

H.R. 1362 AND DRAFT BILLS REGARDING THIRD PARTY REIMBURSEMENT AND PHYSICIANS' SPE- CIAL PAY PROVISIONS

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

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H.R. 1362 AND DRAFT BILLS REGARDING THIRD PARTY REIMBURSEMENT AND PHY- SICIANS' SPECIAL PAY PROVISIONS

THURSDAY, MAY 8, 1997

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

The subcommittee met, pursuant to call, at 9:30 a.m., in room 340, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Cooksey, Gutierrez, Evans, Kennedy, Doyle, and Peterson.

Also Present: Representative Snyder.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning everybody. The Veterans' Health Subcommittee hearing on legislative proposals will convene. And to start off, I have an opening statement, and then I'll call on my colleagues.

In meeting recently with representatives of major veterans organizations, the number one concern I heard was VA health care funding. That concern also comes across loud and clear in our committee's report to the Budget Committee on the VA fiscal year 1998 medical care budget.

Our expression of concern, of course, was based largely on the Administration's unprecedented reliance on the so-called third-party collections to meet its budget needs for fiscal year 1998. There are many problems with this concept, not the least is that it asks for an appropriation of some \$600 million less than the Department acknowledges is needed.

I know many of my colleagues share my frustration with that budget and the Administration's implicit message that Congress will be to blame if it does not pass legislation to allow VA to retain third-party collections.

Our committee is on record as recommending that the VA medical care funding needs in the amount of \$17.6 billion be met through appropriations. Nothing has caused us to change that position. We are also on record as supporting retention of medical care cost recoveries as a mechanism to provide the VA with a new revenue stream.

With those considerations as our framework, we take up a draft bill today to allow VA to retain third-party collections.

The Department has set a goal of developing sufficient new revenues so that 10 percent of its funding would come from non-appropriated funds. In that connection, we will also take testimony today on H.R. 1362—a bill which many of our members have co-sponsored. That bill would establish a demonstration program to test Medicare reimbursement for VA care provided to certain Medicare eligible veterans.

Veterans have long advocated such a reimbursement plan, and it is time that this concept get a fair test. We welcome testimony on this important measure.

As we develop legislation to help address critical VA funding issues, we take note of the many changes underway in the VA health care system today. Among these changes we're seeing VA shift from a hospital-based system to one which relies increasingly on outpatient care. With that, we're also seeing some very real and disruptive downsizing. This raises some serious personnel issues, and we also look forward to testimony on a draft bill to address one of those issues.

We have three panels of witnesses this morning to offer views on these bills. But before we go on to our first panel, I'd like to recognize my friend, Mr. Gutierrez, the ranking member, for an opening statement.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you so much, Mr. Chairman. Thank you, Chairman Stearns, for convening this hearing to discuss Medicare and third-party reimbursements, and VA physicians' special pay legislation. The importance of these issues for the future of veterans' health care in our Nation cannot be overstated.

As the members of this committee know, the Department of Veterans Affairs has identified the collection of Medicare and third-party reimbursements as an important source of income to meet the future needs of veterans throughout America. It is part of their 30-20-10 plan. The VA intends to make up 10 percent of this funding from non-appropriated sources such as Medicare and third-party payments.

I was pleased that this committee agreed that fiscal year 1998 was too soon to depend on these reimbursements to make up for decreasing appropriations. However, the support of this committee, the Committee on Ways and Means, and both houses of Congress, is required for the VA to gain the authority to collect these non-appropriated resources. Prompt action is needed on the legislation we will discuss today.

The Chairman and I have discussed—are both original co-sponsors of H.R. 1362, the Veterans' Medicare Reimbursement Demonstration Act. H.R. 1362 is designed to enable the VA to provide care to Medicare eligible veterans without further burdening the existing VA health care infrastructure.

I am particularly pleased that this legislation will establish a fee for service structure instead of a managed care system. VA outpatient clinics are already extended beyond their designated capacity. Managed care may only contribute to more strains on the VA's outpatient system. The fee for service approach prevents this possi-

bility while ensuring that Medicare eligible veterans may still use their benefits at a VA medical facility.

In addition, this legislation may also save the Medicare Trust Fund 5 percent per year for services performed by the VA during the life of this demonstration project. This is a fact seemingly overlooked by CBO.

While I recognize the complexities inherent to Medicare subvention, the need to find additional resources for the VA to meet its obligations to veterans mandates that we make this option work. The best way to gauge the effects of subvention is by implementing this demonstration project. Third-party reimbursements are vital as well.

Currently, the VA has the authority to collect these payments, but is unable to retain a majority of these premiums. Instead, they are returned to the U.S. Treasury for deficit reduction under pay as you go restrictions.

I am hopeful that this committee and the 105th Congress will realize the need to allow the VA to keep these precious dollars. If we are truly committed to a more efficient, cost effective, and user friendly VA, then we must adequately fund the system throughout this period of transition. This is the most important and most responsible step we can take for the men and women who served and sacrificed in the Nation's armed forces.

I look forward to hearing from the panelists today addressing these issues.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank you.

Dr. Cooksey, would you have an opening statement?

Dr. COOKSEY. No.

Mr. STEARNS. Okay. We also welcome Dr. Snyder, if he has some opening comments. He is not a member, as I understand, of the panel, but he is certainly welcome to participate.

Mr. SNYDER. I wanted to thank you, Mr. Chairman, for letting me sit in on this hearing. You even have my name here and decaf coffee. I'm ready to roll. Thank you very much.

Mr. STEARNS. Thanks for your interest, and we welcome your participation.

With that, we'll start with panel number 1. We have Paul Vande Water, Assistant Director for Budget Analysis, Congressional Budget Office. Paul, we'll start with you first.

STATEMENTS OF PAUL N. VANDEWATER, ASSISTANT DIRECTOR FOR BUDGET ANALYSIS, CONGRESSIONAL BUDGET OFFICE; KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GREGG PANE, CHIEF POLICY, PLANNING, AND PERFORMANCE OFFICER, DEPARTMENT OF VETERANS AFFAIRS, AND WALTER HALL, ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; AND KATHLEEN A. BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF N. PAUL VANDEWATER

Mr. VAN DE WATER. Good morning, Mr. Chairman, members of the subcommittee. I am pleased to represent the Congressional Budget Office in this morning's hearing.

My testimony, as you indicated, will explain CBO's assessment of the budgetary effects of two pieces of pending legislation. The first is H.R. 1362, the bill to provide for Medicare subvention. The second is the draft legislation to allow VA to spend amounts it collects from designated third-party payments and user fees. From a budgetary point of view, the two proposals have several features in common.

First, both proposals would allow some VA medical care to be financed through direct or mandatory spending rather than through annual appropriations. In the case of H.R. 1362, VA would be given authority to spend money it collects from Medicare. In the case of the other proposal, VA would be allowed to spend the money it receives from certain nongovernmental sources.

Second, the additional mandatory resources provided to VA could either supplement or supplant existing discretionary spending, with the outcome depending on the result of future appropriation action.

Third, even if the additional mandatory spending did allow for lower discretionary appropriations in the future, the current budget enforcement rules do not allow a reduction in one category of spending to offset an increase in the other.

In the interest of time, Mr. Chairman, my oral remarks will focus on H.R. 1362, and I assume the full text of my statement will be printed in the record.

One of the legislative goals of H.R. 1362 is that the demonstration project would establish not increase either VA's or Medicare's costs. In theory, VA would continue to pay for the care it would provide under current law to beneficiaries eligible for Medicare. And Medicare would continue to pay for people currently receiving care in the private sector.

Medicare's costs would experience no net change, it is intended, because lower payments to private-sector providers would offset payments to VA. Similarly, VA's net costs would remain the same because the receipts from Medicare would be matched by higher outlays for the care it would provide to extra patients.

In practice, however, we think that assuring budget neutrality for Medicare would be difficult to achieve for three reasons.

First, although VA provides some services that are not covered by Medicare, the bill nevertheless includes those services in calculating VA's maintenance-of-effort level.

Second, even if that oversight were corrected, VA could understate the amount of its current and future workloads that was attributable to the targeted veterans.

And third, adjustments to the required level of effort provided in the bill could allow further shifting of costs from VA to Medicare in later years.

The likely outcome, therefore, would be higher Medicare costs. Determining how many Medicare beneficiaries receive care from VA is difficult enough in the short term. But that uncertainty only grows over time as populations change and the availability of discretionary funds varies.

VA and HHS also face different incentives and access to information. It would be difficult for the General Accounting Office, or any other auditing agency, to determine the financial outcome of the demonstration project. It, too, would need to rely on estimates and assumptions about events and behavior that would have been different under current law.

As introduced, H.R. 1362 would probably raise Medicare's costs by \$50 million a year or more. Because VA could count services that are not covered by Medicare toward its maintenance of effort, the cost could even exceed the cap set in the bill for Medicare's expenditures. Medicare would pay to private providers or VA for the costs of covered services that are provided and funded through VA under current law.

If the bill's language were modified to focus the maintenance-of-effort requirements only on services covered by Medicare, the bill would cost roughly half as much.

In conclusion, Mr. Chairman, both proposals would increase mandatory spending and would be subject to the pay-as-you-go procedures established in the Budget Enforcement Act. Those increases in mandatory spending would allow discretionary authorization to decline by the same amount. Whether discretionary savings would actually occur, however, would depend on annual appropriations action.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Van de Water appears on p. 62.]

Mr. STEARNS. Thank you.

Our next speaker is Dr. Kenneth W. Kizer, Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs.

Good morning and welcome.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H.

Dr. KIZER. Good morning, Mr. Chairman, members of the subcommittee. I want to thank you for your efforts to advance proposals to authorize a Medicare pilot project, as well as the VA retention and use of MCCR funds. These proposals would significantly aid our efforts to restructure and improve the veterans health care system—efforts that you alluded to in your opening comments.

The President's proposed 1998 budget would permit VA to better serve veterans, as well as serve somewhat more veterans over the

next five fiscal years. However, achieving these goals is contingent upon the legislative changes that are under consideration today.

The President's budget includes important goals for VA: to reduce our per patient expenditures by 30 percent, increase the number of patients treated by 20 percent, and, as you noted, obtain 10 percent of our operational budget from non-appropriated sources by the year 2002. And while I think most would agree that these are aggressive goals, we believe that they are certainly consistent with what is occurring in other integrated health care systems and that they are realistic targets.

Assuming that Congress will enact the legislation to authorize Medicare reimbursement and the retention of MCCR funds, we really do believe that we can cut costs, treat more veterans, and become less dependent on appropriated funds over the next 5 years.

I have provided a more formal statement, which contains a more detailed analysis of the Subcommittee's MCCR and Medicare pilot proposals and the changes that we suggest might be made in those bills, and in the interest of time, I am going to briefly comment on these proposals.

I'd also like to note here that I am not in a position to comment on the physicians' retirement proposal, other than in passing.

First, your draft bill to allow VA to retain and use MCCR recoveries is very similar to the Administration's proposal, and our recommendations for change are largely technical. I understand that the recently concluded budget negotiations include this source of funding for the VA, although we haven't seen the exact language yet.

Consequently, enactment of this legislation is really foundational to our ability to treat the number of veterans that we are projecting for fiscal year 1998 and beyond.

Secondly, we support enactment of H.R. 1362, assuming that the changes that are discussed in the formal statement can be effected. As you know, the Department has been working with HHS and OMB for almost 2 years now to design a pilot project for Medicare reimbursement. With the strong support of the President, we transmitted to Congress in October of 1996, and again in February of 1997, a draft bill that was acceptable to both VA and HHS.

Since February, a working group of VA and HCFA officials has been negotiating a memorandum of agreement, which would specifically detail how this project would operate. And while the current draft of this agreement hasn't been formally endorsed by all parties, the working group has reached agreement in principle on all of the major issues and is currently working on a few of the more technical details. We're confident that agreement on this can be completed very soon.

An important change that I would note here to H.R. 1362, that we recommend is to permit VA to obtain Medicare reimbursement on both a fee for service and a capitated basis. We'll be ready to implement a managed care demonstration project for Medicare reimbursement by January 1st of 1998, and we believe that we really should test both models from the outset.

We also think that we need to have the authority to continue the pilot while the Administration and Congress consider the results of

that pilot, because if we didn't have that capability would almost certainly disrupt the individual patient care with potentially untoward consequences.

Again, we thank you for moving forward on this legislation, and we look forward to working with you and the committee staff on some of the details.

On the third measure, I would note that there are currently statutory financial penalties that discourage VA physicians and dentists from retiring before December 31, 1999, and that your draft language addresses this issue. I would also note that the penalties that currently exist do work against our efforts to restructure and downsize, where appropriate, VA's workforce and to optimize the number of primary care providers that we utilize.

We are currently working with the Administration to review the draft, because this does have implications that go beyond the Department of Veterans Affairs. When that review is completed, we'll forward the Administration's views to the committee.

Let me just conclude my remarks very quickly to express my strong disagreement with the CBO's financial analysis. We have been working with the Administration for over 2 years to design a Medicare pilot project that would not result in shifting of care covered by VA appropriations to Medicare. Your bill also has provisions that are aimed at guaranteeing that this does not occur.

Given the very explicit language of your bill and the stated intent of all parties that have been involved in developing this proposal, it is really—I guess the best I can say—mystifying how CBO can assume that 100 percent of our efforts in this regard will fail, and that there will be a \$50 million or greater increase cost due to the pilot project.

Achieving this would require, in reality, that all participants involved in this effort—VA, the Department of Health and Human Services, OMB, the Government Accounting Office, as well as a private contractor—would basically have to violate the law. And while on the one hand I am flattered, in a sense, that CBO believes that we might actually be able to pull something like this off, I think it simply lacks any semblance of credibility.

Instead of using this forum—and noting that the red light is on, I'm not going to point out the inadequacies and the limitations of the CBO analysis—which I understand that they have informally acknowledged—I would like to note that the VA, and I suspect HHS and HCFA as well, would like to work with the CBO to improve the soundness and the legitimacy of their present analysis.

With these comments, I will conclude and look forward to working with you to gain enactment of these important proposals.

[The prepared statement of Dr. Kizer appears on p. 71.]

Mr. STEARNS. Thank you.

Our next panelist is Kathleen Buto, Associate Administrator for Policy at the Health Care Financing Administration.

Welcome, Kathleen.

STATEMENT OF KATHLEEN A. BUTO

Ms. BUTO. Good morning, Mr. Chairman, and members of the subcommittee. And I am very pleased to be here to discuss the President's legislative proposal, as Dr. Kizer has.

We call this the Medicare subvention proposal. This means that Medicare payment for care provided to Medicare beneficiaries will be recognized in federal facilities. The President has expressed strong support for the Medicare/VA subvention demonstration that will provide needed—and this project will provide needed information on its effects.

The project will be conducted by my agency, the Health Care Financing Administration, within the Department of Health and Human Services and the Department of Veterans Affairs jointly. Under this demonstration, Medicare will pay for health services in the VA system for certain individuals who are eligible for both Medicare and veterans benefits.

We believe that we can test efficient ways to provide quality services for these beneficiaries at selected sites, and at the same time protect the Medicare Trust Funds.

Currently, there are about three million veterans over age 65 who meet the Category "C" requirements. They are veterans who have neither a service-related disability nor sufficiently low income to receive VA care on a high priority basis, but have dual eligibility from VA and Medicare. In the past, both programs have provided access to health care for them. We hope that a Medicare subvention model will increase access to quality for these individuals with administrative efficiencies for both programs.

HCFA has been working with VA for 2 years, as Dr. Kizer noted. In these collaborative design efforts, we have really two imperatives from the health care financing perspective. One, protect beneficiaries, and two, protect the Medicare Trust Funds.

As you know, the Medicare trustees have just reported that Medicare's hospital insurance Trust Fund will be exhausted in the year 2001. The Administration is committed to balancing the budget, extending the solvency of the Trust Funds, and keeping benefits available for all Medicare beneficiaries. Thus, the design of the demonstration will include strategies to prevent further depletion of the Trust Funds.

HCFA and the VA are now working on the memorandum of agreement, which will spell out the operational details of the demonstration, including that VA must maintain its current level of financial effort rendering health services to dual eligibles before it can receive Medicare payment.

Agreement has been reached on many of the details for managed care. After the VA has met its level of effort in a demonstration area, Medicare would pay a capitated amount equal to 95 percent of what we pay private HMOs, after excluding some of the costs that are not relevant in the demonstration. These excluded costs would be such things as medical education, disproportionate share, hospital payments, and capital that are already provided under VA's appropriation.

Medicare would pay the fee for service sites in our demonstration 95 percent of current fee for service rates, after removing some of the costs I just mentioned. At the end of each year, HHS and the VA would reconcile and correct any payment discrepancies, and the VA would allow audits by HCFA and the HSS inspector general.

If found that Medicare costs are more than they would have been without the demonstration, the two departments will take correc-

tive action, including, for example, repayment, adjusting payment rates, or terminating the demonstration. In addition, a cap would be placed on total Medicare payments to VA for each demonstration year.

The demonstration will expand beneficiaries' freedom of choice. They can use their Medicare eligibility to obtain care from the VA, or they can obtain care from civilian providers. VA providers also must adhere to Medicare's conditions of participation for quality and other quality standards, and provide the complete range of benefits that Medicare provides in the HMO model.

We believe that we've taken all possible steps to protect beneficiaries, the Trust Funds, and VA from harm. There will be a rigorous evaluation. I won't go into it. But we're going to answer a number of questions about the pilot and whether or not the impacts and costs that we anticipate really are what play out when we have the demonstration.

At the end of 3 years, we will see how the coordination between our two programs improves efficiency, access, and quality for dually eligible beneficiaries.

Mr. Chairman, the bill that you have introduced, H.R. 1362, is similar to the Administration's bill, but not identical. There are significant differences between our bills. First, H.R. 1362 would authorize a fee for service model demonstration in three VA regions.

The Administration proposes to conduct both a fee for service in four sites—a pilot project—and a managed care model in either four sites or one VA region, for a total of about eight sites. Thus, H.R. 1362 would actually involve a much larger geographic area of commitment with correspondingly greater financial risk to the Medicare program and would not include a managed care model.

Second, H.R. 1362 sets Medicare payment rates at 95 percent of amounts paid by Medicare to the private sector. Our bill sets payments at 95 percent of private sector payment, after excluding costs associated with direct and indirect medical education, and so on, as I've already described. These would be covered by the VA appropriation.

Third, H.R. 1362 reduces the VA level of effort in future years to account for changes in veterans' eligibility resulting from the Veterans' Health Care Eligibility Reform Act of 1996, and our bill does not adjust the level of effort. Also, your bill calls for a report on the managed care demonstration by March 1, 1999, whereas we propose to proceed with that model.

Recognizing that the red light is on, I'm going to conclude my remarks by just pointing out that there are similarities between our proposals that will allow us to work together to reach agreement.

Thank you.

[The prepared statement of Ms. Buto appears on p. 80.]

Mr. STEARNS. Thank you.

Before we start, we have the ranking member of the full committee, Lane Evans, and I certainly want to give my good friend Mr. Evans an opportunity for an opening statement before we start the questioning.

Mr. EVANS. Mr. Chairman, I would just submit it for the record.

[The statement of Hon. Lane Evans appears on p. 58.]

Mr. STEARNS. Thank you.

Let me start with my questions. Let me just start with the CBO, Mr. Van de Water. And I have great respect for CBO, and I look to them for many answers. So I'm just trying to better understand your opening statement.

You mentioned the three ways that the veterans hospitals could shift costs, which would create a \$50 million deficit per year, and you mentioned the third one was shifting VA medical costs, because they are already doing it and so they'll shift it back. The second, you said there is a workload within the VA hospitals which would make it. And then, the first one was what? What was the first reason?

Mr. VAN DE WATER. All of the reasons, Mr. Chairman, have to do with identifying the current VA level of effort. They are basically three different ways of looking at the same thing.

As Dr. Kizer's prepared statement indicated, and Ms. Buto's as well, there are significant problems in estimating current VA spending for the targeted veterans who are participating in these demonstrations. And Dr. Kizer, in his written statement, also indicated that there are several elements of H.R. 1362—which is the bill we were asked to focus on—that are not in the Administration's proposal and that would heighten the difficulty of assessing the VA's current level of—

Mr. STEARNS. The real first question is: between the Administration's bill and our bill, which one would be less costly?

Mr. VAN DE WATER. The Administration's bill goes farther than H.R. 1362 to address the issues that we have identified, so the Administration's bill would be less costly.

Mr. STEARNS. But at this point, you can't say how much less costly. You just feel intuitively that the Administration's—and remember now, just for the members here, the difference between the Administration and our bill—the general intent is the same.

It's just, as I understand it, Ms. Buto, the number of sites, and instead of having—you have fee for service plus HMO or managed care. So you have that nuance. Is that true?

Ms. BUTO. That's true. Number of sites is one of—

Mr. STEARNS. And how many sites do you have?

Ms. BUTO. We have a total of—

Mr. STEARNS. Eight?

Ms. BUTO (continuing). Probably eight.

Mr. STEARNS. Eight. And we have three.

Ms. BUTO. Yours has three geographic areas, and we understand that may be a number of sites. It looked like a much broader geographic spreading. It may be our misunderstanding, and you've just intended three sites.

Mr. STEARNS. Okay. Well, we put a cap on this.

I think, Mr. Van de Water, what you're saying basically is the VA hospitals will see this demonstration as the ability to cost shift. Isn't that sort of the summary of your reasons? They'll figure out a way to—

Mr. VAN DE WATER. That could well be the result.

Mr. STEARNS. Okay. So what we're doing is going to incentives here. Is there incentives in place to make this a cost savings?

Now, as I understand it, Medicare is going to give a 5 percent discount for the VA to do these services. So isn't it in the best in-

terest of the Veterans' Hospital, at least for the demonstration, to make this work and not cost shift? And, in fact, don't you think if I was an administrator, or you were an administrator, wouldn't you say, "golly, let's get this thing to work," you know, at least during the pilot project?

Mr. VAN DE WATER. The problem isn't the lack of incentives, Mr. Chairman. The problem is trying to identify this maintenance of effort. As Dr. Vladeck, the administrator of HCFA, said in testimony that he gave before the Ways and Means Committee last year, the VA health care system, in his words, is not very sophisticated and is not very far along in being able to estimate its existing level of effort with regard to the targeted veterans for whom this demonstration would provide.

As we work with VA, if we can reach some understanding as to what the current level of effort is, and if we think that the demonstration would assure that VA continued to provide that maintenance-of-effort level, then no costs would attach to the proposal. But—

Mr. STEARNS. Well, that's what we're trying to do. You're citing here the reasons why you think there will be a cost overrun, it will cost above the cap, and we're trying to find out which are the reasons that we can correct, either through the Administration's bill or our bill, because I think honestly that the Administration and Congress and the Veterans' Hospital, and the veterans, all want this VA subvention bill. So what we have to do is incorporate your ideas, if we think so.

But when you say the VA hospitals are not sophisticated, wasn't that public testimony on the basis of fee for service? It was managed care they were talking about and not the fee for service, because they understand fee for service after all of these years, but they're not sophisticated in terms of managed care. Isn't that true?

Mr. VAN DE WATER. VA is not collecting fees for most of the care that it delivers, so I wouldn't use that terminology.

Mr. STEARNS. Ms. Buto, do you mind commenting on what specifically the CBO says is wrong with this bill in terms of how it will create cost overruns?

Ms. BUTO. Yes. I actually—

Mr. STEARNS. Because what you explained in terms of your accounting measures in your administration, it sounds like you'd be able to monitor this pretty carefully.

Ms. BUTO. There were two things that I think the CBO testimony pointed out that our bill directly addresses that H.R. 1362 doesn't address or addresses in a different way. Let me just mention what they are.

The first one has to do with removing medical education and some of the kind of funding that Medicare pays that are capital funding for facilities that are covered by the VA appropriation. We would take that out of our payment, so that some of the issues of, if you will, duplicate payment by Medicare would be removed under our proposal.

The other issue which was raised, which is not particularly in our bill but which we are discussing in the memorandum of agreement, is that in, for example, our DOD subvention proposal and memorandum of agreement we do not pay for the non-covered costs

that Medicare, in a benefit package, doesn't cover, like drugs. We don't cover certain benefits.

Again, we would take those out. I think CBO specifically raised the issue in its testimony about counting those in the level of effort when, in fact, they are really not comparable to what Medicare would be spending. So those two differences are the kinds of things which I think there is room for improvement as we try to work these numbers. They are pretty easily defined.

The harder question is the one that Mr. Van de Water raised of getting good data on how much are we spending on the people who are going to be using the demonstration, the Category "C" eligible individuals. We don't have very good information on that, and that is going to be the reason we want to reconcile at the end of the year, to see what actually was spent and try to figure that out more precisely. That's why we have some of those requirements in the bill.

Mr. STEARNS. Okay. My time has expired. We can make those changes, the two changes—Congress can—that the Administration is suggesting to get a better bill. So I thank you.

And now I'll recognize the ranking member, Mr. Gutierrez.

Mr. GUTIERREZ. Thank you very much. I just want to follow up, Chairman Stearns, because I think this issue needs some clarification.

Mr. Van de Water, you indicated in your testimony that you believe that H.R. 1362 would give the VA incentives to provide more uncovered, and presumably inappropriate, care to Medicare eligible targeted veterans, taking additional resources from Medicare Trust Fund beyond what this bill would authorize. Is it really CBO's contention that the VA would resort to providing unnecessary care to game the system by the VA?

Mr. VAN DE WATER. Absolutely not, Mr. Gutierrez. That was certainly not our suggestion. We were focusing on the issue that Ms. Buto raised of distinguishing between services that VA provides that are covered by Medicare and those that are not.

The services that VA provides that are not Medicare-covered services are surely appropriate services. But if VA were to substitute that type of service for services that are covered by Medicare, and were allowed to count that against its maintenance-of-effort requirement, then there would be a substitution of costs from VA to Medicare. However, there would be no issue of any inappropriate services being delivered.

Mr. GUTIERREZ. Do you think that we can work these differences out so that we could come up with more certain numbers and more certain strategies? And what kinds of things can we do to accomplish that?

Mr. VAN DE WATER. I think that certainly most, if not all, of these differences can be resolved. As Ms. Buto indicated, the issue of distinguishing between services covered by Medicare and those not covered is addressed in the memorandum of understanding that the Administration is developing. It was not addressed in H.R. 1362, but that should be taken care of.

In terms of the adjustments to the maintenance of effort that are allowed in H.R. 1362, those adjustments could be deleted, as they are in the Administration bill.

Also, in terms of determining what the current maintenance-of-effort amount is, we would be happy to work with both VA and HCFA to try to clarify what that level is. But, to quote Ms. Buto, we don't have very good information, and that is precisely the problem. But we will work as hard as we can to get these differences resolved.

Mr. GUTIERREZ. Dr. Kizer, well, we know that the CBO believes if this subvention legislation is enacted the VA will underestimate the level of health care that it has been providing to Medicare eligible veterans, almost so that it can shift health care expenditures to Medicare Trust Fund.

I mean, sometimes I read it, and I know Mr. Van de Water would probably take exception, but it's almost as though the people at the CBO believe that you folks over at the VA are going to do some pretty underhanded stuff. And given your earlier comments, maybe you could just shed some light on what this committee should know about what the CBO is saying about what you're going to do, so that we can help clarify who is on first and who is on second, and just what is going on here.

Dr. KIZER. Let me try to respond to you in a couple of ways. One, I think our initial reaction in reading their testimony was that we were considerably offended, because the absolute clear implication of their statement is that we would commit fraud, and that is just wrong!

There is absolutely no intent to do this. And perhaps we may have overreacted to their words. After hearing Mr. Van de Water, his comments provide some level of reassurance that maybe that wasn't what they were saying. Maybe it was based on something else. But I think we need to continue these discussions.

Second, I guess I would note that all of the points contention, or at least all that we understand are points of contention or disagreement, here are things that seem like technical details that we can work out in a way that would reassure everybody, and that would provide the requisite comfort level that would be necessary to pursue this.

And just two other points. The third one is that it's our belief, our strong belief, that this pilot would not only be beneficial to veterans and would allow them some increased freedom of choice, but that it would also be salutary to the Trust Fund, because while, as Ms. Buto has noted, VA would be paid 95 percent less a number of other things, so that the net amount would probably be closer to 90 percent of what would be paid to the private sector. This would equate to a substantial savings to the Trust Fund.

And finally, the last point I guess, is having run the Nation's largest Medicaid program for a long time, I have considerable confidence in the ability of the HCFA auditors, as well as GAO auditors, to uncover and find any little potential that someone might be claiming something that is not what they are entitled to. It certainly was never my experience running the MediCal program that anything at all got by the auditors.

Mr. GUTIERREZ. Thank you. Well, I'm not going to follow up, because I know there are other people, and we've got a couple of doctors here that can help figure this out for us also.

But I would just like to finish by stating that, Mr. Van de Water, certainly I know that members of the committee want to continue to work with you over at the CBO so that we can gain better service for health care for our veterans in terms of working on the numbers. And I appreciate your comments earlier in response to my initial question.

You know, it wasn't only my reaction, but the reaction of the staff as we evaluated the comments made by the CBO in response to this. We kind of share the sentiments of the people at the VA that a reading of it can be interpreted as less than favorable in terms of the intentions and what they would do under circumstances.

So thank you so much, Mr. Van de Water, for being here. I really look forward to working with all of you.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank you. Dr. Cooksey.

Dr. COOKSEY. Thank you, Mr. Chairman.

Let me preface my remarks by saying that I have some concerns about this whole concept of subvention. I assume that you, Dr. Kizer, were in the military during the Vietnam period also. You're a physician.

Dr. KIZER. That's correct on both counts.

Dr. COOKSEY. And, you know, during that time period, the people in the executive branch of government, from 1963 through 1969 at least, at best were dishonest with the American public, and certainly with those of us in service. And possibly, at worst they were derelict in their duty.

And so I am concerned about a concept where you're not appropriating the money to the veterans that they deserve. I think that the veterans should have the money appropriated. Period. End quote. And not depend upon some questionable economic device or mechanical device.

