN are expected to have clinical care activities, and it is a stress on them when they have to do more. We are trying to do our very best to make sure that they have guarded time to complete their research activities.

I mean, it is a double edge. We improve the efficiency, but it is harder when you do more things in the same length of time.

Mr. SNYDER. My time is up. Thank you.

Mr. SIMPSON (presiding). Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

Mr. Trujillo, first of all, I think you are too young to retire.

Tom, I think I was hearing you, where you were identifying as politics all being local, and I heard, as a Hispanic I heard about politics being loco. There is no doubt that this budget is crazy—

Mr. TRUJILLO. No comment.

Mr. RODRIGUEZ (continuing). In terms of trying to accomplish some of the things that we are trying to do.

Let me—back home, I represent San Antonio in south Texas, and for the very first time in Alonistene, the last or so, we have seen an opportunity 200 miles away from San Antonio that I also rep-

resent where there was no access to, you know, they had to go all the way to San Antonio to get service, and now we have seen the possibility of some clinics and that kind of thing, so that has been real good. Although, at the same time, it seems like we have already moved to cut a lot of the rehab activities, and we are getting a lot of concern by a lot of the veterans that that is essential for some of the things that they need, the rehabilitation aspects of it, and it seems to have been identified as something that is like a luxury, when in all honesty it is something that is real serious, and I would want you to comment on that.

And, I also would want to get some feedback. I know we established some pilot programs regarding third party reimbursements, and at least I am under the impression that San Antonio and that region is one, because, I mean, when you go all the way to Brownsville there is nothing down there and it is almost 250 miles away from San Antonio and that region. We have one other center, which is Carville, which is north of us instead of south, and I hear that that might be closing down, and I do not know if you want to comment on that. There are four Congressmen out of San Antonio, it is not in my area, but it does service some of my veterans in my area, and I would want to get some kind of feedback from you.

And, for my friend who was talking about VERA, let me just say that we are still fighting. Sometimes I have seen that data, there is about \$1,000.00 disparity between other areas and what we have in comparison, and I know that, you know, some of my counties double in the number of population because of the winter birds that we get and a lot more veterans that come in in Zapata and Stark County and some of my lower counties on the border. And so, I wanted to see if you could comment, both on the existing cuts already on rehab activities, and secondly, on the third party reimbursements, in terms of where we are to try to move on that area.

Dr. GARTHWAITE. Thank you, Congressman, and, clearly one of the major initiatives of our reinvention has been to put access to VA health care where veterans are, and I have used the southern Texas, Rio Grande Valley, as an example of why we have had to make changes. It is not acceptable to drive 400 miles for your high blood pressure check, and we are pleased that we are making progress in providing access locally.

I believe rehabilitation medicine is a critical part of delivering medicine, and I was not aware that there are some perceived changes in delivering rehab medicine in that area of the country. We will take a look at that and try to get you a specific answer as to what's going on.

What was the other part?

(Subsequently, the Department of Veterans Affairs provided the following information:)

The VISN 17 budget allocation to the South Texas Veterans' Health Care System for FY99 required \$9 million in budget reductions. Vertical cuts and consolidations submitted to program offices for review included consolidation of 20 acute rehab beds into a 90-bed Extended Care Center. The most common diagnoses in the acute rehab unit were acute stroke, amputation and joint replacement rehabilitation. Staff in the extended care unit is responsible for preexisting care plans for stroke and amputation patients and rehabilitation planning is still provided by Physical Medicine physicians. Staff from the consolidated acute rehab unit still performs the required therapy. In addition to this inpatient program, physical medicine runs an outpatient program that has not changed in the last year.

Rehabilitation is also provided for substance abuse patients in a 26-bed inpatient detox and stabilization unit. A 20-bed intermediate care unit for dual diagnosis and homeless patients with substance abuse was closed November 1, 1999. These patients are currently treated in an outpatient substance abuse program with housing in a contracted halfway house. Capacity for rehabilitation services in spinal cord injury has not changed in the past year.

Moving of the site for rehabilitation services in order to reduce staffing initially caused disruption in normal communication and referral patterns. However, this disruption has been resolved and the consolidation of rehabilitative medicine services has had no negative impact on the level or quality of rehabilitative services provided to our veterans. South Texas continues to provide a comprehensive level of service.

Mr. RODRIGUEZ. The pilot program on third party reimbursement.

Dr. GARTHWAITE. Right. Third party reimbursement. We continue to fall a little bit short of our goals, which we set fairly aggressively. We increased the amount of money we are taking in with third party reimbursement and are returning that locally for care of veterans in that area, and we are pleased that we continue to produce more.

We have significant changes to make, and to be honest with you they start at the very front end and are all the way through the billing cycle. We did not grow up as a health care system having to do billing, and so that is not built into our culture. Most other health care systems that did not do this well are currently out of business, so the private sector does this very well. We did not have to do that until the Balanced Budget Act of 1997 made those collections a part of our funding stream.

We are at work very hard now with SWAT teams and aggressive educational efforts, and changes in structure and processes, the use of outside consultants in some places, where we are really looking very hard at how we can appropriately bill for veterans care under medical care cost recovery, and how we can take that money and then return it to the care of veterans in the area. And, I think we are making progress, I think we have significant work to do in this area. I would not say otherwise.

Mr. RODRIGUEZ. Yes, and then just in terms of your budget, I know that we want to continue to move on those clinics. I know that Congressman Shows from Mississippi talked about—or wanted me to ask you also about the clinics, to make sure if that is going to have an impact based on the budget that you have now, and I am also very supportive of the importance of looking at the homeless veterans. There is nothing more depressing than to see a veteran that is homeless out there and that we are not doing sufficient enough, not to mention that around the border we have a large number of individuals with non-resistant tuberculosis, and that kind of thing, and, in fact, in Mexico there is some startling data of over 11,000, you know, individuals, and it is right across the border.

I wonder if you could make some comments as it deals with nursing homes also. Because of the fact, and I am just going to throw this caveat, one of the concerns is that you are dumping them into the nursing homes and not providing the care, and I am wondering, just how cautious are we going to be in that effort, in terms of providing alternatives such as, you know, homeless shelters, as well as nursing homes.

Dr. GARTHWAITE. Well, certainly, and it is not our intention to dump any patients anywhere, it is our intention to place them appropriately where their care needs would dictate. We, obviously, have significant issues with regards to being able to afford all of long-term care that all veterans would like to have, and we do have a report from an outside panel being circulated for comment and a group looking at coming forward with some recommendations that we will obviously share with the committee and broadly with our stakeholders with regards to long-term care. The bottom line, of course, is that it takes a lot of money to expand services.

We do have some modest expansions for our home-based primary care initiatives in this particular budget.

In terms of homeless, I think we continue to be one of the major providers of hands-on care for the homeless. I think we are encouraged by our efforts and to the extent we can, we will free up new dollars to put into those efforts, because as I mentioned before we think that is the right thing to do from a lot of perspectives, most importantly, from the veteran's perspective.

Mr. RODRIGUEZ. Mr. Chairman, can I ask one more question, real short?

Mr. SIMPSON. Sure.

Mr. RODRIGUEZ. Following up on Doctor Snyder's question regarding teaching, I am not sure what role we play, but I know in my area we have a teaching hospital, and we have both the Air Force and the Army participating. As it relates to the teaching aspect of it, what kind—and the talk about cutting down on hospitals, and I know we have to, you know, trim down, what kind of impact does that have on the teaching aspect of it, in terms of future physicians and nurses and everyone else?

Dr. GARTHWAITE. I think the specific impact the VA has, is that we have decreased the total number of residency slots over a 3-year period following recommendations from a panel chaired by the former head of the Association of American Medical Colleges.

The biggest issue, I believe, in health care education today is that the training of doctors has traditionally been an inpatient exercise, and we have dramatically changed where we deliver care. So, if we are delivering primary care in a small community-based outpatient clinic fairly far from the tertiary medical center, we need to somehow have the medical schools and the training programs reinvision where they are going to have to deliver the training for those new doctors as they come along, and other health care providers.

So, the big transition for medical schools is changing the educational models. They see that, in fact, in part on their own, and in part, I think, to the response to the way we are changing the health care system in the VA. I don't see that traditionally academic institutions are quick to embrace that change. These things have built up over a long period of time, and medical schools have significant other issues as well.

So, I think we are making progress. I think that medical schools are changing. I would challenge them to change a bit faster, because we need to change the way we deliver care faster than they seem to be adapting to us, but I think they have picked up the pace more recently.

Mr. SIMPSON. Mr. Smith.

OPENING STATEMENT OF HON. CHRISTOPHER H. SMITH

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

Sorry I am late, but I will look at the testimony, and I just have a couple of questions, and, Mr. Farsetta, thank you for your help in the past and your availability to meet with me and my staff over concerns about our local health care facilities, including the Brick Clinic. And, I was just wondering if you could tell us if the President's Fiscal Year 2000 budget were to be passed, as you know we are trying to add back those specialty care items that have been lopped off, what would be the impact on the Brick Clinic, and, specifically, what would be the impact on your region generally?

Mr. FARSETTA. It is hard for me to comment specifically on the impact on the Brick Clinic. I mean, the Brick Clinic is a productive clinic, it provides various central services to veterans in the central and southern part of New Jersey. It is a fairly efficient clinic, and it really is a direction that the VA is moving in, so I can't tell you specifically what is going to happen to the Brick Clinic.

But, in the overall context of the budget, I identify between VERA and budgetary absorptions of numbers close to \$100 million. A \$100 million reduction in a network that has already experienced a reduction in purchasing power of about \$150 million is really a staggering amount of money.

The ability to continue to effect reductions across the board, meaning every hospital, for example, the New Jersey hospitals constitute roughly 22 percent of our budget, to think that I could get \$22 million additionally out of Lyons and East Orange, when I have taken out \$25 million this year, is very difficult to ask, without thinking about some alternatives, and that would encompass the whole network. That has to do with shedding some infrastructure, and shedding infrastructure means, in all honestly, either changing mission of hospitals or closing hospitals.

So, I put it in the context of what has happened historically and what is being asked now, and what may be asked, in point of fact, in the future, because I am looking beyond 2000, I need to look at 2001 and 2002.

The other issue, that the idea of generating significant dollar savings for next fiscal year, since 70 percent or 75 percent of our dollars are tied into people, to begin to generate savings quickly is really not something that is very probable, because even if we go through a RIF process, which I think is a horrible thing because you are really affecting the livelihood of a lot of people, RIFs don't come without expense, and a RIF will probably cost us at least \$30,000.00 to \$40,000.00 per employee. So, even if the employee were to leave, because you identified a RIF, somebody is still going to be paying for that for the better part of, perhaps, a year. It really is a product of how long the employee has worked.

So, as I told the panel earlier, I do not have a good answer, because right now I am not sure that there really is a good answer.

Mr. SMITH. Is it not true, though, that VISN 3 has really taken it on the chin, perhaps, disproportionately, vis-à-vis the rest of the other areas?

Mr. FARSETTA. We can hold another hearing on that. I do think that VISN 3 has had the most substantial loss under the VERA model, and while I think part of that is justifiable relative to inefficiencies in the VERA, I think the other part of that is a product of our case mix, the kinds of patients that we take care of, and the way our network was constructed.

As an example, we have the largest percentage of AIDS patients in the entire VA system. A problem that—and, as expensive as that has been with the funding of Hepatitis C we will have a much more substantial population at risk. So, while other networks may be talking about \$20 or \$21 million to deal with Hepatitis C, I am looking at probably \$71 or \$72 million over the course of 18 or 24 months. So, we are looking at—and that, basically, is just my case mix, it has nothing to do with whether my people are efficient or inefficient, it has to do with the population that present itself at our institutions.

Mr. SMITH. Doctor Garthwaite, knowing that our case mix, perhaps, is a bit different than other VISNs, will that be taken into consideration if there—especially if there are add backs by this committee and by the Appropriations Committee, because our concern is, and we went through this exercise last year as we were talking about putting back a substantial amount of money, it looked as though, and, perhaps, is so, that we get very little of that. And, we do have a very, you know, unique mix of veterans. Mr. Farsetta talked about the number of AIDS patients, and I think Hepatitis C will be another. We do also have one of the few spinal cord injury—

Mr. FARSETTA. Three

Mr. SMITH (continuing). Not one, three,

Dr. GARTHWAITE. He reminds us of that.

Mr. SMITH. And, Alzheimer's disease, I mean we have—there has been a real responsiveness to the real problems of our area.

Dr. GARTHWAITE. I would just say that we recognize that several VISNs have been challenged, perhaps, out of proportion to others. There are three that have been exceptionally challenged by the VERA model, those are 1, 3 and 12.

I do not think it's just AIDS, because we account for AIDS in a special category of funding that I think probably is fairly reasonable and provides the resources to account for that. I think there are a couple things that as I have looked at that are relatively unique between the networks that are the largest VERA disadvantaged, if you will. One is, and, perhaps, the primary one, is that we had in the past, in our rush to affiliate with medical schools, tried to match VA facilities with medical schools in the area. In those three cities, Chicago, Boston and New York, six medical schools are within a 1-hour driving distance of a central point. That leads to duplication of services. It leads to competition among the medical schools and the private sectors that carries over into the VA and so forth. We are working hard with our partners in academic medicine to try to restructure how we deliver care, and to look at redundancies of programs, and whether we are just keeping programs alive because we have always done it, or whether we have to look for ways for them to partner to have a meaningful and efficient neurosurgery program, cardiovascular surgery program

and a variety of others. I think those are some of the real challenges that are also in the budget.

We have some hospitals that, frankly, could be combined, and that we are going to have to look at, in those three areas as well. We have a lot of extra floor space. We have a proposal in the budget of ways to deal with some of that excess space as well, yet to retain those funds for the service of veterans.

So, I think there are complex reasons why Jim's network comes out with most of the numbers as relatively inefficient, certainly not something that anyone has set out to do, but there is a lot of history, a lot of what we have built, a lot of expectations. I think in the past we made a trade off between the longer lines in the south and having several affiliations in one city, but I think we are going to have to face down some of those challenges in the next several years as well.

Mr. SMITH. Okay, thank you. I see my time is up.

Mr. SIMPSON. We have sufficient time for another round of questions.

Mr. Doyle?

Mr. DOYLE. Thank you, Mr. Chairman.

And, I think Doctor Snyder alluded to this, too, you know, the exact wording from Doctor Kizer, he said he believes we are in a serious and precarious situation. If we don't institute these difficult changes in a timely manner, we face the very real prospect of more problematic decisions. For example, mandatory employee furloughs, severe curtailment or elimination of programs, and possible unnecessary facility closures. And then he asks that we establish this protocol very quickly, so that they can do this right sizing.

A couple of quick questions. Have any of you VISN Directors submitted any recommendations as we speak to the Secretary for these types of restructurings that Doctor Kizer alludes to? And, two other questions, too. I don't know if anyone has asked about—I'd like you all to comment on waiting times in your VISNs. We hear stories throughout different VA networks of 4 months to a year waiting time for patients to get care. If someone has to wait a year for an appointment, that is, to me, like just a denial of care, and is that occurring in your VISNs?

And then lastly, we hear suggestions that nurses are being routinely asked to work double shifts in the hospital. Is that occurring in your VISNs? How valid is that type of information we are getting?

Mr. FARSETTA. I will try to respond. I do have a request in to the Department for a RIF for two of my institutions that would total close to 400 employees, and we are awaiting the status of it. We know it is in, we know it is being approved, it has not been approved.

Waiting times, by and large, have gotten worse, but as it relates to the specialty care we are still, by and large, within 30 days. As it relates to primary care, we've seen a significant increase in the wait for primary care, but by the same token, every one of our hospitals has what we call an "urgi-care" center, so anybody who needs to see a physician quickly, that would not be regarded as a routine appointment, is able to access a provider, either a primary care provider or a specialty provider.

Mr. DOYLE. What would you say the average wait is? I mean, you say—

Mr. FARSETTA. The average wait for primary care is 17 days and for specialty care it is about 27 days.

And, as it relates to nurses working double shifts, I can only go by my overtime numbers. My overtime numbers in most of my institutions are relatively stable, but that doesn't mean that there are not times where it is felt that because—generally, it is because somebody calls in sick, or somebody decides to take emergency annual leave, that the coverage you need requires that there be an additional nurse there.

I do not have evidence that that necessarily is going on, but it is not unusual in hospitals for someone to call in and you need to provide coverage, and that coverage is usually done on an overtime basis.

Ms. MILLER. I would like to also make a comment. We have no pending RIF requests at present. I anticipate that in 2000 we will need to have some targeted small RIFs in various program areas.

We just had a Joint Commission review of our network, and one of the issues that that Joint Commission looked at was whether or not we were meeting the 30-day time line for appointments across the whole network. They found that in about 12 percent of the clinics we weren't within that 30-day time line. We are seeing some increase in waiting times.

Some of those are not related to budget issues. Some of those are related to the fact that we are having a difficult time getting certain types of physicians on staff, for instance dermatology, very hard to find and very hard to buy in the community. We continue to experience waits in some areas not related to budgetary issues.

However, I would also like to point out that when there is a need for a patient to be seen, if it is urgent or emergent, we have a system for over-booking, so that it is not a problem to get a patient in who needs to be seen without that wait.

We have no waiting times that I am aware of for inpatient, and right now our overtime is stable, and I am not aware of nurses routinely working double shifts.

Mr. DOYLE. Thank you.

Dr. GALEY. We have similar situations in our VISN. Let me speak specifically about RIFs and staffing adjustments. None are on the books right now. Next year, depending on which of the unfunded mandates we are going to have to deal with, and I am referring specifically to emergency care, if that is added on it significantly changes what we expect we will have to down size to.

Currently, with the plans that we have on the table, we are looking at someplace between a 300 and 500 FTE reduction within our VISN. If we add ER into the mix, we are probably going to be up closer to 800, so that is what we would be looking for in the year 2000 to reduce as far as RIFs and staffing adjustments go.

Waiting times, we are starting to see an increase, even though we have invested heavily into primary care clinicians and providers, and to specialty care providers we are seeing increasing waiting times. Primarily in the primary care area, we are seeing waiting times that were in the 30 to 50-day range going upwards to 150 days in some instances. That is to the next appointment, and that

is because of the very large numbers of veterans that we are seeing that are now asking for services that have their access point through our primary care clinics.

We have planned for a 3 percent growth per year to reach 20 percent, we are seeing 7 percent plus per year, and that is without any advertising or any trying to increase those numbers. So, that is the reason for those waiting times.

People who are urgently or emergently ill get in to be seen immediately.

And, your last question was about nursing staff. We are starting to see problems, especially in specialty care nurses, ICU-trained nurses, just because of the ability to recruit them and retain them within all of our medical centers in our metropolitan areas in the northwest. This is not just the VA problem. So some of those individuals are working double shifts.

Mr. DOYLE. All right, thank you, Mr. Chairman.

Mr. STEARNS (presiding). I thank my colleagues. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman, just three or four, I think, fairly quick questions.

Doctor Galey, you made a comment in your opening statement about you having more veterans coming into your system over the last couple of years than anticipated, but, you know, I visited with administrators a couple years ago about the 30/20/10 thing, when I was a first month member, you know, I was told at the time it was not going to work, it was going to be a real problem, that veterans were going to come but the resources were not there to take care of them. So, in a way, I mean, it kind of rings a little hollow with me as, I do not want to say an excuse, I understand it is a real challenge, but this was part of the plan, was to attract more veterans. Is it the problem that Doctor Garthwaite referred to, that the third party reimbursement and all that has not kept pace with the number of veterans coming in?

Dr. GALEY. Well, that is certainly part of it, but the idea of bringing in 20 percent is something that we will far exceed within the time frames we are talking about.

Mr. SNYDER. I see, so you met that part of your goal—

Dr. GALEY. We are going to reach that 20—

Mr. SNYDER (continuing). You made that part of your goal fairly quickly.

Dr. GALEY (continuing). This year or midway through next year, and that is with—I mean, we have not put up walls, but we are not encouraging them to come through the door. We have places where we are seeing ten and 15 percent increases in the veterans that are coming through the door. We have a very, very robust product in a very competitive environment for very highly penetrated managed care, and when they look at what they get from the managed care organizations, and they look at what they get from the VA, we are a better plan.

Mr. SNYDER. I understand.

I want to ask Mr. Trujillo and Mr. Farsetta just for a quick answer if you would, and we appreciate you being here. Within this process that resulted in the budget that occurs year after year, do you all feel, and did you, Mr. Trujillo, feel at the time you were working that you have ample opportunity to express your needs,

and your opinions, and feedback on budgets, and you can this thing ain't going to work, I mean, do you feel it is a fairly free system for you to express yourself?

Mr. TRUJILLO. I believe so, within the system we have that opportunity. As Doctor Garthwaite mentioned, as network directors, we met on a monthly basis and had communication on a weekly basis, and more often than that, and I felt very free to express our concerns.

Mr. SNYDER. Mr. Farsetta?

Mr. FARSETTA. I feel exactly the same way, and I think that what I expressed today Doctor Garthwaite has heard me say on many occasions in many sessions.

Mr. SNYDER. He did not look shocked.

And, Ms. Miller, I have an interest in this Hepatitis C issue, and you made a comment about it, could you give me the 30-second summary of what you see as the magnitude of the potential challenge out there for the veterans health care system over the next few years?

Ms. MILLER. I would be glad to, although, it is certainly from a layman's terms, and there are others who may be more appropriate from a clinical perspective to address it. But, we anticipate a prevalence in our network somewhere between 8 and 10 percent. We have a very urban network for the most part, with just one portion of the state that is an exception to that. We have talked about the screening process. We have set up internally a mechanism for how we will deal with screening and the referral of tests. Our concern is whether we have an adequate number of specialists for the patients we identify, and then what will be the consequences as we move forward, vis-à-vis advanced liver disease, transplants, et cetera.

So, there are many issues that are out there that we are just beginning to get experience with. We have put together a work group within our network to outline the policy and the approach involving the clinical experts, but I think we have a lot of unanswered questions that until we get into the screening process, and have a better feel for numbers of veterans, that we would not be able to answer.

Mr. SNYDER. Yes, and I think in some ways the VA system is ahead of the curve on this, compared to the rest of the world or the rest of the country. So, when you say you have got a lot of unanswered questions, I do not want our audience to think that somehow everybody else has the answers and you do not, because this is new terrain for us.

Doctor Garthwaite, my last question, first a comment, and I asked Doctor Kizer when he was here a couple weeks ago if he would provide in written form to the committee an analysis of the 30/20/10 and how you—you know, what your baseline was, where you see you are at right now, where you see you are in the future. You had a reference to it in your written statement, but I would like to see the numbers a little better, how you get at that point.

But, my final question is, you know, I hear criticism of this budget from different people, that this Administration does not care about veterans, and where I hear the phrase Administration, I mean, you are part of the Administration, but you care about veter-

ans, Mr. West is a part of the Administration, he cares about veterans, the President is part of the Administration, he cares about veterans, but somewhere along this process, you know, it gives the impression it does not care about veterans. I mean, that's the—when you see the budget numbers, you know, I think it is a reasonable thing for somebody to say, somehow this process did not work this time.

And so, my questions are two, everyone, where did the process break down, and, number two, how do we get out of it? Are you just—are you, as the Administration, just counting on Congress to add dollars and save your bacon? All in the spirit of candor today.

Dr. GARTHWAITE. Right.

Yes, clearly we care about veterans, and I think when we said there are some changes from the 5-year budget agreement that we had to put forward, we did that in the spirit of saying, we wanted to give the maximum amount of care to the maximum number of veterans and these issues needed to be addressed.

The whole budget process looks across all of government and tries to weigh numerous very difficult choices, and, you know, that is not a process that, at least in my level of Veterans Health Administration, we are in control of. We can say what we can do if you give us additional money, and we can try to convince you that with the money that we got we worked as hard as we could to put it to the best use to serve the most veterans.

But, it is simply not, I do not believe, my position to do other than to advocate to tell you very clearly what we can do, have done in the name of veterans. I think we can point very specifically to 300,000 to 400,000 additional veterans getting care in VA facilities with minimal and, in fact, decreased buying power in our budget. I think that is a wonderful story that demonstrates commitment of many, many people to change their lives and to change how they do business for a good reason.

The total number of dollars, I do think is really a political process. I think our best role is in making best use of those dollars and in advocating by saying what we could do if we have additional dollars, what additional needs of veterans we might be able to meet.

Mr. STEARNS. Thank you, Mr. Chairman, we are just going to finish up with Mr. Smith of New Jersey.

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

Mr. STEARNS. Then the panel will be finished and we will go to the second panel when we get back after the vote.

Mr. SMITH. Doctor Garthwaite and the other leaders of their various VISNs, you know, there is talk of unfunded mandates and what that could do in terms of wreaking havoc on your own budget, so at a time when we have got less and to demand more seems, on its face at least, ludicrous and not a wise use of money.

At the last hearing with the Secretary, I raised the issue, and I was joined by Chairman Stump and many others who are concerned about this, that the apparent proposal to include in vitro fertilization as an infertility which was expressly prescribed by Section 106A of Public Law 102-585, relating to health care services for women, is contrary to congressional intent, both the spirit and the letter of the law, and yet it would appear the Administration

may want to provide that anyway, notwithstanding a clear proscription in the law.

Could you tell us exactly where is the impetus for this coming from, especially given our absolutely scarce resources? What impact might this have on the VISNs? This is very controversial and an extremely expensive procedure, rife with controversial ethical issues about what you do with embryos that are routinely poured down the drain. I mean, even if you take the ethics issue out of it, it still becomes a very expensive and the efficacy of it is in question in terms of how often it succeeds.

In recent years, there have been serious questions about in vitro clinics, methodology employed, the cryogenic freezing of these individuals, who do they belong to, are they property? You know, there is a host—there's a myriad of ethical questions that seem endless, and yet this controversial step seems about to be taken, which will cause, I can assure you, a major, major fight in this committee, and on the Floor, and everywhere else, that seems unnecessary at a time when we want a consensus to grow the budget for veterans.

So, I just ask you, if you could, where did this come from? Why break the law?

Dr. GARTHWAITE. We have no intention of breaking the law. We have a group that is struggling with some of the very issues that you suggested, and trying to see whether we can put forward a reasonable policy that we can have reviewed by General Counsel with regards to all statutes, and that would be of service to veterans.

I would only say, in terms of why do this, two things that I think are really important. First, there are service-connected veterans who, as a result of their service, may be unable to conceive, and so the question is if the role of the Veterans Health Administration is to treat their service-connected disabilities or things that rise out of their service-connected disability, I think we owe them that.

And, the second is that if you are a health care provider now, eligibility reform asks us to provide health care that veterans need. Then you have to make the decision as to what is included in your benefit package and what is not, and I think that is the kind of debate that we are having.

This is one particularly challenging area in which to have that debate, and we are at a point where we do not have final policy to put forward to our lawyers to review in that regard. We heard your statements on the 11th and appreciate them.

Mr. SMITH. Oh, I do appreciate that, and I would just encourage you to consider that this is something that the committee has looked at, carefully considered, and the Congress clearly proscribed it in the statute.

The concern that I have on a larger basis has been, there has been, and Donna Shalala did this yesterday, or at least reiterated it, with the whole issue of stem cell research under the auspices of NIH, completely contrary to the spirit and the letter of the law on the use of embryos for research, and yet some tortured configuration of law has been applied by the General Counsel over at HHS. The same thing happened at AID on the subcommittee that I chair, where money that had been clearly proscribed for the use to organizations that co-managed forced abortion policies, all of a sudden was rewritten after it was a clear, almost a starry decis

type of situation where the Bush and Reagan Administration had a clear understanding of what the language meant, only to have that completely reinterpreted by the General Counsel over at AID. I'm sorry I see a pattern.

And, I hope this is not true here at the veterans, where we have always been all about consensus. When you trip over each other on the Democrat and the Republican side to do more for veterans, this is the ultimate consensus breaker, this and abortion, so I would hope that you would carefully reconsider.

Dr. GARTHWAITE. We will.

Mr. SMITH. Thank you.

Mr. STEARNS. I thank my colleague, and I thank the panel for their time and efforts, and we appreciate your coming, and we will now adjourn temporarily while we go vote, and then reconvene with panel number two.

