VETERANS EQUITABLE RESOURCE ALLOCATION SYSTEM (VERA)

FIELD 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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VETERANS EQUITABLE RESOURCE ALLOCATION SYSTEM (VERA)

THURSDAY, APRIL 3, 1997

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

The subcommittee met, pursuant to call, at 9 a.m., at the Gainesville VA Medical Center Auditorium, 1601 S.W. Archer Road, Gainesville, FL, Hon. Cliff Stearns presiding.

Present: Representatives Stearns.

Also Present: Representative Thurman.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. We will have the subcommittee come to order. Let me welcome all of you this morning. It is a beautiful Florida day here in Gainesville.

Let me open up by apologizing for cancelling our hearing of March 26. I came down with a cold, and I still have a few remnants of this cold. I apologize to those of you who came, that, unfortunately, we did not have the hearing.

I am very pleased we are having the hearing today in this wonderful facility. I have my colleague, Representative Karen Thurman, whom I admire and respect, who is working this area as a Member of Congress. I had the good fortune to represent this area for 4 years, and now it is in the able hands of Congresswoman Karen Thurman.

Today to me is almost a celebration, because when I first went into Congress, I put into the House of Representatives a bill called the Veterans Bill of Rights, and this Veterans Bill of Rights, the whole idea was the allocation of funds should follow the veterans, and, more importantly, no one should be denied benefits because of geographic location.

So today we have for the first time the Veterans Equitable Resource Allocation system that has passed Congress, and we are going to talk about this today and see how this is going to be implemented, so that once and for all those parts of the country that have been getting the money where the veterans population has been decreasing will no longer be able to operate with that surplus.

It will have to operate much more efficiently. And then the cities and towns in the southeast particularly, in Florida and Arizona and Texas, will start to get more funds.

So I view today as somewhat of a celebration for something I have been working on, and also that Karen Thurman, Representa-

tive Thurman, has been working on. And if we can get this hospital and other hospitals in Florida to start to get the resources they need, we will have done a great service to veterans.

With those sort of impromptu comments, let me move to my opening statement.

In January, at the start of the 105th Congress, I was honored to be selected as chairperson of a very key congressional committee, the Subcommittee on Health of the House Veterans' Affairs Committee. In that same month, the Department of Veterans Affairs released its preliminary plan for reallocating funds to the VA health care system. Under the VA plan, Florida for the first time was to get a fair share of the Veterans Affairs dollars. Regions of the country with declining veteran populations would lose some funds under this plan.

Suddenly we started hearing complaints that the plan was unfair, as well as demands that the plan be dropped. It was at this point that I determined that as my first official act as Chairman, I would convene a hearing in Florida on this VA plan.

I want this hearing to set the record straight on what must be done to achieve fairness for all veterans. This hearing is a first step towards making sure that the VA funding plan is carried out and that the Florida veterans get their fair share.

We have been fortunate over the years to treat veterans issues in a truly bipartisan manner. Veterans affairs is one subject on which there is no disagreement between our political parties. That important principle is reflected here today as I am joined, as I mentioned, by my colleague and good friend, Karen Thurman, who represents this district.

Despite party differences, Representative Thurman and I have worked side by side in support of Florida veterans. Both of us have pushed for years to achieve fairness in the VA national medical funding decisions. At last, my fellow veterans, the weight of our arguments prevailed. A tough law was enacted last year that directed VA to come up with and carry out a plan to shift funds so that veterans have similar access to care, regardless of the region of the country in which they live.

It has become clear, though, that while there is bipartisan support for veterans health care, some of our colleagues in the northeast are trying hard to undermine this plan. In fact, 2 weeks ago, one of my New York colleagues introduced a bill cosponsored by 24 other New York Congressmen to stop the VA from carrying out its funding plan. That bill was referred to my subcommittee and, frankly, as far as I am concerned, that bill is not moving forward.

The time has come that the people in the southeast, where the population is moving, should have their fair share. The money must move where the population is located.

We have a great lineup of witnesses today. Their testimony will be important in helping my colleagues in Washington, including the New Yorkers, to understand the demographics of Florida, the specialized health care needs of all of our veterans, and the toll that long years of underfunding has taken. We will make it abundantly clear that it is critical that the VA implement its funding reallocation plan.

My friends and fellow citizens, finally, I hope this hearing will also help document what the needs of the future are and to assess how far the funding reallocation will go in helping to meet those needs.

Before asking our first panel to testify, of course, I would like to thank my colleague, the gentlewoman from the district here, Representative Karen Thurman, for joining us and to invite her to make opening remarks too. Karen.

OPENING STATEMENT OF KAREN L. THURMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mrs. THURMAN. Thank you, Mr. Chairman. I want to thank you for having this hearing, and I know during the time that you represented Gainesville, that they appreciated all the hard work that you did. So you have probably as good or a better understanding of most of these issues as they relate to the area we are sitting in today.

I also bring greetings from Representative Corrine Brown, who serves on this committee, who also has worked—I talked to her yesterday afternoon; she would love to have been here, but had schedule conflicts because of what changed, because of the hearing, and was unable to make it.

Yesterday afternoon I spent some time with Senator Graham, who also sends his regards and certainly is somebody we should recognize for some hard work that he did in the funding formula change as well.

April 1 is a momentous day for Florida's veterans. For more than 2 years we have fought together with subcommittee Chairman Stearns, Representative Brown and Senators Graham and McCain and, I have to tell you, the entire Florida delegation, to change the method by which the Department of Veterans Affairs allocates resources to our Nation's veterans.

On Tuesday, the Veterans Equitable Resource Allocation, the VERA program, went into effect, channeling over $57 million in vital health care dollars to the Florida and Puerto Rico network. An additional $93 million can be expected next year. This has been a hard-fought battle, and clearly Florida's veterans have won.

Just as an aside, I must say though, too, the veterans in this State really took the cause to heart. Many veterans have come from other areas around this country. They were in constant contact with their representatives from the other States that they came from to let them know how important this was, so I certainly think that our veterans who are here and settled in Florida—we are glad to have them here—really played a major part in this battle, helping us to get this legislation passed.

The fact of the matter is that Florida's veterans have had to endure some difficult situations brought about by funding inequities. I know that this money will make a tremendous difference. However, I would like to stress that these changes are not the answer to the inequities in veterans' health care, but rather the mark of a new beginning in veterans' health care services. Together with the implementation of the new 22 veterans' integrated service networks and veterans eligibility reform passed in the last Congress, we are on the road to creating a new and better VA.

Let's look back a moment between 1980 and 1990. About 350,000 veterans decided to make their home in the Sunshine State. That means that every day of the year for 10 years, 96 veterans moved to Florida.

In contrast, between 1985 and 1990, the VA's budget allocation for the Southern Region, which includes Florida, showed no increase. The VA outpatient clinic in New Port Richey is a perfect example of what has been occurring in Florida.

In 1985, the clinic served 7,000 patients. By 1995, clinic visits exploded to 36,000.

Now, to our future. Through VERA and the supplementary $57 million, more than 8,000 additional veterans will receive health care in Florida and Puerto Rico, roughly 3,500 at the Gainesville VA Center. The VA can continue its efforts to link communications at the VA medical centers throughout Florida and the country.

The Gainesville VA Medical Center is also going to increase its outpatient capabilities by 2,500, as well as establish a new psychiatric primary care clinic. By passing the Veterans Equitable Resource Allocation measure, Congress has displayed its commitment to those who fought bravely for this country.

While this measure is not a cure-all, I believe it is going to be the first step on a brilliant path. I look forward to our testimony today and questions and answers that we will be able to engage in.

I again thank the Chairman for having this and look forward to working with him on other VA and veterans issues that come before the Congress.

Thank you.

Mr. STEARNS. I thank my colleague.

Now we will start the testimony of witnesses. Our first witness is Dr. Bob Roswell, Director.

STATEMENTS OF DR. ROBERT H. ROSWELL, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 8, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MALCOM RANDALL, DIRECTOR, GAINESVILLE VA MEDICAL CENTER; RICHARD D. ISAAC, DIRECTOR, WEST PALM BEACH VA MEDICAL CENTER; AND RICHARD A. SILVER, DIRECTOR, JAMES A. HALEY VA MEDICAL CENTER, TAMPA, FL

Mr. STEARNS. Bob, come on up. Let me welcome you this morning. I am delighted to have you here and appreciate your coming forward.

STATEMENT OF DR. ROBERT H. ROSWELL

Dr. ROSWELL. Mr. Chairman, may I ask some of our medical center directors to come up?

Mr. STEARNS. Absolutely. Dr. Roswell, we do have John here with a little clock which we are sort of trying to keep, just to keep it moving. If you need some extra time, we are not going to be very regimented about this. John does have an opening time clock. Your opening statement is allocated for approximately 5 minutes.

Dr. ROSWELL. Thank you, Mr. Chairman. It is certainly my pleasure to be here to appear before the subcommittee this morning, and I can assure you, we join you in your celebration of new and additional funding for veterans' health care throughout Flor-

ida. We also have waited a long time and are delighted that finally Florida veterans are receiving additional dollars in health care benefits that they have earned through their dedicated and patriotic service to our country.

Although the veteran population today has declined to only slightly more than 26 million, the veteran population today is older and sicker. Many of those veterans are at or beyond the age of 65 where the consumption of health care resources can be increased by a factor of three- or fourfold.

The population of veterans is not only older and sicker, but has also shifted dramatically over the last decade, as the Congresswoman alluded to. We have seen a tremendous migration of veterans to the south and southwest regions of the country. The result has been that the system of VA health care resources, which once very effectively served America's veterans, no longer is adequate to meet the health care needs of veterans based on their current location, age, and state of health. And this is why we feel that the Veterans Equitable Resource Allocation process is so desperately needed, and we are so delighted that you have supported this process as we see it to its implementation this month.

Historically, the Department of Veterans Affairs used a major construction strategy to keep up with the changing demands for VA health care needs, for veterans' health care needs. New medical center construction represented a way to bring additional dollars, additional health care treatment capacity, and staff and personnel to meet those needs. However, today, the use of major construction no longer seems appropriate to keep up with the changing demand for veterans' health care, and there are several reasons behind this.

First and foremost is the fact that health care today is delivered predominantly on an outpatient basis. We deliver health care much more efficiently than we once did, and we have less reliance upon hospital beds as a way of providing comprehensive health care.

But more significant is the fact that our major construction program often takes as long as 7 to 10 years to effect new construction. That time is required for the planning, the design, seeking the necessary authorizing and appropriation legislation and then beginning the implementation process of constructing and activating new medical centers.

The 7–to–10–year time lag is insufficient to meet today's changing health care demands. That, coupled with the new technologies and new mechanisms of health care delivery, makes this process inadequate for meeting shifting needs for veterans' health care.

That is why the Veterans Equitable Resource Allocation process that you have spoken of truly represents a new way to begin to shift dollars to where veterans are and, more importantly, to where veterans rely upon the Department of Veterans Affairs and its VA health care resources for their health care needs.

Florida is very typical of the dynamic I spoke of. Florida has a population of approximately 1.7 million veterans. As the Congresswoman alluded to, over the last decade we have seen a tremendous migration of veterans to Florida, and we still see almost 60 veterans a day adding to the population in Florida.

It is interesting to note that over the last 15 years, while the national veteran population decreased by 10 percent, the Florida vet-

eran population actually increased by 26 percent. And yet over the last 10 years, we have had no major construction of new hospitals in Florida, except for the very nice facility in West Palm Beach. Simply put, the construction program has not been adequate to keep up with the new demand for health care throughout Florida.

The Veterans Equitable Resource Allocation will begin to shift dollars, based on a capitation basis, to help meet those needs. The Florida and Puerto Rico VISN is one of 22 new Veterans Integrated Service Networks. It serves the greatest number of veterans with service-connected disabilities of 50 percent or greater, which is significant because they consume health care resources at a much higher rate than their veteran counterparts. It also serves the greatest number of veterans nationwide of all 22 VISNs with serious mental health disorders and the second largest population of veterans afflicted with the HIV-AIDS virus.

As a result of the tremendous demand for care, we simply do not have sufficient resources in Florida to meet all of those needs, and, unfortunately, we are forced to turn away some veterans with lower eligibility criteria who in other cases may be able to access care in other parts of the country. This is particularly true of the seasonal migration to Florida, when veterans from the north and northeast who are accustomed to receiving health care services through the VA are declined those same services in Florida because of our limited resources.

As you alluded to, the Veterans Equitable Resource Allocation implemented this month will bring an additional $57 million into Florida; and we are delighted with that, and I would like to take just a moment to talk about how that money will be used.

Certainly a substantial portion of that money is necessary to cover the inflationary costs associated with providing health care in annual pay raises and benefit increases. That will consume about $28 million of the $57 million. An additional $15 million will be needed to cover activation needs of new facilities and new minor construction projects. We will also need to improve our telecommunications infrastructure with part of that.

But we believe at least $14 million, coupled with additional millions of dollars, generated through more efficient operation as an integrated health care delivery network, will be made available to improve not only the continuity and quality of care, but also the access to care to veterans throughout the State of Florida.

This year we expect to treat over 8,000 additional veteran users throughout Florida. In figures I reviewed just this week, we have already seen an additional 4,800 veterans during this fiscal year.

Considerable amounts of care will be provided through expanded community access, and we are delighted to tell you that new community-based outpatient clinics will be established in Homestead, FL, in Sarasota, in the Bartow area, and in the Viera area of Brevard County this year.

We also are working in collaboration with the readjustment counseling service of the Department of Veterans Affairs to use VA's existing resource of readjustment counseling centers, 14 of which exist in Florida, as new primary care access points. We have already implemented such a program in Key Largo and are looking

to expand that at the remaining 13 veteran centers throughout the State.