But that said, it is my understanding that the Veterans Administration expected to move into a managed care concept, and you really haven't, as we alluded to earlier, been involved in managed care. Most of us that have been in the private sector have not been in managed care as much as you have in California.

But how will they make this transition and make it work and make it, number one, provide quality of care for the veteran?

Dr. KIZER. A couple of things. One, I would just note that the philosophical perspective that you advance is one that I couldn't disagree with. I guess part of the problem in that regard is that the reality and what we philosophically might both agree to may be in some conflict here, that is, there seems to be a conflict between philosophy and the budget realities of the future.

From a quality of care perspective, let me say that having worked in the private sector and worked with large managed care companies, as well as overseeing the care that is provided by private hospitals, I have no doubts at all that the care that is provided in the VA is absolutely on par with what is provided in the private sector.

And if you consider things like the JCAHO accreditation scores, you note that the VA is significantly higher than the private sector. That is not to say that problems don't occur, and that human er-

rors don't occur, however, in the aggregate, VA care is of very high quality.

Also, it is, I think, of note that some of the things that we have put in place in the last 2 years as far as our evolving comprehensive approach to quality care management is increasingly being viewed by others as really a model of what or how one should approach quality in a large system. That begins with things such as accreditation and credentialing, and then puts in prospective measures like clinical guidelines, and ends with detailed evaluation. This is a full, comprehensive approach to quality of care. And I'd be happy to talk with you in more detail about the specifics of this, should you want to.

Dr. COOKSEY. Good. Well, you know and I know that, as physicians, quality of care should be the determining factor in the direction of health care and not cost of care. When you have quantity of care, the physicians are involved and you are concerned about the welfare of the patient. When you have quality of care, you have bureaucrats, you have business people, you have MBAs, and they don't always really understand what quality of care is.

So I feel very strongly that it should be quality of care that is our criteria. When we have quality of care, it will ultimately result in a reduction of cost, because that is a proven principle. It's there. It's known. It is unquestionable in my mind.

Another concern I have—

Dr. KIZER. Let me just, if I could, interject one thing.

Dr. COOKSEY. Sure.

Dr. KIZER. Because I agree with that. The one unique opportunity that the VA has here, and it's something that we're trying to capitalize on, is applying managed care principles in an environment where the for-profit motive is not the driving factor.

As I think you well know, what is occurring in the private sector and what is of concern increasingly to the public, as well as elected officials, is how managed care principles are being distorted or taken down the wrong path, because they are being driven too often by a for-profit motive, which sets up a whole different mindset than applying those same principles in an environment where the driving force is quality of care.

I think the VA has the opportunity to utilize some of these principles in an environment that is not driven by returning another penny of earnings to the shareholder at the end of the quarter.

Dr. COOKSEY. One other quick question. In looking over Dr. Spagnolo's testimony, it is my impression that the administrators of the hospitals are going to have a lot of latitude to make some—really arbitrary decisionmaking in their reduction in force of their staff. What protections are there to protect physicians who might otherwise be willing to stand up and say, "Look, there is a problem with quality of care"? And they know that if they stand up and speak out and do what is best for the veterans, they may be a victim of this RIF process under this rather arbitrary decision system.

Dr. KIZER. Well, a couple of things. One, the decisions are not arbitrary; the basis for making the decisions are really driven by things like needing more primary care practitioners, as opposed to specialists, in certain areas. As we look at merging and consolidating some of our facilities, we can get more out of some of the exist-

ing workforce. And so the decisions are not in any way arbitrary. They are predicated on some goals and directions aimed at improving the quality of care that we provide.

The other thing—and I think it really can't be ignored—is that as civil service employees, the level of protection that is afforded, and the rules by which reductions in force have to be accomplished, are very clearly specified and stated in law. The protections that are afforded to our employees in general, including physicians, go way beyond anything that you would find in any other setting.

Dr. COOKSEY. Thank you.

And thank you, Mr. Chairman.

Mr. STEARNS. Thank you.

Dr. Snyder, do you have any questions?

Mr. SNYDER. Yes. Thank you, Mr. Chairman.

Mr. Van de Water, you may have said this in your written statement, but do you have any opinion on this issue of should the subvention study include the capitated part of it?

Mr. VAN DE WATER. CBO does not make recommendations for or against particular pieces of legislation. So——

Mr. SNYDER. Are you satisfied that if the capitated part of it is included that the resources are there, and the framework, to do an adequate study of both the capitated and the fee for service?

Mr. VAN DE WATER. We have not seen the memorandum of understanding to which Ms. Buto referred. We would assume that the appropriate provisions were being made, but I can't vouch for that because we have not been involved in those discussions to date.

Mr. SNYDER. Thank you. Dr. Kizer, as I talk among committee and staff, I think this issue of the capitation in the Medicare subvention study is a pretty big issue with this committee. A few questions on that.

If we don't do the capitated part of the study and just do the committee's bill with the fee for service, what impact down the line does that have on your 30-20-10 plan?

Dr. KIZER. A priori it wouldn't have any specific impact. What you would lose, though, is the opportunity to do an assessment of that question. And I think if you're going to give the idea of subvention a fair test, you need to look at both options.

And, of course, as Ms. Buto and, I think, I may have noted, there are many provisions in the agreement that should it not be working, either from a fiscal point of view or a quality of care point of view, we could stop the test at that point. But we do not expect that would happen.

I think if you're going to adequately test Medicare subvention, you need to look at both models, particularly insofar as the rest of the country is so rapidly moving to managed care. It's something we need to look at.

Mr. SNYDER. You're currently taking some third-party payments that go in the general treasury. Is that all fee for service, or do you have any capitated contracts around the country?

Dr. KIZER. It's the reimbursement from the private payers, and it's essentially all on a fee for service basis.

Mr. SNYDER. I think Mr. Gutierrez made the comment in his opening statement, and I've heard this criticism also and have talked with at least one hospital administrator, there is some con-

cern that the managed care aspect of it, the capitated part of it, may increase the volume of patients, that it will cause some problems with higher priority veterans getting the same level of care. Do you have some comments on that?

Dr. KIZER. One of the things that has been very clear, I think both in policy and in some of the program changes, is that we view our commitment and our mission to take care of those veterans first and foremost and above any other operating requirements. Indeed, in the new veterans equitable resource allocation methodology, the reimbursement from appropriated funds is solely targeted to Category "A" veterans, or those who have higher priority for access to VA health services. I think that should, and certainly for our administrators certainly does, send the message that Category "A" veterans are our first and foremost priority.

I think it is important to understand that insofar as there are lots of fixed costs built into providing health care, and if there is excess capacity in some areas, then VA could take care of a certain number of higher income patients for very small marginal costs that would bring some revenues with them, and enhance our ability to take care of more of those Category "A" veterans who don't have access to other health care.

So, it basically becomes a win-win for both higher income veterans who might choose to be taken care of at the VA and Category "A" veterans who may not have access to other sources of care.

Mr. SNYDER. If I am a VA hospital administrator, and I see this plan coming down the pike—and put yourself in the posture of you're going to be the hospital administrator—what problems is this study going to create for me as a hospital administrator at a busy VA?

Dr. KIZER. The problems, in my mind, would largely be logistical. That's why, as we have worked with HCFA, in reviewing initial site selections we have identified facilities in our current array of assets that are more prepared than others to do this as far as the sophistication of their cost accounting systems, their billing systems, their utilization management, and other things, which are all essential. Those improvements are being put in place in all facilities, however, some are more advanced than others at this time. As part of the site selection criteria, those are the sorts of things that are being looked at.

So I don't know that there are any a priori things that would cause me great concern, other than the fact that the level of accountability that will be required, from a quality of care as well as from a fiscal and other perspectives, may be ratcheted up a notch higher. But it's happening everywhere in the system anyway, and it's really just a matter of timing.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. STEARNS. Thank you. Mr. Peterson.

Mr. PETERSON. Well, we have a vote. I apologize for being late.

Mr. STEARNS. Okay.

Mr. PETERSON. I had another—

Mr. STEARNS. That's fine.

Mr. PETERSON. So I don't know what has been asked, so I think I'll just pass.

Mr. STEARNS. Well, I think what we'll do is come back after we vote, and we'll do another round of questioning, just for 2 minutes. Because, you know, I think what we're trying to do is come up with ways we can improve the bill, and the Administration has pointed out some good ways. And hearing the testimony of Ms. Buto has given us some ideas, too.

So we're going to come around for another 2 minutes after we vote, so I appreciate your patience.

The subcommittee is adjourned temporarily.

[Recess.]

Mr. STEARNS. We'll reconvene the hearing on the Subcommittee on Health and continue our questioning with Mr. Peterson.

Mr. PETERSON. Thank you, Mr. Chairman, and again, I apologize for being late and hope that I am not rehashing some ground that has been covered.

But what I am concerned about is this estimate, Mr. Van de Water. Could you explain to me again how you came up with this \$50 billion? In talking to some other members, they weren't totally clear on all of the points that—

Mr. VAN DE WATER. Certainly, Mr. Peterson. The issues, as Dr. Kizer indicated shortly before the recess, are indeed somewhat technical. That is a good way of describing them. But they are important for determining the budgetary effect of the proposal.

The single most important issue affecting the \$50 million estimate for H.R. 1362 is defining what types of services are counted in assessing whether VA is meeting its maintenance of effort requirement. VA provides certain medical care services that go beyond the package of benefits that is covered by Medicare—for example, long-term care and pharmaceuticals, to name just two.

To the extent that VA is providing those types of services to the targeted veterans, those should not be counted towards the maintenance of effort requirement, because they are not services that Medicare would have been providing to those patients.

This is a matter that is easily rectified. Ms. Buto indicated that it is addressed in the draft memorandum of understanding that is being developed between HCFA and VA. However, it is not yet a provision of H.R. 1362, and we were asked to address that particular bill.

Mr. PETERSON. So how much of the \$50 million is that?

Mr. VAN DE WATER. Probably about half of that.

Mr. PETERSON. Okay. And you think that that can be fixed, meaning that there's a way—

Mr. VAN DE WATER. Yes.

Mr. PETERSON (continuing). To fix this legislation—

Mr. VAN DE WATER. Yes.

Mr. PETERSON (continuing). So that the cost can be eliminated?

Mr. VAN DE WATER. Actually, I misspoke. At least half of the \$50 million is attributable to the factors that have already been identified this morning that are easily fixed.

Mr. PETERSON. Okay.

Mr. VAN DE WATER. The definition—

Mr. PETERSON. That was what I was trying to get at in asking these questions, is there a way that we can address this issue so we—because I think if we end up with a \$50 million cost, we're

going to have problems. And we have to have some way or another to figure out how to get around this.

Mr. VAN DE WATER. As I indicated earlier, Mr. Peterson, I think all of these problems are potentially fixable, and the Administration in the testimony this morning has already indicated ways that could resolve at least half of that issue.

Mr. PETERSON. But the other half that is not—

Mr. VAN DE WATER. The other half, as I say, is potentially resolvable, but it involves further discussions in terms of these data that Ms. Buto indicated are not in very good shape at this point.

Mr. PETERSON. So you can't—nobody can give us an indication of how we could address the other \$25 million?

Mr. VAN DE WATER. It can be resolved through discussions between HCFA, VA, and ourselves to try to clarify what the current level of effort is.

Mr. PETERSON. But it's going to take some time, in other words. You don't have an answer right here today?

Mr. VAN DE WATER. It can't be resolved this morning, no.

Ms. BUTO. If I could just make a comment. I think one of the reasons for the cap in our proposal is to specifically address that. In other words, once expenditures reach the level that people agree is appropriate given the population, they would be capped. That will ensure that no more money, no more cost if you will, goes into the program. That will assure—it's like an insurance policy.

Mr. PETERSON. One other thing—after having gone through this budget situation and gotten this surprise on Thursday night that all of a sudden CBO found \$225 billion, or whatever it was, you know, and having sat through all of these meetings where they were arguing between OMB and CBO, does OMB look at bills like this one? And do they agree—is there an agreement between OMB and CBO on this bill, or not? Can anybody answer that?

Mr. VAN DE WATER. I certainly can't speak for the Administration, but I have not seen its estimate of H.R. 1362. And indeed, I think your panel agrees that on some of the issues that distinguish H.R. 1362 from the Administration proposal—

Dr. KIZER. I would just note that OMB has been an intimate partner throughout the discussions with HCFA. They have looked at this, and everything else we do, with a very high power microscope, as far as fiscal implications. While I can't comment as far as their agreement with CBO, I can assure you that they have looked at this with a lot of resolution and are as confident as HCFA that there are provisions in there that will protect the Trust Fund.

Ms. BUTO. Just to clarify, we do not have an administration estimate on H.R. 1362, and we don't have one on our bill until we complete the particulars that we're still working out, such as the cap, and so forth.

Mr. PETERSON. Okay. But the net—the probable result of that will be that there will be some massaging of this legislation, and whatever the final—whatever OMB gives you is going to say that it's cost neutral. That's going to be the result of this.

Ms. BUTO. Again, we are trying to work out the details of what we think the cap should be. In other words, what we project we'll be needing to spend for this. The issue will be, then, how it is

scored. So it is sort of a two-step process, and it will be iterative. Our obvious goal is to try to make it cost neutral to the Trust Fund, but we'll have to go through that process to find out.

Dr. KIZER. Well, I think, to answer your question more directly, a basic tenet of this discussion from the outset, starting 2 years ago, is that it has to be budget neutral. Indeed, we believe that it will not only be budget neutral but that it will create savings for Medicare.

Mr. PETERSON. My time is just about up. What is this cap? You say you're going to cap it.

Ms. BUTO. We're going to put—

Mr. PETERSON. Is that going to have the impact of cutting some people out of this, or limiting it? Or what is this cap?

Ms. BUTO. No. The cap applies to Medicare payments to the VA for this demonstration. And what it means is we will estimate how much Medicare will be reimbursing the VA for these services. And it is sort of, as they say, an insurance policy or an upper limit for what we will pay. But no, people will continue to get services. Many of these people are getting services now through Medicare.

Mr. PETERSON. But it will limit the amount of the people that can go into the demonstration project.

Dr. KIZER. That's correct. Another way of looking at it is by setting a cap that limits the number who can participate in the pilot.

Mr. PETERSON. Okay. Thank you.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank you.

Now I'll continue with just 2 minutes, another round quickly, of questions.

Dr. Kizer and Ms. Buto, what are your views on the recommendations of the Non Commissioned Officers Association that military retirees should be a targeted priority under VA medical care subvention legislation? And what do you think the selection criteria for this demonstration project should include for the location of participating facilities?

So you've got sort of two questions in one, if you would be so kind as to address that.

Dr. KIZER. The selection criteria, as far as sites, include a whole host of things, such as the ability of the potential designated sites or the robustness of their cost accounting systems, their billing utilization management, and all of those infrastructure things that exist.

It would include things such as what is the overall market, health care market there as far as penetration of managed care, other things, what are the socioeconomic demographics of the population, and what would be the demand. And there's quite a number of other things that we'll be happy to articulate in more detail.

As far as the preference of one group or another, our first and foremost priority has been to make this an option for those persons who are both veterans and Medicare eligible, and meet the fiscal criteria that have been noted earlier.

As far as prioritizing among those veterans who are Medicare eligible, the pilot would not do that. And indeed, I think there may be some philosophical reasons why that might not be appropriate to try to prioritize. What we'd like to do is to make it an option

and open for those who would choose to get their care at the VA facilities.

Mr. STEARNS. Ms. Buto.

Ms. BUTO. I wouldn't add very much to what Dr. Kizer said, except to say that one of the issues of the capacity of the system, that the system is already being taxed. And it probably is not as good a candidate as one which has more capacity and more ability to provide both outpatient and inpatient services.

Mr. STEARNS. I'd like both of you, if you would, to submit for the record your site criteria, so that we have it in writing and we have the testimony. But if you might give us more details, Ms. Buto and Dr. Kizer.

Dr. KIZER. I'd be happy to.

Mr. STEARNS. So, Dr. Kizer, you, briefly, don't agree with the Non Commissioned Officers Association that military retirees should be the targeted priority, is that my understanding?

Dr. KIZER. Well, I think it would not be appropriate for us to designate a veteran as—or because they belong to one organization or another, as having higher priority than others. We have set criteria as far as meeting some threshold things, income and other criteria such as that.

Ms. BUTO. The other thing to mention about that is that we are undertaking a similar pilot project, or we intend to, with the Department of Defense involving military treatment facilities. Military retirees are obviously the group we're looking at there. So there will be opportunities, both in this demonstration and in the DOD subvention demonstration, for participation.

Mr. STEARNS. Okay. My time is up. Dr. Cooksey.

Dr. COOKSEY. Thank you, Mr. Chairman.

Ms. Buto, we've got something going on with HCFA that is of concern to the medical professional's practice expense issue. Hopefully, you're not involved with that. But, you know, HCFA was given a mandate by the 104th Congress, our predecessor, to come up with a solution by January 1.

The model that they chose—the question there, you know, was not responded to. There was a poor response. As a result, they have really chosen at one point to use what we consider a flawed model to determine what the solution should be. The methodology, the idea of saying, "Well, we don't really have an accurate way of evaluating this, but we'll do this because even though it's not accurate, we've got to do something by this deadline."

Now, what can you do to assure me that nothing is going to be done like that for our veterans, or against our veterans, or to the detriment of our veterans?

Ms. BUTO. Let me comment on that first. We do have a deadline, but the methodology really involved convening 15 physician panels to tell us what the direct cost to their practice was. We had 15 different panels, different specialties, and so on.

The issue around the survey had to do with indirect costs, which were 45 percent of the payment. And almost any business, including Medicare, has to figure out indirect costs using some kind of a formula. What we hoped the survey would do was to help us make it more specialty specific, and we're looking at some ways to do that.

But it is achievable, we believe, in the timeframe we have. We're working toward that, and we hope within the next, really, few weeks to have a proposed rule out with plenty of time over the next year or so to refine the values and to look at things like whether we ought to make changes in them. So I think—and I know Congress is considering whether we ought to phase them in rather than doing them all at once. And there are a number of things going on to look at the issue that you raised concerns about.

So, you know, I guess I would differ with you a little bit about whether or not this is a flawed process. I think the reason concern is around the fact that it is all happening at once. There is no transition, no phase in, as well as some of the issues of the methodology.

On this one, on the VA subvention demonstration, we're really talking about well established payment system models—the inpatient payment system under the fee for service, as well as the RVS system, whatever fee schedule we use, and other supply systems as well. And our capitation method, which is based off of fee for service, will be used in the capitation or the HMO side of the demonstration.

One of the things to point out about these different methods is that they are really just payment methods, so that the capitation method under the managed care model allows the VA to take the whole Medicare set of dollars, if you will, and manage those dollars and use them appropriately to bring in more primary care, more outpatient services, etcetera.

It is hard to do that under fee for service, because most money gets paid for inpatient services. If you don't have an inpatient admission, the VA is not going to get dollars for that foregone admission. And so they have a hard time converting that money into more services. The managed care capitation approach allows them to use that more flexibly, and that's really the idea behind trying it out under the demonstration.

But to answer your question, the methodologies are well established. They're what we're using now and have been using for many years.

Dr. COOKSEY. Well, the net result, though, whether you're in the private sector, the public sector—and I hope it does not happen with the veterans—if the dollars are not there to pay the cost of running the system, health care is not delivered. I don't want that to happen to our veterans.

Ms. BUTO. And we don't want that to happen to any Medicare beneficiaries, veterans or other individuals. And we do a yearly report as does the Physician Payment Review Commission, and an assessment and survey, to figure out where or if there are any access problems related to beneficiaries getting necessary care. Neither we nor the PPRC have found that there are access problems related to these payment systems as yet.

And obviously, we need to do more in the area of managed care to see what is going on. We're planning to do a survey of beneficiaries to find out if they are satisfied in feeling like they have access to needed services. That is the kind of thing, and the quality protection we would build into the demonstration model.

Dr. COOKSEY. Thank you.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank the member. Dr. Snyder.

Mr. SNYDER. Thank you, once again, Mr. Chairman.

Mr. Van de Water, a brief answer if you would, please. Following up on what Mr. Peterson had to say trying to resolve the second half of the \$50 million, is it fair statement to say that what you're talking about is you all sitting down as analysts and researchers and administrators and probably through your memorandum of agreement being able to work out the bulk of that, not talking about a rewrite of the bill or major changes in the bill, is that a fair statement?

Mr. VAN DE WATER. It might well be necessary to reflect some of—

Mr. SNYDER. Some of that.

Mr. VAN DE WATER (continuing). Some of this in the legislation, yes.

Mr. SNYDER. Okay. Thank you.

And, Ms. Buto, again I want to go back to this managed care aspect, the capitated part of it, because I think that is an issue for some members. We're talking now about extending managed care capitation to the VA system. But is it not a fair statement to say that we're still doing some struggling with Medicare capitation in the private sector? I mean, you must have some ongoing discussions about rates and fees. I mean, I'm certainly hearing from my physician friends that the facts aren't in on that yet.

Ms. BUTO. Medicare pays HMOs and Medicare under a formula. We really don't get to negotiate. In fact, the President's budget essentially asks for more authority to do some of that purchasing, but there is a formula that is in the statute.

The negotiation you're talking about occurs when the HMO takes that total capitation payment, if you will, and they say then to a physician group, "Okay. We're going to negotiate a fee with you." And there has been some dissatisfaction at that level.

We just issued this year a regulation that talks about what kind of physician incentive arrangements managed care plans can have, what kind of indemnity or insurance they have to provide to make sure the physician does not feel at risk in ways that would damage the quality of care. These are complicated rules, but they give us better assurance that that relationship will be protected, the physician will be able to provide the needed care.

There have been a number of other things put out lately, sort of mammography area—the breast cancer surgery area, where there was concern about outpatient breast cancer, and so on—these kinds of protections that we have supported and put into Medicare as well.

Mr. SNYDER. And, Dr. Kizer, I want to give you a chance to say anything you want to about the managed care aspect of it. The issue comes up that—and maybe it's a criticism of the 20 percent part of the 30-20-10 plan, which is VAs are busy enough, the lines are long enough, the waits are long enough. Won't the managed care part of it just exacerbate those particular problems? And then any other comments you have on the managed care.

Dr. KIZER. Actually, no, I think the managed care aspect would enhance our ability to deal with that. because it really reinforces

the fiscal incentives to optimize the location and venue of care. And, you may not know, but one of the things that we have done over the last 18 to 24 months is put in place managed care principles in the VA. For example, we have now sited or are in the process of siting 90 new community-based outpatient clinics, which are having a very beneficial effect as far as decreasing waiting times and increasing access. Likewise, as we pursue other things like increasing the amount of surgery that is done on an ambulatory basis, we're seeing waiting times drop, productivity increase, and overall quality of care improve, as reflected and measured by rates of complications and other things.

So again, really, the opportunity that exists here, and which we feel so strongly about, is being able to operationalize some of these principles in a way where the return on investment, if you want to think of it in those terms, is really the quality of care, the improved access to care, and the increased value of the health care that is provided. It is not driven by solely fiscal motives, but how we can get the most health care return out of the dollars that we have.

And we think that a managed care model is certainly something that we need to test, as well as a fee for service model.

Mr. SNYDER. Thank you, Dr. Kizer. I think I agree with you, by the way. I just wanted to give you the opportunity to make your cases here.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank the member. Mr. Peterson.

Mr. PETERSON. Well, I'm trying to figure out how this is all going to work. You know, we have been—our group, the blue dog Democrats, have been working on this budget and Medicare, and we know enough about this to be dangerous. But I have become convinced, you know, that where we need to go is get away from this managing things with price controls and getting to some kind of competition model and opening up the system and Medicare so people can have choices, and so forth.

And apparently, we don't really know what is in the budget agreement. Nobody will really tell us. They say that it's along the lines of what the blue dogs put together, but we'll see.

But anyway, my question is, I'm trying to understand how this is going to play out. If we get what was in there, you know, we're going to raise the AAPCC in the rural areas, and we're going to I think maybe set up a climate where we're going to get—actually get some choice and get some things happening.

So what I'm trying to figure out listening to all of this is, how is this actually going to work? Beyond the demonstration, how is this going to phase in and how quick would we get to the point where the VA would be a complete choice that somebody could make just like an HMO or whatever else? Number one.

And, number two, have you folks been in the loop on whatever is being done down there with Medicare? Are you at the table? And is this going to get to be part of the deal? Maybe this is above your pay grade.

But, you know, we're having a meeting this afternoon, our group. We're not going to give up on this Medicare thing. We are going to—if they go off in the wrong direction, we're going to do our own

bill and try to force them back to where we think they ought to go. And so I'm just kind of trying to get the lay of the land here in kind of broad terms of how this is going to fit in, and where this is going, and is there some way that we could be helpful to get where we need to go.

Ms. BUTO. The folks in our Department and at OMB who are working on the Medicare budget are working on this as well. It's all part of the same package. So you can be assured that everybody who is working on this is in the loop on the broader Medicare issues. That's why we built in so many protections, as you can tell, in the methodology. So there is that issue.

We don't—on the issue of expanding choice and raising the floor for HMO payments, we think this is very consistent with that overall approach. That approach really goes to the question of fairness in the HMO payment. And we think this will—and increasing choice, and we think this will go very much in the same direction.

This is a pilot project, so we're not saying when it will actually become a regular option. That's the point of the pilot is to figure out how to make it work in a way that could be looked at.

Mr. PETERSON. I guess the one concern I have is: are you putting so many safeguards and so many caps on it that it maybe won't work?

Ms. BUTO. We don't think so. We think it's quite viable this way.

Mr. PETERSON. Well, I hope that that is, in fact, the case. It sometimes—

Ms. BUTO. The alternative is that there is a bigger drain on the Trust Fund, and it is one that we think is not appropriate.

Mr. PETERSON. Thank you.

Mr. STEARNS. I thank the member.

I want to thank panel one for your patience while we interrupted with a vote, and I appreciate sincerely your coming here this morning.

And now we'll take panel number two.

Dr. KIZER. Thank you, Mr. Chairman.

Mr. STEARNS. Good morning to the panel number two, which includes John Vitikacs, Assistant Director of the National Veterans Affairs and Rehabilitation Commission, American Legion; Joe Violante, Deputy National Legislative Director, Disabled American Veterans; Richard Wannemacher, Jr., Associate National Legislative Director, Disabled American Veterans; Dennis Cullinan, Deputy Director, National Legislative Service, Veterans of Foreign Wars of the United States; and Colonel Charles C. Partridge, U.S. Army (Retired), Legislative Counsel, National Military and Veterans Alliance.

Gentlemen, I want to welcome you, and we look forward to your opening statements.

STATEMENTS OF JOHN R. VITIKACS, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; RICHARD A. WANNEMACHER, JR., ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; DENNIS M. CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND COL. CHARLES C. PARTRIDGE, U.S. ARMY (RET.), LEGISLATIVE COUNSEL, NATIONAL MILITARY AND VETERANS ALLIANCE

STATEMENT OF JOHN R. VITIKACS

Mr. VITIKACS. Chairman Stearns, members of the subcommittee, good morning. The American Legion appreciates the efforts of the subcommittee for initiating measures to generate new non-appropriated revenues for the Veterans Health Administration. Topics under consideration today are critical to the future of the Veterans Health Administration.

The American Legion supports the concepts underlying the pilot Medicare subvention program and the draft bill on the recovery of third-party receipts. The Congress must create and test new funding streams to provide creative solutions to VHA's funding predicament. The proposals under consideration present a sincere effort to strengthen, support, and sustain an essential national resource.

Mr. Chairman, the measures contained within H.R. 1362 should be applied as appropriate to both acute hospital and chronic long-term care and community-based treatment programs. Once a veteran qualifies for VA health care, all public and private payment options should be considered. The American Legion suggests incorporating both fee for service and a management care model in the Medicare subvention program. It is important to measure patient satisfaction with each model and the relative cost savings.

The American Legion appreciates the recent House Veterans' Affairs Committee recommendation to include a funding increase of \$641 million above the President's fiscal year 1998 VA medical care budget request. The American Legion is concerned about the uncertainty of VHA attracting sufficient new revenues to offset a no growth budget as proposed by the Administration for the period fiscal year 1998 through fiscal year 2002.

Still, the issue before the subcommittee is what new proposals must be tested and applied to solve VHA's long-standing funding concerns. The American Legion urges that the final legislative recommendation also includes the concepts contained in the GI Bill of Health. The GI Bill of Health grasps the understanding that the VA health care system can no longer rely on federal appropriations to ensure its long-term survival.

The GI Bill of Health, together with the Medicare subvention and third-party legislation, advances the goal of providing a continuum of health care services to all veterans while allowing the system to collect and retain payments for the service it renders. Concurrently with the federal appropriations process, these proposals can have a tremendous impact in making the VHA system financially sound.

A recent study mandated by Public Law 103445 entitled "Feasibility Study," transforming the Veterans Health Administration into a government corporation, arrived at many of the same conclusions and offered similar recommendations as the American Legion's GI Bill of Health.

In addition, the American Legion strongly supports H.R. 335, a commission on the future of America's veterans. H.R. 335 authorizes an advisory board of experts and stakeholders to review proposals for the future of VHA and to develop a comprehensive program to test and evaluate new solutions to old problems.

Beginning October 1 of this year, VHA plans to start a pilot enrollment program for veterans as required by the recently passed eligibility reform legislation. Adding two million service disabled veterans who are not currently using VA care to the existing 2.7 million system users will add further concerns to an already overburdened system. It is, therefore, extremely critical that new VHA funding sources are approved and in place by the start of the eligibility reform enrollment system.

With regard to the draft bill on VA physicians' and dentists' special pay issues, we request having our complete statement on this matter entered into the record.

Mr. Chairman, that completes my statement.

[The prepared statement of Mr. Vitikacs appears on p. 86.]

Mr. STEARNS. So ordered. Colonel Partridge.

STATEMENT OF COL. CHARLES C. PARTRIDGE

Colonel PARTRIDGE. Thank you, Mr. Chairman. We appreciate the opportunity to present the views of the National Association for Uniformed Services and the National Military Veterans Alliance.

We have worked on Medicare reimbursement or subvention for quite some time, and just to put it in perspective, it took less time for the Manhattan Project to produce the atomic bomb in World War II than it has to even get started on this. So we really appreciate you holding this hearing.