[Recess.]

Mr. STEARNS. The Health Subcommittee will reconvene, and we will have panel two. We have Mr. Nick Bacon, Mr. Dennis Cullinan, Ms. Jacqueline Garrick and Mr. Richard Wannemacher, Jr., and we welcome all of you, and at this point if there is no objection we will move right to your opening statements, and we would like you to stay within the 5-minute period, so we will start off with Mr. Bacon.

STATEMENTS OF NICK D. BACON, DIRECTOR, ARKANSAS DEPARTMENT OF VETERANS AFFAIRS; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; JACQUELINE GARRICK, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; RICHARD A. WANNEMACHER, JR., ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

STATEMENT OF NICK D. BACON

Mr. BACON. Thank you, Mr. Chairman, distinguished members of the subcommittee. I appreciate the opportunity to address the Administration's VA Health Care 2000 Budget.

The veterans of this country continue to be slapped in the face and ignored by this Administration. At a time when we ask our military to give more and more, with less and less, at a time when our leaders scratch their heads and wonder why we cannot retain our soldiers and sailors, at a time when costly well-trained pilots exit our Air Force faster than we can train them, we ask what is wrong as we cut deeper into the VA Health Care Budget.

In my opinion, sir, our servicemen and women look at how they are treated, look at how our veteran heroes are treated, compare it to the hundreds of freely offered benefits that continue to get funded, and say, "Goodbye, Uncle Sam, who needs you?"

This Administration in short does not understand anything about the military or about our veterans, and I believe, sir, could care less.

This proposed budget is not only unrealistic, it is totally unjust. The budget contains \$18.1 billion for medical care. This requires third party medical collections of \$749 million—this is just smoke

and mirrors. In fact, the President's Budget calls for over \$1 billion in cuts.

The Administration says they are going to open 89 new outpatient clinics and treat 54,000 more patients in fiscal year 2000, an additional \$40 million to assist homeless veterans, \$250 million to combat Hepatitis C, and I understand by many health care professionals this could cost as much as \$600 million, and another \$106 million to fund long-term care programs. Also included in the budget are 440 full-time claims positions, new cemeteries, VA construction programs, \$50 million in nurse education initiative programs, and so much more. Where is the money? To quote an old commercial, "Where's the Beef?"

Mandates without funding, that is what we continue to see—open enrollment, veterans scream, great! No funding. New clinics, a wonderful idea. No funding. RIF's and hiring freezes continue. resources to support the federally mandated national emergencies and our Armed Forces during a time of war is, I guess, totally forgotten. Expanding uniform benefits to include maternity—not funded. This list goes on and on. The VA is going to do this, they are going to do that, and my in box is always full of news releases, day after day, it looks got, but "Where's the Beef?"

If you very carefully read the small print on page 3–52 of volume 5, Fiscal Year 2000 budget, you will see increases and decreases of some areas. But most of all you will please note the FTE reduction of 6,949, if you were to add back 699 for Hepatitis C programs, extended care and homeless, you have an employee reduction of 6,250. Of course, that is the real money that pays for this Budget 200, rob Peter and pay Paul.

By the way, who is going to pay for the cost of living increases to the employees? What about the added costs for prosthetics? I would just like to add there for a moment, you know, when we opened up this enrollment and offered prosthesis to non-service connected veterans, that cost when really way up, especially with hearing aids and such. The increase of drugs alone has risen about 10 percent a year, while we have been on a straight line budget for the last 4 years, correcting my presentation here, I have 3 years in here, actually this would be the fourth year. To fight the increase of drug cost and inflation, VA went to the National formulary System of buying drugs, limiting the types of medication available to VA doctors and no choice at all for our veterans. While the rest of the world enjoys the new medical science pharmacy breakthroughs, our veterans cannot even get normal desired drugs. Is something wrong with this picture? Hello out there! Mr. President, is anyone home? We have worked on Doctor Kizer's 30/20/10 plan. We have stretched the rubber band as far as it will go! We are treating 20 percent more veterans.

As medical costs continue to increase, how can VA Medical Centers do what no other medical system can do, and that is cut their costs 30 percent? And, for the 10 percent collections from third party reimbursement, that is as much of a joke today as it was 3 years ago when I sat here with the National Association of State Directors and we addressed that issue to Doctor Kizer when they were more than 75 percent below their objectives, and still we've had no answer.

The Department of Veterans Affairs has cut more than 20,000 jobs, cut more than half its hospital beds, and cut nursing home care, putting more and more burdens on the states, and still they want to cut thousands or more health professionals. If it were not for the wonderful health care Administrators that we have in the system, and the professional staff of the VA health care, we would have already been put out of business. They have overcome every objective, every obstacle put in front of them, and now they need our help badly.

In conclusion, Mr. Chairman, the American veterans around this country salute you and the Subcommittee on your ongoing concern for American veterans, particularly, for those older World War II veterans who need our help now more than ever. There is over 6 million World War II and Korean War veterans in this country who need care more today than they ever have. So, please, sir, let us not bury them while they are still living.

Again, thank you for allowing me the opportunity to address the Subcommittee on behalf of all veterans everywhere. God bless America.

Mr. STEARNS. Mr. Bacon, thank you very much. It is customary for a witness' Congressman to make a few comments, and you have a fine one in Mr. Snyder. It is my apologies to him for not asking him to speak first in introducing you. It is customary to do that. It is my fault.

Mr. BACON. Thank you, Mr. Chairman.

Mr. SNYDER. Well, thank you, Mr. Chairman. I appreciate the opportunity. I would just want to say, Mr. Bacon obviously knows these issues well and has studied them well. He has known it for a long time.

What you may not know is, Nick is a Medal of Honor winner, and because of that, and because of just the man he is, people that work in the veterans hospital and veterans trust Nick Bacon. And so, I can assure you that his comments reflect a great deal of the thoughts from people he hears from back home.

Appreciate you being here, Nick.

Mr. BACON. Thank you, sir.

Mr. STEARNS. Thank you, Mr. Snyder.

[The prepared statement of Mr. Bacon appears on p. 72.]

Mr. STEARNS. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman, and members of the subcommittee.

On behalf of the men and women of the Veterans of Foreign Wars, I express our deep appreciation for inviting our participation in this most important hearing today. Securing sufficient funding for VA Medical Care has now taken on such a note of urgency that if we fail in this regard, its continuing existence as a viable health care provider for veterans is seriously in doubt.

The Administration's proposed budget for the Department of Veterans Affairs is devastating to this nation's veterans. This proposed budget will seriously undermine VA's ability to provide quality, timely, accessible care for veterans.

The VFW hears daily complaints of increased waiting times for veterans to see a specialty provider, such as an orthopedic doctor or a dermatologist. This is happening throughout the country.

Worse in the specific, however, is the 1-year wait for hip replacement surgery in Ann Arbor, and the 1-year wait for dentures in Maine, and the 1-year wait for a dermatology appointment in New Orleans. These are only a few of the examples of the tragic nationwide epidemic, an epidemic of increasing waiting times and delays in getting appointments, which, in these examples, can only be interpreted as a denial of care, and will only get worse this year and next, because of the proposed budget.

This funding proposal is unrealistic and unfair, and will not meet the needs of America's veterans. It is unfair in that in the presence of the largest budget surplus in recent history, while other federal agencies have double digit increases, veterans are being asked to once again sacrifice with what is, essentially, a negative growth budget, a budget that, indeed, threatens the very existence of veterans health care.

Mr. Chairman, I would thank you for your remarks earlier today regarding the testimony of Secretary West at the full committee hearing on the 11th. The VFW was deeply disappointed and disturbed, in the face of overwhelming evidence to the contrary, the Secretary asserted that the funding level was sufficient for fiscal year 2000. Clearly, this funding level results in cuts, curtailments and even elimination of services. We can even foresee the possibility of veterans—needy veterans being pushed out of the system altogether.

It is also clear to us that veterans are not a priority with this Administration. With respect to our expectations of the Secretary of Veterans Affairs, we expect this: we expect compassion, not callousness; we call for candor, not circumlocutions; and we demand advocacy, not capitulation.

Mr. Chairman and members of the subcommittee, we pledge to work together with you to right this budgetary wrong for the sake of America's veterans in need.

Thank you.

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

Mr. STEARNS. Thank you. Ms. Garrick.

STATEMENT OF JACQUELINE GARRICK

Ms. GARRICK. Mr. Chairman and members of the Committee, good afternoon. The American Legion is thankful for the opportunity to be here today and submit its full testimony for the record on the Fiscal Year 2000 VHA Budget. The intention of this statement will be to focus on solutions to the existing and projected budgetary problems of VHA.

During site visits last year, the American Legion witnessed the negative impact the Balanced Budget Agreement is having on service delivery throughout many of the networks across the country. Network Directors spoke very earnestly about their ability to provide care into fiscal year 2000 under the current budget constraints, and I believe they did the same thing here today.

The American Legion has been briefed on the possibility of the shortfalls that would force VHA to choose between patient safety

and facility closures, which is exactly what looms gloomily on the horizon if VHA decreases by another 7,000 FTE.

In addition, VHA has identified new demands that will be placed on the system that were not previously considered when the Balanced Budget Agreement was crafted. These items are Hepatitis C, long-term care, emergency services, the additional 54,000 veterans being treated, 89 new outpatient clinics, new initiatives for homelessness, Medicare inflation and pay raises.

A children's story teaches us that it is time to say the emperor has no clothes. A no-growth budget will not allow VHA to meet these objectives, and if VHA continues on its current course it will be forced to continue reductions in direct patient care. The American Legion cannot help but wonder, is this in the best interest of our veterans?

Mr. Chairman, congressional support for VHA programs and services must be provided for the next fiscal year, and a long-term strategy must be developed to safeguard the veterans health care system.

In fiscal year 2000, the American Legion proposes an increase in direct appropriations of \$1.4 billion for VHA. This amount will raise VHA funding to \$19.5 billion to provide expanded clinical initiatives, cover medical inflation and employee cost of living, and ensure care for aging veterans. To do anything less is unconscionable.

As a long-term solution to the VHA budget, the American Legion has proposed the GI Bill of Health, which addresses the issues most significant to the American Legion regarding the current and future VA health care system. These concerns are for quality, access to special programs, such as mental health, and funding. The GI Bill of Health is a blueprint for preparing VHA to meet the health care needs of veterans and their eligible dependents in the 21st Century.

Under the proposal, all veterans and their dependents would have access to the VA health care system. All priority veterans would receive health care treatment at no cost to them, all other veterans and dependents would identify a payor for care. VA would retain and expand access, and strengthen specialized treatment programs. VA would offer defined benefits packages on a premium basis to all eligible veterans and their dependents. VA would bill, collect and retain all appropriate third party reimbursements, co-pays, deductibles and premiums. VA would create a health plan network consisting of public, private and providers. VA would open access to more health care facilities within local communities through sharing agreements and contracts with public health providers.

The American Legion predicts the GI Bill of Health will follow a similar course of incremental reform, as has been the experience of the private sector, since certain components of the GI Bill of Health have already been implemented. However, there are three key components of the GI Bill of Health that still need to be enacted. These components are for VHA to gain the authority to treat veterans' dependents, Medicare subvention and the creation of a premium-based plan. The enactment of the GI Bill of Health would direct VA to offer veterans and their families, on a premium basis, a choice of standardized benefits packages. Beyond this, VA or pri-

vate insurance companies could offer additional benefits, each with its own configuration of co-payments and deductibles. Premium supported packages would offer an additional range of benefits to eligible veterans and their families and provide VHA with a means to pay for medical care.

Mr. Chairman, in the spirit of lessons learned from incremental reform, and based on your recommendation during the 105th Congress, the American Legion proposes that the next component of the GI Bill of Health that should be considered is expanding access to VHA services to veterans' dependents as a test pilot under the CHAMPVA provisions of Title 38, USC 1713.

As a nation, we care for families while the service member is on active duty or retires under TriCare. The Veterans Benefits Administration provides benefits to family members, but the Veterans Health Administration turns a blind eye to disabled veterans whose families need health care. Ultimately, we discriminate against veterans who are married and may have children. How then can we ask the men and women to defend this country, but then give them no means to protect their own families?

In a study conducted by VA, researchers found that 83 percent of the spouses reported that they would choose to receive their medical care at VA, if allowed to do so. The research group concluded, spouses of male veterans represented a sizeable group that could be incorporated into the VA system. These are the partners VA depends on.

It is the vested interest of VA to ensure these care givers are healthy and well supported, if it intends to shift to an outpatient model. Wives also tend to be younger and healthier than their male counterparts, and are usually the decision-makers in the family. VA needs these people.

Currently in the private sector, managed care succeeds because they avoid adverse selection by maintaining a younger, healthier enrollee pool that offsets the costs of the more medically-needy patients. Managed care organizations profit as their risk pools grow. In VA, this profit could be reinvested back into the health care delivery system. VA needs this influx of healthy dollars to increase its buying power.

Doctor Kizer has supported the notion that it makes sense for VHA to treat veterans' dependents. He has stated in our magazine that there is no reason why the same physician could not treat the wife and husband as well. VHA has the capacity and structure to do this, and if it could retain the funds. Several network directors have already come forward to volunteer for this project.

Mr. Chairman, the final vital step for survival of VHA supported by the Legion is Medicare subvention. VA can provide quality care to medically-eligible veterans at a reduced rate, because of its infrastructure, economy of scale and purchasing power.

In conclusion, funding for VA medical care is dangerously low. The results of insufficient funding over the past several years have greatest impact during fiscal year 2000. The Administration proposes to reduce FTE by 7,000 positions, if this happens VHA facilities will be cutting into the bone, as there is no fat left to trim. Veterans will have no where to go.

Congress can no longer merely react to VHA's funding problems, it must act. The VHA health care system cannot be left teetering on the brink of collapse for the new millennium.

Mr. Chairman, the American Legion recommends three crucial steps be taken to protect veterans. First is for Congress to adopt the fiscal year 2000 budget request that the American Legion has submitted. Second, Congress should closely examine the GI Bill of Health and commit to test piloting its key components, beginning with dependents. Third, Congress must move forward with Medicare subvention and, in turn, VA must improve on its MCCF collections. Veterans deserve more than they are currently getting, and these steps need to be taken to protect the duly-earned health care rights of this nation's veterans. It is our turn to save Private Ryan.

Mr. Chairman, that completes the statement, and I will be happy to answer any questions.

[The prepared statement of Ms. Garrick appears on p. 82.]

Mr. STEARNS. Thank you. Mr. Wannemacher.

STATEMENT OF RICHARD A. WANNEMACHER, JR.

Mr. WANNEMACHER. Thank you, Mr. Chairman, and the Subcommittee members that are here, I am pleased to appear before you and present the views of more than 1 million members of the Disabled American Veterans and our Women's Auxiliary, on the Administration's Fiscal Year 2000 Health Care Budget.

The VA is faced with a dilemma of increasing demand and medical inflation, rising medical care costs, and perennially inadequate decremental budget.

The DAV was one of the national veterans service organizations that have called on the VA to release its plans to furlough employees, severely curtail or eliminate medical services, and a list identifying VA Medical Centers that could unnecessarily closed under the Administration's flat lined Fiscal Year 2000 Budget proposal.

You heard VISN 3 director Mr. Farsetta this morning indicate that furloughs would have to be considered as well as the closure of up to 3 facilities. You also heard first hand how the VISN Directors are going to have to react to this budget. As the *IB* pointed out, the current situation is bigger than just VHA alone, the Administration has let veterans down and it is now time for Congress to stand up for America's veterans and provide VHA with the financial support necessary to meet the needs of America's sick and disabled veterans.

The current budget proposal is more than \$3 million less than what is needed to adequately serve the health care needs of America's sick and disabled veterans. That is 15 percent less than what is needed to keep up with the demand for care and the equivalent of shutting down 26 VA hospitals.

Along with the flat line proposal, are estimates as to the amount of additional revenues that could be obtained from third party reimbursement for care for non-service connected conditions. You heard Doctor Garthwaite state that they are falling behind this year's recovery, look what we are faced with for the year 2000.

Thankfully, the full Committee, under the leadership of Chairman Stump, and the Subcommittee under your leadership, saw through the rhetoric last year and provided \$278.025 million above

the Administration's Fiscal Year 1999 proposal. This year the Administration's proposed budget for VHA totals \$18.1 billion; however, this is not the real number either. The actual appropriated dollar amount VHA will receive is \$17.306 billion the same level as that appropriated last year.

To generate savings and to be able to afford the care for its patient work load, the VA plans a staffing reduction of 7,830 employees. This reduction in staff results in reduction of critical staff to patient ratio. This is particularly troubling for the DAV because studies have shown a direct correlation between quality of care and patient staffing levels. It is the vigilance of the professional nursing staff that prevents complications. Quality is achieved when health care providers are given the freedom and resources to practice the most effective and scientifically proven medicine available.

DAV is currently conducting an independent survey of VA Medical Centers. We have asked our 189 hospital service coordinators (HSCs) stationed throughout the nation to give us a monthly assessment of what is going on out there. The survey indicates that the VA health care is suffering from long-term effects of economic asphyxiation.

The survey shows veterans are having to wait longer, to see a VA health care professional for services, some must wait months for a specialty clinic appointment—a fact well emphasized on February 11 when we heard from a member of this Committee how she was faced with having to react to a veteran constituent who had a lump and could not get into the VA health care system for 6 months.

The budget inadequacies will also cause the rationing of prosthetics and durable goods in order to keep pace with the inadequate funding levels. The current prosthetics policy, based on budget constraints, requires that VHA now use a preferred vendor, who must provide services at or below the Medicare rate. You heard from Laura Miller, Director of VISN 10, state that she was already facing a \$500 million prosthetics budget shortfall. And that she did not know how she was going to be able to face it.

Our question is, since when does Medicare set the standard for VA care? Since when do the clinical needs of veterans fall below those of other segments of our society, especially when providing quality health care to combat disabled veterans?

The DAV was recently contacted by a veteran from your district, Mr. Chairman, who went to the VA hospital to get a prosthetic device, which was prescribed to him. He was told, we have to go below the Medicare rate, if your provider will provide your prosthesis at a cost below the Medicare rate, then he can do the services. That is wrong! This veteran is 100 percent service-connected double amputee, and he is going to have to stand in line and get what he feels is an inferior product, and that's just blatantly wrong.

Mr. Chairman, the continued flat line, inadequate budget, is already negatively impacting the nation's sick and disabled veterans. Clinicians may or may not be making the appropriate efforts to develop community support programs for veterans who are suffering mental illness, but we are seeing that it is the fiscal departments that are making the staffing and program decisions, it is not the

clinicians. Clinicians are being told, this veteran has to go because we cannot afford to keep him or her within our system.

The Administration's Fiscal Year 2000 Budget discriminates even within the veterans population when we are talking about emergency services. The President's Patient Bill of Rights said that every American was going to have access to emergency care. He forgot to say that veterans were not included as persons who were going to be provided emergency health care.

The budget reflects that one of the most critical needs VA is facing is Hepatitis C. As was mentioned earlier, there is no money for Hepatitis C, the treatment policy must come out of existing resources. The VA estimates that it is going to cost \$135.7 million in fiscal year 2000. It is hard to understand, in light of today's robust economy, and large surpluses, that the Administration could have this callous disregard for those who have served.

Before closing, I just want to say that yesterday the committee heard from former Senator Dole and the Transition Commission. We support many of the goals that the Transition Commission has. But, one of the recommendations that was brought to light was that they want to allow the Department of Defense to pass to the private sector the cost of health care for service-connected disabilities. That is exactly the same reason that the DAV did not support Medicare subvention last year. Recently, we were advised that the Veterans Administration has a new accounting system that is going to be able to identify and cost account health care expenditures. With this new found ability, DAV is willing to agree to a pilot program for Medicare subvention. We wish also to point out that a pilot program for Medicare subvention is not going to alleviate the immediate needs VHA is facing today.

We will be glad to sit down and work with the Committee, and with VHA, while continuing to voice our opposition to allow third party payers to pay for service-connected disabilities.

Thank you very much for the opportunity.

[The prepared statement of Mr. Wannemacher appears on p. 93.]

Mr. STEARNS. Thank you, and I think we will say amen to what all you folks have said.

My colleague from Pennsylvania had mentioned the budget caps, and I think he has made a very good point, but we are not here to say that it cannot be done, because we on this Committee think it can be done. When I am down in my district, no one ever complains of the Federal Employee Benefits Program. It is a program that the employees enjoy. They never complain about it, but I hear complaints from veterans.

Now, the government employees did not have a contract with the government, and were not told by the recruiter that, we will take care of your health care if you stay in the service 20 years and you get disabled. Why is it that the Federal Employee Health Program is without any blemish, or at least does not have a problem, yet we are continually talking about veterans.

So, I have told the staff here that we want something bold, we want to do something different. So, when the Administration comes back and presents its budget, all of us get frustrated.

Now, they say there is not enough money because of the budget caps, but I submit that some of the money that the President is

proposing in new spending, how can he justify new spending when we are not even reaching the commitment for the veterans? And, we know that there are some Americans who are getting health care from the United States government where it is working, so I submit that we have got to convince the White House to resubmit another budget, and I will tell you something else. The Department of Energy has a budget, as I recollect, almost comparable to what we have for veterans. Now, the price of oil was \$72.00 a barrel when we had an oil crisis, so we developed the Department of Energy.

The budget has continually gone up, and up, and up, and yet now the price of oil is \$14.00. I spoke to the Edison Electrical Institute this morning. They picked me up in an electric car. It was made by General Motors. Toyota picked up the rest of my staff in a Toyota electric car, and I just submit that the money we are spending on other programs, like the Department of Energy, could be reallocated to veterans. I think we are spending about \$38 billion in the Department of Energy. It is a huge building, tons of employees, lots of policy statements, all the time generated. They come to the Commerce Committee I serve with their testimony.

But, I submit the President could go back and have made a little redistribution from some of these programs that, in my opinion, are not important, almost obsolete, and put them here and make the commitment.

So, you know, I think whatever side of the aisle we are on, we are asking the President to, if you are talking about new spending programs, hold it, hold it. I think the comment, "Hello, Mr. President, is anyone home," we have got to have the commitment for veterans.

So, I am committed in the 106th Congress with my colleagues on both sides of the aisle to do something bold here, something to make not just the suggestions that the American Legion are making, but try and come up with a system here so that all of us when we go out we don't hear complaints. We want it like the Federal Employee Health Benefit, the people are satisfied. They are getting timely service, and it is efficient and there's not waste, fraud and abuse.

I am going to ask each of you a real tough question, and then I will go on to my colleague. Assuming Congress cannot meet its full goals that they have identified, would you give higher priority to preserving current programs than to the new commitments, for example, like covering emergency care? It is tough, tough, because let us say the President does not come back and we are sitting here fighting this out. Where do you come down with higher priority, to preserving current programs or new commitments like emergency care?

Mr. BACON. Well, personally, I do not think we can increase or utilize new mandates if we cannot take care of the programs that are in place. We have tried every initiative that I can see in local hospitals, at least in our VA center, to generate additional funds. We have this partnership with other facilities. We built a female veterans clinic, and to my way of thinking at that time we had no real need for that clinic, it would have been much cheaper, I believe, on the hospital to have just farmed that out. But, instead

now, we bring other female patients into the hospital to generate dollars, especially for the unutilized equipment that, obviously, is female oriented. And, why do we create new programs when we cannot fund old ones, is my question.

Mr. CULLINAN. Mr. Chairman, speaking on behalf of the VFW, I would have to say that providing treatment for Hepatitis C, and providing emergency room care really are not new programs. They are extensions of VA's current statutory obligation to provide a continuum of care.

Having said that, the onus really is upon all of us to secure those additional dollars. I could not agree with you more when you said earlier, there seems to be money for other programs but not for veterans. We well understand the discretionary cap. There is a movement afloat to get that lifted, brought up a little bit, but even if that does not happen there seem to be dollars for these other programs, and they should be channeled into veterans.

Ms. GARRICK. I think the statement of the VFW reflects sort of what the Legion has been thinking, in terms of, these are new initiatives, they are not new programs. They are designed to bolster already existing programs, so it is not like the VA has gone off in a totally new direction. The programs that are already there need improving and I think there needs to be a constant and ongoing evaluation of the programs that are ongoing, and then some of these new initiatives and how they fit in, where they fit in, and if they replace some of the other programs.

But, I agree that things like Hepatitis C, and emergency services, and homeless veterans, these are things the VA has always had within its system. I think it is looking at ways to better deal with those things, and I think the budget surplus should be looked at as a way of encouraging that, and we do need to look at the VA budget, not as pinning old programs against new programs, but rather, reinforcing what the VA is trying to do to build a health care system.

Mr. WANNEMACHER. I would agree with the previous two speakers, that Hep C is not a new program, it is just a newly discovered blood borne infection. Blood Screening for Hepatitis C was not done until the 1980s, and now they found it is prevalent in the Vietnam veteran community. Compensation has always been available for direct service connection and health care goes along with it when the causal relationship is established.

When you asked us to choose between emergency services and something else, you know, when the President says everybody else gets it but veterans do not, that is where you have the complaints, where, you know, what am I, a second class citizen?

But, I just want to say thing, Mr. Stearns, and Congressman Doyle mentioned it earlier today, when we lift the caps, there was no problem in this Congress last year when you lifted the caps on transportation, and there should be a commitment to lift the caps on veterans programs also, to enable the Veterans Administration to do more and to do it more efficiently.

Mr. STEARNS. Yes, sir.

Mr. BACON. Mr. Chairman, could I make one more statement?

Mr. STEARNS. Yes.

Mr. BACON. Sometimes VA creates their own problems, and it is not done directly by planning it, it happens because of cutbacks and things of that nature. For an example, we used to have in-house drug and alcohol programs, well, one of the first—when we started closing beds in the hospitals the first wards to go was inpatient programs for alcohol and drug abuse, and things of that nature.

At another time, we turned right around and dumped the domiciliaries and the nursing homes back on the states, I should say, Medicaid. And, what happens there, we have created a lot of these homeless folks that we are looking at now with priorities by simply downsizing our own system. We have to be very careful, when I say I vote for protecting the old programs first, as the gentleman on the end submitted, you know, if they are service connected for those disabilities, and assuming they would be, especially for Hepatitis C, there is no reason VA should not fund that anyway, as a special program to set up a research center on the East Coast and one on the West Coast, I do not see why we are separating monies here and saying we are going to fund this new program at X number of dollars, and we are looking at taking that out of the existing resources, thus reducing health care professionals again, creating even a larger burden.

So, that is where I was trying to make my differences, not that I do not support new programs, if you want to call them that, but responsibilities to the veteran.

Mr. STEARNS. All right.

Now, Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

Thanks for being here today, and please know that we share your frustration and concern over this budget.

Really, just a couple of comments, Mr. Chairman. I have, you know, watched lots of presidential budgets be dead on arrival over in this place, and I just think that we need to keep the pressure. This committee, I think you are going to see, take action to increase this budget and to put something out of this committee that will have a much higher authorization than what we are seeing in this budget.

The battleground is going to be with the appropriators, and we ought not to let them weasel out of their responsibilities by saying, well, the Administration did not ask for this money, so why should we give it to you, because that is what is happening here each year.

And then, the other thing that happens is, people try to trade programs against another program. We get bills on the floor saying, you know, let us cut a billion dollars out of this program and put it over to veterans, and then we start breaking people up depending on where they are from, and we get the shaft every year.

I think the Veterans Administration has done their fair share in the efforts to balance this budget. I think that is totally clear, and I think we need to keep the pressure on everybody, Democrats and Republicans, appropriators and all members of Congress, this year, this time, when we ask for that higher authorization to put that money in there, and we are going to need your help. I mean, the VSOs are really, without you it does not happen. I mean, it is going

to be the pressure that is done at the grassroots level, with members of Congress, not so much in this committee, I think you are preaching to the choir here, but outside of this committee we are going to need some support, first from these appropriators, and then on the Floor, to get this budget done.

There is just no way in the world that this system can continue being flat lined, and everybody knows that. To watch members of the Administration and the VA here try to put a good face on this, and they are in a difficult position, you know, they are this catch-22, that, you know, you cannot hide them lying eyes, there is not anybody here that can convince us that this thing works.