We will be using telemedicine, a new technology, to link our medical centers and to improve access to specialty consultation that once necessitated lengthy waits and long-distance travel to our tertiary medical centers, such as the one we are in this morning. By using telemedicine, physicians seen at our community-based clinics and satellite outpatient clinics will be able to access specialty consultation without these lengthy waits or the need to travel.

I think we have tried to give you an overview of how the Veterans Equitable Resource Allocation will truly improve care for veterans in Florida. We believe that it will greatly enhance access to care, providing the same high quality, but making that care available in a more timely manner.

We are delighted that the VERA program is available. We recognize that the VERA program provides funding based on the veteran users, whether they be basic care patients or special care patients, and we believe that this process will ultimately serve the comprehensive needs of Florida veterans.

Thank you, Mr. Chairman. I would be happy to answer any questions you may have.

[The prepared statement of Dr. Roswell appears on p. 59.]

Mr. STEARNS. Thank you, Dr. Roswell.

At this point, I certainly want to welcome the administrator of this hospital, Mr. Randall.

Mr. Randall, maybe you would like to make some comments at this point before we move forward.

STATEMENT OF MALCOM RANDALL

Mr. RANDALL. Thank you, Mr. Chairman.

Mr. Chairman, Congresswoman Thurman, I would like to speak to this hospital and how the influx of veterans and the lack of resources have prevented us from providing service to everyone that we would like to provide service to.

For example, we have been turning away for care service-connected veterans with long-term chronic conditions. Of course, if these people become acute, they are going to immediately become hospitalized or given outpatient care.

But, nevertheless, I constantly see veterans who move to Florida from the northeast and who come to apply to us for care and we say, "Sorry, you are not high enough on the priority list." And they say, "Well, we were carried for 30 years in New Jersey at the VA there. Isn't this the same VA?"

Well, actually, it hasn't been the same VA because we haven't had the resources. Now I think there is good news ahead.

For example, one of the things that has happened here at the VA Medical Center, Gainesville, during fiscal year 1996, about 36,000 unique veterans were treated at this medical center, and over 20 percent, or higher of those people are rated 50 percent service-connected or higher. Approximately 5,000 new veterans, never before seen at this medical center, a year, apply for care. And this continues. Every year we have in that range new veterans who have never before used this center.

So the demand in Florida is continuing to increase. With the additional money through the Veterans Resource Allocation System, plans are in place, and we are ready to activate new access points and to add to the staff of both the Jacksonville and the Daytona outpatient clinics so that they can increase the number of veterans who are enrolled in primary care.

This will enable us to put 2,500 veterans in our new geriatric primary care clinic. It will also permit us to place 750 veterans in our new psychiatric primary care clinic. This is a great step forward, if we can get these people in primary care.

Through the good offices of you, Mr. Chairman, and Congresswoman Thurman, we will expect to receive a $5 million increase in our budget in 1998 over our budget in 1996, and this is an increase of approximately 5.4 percent.

In addition to this, we have a new ambulatory care addition under construction, and, incidentally, I would like to thank the Chairman and Congresswoman Thurman for their efforts to keep this project on track for badly needed space. It will provide us with an additional 87,000 net square feet of space. It will enable us to renovate, and backfill, 17,000 square feet, and the entire project is being constructed at a cost of approximately $20 million. This will enable us to have new and expanded special clinics and new surgical suites to perform outpatient surgery more efficiently and expeditiously.

One of the things that has helped us in our programs has been our continuing relationship with the University of Florida. For example, the College of Medicine and the VA jointly purchased a 3 Tesla MRI, and it is installed in the tunnel connecting VA and the university on the VA side of the tunnel so that it can be used by both parties. I am quick to say that we probably use it more than the university, but that is fine, because it was a joint purchase for joint use.

Incidentally, this 3 Tesla MRI is one of about six in the world. With these kinds of facilities, and also the exchange of personnel that we have with the school, we are playing an active part in the Brain Institute which has been established at the University of Florida; and the physicians on our staff are playing a significant role in the Brain Institute.

That concludes my statement, Mr. Chairman.

Mr. STEARNS. I want to thank my good friend.

Let's have Mr. Silver from Tampa, if you have some opening comments you would like to briefly give.

STATEMENT OF RICHARD A. SILVER

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

As the director of the VA hospital in Tampa, we experienced during fiscal year 1996 an explosion of workload to the extent that we ended up being the second busiest facility in the country. We had over 454,000 visits—that is an amazing number—in three clinics and we served more than 49,000 unique SSNs (veterans). We have Port Richey, we have the Tampa hospital, and we have Orlando.

As Dr. Roswell alluded to the fact, there is activation planned for a new clinic in Viera, and for a new clinic in Bartow.

The Viera clinic, as you know, will be on the site that was originally planned for the East Central Florida facility; and the COBRA activity in fiscal year 1996 which authorized the clinic, we decided instead of waiting for the clinic to be built before we accessed veterans in that area, we would do something innovative and we would plan to contract and lease a space so we could start serving veterans and bridge the gap, because the new facility would not be available until December 1998.

So we are looking forward to expend the revenue, the resources that we are planning to get under VERA. That $57 million will be put to good use.

Mr. STEARNS. I would say. Thank you.

Mr. Isaac from West Palm Beach.

STATEMENT OF RICHARD D. ISAAC

Mr. ISAAC. Thank you, Mr. Chairman, Congresswoman Thurman. It is certainly my pleasure to be here today representing the Sunshine Health Care Network's newest facility at West Palm Beach, FL.

Our medical center opened just 21 months ago, but in that short period of time, we think we have made significant progress in both meeting the previously unmet health care needs of south Florida veterans, and also in operationalizing a model of health care envisioned by the new Veterans Health Administration.

The West Palm Beach Medical Center was under construction at the time of the great national health care reform debate several years ago. We recognized that the health care landscape would probably change from that debate, but we could not necessarily predict the outcome. We also were in the middle of building a brand-new VA facility that was built for something quite different than what we thought that landscape would be.

We set our course for activating our medical center with primary ambulatory care as its centerpiece. It is my pleasure, and I am proud to tell this committee today that 100 percent of the veterans enrolled at our West Palm Beach facility are enrolled with a primary health care team.

This has had tremendous impact, not only from the patients' perspective, but on our ability to manage the rather large workload demand that we have been experiencing. For example, our facility was built with a projected outpatient workload of only 143,000 visits. In our first full year of operation, we exceeded 228,000 outpatient visits.

During the first 6 months of operation, an average of 71 new patients registered for care at our facility every business day. This was after we had accepted approximately 4,000 applications prior to the construction actually being finished.

In the past 6 months, this rate has dropped off, but it has dropped off only to a rate of 46 new veterans each and every day of operation.

The most important thing about all of these numbers is really the subject that we are here to talk about today, and that is VERA. Without VERA, I am certain that we would have been faced with the prospect of limiting access to veterans beyond those affected by our current restrictions. That prospect was probable as early as the

fourth quarter of this fiscal year at West Palm Beach, and because of VERA, luckily we will not have to do that.

I project that we will provide care for 800 to 1,000 more veterans in Palm Beach this year because of VERA than we would have without it.

I have not been around as long as many of my colleagues at the table here, but I will say that I have been watching these migration trends into Florida and the southeast since the early 1980s. It is probably an understatement for me to say that VERA is long overdue and extremely welcomed by the veterans of Florida. Perhaps some day, through programs like VERA, veterans throughout this country can enjoy equal and level access to VA health care facilities, which basically is your aim in providing this legislation; and we thank you very much.

Mr. STEARNS. Thank you.

I appreciate you folks taking the time to drive up here, and I cannot tell you how important it is that you contribute to this meeting we are having.

With 60 veterans a day coming in, that is roughly around 21,000 new veterans a year, and, of course, that explains the staggering new volume that you mentioned at your hospital, Mr. Silver, and you mentioned at yours. Of course, what we are going to talk about today is this phase-in.

Dr. Roswell, before we start, is there anyone else you would like to make an opening statement before we begin the questions?

Dr. ROSWELL. No, I think we can begin the questions.

Mr. STEARNS. Just for the record, can you just briefly describe how this new formula will work? When I talk to my colleagues from New York and they come up to me and say, "You know, this is going to hurt us dramatically," I say, "Wait a second, this is going to be a phase-in."

That is why Mr. Randall, when he talks about receiving only a 5.4 percent increase, this is going to slowly pick up. Obviously, 5.4 percent is not even keeping up with his volume, and we need to increase the amount of money that comes to this hospital much more.

So if you could describe a little bit of how this formula is going to work and this phase-in, because I say to the people in the northeast, you are going to have to operate more efficiently on less money, but you are going to have overwhelmingly more money than the hospitals, particularly in my State. So, with that, if you don't mind?

Dr. ROSWELL. Certainly. The way the new VERA process works is it emulates a capitation system. In essence, we look at all veterans who have used the VA over the preceding 3 years. Veterans are classified into one of two categories: Those who receive routine services are classified into a basic care patient category, which is the majority of the 2.7 million veterans the VA treats nationally each year.

Some veterans, however, consume tremendous health care resources because of very specialized, long-term needs, such as those in need of organ transplantation, those who have suffered traumatic brain injuries or spinal cord injuries or are suffering from

blind rehabilitation. And approximately 150,000 veterans nationwide fall into this category we call "special care."

We then take the total VA appropriated medical care dollars nationwide that were used to provide care for those veterans who fall into this basic care category, and the total veteran population is divided into the total dollars to provide that care to come up with a capitation rate for those patients.

In the case of basic care patients, that amount is approximately $2,600 per year. In the case of the specialized patients, because of their much more extensive needs, that amount skyrockets to approximately $36,000 per year.

Then each Veterans Integrated Service Network has a count done to determine how many patients in each category received care over the past 3 years in the case of basic care patients, over the past year in the case of the special care patients. The total dollars in the system are then distributed based on the actual number of veterans treated—not the population, but the actual number of veterans treated during the previous year.

So, in our case, we treated some 255,000 basic care patients and another 10,000 special care patients. Based on these model dollars, then, our additional increase in resources would be in excess of $90 million.

There are a couple of adjustments made to the model that I should point out. There is an adjustment based on the labor index. Because of lower average salary costs in Florida, coupled with the fact that our staffing patterns are more austere, because we have been historically underfunded, we sustained a $36 million reduction as a result of the labor adjustment.

There is also an adjustment based on VA's mission of medical education and research, and, again, dollars used to support those two missions are distributed pro rata to the facilities based on their respective amounts of medical education and research at each of the individual Veterans Integrated Service Networks.

There is also an adjustment for our nonrecurrent maintenance needs to maintain our facilities, as well as the equipment needs, which are a special fund limitation.

Those factors then go into the modeling and the distribution is developed. For fiscal year 1997, had we fully implemented the VERA process, we would have seen a gain of over $93 million in the Florida-Puerto Rico VISN; however, because of concerns about continuing to provide continuity of care to existing users, Secretary Jesse Brown felt very strongly—and I support his position—that no veteran currently receiving care should have that care terminated as a result of the VERA process.

So a policy decision was made to phase the implementation of the VERA process. This year, losing facilities are capped to lose no more than approximately 5 percent of their total operating budget, and gaining facilities won't receive their full gains.

For example, our VISN should have sustained an over 10 percent increase in our total resources, based on this model; our actual increase is just about 6 percent. The expectation is, it is over a 3-year period, which will give sufficient time to give losing networks time to adjust and downsize programs where the need no longer exists; and it will also allow gaining facilities, such as ours, to invest

in the new outpatient clinics and to contract for the needed services that we are not currently able to provide. It will allow time for that to take place.

So a phase-in over 3 years is planned to make sure that continuity of care is sustained, as well as quality of care in all parts of the country.

I should point out one additional factor, and that is that the VERA process is an ongoing model, it is a dynamic model. So it is not that we are due $93 million in Florida. Rather, as we expand facilities and continue to see additional veterans migrating to Florida, the VERA process will be recalculated each year, so that figure could rise well beyond $93 million. But we will have to wait until the future years to see what the demand in Florida is to determine exactly what our future year allocation will be.

Mr. STEARNS. Let me follow up and ask you to be a little more parochial here.

You mentioned that the funding level will mean that really during this phase-in process, the veterans hospitals in the State will get maybe 5 or 6 percent, but really 4 percent less than they need, you indicated.

Dr. ROSWELL. Four percent less than what they would receive if we had a truly implemented capitation system.

Mr. STEARNS. Yes. This phase-in is occurring over 2 to 3 years?

Dr. ROSWELL. That is correct.

Mr. STEARNS. And then it will be full funding. But if over 2 or 3 years they are losing at the rate of 3 or 4 percent, they could start out of the box in 3 years at 12 percent behind. So my question is, the significance of the capitation funding for the out-years, I would like your personal view from the perspective of Florida's veterans on any aspect of this formula that we might want to see fine tuned. As Representatives from Florida, the gentlewoman Karen Thurman and myself, what should we as Members of Congress fine tune or revise to achieve greater equity here? Because in the end we have had to fight the good fight, and now we have it, but I don't want the comment, it is coming at the huge expense of the 21,000 new veterans coming in and, finally, in 3 years we are still 12 to 15 percent behind.

Dr. ROSWELL. Well, I support the phase-in, but I think there are changes that need to be made in the model once it is fully phased in.

The two concerns I have have to do with the labor adjustment that resulted in a negative adjustment of $36 million to Florida and Puerto Rico. That reflects a lower average salary cost, which is appropriate, but it also reflects lower staffing ratios. Because we have historically had fewer funds, we have had to provide comparable care with a less intense staffing mix of registered nurses, of nursing assistants, LPNs and physicians.

