

**STATEMENT OF
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THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
H.R. 2379, THE RURAL VETERANS ACCESS TO CARE ACT OF 2003
AND
H.R. 3094, THE VETERANS TIMELY ACCESS TO HEALTH CARE ACT OF 2003
SEPTEMBER 30, 2003**

Mr. Chairman and members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on H.R. 2379, The Rural Veterans Access to Care Act of 2003 and H.R. 3094, The Veterans Timely Access to Health Care Act of 2003. We commend the Subcommittee for holding this hearing to discuss these two important pieces of Veterans' Health care legislation

H.R. 2379, the "Rural Veterans Access to Care Act of 2003"

This legislation would require each Veterans Integrated Services Network (VISN) within the Veterans Health Administration (VHA) to reserve five percent of its total annual appropriation to provide services at non-VA medical facilities for veterans who must travel more than 60 minutes to a VA facility. The American Legion has long advocated for and supports the goal of providing greater access to health care for veterans in rural or geographically remote areas where VA has no medical facilities. The American Legion; however, does not believe that forcing VISNs to divert badly needed resources to non-VA providers is the solution.

The Capital Asset Realignment For Enhanced Services (CARES) process currently underway is intended, in part, to address the very issue that is the subject of this legislation by identifying regions that are medically underserved for veterans (service gaps). CARES Access Driving Time Guidelines used to develop planning initiatives are identical for primary care in highly rural areas to the driving time proposed in this legislation: 60 minutes. The CARES Draft National Plan does not employ the "one-size-fits-all" approach of this bill, but rightly relies on a mix of realignment of existing VHA facilities, establishment of new ones and contracted services to reduce gaps in services to veterans in highly rural areas within each VISN.

The plan proposed in H.R. 2379 would complicate the Veterans Equitable Resource Allocation (VERA) system now in place by requiring every VISN to sequester 5 percent of its appropriation, regardless of whether highly rural or geographically remote areas exist.

The VA health care system started FY 2003 with five months of a continuing resolution that placed all VISN's in the predicament of conducting FY 2003 business with a FY 2002 budget; they started the current year in the red. To have only seven remaining months in a fiscal year to operate with a known budget is extremely difficult. To require a 5 percent reserve of an operating budget that is already insufficient compounds this chaotic situation and takes away some of the flexibility VISNs have in allocating resources within their region.

The American Legion is also concerned about reimbursement rates. This legislation does not specify reimbursement rates for services. Generally, payment rates for medical services purchased by the Federal government are predicated on the Medicare Part B guidelines of the Centers for Medicare & Medicaid Services (CMS). If enacted, what limits would be placed on charges made by contract providers? While a potential windfall for the contractors, it could prove too costly for an already seriously underfunded budget.

Additionally, there is no guarantee that doctors, hospitals or clinics in highly rural or geographically remote areas would be able to accept new VA patients, especially where a high percentage of the patient base is already dependent on Medicare Part B and Medicaid. Many rural and geographically remote areas are medically underserved due to health professional shortages. They also have a high percentage of the population living below the poverty level and many over age 65 and they also have high infant mortality rates. Because of the disproportionate numbers of the elderly and poor in rural areas, rural community clinics and hospitals often find themselves in financial trouble and are forced to choose between closure and a shift in core strategies away from acute inpatient care. Successful conversion to an organization that provides non-acute health care service is more apt to occur than closure when the population's demand for health care and ability to pay for it are high, competition from other hospitals is substantial, and hospitals have established strategies to provide alternative forms of health care, according to a study supported by the Agency for Health Care Policy and Research. Unfortunately, these success factors are rarely present in highly rural or geographically remote areas.

H.R. 3094, the "Veterans Timely Access to Health Care Act of 2003"

This legislation addresses access to care by requiring VA to furnish health care services in a non-Department facility for veterans waiting beyond 30 days for primary care. While The American Legion conceptually agrees with the necessity to address the problems in access to VA health care, there should be reservations about this legislation as an unfunded mandate. Authorization is provided but there are no accompanying funds.

The legislation also offers a solution to the internal delays in service by authorizing treatment outside of the system. It does not address the root causes of the problem, which are inappropriate funding, an adequate and appropriate staff mix, and state of the art health care facilities that allow sufficient space and function for the optimal delivery of care.

Mr. Chairman, The American Legion adamantly believes that the long-term solution to these questions is to be found in mandatory funding for VHA. Funding for VA health care currently falls under discretionary spending within the Federal budget. VA health care budget competes

with other agencies and programs for federal dollars each year. The funding requirements of health care for service-disabled veterans are not guaranteed under discretionary spending.

VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year. Under mandatory spending, however, VA health care would be provided funding by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care entitlement of veterans.

I thank the Subcommittee for this opportunity to present The American Legion's views and look forward to working with you and the Subcommittee on these issues.