So, we are going to make the effort out of this committee, we are going to need your help at the grassroots level to put the pressure on these members of Congress.

Thank you for being here.

Mr. STEARNS. Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

I wanted to ask our three VSO representatives, I am trying to understand how this process works in the budgetary, you go through your own cycles I know, and each year things come along, do you have the opportunity, or is there an opportunity to have direct input to OMB?

Mr. CULLINAN. In a sense, we endeavor in a way vicariously. We work, of course, with VA, because they are the ones who have the direct interaction on the passback function, and, of course, we try to influence to the best of our ability. We have met with the OMB Director. We have met with the Assistant OMB Director, and we agitate VA.

Mr. SNYDER. Each year you personally meet with OMB personnel?

Mr. CULLINAN. Yes, together with the *Independent Budget*, we as a group have gone there.

Mr. SNYDER. Did you do that this year?

Mr. CULLINAN. Yes, we did, our Executive Directors did it.

Mr. SNYDER. And, I do not mean to inquire if these are meetings that you would sooner not talk about, were your meetings with them prior to the number coming out?

Mr. CULLINAN. Yes, they were.

Mr. SNYDER. So, you did not have any way of—I mean, you did not expect to see that number come out that low, given what Secretary West requested then?

Mr. CULLINAN. Our meetings were cordial, but I would have to say that they were not overly productive. You know, we were informed that the top priority is saving Social Security and, of course, no one could argue with the necessity of doing that, but on the other hand there did not seem to be any flexibility with funneling money into VA and the veterans programs.

Mr. SNYDER. At the time of your meetings, had the VA submitted their budget request, were you working with that number, the \$1.37 million more?

Mr. CULLINAN. I am sure that they had. I am sure that they had done it at that point. And, we know, we know from the hearing of the 11th, that there was movement back and forth, that there was

an initial proposal which was about \$1.4 billion more than we wound up getting.

Mr. SNYDER. Yes.

Mr. CULLINAN. So, all of that was taking place.

During that period, of course, we were holding our meetings and doing what we could by working with VA.

Mr. WANNEMACHER. What OMB said was that the VA gave a credible argument on Hepatitis C, but there is no additional money. OMB, also set the *Independent Budget* VSOs up by saying, this is what your numbers are. With these numbers, what programs do you think we can cut. Doctor Kizer has just announced enrolling all seven priorities, do you really think that VA can care for all seven priorities with these numbers? And, there were some discussions, and then OMB came back and said the VSOs were opposed to Doctor Kizer for enrolling all seven. That is just not true nor what was said.

Mr. CULLINAN. No, and that is not a single event either, that is a trend. We have met, you know, it is an annual event now that we march over there and conduct these meetings, but we have not gotten anywhere.

Mr. SNYDER. Meetings can kind of become habits more than productive experiences. There is a breakdown in this process somewhere, and I am new here.

Mr. Bacon, appreciate your being here.

Mr. BACON. Thank you, sir.

Mr. SNYDER. Thank you for coming.

Thank you, Mr. Chairman.

Mr. STEARNS. Well, I want to thank the panel very much for coming, and we know how busy you are, like we are, and we appreciate your time, and my staff has been writing down your comments. It is a battle, but there is no reason we have to compromise, because we have made a commitment, and it is like Social Security. We made a commitment, we have to obligate it, and the veterans are the same way, and this system has got to work in a way that has enough funding, it is efficient enough, and the people say I am very, very satisfied on a universal basis, and that's what we are working towards.

So, thank you very much.

Mr. STEARNS. I will call up now panel number three. We have Mr. Harley Thomas, Ms. Veronica A'zera and Mr. George Duggins. Appreciate your patience in waiting. We started this at 10 a.m., and you folks have stood by and helped us. We saved the best for last, so with this why not start out with Mr. Harley Thomas, if you will start with your opening statement and we will work across.

STATEMENTS OF HARLEY L. THOMAS, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; VERONICA A'ZERA, LEGISLATIVE DIRECTOR, AMVETS; GEORGE C. DUGGINS, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

STATEMENT OF HARLEY L. THOMAS

Mr. THOMAS. Thank you, Mr. Chairman.

I have here a copy of an open letter of appeal to all members of the House and the Senate, drafted by the *Independent Budget* authors, and I would like to submit this for the record, if I could.

Mr. STEARNS. Without objection, so ordered.

[The statement of the *Independent Budget* appears on p. 103.]

Mr. THOMAS. Mr. Chairman, members of the subcommittee, on behalf of the Paralyzed Veterans of America I am honored to be present and submit our views on the Administration's Fiscal Year 2000 Medical Budget for DVA.

Mr. Chairman, the Administration's Fiscal Year 2000 Budget "ignores the increasing cost of caring for veterans, especially the aging veterans of World War II who depend on the VA health care." By once again proposing a straight-lined appropriation, the President is ignoring the true cost of health care for veterans, especially the more-costly care needed by our older veterans, our poorer veterans, and our veterans in need of specialized services, such as spinal cord dysfunction.

This budget ignores the very real cost of medical care inflation, and the increased costs associated with caring for an aging veteran population.

Last year, the Under Secretary for Health was quoted in the Washington Post as saying, that without additional funding, the VA health care system would "hit the wall." In his February 8, 1999, memo to Secretary West, Doctor Kizer announced his intention to begin massive cut backs in staffing and resources now to prepare for even larger cuts imposed by the disastrous 2000 budget.

Realistically, veterans don't stop needing health care just because OMB has decided they should not have a hospital to go to. Based on *Independent Budget* projections, the first step in this process would be to close the equivalent of 26 VA hospitals, including a reduction of nearly 8,000 health care staff, and erosion in the missions of scores of other facilities. Based on current law, VA can only provide health care to the number of veterans it has funding to care for. Under this scenario, thousands of veterans seeking earned health care benefits will be turned away.

Obviously, VA already has its plan, as Doctor Kizer wrote in his February 8th memo—the plan to "right size" the VA system. Rather than keeping this plan a secret, we believe the veterans of this nation and the Congress have a right to see it. How many hospital beds are going to be shut down? How many doctors, nurses and health care providers are going to be fired? Above all, which hospitals are going to close? Where are these closures going to take place—in what areas of the country? In whose state? And, even better, in whose congressional district?

Last year, Doctor Kizer said he wanted to have VA be able to admit all veterans to the VA health care system. Clearly, under the proposed budget this is not going to happen. We want to see the "triage plan" showing just who is going to get into a VA hospital and who is going to be turned away at the door.

Mr. Chairman, as you are no doubt aware, PVA has continually expressed concerns regarding the VA's provision of specialized services, specifically care and treatment for veterans with spinal cord dysfunction. Beginning last summer, we raised the issue of declin-

ing capacity and what we perceived as the VA's lack, of emphasis for specialized services. The full House Committee on Veterans' Affairs responded to our concerns by requiring VA to continue reporting on the maintenance of capacity for an additional 2 years, and included statutory language establishing performance standards for VA managers regarding the provision of specialized services. For these efforts, we thank you and the Congress for your responsiveness. Doctor Kizer also reacted to this issue we raised, and on October 23, 1998, transmitted his proposal for the VA spinal cord injury/disorders program to Secretary West, who also concurred in them.

Of major importance, among other important improvements to SCI programs, the Under Secretary has agreed to centralize decisions regarding staffing and bids. This is a favorable step forward.

Mr. Chairman, members of the subcommittee, today PVA must question whether these efforts and commitments are in vain, due to the shortfalls in the VA health care that we envision in the President's budget. No matter what agreements are made, no matter what laws are passed, or the sincerity of promises, all will be negated by the anticipated absence of necessary resources if the President's budget proposal is not substantially altered.

We recognize that this subcommittee does not appropriate dollars, but we do know that you can authorize them. The authorization process must recognize the real resources requirements of the VA. We look to you and your expertise in veterans issues to help us carry this message forward to your colleagues in the Budget Appropriations Committee and to the public. This year, more than ever, we need your help.

Mr. Chairman, I thank you for this opportunity to present our views, and I will be available for any questions.

Mr. STEARNS. Thank you, Mr. Thomas.

[The prepared statement of Mr. Thomas appears on p. 106.]

Mr. STEARNS. Veronica A'zera.

STATEMENT OF VERONICA A'ZERA

Ms. A'ZERA. Yes.

Mr. Chairman, I am Veronica A'zera. I am the national legislative director for AMVETS, and we appreciate the opportunity to join with our distinguished colleagues from the veterans' community to provide testimony to the House Veterans Affairs Subcommittee on Health regarding the Department of Veterans Affairs medical care budget request for fiscal year 2000.

I am not going to spend a lot of time repeating what you already know, and as Mr. Doyle said, we are preaching to the choir. But, to quote the VISN 18 Director, "This budget stinks." We agree with that. The Clinton/Gore Administration proposed budget for Department of Veterans Affairs for Fiscal Year 2000 is \$3 billion less than is needed to adequately address the health care needs of our nation's veterans.

The budget shortfall is so significant that it imperils the health and benefits of millions of veterans. Given the Administration's proposal, this situation will continue to worsen.

You know it, we know it, and now with the infamous Kizer memo we know VA knows it. The VA budget plan proposes new health

care initiatives but provides no new dollars. VA is expanding health care and other benefits to veterans suffering from Hepatitis C-related illnesses, veterans in need of emergency care, and long-term care, yet the budget proposal cuts 8,000 VA health care staff and hundreds of millions of existing budget dollars to pay for these initiatives.

If I can, I can probably clear up a little bit more about what Mr. Snyder was asking for as far as our budget process. We did meet with OMB, I was present at all those meetings, and I can tell you that this year we presented a Critical Issues document for the first time as a part of the *IB*, to address OMB directly, and to let them know what we felt were the important critical needs of the VA to address. And, as my colleagues mentioned before, it was a deaf ear.

So, no, I was not surprised when I saw the budget, but I was surprised by their candor to us that it was not a priority.

There is a list of the critical issues that we informed OMB on and the Clinton/Gore Administration, and I also want to tell you that we have requested a meeting with Vice President Gore and the White House several times and we were not able to do that at all. They did not grant us with a meeting. But, all the issues that we addressed are part of my written testimony and also in our *Independent Budget* document.

In closing, I want to thank the committee and the Veterans' Affairs Committee, the Full Committee, for helping us out in previous years. I think it was really ironic that the same week the movie, "Saving Private Ryan," was re-released the Clinton/Gore Administration's detrimental budget was also released.

We join with you in the battle to save Private Ryan's health care, it's a battle we have been fighting since the Balanced Budget Act of 1997 froze discretionary spending for the 5-year period.

And, as someone else also mentioned earlier, that that has already been busted, so we do not see a reason why it cannot be changed for the VA also.

The Private Ryan veteran population is rapidly aging and in need of ongoing treatment for complex chronic conditions. According to the VISN Directors we heard from this morning, this budget crisis comes at a time when the need for VHA services has never been greater.

Thank you again for this opportunity, and we look forward to working with you, and we do have plans, Mr. Doyle, of talking to the appropriators. Last year, we held town hall meetings, which a lot of the members here were a part of, and we will be holding those again around the country to bring these issues up and meet personally with the appropriators to explain to them and to educate them on the critical issues.

We thank you for this opportunity.

[The prepared statement of Ms. A'zera appears on p. 119.]

Mr. STEARNS. Thank you. Mr. Duggins.

STATEMENT OF GEORGE C. DUGGINS

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

I am George Duggins, National President of Vietnam Veterans of America, and my oral comments will echo my colleagues. I know our Government Relations Director is sitting back there pulling his

hair out right now. But, as a twin-tour Vietnam vet, I just wanted to talk to you, and it is the system.

I was sitting here this morning listening to the first panel. The VA was saying that they were having a problem doing third party billing. The third party billing is not a rocket science. I mean, my company does it every day, and the people who do it are on the low end of the pay scale. So, while it's not a rocket science, it (the problem) is the system.

If the VA system had to compete with a private system, this system would fail every time. It is the system. We have to get into the system, look at it. No matter how many dollars we know that the \$17 billion is not enough. We know that there needs to be more, but how are those dollars going to be used? Are we going to get the best bang for the buck? I do not think so, and we will be sitting back here next year saying the same thing over and over. It is the system, we just have to look at this system.

You can recognize a wound from a guy who has had his arm blown off or he is missing a leg, and the VA addressed that real well, but how do you put a Band-Aid on a mental illness? Today, I heard very little. I heard a lot of budget figures thrown out, but no one has talked about the "wellness" of veterans, and the bottom line of this thing is that veterans get well.

You know, if we have to give this veteran a voucher and let him go somewhere to get well, the bottom line is that the veteran gets well, and I have not heard that addressed today. I have heard numbers, we are putting a price tag on veterans health, and you cannot do that, it is not right to say that, okay, we are going to spend \$300.00 and that is your limit. If you do not get well with that—it (the problem) is the system.

Something has to be done to really, truly look at how the system operates. When a veteran has a mental problem, and he goes to the VA hospital and the system tells him, "okay, you have to come back in 6 months for an appointment," it is the system. That is wasting the veteran's time, it is going to aggravate him, he is going to do something probably to himself or to his family. We have to look at the "system." The system is failing the veterans, and we are pleading with Congress to restore some type of sanity to the VA system.

Dollars may not necessarily be the answer that we are looking for here. I tell you, sir, it is the system, and thank you very much for listening to me.

[The prepared statement of Mr. Duggins appears on p. 124.]

Mr. STEARNS. Mr. Duggins, thank you very much. I think we would all agree that the culture within the veterans delivery system has to be changed, too, and dollars is one thing, but the efficiency, the general procedure has to be sort of revolutionized so that we look at veterans as a complete system that we take care of.

Mr. DUGGINS. I agree with you, sir, and you said it yourself, that the other government health care agencies are working fine.

Mr. STEARNS. Working fine.

Mr. DUGGINS. Again, it is the VA system.

Mr. STEARNS. And, none of those folks had the commitment like the veterans did.

Mr. DUGGINS. I work in the private health care industry, and, you know, with \$17 billion we can treat an awful lot of veterans.

Mr. STEARNS. Oh, sure.

Mr. DUGGINS. And, we can do it well, and that is what I am not seeing at VA, is the bottom line that the veterans getting well, is to get someone in the system, get him out of the system, and he becomes a functional person again. That should be the bottom line.

Mr. STEARNS. Well, we are going to try with legislation this year, and I hope my colleagues will support me, to boldly step forward here and try to do something different here, so that some day a member of Congress can go back to his district and get no complaints, like the Federal Employee Health Benefits Program, and that we are not faced with a budget shortfall, and that both the Executive Branch and the Legislative Branch are committed to funding this.

Mr. DUGGINS. But, do you agree with me when the first panel sat here and said that, you know, we are having problems doing third party billing, I have a real problem with that. People do it every day, and it is not rocket science.

Mr. STEARNS. The third party billing.

Mr. DUGGINS. Right.

You know, it is like, what is the problem with doing third party billing? I just do not understand why. How much is it going to cost for them to do something of that nature? That money could be used to treat veterans with.

Mr. STEARNS. Well, I agree, and that is an area we are going to look at, and I think it is an area we can address. I think Ms. Veronica A'zera indicating in the movie "Private Ryan," when it came out and sort of the irony of it, saving Private Ryan, and here we are in Congress, we have to save veterans, so I am in complete agreement.

Are there any questions from my colleagues?

If not, we want to thank you very much for your patience in waiting this whole time, and we want to thank you again for your comments, and together we will work. And, I think if you could work through the appropriations process that would help, too.

Thank you.

And, the Subcommittee of Health is adjourned.

[Whereupon, at 1:02 p.m., the subcommittee was adjourned.]

A P P E N D I X

State of Lane Evans
Ranking Member, House Committee on Veterans Affairs

Subcommittee on Health
Hearing on VA Medical Care Budget for FY 2000
February 24, 1999

Thank you, Mr. Chairman. Good Morning. I am pleased to be here today to discuss the VA Medical Care budget for FY 2000. Today, we will hear from the system's officials, its advocates, and state veterans' officials, many of whom will reiterate concerns that were raised in testimony before the Full Committee a couple of weeks ago.

At that time, Members of the Committee were almost unanimous in deeming the budget inadequate. We heard that the Independent Budget called for \$3 billion more than the Administration's request; American Legion recommends an additional \$2 billion; and VA itself originally requested \$1.2 billion that was not ultimately included in the budget submission. I fear that this inadequacy will translate into some very real consequences for the VA and the veterans who rely upon it for health care. I am eager to hear from the officials that must live with these consequences and encourage their candor in helping us understand what will happen if the requested VA health care budget is enacted.

For the fourth consecutive year, there is no growth planned for VA Medical Care funding. While the President's budget supports a number of important initiatives, it offers no new dollars to support them, and in fact, notes that VA must find \$1.1 billion in "management efficiencies" in order to fund them. Even to maintain services it must absorb \$870 million for the pay raises mandated for all "general schedule" federal agency employees, for inflation, and for uncontrollable rate and workload increases.

Some have suggested that the fat in the VA health care system has already been trimmed. Since its initial budget "freeze" in fiscal year 1997, VA has made a number of extremely painful changes in its health care system. Some of these changes were necessary for VA to adopt the practices of a modern and proficient health care provider in today's market. Between the beginning of the freeze and the end of fiscal year 2000, VA will eliminate almost 10% of its workforce. Since fiscal year 1996, the agency has closed almost 40% of its authorized operating beds. It has integrated or consolidated about 40 of its health care facilities. It has even eliminated acute inpatient care--an untenable idea as recently as 5 years ago--

at several VA medical centers, but the President's Budget now counts 166 medical centers where VA is still identifying 172. Even during this time of downsizing infrastructure, efficient management has allowed VA to open hundreds of community outpatient clinics and treat thousands of additional veterans.

But not all is well. In budget testimony for fiscal year 1998, the Under Secretary for the Veterans Health Administration, Dr. Kenneth Kizer said that VA would "hit the wall" if it did not receive the expected influx from non-appropriated sources. It hasn't. Congress has failed to consider a reasonable Medicare Subvention proposal and VA is having more difficulty collecting third party payments than it expected. These programs were to allow the only growth the enormous system would realize. Imagine Kaiser Permanente, Columbia/HCA or even Medicare expecting no growth in revenues for four years and the magnitude of this problem becomes clear.

Unfortunately, as with private sector health care systems, the first patients that feel the pinch tend to be those who are most vulnerable because their complex health problems are expensive to treat. It is becoming increasingly apparent that VA is making the same choices that those in the private sector have--eliminating inpatient long-term care for the frail elderly, severely restricting inpatient psychiatric care, and creating queues and more subtle systems of rationing for specialized care and prosthetics. VA has reported a 20% drop in those it treats for chronic mental illness and substance abuse. At a Subcommittee on Health hearing last summer, veterans with spinal cord injury, who have been blinded, who use prosthetics or for those with post-traumatic stress disorder--were eroding. This is just the tip of what many system advocates believe in an endemic problem.

VA is not Kaiser Permanente. It is health care system created for veterans and their special health care needs. It is a special, and largely unrecognized, part of the nation's public health infrastructure. It should not be allowed to wither on the vine because veterans are no longer the "flavor of the month".

I intend to work closely with members of Congress and the veterans' community to make substantial increases in the appropriations for veterans' health care. I want it clearly understood that VA's health care system is at risk and that this funding is sorely needed. I look forward to the testimony today. Thank you.

THE HONORABLE MICHAEL BILIRAKIS

**SUBCOMMITTEE ON HEALTH
FEBRUARY 24, 1999**

**HEARING ON VA MEDICAL CARE
BUDGET FOR FISCAL YEAR 2000**

THANK YOU, MR. CHAIRMAN.

**I WANT TO COMMEND YOU FOR SCHEDULING THIS TIMELY
HEARING ON THE VA'S FISCAL YEAR 2000 MEDICAL CARE BUDGET
REQUEST. I WOULD ALSO LIKE TO WELCOME OUR WITNESSES TO
THE SUBCOMMITTEE THIS MORNING.**

**LIKE MANY OF MY COLLEAGUES, I HAVE SOME STRONG CONCERNS
ABOUT THE ADMINISTRATION'S REQUEST FOR VA MEDICAL CARE
FUNDING. AS THE REPRESENTATIVE OF A DISTRICT WITH A LARGE
VETERANS POPULATION, I STRONGLY BELIEVE THAT WE MUST DO
EVERYTHING WE CAN TO REPAY THE GREAT DEBT THAT WE OWE
THE MEN AND WOMEN WHO ANSWERED THE CALL TO DUTY.**

**UNFORTUNATELY, THE ADMINISTRATION'S BUDGET REQUEST
MAKES IT VIRTUALLY IMPOSSIBLE FOR THE VA TO LIVE UP TO THIS
COMMITMENT. FOR EXAMPLE, THE BUDGET CONTAINS NO
MONEY FOR THE INCREASED COSTS OF EXISTING PROGRAMS --
COSTS WHICH ARE CLOSE TO \$1 BILLION.**

HOW DOES THE VA EXPECT TO OPEN 89 NEW OUTPATIENT CLINICS AND TREAT 54,000 MORE VETERANS IF ITS BUDGET REQUEST DOES NOT EVEN INCLUDE FUNDS TO COVER INFLATION OR ROUTINE PAY INCREASES? THE ADMINISTRATION'S BUDGET ALSO DOES NOT TAKE INTO ACCOUNT THE INCREASED NUMBER OF VETERANS BEING CARED FOR IN STATE HOMES AND FOR CHAMPVA.

THE ADMINISTRATION'S REQUEST ALSO CONTAINS NO NEW MONEY TO FUND THE INITIATIVES PROPOSED IN THE BUDGET SUBMISSION. THE FUNDING FOR THESE PROGRAMS IS OVER \$500 MILLION. WHILE THE SERVICES PROPOSED IN THESE INITIATIVES ARE NEEDED, THE VA'S HEALTH CARE BUDGET IS ALREADY STRAINED TO THE BREAKING POINT. HOW DOES THE VA EXPECT TO PAY FOR THESE INITIATIVES WHEN IT CAN'T EVEN MEET THE CURRENT DEMAND FOR SERVICES?

AS ALWAYS, MR. CHAIRMAN. I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF OUR SUBCOMMITTEE TO ENSURE THAT OUR VETERANS RECEIVE THE HEALTH CARE SERVICES THEY HAVE EARNED.

THANK YOU, MR. CHAIRMAN.

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Statement of Representative Luis Gutierrez
Hearing on VA Medical Care Budget for FY 2000
February 24, 1999

Thank you, Mr. Chairman. I thank the witnesses for taking the time to be with us this morning. I look forward to hearing their comments and insight regarding the VA medical care budget for fiscal year 2000.

Mr. Chairman, I will reiterate the sentiments that I shared with this committee last week at our first full committee hearing. I strongly believe that the Administration's proposed budget for veterans' medical care is inadequate. VA hospitals across the country must struggle year after year to take care of our veterans, but they do not have the resources to do so. The Administration says it wants to open more clinics and treat more veterans. But Mr. Chairman, this is impossible with a medical budget that shows no increase from the previous fiscal year. We must also not forget that this budget proposal does not take into consideration the costs incurred from inflation and VA employee raises.

If Congress is fully committed to the men and women who have sacrificed for our country, we must heed the recommendations of the witnesses who are here with us today. Representatives from the veterans service organizations and the men and women who work in the veterans hospitals will tell us straight and to the point, "The Veterans medical budget desperately needs more money."

Mr. Chairman, we must not ignore their pleas.

STATEMENT OF THE HONORABLE MIKE DOYLE (PA-18)**Committee on Veterans' Affairs
Subcommittee on Health****Hearing on the VA Medical Care Budget for FY 2000****February 24, 1999**

I want to thank Subcommittee Chairman Stearns for convening today's hearing to further examine the VA Medical Care Budget for fiscal year 2000 as proposed by the Administration. I also want to welcome all of my fellow colleagues who are present here this morning.

In addition, I want to thank those of you who are here to testify before the Subcommittee for taking the time to share your expertise and insight on VA medical care and related funding issues. Your efforts are greatly appreciated and will assist members of the Committee in our work to fashion budget recommendations that accurately reflect and meet the needs of all veterans.

Before I begin my remarks, I ask unanimous consent that the testimony which was prepared and submitted by the American Federation of Government Employees (AFGE) be included as part of the record.

In the interest of time, I will keep my opening comments brief and to-the-point. I think it is safe to say that there isn't a whole lot to like about the Administration's overall budget for the Department of Veterans Affairs. And there's even *less to like* --- *if that's possible* --- about the woefully inadequate funding levels specified for medical care. As was made clearly evident in the full Committee's February 11th hearing on the overall budget, members on both sides of the aisle are particularly concerned about VA medical care programs.

Unlike committee dynamics you may observe elsewhere on the Hill, the concern that members of our committee have does not stem from internal bickering over obscure matters, but from our real doubts about whether we are fulfilling our commitment to our nation's veterans. And I'm not talking about fulfilling our commitment in *valiant terms* as outlined in the recently released report by the Congressional Commission on Servicemembers and Veterans Transition Assistance. ---- I'm talking about fulfilling the most *basic* of our commitments - **the right of a veteran to have access to high-quality health care and to receive treatment in a timely manner.**

No matter how you look at it, the Administration's Medical Care Budget doesn't add up -- not in terms of funding new initiatives such as treatment of Hepatitis C or even maintaining existing programs. In fact, it falls \$1.1 billion short in terms of keeping up with inflation and paying the salaries of hard working VA employees. - I could go on in more detail, but I will reserve some of my more specific concerns for the upcoming rounds of questions.

In good conscience, we must do everything we can to prevent the proposed funding for medical care from going unaltered. The Medical Care Budget is not just simply inadequate, but seriously compromises the professional integrity of the VA system in regards to the level of quality care that is being delivered and adequate staffing positions in various sectors. Without significant overhaul, FY 2000 funding levels also pose a significant danger to the long-term viability of the system.

It is my hope that subcommittee members will not only emerge from today's proceedings more informed about the funding levels for the Medical Care Budget and their potential implications ---- but more energized about the need to clearly articulate to those whose decisions will greatly affect their day-to-day lives our concerns about the *vets back home*.

AFGE

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STATEMENT SUBMITTED BY

**BOBBY L. HARNAGE SR.
NATIONAL PRESIDENT**

**AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFL-CIO**

TO

**THE SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS AFFAIRS**

ON

FY 2000 BUDGET FOR VETERANS MEDICAL CARE

FEBRUARY 24, 1999

**CONGRESSIONAL
TESTIMONY**

1-800-368-5878



Mr. Chairman and Subcommittee Members: My name is Bobby L. Harnage. I am National President of the American Federation of Government Employees, AFL-CIO, which represents 600,000 federal workers across the nation. AFGE represents some 120,000 workers at the Department of Veterans Affairs (DVA). It is the daily dedication and professional attention of these front line health care workers that transform the government's promise of quality health care into reality for veterans.

Caring staff -- not managed-care cost-cutters -- keep the Veterans Health Administration focused on its mission. But caring staff depend on sound budgets.

Budgets are a moral statement of our nation's priorities. The DVA budget proposal for fiscal year 2000 makes clear that this administration is intent on dismantling the DVA and turning the government's back on the men and women who served when called and sacrificed without question.

In their budget for FY 2000, Secretary Togo West and Under Secretary for Health Dr. Kenneth W. Kizer have recommended a \$17.306 billion appropriation for veterans health care. This will be the fourth consecutive year that DVA health care funding has been all but frozen. It is the sixth year in which the DVA has called for cuts in staff that are responsible for direct patient care. AFGE regards this budget proposal as further evidence that many Administration officials, who seem intent on dismantling the DVA, are turning their backs on their promise to care for the men and women who sacrificed their bodies and minds for our country.

The Administration's Budget proposal for DVA is Based Upon Several Dubious Assumptions

1. It wrongly assumes that the health care needs of more than 25 million veterans are diminishing simply because they are getting older. That the nation's 6.3 million WWII veterans, 6.1 million Korean War veterans, 8.1 million Vietnam Era veterans, and 2 million Gulf War veterans are getting older means they will require more -- not less -- specialized medical treatment and long-term care.