So the labor adjustment reflects that more conservative staffing mix, which I think does a disservice to Florida's veterans. We would like to see some adjustment to the labor index to reflect only the labor cost, not the staffing component.

The second area that concerns me is that, as I have alluded to, the construction, the existence of VA facilities, is a major factor in our ability to provide care, because VA's construction program has

not been able to meet the timely need of increased demand in Florida. We have therefore been forced to rely upon leased facilities as opposed to constructed facilities.

The VA construction program provides that construction as an outright grant through an appropriation process, as you well know. The VISN then, in essence, takes control of that facility and operates it.

Unfortunately, in the case of leased facilities, we now, beginning in fiscal year 1998, must bear the cost of leasing those facilities. The cost of leasing those facilities will have to come out of the VERA dollars.

In our case, we estimate that cost to be somewhere between $8 to $10 million a year that must come out of our VERA allocation to, in essence, pay for our facilities each year, where other regions who have adequate construction do not bear that same cost.

Mr. STEARNS. I have one more question, and then I will let Representative Thurman ask her questions.

You talk about the per capita income in Florida being less than, perhaps, in the northeast, and this causes a shift in the formula. But we have a lot of people coming to Florida who are severely disabled, who have major problems. It seems to me—it has always seemed to me that offset the fact that we might have a per capita income that is less, because we have veterans coming down here very sick.

So the question is whether the capitation formula provides this network any more per patient for those severely disabled, service-connected veterans than would another network with very few such veterans.

Dr. ROSWELL. I believe it will, Mr. Chairman. The VERA model, as I mentioned, categorizes patients into two categories. We actually began the process by categorizing patients into five categories, based on the complexity and severity of their disabilities, and found that the dollars shifted by using five different patient categories was essentially the same as the dollars shifted using the two categories.

Now, obviously, a VISN such as Florida and Puerto Rico that has older, sicker and more disabled veterans will have more veterans in that special care group, so we will generate additional resources, because veterans in the special care group bring in $36,000 a year, as opposed to $2,600 a year for the basic care patients.

As long as we revisit on an annual basis, as I believe the Department will do, the patients that are categorized into each of the two categories of basic and special care, I believe the model will adequately meet Florida's needs for increased disability.

Mr. STEARNS. Is there any one of the administrators from the other hospitals who would like to add any other comment to what Dr. Roswell said?

Dr. ROSWELL. If I could, Mr. Chairman, I would like to introduce our other medical center directors who are here.

Mr. STEARNS. That would be excellent.

Dr. ROSWELL. Let me just turn around. Mr. Tom Doherty, D-O-H-E-R-T-Y, is the Director of our Miami VA Medical Center.

Mr. STEARNS. Tom, welcome. Nice to have you here.

Dr. ROSWELL. Mr. Nevin Weaver is the Associate Director and Acting Director today at our Bay Pines VA Medical Center.

Mr. STEARNS. Welcome.

Dr. ROSWELL. Ms. Genie Norman is the Director of our Lake City VA Medical Center.

Mr. STEARNS. Very good.

Dr. ROSWELL. We also included in the VISN a medical center in San Juan, Puerto Rico; Mr. Jamie Palmer is the Director there. He was unable to be here today.

Mr. STEARNS. Let's give all those folks a warm welcome. Mr. Randall.

Mr. RANDALL. Mr. Chairman, I would like to amplify something that I said about the 50 percent of the outpatient workload being for service-connected veterans.

At Gainesville, over 20 percent, of our 36,000 unique veterans are rated 50 percent service-connected or higher. So as Dr. Roswell said, these are the people who are most seriously disabled who require much more treatment and care. So I would have a hunch that that same situation may be true at other facilities in Florida. But it does place an additional workload, which, of course, requires more resources, on us at Gainesville.

Mr. STEARNS. Thank you.

Well, at this point, Representative Karen Thurman.

Mrs. THURMAN. Thank you.

I would agree with the chairman that that is a very big issue for us, because we do have an older population, we have a more disabled population, and it certainly has created some different problems for us than in some other areas. But I hope we can make sure that that happens.

I am curious, Dr. Roswell, particularly with the numbers that have been thrown out here today, if we base the allocation of funds on the previous year's veterans being served, one of the things, because of the formula in the past, since 1980, really has never been adjusted for the population for the State of Florida.

How do we catch up, and how does Mr. Silver or Mr. Randall or Mr. Isaac really determine the number of veterans that could have been served versus the number of veterans that are served?

I think that that is extremely important because, as I said, if you are basing it on a 1980 filling, you are basing it on the year before performance, but we have no ability to move those numbers into that formula, those that we actually turned away. How do we address that?

Dr. ROSWELL. Well, it is a difficult question but a very good one. Certainly when we have been underfunded, our ability to provide care for veterans is decreased without those resources, so the amount of veterans we provide care for and, in essence, bring dollars in for under the capitation process is reduced. In essence, we are handicapped because we have not had resources previously.

Mr. Isaac probably didn't tell you, I know he didn't tell you, but his medical center, activated just 21 months ago, had over $17 million in activation funds withheld. Despite that shortfall of $17 million in activation, Mr. Isaac at the West Palm Beach facility has been able to exceed his projected outpatient workload by a factor

of greater than 50 percent. That is the kind of efficiency we do on a daily basis in Florida and Puerto Rico.

We are being more efficient, using lower-cost facilities, contracting for care when it is more cost effective, and we believe that over time, by working together as an integrated team of health care providers, achieving the efficiencies in health care delivery, we will be able to catch up.

Mrs. THURMAN. Mr. Silver, you mentioned in your remarks that you are also the administrator over the new Port Richey facility which is also a part of the district.

I might add that I now represent, Mr. Chairman, the number one national number of veterans in the country. So, needless to say, this is a very big issue for us in our area.

Would you give me some detail of what is happening in new Port Richey and the outpatient clinic, because I think that will be of interest to many veterans in this district.

Mr. SILVER. Yes, Congresswoman. As you mentioned, the fiscal year 1996 workload at Port Richey was in excess of 30,000. We are now projecting that that workload over the next 5 years will probably grow to in excess of 50,000. As a result of that, plans are under way to expand the Port Richey clinic.

Unfortunately, we are landlocked on the leased space we are in, so we are looking at additional space. A solicitation for bid is now out in the market, and we have designated the area that we would like to have the new clinic located in, and a design-build contract will probably be effective this year.

Mrs. THURMAN. I am going to be down there tomorrow. Is there anything you would like me to tell those veterans at the POW-MIA meeting?

Mr. SILVER. Tell them that they are showing us the money finally.

Mrs. THURMAN. Okay.

Dr. Roswell, you also mentioned in your statement the communications issue. Could you give us an idea of when that may come into effect and what we can expect from that as far as helping veterans within this State?

Dr. ROSWELL. Well, we feel very strongly, Congresswoman, that veterans shouldn't have to travel great distances to access care and services. While we are looking at being more efficient and in some cases consolidating certain support functions for patient care, one thing that has been made very clear to me as I have talked to veterans throughout the State is that we do not want fewer sites where we can receive care; rather, we want more sites where we can receive care.

So as we look at being more efficient, we are talking about consolidating things that are transparent to the veterans such as the fiscal services, the contracting, the procurement, but not reducing sites of care or scope of care in our individual sites.

So, for example, we are not interested in closing a surgical program at a site or reducing mental health services at a site. We may be interested in being more efficient in supporting those through sharing resources, but we don't want to reduce the location and sites of care; rather, to expand them.

One of the things though that is a burden and is a problem to our veterans is, as they become older and develop more complex medical conditions, they often do require very highly specialized consultation and, in some cases, surgical care. Understandably, much of that care is available only in our most complex medical centers, such as the Gainesville Medical Center, the Tampa and Miami Medical Centers.

Historically, veterans have had to travel great distances to receive that care and often wait even weeks and in some cases months to receive an appointment with a specialty physician at one of those medical centers.

The telemedicine implementation I spoke of will actually link all 13 of our major outpatient clinics with the seven medical centers, allowing patients to access a specialty physician via interactive video and audio connections. We are in the process of selecting that equipment, have budgeted for the current fiscal year, and expect to procure the system prior to September 30 of this year.

Mrs. THURMAN. Oh, good. Good.

I am going to ask a question that probably is not a very popular question, but it needs to be brought out, and maybe you can shed some light on it for the purpose of people that might be here, and that has been the issue of sexual harassment that has arisen in some of the hospitals or some of the things that have been going on.

I know you and we have had a discussion, but it might give you an opportunity to talk about how that is going to be resolved and what you are doing in the administration and then specifically at the hospitals.

Dr. ROSWELL. Well, I can assure you that I personally and the entire VISN leadership fully support Secretary Jesse Brown's zero tolerance for sexual harassment. While it is unfortunate that publicity recently has brought this issue to light, being an eternal optimist, I welcome that as an opportunity to reexamine our sexual harassment policies and to assure that no employee and no patient anywhere in the Sunshine Health Care Network is subjected to or forced to endure any form of sexual harassment.

Through our series of town meetings, working with the various medical center staffs, we are reaching out to ensure employees that this is our policy, that we will not tolerate any form of sexual harassment, and actively encouraging employees to report any such events where we will take swift and full action as we are permitted to.

Mrs. THURMAN. I appreciate your honesty.

I join the chairman in thanking all of you, and Mr. Randall, who has, I guess, and Mr. Silver have—who kind of looked a little strange, Mr. Isaac, when you talked about how long. I know you were not talking about age, you were talking about experience.

Mr. SILVER. Absolutely.

Mrs. THURMAN. I know we are always pleased to have Mr. Randall for what he does and Mr. Silver for what he does, and we certainly appreciate both of you two being here today.

Mr. STEARNS. I thank my colleague.

Let me just follow up with a few questions that came to mind. Dr. Roswell, in detailing how you will use the VERA funds, your

testimony did mention the new clinic in Brevard County. Since the construction funds appropriated for that clinic do not pay for the cost of equipment or hiring clinic staff, will VA headquarters provide you with the activation funding? That is a question we had.

Dr. ROSWELL. It is not clear at this point. In fiscal year 1997, activation needs were in part met by reserve monies that were created in VA Central Office. We had approximately $11.5 million in activation needs in fiscal year 1997. We received almost $10 million to cover the cost of those activation needs.

The Brevard outpatient activation, which is scheduled for completion in late 1998, will carry with it a fairly substantial activation cost. It is certainly our expectation that we will request activation funds from our VA headquarters. We are optimistic that we will be able to receive some portion, if not all, of those activation funds.

However, historical experience suggests that we probably will not receive all of the activation funds. So we are now in the process of, if you will, budgeting ahead, looking at where we can set aside activation dollars with resources that may be available this year to begin to purchase the necessary equipment to outfit the clinic and anticipate that at least a portion of those allocation funds will come out of Florida's VERA allocation.

Mr. STEARNS. This has always been a puzzle to me. Here we are talking about more funds going to Florida, and yet you don't even have the funds for activation. What about Orlando now? We have a nursing home down there; right? We have other facilities proposed. What are you going to do about that if you don't have the funds for the one in Brevard?

Dr. ROSWELL. Well, in the case of Orlando, the Department of Veterans Affairs recently took title to the former Orlando Naval Hospital. We now, in essence, own that facility.

There was an appropriation in fiscal year 1995 that set aside $14 million to renovate that facility and build a nursing home on the location. Because of the Secretary and President's budget request to build a new medical center in Brevard County, that was held in abeyance by Chairman Stump.

However, with the initiation of construction for the Brevard clinic, we anticipate beginning our efforts to use the $14 million that we were appropriated to make the necessary structural modifications as well as build a 120-bed nursing home at the Orlando site.

But, once again, you are absolutely correct; those monies will pay for renovation and construction but not cover the cost of activation. So, again, we are budgeting as a VISN but are also expecting that our request for supplemental monies from VA headquarters will be heard.

Mr. STEARNS. Some of the money you mentioned is coming from a construction fund though.

Dr. ROSWELL. Right. The construction money, the $14 million I spoke of, is construction money. Therefore, it can't be used for equipment or operational staffing. For example, to staff a 120-bed nursing home, it requires a number of employees who provide care around the clock.

Those employees, their associated salary dollars, if activation monies are not made available—and in fiscal year 1997 only equip-

ment dollars were made available, no recurring personnel costs were made available—those would have to come out of the existing VISN budget.

Mr. STEARNS. One of the things I see as a member from Central Florida is, you keep being forced to take funds from the Florida funds, where it seems to me it should be coming from the national, and the Central Office should be providing these funds for activation and other things, and you shouldn't be forced to rob Peter to pay Paul. Am I wrong?

Dr. ROSWELL. Well, no, you are certainly not wrong; I believe you are correct. I think the philosophy in headquarters is to try to move as much of the medical care appropriation out to the field, and I support that philosophy because it gives us greater flexibility in how we utilize those funds.

A second part of the current philosophy, the policy, if you will, at headquarters, is based on the fact that, if we truly have an additional need for care, then as we invest existing dollars into expanded or new facilities, the care provided will bring additional dollars in through the VERA process.

Unfortunately, as the Congresswoman pointed out, that results in a lag, because you have to invest the money up front to create the facility to provide care to veterans, which will only bring new VERA dollars in, in the outyears. So we have to be very careful how we budget.

Mr. STEARNS. Does this diminish the effect of VERA?

Dr. ROSWELL. It does to a certain extent. It delays the implementation. We have struggled——

Mr. STEARNS. Further delays.