We support Chairman Stump's H.R. 1362 to establish a demonstration project. We would prefer that we not have a demonstration and move directly into it and perhaps in phases. But given the constraints by the CBO and Health Care Financing Administration, this is probably the best we can hope for, and we support the bill. We particularly like the fee for service model that this bill represents.

Our members look at the Medicare benefit as a benefit they've paid into so when they reach their appropriate age they have a Medicare benefit, and those who are retired have a military medical benefit. They'd like to take that Medicare benefit and use it wherever they can. If they want to use it downtown, fine. They would like also to be able to use it at the VA Hospital. So we like the philosophy behind that.

Concerning the demonstration, we would like to see the evaluation periods shortened, perhaps to 6 months, so that they can—so it will be an ongoing evaluation. And once the kinks are worked out, once everybody is convinced it is going to save money—and we're convinced it will save money—it's going to save the Health

Care Financing Administration money, and it will help the VA do its job, then we could go ahead and implement it.

The Department of Veterans Affairs estimates some 500,000 veterans die in the United States each year. Every year that we delay this, there are some of those veterans who are dying who could otherwise use their benefit in a VA hospital and are not able to do it.

We also recommend that cost sharing be waived for retired veterans. Based on the point I made earlier, based on Exhibit B, which would be part of the record, we believe that is justified. Many of these veterans have Medicare Medigap policies. In that case, the VA would continue to bill those Medigap policies for those who have it.

Regarding the third-party collection effort, we strongly support a bill to revise the way the third-party collection effort is being made. Our basic point is that the money should be collected as close to the point of service as possible. It should be used as close to the point of service as possible, and, of course, the VA should improve its procedures for collecting these fees. We believe fees should be collected for inpatient services, outpatient services and prescription drugs. If a capitation model is approved, of course, capitation funding should be provided.

We believe collection on this basis would more closely resemble the free enterprise system which seems to work very well, and we would like to see—we just believe it would improve the operation and the energy of the VA medical facilities. And we strongly support your provision to exclude these funds from any OMB estimates relative to required appropriations.

This should be rigidly enforced, and it has got to be monitored, because if it's not monitored somehow or other the comptrollers are going to take this into account and cut the appropriations.

Thank you very much, Mr. Chairman, for the opportunity to present our views.

[The prepared statement of Colonel Partridge, with attachments, appears on p. 90.]

Mr. STEARNS. Thank you, Colonel.

Next is Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman, and members of the subcommittee. On behalf of the 2.1 million men and women of the Veterans of Foreign Wars, I thank you for requesting our participation in today's most important legislative hearing relative to the VA health care system.

As you are aware, the VFW has played a strong and active role through the years toward ensuring that all of this Nation's veterans have ready and timely access to top quality VA health care. Thus, we are highly gratified at being included in today's hearing.

Before addressing today's initiatives individually, allow me to unequivocally state that the VFW is committed to seeing the Congress fully fund the VA health care system. At this juncture, only full appropriation support can ensure sufficient funding to provide all eligible veterans with high quality care. Additionally, VA has now set about the Herculean task of transforming itself from an in-

patient centered hospital system to an outpatient-oriented provider of modern health care.

While the efficiencies inherent therein will certainly save tax dollars in the long term, an infusion of capital up front is needed to bring it about. Appropriation support must not be allowed to flag at this critical point in time. It is for this reason that the VFW has championed the causes of both Medicare subvention and retention of third-party insurance collections for VA, but not to take the place of full appropriation support.

The rapid aging of the veteran population, together with increased utilization under eligibility reform, has made the need for additional non-appropriated dollars even more critical. Thus, the VFW enthusiastically supports the thrust of two initiatives under discussion today as they move towards achieving these priority goals.

The first bill we will specifically address today is H.R. 1362, the Veterans' Medicare Reimbursement Demonstration Act of 1997. Calling for VA facilities to be selected from three separate geographical areas, with at least one near a closed military medical facility, this legislation takes advantage of the fact that VA is uniquely qualified to carry out such a demonstration project.

With the world's largest integrated medical system, VA is a direct provider of medical care, not merely a referral agent or a payment conduit, as is the case with most other federal medical programs.

While this bill would have the immediate benefit of directing desperately needed additional dollars into the VA system, it would also offer the most accurate picture of what effect Medicare subvention in the main would have on the Trust Fund. The VFW strongly believes that cost effectiveness of VA medical care will result in significant net savings to the Medicare Trust Fund.

H.R. 1362 represents an excellent opportunity to prove this point, while bolstering the VA system in the process. It enjoys strong VFW support.

Next under discussion is the draft bill to provide for the retention of third-party collection by VA. While strongly supporting this initiative, we note it would effectively create a third-party retention demonstration project of limited duration. We would, of course, prefer to see the enactment of legislation making such authority permanent.

We are also troubled that this proposal would have the unobligated balance remaining in the fund after the demonstration project's termination be deposited in the general Treasury fund as miscellaneous receipts to go towards deficit reduction. Given VA's critical need for additional dollars, and the veterans' already considerable sacrifices on the budgetary front, we hold it to be only prudent and fair to provide that all unobligated collections remain within the VA health care system.

Last under discussion today is draft legislation to lift the application of otherwise applicable financial penalties to certain retirement eligible VA physicians and dentists who hold positions which would not be retained because of changes in staffing arrangements. The VFW concurs that this draft proposal could help VA meet its

new staffing requirements by facilitating the voluntary retirement of these highly compensated individuals. We have no objection.

Mr. Chairman, this concludes my written remarks. Once again, I thank you on behalf of the men and women of the Veterans of Foreign Wars. I'll be happy to respond to any questions you may have.

[The prepared statement of Mr. Cullinan, with attachment, appears on p. 100.]

Mr. STEARNS. I thank the gentleman.

I'm going to go to Mr. Joe Violante, who is Deputy National Legislative Director of the DAV. And I think he'll introduce the other individual.

Mr. VIOLANTE. Thank you, Mr. Chairman, members of the subcommittee. It is my pleasure this morning to introduce the newest member of DAV's legislative staff who will be presenting our views this morning.

Richard A. Wannemacher, Jr., is a combat Vietnam veteran who was appointed Associate National Legislative Director in August 1966. Dick joined the DAV's professional staff as a national service officer at the Buffalo, New York office in 1978, working there until 1980 when he was transferred to the DAV office in Albany, where he served as supervisor. In 1995, Dick was transferred to the National Service Office in Washington, DC, where he served as assistant supervisor until his current appointment.

A native of the suburb of Buffalo, Dick enlisted in the U.S. Navy in 1967. While serving in Vietnam with the Navy's River Division 593, he received multiple shell fragment wounds to his head, chest, and arm, due to an enemy satchel charge explosion. He was retired from the Navy in 1969 due to his service-connected disability.

Dick earned an Associate Degree in Business Administration from Erie Community College, a Bachelor's Degree in Environmental Studies from Buffalo State College, and pursued a graduate degree in studies in business at Canisius College in Buffalo. Dick was our state commander of Department of New York in 1992 to 1993, and he is currently a member of DAV's Chapter 4 in Silver Spring, MD, where he serves as chapter service officer and legislative chairman.

Mr. Chairman, I'll now turn this over to Mr. Wannemacher. Thank you.

Mr. STEARNS. Thank you, and welcome, Mr. Wannemacher.

STATEMENT OF RICHARD A. WANNEMACHER, JR.

Mr. WANNEMACHER. Thank you, Mr. Chairman. Members of the subcommittee, good morning.

As an organization of more than one million service connected disabled veterans, DAV has special interest in maintaining the strong health care delivery system to care for veterans' medical needs. If the VA health care system is to remain a viable provider of care for this Nation's veterans, it must have adequate resources and must maintain and make necessary improvements to its infrastructure.

The DAV, therefore, supports legislation to permit VA to keep and use collections from third parties and Medicare to strengthen the system and make it better able to meet the health care needs

of an aging veterans population at a time when delivery of health care is undergoing radical reforms throughout the private and public sector. This presents a formidable challenge for VA—one that would require full support from the Congress.

It only seems logical that VA should have every incentive for optimum and efficient collection from third-party payers. It also seems logical that VA should be able to keep and invest these collections back into the system. Therefore, Mr. Chairman, the DAV fully supports your draft bill to authorize VA to retain third-party payments.

Similarly, the DAV fully supports H.R. 1362, which would authorize demonstration projects for the collection and retention of Medicare payments. It is to be hoped that the substantial portion of third-party collections would revert to the collecting facility to ensure equitable distribution and stimulate local incentives for maximizing collection efforts.

Because the VA health care system has operated with restricted funding levels for years, and because it must modernize as a cost of providing health care in the most effective, efficient, and state-of-the-art manner, these third-party and Medicare collections must be made available to the VA to supplement full appropriations, however.

Unfortunately, this Administration's budget would use these funds to replace reduced appropriations. Not only is that objectionable because it will not allow VA to enhance its ability to provide health care in a modern setting, it is objectionable because it involves several unacceptable risks. First, VA collections have been falling in recent years, and projections may be too optimistic.

Second, relying on collections to replace appropriations when the passage of authorizing legislation is not assured could very well leave VA with totally inadequate appropriations and without the availability of third-party collections, which would be disastrous under any reasonable prediction.

The full committee's views and estimate discussed these dynamics, and the unavoidable doubts VA's plan raises. I can only say that DAV fully agrees with the committee's views and estimates.

In addition, even assuming passage of the necessary legislation—and that may be a large assumption—and that all elements of the VA plan are fully realized, the overall funding request is inadequate in our view. The Administration's budget would increase health care funding only 5.4 percent over 5 years.

As the Senate Veterans' Affairs Committee observed in its views and estimates, even with legislation you are currently considering, the funding streams would not even be sufficient to cover the cost-of-living adjustments for VA's 225,000 plus employees, estimated by VA to be \$387.9 million for fiscal year 1998 alone.

Therefore, Mr. Chairman, while we fully support these bills and efforts within the committee to provide VA with this much needed funding, these monies must be in addition—not in place of—full appropriations and adequate funding for VA health care, must be assured independent of this very worthy effort.

In closing, Mr. Chairman, I would like to say that the DAV appreciates the concern, support, and dedicated efforts this sub-

committee and the full committee have shown in dealing with this difficult issue.

That concludes my report, Mr. Chairman, and I would be happy to respond to any questions you or the members of the subcommittee might have.

[The prepared statement of Mr. Wannemacher, with attachments, appears on p. 107.]

Mr. STEARNS. Thank you, Mr. Wannemacher, and we are certainly delighted to have you testify. And, of course, congratulations on your new position.

I think this is for all of you at this point. The question would be: the committee is trying to understand how much demand would be anticipated with this program, and maybe you might give me what you think. Specifically, higher income veterans have been unable to get care from VA in the past and have gotten care elsewhere. When you throw in the higher income veterans together with everybody else who is Medicare eligible, what do you think would be the demand we can anticipate in this demonstration program?

And we can just start from my right and just go to the left, if you don't mind.

Mr. VITIKACS. Mr. Chairman, that seems to be the hundred dollar question. I believe that there has to be—the demand is going to be relative to the incentives that veterans will have to come to the VA for their health care as opposed to the private sector. As I understand it, there will be—VA is going to be developing very specific health benefit packages, which may have some certain services included that would not generally be available under the Medicare program.

In the private community, there will be a pharmaceutical benefits package as well. So it really depends, the answer to that, on the incentives—

Mr. STEARNS. Good point.

Mr. VITIKACS. (continuing). That veterans will have to come to VA.

Mr. STEARNS. If you develop an HMO package which includes all pharmaceutical drugs, and those individuals are pretty healthy and might have a high deductible, they might have access in greater proportions than others.

Mr. VITIKACS. And I think the bottom line is what is it going to save the veteran out of his pocket, if anything. It's something else to look at.

Mr. STEARNS. Okay. Colonel.

Colonel PARTRIDGE. I think the first issue is going to be which hospitals are going to do it. There are some hospitals out there, such as Grand Isle, NE and others, that veterans—that retirees and veterans are trying to get in. And if a site is selected like that, I think you'll have very good response.

I think one of the problems has been that over the years retired veterans have been turned away from these hospitals, so it's going to be a matter of attracting them back in. And I think that is where the publicity and the type of package come into play. I think the deductible and co-payment, unless they have a Medicare supplement, will help attract them in. And the pharmacy benefit will

help attract them in, because there is no pharmacy benefit under Medicare.

So I think a package something like that will be very attractive.

Mr. VITIKACS. Mr. Chairman, if I might, I am following up on the gentleman's question. If these Medicare veterans do have Medigap insurance policies, and under the MCCR collection criteria today VA can forego the out-of-pocket co-payment from Medicare eligible veterans with Medigap insurance. So perhaps this would be an added incentive that that Medigap payment to VA can substitute for the out-of-pocket co-payment, and that would be a tremendous incentive.

Mr. STEARNS. Okay.

Mr. CULLINAN. Mr. Chairman, I would say that I would have to agree with Colonel Partridge that in those areas where there is a significant retiree population, that you'll have very good participation right off the bat. For the rest, let me say we believe that VA is a provider of quality health care, and there is a movement afoot within VA to not only improve the quality of the care it provides, but its image as well.

But in order to attract the higher income insured veteran into the system, it is going to have to get that underway. In other words, the VA is going to have to be enabled to open itself up to these veterans, and then we believe the word will get out. As you put together an HMO-like package, including pharmaceuticals and the like, we believe veterans will turn to VA. A number already do for certain types of care.

You know, VA is expert with respect to cardiology. I, too, am from Buffalo, New York, and I happen to know up in that area that if you have a problem with your heart and you can get into VA, you'll certainly do it, because the care level is so high. So that's a contributing factor as well.

And I would add one other thing with respect to the waiver of co-payments and the like. The VFW is of the opinion that all veterans, everything else being equal, are equal, are alike, and we believe that they should all be treated equally regardless of duration of service. So we would certainly like to see any co-payment and the like waived, but for all veterans—all veterans participating in the program.

Mr. STEARNS. Okay. Mr. Wannemacher.

Mr. WANNEMACHER. I'd have to agree with the other three commenters as far as what the benefits package is. The Department of Veterans Affairs currently is developing a standard benefits package throughout the Nation, and it's a nice package. It includes pharmaceuticals, prosthetics, and all acute care, and special surgical procedures. So what is in the benefit package is paramount.

I don't really know if we could make any estimates, though, as to the exact figures. We'd have to examine the whole package. But I think a good examination of the benefits package, and also the Administration's Medicare subvention program that they're looking at, as well as yours, Mr. Chairman, would go a long way in being able to get those analytical figures.

Mr. STEARNS. Mr. Violante.

Mr. VIOLANTE. Mr. Chairman, I don't know that I have much more to add to that, other than there is a lot of factors that need

to be considered, and obviously the packet is one. And I tend to agree in those areas where there are a large number of retirees, since our government has let them down in other ways, that they might be interested in using the VA facilities. Other than that, I really don't have any estimates.

Mr. STEARNS. Thank you. And my time has expired. Dr. Cooksey.

Dr. COOKSEY. Thank you, Mr. Chairman.

Let's say these two pitchers had the funding for the veterans. One of them has the funding for the veterans. Which one would you rather have for the funding for the veterans for next year, for these programs—this pitcher or this pitcher? No takers?

Colonel PARTRIDGE. No takers.

Dr. COOKSEY. Well, this one has nothing in it. That's my concern.

You know, it looks to me that there is a very valid reason to be concerned that there is not—that these projected collections are overly optimistic. And unless we have the appropriations there, you know, for the veterans' hospitals, it is not going to happen.

My next question: how would the veterans' group like to have the same health care system that the members of the bureaucracy have, that the postmen have? And yes, that most of the members of Congress have—the FEHBP as a model?

Mr. VITKACS. I presume we'll go left to right.

That's what the GI Bill of Health, the American Legion proposal addresses, and that is the VA developing a very specific defined health benefits plan that mandatory veterans would receive their care through VA if they choose through appropriated dollars. And the current Category "C" discretionary veterans would be able to utilize the VA system by bringing with them their own various health payment plans.

So yes, to answer your question, veterans would enjoy having the knowledge of specifically what they are eligible to receive, what array of services, what array of benefits, and if they're not included in the "shall provide" category of care, that they be able to still utilize the VA health care system on a choice basis with their own health benefit coverage.

Colonel PARTRIDGE. Military retired veterans are the only federal employees who lose their guaranteed benefit provided by—guaranteed by the Government at age 65. Correcting that injustice has been a long-time objective of ours.

There are a couple of bills out there. Representative J.C. Watts and Representative Thornberry have introduced two bills that would resolve this problem, and we think it is a great step in the right direction. We believe that that is the answer for the veteran with 20 or more years of service who served until retirement. And we strongly support that.

We think it would help the VA as well, because, once again, they could use that benefit in a VA hospital. Just take the plan. That would be very simple, to collect it just like they do other third-party collections.

The CHAMPUS program, which Congress designed in 1967 to be the equivalent of FEHBP, has essentially been destroyed by the Department of Defense. They have used it as a cash cow to fund other programs.

Thank you for the question.

Mr. CULLINAN. Dr. Cooksey, I would first say that the VFW very much appreciates your comments earlier and just now with respect to the appropriations pitcher. We certainly want to see one that is full enough to fill every glass that needs to be filled.

With respect to the other part of your question, at our national convention often times the subject of the health benefits available to others—the Federal Government and, indeed, in the Congress—comes up. And I can tell you that our membership would have a keen interest in being afforded the same health benefits package as the Congress.

Unfortunately, we can't usually guarantee them that that's what we're going to get them, but yes, indeed, they would love to have that.

Mr. WANNEMACHER. Doctor, I think you have to look more at what the VA health care system has done for the world and for the veterans who became disabled in defense of a free and democratic America.

The Veterans Administration health care system is the largest educator for health care practitioners throughout the world. The research that is provided by the VA health care system helps throughout the world as well. The VA also serves as a backup in national disaster for the Department of Defense.

And most importantly, the Veterans Administration, in today's model under the direction of Dr. Kizer, provides quality, cost effective health care. And if you and your health care provider can be guaranteed this same package that veterans enjoy today, then maybe you should look at the VA health care system for health care.

Dr. COOKSEY. That's a good response, and I appreciate that.

And I, too, know that there are some veterans' hospitals and some veteran hospital physicians that are providing good health care. There are problems there in certain hospitals and certain situations, like there are in the private sector. But the ultimate goal is to bring the quality of care up for everyone, and particularly individuals with service connected injuries, particularly individuals like you.

I mean, I saw the area where you were from the backseat of an F-4, and I was glad I was not down where you guys were. You know, and you deserve very special consideration. And I have veterans in my area that in many cases have nothing else. Veterans that are our age that have nothing else to turn to except to the veterans' hospital. They are either unemployed, unemployable, or, in a low income situation, and they need it. And I think that is an option.

I do think that Chairman Stump's bill is the best we can look for under the current circumstances, and it's sort of the situation that Congressman Peterson is in.

I don't know the details of this budget bill yet. I've been to a couple of meetings. But I want to make sure that the veterans that have service connected injuries do not get short changed in the budget shuffle. If they were all veterans in that budget shuffle, they would be better off.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank you. I thank the member.

Mr. Gutierrez.

Mr. GUTIERREZ. Yes, Mr. Chairman, I first wanted to apologize to all of the panelists for having arrived late. I'd like to ask one question of Mr. John Vitikacs of the National Veterans Affairs and Rehabilitation Commission.

I am curious about your proposal for the VA state Medicaid subvention project. Would you tell me how you would establish such a project that would work?

Mr. VITIKACS. Well, I would be more able to define a more broad concept as opposed to specifics. We have many veterans today who are Medicaid eligible, and they are, in fact—fall into the “shall provide” care category within VA on both an inpatient and outpatient basis. Now, most recently, on the outpatient basis with eligibility reform.

We're only raising the question here: is there perhaps greater cooperation possible—is greater cooperation possible between the VA and state governments to provide services to those who would qualify under the state Medicaid program? And without having specific details to address your question, primarily we'd just like to put this issue on the table for further review and discussion.

We think that there is—if we're going to look at all sources of potential non-appropriated funding for the VA system, that this can be something that can be examined the same as the other proposals that we're addressing today.

Mr. GUTIERREZ. I think, Mr. Chairman, if we might officially make an official inquiry to the Veterans Administration about how they see this working—you know, the possibility of something modeled after what we're doing at the federal level at the state level, just to see how they might view that—any, you know, holes that—you know, valleys, things that we might have to overcome. But how we could do that, because I think it's a great idea, and I'm going to go share it with some of my good friends in the state legislature. I think it's great. And, you know, sometimes we forget about all of the states and the Medicaid program.

Thank you so much for raising the issue. I think it's a valuable one.

And once again, Mr. Chairman, to you, to members of the subcommittee, and to the panelists, my apologies for having returned so late. Thank you so much.

Mr. STEARNS. I thank the member. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. Vitikacs, your statement—the American Legion makes a very strong statement—in fact, a very awkward one I think—in support of including the managed care as part of the demonstration project. Are most of the veterans groups in agreement with that, or is that a detail that has not been—

Mr. VITIKACS. I can just speak to our own organization, that we feel, as we heard in the testimony this morning, that to conduct a fair assessment of veteran preferences, patient satisfaction, as well as relative cost savings in a demonstration fee for service program versus a managed care model, that if we're going to take time and effort to develop a demonstration program, let's make it as broad as possible, and evaluate more than just one approach.

Mr. SNYDER. Right.

Colonel Partridge, I think you made the Manhattan Project comparison.

Colonel PARTRIDGE. Yes, sir.

Mr. SNYDER. Do you have any comments on this managed care aspect?

Colonel PARTRIDGE. We have no problem. We think it would probably be a good idea to test the managed care piece of this. Our experience has primarily been with the Department of Defense effort, where the only thing they are testing is managed care. And we just seem to be running head long into a managed care environment, and that's why we were delighted to see this bill had the fee for service piece. That's our view. We would have no objection to doing the other as well.

Mr. SNYDER. And Medicare has, I think, made a very strong guarantee that there will always be a fee for service option.

Mr. Cullinan, you made a comment about HMO models, so I assume that you are in support of the managed care part of it. Do you have any comment there?

Mr. CULLINAN. Yes, sir. By force of national resolution, the VFW calls for all veterans who avail themselves of VA health care to be provided with a full continuum of health care. And that certainly embraces the managed care.

Mr. SNYDER. So you would support the concept of the study of both at this point?

Mr. CULLINAN. Both the concept, the study, and the reality.

Mr. SNYDER. The reality. I understand. The Manhattan Project metaphor, once again.

Mr. CULLINAN. Right.

Mr. SNYDER. And I guess my concern, going back to your Manhattan Project metaphor because I like it, that if we don't do the managed care study now, and then 2 or 3 or 4 years down the line we start thinking, well maybe we need to move into managed care, we will have put ourselves back in another Manhattan Project when it may be the investment of time, recognizing that, you know, it may not work out. And it may be time to do it.

Mr. Wannemacher, do you have any comments there?

Mr. WANNEMACHER. I'd have to agree with what the others have said. If you're going to look at the subject, you'd better look at the whole subject.

Mr. SNYDER. Yes. And then a question for the man from the American Legion. This discussion about if we're going to have some hospitals that are so busy right now that, as we increase our participation by the goal of 20 percent over 5 years, we're going to have some problems. I guess your thoughts—and I think the goals of the VA, too, about more outpatient care and some outreach facilities for better geographic access—that is going to take care of part of that problem down the line if we move in that direction. Is that—

Mr. VITIKACS. If the question is what criteria should be developed, certainly, we want to look at the rural health care facilities.

Mr. SNYDER. Right.

Mr. VITIKACS. We want to look at the full service facility. That's the urban highly affiliated tertiary care facility. We're going to have a broad array of VA hospitals included in the ultimate study,

as well as what other topics were mentioned this morning, and that is the management ability of cost accounting utilization management, socioeconomic demographics, as well as veteran demographics. So I think we need to really not exclude anything but include all of the available options.

Mr. SNYDER. And I assume it's a fair statement to say, also, that you all—if this bill passes, and we all hope it does in some form, that you all are going to be monitoring this also from your perspective.

If I could just make one final comment. I spoke at an American Legion auxiliary—the Women of the American Legion—a couple of weeks ago, and brought up the topic of Medicare subvention and mentioned the word and got a lot of heads nodding in the audience. So somebody has been doing their work out there.

And I'll just make the comment, I don't know how easy a sell this is going to be to get these bills through Congress, but I sure hope you all are prepared to not just educate the Veterans' Committee, as I know you will be, I mean, you need to go out there and really work on the rest of Congress with whatever the final version.

Thank you very much.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentleman.

I think we are completed.

I'm just curious, does anyone know how we got the word "subvention" for this? (Laughter.)

I know when it first came to me and I heard it, and the veterans were telling me in town meeting, I went back and I said, "How did they come up with subvention as a word?" I mean, I could come up with some more appropriate terms.

But at any rate, I want to thank——

Dr. COOKSEY. Mr. Chairman?

Mr. STEARNS. Yes?

Dr. COOKSEY. I can assure you it was not a physician that came up with that term. I bet it was a lawyer. (Laughter.)

Mr. STEARNS. I thank the panel.

Mr. STEARNS. We'll now welcome the third panel, Dr. Samuel Spagnolo, President, National Association of VA Physicians and Dentists; Chuck Burns, National Service Director, AMVETS; Kelli Willard West, Director, Government Relations, Vietnam Veterans of America; John Bollinger, Deputy Executive Director; Paralyzed Veterans of America; and Larry Rhea, Deputy Director of Legislative Affairs, Non Commissioned Officers Association.

Let me welcome the distinguished panel, and I think we'll start with Dr. Spagnolo and his opening statement. And I appreciate everybody sitting through the other two panels and their patience. And I think you heard the same information that we did, so you have the benefit of what they said.

So with that, let me open up.

STATEMENTS OF SAMUEL V. SPAGNOLO, M.D., PRESIDENT, NATIONAL ASSOCIATION OF VA PHYSICIANS AND DENTISTS; CHUCK BURNS, NATIONAL SERVICE DIRECTOR, AMVETS; KELLI R. WILLARD WEST, DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA; JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR; PARALYZED VETERANS OF AMERICA; AND LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION

STATEMENT OF SAMUEL V. SPAGNOLO, M.D.

Dr. SPAGNOLO. Thank you, Mr. Chairman, and members of the subcommittee.

I, too, sat through this morning's session and found it very interesting. And actually, before I make my remarks, my only comment, I guess, having listened to all of that is that I'm very sure now that 30 years ago I made the right decision to be a physician and not an administrator.

But with that being said, I am honored to be here and appreciate the invitation. I have served the health care needs of the veterans for nearly 30 years. It seems like a long time, and I guess it has been. And I come to you today as President of the National Association of VA Physicians and Dentists. I am very proud to represent this organization. These are dedicated men and women who are committed to improving the health care of America's veterans, those veterans who have put their life at risk to serve this country.

I also, this morning, found it somewhat interesting again to be receiving what seems to be a mixed message from the Administration: "We want to bring in lots of new patients, but we also want to fire all of the doctors." And that seems to me a bit strange. So think about that a little bit.

NAVAPD is very pleased that you have put this draft bill on the agenda this morning and are trying to address some of the needed changes in Public Law 102-40. As you are well aware, this is the first time in the history of the VA that the VA has plans to eliminate physicians and dentists.

This is being done under a very new directive, which has been titled 5111, and which gives very broad authority to hospital administrators to fire physicians and dentists. Under this new authority, there are many facilities around the country that are bracing themselves for major reductions. Long Beach, for instance, has been told they're going to lose 15 percent of their physicians and dentists across the board. At what price are we going to destroy 15 percent of those people and destroy their careers?

I recently wrote that this directive, 5111, and the atmosphere of secrecy in which these reductions in force have been planned, has fostered distrust and sparked a wave of rumors, all of which have undermined physician morale. It's a very serious situation.

More than a year ago, I wrote Under Secretary Kizer, and I suggested to him an alternative to these firings—a very simple solution. Let's do something to suggest and improve the possibility for voluntary retirement. This would eliminate the need perhaps for all of these firings.

Let me also state that NAVAPD is not necessarily opposed to the elimination of some positions, and we're not suggesting that some reduction in Title 38 personnel, at certain facilities, is unreasonable. The VA is caring for less patients. There is a lot of redundancy in the system. And there may be certain places where reduction in force may be an appropriate thing to do. We are saying that these things should be voluntary and not result in firings.

The current draft legislation is a first step. We are very supportive. However, it does not include the provision of voluntary leaving. Simply striking Section C, under paragraph 2, would restore back to the physician the right to make their own retirement decisions. NAVAPD thinks this is a fair way to do it. In fact, we think it's the right thing to do.

I appreciate the opportunity to come here. I thank you very much for taking a look at this critical issue for the physicians and dentists, and I'd be happy to work with you further on a draft bill.

Thank you very much.

[The prepared statement of Dr. Spagnolo, with attachment, appears on p. 112.]

Mr. STEARNS. I thank you.

And Chuck Burns is next.

STATEMENT OF CHUCK BURNS

Mr. BURNS. Thank you, Mr. Chairman. I'll be very brief. I am not going to gild the lily with anything additional. I think it is obvious that all of the VSOs are strongly supportive of this legislation.

AMVETS, in conjunction with the independent budget, DAV, PVA, VFW, has been supporting and calling for initiatives such as these for several years. We support the idea that VA has to evolve to meet the needs in a new health care environment. Medicare reimbursement, retention of third-party collection, and user fees meet the objective of supplementing VA's budget.

We are adamantly opposed, however, to these dollars being used to offset federal appropriations that are required to cover the cost of anticipated increase in workload at VA. They should not be used as substitute funding by OMB as contained in the Administration's request to straight line VA appropriations through the year 2002. By straight lining the VA appropriations, we feel the Administration is, in essence, gambling with the health and well being of millions of veterans.

Regarding Medicare reimbursement, obviously, we are in agreement with our fellow VSOs in that this is a good idea. It would offer low priority veterans an opportunity to use Medicare to reimburse their VA care, thereby saving federal tax dollars. The only thing keeping this optimal program from taking effect is the complicated rules for scoring such legislation, as we heard earlier this morning.

