STATEMENT OF
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SECRETARY
DEPARTMENT OF VETERANS AFFAIRS
ON
PROPOSED LEGISLATION
BEFORE THE
SUBCOMMITEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here this morning to comment on H. R. 2792, the "Disabled Veterans Service Dog and Health Care Improvement Act of 2001." If enacted, this bill would authorize the Secretary of Veterans Affairs to make service dogs available to disabled veterans and to make various other changes in health care benefits provided by the Department of Veterans Affairs. This morning I would like to briefly summarize the various sections of the bill, and provide VA's views of these sections.

Section 2 - Service Dogs

The bill would amend the existing law to expand VA's authority to provide guide dogs to blind veterans. Current law limits the provision of guide dogs to blind veterans who are entitled to disability compensation. The bill removes that limitation and would authorize VA to provide service dogs to veterans who are hearing impaired or who have spinal cord injury or dysfunction or other chronic impairment that substantially limits mobility. Service dogs can assist a disabled

person in his or her daily life and can assist that person during medical emergencies. They can be trained in many tasks, including, but not limited to, pulling a wheelchair, carrying a back-pack, opening and closing doors, helping with dressing and undressing, retrieving dropped items, picking up the telephone, and hitting a distress button on the telephone. Some service dogs can perceive when the disabled individual is in distress and can find help. Dogs can also assist the hearing impaired by alerting them to doorbells, ringing phones, smoke detectors, crying babies, and emergency sirens on vehicles.

The existing statutory authority allows VA to pay for certain travel and incidental expenses incurred by veterans while adjusting to seeing-eye or guide dogs. The bill would amend the language to allow VA to pay these expenses for all guide dogs or service dogs covered by this legislation.

Mr. Chairman, the benefit of guide dogs for the blind is well known, and we support having authority to also provide service dogs for veterans who are hearing impaired and who have spinal cord injuries or other chronic impairments, and to pay for certain costs associated with adjusting to the dogs. However, we believe the provision of guide dogs and service dogs should continue to be limited to veterans who are entitled to service-connected compensation. If this provision becomes law, we would promulgate prescription criteria and guidelines to insure that we provide dogs only to those veterans who can most benefit from them.

Section 3 - Maintaining Capacity

Section 3 of the bill addresses VA's statutory obligation to maintain the capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord dysfunction, blindness, amputations, and mental illness. As you know, Mr. Chairman, Congress imposed this requirement with the enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Public Law 104-262. The law requires that capacity be maintained at its 1996 level. The bill would amend the statute to require that VA maintain this capacity not only in the Department as a whole, but within each geographic service area, or VISN, of the Veterans Health Administration. Additionally, the bill adds new language stating that the capacity to provide specialized treatment and rehabilitative needs of disabled veterans within distinct programs or facilities must be measured by the annual amount spent for the care of such veterans in dedicated programs that provide these services through specialized staff. VA's obligation to report on compliance with this requirement is extended through 2004.

Mr. Chairman, we do not object to the provision which would require maintenance of capacity within each geographic service area. This provision is consistent with our desire to ensure that there is equality of access to quality specialized services. However, in order to accomplish this, we propose that the capacity be based on the enrolled veteran population in each geographic service area. In addition, we oppose the provision that would measure capacity by

dollars expended. The cost of care is not an adequate measure, by itself, to demonstrate whether VA is maintaining the quality of and access to specialized care. Cost alone is not a valid and reliable measure of capacity. Limiting the capacity report to measurement of dollars expended will neither indicate nor ensure that VA is upholding its commitment to these high priority patients. Capacity must be measured by the actual number of patients receiving care in the specialized programs, the quality of the care provided, patients' health outcomes, and patients' access to that care, including waiting times for appointments.

Furthermore, Mr. Chairman, it is currently not possible to know whether the amount of care and the dollars expended in 1996 were optimal for measuring capacity in the targeted special programs. The care provided in 1996 provides only a snapshot of what was then a rapidly changing VA health care delivery system. It is not clear that 1996 can or should serve as a baseline out to 2004, as proposed by this bill.

We understand that the staff of the Senate Veterans Affairs' Committee is developing a different position with regard to VA's obligation to maintain capacity. We would be happy to work with both the Senate and House staff on this issue to develop amendments that would allow us to provide the best possible information on VA's capacity for treating veterans with specialized treatment and rehabilitative needs.

Section 4 - Means Test Threshold

Mr. Chairman, section 4 would establish new geographically based income thresholds for VA to use in determining a non-service-connected veteran's priority for receiving VA care and whether the veteran must agree to pay copayments in order to receive that care. This would be an alternative to the threshold presently set by statute. As you know, Mr. Chairman, the law now requires that most veterans enroll in our health care system in order to receive care. Enrollees are placed in an enrollment priority group that is based, in many instances, on their level of income and net worth. Although we currently provide care to veterans in all enrollment priority groups, if there were medical care funding shortages in the future, it might be necessary to determine that those non-service connected veterans with relatively higher incomes must be disenrolled, meaning they could no longer receive VA care. Current law establishes, on a National basis, the specific income thresholds that we must use to determine the priority group of any given enrollee with no service-connected disability or other special status. We place higher income veterans in priority group 7 and lower income veterans in priority group 5.