Dr. ROSWELL. Further delays. We have struggled with an effective funding methodology since 1984 when HCFA introduced the DRG reimbursement rate for medicare. We began with a process that was based on DRG's but found that was ineffective and, in effect, resulted in serious gaps in quality.

More recently we went to a process that actually projected future workload and projected future needs, but, again, the formula was extremely complex, difficult to understand, and it was very, very difficult to determine what your future year allocation would be.

The VERA process, though not a perfect process, is a comprehensible process that we can understand. We can project what our future year workload will be, and we can have a much greater confidence in our outyear budget projection capability than we have ever had under any previous funding methodology.

Mr. STEARNS. In your testimony, you talked about construction, hospital construction. Without new hospital construction, and 21,600 new veterans a year coming in here, how do you expect to meet the increased demand for veterans' care in the underserved areas of Florida?

Dr. ROSWELL. Well, ironically, despite the fact that we have an unmet demand for care in Florida, last year, fiscal year 1996, we actually closed almost 500 hospital beds. The problem is not too few hospital beds, it is a maldistribution of hospital beds.

We have actually in some cases excess bed capacity in our large metropolitan medical centers but have insufficient bed capacity in

the underserved areas, such as Brevard County, such as southwestern Florida, or the Panhandle area.

Because construction is not available to meet those needs, we have a two-pronged strategy to deal with that. The first calls for using new expanded sharing authority, which the committee was very helpful in obtaining for us, to actually procure emergency hospitalization by purchasing that within the local community.

We anticipate in the Brevard County area, for example, because the new facility will only be an outpatient clinic, we will actually begin the process of contracting for emergent hospitalization for veterans in dire need of hospitalization.

However, because we have excess capacity, albeit maldistributed, veterans who have nonemergent hospitalization needs will have to be transported at VA expense to one of our existing facilities where that hospital capacity is available. Ultimately, it becomes a cost-benefit analysis of how we can best meet the hospitalization needs.

Certainly we put quality of care and convenience to the patient uppermost in that equation, but ultimately we have an accountability to the taxpayers and a budget limitation determined by the new VERA process.

Mr. STEARNS. Let me conclude by asking a question that is perhaps another parochial interest to Representative Thurman and I. How do you respond to those that say that the VA continues to need hospital beds in East and Central Florida and yet should use the former Orlando Naval Hospital in part to provide some of that care?

My congressional district goes from the tip of Orlando all the way up to the Georgia border, including western Jacksonville and Union, Backer, and Bradford. Representative Thurman's district, of course, goes all the way above Tampa. So between the two of us—and then you include Tillie Fowler and John Mica. I mean, we have this whole area, yet our veterans are told just to go down to the Orlando facility.

Dr. ROSWELL. Well, one thing veterans tell us is, they don't want to travel great distances when they require hospitalization. We fully recognize that. But we also realize that because of the distributed veterans population in both of your districts, that a single hospital, be it in Brevard County or in Orlando or in your district, Congresswoman, will not meet all of those needs, because veterans, quite frankly, and understandably, expect health care to be local; they want local hospitalization.

We have actually done some fairly elegant staffing and planning models looking at the Orlando hospital to determine if a hospital would be better suited there. We would expect that we probably would have an average daily census of no more than 30 or 40 patients if the Orlando hospital were converted into a medical-surgical hospital.

Even those veterans would still have to travel to Tampa, West Palm Beach, or Gainesville to receive certain types of specialized services. Unfortunately, these specialized services are increasingly what constitute the need for hospitalization today.

So, again, with that in mind, our strategy is to use existing bed capacity in the non-Federal sector and contract for those hos-

pitalization needs. But we have to recognize that that represents an additional cost.

Mr. STEARNS. Congresswoman Thurman.

Mrs. THURMAN. In that context, let me see if we can understand a few things that might be helpful for us in this discussion. One of the things that we know is that if you use outpatient services, that it is a cheaper way to deliver services.

In this formula, do we take into account the cost reduction that we might have in giving veterans services to raise maybe some of those other dollars in areas where veterans will need beds within hospitals? Is that going to help us at all with the dollar allocation?

Dr. ROSWELL. It might. It is actually a dynamic process. For example, in fiscal year 1997, as I mentioned, about 68 percent of our total medical care appropriation was distributed to basic-care patients. It is very possible that next year that will be a greater number or a lower number based on changing health care delivery strategies.

Obviously, we would like to move to provide health care that will actually maintain health care and reduce the need for hospitalization. Ultimately, we would like to be able to improve the health and functional well-being of the veteran population in Florida. If we are successful in doing that, we know we will have fewer patients in the high-cost special-care and more in the basic-care category.

We also, though, have to recognize that a tremendous part of the VA health care system is to be there to meet these specialized needs. So we can't do anything to detract from our spinal cord injury or blind rehabilitation facilities. We want to protect those, because those provide a level of catastrophic care that, quite frankly, is unavailable anywhere else to this population.

Mrs. THURMAN. Do you have the flexibility within the model of VERA to do that?

Dr. ROSWELL. We do in a way, because basically how we take the basically $1 billion a year that our VISN receives and distribute that to provide care determines how many dollars at least we are contributing to the basic care category.

We firmly believe that we need better access to underserved populations, so our primary strategy is to use the additional dollars to activate new access points, new primary care clinics in underserved areas.

We do recognize though that as we expand our market share and provide services to additional veterans, there will be veterans who have very specialized needs and will require the blind rehabilitation, the chronic mental illness care, the rehabilitation care available through the VA.

Mrs. THURMAN. One other thing: As you know, there are pieces of legislation where we have talked about the use of medicare reimbursement to the VA. What is your support on that? Are we doing anything? Do you see that happening? If so, do we see any reduction in VA allocations because of that? Maybe you can just give us a brief overview of what is happening there.

Dr. ROSWELL. Thank you very much, Congresswoman. I would be delighted to do that.

The actual President's 1998 budget request for VA health care reflects that very strategy you spoke of. In fiscal year 1998, President Clinton has requested no increase in our medical care appropriation; rather, offsetting the additional inflationary cost, that is approximately $500 million a year, by seeking legislation that would allow us to bill insurance companies for care provided to non-service-connected veterans, and retain those dollars for local use.

We currently do that, but the money is returned to the Department of Treasury. Nationally, that accounts for almost $500 million a year.

Also in the 1998 budget request is a legislative request that would allow VA to, for the first time, provide care to Category C veterans, those who have lower eligibility because of higher income levels, who are normally not eligible for VA care. It would allow us to provide care to Category C veterans who have medicare eligibility, presumably mostly over the age of 65. This would allow those veterans, in essence, to now seek their care through the VA. We would be able to bill the Medicare Trust Fund and retain those dollars locally.

I believe it is a win-win-win situation because, one, it brings in new dollars to the VA to allow us to expand our programs.

Secondly, it actually reduces the outlay of the Medicare Trust Fund because we have agreed to bill the Medicare Trust Fund at less than their allowable billable rates. So we would be billing 95 cents on the dollar, or 93 cents on the dollar, representing a savings to the Medicare Trust Fund.

Thirdly and most importantly, it is a win for veterans because it means that additional veterans will be able to receive high-quality care through the Department of Veterans Affairs facilities.

Mrs. THURMAN. Although I do see a little concern there, and I will say I agree that that is the right thing to do and I think that is the right road to travel down, my concern is, particularly in Florida, other States who are actually losing their veterans population who are not having the same overcrowded problems that we are, the question that will happen to Florida is, will we get shortchanged in that as well, because even though—I mean, what we are going to hear from our constituents is: Look, I am a sub-C or defined as C. I have come to Florida. I can't get that care because there is no ability for that care in Florida because we are overinflated. That is an issue.

Dr. ROSWELL. I agree with you.

Because we have limited excess capacity, we would have to do this on a phased implementation. Ultimately though, the strategy is to use marginal capacity to provide care that would bring in full funding, which would then allow us to reinvest those additional dollars, nonappropriated dollars, to expand our overall treatment capability.

Mrs. THURMAN. That is what I really wanted to hear.

I would just say for myself, and I know others in our delegation, if there is a way, as this legislation starts to move through Congress, I hope you will keep us informed so that we can make sure what you have just said in your last statement—that we can make

sure that that happens and happens correctly, because I think it is really very important.

Dr. ROSWELL. We will be happy to do that.

Mrs. THURMAN. Thank you.

Mr. STEARNS. I just might point out, we hope to drop a medicare subvention bill in the next couple of weeks, so we think it is important too.

I want to thank all of you gentleman for your time, and I appreciate your coming forward.

Mr. STEARNS. Now we will go to Carlos Rainwater, Executive Director of Florida's Department of Veterans Affairs.

Good morning, Mr. Rainwater. Let me welcome you, and let us hear your opening statement.

STATEMENT OF CARLOS RAINWATER, EXECUTIVE DIRECTOR, FLORIDA DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL HAHN, LEGISLATIVE AFFAIRS DIRECTOR

Mr. RAINWATER. Thank you very much.

I have with me and have asked to join me at the table Michael Hahn, who is our legislative affairs director. He represents the Florida Department of Veterans Affairs. He is permanently based in Tallahassee.

I appreciate the opportunity to be here and speak briefly on our perspective on the veterans' equitable allocation resource model.

I would like to begin by giving a very brief personal history. For 33 years I was a senior manager in the VA. Just last year, I retired from VA and Governor Chiles appointed me as the Executive Director of Florida Department of Veterans Affairs, where I am serving at the present.

You have heard much about the veterans population migration to our State, the reasons for that, which are many, but just to give some impact perspective, over the past—from the period 1980 to 1990, one-half of all the veterans nationwide who relocated, relocated to Florida. That is a rather profound percentage of veterans population.

As a matter of fact, the growth of veterans population in Florida exceeded the next highest growth rate of veterans by 400 percent over that decade.

So, without being redundant with what our friends in the VA have already told you, the profound effect of this population has greatly diminished the ability of the VA in Florida to serve the health care needs of our veterans.

More specifically, over that decade, Florida experienced a net increase of 349,451 veterans. The State of New York lost 357,394 veterans population over that same decade. That is a profound shift of the veterans population and the demands for health care.

There is still some growth in the veterans population. Although nationwide the 26 million veterans population is declining, the growth rate continues, although somewhat mitigated, here in our State of Florida.

So, at the present time Florida has over 1.7 million veterans, and, has already been pointed out, those veterans are aging, they

have serious disabilities, and demands and requirements for health care continue to increase.

I was initially assigned by the VA to the St. Petersburg Regional Office in 1972, and from 1972 until 1995 when I left St. Petersburg, I can personally testify that Florida veterans have not had the same level of access to care and benefits as veterans in other States.

In my 33 years with the VA, from 1963 to 1996, I served in various VA facilities in Georgia, Louisiana, Iowa, Colorado, Pennsylvania. I had a view from the inside on the effect of the imbalance of the allocation of VA's resources, and I can assure you there is a vast difference in the way VA delivers its benefits and health care to veterans from State to State.

In my view, there are many reasons for this imbalance. Some of those reasons are internal to VA and to the political intrigue that goes on within that agency. Most of those reasons, however, are external to the VA, over which VA had very little control.

But we are grateful today that through the efforts of Senator Graham, Senator McCain, supported strongly by our friends in the Florida delegation, that the VERA process is in place and veterans do have hope of getting access on an equal level with their brothers and sisters in other States.

Obviously, we in Florida want nothing more than our fair share of VA's health care resources. As Dr. Roswell has already pointed out, we do not seek to diminish or terminate the care being given to veterans in our sister States to the north. But there are many factors in computing that fair share, some of which have already been mentioned this morning.

Florida's veterans population is second highest in the United States. Florida has a higher percentage of veterans with service-connected disabilities than any other large State. Florida veterans are, on the average, older than veterans in any other State. And probably most important, the majority of Florida's 1.7 million veterans have come here from those very States who are now strongly opposing the VERA model.

Veterans of Florida now have hope that they will be able to access the VA's excellent health care system at the same level as veterans in other States. The VA managers that you have heard from and their dedicated employees here in Florida have struggled for years to provide adequate benefits and health care for veterans in an environment of underfunding and understaffing. I know, because I was one of those managers for many years.

The VERA model has the potential to change that environment, and all of those of us who work for veterans in Florida ought to do everything we can do to ensure that that level of access improves.

The VA, under the leadership of Dr. Kizer, is rapidly moving into a current mode of delivering health care, that is, through expanded access points and the primary care methodology. The emphasis is now on preventing admissions to bricks-and-mortar facilities and moving to programs of managed care and mitigating necessity for hospital admission.

However, for the new approach in health care to work in Florida, the VERA model must be put into operation as outlined by the VA.

So we at the Florida Department of Veterans Affairs strongly support the VERA process. We strongly support Dr. Roswell and the Directors of the Florida VA health care system. We are their partners in trying to achieve an equitable level of access for Florida's veterans.

Finally, I feel that we ought to view the level of services that the Government provides veterans as a litmus test of just how well government works. Veterans are a special group, clearly deserving of a high level of service from government, and for us to fail to provide those adequate services is just not acceptable.

Thank you. That is a brief synopsis of my prepared statement, and I will be happy to respond to questions.

[The prepared statement of Mr. Rainwater, with attachments appears on p. 65.]

Mr. STEARNS. Thank you, Mr. Rainwater.

I just want to reiterate what you pointed out, that that veteran population shift occurred from 1980 to 1990. Those are enormous figures with your roughly 350,000 new veterans in Florida and how many veterans left the State of New York.

You have heard Dr. Roswell and you have heard him talk about the VERA model and everything. What do you think about what he said about the strategic plans for Florida, and particularly what do you think relevant to Central Florida?