Moreover, the type and quality of health care that aging and other veterans receive at the DVA is unmatched and often unavailable from the private sector. This is especially true for 21 percent of the DVA's patients who have no health insurance. And can we risk underestimating the future medical needs of the roughly two million men and women who served in the Gulf War. The private sector is ill-equipped to handle Gulf War illnesses, spinal cord dysfunction, prosthetics, psychiatric patients, and homeless veterans who are entitled to health care services from the DVA.

Nonetheless, the DVA budget would cut acute hospital care by \$522,646,000. The proposal cuts psychiatric care by \$159,161,000 and cut rehabilitative and sub-acute care by roughly \$71,700,000. Worse, these cuts do not take into account the projected short-fall in the FY 1999 budget which is inadequate to meet current staffing levels and

health care service demands.

2) The budget proposal also mistakenly assumes that savings can be generated by reducing the DVA's in-house workforce by roughly 8,000 direct patient care workers. In calling for such a drastic staffing reduction, the DVA budget proposal sweeps the cuts under the label of "management efficiencies." The ramifications of such cuts is neither prudent management nor an efficient means of assuring veterans high quality health care. Moreover, it is insulting to staff who have been ordered to do more and more with less and less.

AFGE members know all too well that DVA staffing levels have been inadequate for years. An 8,000 staffing decrease in FY 2000 will follow six years of cutting the staff who serve patients directly. Including the cuts proposed for FY 2000, the DVA will have cut in just seven years roughly 28,500 employees who are responsible for direct patient medical care. (The 28,500 figure does not include the cuts to staff responsible for medical and prosthetic research or the cuts to medical administration staff.)

In preparation for a FY 1999 budget shortfall and anticipation of the fiscal year 2000 budget request, Under Secretary for Health Dr. Kizer, has already called for rapid processing of furlough requests and reductions-in-force.

Proposed staffing cuts, furloughs, and the elimination of medical services can only place veterans in greater jeopardy. Veterans will have less access to care and the care they manage to receive will not be high quality. Even the most dedicated, professional and committed staff can not provide quality care if their resources are stretched too thin.

Nurses at some hospitals are already being forced to work two shifts a day. The staffing of some hospitals is so tight that in order to have even the most minimal coverage, directors regularly order Registered Nurses to work 16 hours a day. Our members know that forcing nurses to cover two-shifts, day after day, takes it toll on the quality of care those nurses can provide to their patients. This is not "management efficiency."

Doctors at some facilities are already grappling with the consequences of inadequately funding veterans medical care. Doctors are being forced to consider which patient should get a needed surgery – either the cancer patient or a deaf veteran who could benefit from an ear implant to restore hearing. The hospital won't have the resources to perform both medically advised surgeries. This is not acceptable.

DVA's medical care staffing levels are not based upon the real needs of veterans. The DVA has established procedures to determine the staffing needs of each medical facility and each health care ward or unit. The methodology relies upon an expert panel which includes direct patient care staff to determine the appropriate staff mix (e.g. Registered Nurses, Licensed Practical Nurses, nurses aides, etc.) needed to provide

quality care to patients. DVA's budget proposal is not based upon this recommended staffing methodology.

On behalf of the women and men who care for our nation's veterans, AFGE urges Congress to reject the DVA's recommended fiscal year 2000 budget. The budget for veterans health care must -- at minimum -- support the existing staff levels at hospitals and allow hospitals to begin to fill the staffing capacity that has been eroded by six years of staffing reductions.

3) The Administration's budget proposal makes unrealistically optimistic estimates of collections from third-party insurers for veterans receiving care from the DVA in order to justify cuts in appropriations. The DVA makes this assumptions as part of its "30-20-10" strategy. The 30-20-10 plan involves a 30 percent reduction in the cost per patient, 20 percent increase in new unique Category A patients, and a 10 percent increase in funding from outside sources to offset reductions in appropriation funds.

As discussed above, the bulk of the 30 percent reduction in cost per patient is coming from the drastic and unacceptable reductions in staff. With regard to the 20 percent increase the number of new patients, Congress must look to revising the Veterans Equitable Resource Allocation System (VERA). Under the VERA model, only Category A patients will be funded. Thus, VERA shuts veterans out of the system.

The 10 percent increase in third party reimbursement offers the most promise but only if such collections truly supplement -- not substitute for -- adequate appropriated funds. The DVA's proposal would have the pie-in-the-sky predictions for third-party reimbursement displace real appropriated dollars. The DVA has never met its targets for third party collections. Over the years the DVA has only been able to recover less than half of the money it has attempted to collect from private insurers. Given this history, Congress should be wary of cutting appropriations based the DVA's overly optimistic estimate that it will collect \$761 million in FY 2000.

The tragedy of it all is that Veterans Health Administration's (VHA's) budget to begin with was inadequate. We cannot imagine DVA operating on a straight line budget even with third party reimbursement and Medicare. This proposal should be thrown out and Congress should instead begin linking VHA's budget to medical inflation costs and full staffing levels for the needs of veterans.

AFGE firmly believes that our government owes veterans much; at the very least, our government owes them adequate health care. We must treat our veterans in a high quality, caring environment, which truly has their interests as the bottom line. Quality of care -- not simply "cost" -- must be the factor of importance. Dignity, duty and our obligation to provide quality care must be considered a budget priority.

That concludes my statement.

**STATEMENT OF
THOMAS L. GARTHWAITE, M. D.
DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES**

FEBRUARY 24, 1999

Mr. Chairman, members of the Committee, the President's budget for veterans medical care for Fiscal Year 2000 builds on VA's previous accomplishments and complies with the Balanced Budget Act of 1997.

The budget provides \$18.1 billion, including \$749 million in medical collections, to provide medical care to eligible veterans. Highlights of this request include:

- VA will open 89 new outpatient clinics and treat 54,000 more patients in 2000 than in 1999, a 1.5 percent increase.
- We are proposing \$50 million in additional funding to help homeless veterans, including \$40 million in medical care and \$10 million in mandatory transitional housing subsidies. This funding will allow us to support 1,385 new community-based beds and treat 12,000 more homeless veterans.
- An increase of \$136 million for VA's efforts to combat Hepatitis C.
- An increase of \$106 million in VA's long-term care alternative programs.
- While not included in the budget, the Administration will continue to seek authorization of a Medicare subvention pilot program.
- The budget includes a legislative proposal to authorize VA to cover the cost of out-of-network emergency care for enrolled veterans with compensable disabilities related to military service.
- The budget includes a legislative proposal to establish smoking cessation programs for veterans who began to smoke during military service. This program will be designed to reach veterans throughout the country by using contractors.

Mr. Chairman, the Fiscal Year 2000 request recognizes the dramatic changes that have occurred in the past four years. In that time, we have increased the number of veterans treated, improved the quality of our care, and

improved customer satisfaction. At the same time, we have reduced the per-patient cost of providing care and we have changed the culture of VA healthcare.

Our goal is to provide world-class quality healthcare to as many veterans as possible. VA has successfully organized a system of coordinated healthcare delivery focused on continuous quality improvement that is patient-oriented, ambulatory care-based and results driven. We now treat patients in more appropriate settings for their problems. Veterans have embraced the use of primary care providers and care teams for their health needs.

These strategies will assure the viability of the healthcare system well into the next century. They will also prepare VA to continue to meet the diverse healthcare needs of the veteran population. We believe that the new VA system should serve as a model for future integrated healthcare systems, both public and private.

In 1998, our department committed to the goals of reducing per-patient cost for healthcare by 30 percent, serving 20 percent more veterans, and increasing alternative revenue sources to 10 percent of all Medical Care funding. VA is still committed to meeting these goals, while assuring that quality of care is maintained in our system.

VA is on track towards its long-range goals of 30/20/10. Compared to the 1997 baseline, we project the following results in 2000:

- reduce per-patient cost by 18 percent,
- serve 16 percent more veterans, and
- increasing non-appropriated funding to 5.1 percent of the Medical Care budget.

This will be accomplished in large measure by continuing to shift excess acute inpatient resources to expand and enhance outpatient care and other types of care in the most appropriate setting. Ongoing efforts to re-engineer our health care delivery structure and mechanisms and our business practice initiatives will also contribute to these goals. We will continue to insure that taxpayers receive full value for the funds they entrust to us.

Medicare subvention would allow VA to collect funds from Medicare for healthcare services provided to Medicare eligible, higher income veterans without compensable disabilities. Adoption of this demonstration program is VA's top legislative priority.

We will not be able to obtain 10 percent of our funding from alternative revenue sources in the future if Congress does not pass the Medicare

subvention pilot legislation. If this pilot proves successful in improving outcomes and lowering costs, our goal would be to open up VA reimbursement throughout the system. I ask for your support of the Administration's proposal in this area.

VA is also proposing a change in appropriation language to provide for two-year spending availability for up to 5 percent of our resources, excluding those funds set aside due to delays in providing medical equipment.

We support this proposal because it promotes more rational spending decisions and recognizes the need for management flexibility during this period of significant change for VA healthcare.

As I mentioned earlier, the Administration is requesting authorization of a new smoking-cessation program for any honorably discharged veteran who began smoking in the military. The program would be delivered by private providers on a per capita basis. Any veterans who began smoking in the military would be eligible for this new program, to the extent resources are available. The Administration will seek authorization of this program in the near future.

Once this program is authorized, the Administration will submit a budget amendment requesting an appropriation of \$56 million for this new activity. It is estimated that between 500,000 and 600,000 veterans would avail themselves of this valuable program over the next five years.

For Medical and Prosthetic Research, a total of \$316 million and 2,838 employees will support more than 2,100 high priority research projects to enhance the quality of healthcare of the veteran population. This level of funding will allow us to maintain the operation of research centers in the areas of Gulf War veterans' illnesses, diabetes, Parkinson's disease, spinal cord injury, cancer, prostate disease, depression, environmental hazards, women's issues, as well as rehabilitation centers and Health Service Research and Development field programs.

In these areas, no other federally supported clinical or research entity can initiate or complete such critical and ambitious research activities on behalf of America's veterans. Our department will continue to increase the amount of non-appropriated research funding we receive from the private and public sectors.

The Balanced Budget Act of 1997, Public Law 105-33, allows VA to retain all collections from third parties, copayments, per diems, and certain torts after June 30, 1997. These collections are deposited in the Medical Care Collections Fund and are available for transfer to the Medical Care appropriation. The funds remain available to VA until they are expended.

For FY 2000, VA estimates that more than \$761 million will be collected through this effort—and revenues will grow to over \$1.2 billion by 2004. To accomplish this growth, we are in the process of changing our billing rates to reasonable charges for inpatient and outpatient procedures; identifying more patients having insurance; and improving our debt collection efforts.

The Medical Administration and Miscellaneous Operating Expenses, or MAMOE, activity is requesting \$61.2 million in appropriations to fund 573 employees who will support VHA operations in Fiscal Year 2000. Transfers of \$415,000 and \$7.1 million in reimbursements will supplement these funds.

This request is somewhat different from past years in that it includes reimbursement authority for activities related to the Facilities Management Service Delivery Office. Facilities Management will begin to receive reimbursement from VHA, VBA and NCA for field-related project management.

This reimbursement will allow VA to use appropriated funds to hire additional staff in the areas of quality management and performance measurement. Capital policy activities will continue to be funded by the appropriation.

Mr. Chairman, this concludes my summary of the medical care, medical administration, and medical research budget requests. I will be pleased to respond to your questions.

TESTIMONY BEFORE THE HVAC SUBCOMMITTEE ON HEALTH
FEBRUARY 24, 1999

My name is Tom Trujillo. As many of you know I recently retired from the Veterans Health Administration after over 32 years of service. I started my career in hospital finance and have many years of experience with medical center health care budgets, as a Financial Manager, Associate Director, Director, and Network Director. I appreciate being asked to testify before you today. First of all it is a great honor and privilege. Secondly, I am very concerned with the subject I am being asked to speak about today, and that is the FY2000 budget.

Before I start with that subject I would like to give you a little bit of where I'm coming from. At the time of my retirement I had the privilege of being the Network Director of VISN 18 which covers Arizona, New Mexico, and the western part of Texas. If you can imagine in your mind's eye that geographical area, you can see that the Network Director of VISN 18 has responsibility for the health care of veterans living in a huge area (800,000 veterans in 361,000 square miles). Being responsible for the healthcare of the veterans in this area was by far the most rewarding and challenging part of my career. Many of the veterans in this area do not have access to health care. Many have no health care insurance. There are high numbers of minority veterans, in particular Native Americans, who have not been given adequate care to prevent some of the more prevalent medical problems that occur in their particular population. I take a great deal of pride in the fact that over the last three years staff at the VISN 18 facilities have made great strides in improving the health care of a great many people in this large area of our country.

In order to explain what I mean I'd like to speak a little bit about the VA health care system during the last 30 years. When I started working for the VA, the system was basically a hospital system. If you were sick enough to be hospitalized and met certain criteria, we could take care of you. We all felt good about what we were doing because we were helping a lot of elderly WWI veterans, many WW II and Korean Conflict vets, and the newly arriving mentally and physically wounded vets of the Viet Nam war. Our rehabilitation programs, such as blind rehabilitation units and spinal cord injury centers, were and still are second to none in the world. The VA continues to be a leader in prosthetics research, and our facilities have dispensed prostheses which have enhanced the productive lives of thousands. We were criticized for the fact that our lengths of hospital stay were longer than those in the private sector, but our mission of taking care of the recently wounded as well as the elderly justified what we were doing, and I think we did it well. The VA's other missions of medical education and research, as well as outreach and support to indigent vets, also helped to justify our costs and made us feel that we were making a positive difference. The mutually beneficial relationships we forged with the nation's medical schools also helped us to solidify our major role in America's healthcare community. But we were still primarily a hospital-based, inpatient system.

About four years ago, Dr. Ken Kizer was appointed to head the Veterans Health Administration. He brought fresh ideas to the Department of Veterans Affairs and with the help of you gentlemen, who gave us health care eligibility reforms, completely changed the way we do business. The guiding principles for this change are contained in Dr. Kizer's "Prescription for Change."

I would like to talk a little about what has happened over the last 3-4 years because I believe we have moved this Department further during those years than any federal agency has been moved in the history of government. Four years ago, modern medicine was rapidly moving towards ambulatory and preventive health care, but we were still being funded by the number of inpatients we treated. HMO's were going to great lengths to reach out to their patients and provide greater accessibility, but we were still "Building Bound" and generally only provided care in the traditional hospital-based facilities that were built right after WWII. The truth of the matter is that VHA was becoming a dinosaur that was rapidly moving toward extinction.

Over the last 3-4 years we have reduced the number of hospital beds nationally from 50,518 to 26,204. We have reduced our lengths of stay from 14.1 to 11.9. The number of bed days of care has decreased from 2,519 per 1000 patients to 1,332 per 1000 patients. Ambulatory surgery has become the norm rather than the exception. The number of access points away from the hospitals have been greatly expanded. The number of veterans we treat has increased by 15.1%. We are now providing full spectrum primary care services to all of our patients and as a result they get more comprehensive care than is provided by most of the health maintenance organizations. There are many other things I could say about what we have done nationally, but time prohibits me from continuing. I would like to point out however, and I point it out with great pride, that we have done this with a real dollar, flat line budget.

This brings me back to the reason I am here today, that is, to talk budget. I will admit that by accomplishing these changes, we have stretched ourselves way too thin and like the proverbial rubber band, we are "ready to snap." This fiscal year VISN 18 received a VERA funding increase of 3.58%. All of this was quickly eaten up by the 3.8% salary cost increase, the mandatory funding of previously centralized programs, the rising inflationary costs in health care, and the increase in the number of veterans coming to us for care. This fiscal year we are experiencing serious financial problems, and we are one of the networks who "gained" the greatest percentage financially (see Figures 1, 2, 3, 4). These figures indicate a shortage of funds for current year operations which immediately are compounded into FY 2000 without considering the salary increase and additional FTEE to accomplish increased workload. My estimate of shortage in FY 1999 is approximately \$15 million, and with a straight line budget for FY 2000 the shortage would be approximately \$30 million. Imagine the situation in those networks where no funding increase was received.

All of the facilities in VISN 18 are scrambling to deal with budget shortfalls, and I would like to share with you a couple of specific examples. The Phoenix VA, which has historically been one of the most efficient hospitals in the VA system, reduced its lengths

of stay by about 50%. Through a judicious use of current admission guidelines, they were able to reduce admissions to inpatient care by 30%. This effort provided them with the opportunity to close underutilized beds, which they did. The resources saved were reallocated toward enhancing outpatient care capacity to address the increase in workload shifted to that area. The reallocation worked well in 1998 and they were able to provide more and better health care to a larger number of veterans at about the same funding level. In the first quarter of this year, the number of new veterans coming to the facility (that is, new patients, never seen before) increased by 12.5% causing a shortage of beds and funds. This is a major problem that the facility is having great difficulty dealing with. In my opinion they are walking a precariously fine line that they could cross over at any time. The ramifications of crossing this line are a reduction in the quality of care to an unacceptable level. There have already been three or four occasions this year when they have had to notify local ambulance companies to "by-pass" and not bring emergency cases to the facility due to shortages of intensive care beds.

Big Spring VA Medical Center, a small hospital in West Texas, is also having major funding problems due to an unprecedented increase in workload for that facility of 13.4%. Those of you familiar with this part of Texas know that it is medically underserved, with many small towns spread over a huge area. Big Spring VAMC has set up six community based outpatient clinics to take care of the primary care needs of veterans and the response has been overwhelming. Almost every new patient we have seen is indigent, uninsured, and in need of care. They have no where else to go and are unbelievably thankful for what we are trying to do.

I have used these two examples because they represent both ends of the spectrum in VA health care, the large urban complex hospital and the small rural facility that serves a scattered population. I think it's important to look at these in this way because the men and women who have served our country don't just come from highly populated areas, they came to serve from every nook and cranny in this great nation of ours, and returned home to urban and rural areas alike. We have established good, strong systems to provide for some important needs and we should not do anything to those systems except improve them.

There are things happening nationally in health care that concern me greatly. Hepatitis C is a blood borne virus that must be identified and promptly treated. This new requirement will be very expensive, but we are obligated to screen our veterans and treat them quickly, before they are beyond treatment. New and better drugs are being developed every day that extend the lives of people infected with the AIDS virus. Unfortunately the drugs are also very expensive. We are obligated to either provide these treatments as they become the standard of care in our country or get out of the health care business. In addition, the provision of emergency care and additional care services for female veterans under Enrollment will increase our costs to an extent that has not yet been quantified.

One of the areas that also concerns me as a health care professional is the number of patients who are coming to us due to problems with their HMOs. VISN 18 has a high market penetration of HMOs and many do not provide the standard of health care quality

found in the VA. Elderly men who can no longer walk are coming to us for joint replacements because their health plan is rationing care and has decided it will not provide this expensive procedure. Many are coming to us for second opinions, and when they find that we are able and willing to treat them they want to stay with VA as a provider who is concerned about improving, rather than rationing, their care.

As the population ages we are receiving many patients who are being pushed out of local private facilities as their insurance runs out. I am sure all of you have received heart-rending requests from your constituents asking for help in these situations, and I am sure that many times the problem was solved by a referral to the VA. I can't tell you how I feel about the hundreds of letters written to the facilities in my VISN thanking our staff for the loving care their father, mother, brother, or sister received at one of our facilities, especially during the last days of their lives.

I would like to point out that the cost of care in my VISN is a great bargain for the American taxpayer. We treated over 167,000 veterans last year at a cost of less than \$3,600 each. The cost of the average patient under Senior Care, the name for the Medicare HMO in our area, is over \$6000 per patient. Remember that most of the people who come to us have multiple body system diseases and comorbidities, and we furnish a much broader spectrum of care than Medicare provides.

What is the proposed FY 2000 budget going to do to the system I spent my life working for? I read where Congressman Evans said that this budget is like a "house of cards" which may work for a while but eventually will fall. I would go even further and say from the view of a VISN Director that administering this budget would be like trying to build that "house of cards" in an Oklahoma tornado.

We have squeezed almost every efficiency we can out of VISN 18. We have established standardized pharmaceutical formularies to make sure the dollars we spend are appropriate and maximized, yet this year we estimate an increase in dollars spent in this area to be \$8.0 million. Staffing ratios in our inpatient units are below what they should be. We have closed or reduced as many programs as we can under the current laws. We no longer furnish, for example, PTSD or Alcohol treatment on an inpatient basis. We have consolidated procurement of materiel and supplies. We have reorganized our organizational structure at each facility and will be realigning Prosthetics and Information Resource Management services in FY 1999. There may still be some efficiencies out there, but I can assure you they are minimal. In no way can we come up with the arbitrary "efficiencies" required by this budget.

Look at it sensibly. If this budget were made operational, all of the reductions required would be in personnel. We are a service industry and approximately 60% of our budget is in personnel. "Efficiencies" of a billion dollars would cost us about 20 employees per million dollars, 2000 per hundred million, and 20,000 per billion. It's simple arithmetic, and no matter what you call it, the fact is we would have to have large Reductions In Force (RIF) and close numerous facilities to live within this budget. 20,000 employees would equate to the loss of 12 facilities the size of the largest facility in VISN 18.

I, of course, do not know what VISN 18's share of the budget will be, but based on the capped VERA methodology my estimate would be that this budget would mean a reduction somewhere in the neighborhood of 600 full time employees. We would have to close at least one facility, close community based clinics, discontinue or greatly reduce both VA and contract nursing home care since they are not mandated programs, and of course reduce workload by only taking care of the higher categories of care. All of these are drastic steps backward in providing care to our veterans, who answered the call when we needed them.

Gentlemen, I would like to close with a plea to you to take care of our nation's veterans in their time of need. I am often amazed at how destiny and coincidence converge to make a strong statement that seems to transcend our normal perception of life's events. In one corner of the world American forces once again stand at the ready, prepared to enforce the international community's sanctions against Iraq and preclude their ability to rebuild an arsenal of mass destruction. While at the same time it is necessary that I stand before you with my hat in hand, pleading that adequate resources be directed to preserving the health care structure to care for these veterans when they need it.

I appear before you today as a private citizen. It is no longer of daily concern to my livelihood what the VA budget is. It is however, of daily concern to my heart and my conscience, as it should be for every American. Throughout this century, each time the freedom and security of our shores or that of our allies has been endangered, America's armed forces have risen to the challenge and served with courage and honor. Those men and women didn't stop and ask for justification or hold hearings, but immediately stepped into the line of battle and gave their all to assure our country's freedom. The very least that we owe them in return is the assurance that when they need our help, when they need health care or social services, there will be facilities and staff ready and able to provide the best our nation has to offer. To do anything less brings dishonor to these United States of America. Thank you for this opportunity to testify before you today.

Selected Workload and Cost – VISN 18

	<u>FY 98</u>	<u>*FY 99 Projected</u>	<u>% Increase</u>
Unique Patients	167,766	181,187	8.0
Outpatient Visits	1,509,156	1,630,000	8.0
Pharmacy	58,609,205	66,314,442	13.1
Prosthetics	19,574,388	22,286,001	13.8
Laboratory Cost	7,759,127	8,696,976	12.1
Radiology	7,003,412	7,972,228	13.8

*Projected FY 99 based on 1st quarter increase in uniques plus 5% increased cost.

Figure 1.

*Comparison of FY 99 VERA Funding with FY 98 – VISN 18
(Dollars in Thousands)*

	<u>FY 98</u>	<u>FY 99</u>	<u>% Change</u>
VERA Model \$	520,744	539,363	* 3.58
Equipment	18,518	20,251	9.36
NRM	5,795	7,367	27.13
	<hr/>	<hr/>	<hr/>
Total	545,057	566,981	4.02

*For FY 99 received \$5,005 million for Programs that had been centralized in past years. When you consider this adjustment, the actual overall increase in operating dollars was \$13,614 million (\$18,619 million - \$5,005 million) or 2.61% net increase.

Figure 2.

**Comparison of FY 99 VERA Funding with *FY 00 – VISN 18
(Dollars in Thousands)**

	<u>FY 99</u>	<u>*FY 00</u>	<u>% Change</u>
VERA Model	\$ 539,363	553,500	2.6
Equipment	20,251	20,500	1.2
NRM	7,367	8,000	8.6
Total	566,981	582,000	2.6

*These figures are my best guess as to what the FY 00 funding might be.

Figure 3.

**Comparison of MCCR FY 98 with FY 99 Estimated – VISN 18
(Dollars in Thousands)**

	<u>FY 98 Actual</u>	<u>FY 99 Goal</u>	<u>FY 99 Estimated Collections Based on First 4 Months</u>
MCCR Collections	\$21,744	\$22,831	\$22,000

Figure 4.

**Statement of Nick D. Bacon, Director of
the Arkansas Department of Veterans Affairs
before the
House Veterans' Affairs Subcommittee on
Health, United States House of Representatives
on
The Administration's Year 2000 Budget submitted
to Congress on February 1, 1999.**

Mr. Chairman, distinguished members of the subcommittee, I appreciate the opportunity to address the Administration's VA Health Care 2000 Budget.

The veterans of this country continue to be slapped in the face and ignored by this Administration. At a time when we ask our military to give more and more with less and less, at a time when our leaders scratch their heads and wonder why we cannot retain our soldiers and sailors, at a time when costly well trained pilots exit faster than we can train them, we ask what's wrong as we cut deeper into the VA Health Care Budget.

In my opinion, our servicemen and women look at how they are treated, look at how our veteran heroes are treated, compare it to the hundreds of freely offered benefits that continue to get funded, and say, "Good by Uncle Sam, who needs you?"

This Administration in short does not understand anything about the military or about our veterans and could care less.

This proposed budget is not only unrealistic, it is totally unjust. The budget contains \$18.1 billion for medical care. This requires third party medical collection of 749 million dollars - this is just smoke and mirrors. In fact, the President's Budget calls for over one billion dollars in cuts.

The Administration says they are going to open 89 new outpatient clinics and treat 54,000 more patients in FY 2000, additional \$40 million to assist homeless veterans, \$250 million to combat Hepatitis C (I am told by many VA Health professionals that this cost will be as high as \$600 million), and another \$106 million to fund Long Term Care programs. Also included in the budget are 440 full time claims

positions, new cemeteries, VA construction programs, a \$50 million nurse education initiative program and so much more. Where is the money? To quote an old commercial, "Where's the Beef?".

Mandates without funding, that's what we continue to see - open enrollment, veterans scream, great! No funding. New clinics, great! No extra funding. RIF's and hiring freezing continue. Resources to support the federally mandated national emergencies and our Armed Forces during a time of war is, I guess, totally forgotten. Expanding uniform benefits to include maternity - not funded. This list goes on and on - (the VA is going to do this and this and this - Looks good on their news releases, but "Where's the Beef?").

If you very carefully read the small print on page 3-52 of volume 5, FY 2000 budget, you will see increases and decreases of some areas. But most of all you will please note an FTE reduction of 6,949, add back 699 for Hepatitis C, extended care and homeless, you have an employee reduction of 6,250. Of course that is the money that pays for this great 2000 budget, rob Peter to pay Paul.

By the way, who is going to pay the cost of living increases to the employees? What about the added cost of prosthetics? The increase of drugs alone has risen 10 percent while we have been on a straight line budget for three years. To fight the increase of drug cost and inflation, VA went to the National Formulary System of buying drugs. Limiting the types of medication available to VA doctors and no choice for the veteran. While the rest of the world enjoys the new medical science pharmacy breakthroughs, our veterans can't even get normal desired drugs. Is something wrong with this picture? Hello out there! Mr. President, is anyone home? We have worked on Dr. Kyzer's 30-20-10 plan. We have stretched the rubber band as far as it will go! We are treating 20 percent more veterans.

As medical costs continue to increase how can VA Medical Centers do what no other medical system can do, that is cut cost by thirty percent? And for the 10 percent collection from third party insurance; that is still as much a joke today as it was three years ago (a joke that is not very funny).

The Department of Veterans Affairs has cut 20,000 plus jobs, cut more than half its hospital beds, cut most nursing home care, putting more and more burdens on the states and still they want to cut thousands of health care professionals.