Retention of third-party collections, obviously, again VA should be allowed to retain the additional revenues veterans bring into the system. We believe that VA headquarters should eliminate its centralized medical care cost recovery office and authorize VA networking directors to contract for their cost recovery efforts as in the private sector.

We believe that allowing VA to retain the cost of care from third parties will ensure a fully supported recovery effort. With the additional funds, VA would be able to enhance care for current users and increase access for low priority veterans.

AMVETS is also supportive of the notion that if VA is permitted to collect and retain third-party funds, it could begin treating the veterans' adult dependents. Obviously, additional people in the VA system would provide additional resources and would enhance care available to high priority veterans. It also creates choice.

And we believe that this should be examined as a new business opportunity under which VA could control treatment of dependents and ensure their ability to pay before service was rendered. We caution that this should not be done so as it reduces services or quality of care to veterans.

We strongly urge Congress to authorize Medicare reimbursement for higher income veterans and their dependents, and retention of third-party reimbursement for current veteran users, new veteran users, and veterans' dependents. VA must change to survive, and we view some recommendations and prescription for changes as proof that VA concurs with many of our past recommendations.

Mr. Chairman, I would ask that my written statement on lifting the application for certain retirement eligible veterans be made part of the record.

This concludes my statement, and I appreciate the opportunity to testify.

[The prepared statement of Mr. Burns appears on p. 119.]

Mr. STEARNS. So ordered. Thank you.

Mr. West? Ms. Kelli, excuse me.

Ms. WEST. That's quite all right.

Mr. STEARNS. Ms. Kelli West.

STATEMENT OF KELLI R. WILLARD WEST

Ms. WEST. Right. Good morning, Mr. Chairman, and members of the subcommittee. On behalf of Vietnam Veterans of America, I appreciate the opportunity to be here and discuss these very important issues.

We believe that the Medicare reimbursement bill and the MCCR reimbursement bills are, in combination with eligibility reform passed in the last Congress, probably the most important health care legislation coming before this committee in recent history.

We support both of the bills, and in the interest of being brief, I'll just raise a couple of comments about the bills.

With regard to the MCCR reimbursement legislation, we would recommend that the committee, either in the legislative language or in committee report language, make some recommendations to the VA about how reimbursement and collections should be split between the local facilities and/or the VISN and VA's national objectives.

I don't have any specific percentage in mind as to what we feel should be kept at the local level. But we do feel very strongly that a large portion, as large as possible, be retained at the local level so that incentives for improving services and collecting the reimbursements will be in place.

With regard to the Medicare reimbursement legislation, there are two provisions that we feel could be improved upon. We're concerned that excluding high income Medicare eligible veterans is, first of all, restricting their choices, and also may not give an accurate read on the pilot project. Similarly, imposing a \$50 million per year restriction on the Medicare payments may exclude some veterans from participating in the project and may, again, skew the data on costs and participation.

We do want to raise, in this forum, a concern we have raised before regarding how all of these changes are affecting specialized services, including post traumatic stress disorder and substance abuse treatments. We don't disagree entirely with VA's objectives of shifting these to more outpatient-based treatment modalities, but we are concerned that inpatient treatment should not be totally eliminated. There are certain veterans for whom that kind of therapeutic setting will be the only method appropriate for treating their complex multiple problems.

A case in point is the homeless veteran population. If a homeless veteran has a substance abuse problem, in combination with a post traumatic stress disorder situation, they don't have anywhere to serve as a respite while they are receiving only outpatient treatment. So we're pleased that this subcommittee has put on your oversight agenda monitoring those changes, and we urge you to be very vigilant, as we intend to be.

In closing, I'd just like to, as many of my colleagues have done, commend the House Veterans' Affairs Committee for your foresight and caution with regard to the budget recommendations of the Administration. We agree wholeheartedly that if this legislation passes to bring the new revenue streams into the VA, these revenue streams should not be used to offset the federal appropriation.

The core purpose of the VA serving service connected disabled veterans and low income veterans has to maintain federal priority, and that can only be done with secure funding.

I'd be happy to respond to any questions. Thank you.

[The prepared statement of Ms. West, with attachments, appears on p. 123.]

Mr. STEARNS. I thank you. John Bollinger.

STATEMENT OF JOHN C. BOLLINGER

Mr. BOLLINGER. Thank you, Mr. Chairman. I'll be brief and would request that my written statement be included in the record.

Mr. STEARNS. So ordered.

Mr. BOLLINGER. PVA strongly supports the proposed legislation that is before us today. We think it's a good idea, and we have encouraged passage of legislation like this for some time now.

We have heard a couple of times this morning that the general intent of both the Administration's bill and this legislation is the same. I think maybe it would be helpful to you as you proceed with this legislation if I could perhaps tell you at least a couple of our concerns in regards to the Administration's bill.

First, we would hope that this pilot project that you're proposing wouldn't lead to legislation beyond H.R. 1362 that would be used to replace appropriated dollars for VA health care. And I think Dr. Cooksey said it extremely well earlier on today. In our support over

the years for this kind of legislation, it has always been with the caveat that these collections would supplement and not be used to replace an adequate appropriation for VA medical care.

As we testified earlier this year, we are very concerned with the Administration's proposal, which banks very heavily on funds from reimbursements instead of using appropriated funds. This is extremely troubling when you consider that Congress hasn't passed such legislation in the past.

It is troubling when you consider that the proposed cuts in appropriated funds will extend up through fiscal year 2002, and that it comes at a time when VA will be treating an increasingly elderly population, and also at a time when these funds are going from—already scarce funds are going from the northeast down to the south at a time when VA is trying to restructure itself. So there are a lot of things coming together here that makes this very worrisome from our point of view.

The other thing I'd like to say is that the—just in regards to the current status of the budget negotiations. It has really placed us in kind of a worst case scenario, because on one hand, if VA does get legislation to keep third-party payments as recommended by the Administration, we have been asked to consider covering that loss to the deficit reduction by agreeing to accept several billions of dollars in cuts in other programs for disabled veterans. And we find that pretty difficult.

Two quick other things. I think one of our concerns is VA's ability to collect this money—I think, historically, the track record hasn't been very good. Collections have actually fallen. I know that the incentives aren't there, but collections have actually fallen in the last couple of years, and the costs of collection have risen. So no question, we think it's a gamble to rely solely on that money to support VA health care.

And finally, just let me say that, Mr. Chairman and members, that PVA members use this system. This is a system we rely on. It's not like going down to the doctor on the corner and getting a prescription. We use the VA for pharmaceuticals, for over-the-counter supplies, rehab., sustaining care, long-term care, acute care. The majority of our members use the VA. We rely on it to get up in the morning, to go to work, to take our kids to school, to do all of those things that perhaps a lot of people take for granted.

So it's a system very important to us, and it's a system that we don't want to gamble on as far as these third-party and Medicare reimbursements are concerned. So we support that proposal, but we want to see the appropriated money there to ensure that the VA is able to deliver quality care.

Thanks.

[The prepared statement of Mr. Bollinger, with attachments, appears on p. 132.]

Mr. STEARNS. I thank the gentleman.

We are going to temporarily recess and reconvene after—I have a car downstairs, so we'll be back shortly.

[Recess.]

Mr. STEARNS. Well, thank you for your patience. I think we'll reconvene the Subcommittee on Health, and we have Larry Rhea is next on the panel number three.

And, Larry, thank you for waiting.

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you very much, Mr. Chairman. I appreciate your patience and attention to this issue this morning. It is encouraging to all of us.

We are pleased to be included among the list of witnesses asked to provide comment and testimony on these measures today, and we thank you very much for having us here to do just that.

In short, Mr. Chairman, the Non Commissioned Officers Association supports the two measures that deal with health care receipts for VA. And since the association does not have a position on the physician pay draft legislation that you're taking a look at, we decline any comment on that particular bill.

I think it is important though that I say NCOA supports H.R. 1362, and I could leave it there. But I think there is one or two things that I maybe need to comment upon. First of all, I wish Dr. Cooksey was here. I certainly would like to thank him for his comments relative to the appropriations. They're right on the mark with what NCOA has said for many, many years.

And that is, if veterans have earned VA health care as a result of their military service, then we shouldn't have to be going through all of these gimmicks as far as funding and everything else. If they, in fact, have earned it as a result of military services, appropriate and adequate appropriations should be provided, and we shouldn't have to rely on Medicare or third-party receipts, or charging some veterans and not charging the others. It doesn't make any sense to us.

But the other compliment that I would like to extend is also to Dr. Cooksey and Dr. Snyder here. Even before we left for the short break there, Mr. Chairman—and to get to this point of being anchor on the last panel, you usually have only the Chairman and the ranking member present. Okay? Now, I know that is out of necessity and required, but it is also as part of an interest on the part of you particularly.

The Non Commissioned Officers Association, Dr. Snyder, and to Dr. Cooksey, even though he is not here now, your presence here for the length of this hearing indicates a real interest in this issue, and for that we are sincerely grateful and we appreciate it very much.

Also, Mr. Chairman, I want to thank you for your question to Dr. Kizer and Ms. Buto in relation to the military retired veterans. And I think Dr. Kizer's response was something along the lines that it would be inappropriate to set priorities for the demonstration's project. Ms. Buto brought up the point that there was a similar demonstration project planned for the Department of Defense that would, in effect, take care of the military retired veterans.

And I noticed a lot of heads in the room at that time shaking up and down in agreement when, in fact, they should have been shaking in disagreement with what those two individuals said. And frankly, I was disappointed in Dr. Kizer's response, because it ignores several things.

The entire VA health care system is, in fact, a system of priorities. H.R. 1362 that we're discussing this morning specifically tar-

gets certain individuals. And it seemed pretty clear to the Non Commissioned Officers Association that somebody who was responsible for drafting the legislation had in mind the military retired veteran in the selection of site facilities for the project, because the measure specifically states that one of the sites selected shall be in the vicinity or within the catchment area of a military treatment facility that was closed as a result of base closure and realignment.

So it seems to me that somebody had given some thought to the military retired veteran in this particular bill, and we appreciate that because surely our view recognizes the plight that these veterans have been suffering for a long, long time.

In regards to Ms. Buto's comments, though, that the DOD piece on Medicare reimbursement would take care of the military retired veterans is simply incomplete at best. Today, only about 25 percent of military retired veterans have access to military treatment facilities. Under the proposed DOD legislation, less than one-third of the military retiree veterans would benefit from that.

So our request of you was simply, in view of the fact that BRAC was included, and it appeared to us that the retired veteran was a target, we are simply asking you to make that explicit in this legislation.

We included in our testimony comments on the cost recovery draft legislation, and the requested waiver of co-payments. Our comments are in our written statement, which you have indicated would be a part of the record. I would ask that your attention be devoted to that request of ours.

And I thank you very much, Mr. Chairman.

[The prepared statement of Mr. Rhea appears on p. 138.]

Mr. STEARNS. Thank you, Mr. Rhea. And as you pointed out, it will be a part of the record. And any questions that the members wish to answer can be put in the record and given to the panel, and then replies can also be returned.

And I think we asked the question, you know, about military retirees being priority, because we wanted to hear for the record what they had to say.

I think we're finished with the panels. Both myself and the other members will proceed with our questions.

I have a general question for all of you, which is: deciding where to locate these particular sites. Dr. Spagnolo had mentioned one particular hospital he is concerned about. Maybe the priority should be for us to look at hospitals. Maybe that is one priority. As I say, which hospitals should the demonstration project be located at which would benefit a hospital that perhaps is suffering some downgrading? I mean, I don't know.

But let me just start from right to left with Mr. Rhea, if you would comment on that, on how you think the site selection should occur.

Mr. RHEA. I think one site was mentioned. I believe it was Mr. Partridge from the National Military and Veterans Alliance mentioned a hospital in Nebraska where veterans, including military retired veterans, are pushing the doors down to try to get in.

Selection of a site such as that might not work to our advantage, and I say that because even under this legislation these veterans that we are trying to attract are the lowest priority as far as treat-

ment within VA. So I would suggest that we would look at facilities that would have the capacity.

Maybe some that are not utilized to their full capacity right now, look at facilities that have a capacity to handle increased people. Because if this is an option, the first time one of these people comes there, endures a long waiting line, or waits 2 months for an appointment, I simply don't think that they are going to stay with it too long when they have other alternatives.

Mr. STEARNS. Mr. Burns.

Mr. BURNS. I'll agree with what has been said earlier in terms of siting these demonstration facilities and just emphasize the fact that wherever they are, they have got to be a full service facility. It can't just be an outpatient clinic. It can't just be a cardiology unit. It has got to be a full service facility capable of treating the needs of all of the veterans in that area.

And I think, if I heard Dr. Kizer's response this morning, the one element that he left out that I was amazed to hear was the veterans population in a certain area. I didn't hear that at all. I think rural health care, the VA consideration, definitely needs to be demonstrated.

I know in my home state of Tennessee we're fortunate to have four VA facilities there, and an excellent facility in Nashville that is affiliated with Vanderbilt University, and another one just 30 miles down the road in Murfreesboro that literally they are knocking the doors down in the rural areas of Tennessee to get into.

And again, I would like to put in a plug for at least one of these areas being in a rural area of the country.

Mr. STEARNS. Dr. Spagnolo.

Dr. SPAGNOLO. Well, I would agree with the comments already expressed. We haven't looked at this critically within our organization. We'd be delighted to go back and take a look at this. But I think if you're going to do these demonstrations, you're going to have to look at infrastructure and need, so we would be happy to come back to you with some more information if you'd like.

Mr. STEARNS. It would be nice to have the perspective of the National Association of VA Physicians and Dentists for the record, if you don't mind. That would be good.

Dr. SPAGNOLO. I'd be happy to.

Mr. STEARNS. Ms. West.

Ms. WEST. Sure. Vietnam Veterans of America doesn't have specific recommendations on which sites should be selected. But I would suggest that the broadest diversity of types of facilities be utilized. As my colleague from AMVETS indicated, test rural, urban, highly concentrated veteran populations, perhaps less concentrated veteran populations, areas where there are high levels of older veterans and also younger veterans.

I think the broader experience we can glean from the demo. projects, the more useful the data will be for future planning.

Mr. STEARNS. Thank you. Mr. Bollinger.

Mr. BOLLINGER. Mr. Chairman, thank you. My recommendation would be for the three sites to cover the range of all specialized services that the VA provides now. So blind rehab., spinal cord injury, mental health, post traumatic stress, all of those specialized services, so that you're sure that you cover all of those. For exam-

ple, there are 22 spinal cord injury centers, so I would hope that at least one, if not two, of the sites would include spinal cord injury facilities along with the tertiary care that supports them in this project.

Mr. STEARNS. Thank you.

Dr. Spagnolo, just a quick question on the physician pay bill. Do you feel the bill, as it is structured now, denies retirement eligible physicians the right to retire? In other words, do you feel, as the bill is written now, it should be improved?

Dr. SPAGNOLO. Yes. As I noted in my comments, it primarily permits those physicians who get targeted for being fired the option, then, to retire without losing their benefit.

Mr. STEARNS. So if—

Dr. SPAGNOLO. We would like to strike that and just let any of the physicians who are eligible to retire, just let them retire. That's our concern.

Mr. STEARNS. Okay. All right. My time has expired.

Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Well, first, I'd like to just state my belief that enabling local VA medical facilities or VISNs to retain a percentage of the Medicare and third-party reimbursements that they collect is something that I think the subcommittee should seriously consider. I think it is an important part of building greater efficiency and local control, certainly incentives into the system.

Ms. West raised the issue and I'd like to just state for the record that I am pleased that she did so.

And then I have one question to Dr. Spagnolo. I'd, first of all, like to assure you that this committee recognizes some of the serious concerns about physician and dentist morale, and the implication it has for quality of VA care. And I wanted to differ with you on one point, however.

The legislation would allow VA to use voluntary separations as a means of reducing the physician workforce. Tenure would protect many of the physicians and dentists that this legislation would affect. Voluntary separations could alleviate the need for reductions in workforce for those with less tenure, in particular, services of facilities that require downsizing. In other cases, physicians or dentists would still have to choose retirement but will receive the benefits of special pay.

What we don't want to have happen, I think, is our most valued and experienced physician staff taking a retirement option when the VA still needs them. And so I just wonder, maybe you could share with us your view on how we can adjust the legislation to ensure that the VA retains the physicians that it needs in the areas and the specializations that it needs them in and the experience.

Dr. SPAGNOLO. Well, I'm not sure how to answer that very straightforwardly and simply, because there seems—there were about five different kinds of questions there. And I don't think any of them have a real simple answer. I just think that we need to make this workable, clean, doable, and rapidly doable—because we don't have time, frankly, to argue over the next 6 or 8 months. I've

already waited a year just to get this far, and when Dr. Kizer could have probably done this easily a year ago.

I don't think you are going to lose the most valuable people in the system, provided you make it a system in which they want to work. But the way this is being done is making it a system where nobody wants to work, and you're going to have trouble recruiting people if you continue to do this.

So let those people, who want to retire, retire. As far as I know, there are no other government agencies in which if you've put in 30 years of service in the Government—some of our physicians have 40 years in with the Government—that you can't retire, because you don't meet the 15-year requirement in the special pay law. So they have only 13 years perhaps in with the VA, and they can't retire. It doesn't make any sense. You have your 30 years in, and you want to retire, let's allow them to retire.

When the original bill was made, the original law 8 years ago, these provisions were slipped in. It's not clear why they were even put in at that time. They didn't belong there, and they really, I don't think, had much to do with recruitment and retention. So let's make it clean. Let's make it simple. Let's get it done. And let's move on, then, to really doing what we're all here to do, and that's improve the quality of care for the veterans. The more this drags out, the more I fear that that is going to be in jeopardy.

Mr. GUTIERREZ. Thank you, Dr. Spagnolo.

And thank all of the members of the panel. I really appreciate your patience and waiting through the morning to give your very valued testimony.

Thank you very much, Mr. Chairman.

Mr. STEARNS. I thank the member. And Dr. Cooksey.

Dr. COOKSEY. Let me ask you, does anybody know, are there any tentative lists, proposed lists, of three areas, three regions for the facilities? Does anybody know? That answers my question.

Dr. Spagnolo, how many MDs, DDSs, DOs, are in the system that you are representing?

Dr. SPAGNOLO. Well, as you know, there are more than 15,000 physicians and dentists in the whole system. We represent, at the moment, nearly 3,000 of those people, in terms of paying members. We feel we represent them all, but some pay—

Dr. COOKSEY. So 15—

Dr. SPAGNOLO (continuing). Some pay their dues and others don't pay their dues.

Dr. COOKSEY. Okay. So 15 percent of 15,000.

That's all. Thank you, Mr. Chairman.

Mr. STEARNS. I thank you, Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

The same question I asked before, please, for Mr. Bollinger and Ms. West and Mr. Rhea and Mr. Burns—the issue of capitation. As you know, I think almost everyone on our committee, on the full Veterans' Committee, is a co-sponsor of 1162. But it does not have a provision in there for the study, including the capitation part of it.

And I think we've had 100 percent agreement from the other VSOs today that we need to include that. If you all could make a comment on that, please.

Mr. RHEA. Certainly, the Non Commissioned Officers Association would have no objection at all to including it in there. And it probably would be very valuable to do so.

Mr. SNYDER. Thank you.

Mr. BURNS. I'll go along with that, and just state that AMVETS believes that you cannot have a viable demonstration project without including some capitation in it.

Dr. SPAGNOLO. No. I have no comment on that.

Ms. WEST. I'd agree with my colleagues that we're going to be able to gain the most valuable information from the demonstration project if it looks at a whole range of issues, including managed care capitation.

Mr. BOLLINGER. And we'd be interested in that analysis as well.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. STEARNS. Thank you, Dr. Snyder.

I want to thank all of the panelists for their patience to wait through our votes and wait through panels one and two. And we look forward to taking and looking and reading your testimony, and see if we can incorporate some of your ideas.

And I just hope that under the 105th Congress we can move this forward. You can see some of the controversy here, and we're going to have to convince our colleagues at CBO, in the case of the Medicare subvention, that there is a way to solve some of their concerns. And we're going to work on that.

So with that, without any further testimony, the subcommittee is adjourned.

[Whereupon, at 12:59 p.m., the subcommittee was adjourned.]

APPENDIX

Statement by Rep. Luis V. Gutierrez
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives
May 8, 1997

THANK YOU, CHAIRMAN STEARNS FOR CONVENING THIS IMPORTANT HEARING TO DISCUSS MEDICARE AND THIRD-PARTY REIMBURSEMENTS AND VA PHYSICIANS SPECIAL PAY LEGISLATION.

THE IMPORTANCE OF THESE ISSUES FOR THE FUTURE OF VETERANS HEALTH CARE IN OUR NATION CANNOT BE OVERSTATED.

AS THE MEMBERS OF THIS COMMITTEE KNOW, THE DEPARTMENT OF VETERANS AFFAIRS HAS IDENTIFIED THE COLLECTION OF MEDICARE AND THIRD-PARTY REIMBURSEMENTS AS AN IMPORTANT SOURCE OF INCOME TO MEET THE FUTURE NEEDS OF VETERANS THROUGHOUT AMERICA.

AS PART OF THEIR 30-20-10 PLAN, THE VA INTENDS TO MAKE UP 10 PERCENT OF THEIR FUNDING FROM NON-APPROPRIATED SOURCES SUCH AS MEDICARE AND THIRD-PARTY PAYMENTS.

I WAS PLEASED THAT THIS COMMITTEE AGREED THAT FISCAL YEAR 1998 WAS TOO SOON TO DEPEND ON THESE REIMBURSEMENTS TO MAKE UP FOR DECREASING APPROPRIATIONS.

HOWEVER, THE SUPPORT OF THIS COMMITTEE, THE COMMITTEE ON WAYS AND MEANS AND BOTH HOUSES OF CONGRESS IS REQUIRED FOR THE VA TO GAIN THE AUTHORITY TO COLLECT THESE NON-APPROPRIATED RESOURCES.

PROMPT ACTION IS NEEDED ON THE LEGISLATION WE WILL DISCUSS TODAY.

THE CHAIRMAN AND I ARE BOTH ORIGINAL CO-SPONSORS OF HR 1362, THE VETERANS MEDICARE REIMBURSEMENT DEMONSTRATION ACT.

HR 1362 IS DESIGNED TO ENABLE THE VA TO PROVIDE CARE TO MEDICARE ELIGIBLE VETERANS WITHOUT FURTHER BURDENING THE EXISTING VA HEALTH CARE INFRASTRUCTURE.

I AM PARTICULARLY PLEASED THAT THIS LEGISLATION WILL ESTABLISH A FEE-FOR-SERVICE STRUCTURE INSTEAD OF A MANAGED CARE SYSTEM.

VA OUTPATIENT CLINICS ARE ALREADY EXTENDED BEYOND THEIR DESIGNATED CAPACITIES. MANAGED CARE MAY ONLY CONTRIBUTE TO MORE STRAINS ON THE VA'S OUTPATIENT SYSTEM.

THE FEE-FOR-SERVICE APPROACH PREVENTS THIS POSSIBILITY, WHILE ENSURING THAT MEDICARE ELIGIBLE VETERANS MAY STILL USE THEIR BENEFITS AT VA MEDICAL FACILITIES.

IN ADDITION, THIS LEGISLATION MAY ALSO SAVE THE MEDICARE TRUST FUND FIVE PERCENT PER EACH SERVICE PERFORMED BY THE VA DURING THE LIFE OF THIS DEMONSTRATION PROJECT. THIS IS A FACT SEEMINGLY OVERLOOKED BY THE CONGRESSIONAL BUDGET OFFICE.

WHILE I RECOGNIZE THE COMPLEXITIES INHERENT TO MEDICARE SUBVENTION, THE NEED TO FIND ADDITIONAL RESOURCES FOR THE VA TO MEET ITS OBLIGATIONS TO VETERANS MANDATES THAT WE MAKE THIS OPTION WORK.

THE BEST WAY TO GAUGE THE AFFECTS OF SUBVENTION IS BY IMPLEMENTING THIS DEMONSTRATION PROJECT.

THIRD-PARTY REIMBURSEMENTS ARE VITAL AS WELL. CURRENTLY, THE VA HAS THE AUTHORITY TO COLLECT THESE PAYMENTS BUT IS NOT ABLE TO RETAIN A MAJORITY OF THESE PREMIUMS.

INSTEAD, THEY ARE RETURNED TO THE U.S. TREASURY FOR DEFICIT REDUCTION UNDER PAYGO RESTRICTIONS.

I AM HOPEFUL THAT THIS COMMITTEE AND THE 105TH CONGRESS WILL REALIZE THE NEED TO ALLOW THE VA TO KEEP THESE PRECIOUS DOLLARS.

IF WE ARE TRULY COMMITTED TO A MORE EFFICIENT, COST-EFFECTIVE AND USER FRIENDLY VA THAN WE MUST ADEQUATELY FUND THE SYSTEM THROUGHOUT THIS PERIOD OF TRANSITION.

THIS IS THE MOST RESPONSIBLE STEP WE CAN TAKE FOR THE MEN AND WOMEN WHO SERVED AND SACRIFICED IN OUR NATION'S ARMED SERVICES.

I AM LOOKING FORWARD TO HEARING FROM ALL OUR WITNESSES TODAY AS WE TRY TO FIND THE BEST WAY TO ADDRESS THESE IMPORTANT ISSUES.

THANK YOU AGAIN.

THE HONORABLE MICHAEL BILIRAKIS

SUBCOMMITTEE ON HEALTH

MAY 8, 1997

HEARING ON PENDING LEGISLATION

Thank you, Mr. Chairman.

First, I want to commend you for scheduling this hearing on several important bills.

H.R. 1362, the Veterans' Medicare Reimbursement Demonstration Act of 1997, calls for the VA and HHS to establish a three-year demonstration project in three of VA's geographic service areas. Under the bill, VA could collect and retain Medicare payments for services provided to certain Medicare-eligible veterans.

As a veteran and the representative of a congressional district with a large veterans population, I strongly believe that this proposal deserves further examination. As the Chairman of one of the congressional subcommittee's with jurisdiction over the Medicare program, I must also take into account the impact that subvention could have on the Medicare trust fund which is facing severe financial difficulties.

In this regard, I am anxious to hear from our witnesses about potential benefits and costs of H.R. 1362. Both the VA health care system and the Medicare program stand to benefit if a budget neutral subvention demonstration program can be devised, and I look forward to working with my colleagues and the veterans organizations on this important issue.

With regard to the draft bill to allow the VA to retain medical care cost recoveries (MCCR), I also believe that third-party reimbursement is another issue which deserves to be examined by our Committee.

Although I strongly disagree with the Administration's budget proposal which relies on the enactment of legislative initiatives to meet the VA's medical care funding needs, I support the use of third party reimbursements as a supplemental funding source for the VA health care system. The draft legislation we are considering today will provide the VA with added incentives to increase their reimbursements from third party insurers.

As always, I look forward to working with my colleagues on this Subcommittee on the issues we are considering today. I am anxious to learn of any recommendations our witnesses may have on ways we can improve the legislation we will be discussing.

Thank you, Mr. Chairman.

**Statement of the Honorable Mike Doyle [PA-18]
Hearing of the Subcommittee on Health
of the Committee on Veterans' Affairs
to consider legislation affecting veterans' health care**

May 8, 1997

I would like to thank our Subcommittee Chairman, Mr. Stearns, and Ranking Member, Mr. Gutierrez, for holding this hearing on these important measures affecting veterans health care. This is a critical time for health care provided by the Department of Veterans Affairs (DVA), as service networks across the nation are making significant changes in the way they provide medical services to our veterans. These changes are especially important in the Pittsburgh area, which includes 3 DVA medical facilities and one of the largest population of veterans in the nation.

I would specifically like to address the bipartisan Medicare subvention legislation we are considering today, which I am pleased to have cosponsored. This legislation, H.R. 1362, establishes a demonstration project under which the DVA would be reimbursed by Medicare for the services it provides to some Medicare-eligible veterans. Enactment of this measure would allow more veterans the option of receiving medical care in DVA facilities. Many veterans, because of funding shortfalls and low priority status, are currently excluded from acquiring this care within the DVA.

This Medicare subvention legislation, as well as the Medical Care Cost Recovery (MCCR) proposal being discussed this morning, have the potential of allowing DVA to tap into non-appropriated revenue sources. While I continue to have concerns about the feasibility of meeting the goals included in the Administration's "30-20-10" plan for DVA health care, which includes both of these initiatives, I do believe that the DVA should be allowed to look past appropriated dollars to ensure its ability to provide sufficient health care to our nation's veterans into the next century.

Statement of Representative Helen Chenoweth

5/8/97

Mr. Chairman, I have received hundreds of letters from retired military personnel over age 65 who feel deeply betrayed by the VA and by their country because they are having difficulty accessing health care. Many veterans, who fought bravely for this country, have been turned away from Mountain Home Air Force Base -- where they had received care for many years -- just because they became eligible for Medicare. To make matters worse, finding a physician, in a sparsely populated rural area, who is willing to take on new Medicare patients has proved extremely difficult. With additional reductions in Medicare reimbursements for doctors on the horizon, I fear that this problem will only grow worse.

I think we are all here today because we believe this is an unconscionable state of affairs, and that Medicare subvention may offer a viable solution. As a cosponsor of H.R. 1362, I am delighted to have this opportunity to hear Mr. Van de Water, Ms. Buto, Mr. Vitikacs, and all of the panelists who are here to share their observations. I look forward to working with each of you to devise a demonstration that meets the needs of Medicare-eligible veterans without adding to the deficit or burdening the Medicare trust fund.