Mr. RAINWATER. In my view, Dr. Roswell has obviously spoken very candidly and truthfully about the health care situation in Florida, and particularly in Central Florida.

In Central Florida particularly, the Gainesville Medical Center, I have always observed, under the leadership of Dr. Malcom Randall, provides a superior level of health care, once you get access to that health care.

The difficulty for years has been getting admitted to Gainesville, particularly in view of their underfunded, understaffed posture for these many years. So anything that can be done to enhance the ability of a veteran to get access to this excellent facility where we sit today should be encouraged and should be supported.

In addition to that, I understand there is some study going on. I was interviewed by a consulting team from Washington looking at the consolidation of services in Gainesville and Lake City.

I believe that we should support that. I believe that Lake City is a very, very friendly environment; it is easily accessible. However, Lake City is not technologically on a par with Gainesville. It never was intended to be. So that merger, I believe, should move forward.

In addition to that, I strongly believe that additional access points ought to be considered in the surrounding counties, not just here in Gainesville and not just in Lake City, because in the VA's new health care model, I believe bricks and mortar are not the key; the key is expanded access points, primarily in managed-care modalities of delivering health care.

Mr. STEARNS. Do you have any comments on the adequacy of the VA's plan for acute hospital beds, psychiatric beds, and, most importantly, nursing home beds?

Mr. RAINWATER. Yes. I believe, as Dr. Roswell pointed out—and I have no reason to doubt what he has stated previously—that the

question is not the lack of hospital beds, it is the location of those hospital beds, both in acute psychiatric, and always Florida has been behind the curve in acute psychiatric beds. That probably needs to be studied very closely in every one of their medical centers.

As for the nursing home situation, of course, as you realize, we in the Florida Department of Veterans Affairs operate a nursing home, and we are building a second nursing home. Our demographics tell us that there is a strong need for expanded nursing home care throughout the State in the veterans population. No matter where you put a veterans nursing home, you could fill it in a heartbeat in the State of Florida.

Mr. STEARNS. I take it then you are fairly encouraged by Dr. Roswell's presentation?

Mr. RAINWATER. I am very encouraged by Dr. Roswell, and I am elated by the entire VERA process. In my experience with VA in Florida, this is huge. Nothing that I have ever experienced in my 33 years with the VA has ever held the promise that the VERA process does for the veterans in the State of Florida.

Mr. STEARNS. Okay. We all go home; the process works.

What are you going to put in place to verify that this is working? What indicators, what management techniques, are you going to do to make sure this is working? If it isn't working, what are you going to do, and how can folks like Karen Thurman and I help you in this process?

Mr. RAINWATER. There is another factor ongoing which wasn't mentioned previously. The VA has an entire new method that they are following in their eligibility reform package. Eligibility reform means that they will now, by, I believe the date is October 1998, have a system of enrollment whereby veterans who are seeking to access the VA's health care system will be required to enroll at the facility or at a VA facility where they are seeking health care.

Those enrollment numbers—first of all, we already have started working on, from the State perspective, our initiative to ensure that every veteran in the State of Florida is aware of the enrollment process, that every veteran participates to the greatest extent possible in the involvement process, and when the VA is armed with those enrollment numbers, then properly administered, the VERA model has to work. It can only work to our advantage.

So to answer your question about what we are doing, we are supporting the enrollment process, we are ensuring that veterans do enroll, and we are ensuring that the VA accurately records those enrollments and can support their funding streams through those numbers.

Mr. STEARNS. Let's say it doesn't work. What are you going to do?

Mr. RAINWATER. That is Michael Hahn's number one job. He takes care of all the numbers. We see thousands of veterans a year. We have our people stationed in every one of the VA medical centers. We will be calling you promptly if it does not work. We hear from them first.

Mr. STEARNS. Okay. So we will be hearing from you then.

Mr. RAINWATER. Absolutely.

Mr. STEARNS. Okay. My colleague, Representative Thurman.

Mrs. THURMAN. Michael, welcome. It is good to see you again.

Mr. HAHN. Good to see you too.

Mrs. THURMAN. I know that we are getting ready to place a nursing home in Pasco County. It went out for competitive bid, and we looked at a lot of issues. Do we know when that groundbreaking is going to be at this point?

Mr. RAINWATER. It is scheduled for Memorial Day, May 30.

Mrs. THURMAN. Good. They are going to be really excited down there.

Mr. RAINWATER. They are.

Mrs. THURMAN. It has come to our attention that there is a possibility that the home loan program might be relocated to Atlanta, saying that is the number one area. That is hard for me to appreciate and understand when we have just talked about all the numbers of veterans coming into the State of Florida.

I don't want to put you on the spot here, but could you give us some good fighting words to talk to the VA about why they should be doing that? I sort of listened to—not sort of, I did listen to Dr. Roswell when he talked about consolidation of services. But on the other side of that, why would you take those services away from where the most population of veterans is?

At the same time, if you can maybe in your capacity, maybe just elaborate on some other issues that we perhaps should be concerned about in our partnership with the State and with Congress and how we might better give a quality of life for veterans in Florida, I would greatly appreciate that.

Mr. RAINWATER. Thank you for the question.

First of all, back to your basic question about why the VA is consolidating part of its home loan activity; there is a long history here. First of all, I will state very candidly that it makes very little sense at all to do that.

For 15 years, I was Regional Office Director in St. Petersburg, with direct responsibility for the home loan program. For the last year I was with VA, I was the Regional Office Director in Atlanta.

I will tell you, the last place you would want to move another activity is to Atlanta. Nothing against those folks, but they have all they can carry on their shovel right now.

The other thing is that, as you know, the St. Petersburg Regional Office is constructing a new $21 million building. That building was designed for that entire home loan activity to be located in. I am not sure what the VA is going to do with that space. I mean, hopefully they will give me a nice cushy office where the home loan program used to be.

Mrs. THURMAN. Then we will let you take the home loan program.

Mr. RAINWATER. Right. Having said that, the truth is, 2 years ago, the VA had an initiative to consolidate many functions nationwide, and, quite candidly, some of that ought to take place, in the benefits side.

The big piece of that was to consolidate much of the Compensation and Pension adjudication process into, I think, 22 or thereabouts centers, with eight of those centers being for home loan activities.

Well, due to some unfortunate events that happened to VA along those times, they were required to scrub the big consolidation, and this home loan piece is just kind of the leftovers from that big piece of consolidation.

Quite candidly, taken alone, that home loan consolidation just doesn't make much economic sense.

Mrs. THURMAN. Another issue we hear a lot about through the office is the appeals process, with the availability of judges and those kinds of areas. I mean, if you were to give us a ball park figure, I mean, I don't know how many judges we even have today in Florida, but I know it is not enough, through the appeals.

Could you give us an idea of where we could expand and help in that area for our veterans?

Mr. RAINWATER. Well, you know, I could go on for 2 hours on this topic, but quite candidly, it has been said that if you took the VA's mission in the claims adjudication process and designed an organization to fulfill that mission, it would look nothing like what we have today.

What is in place today grew like Topsy. It is a convoluted, complex system. Sometimes the various levels of appeal are working at cross-purposes. So quite candidly, the resolution is not so much an additional hearing officer to review people in VA field stations. The solution, in my mind, is in resolving finally the roles of the Board of Veterans' Appeals and the Court of Veterans Appeals in Washington. Those roles almost seem to be at cross-purposes.

Why do you have those two roles? Recently, the Congress commissioned a blue ribbon commission and the report was just published a few months ago that deals directly with that. The resolution has to be someplace between the Board of Veterans Appeals and the Court of Veterans Appeals, both of which drive this entire system, and the system is very convoluted. It duplicates itself and results in a lot of inefficiencies and, most importantly, it results in untoward delays for veterans who are trying to get their claims adjudicated.

Mr. STEARNS. I thank both of you. Again, Michael, it is great to see you.

Mr. HAHN. It is good to see you.

Mr. STEARNS. Mr. Hahn, is there anything you would like to provide?

Mr. HAHN. I would like to make one point about the VERA allocation formula. The discussion that Dr. Roswell carried out on VERA was, I think, a very accurate one, but I think we might go one step further in terms of discussing the special care and basic care allocations of funding.

The special care patients, as Dr. Roswell made clear, carry much heavier weight in the allocation of dollars. The designation of special care patients by VISN doesn't seem to follow any rational pattern that I can detect when I look at the data. If one were to assume that special care patients sprang up just as a function of population, the larger the population, the more special care patients there would be, then you would assume Florida would be right next to the top of the list with the most of those special care patients. In fact, that is not true.

If you were to look at where seriously disabled service-connected disabled veterans lived and allocated the special care dollars, in some sense monitoring those populations, then that would make sense. But in fact, that is not the case.

If we were to look at a comparison between VISN number 3, the Bronx, and Florida, we have three times the number of seriously service-connected disabled veterans as VISN 3. VISN 3, however, actually receives slightly more money in special care money than does Central Florida. I am talking about $363 million versus $365 million. This is roughly 35 or 40 percent of our funding down here in Florida. It would appear that how those monies are being allocated is difficult for just a poor working guy to put his arms around, I must say. I think that is kind of suspect. We will provide you a little more substantial discussion.

Mrs. THURMAN. Michael, for some reason, why did I think that?

Mr. RAINWATER. One other thing I would like to share just before we leave. Just last week we met with our colleagues with the Veterans' Affairs directors nationwide in Washington. Michael had a conversation with the State Director of Veterans' Affairs in New York. Michael attempted to furnish him some of the data that Michael is so famous for gathering, and this gentleman told Michael, "Well, you know, I don't need all your data from Florida. We talk to veterans all the time who come back to New York because they can't get their health care in Florida."

Mr. STEARNS. I want to thank both of you for coming.

I would like to welcome the next panel forward. The panel number 3 is Al Linden, Adjutant, Disabled American Veterans, and Chairman, Florida Veterans' Planning Group; Bill Kirsop, Adjutant, Veterans of Foreign Wars; Dyke Shannon, Adjutant, American Legion; Donald Priem, President, County Veterans Service Officers; and Thomas Corey, of the Paralyzed Veterans of America. Now, we have five of you individuals, so why don't we get one more chair up for them.

Let me welcome all of you gentlemen here to our hearing. Why don't we start with Mr. Linden. Why don't you open with your opening statement, and then we will just proceed.

STATEMENTS OF AL LINDEN, ADJUTANT, DISABLED AMERICAN VETERANS AND CHAIRMAN, FLORIDA VETERANS' PLANNING GROUP; BILL KIRSOP, ADJUTANT, VETERANS OF FOREIGN WARS; DYKE SHANNON, ADJUTANT, AMERICAN LEGION; DONALD PRIEM, PRESIDENT, COUNTY VETERANS SERVICE OFFICERS; AND THOMAS COREY, PARALYZED VETERANS OF AMERICA

STATEMENT OF AL LINDEN

Mr. LINDEN. Thank you very much, Mr. Chairman, and thank you, Mrs. Thurman, for being here today. I agree with you, I think this is a potential celebration. As they say, we want to see the money when it comes down here. But on behalf of the more than 87,000 veterans, disabled veterans in the State of Florida, who belong to our organization and auxiliary, I want to thank you for this hearing.

Also, I am speaking on behalf of the joint Veterans' Planning Group, of which I am the moderator. It is the major veterans' group in the State of Florida. In fact, all the colleagues here at the table are members of the organization and we try to work mainly on State issues. It is a good group.

I am not going to reiterate all the things, other than to say we have got the oldest, most severely disabled population of veterans in the country, and I have the statistics. If you will permit me to enter my entire statement in the record, then it will show the details of those facts.

Mr. STEARNS. It is so ordered.

Mr. LINDEN. Thank you very much, sir. I do want to point out a few things, that the statistics that show that 61 percent of the VA outpatient care in Florida are conditions that are directly related to military service, in other words, service-connected, while the national average is only 46 percent. I think one point that has been lightly touched on is the fact that we have not had adequate resources and people have been denied care for all these years.

There has been numerous studies done on that here in the State of Florida, as well as by the VA Central Office. We have just not had the resources that we need to do it. And many veterans have simply concluded that they can't get care here and have gone back up North.

I know my office being just 15 miles south of here, that hardly a day goes by that someone comes to me and says, you know, they will take care of my service-connected disability, but they can't help my heart condition which is not service-connected.

My only advice has been for them for the last 10 years is go North. I hate to say it, but I think that just proves the fact that we have not—because they have been treated for it up there in New York, Michigan, Illinois, all of those places, they have been treated year after year for it, they come down here, they can't get treatment. So the only advice we have been able to give them in the past is to go back up there and get it, if you can't get it through some other source down here. I think that is an important point.

There are a number of studies that have been done by the VA as it relates to this, and I think in my testimony I have called attention to those studies in relation to those veterans that haven't received the care that they have when they were in other parts of the country. I think that those are arguments that you can use against or with your northern colleagues up there in the Congress who seem to think that they deserve more than their fair share.

VERA, I think, is a good start. I think that it has the potential to finally get equitable resource allocation here in the State of Florida. It is probably the single most meaningful and fundamental enhancement that we have seen in Florida since it started, since my time here in Florida and I think in many, many years in Florida. I know the last 20 years in Florida, our resources have just not been adequate to do the job.

I think VERA will provide us with an opportunity to be fairly treated. I guess my message that I would like to see both of you carry back to Washington is don't let those people up North talk you out of it, no matter what you do, and that means all of you. If there is anything here in the State of Florida we can do to make

sure you are not talked out of it by those people up North or outvoted or whatever they do, we stand ready to do that, because I think this gives us the one opportunity that we have to start getting our fair share.