If it were not for the wonderful health care Administrators and professional staff of the VA health care system, we would have already been put out of business. They have overcome every obstacle put in front of them and now they need help badly.

In conclusion, Mr. Chairman, the American veterans around this country salute you and the subcommittee on your ongoing concern for America's veterans particularly those older WWII veterans who need help now more than ever. Please Sir, Let's Not Bury Them While They Are Still Living.

Again, thank you for allowing me the opportunity to address the subcommittee on behalf of all veterans everywhere.

GOD BLESS AMERICA!

VETERANS OF FOREIGN WARS

OF THE UNITED STATES



STATEMENT OF

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

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

FY 2000 VA MEDICAL CARE BUDGET

WASHINGTON, DC

24 February 1999

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE

On behalf of the men and women of the Veterans of Foreign Wars, I would like to express our deep appreciation for you inviting us to participate in this most important hearing. Securing sufficient funding for the VA Medical Care system has now taken on a note of such urgency that if we fail in this regard, its continuing existence as a viable health care provider for veterans will be very much in doubt.

The Administration's proposed budget for the Department of Veterans Affairs is devastating to our nation's veterans. This proposed budget will seriously undermine VA's ability to provide quality, timely, accessible health care for veterans.

The VFW hears daily complaints of increased waiting times for veterans to see a specialty provider, such as an Orthopedic Doctor or a Dermatologist. This is happening throughout the country.

More egregious in the specifics, however, is the one-year wait for hip replacement surgery in Michigan, and the one-year wait for dentures in Maine, and the one-year wait for a dermatology appointment in Louisiana. These are only a few examples of a tragic nation-wide epidemic. An epidemic of increased waiting times and delays in getting appointments which, in these examples, can only be interpreted as a denial of care. And it WILL get worse this year and next because of this proposed budget.

For a fourth consecutive year, the health care appropriations is flat lined at just over \$17 billion. This provides for absolutely no increase to cover new programs or inflation. Inflation alone will account for nearly \$1 billion. The Administration's budget is worse than a flat line budget; it's a "negative growth" budget that threatens the health and well being of veterans.

I would just make mention that this proposed budget also does not provide any real increase in personnel so vital for important projects needed to correct quality problems in the processing of veteran's claims.

This funding proposal is an unrealistic and unfair budget that will not meet the needs of America's veterans. It is unfair in that, in the presence of the largest budget surplus in recent history, while other federal agencies will have double-digit increases, veterans are being asked to once again sacrifice what is essentially a negative growth budget – a budget that indeed threatens the very existence of the veterans health care system.

The Veterans of Foreign Wars recently reached a milestone of assisting over 10,000 individuals in an expanded outreach program. Our **1-800-VFW-1899 Helpline Poster Program** was designed to reach out and to assist more of our Nation's veterans.

This is in addition to the tens of thousands of veterans, their dependents and survivors, which the VFW assists annually through its national network of service officers.

The VFW Helpline was established in September 1997. Since then it has steadily grown. At the current time, the Helpline receives over 250 calls a week and responds to them within 24 hours. The primary purposes of this program is, first, to assist the individual veteran and second, to collect information to help us assess the impact of the many changes taking place in VA health care and benefits delivery. These changes include the impact the Veterans Equitable Resource Allocation system (VERA) and the budgetary constraints may have on providing quality, timely, accessible health care and delivery of benefits to veterans.

The main source of information comes from our toll free Helpline. We "publicize" the Helpline number monthly in our *VFW Magazine*, have placed public service announcements in newspapers nationally, and have developed a "Poster" program in cooperation with the VA. This unique opportunity has allowed us to build upon the partnership between the VFW and the VA in serving America's veterans. Thanks to the cooperation of the VA, the VFW has been allowed to place posters in highly visible and permanent locations throughout VA health care facilities.

The toll free number on these posters serves as an additional contact point for veterans to voice questions, compliments, issues or concerns. Publicity has been critical in increasing awareness of the Helpline. The VFW's Tactical Assessment Center receives the calls that are then assigned to VFW Field Representatives, other National staff, or Department Service Officers as appropriate. The Tactical Assessment Center monitors 57 VA health care issues and 30 VA benefits issues.

We have found that communications between VA health care providers and veteran patients continue to get worse. Veterans complain that their providers do not talk with them and providers tell us that they no longer have enough time to spend with each veteran. Providers are being made to see more patients per hour forcing them to curtail

or even eliminate much needed patient consultation. Veterans tell us they are dissatisfied with this type of treatment and they feel it has resulted in a decrease in quality.

Providers must be allowed the discretion to spend as much time as is needed with their patients. It is not acceptable that a veteran leaves a provider's office without a clear understanding of the treatment plan and not knowing when the next appointment will be. We believe this connection between what is actually happening and what the providers and veterans feel is best is the result of an inadequate budget forcing management to make health care decisions. Health care decisions must be left to the health care providers. This problem will get worse as the effectiveness of operational funds decrease due to a flat line budget, inflation, pay raises, and other unavailable increases in health care.

As the aging veteran population rapidly continues to rise, veterans are more and more likely to require nursing home care. While this need continues to grow, the VA has been closing nursing home beds throughout the country at a rate that, in our opinion, appears indiscriminate. A recent survey of VA facilities found that more than 300 nursing home beds have closed in the Northeast alone and more than 1,000 beds have been closed nationwide in the last two years. It is all too clear that current budget restraints and the pressure to shift from inpatient to outpatient care are the culprits of these closings.

Calls received, however, indicate an increasing demand for nursing home beds that are being ignored by the VA. A typical call begins, "Can you help me get my husband into the VA nursing home?" Or, "The VA is putting my father out of the nursing home and there is no where for him to go." Or, "The VA threatened to put my grandfather out on the front lawn of the hospital because they do not have a bed for him in the nursing home". Or, "The VA just called and told me to come pick up my husband" Or, "Why can't I get my husband who fought in WWII into the VA. I can't take care of him any more with his Alzheimer's."

Until Congress and the Administration adequately address long-term care, veterans who require nursing home care, and their families, will continue to feel ignored. Until the VA comes out with clear directions on the provision of nursing home care in VA facilities, we will continue to see empty nursing home beds, such as in East Orange, NJ. We will also continue to see attempts to eliminate and further restrict nursing home care, in VA facilities and those provided in the community, as we have seen in Providence, RI VAMC, and facility Directors will continue to tell us that they "just can't afford it anymore."

Waiting times to receive treatment in specialty clinics continues to get worse. Calls from veterans have indicated, for instance, more than a one-year delay to receive dentures in Network 1, and more than a one-year delay to receive orthopedic surgery in Network 11. We have also seen an increase in the number of calls received about obtaining timely appointments in clinics such as Cardiology, Dermatology, Podiatry, Ophthalmology, and a variety of other specialty clinics.

The implementation to primary care was designed to alleviate the overcrowded conditions in the specialty clinics. This goal has not been realized in all cases. Some facilities, such as West Los Angeles, only have one third of their veterans enrolled in a primary care clinic. The vast majority of their veterans are followed in specialty clinics. While the majority of veterans being seen for follow up appointments in primary care clinics are seen in a timely manner, the same cannot be said for an initial appointment for a physical exam. In some cases veterans are told they will have to wait months for their initial physical. West Palm Beach, Salisbury, and Gainesville, Florida all have six-month waits for initial physical exams.

Pharmacy waiting times seem to have worsened over the past year. Calls about one and two hour waiting times to receive medications are commonplace. Waiting times are increasing because staff has been reduced and the outpatient workload has increased. With staffing reductions due to take place in the future, this problem will surely get worse.

There is a multitude of reasons why this transformation into primary care has slowed down, but they are all the result of inadequate budgeting. We are told that facilities have no more space for additional clinics and they have no money to convert empty inpatient space into clinic areas. Further, there is resistance from physicians in specialty clinics to discharge veterans to primary care; and they have little money to hire additional primary care providers or additional primary care providers are not available for the salary they are offering.

The closing of inpatient beds is also occurring at a faster rate than outpatient clinics can keep up with. The outpatient workload has increased by approximately 5 million visits over the last three years while the inpatient workload has decreased by approximately 125,000.

In the final analysis, years of inadequate funding have led the VA Health Care system to a desperate pass. On behalf of all of this nation's veterans in need, we pledge to work with you in securing the additional dollars the system and veterans so desperately require.

Once again, thank you for including the VFW in today's most important forum. I will be happy to respond to any questions you or members of the subcommittee may have



**Dennis M. Cullinan, Director
National Legislative Service
Veterans of Foreign Wars of the United States**

Dennis Cullinan is a native of Buffalo, New York, and was recently promoted to the position of Director of the National Legislative Service of the VFW Washington Office.

Prior to being honorably discharged from the U.S. Navy in 1970, Dennis served as an electronic technician aboard the USS Intrepid (CVS-11) and completed three tours of duty in Vietnamese waters. After his discharge, Dennis studied abroad with two years at the Catholic University of Nijmegen, the Netherlands. He later completed his undergraduate education at State University of New York in Buffalo where he also received his M.A. degree in English

After several years of teaching freshmen composition and creative writing, Dennis became a member of the VFW Washington Office staff in its National Veterans Service department. He later advanced to positions in the VFW's National Legislative Service department and became its Director in August, 1997.

Dennis enjoys an active involvement in crew as a member of the Occoquan Boat Club of Northern Virginia. He and his family reside in Lakeridge, Virginia, where he is a member of VFW Post No. 7916.



The Veterans of Foreign Wars is not in receipt
of any Federal grant or contract.

**STATEMENT OF
JACQUELINE GARRICK, ACSW, CSW, CTS
DEPUTY DIRECTOR FOR HEALTH CARE
NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE VETERANS HEALTH ADMINISTRATION BUDGET
FISCAL YEAR 2000**

FEBRUARY 24, 1999

Mr Chairman and Members of the Committee. The American Legion appreciates the opportunity to continue the discussion of the President's budget request for FY 2000 concerning funding for the Veterans Health Administration (VHA). The American Legion submitted its testimony on the Department of Veterans Affairs FY 2000 Budget before the full Committee hearing on February 12, 1999. Today, this testimony will focus on VHA's precarious funding situation and potential solutions to existing and projected budgetary problems.

The President's FY 2000 proposal recommends only \$18.1 billion for VHA. This budget request dramatically represents the adverse effect the Balanced Budget Agreement of 1997 is having on VHA's ability to provide quality health care to this Nation's veterans. The American Legion continues to witness the negative impact on service delivery throughout all 22 Veterans Integrated Service Networks (VISNs) across the country.

Nationally there is genuine concern for VHA's ability to meet the growing health care demands in the immediate future. Network directors have spoken earnestly about their VISN's ability to provide care in FY 2000 and beyond under the current budget constraints. The American Legion continues to hear of the realistic possibility of shortfalls that would force network directors to choose between quality of care or termination of programs or services.

Mr Chairman, the Administration's FY 2000 budget request for the VHA could very well do further damage to an already fragile health care system. The American Legion is extremely disappointed with the degree of fiscal austerity imposed by the Administration on VHA. Elsewhere in the Administration's FY 2000 budget, there is sufficient evidence of a far more progressive fiscal policy toward certain non-veteran

federal programs. However, the fiscal attention devoted to veteran's health care is extremely regressive.

The Administration continues to rely on unnamed management efficiencies and a full-time employee (FTE) reductions (nearly 7,000 positions) to meet the expanding budgetary needs of VHA. The budget proposal also increases reliance on a currently inconsistent and unreliable Medical Care Collections Fund (MCCF) to generate sufficient recoveries to offset discretionary appropriations.

Yet, VHA continues to recognize its need for increased expanded services

- Treatment of hepatitis C patients,
- Long-term care,
- Emergency services for veterans enrolled in VHA,
- Treatment of 54,000 additional veterans,
- Opening of 89 new outpatient clinics,
- New homelessness initiatives,
- Medical care inflation, and
- Pay raises

The President's recommendations would not allow VHA to meet these objectives. If VHA continues on this "crash course," it will be forced to continue reductions in direct patient care. The American Legion believes the FY 2000 budget proposal for VHA represents a serious breach of faith with America's veterans. In an era of budgetary surpluses (in the billions of dollars), where are the additional resources and long-range plans to permanently strengthen VHA? In recent years, Congress turned to elimination of certain veterans' benefits in an effort to reduce the federal deficit. Now that there is a balanced budget, who is even considering restoring those benefits? Congress can do better in FY 2000 than the Administration proposes. Appropriate funding support for VHA programs and services must be provided. A long-term strategy must also be developed to safeguard the veterans' health care system, a true national resource that benefits all Americans.

Mr. Chairman, to acquire a realistic picture of the current conditions within VHA, listen to the staff who actually provide direct care and services to veterans. There is an immense disconnect between the views of administrators and direct care providers when they describe the state of VHA. It is like speaking to two totally distinct health care systems rather than one. The American Legion encourages the distinguished members of this Subcommittee to interact with the staffs of local VHA facilities to learn about the every day working conditions. Ask the nursing staff and technicians about the demands and stresses placed on them in order to deliver quality health care to veterans. If it were not for the dedicated and compassionate employees at VA facilities, veterans would already be suffering greatly because of the constraints of the budget. Although VHA employees are the final gatekeepers for patient safety and quality care,

they should never have to stand alone in this mission. Every American should demand excellent health care in VHA.

The American Legion is not saying that conditions within VHA are beyond repair. When conditions indicate that problems are building, Congress must try to make corrections sooner, not later. Not dealing with VHA's budgetary problems head-on can result in too many unintended and regrettable consequences that ultimately makes the problems harder to resolve. We must be proactive rather than reactive to the health care needs of America's veterans and their families.

Mr. Chairman, four years ago VHA took a hard look at changes that needed to be made throughout the system. That review resulted in the reorganization into VISNs, enhanced efficiencies, eligibility reform, the implementation of the Veterans Equitable Resource Allocation (VERA) model, greater sharing authority, improved access to primary care, retention of MCCF reimbursements and other reforms. VHA is currently in the last phase of its reform efforts, yet the budgetary dilemma is still not resolved. In spite of all the recently required reforms, VHA continues to fall behind in essential funding. Congress must examine other measures to strengthen VHA programs and services, but more importantly, it must address and resolve its budgetary dilemma.

The focus of the funding problem has been on VERA as demonstrated by the actions of several stakeholder groups. Recently Members of Congress and the Governors of several northeastern states sent a letter to President Clinton describing untenable conditions at their respective VHA facilities. The letter asked President Clinton to support increased funding for the northeastern facilities. Obviously, this was a response to the adverse budgetary impact of VERA in that region of the country. However, as we review the conditions of the entire VHA, there are many parallels throughout the Nation. Even those VISNs that receive increased funding under VERA must continue to reduce staff size and create other efficiencies to adjust to the effects of increased costs. While VERA is a useful management tool, it can only distribute the limited budget that Congress provides.

There are many examples of reduced programs and services throughout VHA. The net effect is that the system cannot adjust and respond to all exigencies while operating under the strict Balanced Budget Act funding caps.

The American Legion proposes an increase in discretionary appropriations of \$1.4 billion for VHA in FY 2000. This amount will raise VHA funding to \$19.5 billion (including MCCF reimbursements) to provide expanded clinical initiatives, provide for medical inflation and employee cost-of-living increases, and provide needed care for aging veterans. To do anything less is unconscionable.

Mr. Chairman, there is a long history to VHA's current budget predicament. After several consecutive \$1 billion increases in medical care funding in the early 1990s, the Balanced Budget Act of 1997 has essentially eradicated earlier budgetary gains. In

constant dollars, VHA funding is no better off today than ten years ago. Awareness exists that the current and proposed FY 2000 VHA budgets are seriously over-extended. What is seriously lacking are constructive recommendations that concentrate on workable solutions rather than rehashing the problems. The American Legion sees a long-term solution within the GI Bill of Health.

THE GI BILL OF HEALTH

The American health care industry is much different today than at the end of World War II. Nevertheless, issues of primary importance to The American Legion regarding VA medical care are not much different.

The most significant issues of concern to The American Legion regarding the current and future VA health care system include:

- Funding,
- Quality of care,
- Access to care, and
- Special care programs

Mr. Chairman, in the early 1980s serious funding constraints began to negatively affect the delivery of VA care. In 1986, Congress instituted a means test and third-party reimbursement program to help stem the tide of funding shortfalls. At the beginning of the 1990s, eligibility restrictions impeded the delivery of cost-effective quality care, archaic management structures slowed system progress, and funding constraints became more acute, in spite of several \$1 billion increases to the VHA's budget under former Secretary Jesse Brown.

Despite an urgent need to address many internal issues, most efforts to reform and modernize VHA were put on hold in early 1993 when the Clinton Administration launched its efforts to reform the nation's health care system. The Administration's "Health Security Act" proposed sweeping changes not only for private health care, but also for government health care. VHA's need to modernize would have greatly benefited under the "Health Care Security Act." All of the major veterans service organizations provided the Administration with constructive input during the preparation of the health care proposal. Although the "Health Care Security Act" did not become law, it became the vehicle for the many changes that have occurred in managed care since that time.

After the "Health Care Security Act" collapsed in 1994, The American Legion developed its own legislative proposal for the revitalization of the VHA. Many of the recommendations of the "Health Care Security Act" were considered and included in the proposal. This effort culminated in the *GI Bill of Health*.

The *GI Bill of Health* is a blueprint for preparing VHA to meet the health care needs of America's veterans and their eligible dependents in the 21st Century Under the proposal:

- all veterans and their dependents would have access to the VA health care system;
- all priority veterans would receive health care treatment at no cost,
- all other veterans and dependents would pay for care,
- retains, expands access, and strengthens VA specialized treatment programs,
- VA would offer defined health benefit packages on a premium basis to all eligible veterans and dependents,
- VA would bill, collect, and retain all appropriate third-party reimbursements, co-payments, deductibles, and premiums -- where applicable,
- VA would create a health plan network consisting of public and private providers,
- VA would open access to more health care facilities within local communities through sharing agreements and contracts with public health care providers

The American Legion predicts the *GI Bill of Health* will follow a similar course as health care reform has followed in the private sector In the years since the "Health Care Security Act" failed, incremental reform continues to creep into the health care industry VHA has also experienced incremental changes, such as the Veterans Eligibility Reform Act of 1996 and new authorities gained under the Balanced Budget Agreement of 1997

Inherent in these reforms are several key components of the *GI Bill of Health* Certain proposals in the *GI Bill of Health* have already been implemented The *GI Bill of Health* components already enacted

- the streamlining of eligibility
- capitation (VERA),
- enrollment
- extension of care to all veterans (priority groups 1 through 7)
- retention of third-party reimbursement
- contracting outpatient services into the local community
- greater cooperation with DOD and
- a defined benefits package plan for enrollees

As a result of these actions, there are only two key components of the *GI Bill of Health* that still need to be enacted

- for VHA to gain the authority to treat veterans dependents, and
- the creation of a premium based plan

The enactment of the *GI Bill of Health* would direct VA to offer certain veterans on a premium basis a "standardized" core benefit package at least equivalent to the

enrollment benefit package offered to higher priority veterans. This health benefit package would be offered to those veterans who choose to enroll in a VA preferred provider health plan. The package could also be offered to eligible dependents on a premium basis. Beyond the core package, VA or private insurance companies could offer additional benefits, each with its own configuration of co-payments and deductibles. Premium-supported packages would offer an additional range of benefits to eligible veterans and provide VHA with a means to pay for that care.

The *GI Bill of Health* recognizes that there is only so much that can be accomplished to strengthen and preserve VA health care through an exclusive reliance on federal appropriations. Simply meeting medical care inflation, pharmaceutical cost increases and employee cost-of-living increases on a yearly basis requires upwards of \$800 million in new budget authority. Add to that the cost of new medical initiatives and other unanticipated expenses, and year-to-year cost increases are not sustainable.

In the short-term, additional discretionary appropriations will help support VHA's funding challenges. Over the long-term, the *GI Bill of Health* is VHA's best hope for meeting its funding requirements.

The *GI Bill of Health* proposes to integrate VA health care with the Nation's private medical providers and provide access to greater numbers of veterans, and certain dependents, using private health insurance. The *GI Bill of Health* also supports VHA's efforts to enact system wide Medicare subvention. These concepts are certainly worth the time and effort for the Subcommittee and the full Committee to explore.

GI BILL OF HEALTH TEST PILOT

Mr. Chairman, The American Legion followed up on your recommendation in the 105th Congress and now proposes that the next component of the *GI Bill of Health* that should be considered is expanding access to VHA services to veterans' dependents under the CHAMPVA provisions of Title 38 USC 1713.

The cry of the VA has long been the quotation from Abraham Lincoln, "To care for him who shall have borne the battle, and for his widow and his orphan." We say that, but when those spouses and children are sick, we leave them out on the street. The deplorable way the families of sick Gulf War veterans were treated only serves to exemplify this point. When these family members initially sought help from the VA for health care because of the hazards of war, they were turned away. As a Nation, we provide health care for military families while the service member is on active duty or upon retirement. The Veterans Benefits Administration (VBA) provides some benefits to family members, but VHA turns a blind eye to the health care needs of a veteran's family. We leave veterans, who choose to use VA, with little means of providing access to quality health care for their family members. We discriminate against veterans who are married and may have children.

The Department of Health and Human Services and Congress realizes that the Nation's children are too precious to leave uninsured. Working together they created the Children's Health Insurance Program (CHIP). The *GI Bill of Health* would allow VA to provide services under this program for children of veterans.

Many female veterans believe that if there were more women treated at VA, then health care delivery for them would improve as well. It only makes sense that programs that benefit female veterans would improve, if more women had access to VA. For instance, VA would have a greater incentive to increase mammography and OB/GYN services.

We also know that women would use the VA, not just because they have told The American Legion, but because they have also told VA. In a study conducted by the VA in San Francisco, CA, researchers found that "83% of spouses reported that they would choose to receive their medical care at VA if allowed to do so." This research group concluded, "Spouses of male veterans represented a sizable group that could be incorporated into the VA system, especially given their strong desire to do so." These are also the partners VA depends on to care for veterans at home. It is in the vested interest of VA to ensure these caregivers are healthy and well supported, if VA intends to shift its focal point of care to outpatient and keep disabled veterans home as long as possible. Females also tend to be younger and healthier than their male counterparts, and are usually the health care decision-makers in a family. This is a cohort that VA needs to capture, if it is to survive.

Currently, in the private sector, managed care succeeds because the organizations avoid adverse selection by maintaining a younger, healthier enrollee pool that offsets the costs for the more medically needy patients. Managed care organizations profit as their risk pools grow. In VA, this profit could be reinvested back into the health care delivery system since there is no expensive CEO or stockholders to pay. VA needs this influx of "healthy dollars" to increase its buying power. Providing care to veterans' dependents is not only an ethical matter, it is a financial necessity.

Dr. Kenneth Kizer, Under Secretary for Health, supports the notion that it makes sense for VHA to treat veterans' dependents. He goes on to support this key provision by stating, "There is no reason why that same physician couldn't treat the wife and husband as well! From the administrative side we have, by and large, the capacity to do that if we could retain the funds that would come with that, whether it was Medicare or private insurance or whatever. Those are marginal costs. We already are supporting the infrastructure, so in some cases if it meant adding on additional physicians or other providers that could be done relatively cheaply."

The American Legion recommends that a criterion be developed for selecting the best possible networks that could support this initiative. Several key issues to consider are geographic distribution of facilities, stakeholder support, and Critical Success Factors (Coopers and Lybrand, 1998). These factors are Leadership, Organization Structure, Accountability, Human Resource Management, and Technology.

MEDICARE SUBVENTION

The American Legion supports Medicare subvention for the treatment of nonservice-connected conditions of Medicare-eligible veterans within the VA health care system. Medicare-eligible veterans should be able to select VA as their primary health care provider under Medicare+Choice. Medicare-eligible veterans being treated for non service-connected conditions are currently billed by VA. VA cannot bill Medicare. Therefore, VA subsidizes Medicare. A veteran is financially penalized for going to VA rather than a private health care provider for the treatment of non service-connected conditions. VA can provide quality health care to Medicare-eligible veterans at a reduced rate, because of its infrastructure, economy of scale, and purchasing power

SUMMARY

It is painfully obvious to The American Legion that the Balanced Budget Act of 1997 is creating damaging effects throughout VHA. For the past two years, funding has been frozen at the FY 1997 level. Apart from insubstantial third-party reimbursements, Congress has not provided adequate funding for the medical programs and services of the Department

Funding for VA medical care is dangerously low, and VHA has not been able to meet its third-party reimbursement projections since enactment of the Balanced Budget Act. For FY 2000, the Administration once again presents unrealistic third-party reimbursement projections. The results of insufficient funding over the past several years will have its greatest impact during FY 2000. The Administration proposes to reduce full-time employment by nearly 7,000 positions in order to adjust to insufficient funding. If this happens, VHA facilities will be cutting into the bone, as there is no fat left to trim. Networks that lose FTE will be forced to close programs in order to protect patient safety. Veterans will have nowhere to go.

Many facilities have already closed programs without prior approval of Central Office. Others are planning to close inpatient services due to a low census. In many cases, a low census is not a reflection of patient demand but rather administrative actions. Instead of seeking to bring in new business as would be accomplished through the *G/ Bill of Health*, VA is making many irreversible decisions to downsize programs and services to save dollars.

For FY 2000, the Administration proposes \$17.3 billion in budget authority for medical care. This level is unchanged from current year services. In order to compensate for cost-of-living increases, medical inflation, new activations, and other clinical requirements, the Administration projects FY 2000 MCCF recoveries of approximately \$750 million. This is a projected increase of \$124 million above FY 1999.

For FY 1998, MCCF recoveries totaled \$560 million, with a cost obligation of \$102 million. Under the best of circumstances, it is highly doubtful that MCCF collections will

net \$750 million during FY 2000. Without a direct increase in federal discretionary appropriations for VHA programs and services in FY 2000, VHA will be forced to accelerate the recent downsizing and consolidation trends.

The American Legion acknowledges that over the past few years it was important to improve VHA's internal efficiencies rather than pump more dollars into an old system. However, there is no further room to improve internal efficiencies without damaging the core programs. It even appears that Members of Congress who are responsible for VHA oversight have come to the same conclusion. It is time to develop a premium support system to supplement taxpayer dollars to strengthen and maintain VHA.

Congress can no longer merely react to VHA's funding problems. During the hearings on eligibility reform a few years ago, The American Legion testified that the system would collapse upon itself if the funding mechanisms were not reformed along with eligibility. That is exactly what is occurring today.

The American Legion once again recommends that Congress closely examine the *GI Bill of Health*, and commit to pilot testing the proposal. A limited *GI Bill of Health* demonstration program can easily be incorporated into a Medicare subvention pilot program.

At a minimum, Congress must develop alternative approaches to ensure that veterans and service members have access to VA medical care paid for by either federal appropriations or through other revenue sources. Veterans deserve more than they are currently getting. These steps need to be taken in order for this Congress and the current Administration to protect the health care rights of this Nation's veterans.

Mr. Chairman, that completes this statement.

**The
American
Legion**



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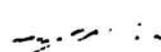
February 19, 1999

Honorable Cliff Stearns, Chairman
House Veterans' Affairs Subcommittee
on Health
338 Cannon House Office Building
Washington, DC 20515

Dear Chairman Stearns

The American Legion has not received any federal grants or contracts, during this year or in the last two years, from any agency or program relevant to the subject of the February 24, hearing concerning The Veterans Health Administration Budget Fiscal Year 2000

Sincerely,


Jacqueline Garrick, ACSW, Deputy Director
for Health Care
National Veterans Affairs
and Rehabilitation Commission

**Jacqueline Garrick, ACSW, CSW, CTS
Deputy Director, Health Care
National Veterans Affairs and Rehabilitation Commission
The American Legion**

Jacqueline Garrick received her BSW and MSW from Temple University in Philadelphia, PA. Upon completion of her master's, she returned to her native New York to become the Program Director for the Vietnam Veterans Resource Center. During her tenure, Ms. Garrick provided individual, group, and family therapy to Vietnam veterans and their dependents. In addition, she ran a program for incarcerated veterans, and began to present on Post Traumatic Stress Disorder (PTSD) for a variety of conferences, universities, and other professional meetings. Since then, she has presented on PTSD throughout the United States, Great Britain, Israel, and the Netherlands. Ms. Garrick became a consultant for Vietnam Seminars and Consulting in 1991, and developed a program for former Soviet Union military members who served in Afghanistan. As part of her consulting responsibilities, she created a self-help guide for these Russian veterans, and traveled extensively throughout the former Soviet Union to teach the techniques in the guide and educated the veterans about PTSD. When Ms. Garrick left her position in NY, she accepted a commission as a United States Army captain, and served as a social work officer at Walter Reed Army Medical Center. During that time, she provided counseling to soldiers who had served during the Gulf War, Somalia, and Haiti. In addition, she covered inpatient psychiatry, neurology, and ICU wards, and counseled soldiers, retirees, and their families on a myriad of issues ranging from end of life to domestic violence. Currently, Ms. Garrick is the Deputy Director for Health care at The American Legion. She is primarily responsible for developing and implementing The American Legion's positions on veterans health care issues.