STATEMENT OF THE HONORABLE LANE EVANSRANKING DEMOCRATIC MEMBERCOMMITTEE ON VETERANS AFFAIRSOPENING STATEMENTMAY 8, 1997

THANK YOU, MR. CHAIRMAN. WE ARE HERE TODAY TO DISCUSS AN ISSUE THAT IS CRITICAL TO VA'S FUTURE: ALLOWING VA TO COLLECT AND KEEP PAYMENTS FROM THIRD-PARTIES AND VETERANS' COST SHARING FOR SERVICES PROVIDED TO VETERANS. THE CLINTON ADMINISTRATION AND VA HAVE REQUESTED THIS OPPORTUNITY TO TREAT NEW VETERAN PATIENTS AND TO PROVE THAT VA CAN BECOME A "PROVIDER OF CHOICE" FOR VETERANS WITH THE MEANS TO OBTAIN THEIR HEALTH CARE ELSEWHERE. THIS INITIATIVE HAS ALSO BEEN IDENTIFIED AS PART OF VA'S LONG-TERM STRATEGY, THE "30-20-10" PLAN, CONTAINED IN ITS BUDGET SUBMISSION FOR FY 1998.

IN PARTICULAR, THIS COMMITTEE HAS WORKED HARD TO IDENTIFY A PLAN TO ALLOW VA TO COLLECT AND RETAIN MEDICARE FUNDING. WE BELIEVE WE HAVE WRITTEN A BILL THAT WORKS TO EVERYONE'S ADVANTAGE —MEDICARE'S, VA'S AND VETERANS'—AND WE HAVE CONFIDENCE THAT H.R. 1362 WILL DO SO. THE GREAT SUPPORT CHAIRMAN STUMP AND I HAVE RECEIVED ON THIS BILL FROM OUR COLLEAGUES ON THE

VETERANS AFFAIRS COMMITTEE INDICATES THE PRIORITY WE GIVE ENACTMENT OF THE "VETERANS MEDICARE REIMBURSEMENT DEMONSTRATION ACT OF 1997". THROUGH THIS BILL, WE HAVE RESPONDED TO THE VETERANS AND THEIR SERVICE ORGANIZATIONS WHO SAID THEY WANTED THE CHOICE OF USING THEIR MEDICARE BENEFITS IN VA.

MOST OF YOU, WHO SUPPORT THE IDEA OF MEDICARE SUBVENTION, KNOW IT WILL ENCOUNTER SKEPTICISM IF NOT OPPOSITION. IT IS NOW OUR DUTY TO LET OUR COUNTERPARTS ON THE WAYS AND MEANS COMMITTEE, WHO HAVE PRIMARY JURISDICTION OVER THE BILL, KNOW WE WANT THIS LEGISLATION ENACTED.

WE BELIEVE THAT OUR BILL CREATES OPPORTUNITIES FOR EVERYONE INVOLVED TO BENEFIT. THE MEDICARE TRUST FUNDS HAVE A CHANCE TO SAVE MONEY BECAUSE VA WILL RECEIVE LESS OF THE REIMBURSEMENT FROM MEDICARE FOR THE NEW MEDICARE-ELIGIBLE VETERANS IT WILL TREAT THAN THEY WOULD PAY TO OTHER PROVIDERS. SPECIFICALLY, MEDICARE WOULD RECEIVE A MANDATORY 5-PERCENT DISCOUNT ON ITS REIMBURSEMENT FOR SERVICES PROVIDED TO ELIGIBLE VETERANS IN VA. FOR THIS REASON, *IT IS OUR STRONG VIEW THAT THIS BILL WILL PRODUCE SAVINGS FOR THE MEDICARE TRUST FUNDS.* VA WILL BENEFIT BY OPENING ITS DOORS TO CARE

FOR NEW VETERANS. MOST IMPORTANTLY, VETERANS WILL BENEFIT BY HAVING A NEW CHOICE OF HEALTH CARE PROVIDER.

TODAY THIS SUBCOMMITTEE WILL ALSO DISCUSS DRAFT LEGISLATION BASED ON VA'S PROPOSAL FOR RETAINING THIRD-PARTY REIMBURSEMENT. WE UNDERSTAND THAT THE BUDGET AGREEMENT ANNOUNCED LAST FRIDAY WILL ALLOW VA TO RETAIN ITS USER FEES. WE LOOK FORWARD TO WORKING WITH THE BUDGET COMMITTEE TO ENSURE THAT VA MEDICAL CARE IS FUNDED ADEQUATELY. I WANT TO MAKE IT CLEAR THAT I DO NOT VIEW THIS BILL AS A MEANS OF LETTING CONGRESS OFF THE HOOK FOR FUNDING VA PROPERLY AND WE, ON THIS COMMITTEE, MUST NOT ALLOW OUR PEERS TO PERCEIVE ANY PROPOSAL TO RETAIN PAYMENTS FROM VETERANS AND VETERANS HEALTH INSURERS THAT WAY. VETERANS HAVE EARNED THEIR HEALTH CARE FROM VA THROUGH SERVICE TO THEIR COUNTRY. WE ULTIMATELY HAVE THE RESPONSIBILITY TO MAKE SURE THAT VA'S RESOURCES ARE ADEQUATE TO MEET VETERANS' NEEDS. WE ALSO HAVE A DUTY TO VETERANS TO ENSURE THAT, BECAUSE VA WILL NOW HAVE A FINANCIAL INCENTIVE TO TREAT VETERANS WITH OTHER PAYMENT SOURCES, THAT THOSE WITH MEDICARE OR PRIVATE HEALTH INSURANCE DO NOT TAKE PRECEDENCE OVER THOSE VA HAS ALWAYS TREATED

FINALLY, A DRAFT BILL TO ALLOW VA TO WAIVE SOME PHYSICIANS AND DENTISTS' REQUIREMENTS FOR RETIRING WITH THEIR SPECIAL PAY WILL BE DISCUSSED. WE WANT TO ENSURE THAT VA HAS THE FLEXIBILITY TO RESTRUCTURE ITS WORKFORCE IN THE MOST CONSTRUCTIVE WAY POSSIBLE. ENCOURAGING VOLUNTARY RETIREMENTS IS ONE WAY OF DOING THIS, BUT IT MUST BE DONE IN SUCH A WAY THAT THE DOCTORS WE STILL NEED ARE NOT ENCOURAGED TO LEAVE.

I AM LOOKING FORWARD TO TODAY'S TESTIMONY AND THE COMMENTS AND OPINIONS TO BE GIVEN TO OUR COMMITTEE.

THANK YOU.

Statement of
Paul N. Van de Water
Assistant Director
for
Budget Analysis
Congressional Budget Office

on
Medicare Subvention and
Other Pending Legislation

before the
Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives

May 8, 1997

Mr. Chairman and Members of the Committee, I am pleased to represent the Congressional Budget Office (CBO) at this morning's hearing. My testimony will explain CBO's assessment of the budgetary effects of two pieces of pending legislation. The first proposal is H.R. 1362, a bill to provide Medicare reimbursement for services furnished to targeted veterans who are eligible for Medicare—a proposal commonly termed Medicare subvention. The second is draft legislation that would allow the Department of Veterans Affairs (VA) to spend amounts it collects from designated third-party payments and user fees. From a budgetary point of view, the two proposals share several features in common.

First, both proposals would allow some VA medical care to be financed through direct, or mandatory, spending rather than by annual appropriations. In the case of H.R. 1362, VA would be given authority to spend the amounts it received from Medicare. In the case of the other proposal, VA would be allowed to spend the amounts it received from certain nongovernmental sources.

Second, the additional mandatory resources provided to the VA health care system could either supplement or supplant discretionary spending, with the outcome depending on the results of future appropriation action. The receipts from Medicare subvention are intended to finance the care of veterans who would otherwise not have access to VA facilities, but that result cannot be assured.

Third, even if additional mandatory spending allows for lower discretionary appropriations, the current budget enforcement rules do not allow a reduction in one category of spending to offset an increase in the other.

Mandatory spending is governed by pay-as-you-go procedures, which require increases in mandatory spending to be paid for by reductions in other mandatory programs or by increases in receipts. Discretionary spending is limited by statutory caps on budget authority and outlays.

MEDICARE SUBVENTION

H.R. 1362 would establish a demonstration project in which Medicare would reimburse VA for the care that VA provides to certain veterans who are also eligible for Medicare. The demonstration project would have the following characteristics:

- o The project would be conducted during the 1998-2000 period in up to three geographic service areas where there would be a high demand for the program;
- o Medicare would reimburse VA at 95 percent of the rate paid to private providers for care given to certain veterans. Those veterans would have to be eligible for Medicare, participate in Medicare Part B, have no service-connected disability, and have an annual income of between one and three times the threshold for veterans medical care. Such veterans receive care from VA if resources are available and if the veteran pays a share of the costs.
- o VA would be responsible for maintaining a basic level of effort in order to be eligible for reimbursement by Medicare. The required level of

effort would be based on VA's estimate of how much it spent for eligible veterans in 1997. That amount would then be adjusted for increases or decreases in appropriations for medical care, any shortfall between the rates of growth in the appropriation and the cost of medical care, and reductions in the priority of eligible veterans stemming from recent legislation;

- o VA and the Department of Health and Human Services (HHS), in consultation with the General Accounting Office, would monitor Medicare's expenditures in an attempt to ensure that it spent no more than it would have without the demonstration; and
- o Medicare's payments under the demonstration would be limited to \$50 million a year.

One of the legislative goals is that the demonstration project not increase either VA's or Medicare's costs. In theory, VA would continue to pay for the care that it would provide under current law to beneficiaries eligible for Medicare, and Medicare would continue to pay for people currently receiving care in the private sector. Medicare's costs would experience no net change because lower payments to private-sector providers would offset payments to VA. VA's net costs would remain the same because the receipts from Medicare would be matched by higher outlays for the care it would provide to extra patients.

Assuring budget neutrality for Medicare would be difficult to achieve in practice, however, for three reasons. First, although VA provides some

services (for examples, drugs and long-term care) that are not covered by Medicare, the bill nevertheless includes those services in calculating VA's effort. Second, even if that oversight were corrected, VA could understate the amount of its current workload that is attributable to targeted veterans. Third, adjustments to the required level of effort could allow further shifting of costs from VA to Medicare in later years.

Under the bill, the required maintenance-of-effort level is based on the total amount of VA medical expenditures for targeted veterans in 1997. However, Medicare does not cover all medical services that VA provides. If VA increased its noncovered services and decreased its provision of covered services by the same amount, it would shift costs to Medicare without reducing its level of effort.

But again, even if that problem was corrected, VA could still shift costs to Medicare by underestimating the level of care that it has been providing. Data for 1997 are not yet available, but VA informally estimates that in 1996 it saw fewer than 35,000 targeted veterans who were eligible for Medicare and provided about one-third of the total health care services that those veterans received. If those figures were correct, assuring budget neutrality would require that the maintenance-of-effort level equal about 22 percent of the Medicare-covered services provided to those veterans. CBO's analysis of data from the 1992 Survey of Veterans and the 1997 Patient Treatment Files indicates, however, that VA provides about 52 percent of covered services for targeted veterans who are eligible for Medicare.

The provisions for adjusting VA's maintenance-of-effort amount could also lead to higher spending for Medicare. According to CBO estimates, the services VA provides to targeted veterans would not fall in proportion to any drop in appropriations as specified in the bill. CBO also expects that the services provided to targeted veterans would decline less than VA would estimate as a result of changes in their priority for services. Those adjustments enable VA to reduce its required level of effort for targeted veterans and thereby increase its payments from Medicare.

As Table 1 shows, the likely outcome would be higher Medicare costs. Knowing how many Medicare beneficiaries will receive care from VA is difficult enough to determine in the short term. But that uncertainty only grows over time as populations change and the availability of discretionary funding for VA's health care programs varies. VA and HHS also face different incentives and access to information.

TABLE 1. MONETARY FLOWS UNDER MEDICARE SUBVENTION

Medicare (Health Care Financing Administration)	Department of Veterans Affairs
Legislative Goal	
Payments to VA under subvention	Receipts from Medicare
Less: forgone payments to private providers care	Less: outlays for incremental medical care
Equals: no net change in Medicare costs	Equals: no net change in VA's spending
Likely Outcome	
Payments to VA under subvention	Receipts from Medicare
Plus: unintended payments to VA because of:	Less: outlays for incremental medical care
o Uncertainty of VA's workload under current law	Less: outlays for other purposes
o Asymmetric information and incentives	Equals: no net change in VA's spending
Less: forgone payments to private providers	
Equals: net increase in Medicare spending	
SOURCE: Congressional Budget Office.	
NOTE: VA = Department of Veterans Affairs.	

As a result, VA would have an advantage in the negotiations with HHS over the base level of care that would work against budget neutrality. Because annual discretionary appropriations currently limit VA's health care funding, the department would have to eliminate personnel or otherwise reduce its program in the face of losses from an inaccurate base level (alternatively, it could expand its programs if it can shift costs to Medicare). However, HHS pays Medicare costs from a permanent and indefinite appropriation that is very large and would not readily reveal a loss stemming from a demonstration program such as this one. It would not be easy for the General Accounting Office or any other auditing agency to determine the

financial outcome of the demonstration: it, too, would have to rely on estimates and assumptions about events and behavior that would have been different under current law.

As introduced, the bill would probably raise Medicare's costs by \$50 million or more. Because VA could count services that are not covered by Medicare toward its maintenance-of-effort, the costs could exceed the cap set in the bill for Medicare's expenditures. Under that scenario, VA's expenditures to care for targeted veterans may equal the maintenance of effort, but Medicare would not cover that care. Medicare would pay to private providers or VA the costs for covered services that are provided and funded through VA under current law. If the bill's language was modified to focus the maintenance-of-effort requirements on services covered by Medicare, the bill would cost roughly half as much.

SPENDING FROM FEES AND COLLECTIONS

The Committee also asked CBO to address the budgetary impact of legislation to give VA the authority to spend amounts that it collects from third parties and user fees. Under current law, VA's net collections are estimated to total \$485 million in 1998, but only about \$300 million a year after that because the collections authorized by the Omnibus Budget Reconciliation Act of 1993 will expire.

Through 1998, VA will collect per diem payments for hospital stays and copayments for outpatient visits and prescription drugs, but it has no

authority to spend those funds. After 1998, VA will continue to collect about \$400 million a year from third parties, and it will spend about \$100 million a year from those receipts to cover the related costs of administration. Thus, the costs of legislation giving VA the authority to spend whatever it collects would be \$485 million in 1998 and about \$300 million a year after that.

CONCLUSION

Both proposals would increase mandatory spending and would be subject to the pay-as-you-go procedures established in the Budget Enforcement Act. Those increases in mandatory spending would allow discretionary authorizations to decline by the same amount. Whether discretionary savings would actually occur, however, would depend on annual appropriation actions.

**STATEMENT OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON DIVERSIFYING FUNDING SOURCES FOR
VETERANS' HEALTH CARE
BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MAY 8, 1997**

Mr. Chairman and Members of the Subcommittee:

I appreciate the Subcommittee's consideration of the legislative proposals before it today.

It is very important that Congress enact legislation authorizing a Medicare reimbursement demonstration and retention of MCCR collections. As you know, the President's proposed 1998 budget would permit VA to serve more veterans over the next five fiscal years; however, achieving that objective is contingent upon the legislative changes before you today. The President's budget also includes the goals of reducing per patient cost by 30 percent, increasing patients treated by 20 percent, and obtaining 10 percent of our health-care budget from nonappropriated sources by 2002. To accomplish this, we must be able to retain all insurance payments, patient copayments, and other third-party reimbursements, and to obtain Medicare reimbursements. Over the next five years, we believe we can cut costs, treat more veterans, and become less dependent on appropriated funds. Enactment of authority for us to retain MCCR collections and

obtain Medicare reimbursement is requisite to meeting these goals.

COMMENTS ON SPECIFIC PROPOSALS

1. **Revising Authorities for Use of VA Medical Care Receipts**

We generally support this draft bill, which we are pleased to note is similar to the Administration's proposal to allow VA to retain our medical care collections to help fund the provision of quality health care to eligible veterans.

Both the Subcommittee's draft, and the Administration's proposal, would replace VA's current Medical Care Cost Recovery (MCCR) Fund with a new special receipt account in the Treasury.

As you know, under current law, VA's third party recoveries and prescription copayment receipts are deposited in the MCCR Fund and are available to VA only for the necessary expenses of identification, billing, and collection of VA health-care charges. In January of each year, the unobligated balance remaining in the Fund from the preceding fiscal year is deposited into the Treasury as miscellaneous receipts.

Under both the Administration's and Subcommittee's proposals, VA would deposit in the new special receipt account all copayments, deductibles, and third-party collections and recoveries under chapter 17 of title 38, United States Code, as well as recoveries under the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.) for VA

furnished medical care and services. Those receipts would be specifically earmarked for VA's use in providing medical care and services under chapter 17 and for reimbursing VA for the costs of identifying, billing, auditing, and collecting amounts owed for VA care and services provided.

The two proposals do differ, however, as to the process by which amounts from the new fund will be made available to the Department. The Administration's proposal would make availability subject to an annual appropriation. Thus, following enactment of our proposal, VA would request that its Medical Care appropriation include language to appropriate "such sums" as VA collects for medical care, and to provide that receipt amounts remain "available until expended."

Availability of fund receipts under the Subcommittee's proposal would be independent of the appropriation process. Nevertheless, funds would be available during any fiscal year only for the same purposes and under the same conditions "as apply to amounts appropriated that fiscal year for medical care."

We would prefer the Administration bill's approach in this regard, and we reiterate our desire that (1) amounts deposited in the new fund would be available without fiscal year limitation, and (2) those receipt amounts could be transferred between the new fund and VA component accounts. This would give us the flexibility we need to make the most effective use of these funds.

We also note that the Subcommittee's draft contains a provision, not found in the Administration's proposal, that

would amend VA's third-party collection authority to base the liability of those parties on "reasonable charges," in lieu of the current "reasonable cost" of VA's provision of medical care and services. We favor this provision. It would provide VA needed flexibility, meshes well with our sharing authority initiatives, and is consistent with VA's objective of putting our health-care operations on a more businesslike basis.

2. H.R. 1362, Medicare Reimbursement

As you know, the Department has been working with HHS and OMB for almost two years to design a pilot project for Medicare reimbursement. With the strong support of the President, we transmitted to Congress, in October 1996 and February 1997, a draft bill acceptable to both VA and HHS. The draft bill contemplates negotiation of an agreement between the Secretaries of VA and HHS prior to initiation of the project. Since February, a working group of VA and HHS officials has been negotiating a Memorandum of Agreement specifically detailing how this project will operate.

Although the current draft of the agreement has not been formally concurred with by both parties, the working group has reached agreement in principle on all major issues and is currently working on technical details. The working group has also been negotiating the site selection process. Once the selection process is agreed upon, the sites will be identified and specified in the agreement. We are confident that we will have the site selection process and the details of the agreement completed very soon.

We have carefully reviewed H.R. 1362, the draft bill which the subcommittee is considering today. We support its enactment with some changes. We look forward to working with you and the other appropriate committees of Congress to enact a measure to permit category C veterans to use their Medicare benefits at VA facilities.

We strongly believe that VA must be permitted to test the feasibility of obtaining Medicare reimbursement on both a fee-for-service and capitated basis. H.R. 1362 would limit the demonstration to fee-for-service reimbursements and delay consideration of the implementation of a capitation model. VA is moving quickly to provide care to veterans on a managed care basis, and the recently implemented Veterans Equitable Resource Allocation (VERA) methodology is predicated on a capitation model. We expect to be ready to implement a managed care demonstration project for Medicare reimbursement by January 1, 1998. Thus, we strongly urge that the legislation be revised to authorize us to test both models from the outset.

The Administration is concerned that H.R. 1362's "maintenance of effort" or "level of effort" provisions may not adequately protect the Medicare trust fund from incurring new costs. Maintenance of effort refers to a sum of money which represents the appropriations that VA currently receives to care for category C veterans who would also be eligible to participate in the project. To avoid shifting the burden onto Medicare of caring for these veterans for whom VA already has received medical care appropriations, the maintenance of effort must be subtracted from the Medicare payments to VA under this project. The maintenance of effort provisions of H.R. 1362 would have

this sum computed each year to account for changes occurring in VA as a result of eligibility reform and implementation of the VERA methodology. This is inconsistent with the Administration's proposal which would not adjust the maintenance of effort to account for changes resulting from eligibility reform or other changes in the VA system, other than changes in the budget. H.R. 1362 would reduce the maintenance of effort if medical care appropriations increase less than the medical care inflation rate and if VA cares for fewer category C veterans due to changed resource allocations or eligibility reform. While these provisions would provide us with greater flexibility, they also may pose a greater risk to the Medicare trust fund. For the purposes of the demonstration, we prefer the level of effort mechanism provided in the Administration bill.

We also urge that the demonstration be opened to all Medicare-eligible category C veterans residing within the pilot sites' catchment areas. As you know, category C veterans have no compensable service-connected disability, have income and assets above the specified income threshold, and currently have the lowest statutory priority for VA care. As a result, many of them are not able to obtain VA care. H.R. 1362 would permit these veterans to participate in this project only if their income is below a threshold of three times the "means test threshold." Single veterans with incomes over \$64,830, and married veterans with incomes over \$77,805, would not be allowed to participate. This provision runs counter to equity and our goal of increasing access to care for both category A and category C veterans. We recommend revising H.R. 1362 to permit all Medicare-eligible category C veterans to participate in the project.

One of the strong points of H.R. 1362 is that it provides VA with authority to care for certain Medicare-eligible category C veterans who might not otherwise be able to receive care under chapter 17 of title 38, United States Code. Let me point out, however, that the category C veterans treated at our Medicare pilot sites would not displace any higher priority veterans. Rather, they would permit us to make optimal use of our physical assets and other resources and could make it possible for us to treat more category A veterans.

Another change we consider necessary in H.R. 1362, is to delete the requirement that veterans' participation in the project be voluntary. That could mean that we might not have any participating veterans. The copayments which VA regularly charges category C veterans are much lower than those which VA would charge under the Medicare project. If we must give these veterans who seek care at a participating site a choice between receiving their care under the Medicare project and outside that project, many will likely choose to receive care outside the project. That is why the Administration's proposal requires all Medicare-eligible category C veterans to obtain care under the Medicare program at the participating sites.

H.R. 1362 would permit VA to conduct the demonstration project at sites within three "geographic service areas." A geographic service area could equate to a VA network. The number of facilities participating, thus, could be more than the number permitted by the Administration-proposed bill. In addition, H.R. 1362 would require that Medicare reimbursements be deposited into the Medical Care appropriation while the Administration draft bill would

require that they be deposited in a revolving fund specially established for this project.

We recommend that you delete the requirement that at least one participating VA facility be in the same catchment area as a closed military medical facility. We are very willing to consider this criterion but believe it should be a site selection factor instead of a statutory requirement.

Any legislation on this issue should include a provision to extend the demonstration for up to two additional years by the mutual agreement of the Secretaries of VA and HHS. The Administration's bill provides such authority. Veterans participating in the pilot project should not be faced with the termination of their VA care while Congress and the Administration deliberate whether to end, continue, or expand the project

We anticipate that a demonstration project which permits category C veterans to use their Medicare eligibility at VA facilities would enable us to provide care to more veterans, both category A and category C. We also believe it would stimulate the VA health-care system to be more efficient. We also believe such a demonstration project would save money for the Medicare trust funds. We thus support enactment of H.R. 1362 contingent upon the changes I have discussed.

**3. ELIMINATION OF SPECIAL SERVICE REQUIREMENTS FOR ALLOWING
PHYSICIAN AND DENTIST SPECIAL PAY TO BE CREDITED FOR
RETIREMENT PURPOSES**

The Subcommittee is also considering a bill that would

eliminate the statutory financial penalties to VA physicians and dentists who would retire before December 31, 1999-- i.e., they would retire if it were not for those penalties. Currently, physicians and dentists must complete 15 years of service in VHA for special pay to count toward retirement, and they must complete 8 years of service in VHA for special pay received since 1991 to count fully toward retirement. Current law provides for 25 percent of the increase in special pay authorized by Public Law 102-40 to be counted for retirement computations for every two years of VHA service since 1991.

The proposed bill also affects the Office of Personnel Management and thus is currently being reviewed within the Executive branch. Upon conclusion of this review, the Administration's position will be transmitted to the Subcommittee.

Conclusion

Mr. Chairman, thank you and the Subcommittee for the opportunity to present the Administration's views on these proposals. We look forward to working with you to resolve the concerns that we have raised. Enactment of legislation authorizing a Medicare reimbursement demonstration and retention of MCCR collections is important and will significantly aid VA's efforts to improve the veterans' healthcare system.

STATEMENT OF
KATHLEEN A. BUTO
ASSOCIATE ADMINISTRATOR FOR POLICY
HEALTH CARE FINANCING ADMINISTRATION
ON
"THE MEDICARE SUBVENTION DEMONSTRATION"
BEFORE
THE HOUSE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON HEALTH
MAY 8 1997



Good morning, Mr. Chairman and members of the Subcommittee on Health, I am pleased to appear before you to discuss the President's legislative proposal to demonstrate Medicare subvention involving our nation's veterans. This project will be conducted by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (DHHS) and the Department of Veterans' Affairs (VA). Under this demonstration, Medicare will pay for certain dual-eligible Medicare/VA beneficiaries in the VA system. In developing this program, we believe that we can test a project which will provide quality service to these dual-eligible beneficiaries and, at the same time, preserve and protect the Medicare Trust Fund for all Americans.

President Clinton has indicated his strong support of a demonstration which will provide needed information regarding the effects of the subvention. The term "subvention" refers to Medicare paying for care provided at federal facilities to Medicare beneficiaries. Currently, Medicare is precluded by statute from doing this. However, the proposed demonstration will provide HCFA with the opportunity to assess the effects of coordination on improving efficiency, access, and quality of care for dual-eligible beneficiaries in a selected number of sites.

HCFA has been working with the VA for the past two years to design a VA/Medicare subvention demonstration program. Under this demonstration, the Medicare program would reimburse the VA for health services provided at selected VA facilities to certain Medicare-eligible veterans. There would be both fee-for-service and managed care (HMO) model sites in the demonstration. Currently, there are approximately three million veterans over age 65 who meet Category C requirements. This category applies to veterans who have neither a service-connected disability nor sufficiently low-income status but are dually-eligible to receive health care through the Department of Veterans' Affairs and the Medicare program. Over the years, the VA and Medicare have separately provided access to care for these dual-eligible beneficiaries. It is our hope that a Medicare/VA subvention model could allow for increased access to quality care, with administrative efficiencies to both programs.

As HCFA and the VA collaborated to design this demonstration, we at HCFA kept our eyes on two imperatives: we must protect beneficiaries and we must protect the Medicare Trust Fund. As you know, the Medicare trustees have just reported that, absent legislation, Medicare's Hospital Insurance Trust Fund, which pays for hospital, skilled nursing facility, and hospice services, is scheduled to become insolvent in 2001. The Administration has expressed its concern about the solvency of the Trust Fund, and has proposed measures to strengthen it each year since coming into office. The Administration is committed to a balanced budget, extending Medicare's solvency, and working to ensure that Medicare benefits are available for all beneficiaries. As we work on the design of this program, we are developing strategies to prevent further depletion of the Trust Fund.

HCFA and the VA have agreed to incorporate a number of provisions in the demonstration design in order to assure that beneficiaries receive quality care, while protecting the two Federal programs from any unexpected cost impacts. In order to meet this objective, we are currently working with the VA to achieve a Memorandum of Agreement which will spell out the operational details of the demonstration.

The Medicare Trust Funds will be protected against the risks of cost-shifting. First and foremost, VA will receive Medicare payments only after it surpasses its current level of effort, which refers to the dollar amount VA now spends rendering health care services to dual-eligible beneficiaries in VA facilities participating in the demonstration sites. This level of effort will be updated for each year of the demonstration.

In the HMO sites, after the VA meets its level of effort in the area covered by the demonstration, Medicare will reimburse the VA on a capitated basis equal to a percentage of the Adjusted Average Per Capita Cost (AAPCC) applicable to the beneficiaries enrolled in the demonstration. The AAPCC is defined as the estimated amount that Medicare would have paid in a geographic area if HMO enrollees had received services in the fee-for-service sector. We have agreed to adjust the applicable AAPCC to exclude some of the costs associated with capital, indirect and direct graduate medical education (GME), and the disproportionate share hospitals (DSH). DSH

refers to additional Medicare payments to hospitals treating a disproportionately large share of low-income patients. These payments are believed to be outside the purview of the demonstration because these activities are already covered by VA's appropriations. After making these adjustments, the reimbursement rate will be set at 95 percent of what Medicare pays risk HMOs. At this time, this would be 90.25 percent of the AAPCC.

In the fee-for-service sites, Medicare would pay 95 percent of the current fee-for-service rates, after removing some of the costs associated with the four factors mentioned above. At the end of each year, the Department of Health and Human Services (DHHS) and the VA will reconcile any payment discrepancies and correct for any mistaken overpayments.

We have designed this demonstration so that there will not be an increase in the total costs of Medicare. If it is found that Medicare costs are more than costs would have been without the demonstration, the two departments have agreed to take any necessary corrective action. For example, the VA may reimburse HCFA; we may suspend or terminate the demonstration; or, we may adjust payment rates. These are some of the most significant steps that we have taken to limit the payment risk to the Medicare Trust Funds. To further insulate Medicare from cost growth due to the demonstration, a "cap" will be placed on the total Medicare reimbursement to VA for each demonstration year. We are working to develop a cap which accounts for estimated demand and facility capacity. Furthermore, the VA has agreed to open its facilities to audits by HCFA and the DHHS' Inspector General.

This demonstration will protect, indeed expand, beneficiaries' freedom of choice --they can use their Medicare benefits to obtain care from the VA, or they can obtain care from civilian providers. Beneficiaries' quality of care will be protected because VA will adhere to Medicare's conditions of participation and quality standards, and provide the complete range of Medicare benefits in the HMO model.

Thus, we strongly believe that we have taken all possible steps to protect beneficiaries, the Trust Funds, and the VA from harm. Will we succeed? The answer will lie in the rigorous evaluation of this demonstration by an independent evaluator. Over the demonstration's three years, the independent evaluator will monitor performance and collect data to answer these crucial questions:

- o Is there an impact on the costs to either the Medicare Trust Funds or VA?
- o Do beneficiaries experience improved access to health care?
- o Is there any change in quality of care provided to the demonstration population?
- o Is there any effect on local health care providers and other Medicare beneficiaries in the surrounding community?