I agree that Dr. Roswell and his colleagues that they are doing an outstanding job with the resources that they have. There is no question about it. I use the system. I use it right here in Gainesville, and I wouldn't go anywhere else.

So I think given that, there is one statement that I would like to make. It is often repeated by many of the veterans that I see, disabled veterans have stated to me, that I will die before I receive adequate VA health care here in Florida. That is not the fault of the VA employees in Florida. But it is the fact that we have not had the adequate resources to do the job.

I think that VERA, plus eligibility reform, are the two most important things, and I commend both of you for being an active participant in those and taking part and making sure that those two things have occurred.

I would be glad to answer any other questions that you may have. I do have one other thing, and I forgot it—I didn't forget it. But we are all getting older here in Florida. As we said, we have the oldest population.

In the VA I have heard a rumor, Mr. Randall told me, some of them are trying to get rid of this geriatric program that the VA has. I am looking forward to that geriatric program here very quickly, and I definitely don't want to see it go away. So anything you all can do on the geriatric education and research, I would be most personally interested in.

Thank you very much.

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

Mr. STEARNS. Thank you, Mr. Linden.

I am going in the order we have on the panel, that the staff has given me. Bill Kirsop is next. Bill, welcome.

STATEMENT OF BILL KIRSOP

Mr. KIRSOP. Thank you. I am glad to be here, and thank you very much for giving me the opportunity to testify.

I will briefly summarize the Department of Florida's VFW position on the Veterans Equitable Resource Allocation Plan, and please take note that I said the Department of Florida VFW. This might not be the feelings of my national organization.

Public law 104–262, the Veterans Health Care Eligibility Reform Reference Act of 1996, we understood would simplify rules for providing health care for veterans. All veterans should receive equal access to VA care, whether they live in Florida or one of our northern States. Many veterans move to Florida in their senior years. At their previous home, they received VA health care. In Florida, they do not receive the same care. Quality of care is the same, maybe even better. Access to care is limited. Why? Resources.

The Veterans Equitable Resource Allocation Plan, we hope, corrects this situation. The reallocation of funding is long overdue. On behalf of the 81,000 members of the VFW in Florida, we tip our hats and thank you.

We have concerns that VA, Congress and the administration needs to address. Will the demand of our ever-increasing veterans population exceed the supply of funding and health care? Statistics point out that Florida, within 3 years, will have more veterans over page 65 than any other VISN. We will never concur with the elimination or downsizing of any facility in Florida. We do not object to elimination or duplication of management as long as it does not affect availability to Florida health care.

I said previously that VERA equitable resource allocation is long overdue. I would like to relate a story to you when I was State service officer for the VFW a few years ago. A veteran aged 62 came into my office. He filed for nonservice-connected pension. While I was filling out the forms, I noted that he had a problem reading what I was trying to point out to him. He told me that he had problems with cataracts and was unable to get cataract surgery.

In our discussion, NSC pension you might know, I have to discuss the veterans income. I found out he was retired from Eastern Airlines. His retirement was $170 per month. I asked him if he retired from Eastern Airlines, is he able to fly for free? He says, yes. I say are you able or do you have any family up North? And he said, yes, I have a daughter in Boston.

I picked up the telephone at my desk. I picked up the phone and called my counterpart at the Boston VA facilities. In 2 weeks, that gentleman had his cataract surgery he could not get in Tampa or St. Petersburg.

I will never forget that story, and I was very proud, me, as a veterans service officer, was able to help that veteran. But I often wondered why did I have to send him to Boston? Maybe with VERA Florida veterans can get their treatment in Florida.

One last thing I would like to point out, and the Congress lady brought this up, and this is the position of our national organization, and that has to do, VERA is a good start. There are other ways to increase funds in our VA facilities. Let the facilities keep the funds collected from private insurance. Let the VA bill medicare. I understand that is a very political issue, but I am saying to you at least give it a trial basis to bill medicare. By doing it on a trial basis, I think you will find out, social security and medicare will agree, that the VA can treat this group of veterans, save medicare money, and bring more funds into the VA system.

One last thing before I am finished. I would be remiss if I did not compliment and thank and applaud VISN 8 for ensuring all veterans' organizations have input to change. For the last year and a half, I have been able to serve on the new business development team under the direction of Director Rich Isaac. I have been educated and hope I have been able to give input. It just shows you how VISN 8 and the veterans' organizations work together so we can provide you what you need to know to obtain additional funds from Washington.

Thank you very much.

[The prepared statement of Mr. Kirsop, with attachment, appears on p. 75.]

Mr. STEARNS. Thank you, Bill.

Mr. Shannon, Adjutant of the American Legion.

STATEMENT OF THOMAS COREY

Mr. COREY. Good morning, Congressman Stearns, Congresswoman Thurman. It is good seeing you again. I appreciate the opportunity to be here. I am not going to be repetitive on things that we have gone through this morning, and I am glad to see that all of the veterans' organizations are here together on an issue that is important to all of us in Florida and has been for a number of years.

[Inserted for the record:]

Today I am representing the Florida Chapters of Paralyzed Veterans of America. We are very concerned about the implementation of VERA. The delay in implementing VERA continues the lack of resources needed to serve our veterans.

There are going to be other changes in the system that affect all veterans and medical centers and everyone is not going to be happy. There is no question that a veteran in the North who needs care is no more deserving than one in the South. But, it is fair to send the funding where the veteran is receiving his care. We hope that this works out in a manner that becomes satisfactory to all veterans and medical centers involved.

We have discussed the concern for years about shifting some funding to follow those veterans that take up their winter residency or relocate to Florida. The VA Medical Centers in the North continue to receive the same funding whether the veterans are away for the season, the funding doesn't follow the veteran. The burden is placed on the Medical Centers that these veterans use in the winter months.

We respectfully request that this allocation of resources be fair and serve all veterans without further unnecessary delays.

Today I am representing the chapters in Florida of the Paralyzed Veterans of America. We all have the same concern that has been addressed this morning about the implementation of VERA and hope that there is not going to be any more delays. In my dealings with some people in the last several weeks on several trips I have made to Washington and talking with veterans from the Northeast and the Northwest, the parts of the country have a concern about what we are trying to do. And I asked them if they could justify to me why we shouldn't take some of the funding from up North? They could not come up with any arguments other than it would affect their veterans and facilities. They tried to skate around the issue which is understandable under any circumstances.

I am sure that your colleagues are going to try to defend their veterans up in that area and keep all the funding there. But there was no good answers out of any of them I talked with other than find the funding somewhere else.

They come down here during the winter, use our facilities. We try to get in the facilities during the winter. We have to wait to get in, wait to be seen. Our appointments are extended out a month or more. The last appointment I had 3 weeks ago, I was waiting in a room with four other people in the room that were down from New York. And this happens a lot. We need to work something out that is fair.

I have had the opportunity and privilege to work with Tom Doherty at the Miami VA for a number of years and also with him Rich Isaacs since the first day he arrived in West Palm Beach and watched the West Palm Beach VA facility grow to what it is today. And I am proud of both those facilities and the changes we are making.

With us moving forward with VERA, we can go further and do what we need to do treating the veterans in Florida, treat them

STATEMENT OF DYKE SHANNON

Mr. SHANNON. Mr. Chairman, Congresswoman Thurman, certainly on behalf of the Florida American Legion, we welcome this opportunity to speak to you today. We represent 122,000 of the stakeholders in this VA medical system here in Florida. As with my colleagues here, what I am going to say is certainly representative of the Florida American Legion and may not necessarily reflect the national organization's full perspective of this whole issue.

We are certainly hopeful that the implementation of VERA will correct the historical imbalance of the VA medical funding in Florida. VERA should greatly assist our regional VISN Director with the means to administer and improve veterans' health care packages, to include improved access, quality of care and the wider spectrum of services.

I think it has probably been said that Florida has more veterans 65 years of age and older who have service-connected disabilities, more than any other State. Many of these veterans have migrated from the Northeast and the Midwest to establish residence here because of the attractive climate, southern hospitality, and the perceived access to veterans health care.

Florida does rank 41st in the Nation with VA hospital beds available, with only 1.3 beds per 1,000 veterans. This constant influx of veterans to Florida and other sun belt States coupled with a below average per capita funding has provided for VA health care services which we rank 42nd as a continual significant shortfall in many types of veteran health care services within VISN 8.

The American Legion national headquarters is generally supportive of VERA. Notwithstanding the fact that for some regions to improve their capability to provide improved veterans health care, such as we have here in Florida, other regions will realize a corresponding reduction. The American Legion has formed a Management Resources Committee to assess the VERA concept on an ongoing basis and to monitor it for its 3-year implementation.

Certainly the American Legion's position is the bottom line is that an eligible veteran should never be denied veterans health care regardless of where he or she resides.

We must all realize that health care in America is going through a renaissance period, not only in the private sector but the public sector, and the VA medical center system as a whole. We would offer a notion to you that in the next 3 years, probably the VA medical system will be completely reorganized and will serve a more diverse client base. I think we have got to be progressive in our VISN of the future in this.

We can't look back and say this is what this looks like, we are going to reshape that. We need to reshape a whole new system to serve the needs of veterans. We certainly are in favor of VERA and the VISN concept, and we feel it is only the beginning of a new and improved health care delivery service.

The key to success in a commercial business, one of the paramount elements is that of location, location, location. It has already been said today that we feel that the key to success of the VA health care system will be accessibility, accessibility, accessibility. It is our hope that the shift of funds will give VISN the opportunities to fulfill the desired access for veterans. Veterans health care

is a Federal issue; it is not a State or regional problem. Congress must take a holistic approach to the care for those who have defended our freedom.

We realize that a reduction in funding for any government agency has political ramifications. Congress must focus on what is best for the veterans and not what is best for politicians' careers.

You know, we appreciate the opportunity for the two of you to be here today. I feel a little bit like we are preaching to the choir because you certainly have been very supportive on veterans' issues across the board. It is quite ironic, a little over a week ago, I had to face a battle similar to what you all face on a regular basis.

At a meeting in Washington D.C. of the American Legion, we had a meeting on VERA, and New York and Ohio and Pennsylvania all voiced their opinion in very emotional terms. I finally had to stand and basically I opened by saying I want to file a minority report here, because this is the best thing that has ever happened to us.

So I share with the battle that you have with your colleagues, and I think it is incumbent upon all of us seated at this table to work with our fellow members to make them realize that in a sense it is their, when I say "their," I am using the term of Midwest, Northeastern United States. It is their veterans we are serving down here, and those funding streams should follow.

One of the areas the American Legion will watch carefully is that of a reduction in any one VISN. We will have to have a corresponding increase in another VISN equal to the reduction. There must be a check and balance system to ensure that these funds are for direct delivery of health care and do not disappear in special projects initiated by the Central Office of the Department of Veterans Affairs.

In conclusion, the veterans of Florida will be much better served with the implementation of VERA. We wholeheartedly support this initiative and sincerely hope it will not become a political football in the next few years.

We commend Senator Graham, Senator McCain, and I want to correct the official transcript. I had a typo in there, for this realistic approach to our veterans health care. We thank the Florida Congressional Delegation for their support. Certainly, VERA is right and fair for all veterans and it is certainly right for this country.

Thank you.

[The prepared statement of Mr. Shannon, with attachment, appears on p. 80.]

Mr. STEARNS. Thank you, Mr. Shannon.

Mr. Donald Priem, President, County Veterans Service Officers. Welcome.

STATEMENT OF DONALD PRIEM

Mr. PRIEM. Thank you, Congressman Stearns, Congresswoman Thurman. I appreciate the opportunity to represent the County Veterans Service Officers Association, State of Florida, and the 30,000 veterans of lake county. I will enter my statement into the record.

properly, get them in and out in a timely manner, which has been the goal of Rich Isaac and other directors.

I have had the opportunity also to work with Bob Roswell on the VISN and to see the direction we are going in, and I am pleased with everything that we are trying to do. I have had the opportunity to meet with Jessie Brown. From the first meeting he called when he was nominated to the position and the first thing we talked about is changing business, changing the way the VA does business. That is what brings us here today. There is going to be a lot of changes and we are going to have to work closely, not only on this issue, but on all issues, to ensure that the veterans receive what they deserve.

I want to applaud those people I have talked about and the other people working in that area in that effort towards quality care for all of our veterans. I thank you for what you have done, and Congressman Stearns, I want to talk with you again about a bill that you introduced and I talked with you last year about it, but we will do some follow-up on that later.

Again, thank you for this opportunity to be here, and I would be willing to answer any questions you have here. Thank you.

Chairman STEARNS. Thomas, thank you. Let me reiterate to the audience and to the panelists that VERA went into effect on April 1. Now, all of us, as pointed out by you gentleman, have the highest hopes for VERA, but I would be less than honest to point out that the funding provided from the initial funding from the administration has been flat over a period of 5 years, and the assumption is that the veteran population is declining. Of course, that doesn't apply to the State of Florida. So Representative Thurman and I and Corrine Brown, and in fact, I think Corrine Brown has a representative here.

Why don't you please stand up and just give me your name?

Mr. MCDANIELS. My name is Tom McDaniels.

Mr. STEARNS. Tom, thank you for coming. So both Corrine Brown and I are on the Veterans' Affairs Committee, and we and others just believe that VERA is starting, but we must be persevering here. Because as Dr. Roswell and others have pointed out, something happens between the cup and the lip. So you have mentioned that you are speaking to the choir. I am sort of the choir master here. We have, through my committee, a lot of things that we can do, establishing eligibility reform, looking at that. It was an order, Public Law 104–262. We have to monitor that to make sure it is implemented and the reform effort is working.