*STATEMENT OF
 RICHARD A. WANNEMACHER, JR.
 ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
 OF THE
 DISABLED AMERICAN VETERANS
 BEFORE THE
 SUBCOMMITTEE ON HEALTH
 COMMITTEE ON VETERANS' AFFAIRS
 UNITED STATES HOUSE OF REPRESENTATIVES
 FEBRUARY 24, 1999*

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to appear before you to present the views of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary on the Administration's fiscal year (FY) 2000 health care budget for the Department of Veterans Affairs (VA).

For well over a decade, VA has been faced with the dilemma of ever-increasing demand for medical care and perennially inadequate, decremental budgets. This year is no different.

The DAV is one of four national veterans service organizations that called on the VA to release its plans to furlough employees, severely curtail or eliminate medical services and a list identifying VA medical centers that could be unnecessarily closed under the Administration's flat-lined fiscal year 2000 budget proposal. The nation's veterans should be allowed to know what services will be curtailed or eliminated and if their local VA medical center is going to be shut down under this restrictive budget. The current budget proposal is more than \$3 billion less than is needed to adequately serve the health needs of America's sick and disabled veterans. That is 15% less than what's needed to keep up with the demand for care and the equivalent of shutting down 26 VA medical centers.

In a memorandum to Veterans Affairs Secretary Togo D. West, Jr., VA Under Secretary for Health Dr. Kenneth W. Kizer said the VA faces "the very real prospect of...mandatory employee furloughs, severe curtailment of services or elimination of programs, and possible unnecessary facility closures." Where is the list of possible facility closures? Veterans and the citizens served by those VA medical centers have a right to know that their lives are going to be severely affected by such closings.

Because of various statutory and administrative barriers, veterans are denied adequate health care implicitly promised in connection with their military service.

The VA health delivery system must encompass, as a minimum:

- The assurance that health care quality is maintained and protected within the VA health care system;

- Entitlement to guaranteed access to a full continuum of care from preventive through hospice;
- Guaranteed funding through adequate appropriations;
- Fair and equitable distribution of resources in treating the greatest number of veterans having priority to VA health care;
- Provision of clinically necessary medications, supplies, prosthetic devices and other over-the-counter supplies;
- Preservation of VA's mission and role as a provider of special services in areas such as blindness, amputation, aging, mental health, and long-term care;
- Maintain the integrity of an independent health care delivery system as representing the primary responsible entity for the delivery of health care services to entitled veterans;
- Maintain an adequate workforce of highly skilled and trained health care providers who are adequately compensated;
- Maintain a strong veteran-focused research program; and
- Third party reimbursements which includes Medicare Subvention that supplements and does not supplant congressional appropriations.

For three consecutive years, the Administration has proposed that the VA's appropriation for health care delivery be flatlined. Along with this flatlined proposal were estimates as to the amount of additional revenues that could be obtained from private insurance companies for the care of nonservice-connected medical conditions.

Thankfully, the full Committee, under the leadership of Chairman Stump, and this subcommittee, under your able leadership, saw through the rhetoric and last year provided \$278.025 million above the Administration's fiscal year 1999 proposal.

This year, the Administration's proposed budget for VHA totals \$18.1 billion; however, this is not the real number either. The actual appropriated dollar amount VHA will receive is \$17.306 billion, the same level as appropriated last year.

The negligible increase is composed of anticipated collections from private (third-party) payers of \$749 million (an increase of \$124 million) over the amount VA is expected to collect this year.

We are very concerned about VA's ability to meet this goal, since the VA has never met its targets for third-party collections. The April 21, 1998, Coopers & Lybrand report indicated that:

"In Fiscal Year 1996, VHA sought recovery of about \$1.6 billion of its costs but only recovered 35 percent of the billed amount, or \$563 million. Not only was this a low dollar amount, it also represented a decrease of more than 5 percent under the previous year's collections."¹ The report goes on to note that in FY 1997 the MCCR recoveries were \$524 million and in FY 1998 to \$598 million. In comparing collections per VA medical center budget, it costs VHA \$0.34 to collect \$1.

This year's target of \$625 million is unrealistic. Under the current rate of collections, VA is not likely to achieve this year's level, nor will it achieve the targeted level of \$749 million for FY 2000. Under the best case scenario, that is a collection level based on the successful ratio of 1996, VA would be \$189 million short of its goal for FY 2000.

The perpetual volatility in the health care marketplace has made it more and more difficult for VA to make its collection quota. It is relatively easy to bill an insurer, but as VA's own numbers show, it is more difficult to collect. This is because a number of factors come into play. Currently, 85% of all insured Americans are under some form of managed care, and few insurers recognize VA as a network provider eligible for reimbursement. Additionally, the shift from inpatient to outpatient care continues to make collections more difficult. Because of the lower reimbursement rate for outpatient visits, VA must collect third-party reimbursement on approximately 20 outpatient bills to produce recoveries equivalent to one inpatient bill.

VA's billing system also exacerbates the collection problem. Although VA is working to change its antiquated billing system, many insurers will continue to deny claims if the claims are not based on actual charges. VA, however, continues to bill according to average costs.

It is important to note that the Treasury no longer guarantees to offset VA collection shortages. If the money is not collected, patients cannot be treated. VA is relying on collection to support its new workload, an expected increase of 54,000 patients in FY 2000. The question that must be asked is where is VA going to get the money to treat these new veterans when it is already hard pressed to take care of its current workload.

To generate savings and to be able to afford to take care of its patient workload, VA plans to reduce its staffing level by 7,830 employees. This reduction in staff also results in a reduction in the critical staff to patient ratio. As VA expands its outpatient services, the proposed budget calls for 89 more outpatient clinics to open, leaving only the sickest and most labor-intensive patients in VA beds. This is particularly troubling to the DAV because studies have shown a direct correlation between quality of care and patient staffing levels. It is the vigilance of professional nursing staff that prevents complications.

Quality is achieved when health care providers are given the freedom and resources to practice the most effective and scientifically proven medicine available. It should also be based on agreement about standards of care and the reduction of variations in practice. An integral part of health care requires the creation of a system that is patient focused coupled with procedures that ensure timely access to appropriate care.

¹ Coopers & Lybrand L.L.P., *VA MCCR National Study Cost Assessment and Best Practices 1-1* (Apr. 21, 1998)

DAV is currently conducting an independent survey of VA medical facilities. We have asked our 189 hospital service coordinators (HSC's) stationed throughout the nation to provide us with a monthly assessment of appointment scheduling times, scheduled appointment waiting times, and staffing ratios.

Our informal survey found that in December 1998, the average wait to see a physician at VA medical center was nearly 38 minutes. By January 1999, the average wait had increased to 42 minutes. The DAV's December survey contained the responses from DAV Hospital Service Coordinators (HSC'S) at 56 VA medical centers, while the January survey figures averaged the responses from 127 VA medical centers.

It took an average of 28 minutes for a veteran to see a physician's assistant in December, but waiting time grew to longer than 31 minutes in January. The wait for a nurse practitioner, however, fell from an average of almost 35 minutes in December to just over 32 minutes in January. Veterans seeing a nurse waited more than 20 minutes in December and an average of 2 minutes longer in January. The wait to have a prescription filled by a VA pharmacist increased by 4 minutes from 31 minutes in December to 35 minutes in January.

The survey indicates that the VA's health care system is suffering from the long-term effects of economic asphyxiation. The survey shows veterans are having to wait longer to see a VA health care professional for services, some must wait for months for a specialty clinic appointment.

The delays experienced by veterans are just one indication of how stagnant funding and an increased demand for services are stressing the VA health care system. As indicated, the survey was begun in December, well before the President released his fiscal year 2000 budget for the Department of Veterans Affairs.

The budget for VA health care funding, which has remained flat-lined and unable to keep up with inflation for years, will now require that 7,830 current VHA employees will be terminated from employment to pay for new health care proposals contained in the FY 2000 budget, such as expanded testing and treatment for Hepatitis C, expanded long-term care programs, improvements in programs for homeless veterans, and medical emergency care services.

On February 11, the full committee heard from members of the Independent Budget regarding all aspects of the budget, with the Paralyzed Veterans of America Executive Director Gordon Mansfield presenting the medical programs analysis. In Mr. Mansfield's testimony, he noted that staffing reductions will negatively impact all areas of health care administrative and clinical positions.

Currently, veterans report waiting months to see a specialist – a fact emphasized by a member of the Veterans Affairs Committee during the February 11 hearing. The budget inadequacies will also cause the rationing of prosthetics and durable goods in order to keep pace with these inadequate funding levels. Current VHA prosthetic's policy, based on budget constraints, requires that a VHA preferred vendor must provide services at a rate less than what Medicare pays for the same service or product.

Our question is: Since when does Medicare set the standard for VA services? And since when do the clinical needs of veterans fall below those of other segments of our society, especially when providing quality health care to combat disabled veterans?

The DAV was recently contacted by a 100% service connected combat disabled veteran attempted to use the prosthetics services of a vendor referred to him because this vendor provided quality products and services. However, this combat disabled amputee was told by the VA that the vendor he chose was required to obtain the appliance and provide the services at a cost of 14% to 16% less than what Medicare paid.

Mr. Chairman, the continuation a flatlined and inadequate budgets is already negatively impacting this Nation's sick and disabled veterans. It is clear that the cost of service is more important than providing quality assured health care.

Another example of how cost is negatively impacting the delivery of health care is in mental health services. It is our belief that VERA distorts the clinical strategic planning process for "high cost patients." VERA reimburses facilities at a rate of approximately \$38,000 per year per special category veteran (spinal cord injury; seriously mental illness; amputation and blind rehabilitation). For the seriously mentally ill (SMI) veteran who is in a long-term care bed, which costs \$100,000 or more annually, the facility administrators view the maintenance of these beds as an intrinsically losing proposition. It is not possible to turn over the beds 3 times a year (VERA break even point) for those veterans who truly need long-term care. Therefore, there is a very strong incentive to close such beds. There are many patients in those beds who really should be in the community, and this is certainly true through out the United States.

Clinicians may (or may not) be making all appropriate efforts to develop community support programs for these veterans, but the decisions about the very existence of long-term psychiatric beds are being made by administrators who are driven by the strong fiscal considerations inherent in a capitation model.

There are no known bed sizing methodologies for long-term SMI needs, so it becomes impossible to point to objective evidence that there are too few beds. We believe, clinical assessment of such needs has become secondary to fiscal assessment and that VERA has resulted in a rapid deinstitutionalization of SMI veterans. There has been no systematic effort to assess if this is done well or poorly. It may well vary from place to place. It is to be hoped that we are not contributing to the well-known trans-institutionalization from hospital to jails that some of the more poorly done state efforts have created (especially California, where the LA county jail is now the largest institution for individuals with schizophrenia in the country). Or to homelessness. Properly done, deinstitutionalization can, in certain cases, dramatically improve veterans lives, but it requires understanding, timely planning, and reinvestment of a significant proportion of inpatient resources into community support efforts. VHA has no idea what the current and near future impact really is. There is no ongoing assessment of reinvestment, and efforts to examine this have been resisted as promoting "special interests." VERA may force funding changes to occur faster than clinical changes can reasonably occur. This is particularly evident in the Northeast, which is being hit the hardest in the country, due to its distribution of long-term medical, nursing home and psychiatric beds. Even with clinical leadership committed to thoughtful and speedy return of institutionalized veterans to community settings, it still takes a

significant period of time to do this safely. There is no, repeat, no apparent process in place to assess what the clinical impact is likely to be of staff reductions occurring before beds are actually closed. It is dangerous to push the system to change by decreasing the staffing first.

We fully support the additional \$105.9 million and 459 employees provided for the improvement of access to long-term care services. We also support the recommendation of the Federal Advisory Committee on the Future of VA Long Term Care to triple VA's investment in enriched housing and Home and Community Based Care (H&CBC) over a 5 year period.

Our survey also found that contracts for veterans placed in non-VA community nursing homes were growing shorter. In December 1998, the average length of the contract for veterans placed in community nursing homes at VA expense was 3.6 months. The average contract for January 1999 was for 2.7 months.

The State Nursing Home Grant program is projected to be cut by 55 percent under the Administration's budget. This is truly a disregard for the Private Ryan's of World War II. Currently there is need for \$1.3 billion to fund planned state home construction projects. However, VA will be able to provide only \$40 million in grants or less than 3% of the current state need.

VA plans to increase outpatient care by \$587 million; this is almost a dollar-for-dollar shift from savings generated by reductions in inpatient care. Although we strongly support the expanded use of outpatient care, it appears that VA is making this shift without the necessary capital investment in such basics as supplies and equipment. In the FY 2000 budget, equipment purchases are reduced by 27 percent and land and structures by 37 percent. How can VA adequately support the addition of 89 new outpatient clinics without the necessary investment in the equipment, supplies, structures, and staff? This is another example of attempting to do a lot more with even less than before.

We are very concerned that the Administration's "Patient's Consumer Bill of Rights" excludes some veterans from having access to emergency health care. The Administration's fiscal year 2000 budget discriminates even within the veteran population by stating that only those who are compensably disabled should have access to emergency health care, even if your only health care provider is the Department of Veterans Affairs. There are approximately 3.1 million veterans who use VA services. Under this proposal only 940,000 veterans will have emergency services eligibility.

It is ironic that nearly one year ago, the President signed an executive order requiring Medicare, Medicaid, DOD, the Federal Employees Health Plan, and, we thought the VA, to provide emergency services to all of their enrollees or eligible beneficiaries. This does not appear to be the case. Under this budget, the Administration has carved away 2.1 million veterans and said that they can not have the same level of services as the other groups. The provision of emergency services is an issue of parity. Through a policy of exclusion from a service considered basic in any health plan, the Administration has put veterans last, not first.

The important medical and prosthetic budget has been frozen at this year's level of \$319 million. This is \$56 million less than the IB recommendation. It has been our hope that the VA

research budget would parallel the increases projected for the National Institute of Health (NIH) budget. Over the next 5 years, the NIH budget is expected to double. It is noteworthy that while the research projects are expected to stay at the FY 99 level of slightly over 2,100 projects, there will be almost 100 fewer people to support the various research initiatives. According to the VA, the loss of 98 employees will make the program more efficient. This is a particularly troubling recommendation because not only will there be fewer researchers engaged in actual research, but there will also be significantly less support coming from the medical care budget to support research activities, such as adequate lab facilities, equipment, and supplies. To make a bad story worse, researchers, because of increased patient care responsibilities, have less time to devote to important research efforts to improve the quality of life for veterans. Under the 30-20-10 formula, there are fewer doctors and more patients, consequently the VA research effort has become a casualty of trying to do more with less.

The budget reflects that one of the most critical issues facing the VA is Hepatitis C. The VA estimates that an additional \$135.7 million in new health care spending will occur in FY 2000. We applaud the Administration for taking the initial steps in identifying and treating this disease; however, the budget does not provide new funding for the testing and treatment of Hepatitis C.

Today, I have only touched on the major failings of the FY 2000 budget. I believe that there are countless other examples of the Administration's total lack of commitment to those who served this country in the Armed Forces. The huge staff reductions, coupled with inadequate resources, will cripple the VA's ability to provide high quality services to veterans. It is hard to understand in light of today's robust economy with a large surplus, that this Administration could have such a callous disregard for those who served.

Before closing though, I would like to point to the Transition Commission's recommendations. There are many fine and appropriate conclusions made by the Commission in identifying a more efficient means by which service members and their families can transition from military to civilian life. We do have some concerns, however. For instance, the Commission made many recommendations to combine VA and Department of Defense (DOD) health care funding, management, and delivery under one system. Obviously, veterans would not be well served by DOD because their needs would be secondary to weapons systems and institutional priorities of the defense establishment. If the recommendation envisions VA providing DOD's health care services, we note the VA's health care delivery system is already suffering from years of inadequate resources and has difficulty just meeting the needs of veterans.

The most disturbing comment made though deals with the treatment of service incurred medical conditions. The Commission recommends that the costs of treating service-connected disabilities be shifted to the private sector. Throughout our Nation's history, the costs of national defense have been the responsibility of the Federal Government. We cannot now, as a matter of Government convenience, merely abandon what is clearly a Government obligation. This would represent a departure from our core national values and is an insult to those who bear the risks and burdens of our national defense.

Another important issue affecting medical care is Medicare Subventions. DAV has historically called for the enactment of legislation for Medicare Reimbursement (Subvention) for the treatment of non-core group (category C) Medicare-eligible veterans.

During the last session of Congress Representatives Thomas and Stump, introduced H.R. 3828 the "Veterans Medicare Access Improvement Act of 1998."

As we noted last session we are concerned about any legislative proposal that would abrogate the VA's and Federal Government's responsibility by allowing a third party, in this case Medicare, to pay for service-connected medical conditions.

The Federal Government, through the VA, must always maintain its fiduciary responsibility and moral obligation to provide and maintain a health care delivery system to this Nation's service-connected disabled veteran. Therefore, enactment of legislation that diminishes and potentially eliminates that responsibility by allowing Medicare to pay for the treatment of service-connected conditions would abrogate the sacrifices made by the men and women who became disabled during military service.

The DAV has become aware of the *Decision Support System* (DSS) which provides VA the ability to compare VA department and facility practices to more efficient private sector practices. This system will also enable VA to maintain detailed provider and patient specific data and the capacity to budget, model and forecast. With this new found capability, a program could be developed which would ensure that Medicare and other third parties are not charged for the care of service connected conditions.

Therefore, the DAV is willing to sit down with appropriate congressional and VHA staffs to discuss legislation that is agreeable to all parties.

Mr. Chairman, Congress and the Administration must keep their promises to veterans by providing an adequate VA health care budget. VA must not be forced to rely on funds from private payers to cover the costs for caring for veterans. The cost of VA health care is a Federal responsibility and must be met in full by the Congress and the Administration. The Administration has let veterans down. It is now up to Congress to properly fund VA health care.

This concludes DAV's testimony on the FY 2000 VA health care budget. We hope our analyses of the issues and VA's funding needs will be helpful to you. We appreciate the opportunity to present our views, and we thank this subcommittee for its continuing support for this Nation's veterans.



DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

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

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

Curriculum Vitae
for
Richard A. Wannemacher, Jr.

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Biographical Data

Birth Date: September 30, 1948
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Military Service

U.S. Navy
Enlisted May 1967 and Disability Retired November 1969

Education

AAS Business Administration
BS Environmental Consumer Studies
Graduate Studies Business Administration

Relevant Experience

Associate Legislative Director, Disabled American Veterans (DAV), August 1996 to present

Assistant Supervisor DAV National Service Office Washington DC January 1995 through July 1996

Supervising National Service Officer DAV National Service Office Albany New York November 1980 through December 1995

DAV New York State Legislative Chairman June 1981 through December 1995

Associate National Service Officer DAV National Service Office Buffalo New York October 1978 through October 1980

THE INDEPENDENT BUDGET

A Budget for Veterans by Veterans

AN OPEN APPEAL TO EVERY MEMBER OF THE HOUSE AND SENATE

YOU SHOULD ASK TO SEE WHAT PLANS THE VA HAS TO REDUCE THE AVAILABILITY OF HEALTH CARE TO THE VETERANS YOU REPRESENT

Dear Member of Congress:

On behalf of the members of AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars, we are writing to alert you to a budget crisis facing the Department of Veterans Affairs Health Care System. Projected budget shortfalls and additional major reductions in the FY 2000 budget proposed by the Administration are forcing VA to make significant reductions and closures in veterans health care programs, services and facilities. We urge you to ask the VA what specific plans they have to reduce the availability of health care to the veterans you represent. We also urge you to restore funding for veterans health care to forestall additional major cuts and reductions in health services for sick and disabled veterans.

For the third year in a row, the Administration has proposed a straight-line appropriation for veterans health care in its FY 2000 budget request. This flat-line budget comes at a time of soaring health care costs and increasing health care needs of a rapidly aging veteran population. The projected shortfall has greatly alarmed VA health care managers, even prompting VA Under Secretary for Health, Dr. Kenneth W. Kizer, to make plans for an emergency reduction in services and programs this year in order to prepare for and avoid even more draconian cuts and facility closures next year.

On February 8th Dr. Kizer sent a memorandum to Secretary of Veterans Affairs Togo D. West, Jr. (enclosed) indicating that the FY 2000 request, including "\$1.4 billion in management efficiencies, poses very serious financial challenges which can be met only if decisive and timely actions are taken." According to the memo, these "decisive actions" centered on "certain strategic planning initiatives" and "recommendations for a variety of program adjustments, including facility integrations, bed reductions, and mission changes." Further, he states, "these changes are, or will be, accompanied by requests for reductions-in-force and staffing adjustments."

Dr. Kizer calls this situation "serious and precarious." He indicates that cuts must be made now to preclude even deeper cuts such as "mandatory employee furloughs, severe curtailment of services or elimination of programs, and possible unnecessary facility closures." Naturally we are concerned over the impact of the

A Joint Project of

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301/459-9600

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VETERANS OF FOREIGN WARS
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Washington, D.C. 20002

202/543-2239

FY 2000 budget recommendations. We have more immediate concern over what "strategic planning initiatives" VA is planning to implement now to make cuts and reductions in programs, services and facilities ostensibly to avoid deeper cuts next fiscal year. The VA has announced that massive reductions and changes need to be made, but has revealed no specific plan outlining just where, when and how these reductions in services and facilities will be made. We believe the veterans of this nation have a right to see this plan. We believe that you, as well, ought to be able to see this plan to know what changes are going to be made to veterans health care in you Congressional District and state.

We urge you to contact the Department of Veterans Affairs to ask them to reveal this plan.

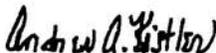
At the same time, as the FY 2000 budget and appropriation processes proceed, we ask for your emergency intervention and support sorely needed additional funding to the VA health care system to forestall major disruption in services this year and next.

Thank you for your continuing concern and support of our nation's veterans.

Sincerely,



Cecil R. Aultman
National Commander
AMVETS



Andrew A. Kistler
National Commander
Disabled American Veterans



Homer S. Townsend, Jr
National President
Paralyzed Veterans of America



Thomas A. Pouliot
Commander-in-Chief
Veterans of Foreign Wars
of the United States

**Department of
Veterans Affairs****Memorandum**

Date: FEB 8 1999
From: Under Secretary for Health (10)
Subject: FY 99/2000 VHA Budget
To: Secretary (00)

1. As you know, current VHA program projections indicate that the FY 99 budget is adequate to meet demands. However, the President's FY 2000 requested budget, and especially the \$1.4 billion of management efficiencies, poses very serious financial challenges which can be met only if decisive and timely actions are taken.
2. Strategic planning initiatives undertaken by VHA networks over the past year are culminating in recommendations for a variety of program adjustments, including facility integrations, bed reductions, program consolidations and mission changes, which reflect necessary shifts in patient care service delivery and practices.
3. In most cases, these changes are, or will be, accompanied by requests for reductions-in-force and staffing adjustments which will better configure our workforce to meet the changing needs of our patients and programs. While difficult, these changes are absolutely essential if we are to prepare ourselves for the limitations inherent in the proposed FY 2000 budget.
4. Please know that I believe we are in a serious and precarious situation and that if we do not institute these difficult changes in a timely manner, then we face the very real prospect of far more problematic decisions, e.g., mandatory employee furloughs, severe curtailment of services or elimination of programs, and possible unnecessary facility closures.
5. In short, the earlier we act in this fiscal year to take the necessary steps to position ourselves for next year's budget, the less likely we will be to face far more drastic and untenable actions in FY 2000.
6. I therefore request that we quickly establish a protocol for rapidly processing requests for actions to right-size the VHA healthcare system. Such a process should identify specific steps and associated timelines for assessing such requests, ensuring proper Congressional notification and issuing approval so that implementation actions can begin.
7. Again, I cannot overstate the need for timely action so as to avoid far more severe actions in the next fiscal year. I am prepared to discuss this with you at your convenience.


Kenneth W. Kizer, M.D., M.P.H.

**STATEMENT OF
HARLEY L. THOMAS, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
THE DEPARTMENT OF VETERANS AFFAIRS'
MEDICAL CARE BUDGET REQUEST
FOR FISCAL YEAR 2000**

FEBRUARY 24, 1999

Mr. Chairman, Ranking Democratic Member Gutierrez, and members of the Subcommittee, the Paralyzed Veterans of America (PVA) is honored, on behalf of our members to present our views on the Administration's Fiscal Year (FY) 2000 medical care budget request of the Department of Veterans Affairs (VA) health care system. Mr. Chairman, the Administration's FY 2000 budget "ignores the increasing cost of caring for veterans, especially the aging veterans of World War II who depend on VA health care." By once again proposing a straight-lined appropriation, the President is ignoring the true cost of health care for veterans, especially the more-costly care needed by our older veterans, our poorer veterans, and our veterans in need of specialized services, such as spinal cord dysfunction medicine.

Realistically, how can the VA sustain cuts of \$523 million in acute care, \$51 million in subacute care, \$159 million in psychiatric care, and \$21 million in rehabilitative care, including care for spinal cord dysfunction and still provide timely quality care for veterans? This budget ignores the very real cost of medical care inflation, and the increased costs associated with caring for an aging veteran population. Does anyone

truly believe that a dollar today will buy a dollar's worth of health care next year? How can capacity be maintained with fewer staff, fewer beds and fewer dollars?

The only increase in medical care funding envisioned by the Administration for next year lies in its estimate that third-party collections will increase by \$151 million. We have voiced our grave concerns regarding this funding scheme in the past, and we must reiterate them again today. By the VA's own admission, last year's estimated collections fell far short of expectations. Can we really expect this scheme to produce an additional \$151 million in FY2000?

Last year, the Under Secretary for Health was quoted in the *Washington Post* as saying, that without additional funding, the VA health care system would "hit the wall." It should, therefore, come as no surprise, this year, that the collision has already taken place. The Under Secretary for Health, in his February 8, 1999, memo to Secretary West announced his intention to begin massive cut backs in staffing and resources now to prepare for even larger cuts imposed by the disastrous FY 2000 budget. So called "strategic planning initiatives" such as program adjustments, facility integration's, bed reductions, consolidations and mission changes basically are designed to change and downgrade the VA health care system as we know it today.

In the early 1980s, President Ronald Reagan's first director of the Office of Management and Budget (OMB), David Stockman, revealed plans to gradually weaken and choke off funding for the VA health care system. Those plans were stopped. Today, President Clinton's Office of Management and Budget, in one open and overt stroke, is calling for, and presiding over, the demise of the VA health care system through intentional budget strangulation. OMB's crafty design is clear, to so weaken VA health care in one bold stroke that it potentially becomes impossible and too expensive to revive it.

How ironic that an Administration that claims so strongly to want to salvage Social Security and Medicare older Americans, would go after aging, sick and disabled veterans with such a vengeance. Realistically, veterans don't stop needing health care just

because OMB has decided they shouldn't have a hospital to go to. Where are the savings then to the Federal Government? Costs have just been shifted to other already overburdened federal and state health programs unless the care is denied altogether.

Based on *Independent Budget* projections the first step in this process would be to close the equivalent of 26 VA hospitals, including a reduction of nearly 8,000 health care staff, and erosion in the missions of scores of other facilities. Based on current law, VA can only provide health care to the number of veterans it has funding to care for. Under this scenario, tens of thousands of veterans seeking earned health care benefits will be turned away.