At the end of three years, we will see how coordination between our two programs improves efficiency, access, and quality of care for dual-eligible beneficiaries. If Congress should decide on a GAO study of the demonstration, both VA and DHHS have agreed to jointly assist GAO with that review and report. In the meantime, we have put the necessary safeguards in place to protect beneficiaries and protect the Medicare Trust Funds, and the VA.

Mr. Chairman, the bill which you have introduced, H.R. 1362, the "Veterans Medicare Reimbursement Demonstration Act of 1997," is very similar to the Administration's Medicare/VA subvention bill submitted to Congress on February 7, 1997. While both bills would authorize a demonstration of Medicare/VA subvention with common goals, there are a number of significant differences. First, H.R. 1362 authorizes a fee-for-service model demonstration with three sites. The Administration proposes to conduct both a fee-for-service model (four sites) and a managed care model (four sites or one VA region). Second, H.R. 1362 sets Medicare payments at 95 percent of amounts paid to the private sector. The Administration bill sets the payment at 95 percent of the private sector, after excluding some of the costs associated with direct and indirect graduate medical education, capital, and disproportionate share hospitals. Third, H.R. 1362

reduces the level of effort in future demonstration years to account for changes in the VA eligibility resulting from the Veterans' Health Care Eligibility Reform Act of 1996. The Administration bill does not include any adjustments to the level of effort based on eligibility reform. Lastly, your bill calls for a report on a managed care demonstration by March 1, 1999. In keeping with our goal of moving toward managed care options for all Americans, the Administration has included a managed care option in the original demonstration. While differences exist between these two bills, we believe there are enough similarities, and mutual interests, to allow for an agreement that would benefit the dual eligible population.

The President strongly supports this demonstration. We are hopeful that this demonstration will succeed, and that through it the beneficiaries we share in common with VA will receive enhanced choices and improved services -- the true "bottom line" in this effort. We look forward to working with the Subcommittee and other interested members of Congress as we seek to improve health care services available to our nation's veterans.

STATEMENT OF
JOHN R. VITIKACS, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

MAY 8, 1997

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to offer its views on legislation related to the Department of Veterans Affairs (VA) medical care system. The topics under consideration today are critical to the future well-being of the Veterans Health Administration (VHA). The American Legion thanks the leadership of the Veterans Affairs Committee for initiating the measures to generate new VHA revenue streams as a follow-on to Public Law 104-262.

H.R. 1362, would establish a demonstration project to provide for Medicare reimbursement for health care services provided to certain Medicare-eligible veterans in selected facilities of the Department of Veterans Affairs. The proposal is named the "Veterans Medicare Reimbursement Demonstration Act of 1997."

Section 2 of the bill directs the Secretary of Veterans Affairs and the Secretary of Health and Human Services to jointly carry out a demonstration project under which the Secretary of Health and Human Services (HHS) provides VA with reimbursement from the Medicare program for health care services to targeted Medicare-eligible veterans in or through facilities of the VA. The Secretaries shall conduct the project during the three-year period beginning January 1, 1998. To the extent necessary to carry out the demonstration project, HHS may waive any requirement of Part B of title XI of the Social Security Act, title XVIII of that Act, or a related provision of law.

The Secretary of VA shall designate up to three geographic service areas from which facilities are selected to participate in the project. The selection plan shall favor those facilities that are suited to serve Medicare-eligible veterans. At least one facility selected must be in the same catchment area as a military medical facility which was closed pursuant to the Defense Base Closure and Realignment Act of 1990; or Title II of the Defense Authorization Amendments and Base Closure and Realignment Act.

Participation of targeted Medicare-eligible veterans in the project shall be voluntary, subject to the capacity and funding limitations of participating facilities. The Secretary shall establish cost-sharing requirements for veterans participating in the demonstration project. Those requirements shall be the same as the requirements that apply to targeted Medicare-eligible patients at non-governmental facilities.

Section 3 of the bill provides that the Secretary of HHS shall reimburse the Secretary of Veterans Affairs for services provided at a rate equal to 95 percent of the amounts that otherwise would be payable under the Medicare program on a non-capitated basis. In cases in which a payment amount may not otherwise be readily computed, the Secretaries shall establish rules for computing equivalent or comparable payment amounts. The amount paid to the Department of Veterans Affairs for any year for the demonstration project may not exceed \$50 million.

The bill requires the Secretaries, in consultation with the Comptroller General, to closely monitor the expenditures made under the Medicare program for targeted Medicare-eligible veterans compared to the expenditures that would have been made for such veterans during that period if the demonstration project had not been conducted. If

the Secretaries find that the expenditures increased (or are expected to increase) during a fiscal year because of the project, the Secretaries shall take steps as may be needed:

- to recoup for the Medicare program the amount of such increase in expenditures; and
- to prevent any such increase in the future.

Section 4 of the bill requires the Secretaries to arrange for an independent entity with expertise in the evaluation of health services to conduct an ongoing evaluation of the demonstration project. The entity shall submit a report on the project jointly to the Secretaries and to the appropriate committees of the Congress not later than March 1 following each year during which the project is conducted.

Each report shall include an assessment of each of the following:

- the cost to the Department of Veterans Affairs of providing care to veterans under the project.
- compliance of participating facilities with applicable measures of quality of care, compared to such compliance for other Medicare-participating facilities.
- a comparison of the costs of facilities participation in the program with the reimbursements provided for services of such facilities.
- any savings or costs to the Medicare programs from the project.
- any changes in access to care or quality of care for targeted Medicare-eligible veterans participating in the project.
- any effect of the project on the access to care of veterans who did not participate in the project and of targeted Medicare-eligible veterans.

For the purpose of this Act, Section 5 of the bill defines "Geographic Service Area" as a field component of the Veterans Health Administration; and "Targeted Medicare-Eligible Veteran" means an individual:

- who is a veteran (as defined in section 101(2) of Title 38, United States Code) described in section 1710(a) (3) of Title 38, United States Code;
- who is entitled to hospital insurance benefits under part A of the Medicare program and enrolled in the supplementary medical insurance program under part B of the Medicare program; and
- whose annual income is an amount between the applicable income threshold under section 1722(b) of Title 38, United States Code, and the amount equal to three times the amount of such applicable income threshold.

Mr. Chairman, The American Legion supports the concept of the Medicare subvention program. The Congress must test new ideas to provide creative solutions to VHA's funding predicament. H.R. 1362 is a legitimate and necessary effort to strengthen, support and sustain an essential national resource.

Veterans deserve guaranteed access to a full continuum of health care services. In addition to the measures contained in H.R. 1362, there may be additional resourceful uses of Medicare subvention for many VHA programs and services. For example, if VHA manages a veteran's rehabilitation care in the community, why should VA provide for the total cost of that care? The Medicare subvention program should not be limited to acute hospital care but could include chronic and long-term community care programs. The American Legion also recommends conducting a trial VA-State Medicaid subvention program. Once a veteran qualifies for VHA care, whether acute or long-term care, all public and private payment options should be considered.

Mr. Chairman, it is often cited that VA care is less expensive than comparable private sector care. If that is accurate, and the dual intention of the Medicare demonstration program is to provide a new revenue source for VHA and to help save the Medicare trust fund precious resources, The American Legion must respectfully ask how the 95 percent Medicare reimbursement rate was determined. Is it possible that further Medicare savings can be achieved, while providing VHA additional resources, at an even lower reimbursement rate? Taxpayers expect the best returns on their investments.

The American Legion suggests incorporating both fee-for-service and a managed care model in the Medicare subvention program. It is important to measure patient satisfaction within each model and the relative cost savings. To not include a managed care model in the Medicare demonstration program denies the trends in health care today toward Medicare HMOs.

The Medicare demonstration program is scheduled to last three years. After a sufficient period of data collection and analysis, the results of the prospective demonstration program, if successful, should be implemented in all Veterans Integrated Service Networks.

The American Legion recognizes that the Medicare demonstration program presents a large risk to the future maintenance of the Veterans Health Administration. That is why it is appropriate to test various revenue generating proposals. The American Legion recommends that the legislative initiative under consideration also include the veterans' health care enrollment concepts contained in The American Legion's GI Bill of Health on a limited pilot basis. The GI Bill of Health recognizes that the VA health care system can no longer totally rely on Federal appropriations to ensure its long-term survival. The GI Bill of Health, together with the Medicare subvention and the third-party reimbursement legislation, advances the goal of providing a continuum of health care services to all veterans, while allowing the VA system to collect and retain payments for the service it renders. Concurrently, with the federal appropriations process, these proposals can have a tremendous impact in making the VHA system financially sound.

With regard to the draft bill on the recovery of third-party receipts by the Department of Veterans Affairs, The American Legion believes the proposal will create a critical pool of additional non-appropriated revenues for VHA's medical care programs. However, it must be cautioned that the proposals to use third-party insurance receipts and the Medicare subvention bill represent a significant departure from past funding practices.

The American Legion does not support the President's budget request for VA medical care for the period FY 1998-2002. The American Legion is concerned about the uncertainty of whether VHA will attract sufficient new revenues to offset a no real growth budget. The Veterans Health Administration must develop an open enrollment program, offer defined health benefit packages to all enrollees, and offer a VA Health Plan to all discretionary care veterans on a premium basis.

The American Legion appreciates the efforts of the Subcommittee to address continuing VA health care funding concerns. The GI Bill of Health offers new solutions to old problems and provides a comprehensive framework for the future of the VA health care system. That is why The American Legion supports H.R. 335 -- a Commission on the Future for America's Veterans. H.R. 335 authorizes an advisory board of experts and stakeholders to review various proposals for the future of VHA and to develop a comprehensive pilot program to test and evaluate new solutions to VHA's constant funding concerns.

Both the Medicare subvention program and the third-party insurance proposal represent significant new thinking with regard to VHA's future. It is uncertain that these proposals alone will provide access to all veterans who wish to receive health care through the Department of Veterans Affairs or provide sufficient new revenues to compensate for medical care inflation, employee pay increases, and other uncontrollable cost increases. The American Legion invites the Subcommittee to meet the challenge of reinventing the VA health care system by incorporating the innovative concepts contained in the GI Bill of Health, along with the legislative proposals before the Subcommittee; and to consider the utility of authorizing a Commission on the Future for America's Veterans, as outlined in H.R. 335.

A recent study mandated by Public Law 103-445, Section 1104, entitled **Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation** arrived at many of the same conclusions and offered similar

recommendations as does The American Legion's GI Bill of Health. This study was conducted by a non-federal entity with no formal input by The American Legion.

The next draft bill under consideration would amend title 38, United States Code, to provide that special pay paid to certain physicians and dentists of the Veterans Health Administration retiring before October 1, 1999, shall be considered to be basic pay for retirement purposes.

Mr. Chairman, The American Legion appreciates the unique set of circumstances that have created the impetus for this bill. The VA physician and dentist special pay law created in 1991 did not anticipate the shift from a hospital-based to an ambulatory care-based system. In that regard, many VA physicians and dentists are delaying retirement to qualify for the applicable length-of-service requirements. This is placing unique pressures on managers to rely on reductions-in-force to right-size medical staffs.

The American Legion has no objections to the bill. There is a possibility that the Subcommittee will need to review the applicability of extending the retirement date prescribed in the bill at a later time. Additionally, other professional employees that have received similar special pay considerations should be extended the same courtesy as the VA physicians and dentists.

Mr. Chairman, that concludes my statement.



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"The Servicemember's Voice in Government"
Established 1968



STATEMENT
BEFORE THE
SUBCOMMITTEE ON
HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

BY

COLONEL CHARLES C. PARTRIDGE, U.S. ARMY (RETIRED)
NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

8 MAY 1997

VA HEALTH CARE ALTERNATIVES

Curriculum Vitae and Organizational Disclosure Statements

Charles C. Partridge

Legislative Counsel

National Association for Uniformed Services

Colonel Partridge, US Army, Retired, has been the Legislative Counsel for NAUS since May 1984.

Colonel Partridge's military career spanned 31 years of enlisted and commissioned service in the reserve and active forces. He served in Vietnam, Germany, Korea and in several installations in the United States. Colonel Partridge served three tours in the Pentagon as a staff officer dealing in personnel matters. He also served as the Chief of Staff of the Army Intelligence and Security Command, Arlington, Virginia and as the Executive, Office of the Chief, Legislative Liaison, Secretary of the Army, the Pentagon. He is a graduate of the Army War College, the Army Command and General Staff College, and has a Masters in Public Administration from Pennsylvania State University.

Disclosure

The National Association for Uniformed Services (NAUS) has not received a grant (and/or subgrant) or a contract (and/or subcontract) with the federal government for the past three fiscal years.

INTRODUCTION

Mr. Chairman and distinguished members of the Committee, the National Association for Uniformed Services (NAUS) and the National Military and Veterans Alliance would like to express its appreciation to you for holding these important hearings. The testimony provided here represents the collective views of our members.

The National Association for Uniformed Services (NAUS) was founded in 1968 to support legislation to uphold the security of the United States, sustain the morale of the Armed Forces, and provide fair and equitable consideration for all members of the uniformed services: active, reserve, National Guard, veteran, retired, and their spouses, widows and widowers. The Society of Military Widows (SMW) became affiliated with NAUS in 1984. Our nation-wide membership is now over 160,000. NAUS represents all grades, ranks, components, and branches of the uniformed services: Army, Navy, Marines, Air Force, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration, their families and survivors.

The National Military/Veterans Alliance represents over 3,500,000 members of the seven uniformed services, officer and enlisted, active duty, reserve, National Guard, retired and other veterans plus their families and survivors. Alliance members which support this statement are listed below:

Air Force Sergeants Association	Naval Enlisted Reserve Association
American Military Retirees Association	Naval Reserve Association
American Retirees Association	Non Commissioned Officers Assn
Korean War Veterans Association	Society of Medical Consultants
Military Order of the Purple Heart	to the Armed Forces
National Assn for Uniformed Services	Tragedy Assistance Prog for Survivors

Surveys of military personnel and their families consistently show that medical care is the top concern of the military community. This comes as no surprise and closely mirrors the concerns of Americans at large. As changes are proposed to the VA health care system, we ask that all changes be made to improve care, not purely for budgetary purposes. NAUS and the Alliance agree with the co-authors of the Independent Budget for Veterans Programs that no group is on the whole more deserving of assistance and medical care than those who have made personal sacrifices in our Nation's defense.

BACKGROUND

NAUS believes that the answer to providing quality medical care for veterans, including retired veterans, involves all avenues of care, particularly the Veterans Administration's hospitals near where military beneficiaries reside. As the total eligible veteran population declines and as the VA shifts its focus from inpatient to outpatient care, military retirees and their families are a logical choice to increase patient loads and to bring additional funding with them from DoD and Medicare. At this point, we must say that we are unalterably opposed to directly billing military retirees for medical services rendered them. Honorable service over an extended period of time (20+ years) and a productive lifestyle should afford these distinguished veterans the opportunity to use VA and military medical facilities at no cost. This is an earned, promised benefit – not welfare or charity. HR 1362 would complete a key part of the NAUS military health care plan summarized at Exhibit A.

On our recent visits across the United States to VA hospitals, NAUS staff members have found an eagerness and an urgency on the part of the VA Administrators to start caring for military retirees and other veterans. The VA does

not have the same conflict of interest in providing health care that DoD has since the VA's primary mission is to care for veterans. Retired military along with disabled veterans are the ultimate veterans who have earned a lifetime of medical care.

Secretary of Veterans Affairs, Jesse Brown, says the idea is to "expand the choices for many veterans, particularly some World War II (and Korean War) veterans who would like to come to the VA but are unable to get care because of budget constraints and strict eligibility criteria." Funding must accompany these words. H.R. 1362 would provide funding for care in VA medical facilities of Medicare eligible veterans who are now disenfranchised.

Medicare Reimbursement

The Alliance supports Chairman Stump's bill, HR 1362, to establish a demonstration project to authorize Medicare reimbursement for health care services provided to Medicare-eligible veterans in selected facilities of the Department of Veterans Affairs. The Alliance also supports Representative Joel Hefley's bills, H.R. 192 which would set up a three year Medicare reimbursement demonstration project at up to five military medical treatment facility sites and H.R. 414 which would implement fully Medicare reimbursement. We understand that Senator Phil Gramm plans to introduce Medicare reimbursement legislation to DoD in the Senate soon. We would like to see full Medicare reimbursement legislation passed promptly for both VA and DoD. If that cannot be done we would support a demonstration project. However, the longer we delay full implementation the greater the injustice to military retirees and eligible veterans.

We are gratified that there is a growing understanding that offering discretionary veterans an opportunity to use Medicare to reimburse their VA care

creates additional access and can actually save Federal tax dollars. The Alliance believes this is a commonsense proposal and deserves immediate enactment. It is consistent with efforts to streamline and share Federal resources, it is politically feasible, and is an excellent way of identifying savings for the Medicare Trust Fund. Study after study has shown that military and VA medical facilities provide significant savings over commercial medical providers which the veterans would otherwise use.

Some features which we recommend be incorporated into VA Medicare reimbursement include:

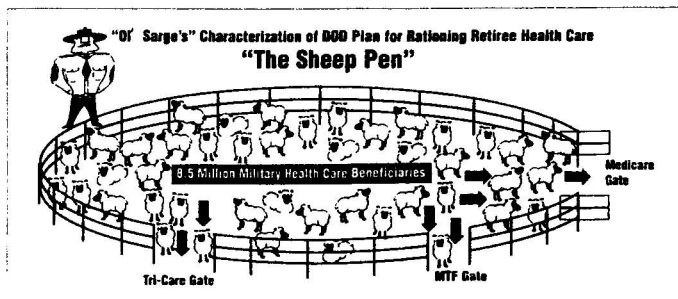
- **Demonstration Phase.** Authority to expand the test after each 6 month period should be incorporated into the bill. The Department of Veterans Affairs Statistical Brief, Projections of the US Veteran Population: 1990 to 2010, states that an estimated 500,000 veterans die in the United States each year. Deaths of U. S. World War II veterans presently account for almost 3 of every 4 veteran deaths and are projected to peak at 380,000 in 2001. A three year demonstration, then a lengthy review, could result in a delay of up to five years or more before a nationwide Medicare reimbursement program is in place. That is too late for these older veterans. They need help now. As quickly as cost savings are determined, the program should be expanded.
- **Cost Sharing.** We strongly recommend that cost sharing be waived for retired veterans. These veterans who served to retirement, many through 3 wars and the 45 year Cold War, were promised free lifetime medical care in exchange for a lifetime of service (See Exhibit B). With the closure of over 58 military hospitals, downsized clinics, a chronically underfunded Defense Health Program, and cutbacks in personnel, hundreds of thousands of retired veterans have been abandoned by their employer, the Department of Defense. These veterans are the only federal retirees

who lose their guarantee of employer provided health care at age 65. Many of these veterans have purchased “Medigap” policies. The VA has the authority to bill these policies and we do not object to that. However, to require this category of veteran to cost-share is wrong and should not be done. If the retired veteran has a “Medigap” or other policy, continue the current practice of 3rd party collections; but if he does not have a policy, then the only party billed should be Medicare, not the retired veteran.

Third Party Collections

We strongly support a bill to revise the authorities relating to third party collections. We support allowing the DVA to keep the amounts collected for services provided by DVA medical facilities. Collections should be made at the level closest to the point of service for which the charge is made and the funds collected, in general, should remain there. This would provide an incentive to the facilities to provide service, attract patients and to collect for their services. The free enterprise system has been proven to be the most efficient means of allocating goods and services, certainly far more efficient than top down command economics. Collecting funds at, or close to, the point of service and leaving most of them there to help fund these services, would energize local DVA medical facilities, reward efficiency and performance, provide incentives that mirror the best results of free enterprise and greatly increase the efficiency of and patient satisfaction with the DVA hospital system and reduce administrative costs. The provisions in the draft bill to exclude these funds from any OMB estimates relative to required appropriations is absolutely essential, should be rigidly enforced, and requires constant vigilance.

Finally, the Military/Veterans Alliance thanks this committee for its support of Medicare reimbursement, for holding this hearing and its interest and concern for our service members, their families and survivors.



The current military medical problem is characterized by many retired soldiers [non-commissioned officers (NCOs)] as a "Sheep Pen" with military retirees being kept waiting for rationed care as shown here.

Some of the problems military beneficiaries encounter are:

- space available care only • medical budget & personnel cuts • reductions in prescription drugs available • 58 military hospitals closed • 26 states have no major MTF • Medicare eligibles cannot enroll in TRICARE • Medicare has no prescription drug coverage • DoD has no plan to care for all beneficiaries • TRICARE will care for only 50-60% • Medicare reimbursement will care for only about 1/3

DoD controls costs by limiting the number of retirees who obtain DoD sponsored care through the TRICARE and MTF gates and inadequate funding for TRICARE Standard (CHAMPUS). Most of the older, sicker Medicare eligible beneficiaries are pushed through the Medicare gate at no cost to DoD but at high costs to the beneficiary.

NAUS Health Care Plan

NAUS has proposed a health care plan that would allow DoD to provide health care for all 8.5 million beneficiaries without keeping military beneficiaries in a "sheep pen" waiting for rationed care which is outlined here.

Primary Medical Care Providers

Military Treatment Facilities (MTFs)

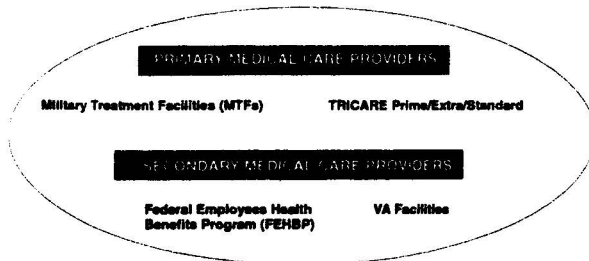
Space available care provided to all eligible beneficiaries. Medicare and FEHBP would reimburse MTFs for care of beneficiaries needed for training.

TRICARE Prime/Extra/Standard - TRICARE Standard must be restored to its original Blue Cross/Blue Shield High Option level standard. Medicare eligibles could participate in TRICARE Prime with Medicare reimbursement.

Secondary Medical Care Providers

Federal Employees Health Benefits Program (FEHBP)

Option - FEHBP would be offered as an option for all retired military beneficiaries who cannot be guaranteed care within MTFs and TRICARE networks. Under age 65 retirees would



be offered FEHBP or a high quality restored TRICARE Standard option.

VA Facilities - Military beneficiaries near VA hospitals could receive care there with reimbursement by Medicare and other third party payers including FEHBP.

This plan would allow DoD to provide promised, guaranteed, accessible health care to all military beneficiaries while providing the necessary patients to MTFs for battlefield readiness training. Any additional cost should not be great because the cost would be offset by restricting individuals to one primary or secondary medical provider. Military retirees should be afforded comparable health care with civilian government retirees.

ARMY

BENEFITS



ARMY BENEFITS HEALTH CARE, HOUSING, SHOPPING AND SCHOOLING

Superb Health Care. Health care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement.

Housing, shopping, schooling and recreational facilities. The Army provides them all – plus excellent pay – to give you a high standard of living in an attractive and wholesome environment.



Maybe the most personally rewarding Army feature of all is the special pride you'll feel performing a valuable service for your country.



Ask your Army Recruiter for more details on all these benefits and how they can benefit you.

ARMY. BE ALL YOU CAN BE.

Not a recruitment poster. See your local Army Recruiter for the latest information.

DA FORM 100-10 (10-1-1991)

• U.S.G. (10-1-1991)



MILITARY MEDICAL CARE PROMISES

Army Recruiting Brochure. "Superb Health Care. Health care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement." [RPI 909, November 1991 U.S.G.P.O. 1992 643-711]

Life in the Marine Corps, p. 36. "Benefits...should you decide to make a career of the Corps, the benefits don't stop when you retire. In addition to medical and commissary privileges, you'll receive excellent retired pay..."

Guide for Educators and Advisors of Student Marines, p. 35. "Retired Marines are generally eligible to receive any type of health and dental care at those facilities provided for active duty personnel."

Navy Guide for Retired Personnel and Their Families, p. 51. "Covered under the Uniformed Services Health Benefits Program (USHBP) are retired members, dependents of retired members and survivors of deceased active duty or retired members. This care is available anywhere in the world either in a uniformed services medical facility (meaning Army, Navy, Air Force and certain Public Health Service facilities) and under the part of the USHBP called CHAMPUS." [NAVPER 15891D November 1974]

The Bluejackets Manual, p. 257. "What Navy Retirement means to you - pay. Continued medical care for you and your dependents in government facilities." [1969]

Air Force Preretirement Counseling Guide, Chapter 5 Medical Care 5-2f. "One very important point, you never lose your eligibility for treatment in military hospitals and clinics." [1 April 1986]

Air Force Guide for Retired Personnel, Chapter 1. "Treatment authorized. Eligible retired members will be furnished required medical and dental care." [1 April 1962]

United States Coast Guard Career Information Guide, USGPO. "Retirement...You continue to receive free medical and dental treatment for yourself plus medical care for dependents." [1991]

U.S. Coast Guard Pamphlet Be Part of the Action, "Reap the Rewards...You can earn retirement benefits - like retirement income...Plus medical, dental care..." [1993]

Hearings on CHAMPUS and Military Health Care, HASC No. 93-70, 93rd Congress "...the government has a clear moral obligation to provide medical care to retired personnel and their dependents...this Committee has found numerous examples of recruitment and retention literature which pledged...medical care for the man and his family following retirement." [Oct-Nov 1974]

VETERANS OF FOREIGN WARS OF THE UNITED STATES



Statement of

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

Before The

Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives

Washington, D.C.

May 8, 1997

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars, I thank you for requesting our participation in today's most important legislative hearing relative to the VA health care system. As you are aware, the VFW has played a strong and active role through the years toward ensuring that all of this nation's veterans have ready and timely access to top quality VA health care. Thus we are gratified to take part in today's deliberations.

Of the three bills under discussion here, two pertain to issues which we believe to be of paramount importance in allowing VA to transform itself into the health care provider of choice for this nation's veterans. These are legislative proposals to provide VA with desperately needed non-appropriated dollars. Also to be addressed is a draft proposal to grant the Veterans Health Administration additional latitude with respect to special pay for certain physicians and dentists.

Before addressing these initiatives individually, allow me to unequivocally state that the VFW is committed to seeing Congress fully fund the VA health care system. At this juncture, only full appropriation support can ensure sufficient funding to provide all eligible veterans with high quality care. Additionally, VA has now set about the Herculean task of transforming itself from an inpatient centered hospital system to an outpatient oriented provider of modern health care. While the efficiencies inherent therein will certainly save tax dollars in the long term, an infusion of capital up front is needed to bring it about. Appropriations support must not be allowed to flag at this critical point in time.

Having said this, I would also convey our belief that VA health care's likely funding levels in upcoming years will not be sufficient to properly provide for a rapidly expanding case load even as the system prepares for the future. The recently completed framework for achieving a balanced federal budget by 2002, while certainly commendable, signals that the already meager flow of discretionary dollars into the VA system will be constricted even more. Couple this with the damage to the system already wrought by years of inadequate budgets, and the need for additional revenue streams is clearly evident.

It is for this reason that the VFW has championed the causes of both Medicare Subvention and Retention of Third Party Insurance collections for VA. The rapid aging of the veteran population together with increased utilization under Eligibility Reform, PL 104-262, has made the need for additional, non-appropriated dollars even more critical. Thus the VFW enthusiastically supports the thrust of the two initiatives under discussion today as they move toward achieving these priority goals.

The first bill we will specifically address today is H.R. 1362, the Veterans Medicare Reimbursement Demonstration Act of 1997. Introduced by the Chairman of the Veterans Affairs Committee, Congressman Bob Stump, this initiative provides for Medicare reimbursement to selected VA facilities for care provided to certain Medicare-eligible veterans. Calling for VA facilities to be selected in three separate geographical areas, with at least one near a closed Military Medical Facility, this legislation takes advantage of the fact VA is uniquely qualified to carry out such a demonstration project. With the world's largest integrated medical system, VA is a *direct* provider of medical care, not merely a referral agent or payment conduit as is the case

with most other federal medical programs. While this bill would have the immediate benefit of directing desperately needed additional dollars into the VA system, it would also offer the most accurate picture of what effect Medicare subvention in the main would have on the Trust Fund. The VFW strongly believes the cost effectiveness of VA medical care will result in significant net savings to the Medicare Trust Fund. H.R. 1362 represents an excellent opportunity to prove this point while bolstering the VA system in the process. It enjoys strong VFW support.

Next under discussion is a draft bill to establish, over a set period of time, a Treasury fund to be known as the "Department of Veterans Affairs Medical Care Collections Fund." Therein is to be deposited Third Party collections to VA for the provision of health care services to certain veterans. This draft proposal would then make Fund amounts, subject to the same limitations as appropriations, available to the Secretary for furnishing medical care and services along with defraying the cost of collection.

As you may be aware, a key VFW objective during this Congress is the enactment of legislation authorizing VA to collect and then retain all third-party payments for the care it provides insured non-service-connected veterans. We also insist that there be no consequent reduction in VA's annual appropriations support. Since 1982 VA's cumulative contribution toward deficit reduction is some \$7 billion. Veterans have already done more than their fair share in service of bringing this nation's fiscal house in order.

We note that the draft bill under discussion would effectively create a third-party retention demonstration project of limited duration. We would, of course, prefer to see the enactment of legislation making such authority permanent. We are also troubled that this proposal would have the unobligated balance remaining in the Fund after the demonstration project's termination be deposited in the General Treasury Fund as miscellaneous receipts for deficit reduction. Given VA's critical need for additional dollars and veteran's already considerable sacrifices on the budgetary front, we hold it to be only prudent and fair to provide that all unobligated collections remain with the VA health care system.

Last under discussion today is draft legislation to lift the application of otherwise applicable financial penalties on certain retirement eligible VA physicians and dentists who hold positions which would not be retained

because of changes in facility staffing arrangements. The VFW notes that in 1991 the Congress enacted special pay authority legislation to help VA remedy problems it was then experiencing in recruiting and retaining physicians and dentists. This "special pay" law's provisions also imposed set time in service and special pay duration stipulations for such pay to be fully credited toward retirement. As VA now shifts to an ambulatory care base system staffing requirements have changed dramatically. Doctors and dentists who would now otherwise retire are holding off based on the economics of the "special pay" law. The VFW concurs that this draft proposal could help VA meet its new staffing requirements by facilitating the voluntary retirements of these highly compensated individuals. We have no objection.