But I want to ask each of you candidly as we move through here for this question and answer period, lots of times when I have my town meetings, I am sure Representative Thurman does too, we hear different voicing of complaints. One thing I hear about, and I mentioned to Dr. Roswell, is this idea of hospital beds and the caring in nursing homes. Now, the Veterans' Administration is talking about farming out emergency care units.

Let me just ask each of you, what are your concerns dealing with hospital construction, nursing homes, and then the important area of taking care of our veterans? Do you see an area where you think we should do something we are not now doing?

I am going to summarize. I am not going to repeat all the demographics that you have already heard on a lot of those issues. I will be very brief.

I would point out two things however: I just received from the Central Office the new veteran population information for 1996, and we have now graduated in the State of Florida to the second highest wartime veteran population in the United States. I would also point out that the veteran population statistical data we have received from VA does not truly represent the veterans population we have residing in the State of Florida. I have written you correspondence on this, Congressman Stearns, the military retirees are not part of that statistical data.

We have 162,000 military retirees in the State of Florida for the 1996 statistics from the Department of Defense. That equation is not part of what the census data gives us. One out of every six individuals that received the census in 1990 had veterans questions on the census. We have talked about that and we hope that there is an expansion of the census document to reflect more questions on all of the census forms so we have better population statistical data in the future.

I will share with you an experience as a county service officer which we have all had here in the 67 counties in Florida. I have had several veterans who came to me with a letter from up North, Northwest. This letter was a solicitation, and it said, "Dear Veteran: You haven't been into our facility for 2 to 3 years. We would like for you to give us a call and we will schedule you for an appointment for a full examination."

I would share with you and I am sure you understand the veterans in the State of Florida who reside here have never had such access. So the veterans come to us and say, well, I don't understand why we can't get the same kind of care here that we get up North. We have to again say, well, maybe that had better go back home, because we can't help them.

As far as the VERA, we support that completely. I would share with you a proposal that the County Service Officers Association and the county service officers throughout the State proposed to Jessie Brown here a while back, several years ago, and he thought it was feasible. We have talk about still having a shortfall in medical care dollars, even under this new concept of reallocating funds. We proposed to Jesse Brown that the medical treatment card that each patient has have a scanning bar, and that an individual who comes from New York or wherever, and he comes into our area for 6 months and gets treated in our facility, Gainesville VA Medical Center, Tampa VA, Bay Pines, the dollars should be transferred to that hospital fund to aid in caring for and cover costs for that treatment, rather than coming out of our hide.

With that, I would again thank you for allowing me to speak at this hearing.

[The prepared statement of Mr. Priem appears on p. 88.]

Mr. STEARNS. Donald, thank you very much. I appreciate your comments.

We also have Thomas Corey of the Paralyzed Veterans of America. Thomas, let me welcome you. We welcome your opening statement.

Why don't I just start with you, Tom, and go from my left to my right? I want to say one other point. Mr. Stump, who is Chairman of the Veterans' Committee, is from Arizona. I am, of course, from Florida, and I am on one of the committees.

Mr. Terry Everett, on the Oversight Committee, is from Alabama, and Mr. Quinn is from New York. So I think for the first time we have in Congress at least on the Veterans' Affairs Committee, a perspective of the need of the sun belt. So I say that with a little bit of confidence and a little bit of enthusiasm that we can make sure that the sun belt States, the area where the veterans are going, will get the needed services. But, of course, we are going to need to hear from you folks at the grassroots level, as well as Mr. Rainwater and others, how we can start to react if this plan is not implemented.

So, at this point, Tom, why don't you just give me your perspective?

Mr. COREY. As far as nursing home beds, there is no question, and I think Carlos Rainwater answered that as well as did others. If we open nursing homes, wherever we open them, we are going to fill them up as quickly as we open them with the dollars available.

As far as new construction, I have a concern about that and where we are doing it, to make sure that that new construction is going to be useful 10 years from now. We have talked about contracting out, sharing services, and I think that is probably an approach we are going to have to do. I don't see any way around that, and I think it can really come out ahead in that area.

I think monitoring that and looking at that rather than new buildings is a way to go. But there are some areas that we could, like the Orlando area and some of the clinics, that are going to be needed where there is a population of veterans moving into those areas that we could justify putting up clinics in that area.

Hospital beds and the closure of hospital beds, and I have seen it in Miami and West Palm Beach, and so far it is working out well with us going towards outpatient care and being more able to do that.

But, again, I think the sharing and reaching out into the communities, jobbing these out with other facilities, hospitals, to take care of veterans in those areas where they have to drive more than 2 hours to go to a VA facility for an appointment, it is going to be more cost-effective for the VA in the long run if they have to pay for the transportation and other costs involved. And for the veteran, we are going to make the veteran happier in most instances. If it is specialized care, that is another area we can work things towards the best interest of the veteran.

But I think most of us that are in that mode with spinal cord injury know that we are either going to wind up in a spinal cord injury center because of the regulations, or we are going to go to a facility and they are going to transfer us to the closest facility with a spinal cord unit.

That is my perspective at this point.

Mr. STEARNS. Mr. Kirshop.

Mr. KIRSOP. As far as construction in the State of Florida, I would not address where to put a hospital. As an individual I be-

lieve it would be hard to justify new hospitals as long as we have 500 beds closed. Outpatient treatment needs to be expanded. That is the way to go. There are more people that can stay out of the hospital by treating on an outpatient basis.

By expanding outpatient, we might be able to save costly hospitalizations. I have often said one of the rulings that always bothered me was the fact the VA might not be able to give this person medication because the rule says he doesn't qualify to receive, being provided medication. But the next page guideline says we can hospitalize them. I have a hard problem with the fact that we can't give them the pills, but if we gave them the pills we wouldn't need to put them in the hospital.

So by expanding outpatient, and if more beds are needed in the State of Florida, there are beds available if the beds closed are opened again. But the main thing that needs to be done, these facilities, the recently closed beds and so forth, they not only don't have the patients, but they don't have the resources to hire the staff they need. I think that needs to be looked at very strongly.

That is really all I have to say on it.

Mr. STEARNS. Thank you. Mr. Shannon.

Mr. SHANNON. Mr. Chairman, I think often we feel like there is a smoke screen to some degree when we talk about that veterans are being turned away and then we find out there are beds closed and facilities. And I don't mean that in any negative connotation to anyone, and it is an allocation of the location of the beds as such. But maybe we as veterans have to come to the reality that we may need to travel a reasonable distance to be serviced.

I think that those beds that are closed, we have got to be creative in ways to use those. Obviously, there needs to be funding to follow. If they are closed and there is no funding, they are closed. But there needs to be funding streams to allow us to be creative, whether those wings be converted to adult day care or possibly acute long-term care facilities for people on possibly ventilators that there is no real hope for them. There has got to be creative use.

I would say, however, the organization I represent is very opposed to vouchering systems, unless it is very special cases or sharing agreements. But as a blanket statement for vouchering, something that we must keep in mind is the VA medical care system not only serves those who have served this country, but it is also a back-up to the Department of Defense, and it is a matter of national security, in our opinion, that these facilities must stay open.

I don't know that, God forbid, we will ever have a conventional war where we have real high casualty rates, but there is no other national health care system to provide for those wounded that are being processed through DOD and then ultimately have to go through because more wounded are being brought in.

So I think it is a matter of national security that the Veterans' Administration be in place and it be healthy, be given the opportunity to be creative and continue to deliver the first class health care that these professionals do each and every day.

Mr. STEARNS. Thank you. Mr. Linden.

Mr. LINDEN. Yes, one of my, I guess, personal pet peeves is that VA nursing, in nursing care, the actual care that you receive is

fine. The problem is that it is expensive to the VA. I have been told, I don't know the facts, but that a person in a VA nursing home costs twice as much as putting them in the private sector and doing it. But whether it is twice as much or not, if it costs maybe a penny or two more, I think it is worth having the veteran treated with the kind of care that he gets in a VA nursing home.

I think one of the reasons that they are closing a lot of these nursing home beds is they have this crazy rule that says that they have to be rehabilitatable to be in a nursing home.

Well, it is a little hard with someone dying with cancer or something like that to be rehabilitated. They stretch it in a lot of cases. But I think that is an area that either through the State veterans nursing homes that we have going here or the VA beds that they have now that they are closing and using for other things, is an area that I think that more money, again, it may take a few more dollars, but that would be money well spent on the veteran.

More community-based outpatients. For example, in Marion County, I think it would be a good spot to have a potential community out-based clinic, because there are more than 4,000 veterans right there in the Ocala area that now have to come to Gainesville.

But as far as making sure that there is more bricks and mortars or hospital beds, I noted that Arnie Palmer, when he had his cancer, went to Rochester. He did not go to Orlando where he lives for the operation. So I think that excellence of care is an overriding criteria to having it nice and close to home.

Now, I think with the nursing and with the community primary care, that is essential to be close to home. But I think if the concentration could be on excellence of care and specialties in some of the places, then that it is where they would go.

I think education, I agree with what Dyke has said, we have got to educate our Members as well. Just because they close that bed doesn't mean that a veteran is being denied care. Because with the modern medicine and the things you do, the hospital is the last place you want to go and stay for a long time, because that is where you can get all kinds of diseases. No matter how good they are, you still can be affected. So you want to get in and get out in a hurry.

So I see that the day surgery and things of that nature that they are doing is a positive thing, and I think that is an education process that we collectively here need to do with our membership, so that when they do close the bed, that doesn't mean they get less service.

But on the other hand, the VA needs to come along and have more timely appointments and things of that nature to counteract that, so that we can say, well, look, you know, it used to take you 6 months to get a pair of glasses. Now it only takes you 2 weeks or whatever. So working together with the VA, I think we can do this without building a whole lot more bricks and mortars.

I would, again, commend Dr. Roswell and his staff. I think we are very fortunate to have him as the VISN director and the directors we have here in Florida. Even if they are getting a little old, they still do an outstanding job.

Mr. STEARNS. Thank you, Mr. Linden. Mr. Priem.

Mr. PRIEM. In numbers of nursing homes, I think we have been a long time due a nursing home that will take care of dementia Alzheimer patients. That is coming to fruition now. We have been needing that for some time. I am kind of like the rest of the gentlemen here. I don't know that we need more bricks and mortar. We are going to a concept of outpatient-type care.

I wouldn't want to see us lose those beds, even though they are not currently being utilized. As we say, we go into a war situation, again, we are going to need them for our veterans coming back.

Mr. STEARNS. Thank you. Mrs. Thurman.

Mrs. THURMAN. Just a couple of statements. Because several of you have mentioned rules and regulations that you believe are antiquated, that actually cause veterans to not get the care or raise the cost of care to veterans, has there been or do you know of any studies that have taken place that actually review those rules and regulations that we might get ahold of to submit to VA, or have you done that? Or would you like to take that task on?

If not now, it certainly sounds to me as you have worked through some of these issues in the capacities all of you have worked with and then as the heads now, there are some areas that might be beneficial for us to look at that we could submit to the Veterans Administration to let them know these are some things, problems.

Dr. Roswell has his hand up, so maybe he can tell us there is wonderful news on top of this.

Mr. STEARNS. Dr. Roswell, why don't you come up to the front and take one of the microphones.

Dr. ROSWELL. Actually, the eligibility reform legislation that was passed in the last session markedly streamlines access to care and gets rid of an antiquated, Byzantine, arcane set of rules that has been alluded to here. We haven't fully implemented it yet, but the dilemma is, the new rule says any veteran accepted for care may have access to any and all services provided by the VA.

Our dilemma is having sufficient resources to accept veterans and having sufficient resources to make those changes.

Mrs. THURMAN. I understand that. But Mr. Kirsop actually mentioned an issue with the idea you couldn't give them medicine but you could put them in the hospital and give them their medicine. That is pretty significant in my mind. I am looking for those kinds of things.

Al mentioned one that is so archaic, or Mr. Shannon, or somebody, situations out there that actually use our health care dollars at a much larger cost than if we were doing some other areas. I mean, I think that is important.

Dr. ROSWELL. You are absolutely correct. We used to have to hospitalize patients before we could obtain entitlement to place them in a nursing home. We used to have to hospitalize patients before we could give them a crutch because they sprained their ankle.

Mrs. THURMAN. Right. Exactly.

Dr. ROSWELL. We used to have to hospitalize patients to do their cataract surgery so we could give them corrective lenses. All of that has changed with the new eligibility reform legislation that was enacted last October. And while we haven't seen the full implementation of that, we expect that many of these really ridiculous sort of rules will be pushed by the wayside with the new eligibility reform.

Mr. STEARNS. When can we expect completion of implementation?

Dr. ROSWELL. Well, the full implementation of eligibility reform is expected for October of 1998. It is being tested October of this year. Already we are making available services to current users.

Part of the problem, unfortunately, is that phrase about who is accepted for care and what services will be provided. The VERA implementation is a critical element of obtaining necessary resources to accept veterans and make available the full spectrum of care.

Mrs. THURMAN. I thank you for that. Al.

Mr. LINDEN. One of the things deals with like prosthetic devices as well. Now that you have accepted a person into the system, before, unless that was service connected, they couldn't get that prosthetic device. Now if they are going to provide all of the drugs, and once they accept them in the system, being that we have an older and more severely disabled population here in Florida, I don't think VERA takes that into account. I think that is something that should be considered.

Mrs. THURMAN. Let me say something here too that I thought was a very interesting comment. I was with Senator Graham yesterday in Citrus County, and there was a veteran there who was very excited about the same issue, and made the comment and thanked Senator Graham and others in the delegation. But he told us a story, and he said, which is why I made the comment in the beginning about the veterans within the State of Florida really were the people that rallied around us to talk to their former Congress people and making sure that they understand what was happening in Florida.