This provision would establish a new, geographically based income threshold that VA could use for placing veterans in priority groups. It would utilize a poverty index developed by the Department of Housing and Urban Development (HUD) to establish this alternative income threshold. The income threshold for

the veteran would be either the specific income thresholds set forth on a National basis, or the amount set forth by the HUD index - whichever is greater. In most instances, this new income threshold would be greater than the current statutory income threshold used for determining whether a veteran should be placed in priority group 5.

We are very interested in examining the use of geographically based income thresholds for placing nonservice-connected veterans in different enrollment priority groups. We recognize that the cost of living in large urban areas is much greater than in many more rural parts of the country. What might be considered a reasonably high income in some locations may be totally inadequate in other higher cost locations. However, at this time we cannot support the specific methodology proposed in this bill. There are many poverty indices that are established in various ways, and there are serious issues about what these indexes really measure. We believe further study is needed to determine the most appropriate method for tackling this problem.

We are currently reviewing the various poverty indices in order to identify the best way to proceed. We expect to have this work completed in September. We would be happy to work with staff members from the Congressional Committees to consider the alternative indices and other changes to ensure that the means test for VA health care is equitable and affords reasonable access to VA health care services.

Section 5 - Pilot Program for Coordination of Ambulatory Community Hospital Care

Section 5 is a provision that is essentially the same as a measure passed by the House of Representatives last year despite the strong opposition of VA. The provision would establish a pilot program entitled "Coordination of Hospital Benefits Program." The program would authorize special benefits for some veterans receiving care in a VA outpatient clinic who need hospital care. Under the program, veterans with third-party health plan coverage (including Medicare and Medicaid) may receive different hospital care benefits from those without third-party coverage. Veterans with no third-party coverage of any sort would be offered hospital care in the nearest VA hospital with the ability to provide care. That facility may not be particularly close to where the veteran resides. On the other hand, veterans with third-party coverage would be offered a choice. First, they could choose to use the nearest VA hospital. Alternatively, they could choose to use a private facility, with VA paying for certain costs, such as the health plan deductible, coinsurance, or the cost of inpatient care or medical services that are not covered by the health plan.

The pilot program would be open only to veterans to whom VA "shall" furnish care, essentially all enrollees except those in enrollment priority group 7. To be eligible, the veterans must also meet certain additional conditions. Specifically, participants must be enrolled to receive medical services from a VA outpatient

clinic, require hospital care for a non service-connected condition that could not be provided by a clinic operated by VA and elect to receive such care under the non-VA health care plan. The program would be limited to veterans who have received VA care during the 24-month period preceding the veteran's application to enroll in the pilot program. In designating the geographic areas in which to establish the program, VA must ensure that at least 70 percent of the veterans who reside in a designated area reside at least two hours' driving distance from the closest VA medical center.

The provision also limits expenditures for the pilot program to $50 million in any fiscal year. Moreover, funds from the proposal must come from the Medical Care Collections Fund and no funds may be used that are otherwise available for treating veterans requiring specialized care.

We strongly oppose this proposed pilot program. The proposal would create a disparate eligibility status based on a veteran's third-party coverage and priority group. We are also concerned that the program would undermine our ability to maintain existing services, especially specialized medical services and programs for veterans. Limiting care to general medical and surgical services would mean that veterans needing specialty health services would still need to come to VA for care. The health care covered by this proposal would be inpatient care for non-service-connected conditions. A veteran currently receiving care for a service-connected condition, for which VA does not or cannot contract locally, would also

be forced to receive care in multiple locations. These types of disparities are not consistent with our goals and strategies of improving access, convenience, and timeliness of VA health care to all eligible veterans.

Funding for the program would be drawn from the Medical Care Collections Fund (MCCF). The Fund's collections, which are available to VA facilities to support current VA-provided medical care, would be reduced by this provision. MCCF collections supplement the dollars appropriated for medical care and are a necessary component of VHA's budget. Use of MCCF funds for this pilot would negatively impact care for veterans not enrolled in the pilot. In addition, this provision may affect the Medicare Trust Fund.