Mr. Chairman, this concludes my written remarks. Once again, I thank you on behalf of the men and women of the Veterans of Foreign Wars for conducting this hearing today in the service of America's veterans. I will be happy to respond to any questions you may have.

Resolution No. 601**REFORM OF ELIGIBILITY FOR ACCESS TO VA HEALTH CARE**

WHEREAS, the existing laws governing eligibility to access VA health care are clearly illogical and virtually ensure that VA is unable to provide a full continuum of care to veteran patients, contrary to sound medical practice; and

WHEREAS, the United States Code, establishes eligibility for VA medical care and a clear statement of obligation by the government to pay for that care is conspicuously absent, a circumstance which places the Department of Veterans Affairs in the position of perpetual supplicant in the matter of obtaining funds to carry out the mandates of the law; and

WHEREAS, VA is required by law to collect payments from third-party health insurers and such collections, other than for administrative costs, do not remain within VA and are instead deposited into the General Treasury Fund; and

WHEREAS, it is our position that all honorably discharged veterans should have a mandated entitlement by law to access the full continuum of VA health care which is defined as ranging from preventive through nursing home care, and which recognizes VA as "case manager" for the full range of ancillary services as well; and

WHEREAS, we further believe that eligibility to exercise that mandated entitlement is satisfied by all veterans who are service-connected from 0 to 100 percent as well as those veterans in receipt of VA pension, and those non-service connected veterans whose lower incomes currently qualify them for limited access on a discretionary basis; and

WHEREAS, the remaining veterans could establish their eligibility by some form of payment option, such as third-party insurance, Medicare, out-of-pocket or even by payment of medical insurance premiums directly to VA; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that the Congress enact legislation bringing order to the present chaos affecting eligibility of VA health care by providing all veterans with mandated access to the full continuum of VA health care; and

BE IT FURTHER RESOLVED, that the Congress and the Administration take appropriate action to ensure that third-party collections by VA remain with that agency and not be offset from its annual appropriation and that Medicare reimbursement to VA be authorized for care provided to veterans again without any offset from its appropriated funds; and

BE IT FURTHER RESOLVED, that specific appropriations support be established for any medical programs directed by the Congress to be provided to veterans both now and in the future.

Adopted by the 97th National Convention of the Veterans of Foreign Wars of the United States held in Louisville, Kentucky, August 17-23, 1996

Resolution No. 603**THE DEPARTMENT OF VETERANS AFFAIRS BUDGET**

WHEREAS, there are presently more than 27 million living veterans of whom over ten million have reached an age where they require increased health care including long-term care; and

WHEREAS, the Department of Veterans Affairs' budget has fallen from 4.3 percent of federal budget outlays in 1970 to an estimated 2.4 percent in FY '95; and

WHEREAS, the laws administered by the Department of Veterans Affairs authorizing benefits for veterans, their dependents and survivors are classified into the following general categories: compensation for service-connected disabilities and death, pension for income maintenance of veterans and survivors, educational and training assistance and loans, servicemen's life insurance, veterans life insurance, hospital and medical care service, nursing home and domiciliary care, including state veterans home construction funds, health manpower training, medical and prosthetic research and burial benefits; and

WHEREAS, it appears that the facilities which the Department of Veterans Affairs presently operates will not accommodate by any measure the anticipated demand for services over the next 20 years; and

WHEREAS, the Department of Veterans Affairs has stated that by the year 2000, an increase in hospital beds will be needed with special geriatric evaluation units at each medical center, and that outpatient clinics should be able to support 26 million visits with the appropriate prevention, geriatric and specialized services; and that additional Geriatric Research Education and Clinical Centers (GRECCs) be established; and

WHEREAS, veterans who served honorably in our Armed Forces during periods of war or hostility have rendered a very special service to our great nation; and if in need of health care, should be timely provided the finest care by the Department of Veterans Affairs; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that we urge the Congress of the United States to pass a budget and appropriations for the Department of Veterans Affairs which will fully fund and maintain the integrity of the benefits and entitlements programs and enhance Department of Veterans Affairs health care system.

**Adopted by the 97th National Convention of the Veterans of Foreign Wars of the
United States held in Louisville, Kentucky, August 17-23, 1996**

Resolution No. 655

VA MEDICARE SUBVENTION

WHEREAS, the VFW views it as essential that the VA health care system be enabled to provide all veterans access to a full continuum of care; and

WHEREAS, the Department has suffered from years of chronic under-funding, limiting its ability to properly care for even its current caseload; and

WHEREAS, it is now absolutely essential that VA be authorized to capture and retain federal dollars in addition to its annual appropriation so as to revamp and revitalize its health care system; and

WHEREAS, a large number of VA's potential patients, especially among the ranks of our military retirees, are Medicare eligible; now, therefore

BE IT RESOLVED, by the Veterans of Foreign Wars of the United States, that we support the swift enactment into law of legislation authorizing VA to collect and retain Medicare dollars.

**Adopted by the 97th National Convention of the Veterans of Foreign Wars of the
United States held in Louisville, Kentucky, August 17-23, 1996**

**STATEMENT OF
RICHARD A WANNEMACHER, JR.
ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON HEALTH
MAY 8, 1997**

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, I am pleased to present our views on the subject of health care delivery by the Department of Veterans Affairs (VA) to this Nation's 26 million veterans.

The DAV is especially interested in additional revenue sources for the VA medical facilities to enhance medical care delivery in a quality-assured, timely manner to sick and disabled veterans, especially those who became disabled as a consequence of military service.

In the invitation to appear before this Subcommittee, it was requested that we address three separate legislative initiatives. The first two would open additional funding streams for the VA while the third initiative would allow certain VA physicians and dentists to receive additional retired pay by considering "special pay" to be basic pay for retirement purposes.

Mr. Chairman, the DAV is very appreciative of your efforts on behalf of America's veterans, especially your continued commitment to those who became disabled in defense of America's freedoms -- freedoms shared by all Americans and many other individuals around the world. We also appreciate the Subcommittee's interest in the financial well-being of those professionals who chose careers that help meet the health needs of those who became disabled in the U.S. Armed Forces.

As you know, the combined views of DAV, AMVETS, PVA and VFW are provided in the *Independent Budget (IB)* we publish each year. The co-authors of the *IB* appreciate the recognition our collective views have received from this Subcommittee in the past. We hope that our analysis of the VA's funding needs will be helpful to you. We believe our recommendations accurately reflect the resources necessary to enable VA to provide an acceptable level of benefits and services for our Nation's veterans and their dependents and survivors.

Many of the veterans VA currently serves have few resources to contribute to their own medical care. Some veterans have private health insurance or are Medicare-eligible. Currently, these veterans are low on the priority ladder and cannot access VA medical care due to space and resource allocation restrictions. We believe legislation allowing VA to retain private health insurance payments (H.R. 1125) and Medicare receipts from the demonstration project (H.R. 1362) will enable the VA to enhance and expand services to meet its mission now and into the next century.

Mr. Chairman, VA's health care system is undergoing dramatic change. Last year, Congress enacted legislation that enabled VA to begin the process of transforming its health care system from a hospital-based system into one that is capable of providing health care in the most cost-efficient setting. The DAV appreciates the efforts of this Subcommittee to help make this critical change a reality. Health care eligibility reform was a good "first step," and DAV looks forward to working with this Subcommittee and the Veterans' Affairs Committees of the House and Senate to ensure that VA has the necessary legislative tools to provide quality, timely and accessible health care for American's service-connected disabled veterans and other deserving categories of sick and disabled veterans.

Proper funding of VA's health care system is critical if we, as a Nation, are to meet our obligation to care for sick and disabled veterans. Recently, President Clinton sent to Congress his proposal to fund veterans health care for fiscal year (FY) 1998. While we do appreciate the President's and VA Secretary Jesse Brown's commitment to care for America's veterans, we are, nonetheless, concerned that VA's FY 1998 health care budget puts that commitment at risk. While VA projects that service will not suffer with the recommended staffing reductions in the Veterans Health Administration, the depth of these cuts cause us concern that VA may be overly optimistic; especially considering the existing strains on the system.

We commend and fully support the efforts of the House Veterans' Affairs Committee to restore necessary funding and employee levels in the Committee's views and estimates for the FY 1998 budget.

H.R. 1125

Introduced by Representative English, this measure allows VA medical centers to bill third-party health insurance carriers for the treatment of nonservice-connected disabilities and retain the costs incurred of providing care or services at the treating facility.

DAV supports the retention of third-party collections in order to provide additional revenues to enable VA to provide enhanced services to our Nation's veterans. We do not support

the President's proposal to use these collections in order to relieve the Federal Government of its obligation to adequately fund VA health care.

The delegates to our most recent National Convention adopted Resolution No. 270, "Supporting the Provision of Comprehensive Department of Veterans Affairs Health Care Services to Entitled Veterans." In paraphrasing the resolution (attached), it is stated that guaranteed funding through adequate appropriations, third-party reimbursement and "start up" transition funding is necessary in order to establish entitlement to VA health care services for a clearly defined category of veterans. The cost of treating sick and disabled veterans must remain the responsibility and obligation of the Federal Government. The Administration's proposal amounts to an abdication of that responsibility.

H.R. 1362

Introduced by Chairman Stump, this measure allows for the establishment of a three-year demonstration project to provide for Medicare reimbursement for VA health care services provided to certain Medicare-eligible veterans.

The VA's ability to participate clinically as a Medicare provider would serve two important purposes. Medicare payments would be an additional source of revenue for the VA, and it could result in potential savings for Medicare. Since we believe VA generally provides health care in a more cost-effective manner than the private sector, Medicare would receive an additional discount on services provided to eligible veterans treated by VA. The Government and the taxpayers, would benefit from the tax dollars saved.

The DAV supports a Medicare reimbursement pilot program as long as service-connected patient care is not compromised at these pilot sites.

DRAFT LEGISLATION

This legislative proposal will amend title 38, United States Code, to provide that special pay received by certain physicians and dentists of the Veterans Health Administration (VHA) retiring before October 1, 1999, shall be considered to be basic pay for retirement purposes.

The DAV is unaware of the impact this draft legislation has on the VA health care system, nor do we have a mandate on this issue, but we are not opposed to its enactment.

This concludes my statement, Mr. Chairman. I would be happy to respond to any questions you or members of the Committee may have.

*Curriculum Vitae
for
Richard A. Wannemacher, Jr.*

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202-554-3501***

Biographical Data

***Birth Date: September 30, 1948
Place of Birth: Erie County, New York***

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

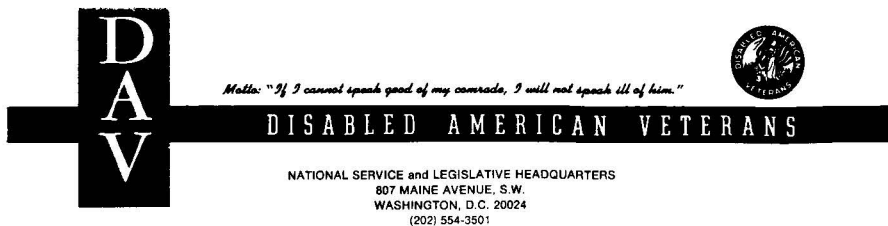
Associate Legislative Director, Disabled American Veterans (DAV), August 1996 to present

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



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.

**National Association of VA
Physicians and Dentists**



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**Testimony of
Samuel V. Spagnolo, M.D.**

**on behalf of the
National Association of VA Physicians and Dentists**

**before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives**

May 8, 1997

Mr. Chairman and Members of the Committee, I am Samuel V. Spagnolo, M.D. I am Professor of Medicine at George Washington University School of Medicine and Health Sciences, where I have been on the faculty for 25 years. I am also Attending Physician at the George Washington University Medical Center and at the Veterans Affairs Medical Center in Washington, DC. I have served the health care needs of our nation's veterans within the Veterans Health Care System for nearly three decades. I come before you today as the President of the National Association of VA Physicians and Dentists (NAVAPD). NAVAPD is the only professional Association representing the nearly 15,000 Title 38 physicians and dentists who work in the VHA. I am proud to represent these dedicated men and women who are committed to improving the health of America's veterans.

NAVAPD is encouraged that the subcommittee is giving consideration to making changes in Public Law 102-40, the so-called special pay law. In doing so you are acknowledging that certain of the provisions enacted by P.L. 102-40 in 1991, when the VA was in desperate need to enhance the recruitment and retention of outstanding physicians and dentists, may no longer be appropriate in a VHA in a downsizing mode. Further it demonstrates your awareness of the significant negative financial impact in retirement that the current state of staff adjustments can have on Title 38 doctors.

Before I present to the committee the Association's position on the draft bill, I would like to comment on the current staff adjustment situation within the VHA; on the effect that it is having now on staff morale; and on the impact it is presently having, and is likely to have in the future, on quality of the care veterans receive within the VA health care system. This topic is relevant to the scope of this hearing, I believe, because the draft legislation before the subcommittee is itself limited to the context of downsizing; that is, the changes the bill proposes would apply only to those Title 38 physicians and dentists whose positions the VA is abolishing.

NAVAPD is clearly on record as opposing the VA's current approach to staff reductions within its medical facilities. As the Members of the committee know, the elimination of doctors within VA Medical Centers throughout the country is being carried out under the guidance put forth in March 1996 in a Directive from VA Under Secretary for Health, Dr. Kenneth Kizer. That transmittal, Directive 5111, gives broad latitude to individual medical facility directors to make far reaching staffing changes, based not on uniform national criteria but on locally-developed standards.

NAVAPD strongly opposes VHA Directive 5111 and believes it should be rescinded. I wrote to Under Secretary Kizer in March 1996, just after the issuance of the directive, and made our positions known. At the time I told him NAVAPD believed that 5111

would seriously dampen morale among Title 38 doctors and that it might lead to serious disruptions within the VA health care system. Time and experience have confirmed that to be the case. Doctors at many facilities characterize the VHA as a system in crisis in which there is tremendous uncertainty both about the future of employment and about adequate staffing levels within the various medical services.

In my letter to Dr. Kizer, I made the case to the VA that I will now make to you. It is a simple proposition --special pay policy can be utilized as effectively to induce *voluntary* separation as it has been used under P.L. 102-40 to recruit and retain physicians and dentists. Reasonable changes to P.L. 102-40 can foster such voluntary separations, and such changes should be viewed as a positive *alternative* to Directive 5111.

In his response to my letter in June 1996, Dr. Kizer indicated the Department's essential agreement with a fundamental principle that NAVAPD had articulated -- that voluntary separations are preferable to downsizing efforts. He also indicated that changes to the special pay law, similar to those NAVAPD proposed and which I will describe in more detail in a moment, could provide the VA with additional flexibilities that could obviate the need for many involuntary separations of Title 38 doctors. Specifically, Dr. Kizer wrote, "The Veterans Health Administration is willing to explore a legislative initiative which would eliminate the requirement for special pay agreements, and the service obligations for special pay to fully count toward retirement. Such changes would provide additional flexibilities allowing large numbers of physicians and dentists to voluntarily leave VA without any financial penalties and reduce the need for involuntary separations resulting from downsizing initiatives. The proposals you have submitted are reasonable..."

Let me stress that NAVAPD was not suggesting then, nor are we implying now, that some reduction in the number of Title 38 physicians and dentists at certain facilities is either necessarily unreasonable or unwarranted. We are simply arguing that voluntary separations are better than firings -- better for employees, better for patients and better for the VA.

The draft bill before you today apparently fails to recognize the value of voluntary separation, a point on which NAVAPD, Dr. Kizer and Secretary Brown apparently agree. Neither does it view special pay law changes as an *alternative* to the VA's current staff adjustment policy. On the contrary, it ties the elimination of current special pay law restrictions specifically to the elimination of jobs, confining it to involuntary separations. Otherwise retirement-eligible doctors would not be given the opportunity to make their own retirement choices. All decisions concerning

employment would remain entirely with the VA. Doctors would not be given the opportunity to leave the service on a voluntary basis under the provisions of the draft bill.

It has long been the position of this Association that the most effective and desirable way to accomplish the goal of reducing the number of Title 38 physicians and dentists within the VA is simply to remove from the law entirely the three financial obstacles to voluntary retirement associated with special pay. They are these: first, the 15 year VA service requirement; second, the requirement of 8 years of obligated service from the effective date of the law; and, third, the requirement that years of service covered under written special pay agreements be measured from the anniversary date of the agreement or result in an individual's being required to refund to the VA a designated percentage of his special pay for that year.

An environment in which job security is uncertain, on the one hand, and the employees' ability to participate in retirement decisions is abridged, on the other, is not likely to attract bright, young talent in the future. The impact of such a flawed policy decision will likely influence the quality of future care for our nation's veterans.

Again, I commend you, Mr. Chairman, for convening a hearing to examine this important issue. But I would also respectfully request that the subcommittee amend the draft legislation, as I have outlined in my testimony, to eliminate entirely the outdated obstacles to retirement that P.L. 102-40 imposes.

In doing so, you will restore the right to make their own retirement decisions to hundreds of individuals who have ably and dutifully served our nation's veterans for decades. More than that, we believe it will be investing in the future excellence of the VA health care system.

We regard this hearing as the initial round in a serious debate on one of the most important issues facing the VA health care system this year, we appreciate the opportunity to participate in it, and we look forward to continuing to work with you as the committee develops final legislation to address it.

* * * *

The National Association of VA Physicians and Dentists (NAVAPD) has received no Federal grants or contracts during the current or previous two fiscal years.

BIOGRAPHIC SKETCH

Dr. Samuel V. Spagnolo is Professor of Medicine at George Washington University School of Medicine and Health Sciences and Attending Physician at George Washington University Medical Center & the Department of Veterans Affairs Medical Center in Washington DC. He is the immediate past Director of the Division of Pulmonary Diseases and Allergy at George Washington University Medical Center and Chief of the Pulmonary Disease Section at the Department of Veterans Affairs Medical Center in Washington, DC. from 1975 to 1994. As Director of these various activities, Dr. Spagnolo was responsible for all of the clinical, teaching, administrative and research activities of these programs. He is also President of the International Lung Foundation.

Dr. Spagnolo has made significant contributions in a variety of fields:

As a teacher, he has personally led the training of #70 pulmonary and critical care specialists and is an active lecturer on the subject of pulmonary and critical care medicine

As a researcher, he has been active in a variety of areas including the diagnosis and treatment of tuberculosis, clinical uses of laser in lung cancer, supportive care for lung cancer patient, the use of new antimicrobial agents, and the use of fine needle lung biopsy for the diagnosis of chest x-ray abnormalities. These research efforts have resulted in the publication of more than 40 scientific papers to date, plus numerous scientific exhibits and three textbooks. Among his scientific reports were the first major review of patient outcome during the early development of medical intensive care units, and the first, 1980, report of pneumocystis Carinii pneumonia (now an AIDS related disease) in patients with lung cancer. More than #200 scientific articles were published by the division's faculty while under Dr. Spagnolo's direction

As a clinician, Dr. Spagnolo has a worldwide reputation as a therapist and consultant. In these roles he serves an international patient community in Europe and the Middle East. In 1981, when President Ronald Reagan was shot by a would-be assassin, Dr. Spagnolo served as the medical chest consultant. His involvement was reviewed in Mortal Presidency by Robert Gilbert, Basic Books, New York, NY, 1992.

He is the recipient of numerous honors and frequently responds to requests from the public media and professional organizations. In addition to his memberships in various professional societies, he has served as President of the District of Columbia Thoracic Society, President of the National Association of Veterans Affairs Physicians & Dentists, and is the immediate past Governor of the District of Columbia for the American College of Chest Physicians having served in that position for five years..

Dr. Spagnolo is listed in the 1996 Golden Anniversary 50th Edition of Marquis "Who's Who in America" as well as Medical Sciences International Who's Who (5th ed). He has served as advisor to various organizations and a consultant to the White House Medical Unit, Walter Reed Medical Center and the Will Rogers Institute. In 1991, he established the International Lung Foundation (ILF) for the purpose of helping overcome the serious deficiencies present in the clinical diagnosis, treatment, and the prevention of lung diseases.

Education: Washington and Jefferson College, BA; Temple University School of Medicine, M.D.

NARRATIVE

I am currently Professor of Medicine and Attending Physician at George Washington University Medical Center and Attending Physician at the Veterans Affairs Medical Center Washington D.C. From 1976 to 1994, I served as the Director of the Division of Pulmonary Diseases and Allergy at the George Washington University School of Medicine and Health Care Sciences and Chief of the Pulmonary Section at the Veterans Affairs Medical Center, Washington, DC.

Prior to my appointment (1976) as Director of the Division of Pulmonary Diseases and Allergy, I served on the faculty of the Department of Medicine at the George Washington University in various positions. From 1972 to 1975, I was an Assistant Professor of Medicine and the Assistant Chief of the Medical Service at the Veterans Administration Medical Center, Washington, D.C., and subsequently from 1975 to 1976, I was an Associate Professor and the Acting Chief of the Medical Service at the same institution. In 1976, I accepted the appointment as director of the respective pulmonary divisions. I became Professor of Medicine in 1981. In addition to my pulmonary responsibilities, from 1986 to 1989, I was also Associate Chairman of the Department of Medicine. During my more than 20 years at George Washington University Medical Center, I have been a member of numerous committees and chairman of several major committees.

As Director of the Division of Pulmonary Diseases and Allergy until September 1993, I was responsible for the clinical, teaching and research functions of the division, the pulmonary faculty practice within the division and all aspects related to the pulmonary fellowship education program. I was actively involved with both the full-time and part-time pulmonary and allergy faculty and was responsible for providing the leadership for the division, which included the respiratory care section and the pulmonary function laboratories of the medical center. Along with these duties, I carried similar duties and responsibilities at the Veterans Affairs Medical Center. Individuals reporting directly to me included members of the full-time pulmonary faculty at both institutions, as well as the chiefs of respiratory care and the pulmonary physiology laboratories.

In addition to my administrative duties, I have published numerous papers and am the editor of three textbooks; 1) Handbook of Pulmonary Emergencies; 2) Air Pollution and Lung Diseases in Adults; 3) Handbook of Pulmonary Drug Therapy. I have been involved in numerous research protocols and continue to provide leadership and encouragement to faculty to pursue their own research interest. Under my direction more than #200 articles were published by the division's faculty. My own research interest has been in the general area of clinical pulmonary disease with emphasis on tuberculosis and physiology. Even while director of both institutions, I devoted a significant portion of my time in the practice of pulmonary diseases including caring for patients with critical care pulmonary and medical problems. I am an active lecturer on the subjects of pulmonary disease and internal medicine and I spend a considerable portion of my time involved with teaching medical students, residents and fellows. Seventy pulmonary disease specialists completed their training under my direct supervision and guidance.

Along with the activities noted above, I have been active in various professional societies, serving as President of the District of Columbia Thoracic Society from 1981 to 1983 and Secretary, Vice President, and President of the National Association of V.A. Physicians & Dentists. In 1989, I was appointed Governor of the District of Columbia, Counsel of Governors for the American College of Chest Physicians. I have given numerous invited lectures and have made multiple appearances on radio and television program. I currently serve as a consultant in pulmonary diseases to various foundations and medical institutions. In 1981, I served as the medical chest consultant in the care of President Ronald Reagan following the attempted assassination. This involvement was reviewed in Mortal Presidency by Robert Gilbert, Basic Books, New York, 1992. During the Presidency of George Bush, I was a consultant to the White House Medical Unit on numerous occasions. I am listed in Medical Sciences International Who's Who (5th ed), and in the Golden Anniversary 50th Edition of Marquis Who's Who in America. I am a Fellow of the American College of Medicine and a Fellow of the American College of Chest Diseases.

Samuel V. Spagnolo, M.D.
Narrative
Page 2

Born and raised in Pittsburgh, Pennsylvania, I received my Bachelor of Arts Degree from Washington and Jefferson College and a Doctor of Medicine from Temple University. I served from 1966 to 1968 as a Commissioned Officer with the United States Public Health Service, assigned to the National Communicable Disease Center in Atlanta, Georgia. I completed my medical residency training in internal medicine in Boston at the Boston City Hospital and at the Veterans Administration Hospital where I was the Chief Resident in Medicine. Subsequently, my medical training was completed as a Harvard Clinical and Research Fellow in Pulmonary Diseases at the Massachusetts General Hospital.

I joined the faculty at the George Washington University School of Medicine and Health Care Sciences in 1972.

I have three children: Samuel John, a 1984 Summa Cum Laude, Phi Beta Kappa graduate of Lehigh University and a systems engineer with Maxxus, a San Francisco based computer software company and subsidiary of Sterling Software Corporation, Dallas, Texas; Brad, a 1st year resident and 1995 graduate of Temple University School of Medicine; and Gregg, a 1993 graduate of the University of California at San Diego and mechanical engineer with Hayes, Seay, Mattern & Mattern an engineering and design corporation in Rockville, Maryland.



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Statement of

Chuck Burns
AMVETS National Service Director

before the
Subcommittee on Health

of the
Committee on Veterans Affairs

U. S. House of Representatives

Thursday, May 8, 1997
Room 340
Cannon House Office Building

Mr. Chairman, I am Chuck Burns, National Service Director of AMVETS, The American Veterans of World War II, Korea and Vietnam. We are grateful to you and the committee for this opportunity to testify before you today. Neither AMVETS, nor myself, have recieved any federal grants or contracts during FY 97 or in the previous two fiscal years.

Mr. Chairman and members of the committee, AMVETS is pleased to present our views on the following proposals:

- o Legislation to establish a demonstration project to provide that the Department of Veterans Affairs may receive Medicare reimbursement for health care services provided to certain Medicare-eligible veterans;
- o Legislation to provide that VA retain third-party collections and user fees in the medical care appropriation; and
- o Legislation to lift the application of otherwise applicable financial penalties on certain retirement - eligible VA physicians and dentists who hold positions which would not be retained because of changes in facility staffing arrangements.

AMVETS in conjunction with the Independent Budget, DAV, PVA and VFW has been supporting and calling for initiatives such as these for several years. It is a known fact that the Department of Veterans Affairs is drastically under-funded and unable to provide either the quality or the quantity of health care intended by the Congress and a grateful nation.

AMVETS has supported the idea that VA must evolve to meet the needs of the new health care environment. Establishing and nurturing new funding streams is a way of supplementing its budget. Medicare reimbursement, retention of third-party collections and user fees meet this objective.

We strongly oppose, however, these dollars being used to offset federal appropriations that are required to cover the cost of anticipated increases in workload.

They should not be used as substitute funding by the Office of Management and Budget as contained in the Administration's request, to straight-line VA appropriations through the year 2002. We believe it is unrealistic for the VA to realize the purported gain from these reimbursements, even if Congress approves legislation providing the authority this year. They are in essence gambling with the health and well-being of millions of veterans.

Medicare reimbursement for health care services provided to certain medicare-eligible veterans.

As it stands right now, the VA does not receive any funding from the Health Care Financing Administration(HCFA), which administers Medicare even though many of the veterans served by the VA are also eligible for Medicare/Medicaid.

Two things must happen to correct the Medicare/Medicaid/VA problem. Congress, must fund the VA so that it can take care of both "low and high" priority veterans. Then Congress must authorize (HCFA) to pay back the funds for these veterans to the VA.

Offering low priority veterans an opportunity to use Medicare to reimburse their VA care creates access and can save federal tax dollars. Funding, at a discounted rate, could simply go to the VA rather than to private-sector providers.

The only thing keeping this optimal program from taking effect is Congress' complicated rules for scoring such legislation. We are hoping that hearings like the one today will help educate members about the benefits of this non-partisan legislation. It's a win-win situation for everyone.

VA retain third-party collections and user fees in the medical care appropriation.
Congress should allow VA to retain the additional revenues veterans bring into the system. We also believe that Headquarters should eliminate its centralized Medical Care Cost Recovery office and authorize VA networking directors to contract for their cost-recovery efforts, as in the private sector.

By our estimates, VA is now spending about 17 cents for every dollar it collects. Some of the problems VA encounters in collecting third-party funds include fee schedules that are incompatible with other payers, failure to seek authorization for payment of care before service is rendered, and practice standards that are different from private sector providers - for example, longer average lengths of stay and more.

We believe that allowing VA to retain the costs of care from third-parties will ensure a fully - supported recovery effort. With the additional funds, VA would be able to enhance care for current users and increase access for low priority veterans.

We also believe that if the VA healthcare system were able to collect and retain these funds, it could begin treating the veteran's adult dependents. Additional people in the VA system would provide additional resources and would enhance care available to high priority veterans. It also creates a new choice for adult dependents who wish to use VA healthcare services alongside their mothers, fathers and spouses. This is not a new idea. A couple of years ago, the Congressional Budget Office(CBO) examined this proposal. They believed that each dependent would cost the Federal government. We believe this should be examined as a new business opportunity, under which VA could control treatment of dependents and ensure their ability to pay before service was rendered. We caution that this should not be done so as it reduces services or quality of care to veterans.

Legislation to lift the application of otherwise applicable financial penalties on certain retirement eligible VA physicians and dentists who hold positions which would not be retained because of changes in facility staffing arrangements.
This bill will help VA meet its staffing needs by facilitating voluntary retirements, and thus lessening the need to rely on reductions-in-force, by lifting

the otherwise applicable length of service requirements, in the case of retirement eligible physicians and dentists who hold positions, which the VA believes are no longer needed. This change would lead numbers of these clinicians to retire up to two years earlier than what is expected under the current law. The employees win because it cancels the need for a RIF and the VA wins because it will achieve some savings. The bill also calls for the VA to reimburse the Federal retirement system from those savings for the additional costs it would likely incur.

We strongly urge Congress to authorize Medicare reimbursement for higher income veterans and dependents and retention of third - party reimbursement for current veteran users, new veterans' users and veterans' dependents.

Va must change to survive and we view some recommendations in prescription for changes as proof that VA concurs with many of our past recommendations.

Mr. Chairman, this concludes my testimony.