Obviously, VA already has its plan, as Dr. Kizer wrote in his February 8th memo -- the plan to "right size" the VA system. Rather than keeping this plan a secret, we believe the veterans of this nation and the Congress have a right to see it. How many hospital beds are going to be shut down? How many doctors, nurses and health care providers are going to be fired? Above all, which hospitals are going to close? Where are these closures going to take place -- In what areas of the country? In whose state? In whose Congressional District? Apart from the impact on veterans, we suppose the White House and OMB obviously think it makes sense to close VA hospitals and shut down health care for veterans right in the middle of the year 2000 election campaigns.

Last year Dr. Kizer said he wanted VA to be able to admit all veterans to the VA health care system. Clearly, that is not going to take place now. We want to see the "triage plan" showing just who is going to get into a VA hospital and who is going to be turned away at the door. All of these plans exist. We, as consumers of VA health care have a right to see them now to prepare our members for the dangers to their health and well being coming down the road.

At the same time the Administration is proposing flat-lining VA medical care funding, it is proposing a \$250 million program to expand testing and treatment for Hepatitis C

related illnesses in the veteran population. The budget calls for a \$50 million improvement in programs for homeless veterans. The budget calls for \$106 million for expanded long term care programs in home and community based services. The budget calls for \$244 million dollars in needed emergency care services. Although these services are badly needed, there are no new dollars to pay for them. To pay for the emergency care services, alone, the budget calls on VA to reduce health care staff by 1,500. Virtually all funding for these new initiatives must come from existing services and a budget already strained to the breaking point. In all, the Administration expects to achieve \$1.4 billion in what it calls "management efficiencies and savings." The VA is consistently being asked to do more with less. Under this budget proposal it is being asked to do more and more and more, with less and less and less.

This year, the Administration's requested appropriation is fully \$2.983 billion lower than the amount estimated by the *Independent Budget*, and is even \$2.428 billion lower than the core-appropriation without third-party collections "added back."

With the financing scheme embarked upon in FY 1998, dollars collected from third-parties were essentially "subtracted" from appropriated dollars. This short-changing of veterans must end. Third-party collections must not be substituted for appropriated dollars, but rather should be used as an alternative funding stream to begin to shore up problems encountered by VA reorganization, and to begin to address the long-term care needs of an increasingly elderly population of veterans. We ask that you assist us in restoring these cuts in appropriated dollars and work with us to use these collections to insure that the health care received by veterans is of the highest quality.

Mr. Chairman, as you are no doubt aware, PVA has continually expressed concerns regarding the VA's provision of specialized services, specifically care and treatment for veterans with spinal cord dysfunction. Beginning last summer we raised the issue of declining capacity and what we perceived as the VA's lack of emphasis for specialized services. The full House Committee on Veterans' Affairs responded to our concerns by

requiring VA to continue reporting on the maintenance of capacity for an additional two years and included statutory language establishing performance standards for VA managers regarding the provision of specialized services. For these efforts we thank you and the Congress for your responsiveness. Under Secretary for Health, Kenneth Kizer, M.D., also reacted to the issues we raised and on October 23, 1998, transmitted his proposal for the VA's spinal cord injury/disorders program to Secretary Togo D. West, Jr., who concurred in them. (Memoranda attached)

Mr. Chairman, Member of the Subcommittee, today, PVA must question whether these efforts and commitments are in vane do to the shortfalls in VA health care that we envision due to the President's budget. No matter what agreements are made, what laws are passed or the sincerity of promises, all will be negated by the anticipated absence of necessary resources if the President's budget proposal is not substantially altered. We call on you and all of Congress to recognize and act upon veterans' needs, not some fiscal scheme that abrogates this Nation's commitment to those who have served.

The Administration has requested an appropriation of \$61.2 million for Medical Administration and Miscellaneous Operating Expenses (MAMOEO), a decrease of \$1.8 million over last year. The *Independent Budget* recommends \$69 million. As health care quality issues become increasingly important, now is not the time to decrease staffing levels needed to monitor, report, and maintain quality. There must be an increased commitment to ensure that veterans receive the quality health care they have earned.

Once again we urge this Subcommittee and Congress to work toward achieving Medicare Subvention for the VA. We strongly believe that this is an important piece of the puzzle in achieving alternative funding streams. PVA believes that if achieved, these funding streams must not be used in lieu of appropriated dollars, rather they must be utilized to supplement appropriated dollars. We must work to ensure that real protections are built into the plan as it moves forward.

Finally, although we fully support a fee-for-service approach, we remain skeptical concerning the efficacy of a managed care approach in Medicare subvention, particularly for veterans with serious disabilities in need of ready access to specialized health care services. The needs of these veterans must be protected. Any managed care component of Medicare subvention must ensure that no higher-priority veteran is displaced and that the needs of disabled veterans are fully realized, and fully protected, in any managed care format.

We recognize that this Subcommittee does not appropriate dollars, but you do authorize them. The authorization process must recognize the real resource requirements of the VA. We look to you, and your expertise in veterans' issues, to help us carry this message forward, to your colleagues on the Budget and Appropriations Committees and to the public. This year, more so than ever, we need your help.

We ask for your assistance to ensure that the VA receives the funding it needs to ensure veterans who rely upon the VA for their health care needs are accorded adequate, quality health care. We ask that you work with us to make certain others in Congress realize the true resource needs of the system and that they do not rely solely on the pie-in-the-sky assumptions contained within the Administration's FY 2000 request. We ask you to reaffirm our Nation's covenant with veterans and to remain faithful to generations of promises. The health, the well being, and the lives of veterans are at stake.

Mr. Chairman, I thank you for this opportunity to testify. I will be happy to answer any questions you might have.

Department of
Veterans Affairs

Memorandum

October 23, 1998

Chief Health Care Consultant to the Secretary

Enhancements to VA Spinal Cord Injury/Disorders Program

The Secretary of Veterans Affairs

- n/p*
See accompanying memorandum
Agree!
1. In follow up to our discussions on October 19 and 20, 1998, the following actions are proposed to strengthen the management and oversight of VHA's Spinal Cord Injury/Disorders Program.
 - A. Centralize decision-making for SCI/D—program changes to VHA Headquarters. Any change to the SCI/D-program proposed by a field unit, including changes in mission, staffing, or bed level, will require the approval of the Under Secretary for Health (USH). In determining whether to approve or deny the proposed change the USH will review the matter with the Chief Consultant, Spinal Cord Injury/Disorders (SCI/D) Strategic Healthcare Group (SHG); Chief Officer, Patient Care Services; Chief Network Officer (CNO); and other entities as relevant to the specific proposed action under consideration.
 - B. National patient referral guidelines will be established so that patient referral policies and procedures are uniform across the VA health care system. These systemwide guidelines should help ensure that SCI specialty care is provided at the right time and right place each and every time. Dr. Margaret Hammond, Chief Consultant SCI/D SHG will be tasked to lead this effort.
 - C. SCI Health Care, Circular M-II, Part 24, will be revised and updated. Again, Dr Hammond will assume the lead for this major undertaking.
 - D. Augment the SCI/D Program staff. In an effort to enhance oversight and management of the SCI/D program, Dr. Hammond's support staff will be augmented by up to 2.0 FTEE, the work location of which (VAMC Seattle or VHA Headquarters) will be determined by her. In addition, a member of the Chief Network Officer's staff will be identified and tasked with being the "point person" for coordinating SCI/D related matters between the Chief Consultant SCI/D SHG, CNO and USH.
 - E. Include input from the Chief Consultant SCI/D SHG in determining the performance rating of both VAMC and VISN directors. This input will relate to the performance of these managers regarding patients having spinal cord disorders and the management of treatment units/programs providing services to such patients. In addition, the Chief Consultant SCI/D SHG will be added to VHA's Performance Measures Steering Committee.

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The Secretary of Veterans Affairs

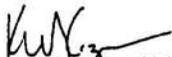
- F. Each VISN shall be required to promulgate an annual performance plan for its management of spinal cord injury/disorders. Such plans, which may be included as a discrete part of a VISN's overall performance plan or as a separate document, shall be specifically reviewed and commented upon by the Chief Consultant SCI/D SHG as part of the plan's approval process by VHA headquarters.
 - G. The Chief Consultant SCI/D SHG shall provide input to the appointing authority on both the selection and performance rating of SCI Unit Chiefs. The Chief Consultant SCI/D SHG shall have at least 2 weeks to develop such input. Disagreements between the Chief Consultant SCI/D SHG and the appointed authority that cannot be resolved between them shall be forwarded to the USH for resolution.
 - H. The Chief Consultant SCI/D SHG shall conduct an assessment of the success of SCI field units in meeting the needs of VA SCI/D patients and prepare a written report of his/her findings for the USH and the Secretary of Veterans Affairs at least once each year. This assessment shall include a detailed analysis of any failure to meet patients' needs and recommend actions for improving the program, as appropriate.
 - I. SCI operating beds will be removed from the performance measure for bed occupancy that is contained in the VISN directors' performance contracts, if this measure continues to be used.
 - J. Three performance measures related to SCI/D care will remain in the VISN Directors FY 1999 performance agreements. These measures are:
 - 1) admission within 24 hours for acute care, 2) appointment with a specialist in 7 days, and 3) transfer of semi-emergent care to an SCI unit within 2 weeks.
 - K. The expired VHA directive relating to nurse staffing for SCI Units will be reissued until the study noted below (paragraph 3) is completed.
2. Directives or other vehicles will be utilized, as appropriate, to effect the action items noted in paragraph 1 above.
3. Please know that several weeks ago I directed VHA's Chief Officer, Patient Care Services, to contract with an outside consultant to evaluate the capacity and quality of VA care for veterans with spinal cord dysfunction. I understand that this very comprehensive contract is about to be actualized.

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The Secretary of Veterans Affairs

4. Please further know that I do not intend to require the Chief Consultant SCI/D SHD to be based in Washington, D.C., since the current arrangement is working very satisfactorily and the advantages of having a clinically active chief consultant outweigh whatever perceived advantage may reside in having this person physically present in VHA Headquarters.
5. Please indicate whether you concur with the above action plan in the space below, and let me know if you wish to further discuss any of these issues.


Kenneth W. Kizer, M.D., M.P.H.

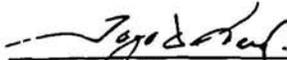
Approve/Disapprove

Date: _____

Comment:

Approved, as reflected in the

accompanying memorandum of 10/1/70.


Togo D. West, Jr.
The Secretary of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

November 13, 1998

MEMORANDUM FOR THE CHIEF HEALTH CARE CONSULTANT
TO THE SECRETARY

Subject: VA Spinal Cord Injury Program

I have reviewed your memorandum of October 23 1998 which proposes actions to implement the decisions of our October 20, 1998 meeting. As reflected by my signature and comment at the foot of your October 23 memorandum, I approve the actions described in the memorandum with the following additional considerations, which should become part of your planned program.

Paragraph I.D. describes a "point-person" for coordinating SCI/D matters between the Chief Consultant, the Chief Network Officer and, the Under Secretary to be located on the staff of the Chief Network Officer. It would be unfortunate if the "point-person" were to become a competing "expert" voice for SCI matters, thus confusing the lines of authority and communication that we are trying to establish for the Chief Consultant on SCI matters. Accordingly, the "point-person" position is to be structured so as not to substitute for the needed communication between the Chief Consultant, the Chief Network Officer and the Under Secretary on all spinal cord-related issues. More specifically, the effort must be to place the Chief Consultant in the loop that involves the Chief Network Officer and the networks under his authority on a day-to-day basis with respect to every spinal cord injury issue, decision, or discussion.

Paragraph I.H. requires the Chief Consultant to conduct an annual assessment of the success of SCI field units. I would prefer that each network officer conduct that assessment in the first instance, to include a self-assessment of how successful they have been in supporting the SCI units under their charge in carrying out their mission. These assessments, as a second step, to be provided to the Chief Consultant for her observations, comments and assessments. Combined by the Chief Consultant into one omnibus assessment for forwarding, her final product should be provided to the Under Secretary and the Secretary.

The study described in paragraph III of your memorandum was not addressed in our discussions. With that in mind, I require that the evaluation,

upon completion, be reviewed by the Chief Consultant and her comments and analysis added to it when it is forwarded for consideration by the Under Secretary and the Secretary.

As we discussed in our meeting on October 20, I am amenable to your desire not to require the Chief Consultant to be based in Washington D. C., but my decision in that respect extends only so long as the current incumbent holds the position. Should there come a time when Dr. Hammond is no longer the Chief Consultant, the issue as to whether the position should then be permanently located at VA Headquarters in Washington, D. C., is to be raised for decision to the Secretary of Veterans Affairs.

As always, your plan is thoughtful and thorough. Please share it with the Veterans Service Organizations, and consult with them as the actions it envisions unfold.

J. H. ...
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Harley Thomas

Harley is a veteran of twenty years military service in the United States Navy. During his military career, he spent a tour in Japan and in 1967 served in Vietnam with Fleet Air Reconnaissance Squadron One (VQ1). In 1968, Harley served aboard the USS Piedmont in support of fleet operations in Vietnam. Harley spent his final tour in the service with the Defense Communications Agency in Reston, VA, where he retired in February 1976 as a Chief Data Processing Technician. Following his military career, he worked in the computer industry as a senior system analyst until 1996. As a member of the Mountain States Chapter of PVA, Harley held the position of Director to PVA National, Chapter President, and Chapter Executive Director. Harley holds a degree in business from the University of Virginia. He is currently employed by the Paralyzed Veterans of America National Office, as an Associate Legislative Director.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 1998

General Services Administration—Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act, 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — \$15,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$243,912* (as of December 31, 1997).

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$63,656 (as of December 31, 1997)

Fiscal Year 1997

Architectural and Transportation Barriers Compliance Board— Develop illustrations for an Americans With Disabilities Act, 42 U.S.C. 12101, technical compliance manual— \$10,000.

Department of Veterans Affairs —Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$975,651.*

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$238,307.

Fiscal Year 1996

General Services Administration— Preparation and presentation of seminars regarding implementation and the Americans With Disabilities Act, 42 U.S.C. §12101,— \$25,000.

Federal Elections Commission— Survey accessible polling sites resulting from the enactment of the Voting Access for the Elderly and Handicapped Act of 1984, P.L. 98-435, — \$10,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$897,522.*

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program — \$200,965.

* This space is authorized by 38 U.S.C. § 5902. These figures are estimates derived by calculating square footage and associated utilities costs. It is our belief that this space does not constitute a federal grant or contract, but is included only for the convenience of the Committee.



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WITH
PRIDE

Statement of

Veronica A'zera
AMVETS Legislative Director

for the
House Veterans Affairs Subcommittee
On Health



Wednesday February 24, 1999
334 Cannon House Office Building

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Mr. Chairman, I am Veronica A'zera, national legislative director for AMVETS. We appreciate the opportunity to join with our distinguished colleagues from the veterans' community to provide testimony to the House Veterans Affairs Subcommittee on Health regarding the Department of Veterans Affairs (VA) medical care budget request for fiscal year 2000. Neither AMVETS nor myself has been the recipient of any federal grants or contracts during FY99 or the previous two years.

I won't spend a lot of time repeating what you already know. We realize we are preaching to the choir. But there are a few critical needs and facts about this potentially devastating budget proposal I would like to share. You may be able to use this information with your colleagues in our fight to get more adequate funding for our failing VA system. The Clinton/Gore Administration proposed budget for Department of Veterans Affairs for fiscal year 2000 is \$3 billion less than is needed to adequately address the health-care needs of our nation's veterans.

The budget shortfall is so significant that it imperils the health and benefits of millions of veterans. For example, currently, veterans with heart conditions may have to wait up to three months to see a specialist at a VA hospital because the VA health-care system has been operating for years under stagnant, inflation-racked budgets. Given the Administration's proposal, this situation will continue to worsen.

Another concern is that the VA budget plan proposes new health-care initiatives but provides no new dollars. VA is expanding health care and other benefits to veterans suffering from Hepatitis C-related illnesses, veterans in need of emergency care, and long-term care, yet the budget proposal cuts 8,000 VA health-care staff and hundreds of millions of existing budget dollars to pay for these initiatives.

In recent years, budgetary pressures have reduced acute-care bed capacity by 48 percent and staffing by 11 percent, while the number of patients treated increased by 10 percent. Although we have to commend VA for its new efficiencies with respect to ambulatory care and the reinvention of VHA, the subsequent downsizing of its medical programs has not been without serious consequences. The impact has been most pronounced upon the quality of care delivered, especially in the specialized programs such as (PTSD) Post Traumatic Stress Treatment, homeless, spinal cord injury care, treatment of seriously mentally ill veterans and long term care.

As I stated earlier, this does not come as a surprise to anyone on this committee. These are the same critical areas Congress asked the United States (GAO) Government Accounting Office to examine in its recently released report on "Major Management Challenges and Programs Risks" at DVA. The January report stated, "VA has not been able to adequately address congressional concern that VA maintain its level of certain high-cost specialized services in the face of the many initiatives to become a more efficient provider of care. The Congress required VA to ensure that its capacity for specialized treatment and rehabilitative services for certain conditions was not reduced below October 1996 levels and that veterans with these conditions had reasonable access to care."

If GAO can't say that VA meets this requirement, how can VA and the Administration say that they are meeting veterans needs? In 1999 we started our consultations early and met with the Office of Management and Budget to educate them on the critical issues facing VA. Their response at both meetings was a clear and resounding, "no additional funding needed, because according to the (GPRA) Government Performance Results Act indicators, VA is meeting all veteran needs."

This is clearly a case of one part of the government not communicating with the other. The GAO report came out in January, plenty of time before the budgets were set. It states, "VA lacks accurate, reliable, and consistent information for measuring the extent to which (1) veterans are receiving equitable access to care across the country, (2) all veterans enrolled in VA's health care system are receiving the care they need, and (3) VA is maintaining its capacity to care for special populations."

How is it that GAO knows this and VA/OMB/the Clinton/Gore Administration doesn't? I can understand them not wanting to take our word for it, but clearly here is an agency repeating what we already know to be true.

Here are the critical issues we informed OMB and the Clinton/Gore Administration about regarding VA:

⇒A medical care budget of \$20.3 billion in FY 2000.

Included in this amount are \$700 million for hepatitis C screening and \$550 million for emergency care services. We need to ensure that all enrolled veterans have access to the full continuum of services.

⇒Collections from third-party payers must supplement, not substitute for, medical care appropriations.

Forcing VA to rely on uncertain medical care cost recoveries puts VHA programs and veterans they serve at a dangerous risk. We also need to ensure that third party payments are only collected for the treatment of nonservice-connected conditions. We have received complaints about VA charging insurance companies for compensation and pension exams.

⇒Adequate funding to ensure greater access to long-term care services.

To meet the needs of this aging veteran population, VA budget must include sufficient resources to ensure that veterans have access to long-term care services. These services include nursing home care, state veterans' homes, assisted living adult day health care, assisted living and respite care.

⇒AS\$69 million budget for Medical Administration and Miscellaneous Operating Expenses (MAMOE).

This goes back to what GAO reported. Decentralization, reorganizations, budget cuts and efforts to reduce spending heighten the need to correct the deficiencies within VA's quality monitoring and assurance program.

⇒Adequate resources to ensure the provision of high quality services for veterans with specialized needs.

As acknowledged by Congress, these services must be preserved to ensure the integrity of VA health system. In addition to the list above this also includes Gulf War Illness, women veterans and blind rehabilitation.

⇒A medical and prosthetic research budget of \$375 million.

Additional funding for medical and prosthetic research is necessary to further enhance VA's research programs.

This is just a brief description of some of the critical issues. The Independent Budget, which this committee has been provided, goes into much greater detail than I can do justice in a matter of minutes.

In closing, I think it was really ironic that the same week the movie "Saving Private Ryan" was re-released, the Clinton/Gore Administration detrimental budget was released. We join you in the battle to save Private Ryan's healthcare. It's a battle we've been fighting since the Balanced Budget Act of 1997 froze discretionary spending for a five-year period. The Private

Ryan veteran population is rapidly aging and in need of ongoing treatment for complex chronic conditions. Sadly for the veteran population, this budget crisis comes at a time when the need for VHA services has never been greater.

Thank you again for this opportunity and we look forward to working with you on these critical VA medical issues.



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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Submitted by

**George C. Duggins
National President
Vietnam Veterans of America**

**Before the
Subcommittee on Health
Committee on Veterans' Affairs**

Regarding

**The Fiscal Year 2000 Medical Care Budget Request
Of the United States Department of Veterans Affairs**

February 24, 1999

Mr. Chairman, my name is George C. Duggins, and I serve as National President of Vietnam Veterans of America (VVA). I appreciate the privilege of joining you here this morning. On behalf of all of our members, thank you for allowing Vietnam Veterans of America (VVA) the opportunity to present our views to you and your distinguished colleagues on the Subcommittee on Health of the Committee on Veterans Affairs in regard to the President's Budget Request for Veterans' Health Care for Fiscal Year 2000.

I wish to note that we are perplexed as how to even begin to respond to the proposed request for FY 2000 for the Veterans Health Care system, as it is so woefully inadequate that nothing in our collective memory at VVA even comes close by comparison.

As you know, Vietnam Veterans of America (VVA) has expressed deep concern about the leadership of the United States Department of Veterans Affairs in regard to the health care services in the recent past. We have expressed particular concern in regard to the operation of the "Special Services Programs" such as treatment for the Blind and Visually Impaired, Spinal Cord Injury, Prosthetics, the program for Seriously, Mentally Ill, and the programs designed to effectively deal with Post Traumatic Stress Disorder and other neuro-psychiatric wounds of war. This VA budget request for FY 2000 only intensifies those deep concerns.

The Veterans Health Administration (VHA), as the system of VA Medical Centers, Outpatient Clinics, Community Care Facilities, and VA Vet Centers is known, is a sprawling and vast collection of sites designed to deliver a multitude of medical treatment and care, and related services. VVA grants that it is difficult to manage such a large system, but we do believe that it is possible to do a much better job than has always been the case in the past, if there are adequate resources available to accomplish the mission.

VVA believes that the central core of the budget problem facing all of us who care deeply about the delivery of quality care to veterans is simply this:

The VA medical structure is set up to allocate resources utilizing a prospective payment model. However, this prospective payment model is within a closed system. If one puts too few resources into this closed system, the increased competition for resources will start to choke off needed resources to the smaller parts of the system (which has been the case for the past two years, and is certainly the case in FY 1999). If far too few resources are put into the system (as is proposed in the Administration's FY 2000 budget submission), then the system begins to cannibalize itself in truly major ways, straining the overall system to the point of possible collapse.

Certainly the VA itself recognizes this fact, which we believe is why the VHA reportedly submitted a request to the President's Office of Management & Budget (OMB) that was between \$19.4 Billion and \$19.6 Billion for FY 2000.

It simply strains credulity that the very bright people at OMB and on the staff of the President and

Vice President are unaware of what such a grossly inadequate estimate of requested funds would do to medical care for veterans, and the additional strain this would place on an already brittle and very stressed system. One has to wonder whether this was a calculated move, possibly taken in the wake of defeat of the veterans community over funding the Transportation Act of 1998 using what we still maintain are illusory in regard to not paying compensation benefits to veterans injured by tobacco use that originated in military service, "saving" up to \$15 Million from veterans benefits (although the funds are real) We do not know the answers to any of these speculations, nor in the end does it really matter for the veteran in vital need of medical care and services. Many veterans entitled to quality medical care find such services unobtainable today. Many more will find the chances of obtaining medical care and services even more remote if this budget request is not dramatically increased.

It is now public knowledge that VHA does not have the money to maintain the system as currently configured because of a significant shortfall in operating resources in the current year (FY 1999) VHA has asked for authority to move forward with cutbacks that include closing of facilities and shifting or reducing staff beginning immediately. It is our understanding that approximately forty sites are already authorized for such actions. In the wake of the testimony of Secretary West presenting the request to the full Committee on Veterans Affairs on February 11, it is now common knowledge that VHA requested authority to proceed with planning for additional reductions to deal with a shortfall of at least \$1.4 Billion (apparently to be dealt with by what is euphemistically called "management efficiencies") in what was already a system preparing for significant retrenchment.

To say that we find all of the above disappointing would be to understate the reactions of our members and leaders from around the country. The failure to forthrightly deal with the extraordinary changes and challenges confronting the VA medical system in strong clear terms, and to exhibit the leadership necessary to secure the necessary resources to accomplish the mission is simply breathtaking.

If the VA request for FY 2000 funds had been two to three Billion dollars more than it actually is, I would be here today lauding the stated commitment to move forthrightly to vigorously test, treat, and compensate for the significant problem of Hepatitis C in Vietnam veterans, which was likely acquired as a result of military service. If this was really an additional \$ 136 Million for this purpose, I would be joyous. VVA feels that Hepatitis C is a serious enough problem that we are joining with the Honorable Vic Snyder and the Honorable Olympia Snowe, and our colleagues at the Veterans of Foreign Wars of the U.S. (VFW) to ensure the continuity of efforts to deal with this critical problem. I would prefer to be here today to applaud the first steps in the right direction in regard to the VA plan to commit an additional \$40 Million toward assisting homeless veterans, and to increase long term care by at least \$105 Million.

Although I am honored and pleased to be here this morning to share our views with you and your distinguished colleagues, I am not elated to have to share our dismay. I am puzzled as to where the money to do all of the fine initiatives described above is going to come from if this request is enacted as submitted. We have studied the VA's six volume budget submittal, and will continue to do so in

the coming months, to try and find the answers we seek. However, it now appears to us at VVA that this is a budget submittal that quite simply "does not add up"

Vietnam Veterans of America does agree with those who say that the VA can do a better job of utilizing the funds they do have to accomplish their core mission of "Caring for him (or her) who hath borne the battle, and for his widow and orphans." First, it has been reported to me that one of the reasons why OMB reduced the request of VHA is that VHA finished FY 1998 with approximately \$600 Million in "savings." We stress that these so called "savings" represent veterans who did not get help for neuro-psychiatric wounds of war and are still an untapped economic resource languishing in public shelters or on the street because there was no effective substance abuse treatment available. These "savings" represent veterans suffering from Post Traumatic Stress Disorder, rated by the VA at 100% total and permanent disability who can only see a psychiatrist once every four months, for forty minutes (and many others who never get any such treatment at all). These "savings" represent the aged World War II veteran who is denied a motorized wheelchair, even though he no longer has the arm strength to be truly mobile in his hand propelled chair. In short, these "savings" represent legitimate services that could be delivered effectively to veterans (including service connected disabled) that would help them achieve the greatest degree of wellness and autonomy possible.

These so called "savings" frankly make us angry, Mr Chairman. To place them in context, we understand that VISN I alone returned over \$130 Million in "savings." At least in part due to these "savings" the VISN Director could earn a bonus that may be as high as \$ 80,000, over and above that individual's salary, which itself approaches that of a Member of Congress. To place these savings in perspective, a good deal of energy, passion, and thought has emanated from the recommendation of the Servicemembers Transition Commission that the veterans' employment system be closely scrutinized and quite possibly overhauled. Your distinguished colleagues on the Subcommittee on Benefits are considering this issue as they review the budget submittal for the Veterans Employment and Training System (VETS) just down the hall, as we speak here today.

The so called "savings" from Region I alone would pay for most of the DVOPs (Disabled Veteran Outreach Program workers) and LVERs (Local Veterans Employment Representatives) for the entire country, just from these six tiny New England states! Imagine what must be happening to the veterans in those six states whose only option for any medical care whatsoever is within the VA medical system. We believe that to let this amount of money go unutilized for the purpose intended by the people of the United States as expressed by our Members of Congress, in the face of such vital need, is simply irresponsible.

Vietnam Veterans of America holds that the purpose of the VA medical system is literally what is stated in their motto, which is "To care for he (or she) who hath borne the battle, his widow and his orphan." To accomplish this mission statement, one has to establish a "Veterans Health Care System" that is focused on the needs the individual has as a veteran. One cannot possibly do this effectively if you do not take a complete military history, do a psychosocial work up where indicated, and test for such conditions and illnesses as the individual might well have been exposed because of the era of the military service, branch of service, duty stations (e.g., Vietnam theater of operations), military

occupational specialty, etc. Perhaps the most glaring example of this is Hepatitis C for Vietnam veterans, but there are many more such conditions such as strongyloides and melioidiasis for those who served on the ground in Vietnam, other tropical diseases for World War II veterans who served in the South Pacific, and "workplace hazards" specific to what the veteran did in military service to country, and when and where he or she did it.