The bill would also require that not less that 15 percent of the veterans participating in the pilot program are veterans who *do not* have a health-care plan. This requirement is confusing, as the purpose of the pilot program is to allow VA to pay for the out of pocket costs that veterans incur through non-VA health plans. It is not clear how VA would achieve this goal for veterans who have no other health care plan. The 15 percent limit might be a false floor or ceiling, depending on the actual number of veterans at a particular pilot site that have no insurance. This could affect the potential outcomes of the pilot. If there are a large number of insured veterans, the out-of-pocket expense covered by VA would be less that the expense of covering the full care provided to an uninsured veteran. This could make the pilot look financially successful. On the

other hand, if the number of non-insured veterans is high, the expenses could make the pilot program less financially viable.

The bill also defines the term “health-care plan” by cross-reference to section 1725(f). The bill states that the term “health-care plan” has the meaning given that term in section 1725(f)(3). However, the referenced section does not define the term health plan or health-care plan, but rather defines the term “third party” for purposes of reimbursement for emergency treatment. We believe that this reference might be an error, and that the intended reference was to section 1725(f)(2). Section 1725(f)(2) defines the term “health-plan contract” which includes, among other things, Medicare and Medicaid plans.

Section 6 - Pilot Program for Contract Hospitalization and Fee Basis Ambulatory Care

This section of the bill would require the Secretary to conduct a three-year pilot program in which veterans receiving fee basis and contract hospitalization would be provided such care through a contractor who acts as a managed care coordinator. The provision states that the program shall be conducted in four selected geographical areas that have mature managed care markets. To the extent practicable all fee basis and contract hospitalization provided by VA in the selected geographical service areas would be provided through the contractor. The contractor must be an experienced managed care coordinator with an in-place network of credentialed providers. All enrolled veterans in a selected

geographical service area who are authorized to use non-VA care services through fee basis programs of the Department, or who are eligible for contract hospitalization, would be automatically enrolled for participation in the pilot program. Once approved to receive non-VA fee basis care, or when they seek care for a health emergency, participants would be given a directory of health care providers from which to choose.

In conducting the pilot program, VA would be required to use standards (commercial-industry or, in their absence, Department standards) for measuring access, timeliness, patient satisfaction, and utilization management. The contractor must establish a toll-free telephone system staffed by registered nurses to provide advice and health care referral information to veterans enrolled in the pilot program on a 24-hour a day, seven-day a week basis, and a veterans service telephone line for the provision of information on eligibility, enrollment, and provider locations. The program also must provide concurrent review, demand management, disease management and health and wellness programs.

Each medical center participating in the program must have a primary care manager. The primary care manager at each VA facility would be responsible for the coordination and case management of each enrolled veteran who is participating in the pilot program to ensure that such veterans receive the appropriate care, and that veterans are brought back into the VA system for follow-up whenever possible and appropriate. The pilot program includes

extensive reporting requirements by VA, and a mandatory review by the Comptroller General.

We are interested in a pilot program to examine the costs and benefits of operating our fee basis program in a new manner; however, we are concerned about some of the restrictive requirements in this specific provision. For example, we would like ensure that VA retains clinical control with respect to the type of care that the patient receives, as well as the amount of care authorized. We would also want to ensure that the costs of any contract would be no more than the current cost for the fee basis program in the selected locations. Finally, we believe that it would be appropriate for VA to continue to provide the toll-free telephone system providing information on eligibility, enrollment and provider locations. We would be pleased to work with staff members of the Committee to consider alternative language that would allow VA the flexibility to evaluate alternative delivery systems without some of the limitations and requirements mandated by this provision.

Section 7 - Recodification of Bereavement Counseling and other Authorities

Mr. Chairman, section 7 of the bill would consolidate, in a new subchapter of title 38, United States Code, all of the various legal authorities under which VA provides services to non-veterans. The new subchapter would include a section on VA's provision of counseling, training and mental health services for family

members of veterans who are receiving treatment. It would also include a section on bereavement counseling following the death of certain veterans. Both types of counseling are currently authorized in the definition of outpatient medical services. This change will make the authority much clearer.

The authority under which we provide CHAMPVA benefits, presently section 1713 of title 38, would be transferred to this new subchapter. A new provision in the bill provides that a dependent or survivor receiving CHAMPVA care would also be eligible for the bereavement counseling and the other counseling, training and mental health services provided to family members under this new subchapter. Finally, the existing authority to provide hospital care or medical services as a humanitarian service in emergency cases would be moved to this new subchapter.

The proposed changes would recodify the currently existing provisions. We support this change, as it would consolidate and clarify the existing statutory authority to provide care to non-veterans.

Section 8 – Extension of Expiring Collections Authorities

Mr. Chairman, this final provision would amend title 38 to extend VA's authority to collect per diem nursing home and hospital co-payments from certain veterans, and to collect third-party payments for the treatment of the nonservice-connected disabilities of veterans with service-connected disabilities. We strongly support

and welcome the extensions proposed in this section. These collections constitute an important and necessary supplement to our annual appropriations.

Mr. Chairman, this ends my statement. I will be pleased to answer any questions you may have.