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A Non-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement of

VIETNAM VETERANS OF AMERICA

Presented By

KELLI R. WILLARD WEST

DIRECTOR OF GOVERNMENT RELATIONS

Before The

House Veterans' Affairs Subcommittee on Health

Regarding

Draft legislation regarding Medical Care Cost Recovery (MCCR)

H.R. 1362, the Veterans Medicare Reimbursement Demonstration Act of 1997

Draft legislation regarding Physician's Special Pay

May 8, 1997

Introduction

Mr. Chairman and members of the committee, Vietnam Veterans of America (VVA) is pleased to have an opportunity to share our perspectives on the legislation being considered by the committee today. These bills, in combination with the eligibility reform measure passed in the 104th Congress, are quite possibly the most important veterans health-care legislation to be considered by Congress in recent history.

Without passage of innovative MCCR collection and Medicare pilot bills, which will dramatically change the funding mechanisms and business practices for the VA, the system is surely doomed to fail at performing its mission of caring for our nation's veterans, and may well not even survive. Federal budgets and available annual appropriations will be ever more restrictive and will continue to reduce services to veterans, many of which are special needs cases for which VA is the only available provider. Passage of this legislation would provide the veterans health-care system a chance to accomplish what almost seems impossible -- improve the access, quality and timeliness of services; provide care to more veterans; improve efficiency; and do so at lower costs and without creating an increasing demand for federal appropriated funds.

At the outset we wish to commend the leadership and all members of the House Veterans' Affairs Committee for exercising appropriate caution and foresight in its recommendations to the Budget Committee regarding FY 1998 medical care expenditures of \$17.6 billion. The committee-passed budget figures have been embraced by the veterans community, rather than the Administration's budget request, because the system is in such a massive state of transition that gambling with the Congress' passage of enacting legislation and VA's ability to meet ambitious collection targets is far too risky. VVA thanks the Committee members for this perspective.

Draft legislation regarding Medical Care Cost Recovery (MCCR)

VVA agrees with the objective and supports the enactment of legislation to permit VA to retain third-party reimbursements. From our review, we believe the draft bill being considered by the committee will accomplish this objective, and we support swift passage of this legislation. The current system which requires most insurance and copayment revenues to be directed to the Treasury in effect robs one group of veterans in order to pay for services to another group. This is because each dollar spent on discretionary-category (Category C) veterans cannot be spent on care for a service-connected disabled or indigent veteran (Category A). Allowing VA to retain these collections will go a long way toward stabilizing VA medical care funding.

The veterans community, including VVA, has long advocated that VA should retain these non-appropriated monies not only to recoup its expenditures on discretionary-category veterans, but also to supplement infrastructure and overhead expenditures which will benefit core group veterans. Without bringing alternative revenue sources into the VA system, it is questionable that the U.S. can sustain the veterans health-care system. Without additional monies, many veterans may be denied services by an ever-shrinking VA health system.

Though the legislation does not specifically address how these collections should be reallocated among the facility, the VISN and the broader VA health-care system, VVA urges the committee to make recommendations to VA in report language. VVA recommends that a significant

portion of the MCCR collections should be retained by the local facilities or at the VISN level. This is essential because these incentives will encourage the facilities to supplement services, to do outreach to its potential patient-base and to collect the insurance and copayments. We do not have a specific percentage in mind regarding such a local-national split on the revenues, but believe it is important that Congress' intent be stated for the record, if not within the bill language itself.

H.R. 1362, VA Medicare-Reimbursement Demonstration Legislation

Likewise, VVA supports the passage of legislation to establish a pilot project to examine Medicare-reimbursement at discounted rates for eligible veterans who seek care at the VA. For the reasons stated above, it is desirable and logical that non-service connected veterans and those who do not meet the means test eligibility should have the option of bringing their health care coverage dollars to the VA – even if that coverage is the federal Medicare program. There are potential cost savings for the Medicare program. This would allow VA to provide better care to more veterans by supplementing its annual appropriation and spreading overhead and infrastructure costs over a larger patient population. And Medicare-eligible veterans would have enhanced choice of providers.

VVA recognizes that political realities and negotiations among various agencies and committees of jurisdiction have resulted in some legislative provisions of H.R. 1362 which we all might prefer be changed. VVA would like to comment on two issues which could be improved upon. These recommendations do not reflect shortcomings in the bill which would preclude VVA support for the legislation. Rather, these are simply for the committee's consideration and perhaps discussion among your colleagues on the other committees with jurisdiction.

- It seems short-sighted and restrictive to preclude veterans with family incomes exceeding three times the means test level from participating in the demonstration project. VVA advocates that all Medicare-eligible veterans be allowed to participate. It does not seem necessary, appropriate or desirable to restrict provider choices for the highest-income veterans.
- Should the \$50 million annual Medicare payment limit be reached, what happens to the veterans seeking care at the VA under this program? Will these veterans be denied care within the VA because Medicare will not pay? Will VA be forced to take a loss on care provided to eligible veterans in excess of \$50 million per year? Imposing such a restriction may preclude the demonstration project from getting appropriate and accurate usage and cost data. VVA recommends that a mechanism be developed to provide the agencies and Congress with advanced warning if the demonstration project approaches the annual limit. Congress should then make a determination based upon preliminary program evaluation whether to provide an exemption to the annual limit.

Draft Bill on Physician Pay

VVA does not have a position supporting or opposing the physician pay draft legislation. The makeup, qualifications and performance of the medical-care provider workforce are certainly issues which the Veterans Health Administration needs to examine as it changes the way it does business. An overabundance of specialists is not conducive to VA's goal of shifting toward outpatient primary care modalities of treatments. Also, the VA does need to have maximum ability to make workforce

adjustments at this time of significant change. The service needs of the veteran population and the manner of providing health-care services have changed nationwide. In general, we agree with the goal of this legislation to provide VHA with greater flexibility in hiring and retaining health-care professionals to better match service capacity with the needs of patients.

General Concerns Regarding Specialized Programs

Having stated that VA needs flexibility in changing its health-care delivery structure, VVA wishes to state for the record our concern that an appropriate level of inpatient capacity -- both beds and staffing -- be maintained in each VISN to accommodate VA's specialized services. We continue to be very alarmed by trends within the last 18 months to shift general mental health, PTSD and substance abuse programs to a completely outpatient basis. A letter I sent to Dr. Kizer nearly a year ago is attached for your reference. The concerns VVA raised at that time remain valid today.

We are very pleased that this subcommittee has made these vulnerable special disability programs an important part of the oversight agenda. We agree with the subcommittee's assessment that mental-health care programs are at risk in the current budget environment. This is true not only within the VA, but throughout our nation's public and private-sector care providers. VVA does agree that many patients can be effectively and efficiently treated for mental health and substance abuse conditions on an outpatient basis. But many veterans have extraordinarily complex physical and mental health problems which only can only be addressed adequately in a controlled therapeutic environment. VA must maintain a capacity to provide this inpatient care in some manner -- either within the VA itself or through contract, sharing or purchase arrangements with non-VA providers.

Similar changes throughout the mental health field will complicate both supply and demand for these types of services. As access to non-VA inpatient mental health and substance abuse programs is further and further restricted, it is only logical that demand for these intensive services within the VA will increase accordingly. Many of these veterans have priority VA eligibility based upon service-connected disability or income. If VA has very restrictive inpatient capacity to treat severely mentally-ill or substance abusing veterans, many will fall through the cracks leaving their lives destroyed and abrogating VA's responsibility to care for this population.

VVA does not evaluate program quality, performance and capacity based solely on funding, bed capacity and staffing levels. But these figures do partially demonstrate the VA's commitment -- or lack thereof as the case may be -- to provide these intensive therapeutic services to veterans. VVA reiterates our recommendation to have this subcommittee conduct rigorous oversight regarding the changes to these and all of the VA's specialized programs. Additionally, we urge you to work very closely with the appropriators to ensure that funding for VA health care is maintained at an appropriate level to ensure services for core-group veterans and specialized programs such as PTSD and Substance Abuse units. We urge the subcommittee to examine the VA's homeless programs in the same manner, because resources for these programs also fall far short of the needs of this unique and under-served population.

Conclusion

VVA agrees with the overall objectives of developing alternative funding streams for VA to supplement the federal appropriation. And we urge swift passage of these bills, so VA can make

additional progress in the transition that is unfolding. The VISN reorganization, VERA and eligibility reform are well underway. The resolution of these funding issues is the next step in providing VA with the authority to evolve into a modern, efficient health-care provider.

VVA remains concerned that the Office of Management and Budget (OMB) and/or Congress may be tempted to reduce the VA's budget and appropriation by the amount of its MCCR and Medicare receipts in the future. It is critical that the federal appropriation be maintained at a level high enough to sustain services to core-group veterans. Service-connected and indigent veterans are the federal government's responsibility -- not insurance companies.

We are also discomforted by real and perceived threats to the viability of VA's specialized care programs, in particular mental health, PTSD and substance abuse programs. VERA does provide financial incentives to VISN directors to enroll specialized care veterans. But access to these resource-intensive specialized services still seems to be restrictive. VVA strongly recommends that additional protections and rigorous oversight of VA's core mission of providing specialized care to veterans be implemented.

Thank you for the opportunity to present VVA's views on these important bills. This concludes our statement. We would be pleased to respond to any questions.



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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

June 7, 1996

Dr. Kenneth W. Kizer (10)
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, DC 20420

COPY

Dear Dr. Kizer:

On behalf of Vietnam Veterans of America, I wish to call to your attention our concerns with contemplated closures of VA inpatient PTSD and substance abuse units, which have been prompted by a number of recent calls from VVA members around the country.

VVA does recognize that some changes in the way hospital-based PTSD and substance abuse treatments are provided are necessary to achieve greater efficiency and improved service -- even in these "specialized services" for which VA is a recognized national health-care leader. I want to be very clear that we are not opposed to making changes, per say. Through greater efficiency, it is hoped that more veterans will have access to these VA services. VVA is simply concerned that these closures -- as currently presented -- might negatively impact patient care.

VVA has and continues to support your reorganization plan outlined in "Vision for Change," which aims to provide health care services to veterans in a more appropriate, cost-effective and convenient manner. We have noted in the past that as long as no existing services are denied to veterans or disrupted with the reorganization, the changes should actually enhance care. Additionally, we have done some preliminary review of "Prescription for Change" and are generally supportive of your blueprint for implementation of this reorganization. It seems, however, that the well-laid plans of your central office staff are not being wholly embraced by administrators in the field.

The comments VVA is hearing from around the country regarding the sudden and proposed closures of VA inpatient PTSD and substance abuse programs are that:

- a) It does not seem that these closures are thoroughly planned out, in terms of making program alternatives, substitutions or accommodations available in order to prevent disruption of service to the local veteran population; and
- b) Even assuming that the alternatives, substitutions and accommodations are properly

Dr. Kizer -- Page 2

addressed in the planning, the public -- and particularly veteran consumer groups -- hasn't been adequately or appropriately informed, thus raising significant, unnecessary misunderstanding and alarm among veterans.

PTSD and substance abuse treatments are readily identified as part of VA's core mission of caring for the special needs of combat veterans. There are very often no comparable private-sector alternatives for veterans seeking these types of services/care. There are certain PTSD and substance abuse patients for which acute-care, inpatient medical treatment of this sort is critically important. And these needs must be accommodated. It is critical that the unique nature and the clinical integrity of these programs are protected and maintained.

VVA's recommendations for addressing this very serious problem are as follows:

Appropriate Alternatives to Current Inpatient Care Models

VVA acknowledges that inpatient programs for PTSD and/or substance abuse may be costly and sometimes not the best method of providing care. At the same time, for many veterans suffering from these conditions, an outpatient program will not meet their clinical needs -- a safe, supervised, therapeutic-setting, overnight accommodation is critical, particularly for veterans on medications, veterans who reside a considerable distance from the VAMC, and homeless/indigent veterans whose day-to-day life circumstance would hinder recovery. An additional factor to consider is the rural versus urban setting -- forcing veterans with these particular conditions to travel from relatively safe rural settings to a VA facility perceived to be in a dangerous urban area can be detrimental to treatment.

Certainly there are alternatives to the up to \$800-a-day acute-care hospital bed that could meet both the objectives of patient care and cost savings. There are many options. Domiciliary or nursing home-style care could be an appropriate model. Also, VVA has long advocated for community-based organizations, such as the VVA- and VA-supported homeless programs in Wisconsin and Connecticut, in which VA establishes sharing or contract relationships with community providers to maximize use of all available resources.

Again, VVA is not directly opposed to VHA's efforts to enhance efficiency by shifting inpatient PTSD and substance abuse programs to alternative care settings. We are very concerned, however, that these alternatives be put into place prior to the closure of hospital-based inpatient units. I would note that VVA strongly urges our leaders to work with program administrators to identify and implement appropriate program efficiencies for VA's inpatient PTSD and substance abuse programs. We urge VA at all levels to consult with the veterans community on these issues as well.

Dr. Kizer -- Page 3

Advanced PR Regarding Program Changes

In many locations, we believe, proper planning and accommodation of veterans with special needs for inpatient PTSD and substance abuse units is taking place. Our strategy for addressing these location-by-location issues has been to put local veteran advocates in contact with appropriate local VA officials to work toward the resolution of such issues. Often this type of communication seems to resolve the concerns. By getting more information to the local veterans community, VA can alleviate many fears and defensive posturing.

It is very important that the veterans community leadership -- consumers -- be involved in and informed of VA's decisions to change the way care is provided prior to changes taking place. This is particularly true of PTSD programs where the local veterans community takes a very real, personal stake in program quality and continuity. By involving VSO leaders in these discussions of how best to shift inpatient PTSD and substance abuse care to a more cost-effective setting, VA will be able to educate the public about the purposes and goals of these changes, and will be able to identify additional community resources which may be of use.

The issue of inpatient PTSD and substance abuse program closures seems to be a "systemic" problem, with similar concerns cropping up in various locations. This is why we are contacting you directly on this matter, Dr. Kizer, in addition to having VVA local leaders work with VA program officials at the local level.

VVA would appreciate any information you may provide regarding which sites around the country are contemplating these kinds of changes to VA inpatient PTSD and substance abuse units, including the alternatives considered and the substitute services to be provided. This will allow us to better respond to our members' inquiries.

Thank you for your assistance in this matter. We look forward to working with you to ensure that the best possible medical services are provided to our nation's veterans.

Sincerely,

Kelli Willard West
Director of Government Relations



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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

KELLI WILLARD WEST Director of Government Relations

Kelli Willard West joined the VVA government relations department in 1993, after serving in the U.S. House of Representatives as Legislative Assistant to Representative Dave Nagle from her home state of Iowa. As VVA Legislative Assistant and subsequently Deputy Director for Government Relations, her areas of responsibility included health care, Agent Orange, PTSD and related issues. In October 1995, she was promoted to her current position as Director of Government Relations.

West is responsible for coordinating VVA government relations and legislative activities; advising VVA leaders on strategy; overseeing and training VVA's nationwide network of legislative coordinators in support of national VVA advocacy goals; and keeping the general VVA membership informed through reports in *The VVA Veteran*.

Kelli received her B.A. in Global Studies from the University of Iowa. She resides in Washington, D.C., with her husband Rich, who is a graduate student at American University.

FUNDING STATEMENT May 8, 1997

The national organization Vietnam Veterans of America, Inc. (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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STATEMENT OF
JOHN C. BOLLINGER, DEPUTY EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH
CONCERNING
H.R. 1362, "THE VETERANS MEDICARE REIMBURSEMENT DEMONSTRATION
ACT OF 1997"
DRAFT THIRD-PARTY COLLECTIONS LEGISLATION
AND
DRAFT VA PHYSICIAN AND DENTIST LEGISLATION
MAY 8, 1997

Mr. Chairman, Ranking Democratic Member Gutierrez, and members of the Subcommittee, the Paralyzed Veterans of America (PVA) is honored to present testimony today regarding the legislative proposals being considered by this Subcommittee.

PVA has always supported allowing the Department of Veterans Affairs (VA) to retain third-party collections and allowing the VA to establish a Medicare subvention demonstration project that ultimately could be expanded to include the entire VA medical system. We support these measures today, but with a caveat: The monies collected from these "alternative funding streams" must be a **supplement to**, not a **substitute for**, an adequate core-appropriation for VA medical care.

Last Congress, PVA supported H.R. 4068, a measure that was similar to H.R. 1362. PVA testified accordingly for the record before all committees of jurisdiction last year. We reiterate our support for the creation of a demonstration project to explore the feasibility of allowing the VA to retain Medicare reimbursements for health care provided to non-care-group Medicare eligible veterans.

The recent release of the report of the Medicare Trustees demonstrating that, without corrective legislation, the Hospital Insurance Trust Fund would be depleted in the year 2001, highlights another benefit arising from enactment of H.R. 1362. Enactment of H.R. 1362, the "Veterans Medicare Reimbursement Demonstration Act of 1997," would help strengthen the Medicare trust funds. Under the provisions of H.R. 1362, the Health Care Financing Administration would reimburse the VA at a rate of 95 percent of regular Medicare payment rates. Allowing new veteran users into the system would also lower the aggregate cost of care for all veterans.

Enactment of H.R. 1362 would be a "win-win-win" situation: The Medicare Trust Funds would save vitally needed dollars while the VA would be able to realize efficiencies leading to lower health care costs and veteran users would be provided additional health care choices. In addition,

Medicare subvention would also initialize for the VA what is a growing trend in all Federal health systems, including Medicare and Medicaid. This trend coordinates benefits and sharing among these systems in order to bring better health care to beneficiaries at reduced cost.

PVA believes that Medicare subvention will result in ultimate cost-savings to American taxpayers while ensuring the best possible care for veterans, especially those veterans in need of specialized services, but we recognize that the data to support these contentions are scarce. That is why we support the demonstration project as established in H.R. 1362. At the same time we are not willing to gamble with the health and lives of our members and all veterans if the estimated receipts from Medicare subvention and retention of third-party reimbursements prove chimerical.

PVA is distressed by the Administration's attitude as evidenced by its Fiscal Year 1998 Budget for VA medical care. User fees and alternative funding streams must never take the place of a federal commitment to the men and women who served in the Armed Forces. Veterans served this Nation, and the health care they earned should not be predicated on monies received from insurance companies. This federal commitment is perpetuated by an adequate core appropriation for VA medical care. PVA is concerned that even with passage of H.R. 1362 and legislation allowing the VA to retain third-party reimbursements before the start of the fiscal year, a

possibility that must frankly be viewed as over-optimistic, that estimates derived from the Administration regarding the monies to be received by the VA, are merely that -- estimates.

Collections of the Medical Care Cost Recovery (MCCR) Program have fallen, while collection costs have risen over the last few fiscal years. Total collections for FY 1997 are estimated to be \$41 million less than total collections for FY 1995. At the same time, the percentage costs of collections have risen from 17.8 percent to an estimated 22.4 percent over this same period (Source: Budget of the United States Government, Fiscal Year 1997, and Fiscal Year 1998). While the trend in collections is downward, and the costs of these collections increases, the Administration's FY 1998 budget estimates that these trends will be magically reversed. The Administration estimates that collections for FY 1998 will be \$58 million more than those estimated for FY 1997, and collection costs are estimated to fall from 22.4 percent to 20.8 percent. Is there any wonder why we are skeptical of the Administration's tenuous estimates and shaky financing schemes for VA medical care?

As we stated earlier, monies collected from alternative funding streams should be supplements to, not substitutes for, an adequate core appropriation for VA medical care. To guard against the use of monies collected from the proposed Department of Veterans Affairs Medical Care Collections Fund as a substitute for an adequate core appropriation, PVA supports the inclusion of language in this legislation mandating that monies collected not be used in lieu of appropriated dollars. Only this will keep faith with the men and women who answered this Nation's call to service.

PVA has no objection to the draft legislation to lift the application of otherwise applicable financial penalties on certain retirement-eligible VA physicians and dentists who hold positions which would not be retained because of changes in facility staffing arrangements.

I would be happy to answer any questions that you may have. Thank you again for this opportunity to testify before this Subcommittee.



DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE COST RECOVERY (MCCR) PROGRAM

(in millions)

FISCAL YEAR	FY1995	FY1996	FY1997 (est.)	FY1998 (est.)
COLLECTIONS	574	557	533	591
COSTS	102	119	120	123
DEFICIT REDUCTION	472	438	413	468
% COST	17.8%	21.3%	22.4%	20.8%

(Source: Administration Budget for Fiscal Year 1997 and 1998)

The Administration budget for VA collection is out of line with historical attempts at collections and costs. The FY1998 budget overestimates the collections and underestimates the administrative costs associated with these collections.

Pursuant to House Rule XI 2(g) (4) the following information is provided regarding federal grants and contracts:

Fiscal Year 1995

Department of Justice - Joint venture to produce procedures implementing the Americans with Disabilities Act (ADA) through certification of building codes \$25,000.00

Department of Veterans Affairs - donated space for veterans' representation \$869,519.26 *

Court of Veterans Appeals, administered by the Legal Services Corporation - National Veterans Legal Services Project \$240,286.

Fiscal Year 1996

General Services Administration - Preparation and presentation of seminars regarding implementation of the Americans with Disabilities Act (ADA) \$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, PL 98-435 \$10,000

Department of Veterans Affairs - donated space for veterans' representation \$897,522.48 *

Court of Veterans Appeals, administered by the Legal Services Corporation - National Veterans Legal Services Program \$200,965.

Fiscal Year 1997

Architectural and Transportation Barriers Compliance Board (ATBCB) - Develop illustrations for an Americans with Disabilities Act (ADA) technical compliance manual \$10,000

Department of Veterans Affairs - donated space for veterans' representation \$224,380.62 (as of 12/31) *

Court of Veterans Appeals, administered by the Legal Services Corporation - National Veterans Legal Services Program \$37,125 (as of 12/31).

* This space is authorized by title 38 U.S.C. § 5902. These figures are estimates and were derived by calculating square footage and associated utilities costs. It is our belief that this space does not fall under the definition of federal grants and contracts.

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Professional Experience.

1992 - present Deputy Executive Director
Paralyzed Veterans of America

1990 - 1992 National Advocacy Director
Paralyzed Veterans of America

1987 - 1990 Associate Director of Legislation
Paralyzed Veterans of America

1986 - 1987 Assistant to the Administrator of Veterans Affairs
Department of Veterans Affairs

1972 - 1986 Veterans Benefits Department
Department of Veterans Affairs

Organizations

Trustee - Paralyzed Veterans of America Spinal Cord Research Foundation (SCRF)

Board Member - Paralyzed Veterans of America Education and Training Foundation (ETF)

Member of Executive Board - President's Committee on Employment of People with Disabilities (PCEPD)

Board Member - National Spinal Cord Injury Hotline

Military

United States Navy, retired in 1970



NCOA

Non Commissioned Officers Association of the United States of America

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**STATEMENT OF
LARRY D. RHEA
DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
H.R. 1362, VETERANS MEDICARE REIMBURSEMENT
DEMONSTRATION ACT OF 1997
AND
DRAFT LEGISLATION ON VA MEDICAL-CARE RECEIPTS**

MAY 8, 1997



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DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Non Commissioned Officers Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

The Non Commissioned Officers Association of the USA (NCOA) considers it appropriate to begin by expressing to the Distinguished Chairman of the Subcommittee our sincere appreciation for this opportunity to testify of these important issues relating to veterans health care. The Association trusts our comments today will be helpful to the Subcommittee Members. Your consideration of our testimony, therefore, is deeply appreciated.

H.R. 1362

VETERANS MEDICARE REIMBURSEMENT ACT OF 1997

NCOA enthusiastically endorses this legislation. The Association thanks the Distinguished Chairman of the Subcommittee for your efforts in crafting this bill and for your leadership in conducting this hearing. The bipartisan support which H.R. 1362 enjoys, both among original co-sponsors and others, is testimony to the need for this legislation. Further, the Association is pleased this Subcommittee and the full Committee on Veterans Affairs plan to act quickly with mark-up scheduled in the very near future. NCOA is hopeful the House will follow suit with prompt floor action on this measure.

As indicated, NCOA supports H.R. 1362 and this Association, probably like most other veterans organizations, would like to see a larger demonstration project undertaken. Nonetheless, NCOA understands the reasons - primarily, assuring no increase in cost to the MEDICARE program - for the limitations within H.R. 1362. Notwithstanding our wish for a larger project, the Association's support for H.R. 1362 is not diminished.

NCOA is particularly pleased this legislation recognizes the health care plight of military retired veterans. Specifically, the Association is grateful that at least one facility selected for the demonstration project shall be in the same catchment area as a military medical facility closed as a result of Base Closure and Realignment (BRAC).

Although it appears that the intent of the above is to give a measure of priority under the demonstration project to military retired veterans affected by BRAC, the legislation does not specifically state such.

NCOA requests, in the strongest possible terms, that MEDICARE eligible military retired veterans be targeted explicitly as a priority by this legislation. The Association believes this certainly should be the case for the facility selected pursuant to the BRAC provisions. NCOA asks that MEDICARE eligible military retired veterans be made a priority for the entire demonstration project for the following reasons.

Military retired veterans are the only category of federal retirees that lose virtually all of their health care options as age 65. The Defense Department's most recent solution, TRICARE, is not available to these over 65 veterans nor is it even available to those under age 65 who do not live near a military treatment facility. Further, in support of the Association's request to make MEDICARE eligible military retired veterans a targeted priority in this legislation, NCOA reminds the Subcommittee of the following facts:

- > 58 military hospitals have been closed
- > 17 more military hospitals are scheduled to be down-sized and down-graded to clinics
- > 26 states - more than half - have no major military treatment facilities whatsoever
- > Space available care in military treatment facilities for non-active duty beneficiaries is near non-existent - for the over age 65 military retired veteran, it is not an exaggeration to say that availability is non-existent
- > IF MEDICARE reimbursement were passed for the Department of Defense, less than one-third of MEDICARE eligible military retirees would benefit and, then only those living near a military treatment facility.

It is important to also remind the Subcommittee of the following: NCOA supported and actively worked for passage of last year's health care eligibility reform measure. To help ensure it's passage, the Association was asked to temporarily set aside one very important issue so as not to delay or derail the legislation before Congress last year. The Association did so on the condition and assurance that the issue of co-payments for health care provided to military retired veterans within VA would be addressed following passage of last year's bill.

Last year's eligibility reform measure has been enacted and is being implemented. Including military retired veterans as a specifically targeted priority within the demonstration to be conducted by H.R. 1362 would be a clear signal that the Committee intends to fulfill the assurances given to this Association just last year. NCOA urges the Subcommittee to do so.

DRAFT LEGISLATION ON VA MEDICAL-CARE RECEIPTS

As with the previous bill on MEDICARE reimbursement, allowing VA to retain third party receipts recovered from the private insurance of veterans and other sources, has been a high priority of NCOA for several years. Therefore, NCOA supports the draft legislation on VA medical-care receipts that is being considered today by the Subcommittee.

This draft legislation, too, provides a great opportunity for the Veterans Affairs Committee to fulfill the assurances made to NCOA last year regarding military retired veterans. Notwithstanding the recent eligibility reform measure, military retired veterans remain an unwanted commodity with the VA health care system unless they bring cash or a checkbook.

Even with the passage of last year's measure, the overwhelming bulk of medical care provided by the DVA will continue to be provided for non-service connected conditions and without cost to the individual veteran. The only exception to the above reality and current practice is the way DVA views the military retired veteran. Somehow, collecting deductibles and co-payments from a non-service connected military retired veteran for treatment within VA is both fashionable and encouraged. For other non-service connected veterans, it not only is unthinkable, it is condemned. VA continues to routinely waive co-payments for non-service connected treatment even when third-party insurance is involved except for the military retired veteran.

Mr. Chairman, it is always interesting to listen to testimony and conversations regarding veterans and the health care they have "earned." It is painfully obvious that the category of longest serving veterans - the military retiree - has "earned" little. DOD has no plan to fulfill its obligation and its as though a military retired veteran within VA is a creature of a lesser order. It is a collective

failure of the entire Congress, DOD and DVA that there is an inability and unwillingness to work together to fulfill promises that were indeed made to military retired veterans.

NCOA has no quarrel with DVA collecting payments from MEDICARE, CHAMPUS, TRICARE or any other third party. NCOA does however have very strong and principled objections with requiring co-payments from the veteran beneficiary who served the longest and under a very clear, distinct promise. Even under current DOD and DVA Memoranda of Understanding and Agreement, military retired veterans have only earned the privilege of paying deductibles and co-payments for health care while other categories of veterans, even though no promise was made or even implied, are extended the privilege of DVA medical care for life, cost free.

The draft legislation on VA medical-care receipts provides a grand opportunity for Congress to start honoring the federal commitment made to military retired veterans and NCOA asks the Distinguished Chairman and Members of this Subcommittee to take the lead. The Association strongly asks that you include language in the bill that would waive any co-payments - from MEDICARE, CHAMPUS, TRICARE, or any other third-party payer - for treatment provided by VA to a military retired veteran.

Mr. Chairman, this is an issue of equity among veterans. NCOA believes NOW is the time to grant military retired veterans equal, cost free access on a priority basis to a DVA system that is, after all, theirs too. It is blatantly wrong - morally and on principal - to view military retirees as the cash cow to fund health care for other non-service connected veterans.

If Congress believes it has an undisputable obligation to provide VA health care for non-service connected veterans, then NCOA suggests Congress has a concomitant obligation to fund it through adequate annual appropriations. Military retired veterans should not be viewed as the deep pockets to meet any perceived notion that Congress may have in this regard. Therefore, eliminate any and all co-payments for health care provided in a federal DVA facility to military retired veterans.

PHYSICIANS SPECIAL PAY

NCOA does not have a position on special pay for VA physicians; therefore, the Association refrains from commenting on the draft bill relating to this issue.

CONCLUSION

In closing, NCOA salutes the sponsors, co-sponsors and the Distinguished Chairman for the initiative that all of you have displayed on both H.R. 1362 and the draft of the third-party receipts bill. NCOA's comments relative to both bills were strong because the Association believes strongly in the concept of equity. Therefore, the Association asks that H.R. 1362 be amended to reflect our earlier request. NCOA also requests that language be inserted in the draft VA medical-receipts that would waive co-payments for military retired veterans.

Thank you.



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