This taking of a military and medical history is just plain common sense, and it is also good practice of medicine. It is absolutely necessary if we are committed to a "wellness" model of returning the individual to the highest degree of self sufficiency and autonomy possible. VVA holds that this not only makes sense, it is our duty as a Nation to do this right. Further, we believe that it should be the explicitly stated goal of every veterans program to help the individual become as self sufficient as possible, and to us this means assisting the individual return to a state of readiness where he or she can obtain and sustain meaningful work. This may not be possible to achieve in every instance, but it should be the goal.

All of the medical experts will tell you that if one practices medicine in such a way as to help the person achieve "wellness" as opposed to just performing medical procedures for the immediate complaint reported by the patient, then it results in less overall cost to the system. The studies done at West Los Angeles VA Medical Center in regard to taking a true "holistic" approach would seem to bear out the cost savings that occur within the Fiscal Year alone, never mind the future years. If the system can be made to systematically concentrate on the needs of veterans as veterans in a rigorously holistic manner, then we will reduce "churning" and prevent many chronic problems from becoming so acute that repeated and/or prolonged inpatient care is required.

I look forward to elaborating on these points thirty days from today, when I present our legislative agenda to you and to your distinguished colleagues from both the Senate and the House of Representatives. The point I wish to make here is that we do believe that VA can use the money it has more efficiently and (even more importantly) much more effectively.

Having noted all of the above, the question that confronts us today is how do we break out of the dilemma we are in as regard to securing enough resources to keep the system going long enough to discuss and debate how to make it work better to accomplish the goals we all share.

Some believe that the way to go with the delivery of care is to privatize it in some manner. That is an option that clearly worked to make the World War II GI Bill the most cost effective investment of a program ever enacted by our Nation's Congress. VVA would point out that VHA already contracts out more than one Billion dollars in services already, and even has a pilot program in operation for contracting out compensation and pension exams. While this path holds promise in the view of some, it also is anathema in the view of others. The strongly held differences of opinion exist within the Domestic Policy Council and OMB, with the veterans' community, the public, and within the Congress. VVA would point out that the same sharp differences of opinion surrounded the decision of General Bradley to affiliate VA Hospitals with the medical schools in the period immediately after World War II.

Nevertheless, this is not our immediate task to discuss this issue. There must be a viable entity to discuss, and that requires sufficient resources. What is clear is that there will continue to be a need for a strong VA health care system as an anchor and central means of both delivering truly high quality care and ensuring the highest possible medical care to veterans ~~as~~ veterans. It is in everyone's interest who cares about the future of our country, and therefore cares about veterans, to ensure that there are enough resources available to maintain this activity, whatever form it may take in the future.

The ordinary processes of the Congress in the making of a budget will not be such as to allow for the adding of the \$2.5 to \$3 Billion it will take just to preserve enough organizational capacity to deliver even the current state of medical care to America's veterans while we seek to chart the ways to improve the delivery of the best possible medical care to veterans in the future. In the "business as usual" scenario, it is unlikely that much more than \$300 to \$500 Million will be added to the Administration's woefully inadequate request for health care, inasmuch as the budget process is played as a "zero sum game," and any money not requested by the President must come from somewhere else.

Mr. Chairman, Vietnam Veterans of America urges that you join with Chairman Walsh of the Subcommittee on Appropriations, as well as the distinguished Chairmen of your respective Committees and your distinguished colleagues on both sides of the aisle to mobilize both the Republican and the Democratic leadership to find a way to fund the VHA at a level of at least \$20 Billion.

We point out that funding VHA at more than \$20 Billion would still be less of a percentage increase than that accorded to Medicare over the last decade, the Federal portion of Medicaid over the last decade, and significantly less than medical inflation over a similar period of time.

If quick agreement does not appear likely here in the Congress, then perhaps enough support can be mustered within the Congress for an alternative approach to take the unprecedented step of sending the entire VA budget submission back to the Administration and give them some time to get themselves better organized, with a charge to come back to the Congress with a more reasonable and thoughtful submission within forty-five days. This would still give the Congress time to adequately consider such a reasonable request.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer any questions that you may have of me. Again, Vietnam Veterans of America thanks you and the distinguished Members of this Subcommittee for your tenacious leadership on so many veterans' health care issues and for considering our views on this issue of vital importance to veterans of every generation.



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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

GEORGE C. DUGGINS National President

George C. Duggins, the national president of Vietnam Veterans of America, is 54 years old and lives in Chesapeake, Virginia. Mr. Duggins served with the U.S. Army Security Agency (ASA) from July 1965 to April 1969, attaining the rank of Specialist Five. Mr. Duggins served two tours in Vietnam: with the ASA in Phu Bai from May 1966 to December 1967, and in Pleiku from April 1968 to April 1969. After his second tour, Mr. Duggins was honorably discharged.

A graduate of Tidewater Community College with a degree in computer technology, Mr. Duggins has been a long-time veterans advocate and has received numerous awards for his service to veterans. He is a life member of Vietnam Veterans of America, holding membership in VVA's Tidewater, Virginia, Chapter 48. Mr. Duggins has been on VVA's national Board of Directors, has served as national chair of VVA's membership, credentials, convention, scholarship, and minority affairs committees. Duggins was elected VVA National President in 1997, following his 1995 election to the position of national Vice President and ascendance to fulfill a vacancy in the position of National President. In 1996, he was a member of an official U.S. delegation sent to Vietnam, Laos, and Cambodia by President Clinton to investigate the POW/MIA issue.

Mr. Duggins is the past chair of the City of Chesapeake's Mayors Committee on Veterans Affairs and is the chairman of the Board of Trustees at Metropolitan A.M.E. Zion Church. He also serves on the Citizens Advisory Board for Huntsman's Chemicals and the Aeolin Club.

Mr. Duggins is employed at OPTIONS Health Care, Inc., in Norfolk, Virginia, as a computer analyst/programmer. OPTIONS Health Care is a national managed behavioral health care company and is the official coordinator of behavioral health care for the U.S. military in the Hampton Roads, Virginia, area and at Fort Bragg, North Carolina. In partnership with Humana, OPTIONS delivers health care to more than one million military beneficiaries throughout the southeastern United States.

Mr. Duggins is married to the former Blanche L. Neal. They have two daughters, Stacey Davida, who attends Virginia Tech University, and Shana Tennell, a senior at Oscar Smith High School in Chesapeake.



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FUNDING STATEMENT

February 24, 1999

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**Responses to Follow-up Questions
Concerning the February 24, 1999, Hearing**

**for
Dr. Thomas L. Garthwaite,
Deputy Under Secretary for Health
Department of Veterans Affairs**

**from
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives**

1. Dr. Garthwaite, everyone up here realizes that you have a tough job coming here to defend a budget that is \$1.2 billion short of what VA originally identified its needs to be this year. That said, I really take exception to VA coming to Congress and stating that it has received "increases" for any of its initiatives—Hepatitis C, homeless veterans or long-term care alternative programs, with the possible exception of the Smoking Cessation program.

How can you justify this use of the term when it is clear you are really going to have to redirect funding from other essential programs? How many hospitals will have to close in FY 2000? How many beds?

Answer: The President's budget assumes resources will be freed up from management efficiencies and redirected toward the initiatives outlined in the budget. These initiatives do not constitute budget "increases", but are "increases" to the individual programs that will receive these redirected funds. Additional funding through increases in alternative revenues and funds available from prior years (e.g., no-year MCCF funds), afforded through effective resource management, will also be applied to pay for these initiatives and anticipated cost increases in FY 2000.

Because of VHA's decentralized decision structure, the specific management initiatives will be decided by the VISNs. This will be accomplished in large measure by continuing to improve clinical processes. In part, this entails a shift to more appropriate care settings, including the shift of excess acute inpatient resources to expand and enhance outpatient and long-term care services for veterans. Another part relates to care management, prevention, and rational use of therapies. Continuing efforts to re-engineer our health delivery systems and our commercial practice initiatives (including a new initiative on inventory management) will also contribute additional savings. As a result of these management efficiencies we have, in the past, been able to increase total patients and outpatient visits and improve our customer satisfaction scores and quality of care performance. We do not currently have plans for hospital closures. We will continue to evaluate the need for both hospitals and beds to ensure the efficient use of available resources.

2. VA is now using a number of fairly restrictive utilization review tools, such as Interqual, to control bed use and to identify appropriate clinical placements. Under the proposed budget, it appears VA will have to continue to tighten the screws. Has this Committee been misled over the years in believing that there are reasons for the discrepancies between treatment patterns for similar diagnoses in the private sector and VA?

Answer: Interqual is not used to control bed use. It is a standard tool used in VA and throughout the non-VA health care sector to assess whether patients are receiving treatment at the appropriate level of care, i.e., acute, sub-acute, observation, etc. We do not believe VA misled the Committee. On the average, VA patients are sicker, older and with more complicating conditions than the

average private sector patient. The tools we use for Utilization Review adjust for some of these differences and VA clinicians, through their individual assessments of the patient's needs, adjust for the remaining differences.

3. Will VA ever be able to accommodate exactly the same standards?

Answer: While VA is already using the same utilization review standards as the private sector, for direct comparisons to be made regarding "standards," we believe adjustments would be necessary for "risk." The Interqual model serves as one of several guides used by a physician in determining the appropriate level of care for the patient. Patients using VA health care facilities are now, as in the past, generally older, poorer and sicker than patients who present at non-VA care facilities.

4. How are factors such as medical complexity, lack of social support and travel distance accommodated by utilization review models?

Answer: Interqual criteria adjust for complexity, but not for degree of social or family support or travel distance. The tool itself does not drive the treatment protocol. The patient's course of treatment, including whether to admit to an inpatient bed or schedule for outpatient care, is based on clinical findings as determined by the physician and the other health team members.

5. The President's Budget identifies 166 medical centers (p. 257, President's Budget) while VA is still maintaining it has 172 medical centers in 1999 (p. 2-83, 2000 Congressional Submission). There is also a significant discrepancy between the estimates of the number of ambulatory clinics VA will run at the end of the current fiscal year 544 (OMB) and 722 (VA) for the current year. What accounts for the significant differences in these numbers?

Answer: The use of 166 on page 257 is an error. The correct number of facilities is as follows:

	1998 Estimate	1999 Estimate	2000 Estimate
VA Hospitals	172	172	172
Outpatient Clinics	551	722	811

The difference of 171 between the 1998 Estimate [551] and 1999 Estimate [722] for Outpatient Clinics is anticipated clinic openings.

6. VA has announced an ambitious program to enhance its pain management and end-of-life care programs. I want to commend VA for identifying an unmet need, which could offer a model for the nation. Will VA have enough resources to fully implement this program if we enact the President's budget submission?

Answer: Over the past year, VHA has initiated system-wide strategies for improving end-of-life care and pain management for our veteran patients. These comprehensive strategies have taken advantage of the opportunities presented by a large, integrated health care system like VA to create far-reaching change. Many elements of these initiatives have already been implemented through re-engineering clinical practices and building on the available expertise of VA staff. We have also received generous grant support from the Robert Wood Johnson Foundation and the Alzheimer's Association for particular aspects of our initiatives. We are committed to pursuing full development of these strategies.

7. Veterans' advocates made serious allegations about VA employees trying to hide delays in prosthetics orders in a Subcommittee hearing last summer. While we have no way to corroborate these allegations, it certainly seems to indicate a systemic problem with processing prosthetic orders. Will VA be able to accommodate all of its prosthetic orders in a timely manner with the proposed budget?

Answer: We believe that delayed prosthetic orders were local and episodic due to personnel turnover issues and poor communication. We are currently examining the processes to look for opportunities to modernize and automate. With regard to the budget, the prosthetics program is expected to be funded at the level needed to meet patient needs. The prosthetics costs for FY 1998 were \$420 million (\$368 million in appliances and \$52 million in repairs). The President's budget includes \$498 million (\$440 million in appliances and \$58 million in repairs) in FY 1999; and, \$523 million (\$462 million in appliances and \$61 million in repairs) in FY 2000. To assure prompt attention to prosthetics funding needs, the Under Secretary for Health has directed the 22 Network Directors to inform the VHA Chief Financial Officer if, at any time during the fiscal year, they believe prosthetics spending will significantly deviate from current budget projections. VISN or Headquarters reserve funds will be used to meet any unbudgeted obligations in this program.

8. Please explain the benefits of a 5% 2-year budget carry-over in more detail.

Answer: Appropriation language is being proposed to provide two-year spending availability for up to 5 percent of medical care funding, excluding the funds for medical equipment that the Appropriations Act delays for obligation until the last quarter of the fiscal year. The two-year spending availability would:

- Provide additional flexibility for managers to operate on an ongoing continuum without the stops and starts that frequently occur under the current annual funding mechanisms;
- Help managers deal with the uncertainties about funding impacts of continuing efforts to restructure VA health care;
- Allow managers to make more rational business decisions due to increased ability to align spending with plans that extend beyond one year, i.e., base spending decisions on operational needs rather than the pending expiration of one-year resources.

9. Dr. Garthwaite, VA's Daily News Summary has several stories about delays in scheduling appointments and inappropriate waiting times. This seems to be a significant indicator of stress on the system. What kind of centralized system exists to identify waiting times for scheduling clinic appointments?

Answer: VHA identifies waiting times in two ways. First is the time lapse between the scheduled appointment time and the time the patient is seen by a clinician, often called "time to be seen." Second is the time lapse between the time a request is made for a non-emergent appointment to a clinic and the actual appointment date, often called "time to next available appointment." Patients with emergent conditions are scheduled by a phone call from one provider (usually a doctor) to another and often result in an "overbooking" of specialty clinic schedules. These personal interactions have not been captured in our data systems. Therefore, in the past, VHA has focused its data collection on non-emergent specialty clinic appointments. The time to next available appointment (or the time to any future appointment as dictated by the data collection protocol) is derived from the VISTA Scheduling Package in individual medical centers where the system is used to actually schedule appointments.

Another difficulty in collecting data on specialty and other clinic waiting times in the past was the fact that there is no uniform clinic naming system. Local facilities prefer flexibility in naming clinics because they often use the Scheduling Package to monitor clinician workload. Thus, they build templates that allow them to match clinicians with clinic workload. Having a large variety of names for clinics makes it difficult to compare activity between facilities and to aggregate data beyond the local facility. The challenge is to retain local flexibility while creating a data system that can generate valid, comparable data that can be used to monitor system-wide trends.

Another approach to obtain data on waiting times was VHA's "Primary Care Survey" which was first done in April 1996 and at six-month intervals thereafter until the last iteration in April 1998. These waiting times data were collected by individual facilities and self-reported to Headquarters. VHA has not collated these data at the VISN and national levels because of concerns about validity.

The short answer is that we do not presently have good data, but believe that we need to get it. The Office of Performance and Quality, in collaboration with the Chief Network office and the Performance Measures Workgroup is currently developing a long-term plan that will allow collection of statistically valid data. While the long-term plan is being developed, a short-term solution will be attempted in order to provide preliminary data. This solution will be based on the use of specific clinic identifiers as opposed to the usual "clinic stops" as the source of the data; a tentative plan is to generate data with this approach on a pilot basis within four months.

We are committed to reducing waiting times. Plans are in process to work with the Institute for Healthcare Improvement in Boston to address this issue. The final plan, which will include data collection timelines, will be completed in early May.

With regard to whether waiting times are an indicator of stress, I would suggest that waiting times have been an issue in VA for many years and are often an issue in the non-VA setting. Certainly, there are some instances where resource constraints impede solving the problem. However, common causes of excess waiting times include inefficient processes, poor communication, difficulties in recruiting specialists, and failure to match the patient's need with the appropriate provider.

10. Monday's Washington Post has an article that suggests another round of buyouts (linked to functions that could be contracted) is expected from agencies by June. Is VA in the process of putting together such a list? When will it be available?

Answer: Prior to the Washington Post's article, VA had surveyed its Headquarters and field facilities to ascertain their need for buyouts over the next five years. This survey was not specifically linked to the contracting issue. Based on the survey, VA is proposing legislation to authorize approximately 8,000 buyouts (voluntary separation incentives) over the next five years. VA believes that separation incentives can be an appropriate tool for those VA components that are redesigning their employment mix and for components that are restructuring and reengineering, as they move towards primary care and new methods of delivering services to veterans. We believe that VA used previous buyout authority conservatively, responsibly, and effectively. VA's previous use of buyouts significantly assisted VA in restructuring its workforce and enabled it to achieve downsizing and streamlining goals while minimizing adverse impact on employees.

**Responses to Follow-up Questions
Concerning the February 24, 1999, Hearing**

**for
Network Directors
Department of Veterans Affairs
(Ms. Laura Miller, Mr. James Faretta & Dr. Ted Galey)**

**from
The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives**

1. Please briefly outline changes in your long-term care programs for frail elderly veterans and for veterans with chronic and severe mental illness that have occurred since the Balanced Budget Act of 1997 locked VA into a "no growth" budget. Would you say overall that these changes have benefited veterans?

Answer from Ms. Miller: VISN 10 experienced a 3.7 percent budget increase from FY 97 to FY 99 due to our favorable workload performance and the outcomes in VERA. In addition, we have undertaken a variety of efficiencies that, up to this point, have allowed us to increase the veterans that we serve. We have maintained our capacity for care of the severely mentally ill and frail elderly veterans.

In regards to the frail elderly, a review of the patients treated in our domiciliary, nursing home, and community nursing home beds reveals a small net increase of patients treated from FY 97 to FY 98. Patients treated in the VA nursing home setting increased by 12.4 percent. It is our intent that, for new patient referrals, we will make every effort to meet the patient's needs in a way that doesn't result in their permanent institutionalization. To that end, we have added new case managers for some of our geriatric patients and have increased the focus on home care, residential care and adult day care services once patients are able to transition from the nursing home environment. These types of services are expected to increase from 24 to 35 percent of our long-term care budget. We are also supporting the efforts to establish a second state veterans home on VA grounds. For patients who have been nursing home patients in the VA for a period of years, a commitment has been made and will be maintained to continue to provide for their care on site.

VISN 10 has continued its commitment to the care of veterans with severe mental disorders. In FY 98, VISN 10 provided mental health care to 26,572 patients as compared to 23,606 patients in FY 97 (increase of 12.6 percent). During FY 98, we provided care to 6,682 patients service connected for a mental disorder, up from 6,202 in FY 97 (increase of 7.7 percent). It is also important to note that we increased the number of veterans treated for service connection for Post Traumatic Stress Disorder by 22.9 percent during a one year period. We have been able to accomplish these increases in the veterans we serve without a decrement in the quality of care provided by improving our delivery systems for the mentally ill, particularly by focusing on community based approaches. For example, we have initiated and completed a project to develop intensive community case management teams for the severely mentally ill at all of our VISN facilities. We have also included mental health services in all CBOCs in the Network, as a matter of policy, to assure that veterans with mental disorders can receive accessible care.

Although we have been able to stretch available dollars through increased efficiencies over the past two years, we are already noting a slowdown in our growth rate. We are faced with increasingly difficult issues of prioritizing funds among the many needs of the population of patients we treat. The frail elderly

and severely mentally ill are among our most expensive patients. New community approaches, when care is provided with the intensity called for, are still very expensive. New pharmacological advances in the care of these patients are also markedly more expensive than older generic drugs. We are gravely concerned with our ability to maintain our commitments within a flat budget scenario into the future.

Answer from Mr. Farsetta: With recent no-growth budgets and the significant VERA reductions that have occurred, the New York/New Jersey VISN 3 Network has been forced to review every program/service provided, specifically focussing on the costs associated with these programs.

The Network has managed to continue providing quality services to patients during the initial years of the budgetary cuts that have been sustained. During this time, we have actually served more veterans than in prior years. However, as indicated at the recent hearing, there is serious concern about how the cuts for the next fiscal year and beyond will impact the Network's ability to sustain and continue the services currently provided.

Long-term/Geriatric Care:

The Network has continued to provide quality care to our frail elderly veteran population. A network-wide task force has recommended and implemented many changes that have improved the access to and quality of services provided, while increasing the options available for our geriatric populations and their families. Some of these changes include:

- Implementation of a network-wide contract for home health services providing increased access to a wider range of home health services than previously available.
- Expansion in access to Contract Adult Day Health Care and Home Health Aide services.
- Growing use of HOPTEL programs (hotel-like rooms available in our hospitals) also assist frail elderly who have difficulty with frequent travel to and from the medical center for ambulatory care.
- Growing integration of Geriatric and Primary Care.
- Uniformity and standardization of admission processes and criteria to Extended Care programs across the VISN to assure a single standard of high quality care.
- Increase in non-institutional care as a discharge planning option.
- Increased availability of Rehabilitation care in the home setting.

Mental/Behavioral Health Care:

The Network Mental Health Task Force has worked to improve care to our veterans and continues to make recommendations that will ensure a seamless delivery of services to this fragile population. During these last years, we have made progress in our efforts towards treating mentally ill veterans. Some of the changes we have made are in the process of implementing include:

- Integrating all Domiciliaries (residential homeless veteran rehabilitation programs) under one leadership to establish them as a resource for the entire VISN.
- VISN 3's national award winning "Homeless Consortium" provides homeless veterans with an integrated approach to care, rehabilitation and housing working collaboratively with many community providers.
- Developing capacity to allow each facility to provide outpatient detoxification and have in-place a protocol for managing acute withdrawal.
- Increasing mental health outreach and services for each community clinic.
- Increase consumer involvement – each facility to establish a consumer consulting council. A customer satisfaction survey to be adopted for all mental

health services in VISN, including focus groups. A performance improvement team will review data from these sources and develop strategic performance improvement plans.

- The number of patients in long-term mental health inpatient units greater than 180 days will be reviewed for more clinically appropriate alternative levels of care.
- The VISN has moved and is moving from a "maintenance" to a "recovery" philosophy.
- Create a standard follow-up for discharged mental health patients to be seen or followed-up within 30 days.
- Integrating the newly funded Mentally Ill Research Education Clinic Center (MIRECC) into the mental health operational plan so as to enhance and evaluate our mental health programs to ensure continued delivery of high quality services.

Answer from Dr. Galey: Changes in VISN 20 Long Term Care programs since enactment of Balanced Budget Act of 1997:

- We have seen increased admissions to our medical centers, with shorter lengths of stay, and thus an increased demand for nursing home care. Patients who need nursing home care have more complex medical and mental health care needs than ever before.
- We have seen a dramatic change in the mission of Nursing Home Care Units, moving away from being a life long placement for veterans, and towards provision of transitional care, where the focus is on promoting the return of veterans to lower levels of care and community based living. The decreased lengths of stay have also enabled us to increase the actual number of veterans treated.

FY 96 - 1838 veterans received nursing home care

FY 97 - 2012 veterans received nursing home care

FY 98 - 2069 veterans received nursing home care

- The average cost of purchasing nursing home care in the community has continued to increase. We have had to shorten contract lengths for the Community Nursing Home Program, reducing VA funding for some veterans, while assuring access to others. We have seen a slight decline in the number of patients treated.

FY 96 - 1510 patients treated

FY 97 - 1441 patients treated

FY 98 - 1417 patients treated

- Demand for inpatient respite care in our nursing home care units has begun to exceed capacity for such care. The need for regular and transitional nursing home care competes with the need for respite care stays in these same nursing homes.
- Increased referral of veterans to Medicaid and Medicare for nursing home care. And this is at a time when the funding of these programs is being cut-back as well. Both have begun to limit payments from some high cost medications and for total parenteral nutrition. The local VA medical facilities then cover these costs.
- Increased collaboration with State VA Homes. However, some of these homes are not able to care for veterans with complex medical and/or mental health needs.
- Increase the number of veterans who are admitted to nursing homes from outpatient care.

We have expanded Home Care services:

- Implemented Homemaker/Home Health Aide services. However, the flat line budget has made it difficult to expand these services to more veterans.
- Implemented Home Parenteral Therapy Services, reducing need for hospitalization for patients on antibiotics, total parenteral therapy, and other forms of intravenous therapy. Costs for all pharmaceuticals have increased dramatically.
- We have increased collaboration with private, non-profit, and local community agencies as we seek new options for community based care for veterans. There is an increased awareness of staff about the various options available in our communities.
- We have reduced the number of veterans treated in adult day care, and are expanding the community and home based case management programs for these veterans.

Overall, have these changes benefited veterans?

Increasing home care services has been a great advantage to our veterans. Many veterans have received IV therapy at home, avoiding hospitalizations and prolonged lengths of stay. Veterans who receive Homemaker/Home Health aide services in their homes are able to stay at home when previously they would have required institutionalization for assistance in meeting personal care needs. An example of this is veterans who are ventilator dependent - formerly, these veterans required long-term hospital and nursing home care, but now some of these patients are able to live at home with the support of VA funded home health care.

Changes in the mission of VA operated Nursing Home Care Units has promoted access to this level of care. However, veterans who wish to reside in a VA operated nursing home for the remainder of their life no longer have that option, except when complex medical needs require this level of care.

VISN 20 has a much greater focus on keeping veterans out of the nursing home and on discharging veterans from nursing home to their homes or a less institutional setting whenever possible. We use a variety of community-based alternatives, including (but not limited to): foster homes, assisted living, residential care, and single room occupancy facilities. We have established collaborative relationships with the communities that our veterans reside in and believe that this promotes the maximum level of independence for the veterans.

Answers to Follow-up Questions for Mr. Thomas Trujillo
Former Director VISN 18

- 1. Mr. Trujillo, I appreciate your frank testimony today. You have shared a very interesting perspective with our Subcommittee. It seems you believe that VA is stretching itself too thin and perhaps taking on too many veteran patients. If you could make a determination about whom to treat in VISN 18 within the existing priority system, where would you draw the line?**

Congressman Evans, with the assumption that VA's budget would be straight lined and that VERA, in its current form, would be used to distribute the budget, VISN 18 would receive a slight increase of approximately \$15 million. This increase will not even cover the approved increase in salary cost much less the increased cost of materials and supplies.

In order to make up an additional \$30 million shortage, my best guess is that in VISN 18 Priority 7 and Priority 6 veterans would have to be denied care.

- 2. Would you say VA is inadequately prepared to respond to the growing need for long-term care?**

Congressman, in order to clarify the question in my mind I will address it from several perspectives. First, I have no doubt that we are adequately prepared from the point of view of quality of care and current capacity. Second, since long term care, and I am defining this as Nursing Home Care needs, fall in the may provide category, VISN 18 will provide long term care only within funds available.

Will the VISN meet all needs for long term care? The answer is no. VISN 18 is currently not meeting all long term care needs. The reason for this is because of having to make up an approximate shortfall of \$15 million. If funds were available, VISN 18 would be able to meet the growing need for long term care by utilizing both internal VHA as well as external private sector resources.

- 3. I worry that Medicare Subvention is being sold as something of a panacea to cure all of the system's funding ills. How much should we reasonably expect Medicare Subvention to help with maintaining VA services for its current users? A lot, a little, or not at all?**

Congressman Evans, I find it very difficult to address this issue objectively. It is my strong conviction that in order to continue to provide top quality care to our nation's veterans funds must be provided through an appropriation. Facilities must know what they can expect in order to appropriately plan what resources they will have to provide care with. Since Medicare Subvention is being proposed as a pilot and limited to \$50 million, according to my understanding, that will not help at all.

The system will have to make extensive preparations in order to comply with Medicare requirements. From my perspective that cost is too great. Veterans have earned care, they were promised care, and they deserve care. The mechanism to fund their care should not be complicated by bureaucratic maneuvering which detracts from what the VHA should be doing.

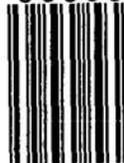
If the objective is to adequately fund VHA enough appropriated dollars should be made available from the very beginning and not have to waste resources in justifying transfer of funds. We should utilize those resources to appropriately continue documenting our quality of care.

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