What Senator Graham told me, and I didn't realize this at the time, was that there was a very critical vote that was dependent on one Senator, and that Senator happened to have been from Ohio. Because he had heard from his former constituents in Florida about what was happening to them and not being able to meet their needs, that he was able to vote with a good conscience to help us get these additional dollars.

So what I would say to all of you is, first of all, thank you for the fight that you have taken to your national organization and splitting with them somewhat over this issue. I think it has been a fight that has been well fought, and obviously Florida veterans should be thankful for that fight and for what you have done.

But I also would suggest, as you have suggested to us, don't lay our swords down, there is still a battle to be fought in Washington, and we need constantly to be aware and watchful of what kinds of things might show up in an appropriations bill without somebody looking. Although in that I would say also, we are very fortunate that we have the Chairman of the Veterans Health Care Committee living in the State of Florida, living in Central Florida, because he has got some staff and himself who will have a very watchful eye on that, and we are appreciative he has taken that chairmanship, because it is extremely important.

But I would never forget where you came from, and I would certainly reiterate that you continue that fight with those Congress people who used to serve you. I think it does make a difference

that they understand what we face here in Florida, and collectively that works.

So I really appreciate everything that you all have done. I hope that the national organization will come around. You certainly have been there to support them over the years on issues that may have not been beneficial to you. But, you know, this is about veterans in this country who served their country, and were willing to give their lives, and many did, and their families.

So I really honestly believe that it is their time to support us and where the veterans live. So I applaud you for what you do.

Mr. STEARNS. I thank my colleague.

I just want to conclude and ask you to explore a little bit something that I have had on my mind. I understand, Mr. Shannon, how you feel about vouchers, and I agree, because vouchers in a sense would probably bring the veterans' system as we know it to a close, because people would not be going to the veterans' hospital, so we need to retain whole series of hospitals and care, not knowing of course what the future is. We have to have the veterans so they have the protection and preservation of their services.

But I want to go off of what Mr. Priem had mentioned dealing with a card in which a gentleman who is from New York who comes into the Gainesville Hospital, and he has this card, and the Gainesville Hospital can indeed bill the hospital in New York.

I understand there are four or five hospitals in Boston alone. And the people from Massachusetts and the people from Boston that come into Central Florida and live in Ocala and Leesburg and Pinellas and Gainesville, and they come to the Gainesville Hospital, what do you think, individually, if you could as we go through the table, of the idea of setting up a mechanism so that this hospital could, indeed, bill the hospital in Boston and in New York City and the Midwest where the population is decreasing, and yet these people are sending out letters begging for veterans to come forward for a physical? Visit your hospital, and they are doing that kind of direct mail, whereas here in Florida we are starving for our resources?

Mr. Priem, if you might just echo a little bit how you feel about this concept of setting up, which, you know, me and the staff have talked about briefly, of some kind of way to allow hospitals, where even if VERA is working, there is going to be a point where, as Dr. Roswell pointed out, they don't have the money for activation.

Mr. PRIEM. I am not sure how you would work the mechanics of it, but, again, as I say, we have discussed this with Jesse Brown. We believe that the dollars are still going to fall short for the medical care that is required in the State of Florida. And to be able to take that card, which, by the way, they are issuing new hospital cards now that are now scannable, and for VA-Gainesville to treat that gentleman from New York or New Hampshire or wherever, and get that money directly sent back into his coffer for that medical care, we think is not an unreasonable position to take. Our reallocation of funds and all has all been supported by our national association, as well as this concept that I have mentioned here.

Mr. STEARNS. Mr. Linden.

Mr. LINDEN. Yes, I would support that idea with the proviso that if a person is a permanent resident of Florida, that they don't have

to do that. In other words, if that is your home address and you are not a snowbird or a person that comes down for 6 or 8 months, I would support that idea. Because I think that sooner or later, we are going to have to have in the northern part of the country something like the military base closings that we have had.

While you gave me the microphone for a second, I belong to the Retired Officers Association, and one of the things, and this is particularly true in Orlando where they have closed out the military, there is an area where I think somehow we need to get the military, retired military people, who are getting towards 65, and maybe that is your test that you want to do for medicare or something of that nature, because, as you stated earlier, you are thinking about medicare subvention. But I think there is a whole population out there that is now going to swing to the VA also that is here in Florida, that are those military people when the military bases have been closed.

So I think maybe you need a card for them also, or at least to think about those people, because they are going to be coming here, especially those that are approaching 65 and have to use medicare. They have been getting basically free medical care and now are going to have to pay Medicare Part A, or whatever it is. So I think there is a whole area there that we need to look at.

But, yes, in general, I think it is a fair program. Again, fairness, that is how you have to sell it, it is a fair, necessary program, and I think it is fair.

Mr. STEARNS. Mr. Shannon.

Mr. SHANNON. Mr. Chairman, I think on first brush that appears to be a possible idea, but I really think in having the opportunity to be third to speak, it gave me a chance to think about it a little bit.

I think if I understand what is being proposed, the concept, and if VERA would end up continuing, would we not be doing a double entry bookkeeping system where we are taking and taking? So I think it would have to be one or the other. That might be a fallback position, because I really believe your colleagues up north haven't seen anything yet on cuts. If they become aggressive and attack the VERA concept, something like this, we probably need to have some alternatives, and this might be an alternative to that.

I think it also would be very hard to plan how to keep a hospital open on anticipated dollars rather than prebudgeted dollars. I may not fully understand this concept, but these folks have got millions of dollars that they have to plan, so they see a budget figure, a base budget figure, and if there is going to be money shifted once that budget starts functioning, that is beyond their control and cannot necessarily be anticipated, there could be serious problems at both ends.

So I think the concept sounds workable, but I am not real clear on all the details of it.

Mr. STEARNS. Okay, good point. Mr. Kirsop.

Mr. KIRSOP. Thank you, Mr. Shannon, for stealing everything I was going to say.

Mr. SHANNON. I looked at your notes.

Mr. KIRSOP. I have to agree with Mr. Shannon. I really felt that VERA was the concept basically about the same thing as putting more money down where the veterans are.

The problem I see with the system enactment is the cost of enacting the system, plus the fact that how would those hospitals in the north, and this time I will speak up for them, be able to manage their resources when they never know day-to-day how much is going to be taken out of them?

So I would say the idea of VERA I would think would make that system not needed. That is my personal opinion.

Mr. STEARNS. Okay.

Mr. KIRSOP. One last thing, when I said that I was speaking, and I am not sure how the VFW supports the department of Florida's VFW's view. I was just able to read how the VFW does feel. They are taking a hands-off approach, and as long as they are doing that, we are okay.

Mr. STEARNS. You lucked out there. Mr. Corey.

Mr. COREY. I think we ought to look at it. I hear what Dyke and the others have said, but I think there still might be some merit to it, to track these things.

We also have to look at it the other way too, that Florida residents who go north for the summer, that have summer homes up there, would they bill us for when they are up there using VA facilities up there? I am sure we are going to be ready for that and that is only fair.

But I think we really should look at what you are talking about, look at possibly billing beyond the VERA. If it becomes a problem maybe we could use that as a tool to further argue for more funding if we are not going to receive what we are looking for now. But to justify the number of veterans that are moving here and the funding we are going to need to take care of them all, we are going to need to look at other ways. But I wouldn't throw it out. It is still something I think we could look at.

Mr. STEARNS. Well, I thank you gentleman.

You know, it is just a thought, and obviously a person who would come to the veterans' hospitals in Florida might have a limit of $2,000 or it might be severe types of health care which would go up to the $35,000 limit, so, you know, how that would work, you don't know. But, remember, all these hospitals are being allocated in their budget funds, and they are not using them, so that is why they are sending out these letters.

So I am trying to realize the facts are that we have a veterans' budget that sort of is topped off with a ceiling. We have a gradual process here for the next 1 to 3 years, and at the same time we have Members fighting this allocation formula under VERA. So I see lots of things that are sort of moving this very slowly. At the same time, I see these 321,000 veterans coming in and I say we have got to do something here.

So, let me just tell all of you that you should all know if you have any additional comments or your opening statements in total you would like to submit for the record, you are allowed to do that. In fact, the record will remain open for a period of 5 days for those statements. So if you have any additional comments you would like to make, we would like to have them.

If you folks do not have anything more, we were going to open up the floor for any veterans that are here that would like to come forward. We did want to allocate a little bit of time. So let me thank all of you gentlemen very much for coming, and I appreciate sincerely your comments.

If anybody who is a veteran would like to come forward to speak, feel free to do so. We would just ask that you identify yourself.

Before I go to you, I would like to ask Mr. Roswell about this idea that I have about having, if you don't mind coming up just to answer this just briefly, the workability of having a veteran who comes from New York or from Massachusetts and Boston, if he came into this hospital or any other, Bay Pines, or any other hospital, could he or she, because as I understand it, you have a card now, and you might tell us a little bit about this card and what this information is on this card, and the feasibility of using this card as a first step of trying to move this allocation more in a de facto fashion.

Dr. ROSWELL. There is a project to give veterans a card which would contain not only demographic information and administrative data, but also possibly some even limited clinical information, such as most recent medications, for example, which would be quite helpful.

The concept of transferring dollars between VISNs is one that has already been addressed in depth, and actually was included in the VERA model this year. When patients are treated in more than one VISN, the dollars I spoke of that went into that $2,600 or $36,000 for special care and basic care patients actually were treated as prorated patients.

Now, that is a terminology that basically means that if a veteran had 40 percent of his care in New York and 60 percent of his care in Florida, then the $2,600 for that veteran's care would be split 60–40 between Florida and New York. It is still an imperfect system, so a policy working group is currently working across what is called "Care Across Networks" to develop a transfer pricing methodology. I doubt, however, that their recommendation at this point is leaning toward a dynamic transfer of pricing that would move dollars throughout the year.

I personally tend to agree with our veterans' service organization witnesses who said that that would be awkward because you wouldn't really know how many dollars you have, whether they are coming or going. Rather, I believe in the future years the VERA will evolve the methodology that looks back historically and says, yes, Florida veterans got so much care out of the VISN, but by the same token, veterans from other VISNs received X amount of care within the VISN. And it is this "Care Across Networks" methodology that will ultimately address that.

Mr. STEARNS. So right now it is just a bookkeeping method, but no actually garnering of the dollars.

Dr. ROSWELL. It is a dynamic process. I will have to tell you that I have just reviewed data within the last 24 hours from the policy working group looking at this, and to my utter amazement, the planning scenarios actually show Florida as a net loser under such a system. So I really have to look into that. But what it implies

is that Florida veterans are getting more care out of State than out-of-State veterans are getting care within Florida.

The only explanation I can have for that is what we have heard this morning, that veterans in Florida are actually leaving the State because they have a better likelihood of accessing care out of State. So ironically, this transfer pricing at this moment could penalize Florida as much as $10 million.

That tells me we have to fully implement VERA, get the dollars where they belong, so we can expand access and scope of services before we begin a more aggressive approach at transfer pricing.

Mr. STEARNS. Boy, that is startling to hear that. Okay. Well, I thank you for your comments.

Good morning. It is still morning. If you will just state your name, and we welcome any opening statement you might have.

STATEMENT OF WILLIAM H. COHEN

Mr. COHEN. William H. Cohen, and I just want to report the excellent care I have received at this hospital, non-service-connected. I don't understand the people who couldn't get heart care. I have gotten medication for high blood pressure and they followed it up.

Anyway, I had a hernia operation here 8 years ago. If I had been told about that by somebody else, I wouldn't have believed it, you know, it was so good. The anesthetist visited me before the operation and afterwards, and two doctors, and I was here for 4 days. The food was wonderful. It was just perfect.

Recently, I have had three serious health problems, and they took care of all three. I had a CAT scan this morning, which I couldn't have afforded otherwise.

So this doesn't mean to knock the other hospitals in Florida. It probably reflects well on at least the local systems.

Mr. STEARNS. Mr. Cohen, thank you. It is always good to hear good news, and we appreciate it. Are you service connected?

Mr. COHEN. No, it is not service connected. That is another thing that surprised me about the good care. Everybody was so personally interested.

By the way, the new geriatric department was just opened. There is a lovely doctor there, a woman, Dr. Hoffman; I will put in a word for her, too. She is a sweetheart.

Mr. STEARNS. Thank you.

Is there anyone else who would like to come forward? Yes, sir? Good morning. Sit right down and just state your name.

STATEMENT OF JOHN HUGHES

Mr. HUGHES. Good morning. My name is John Hughes.

Mr. STEARNS. Good morning, Mr. Hughes.

Mr. HUGHES. I am a service-connected disabled president, and I am president of AFG, Local 2779.

There are two things I am concerned with. One is the contracting out to other hospitals. I agree with Mr. Linden; I think the veterans have to give up something. They have to realize to get the services that the VA offers, quality services, they have to go somewhere else. They may have to travel a little longer.

I think the contracting out, a lot of the places are going to HMOs and stuff, and their major concern is, bottom line, making a profit.

The service is not going to be afforded to the veteran if that is the major concern: How much money can we make? They may even not take the contracts wherever it is needed.

My second concern is the time, the 3 years of VERA phasing in. In essence, I understand what Dr. Roswell is saying, robbing Peter to pay Paul? Well, guess who Peter is? It is the employees, the hospitals themselves who are trying to do the work, who are trying to do the job at a limited resource.

So if something can be done to expedite it, to move it quicker, a 3-year period is a long time.

Mr. STEARNS. Yes. Or to increase the amount of money that is coming in. There is presently a shortfall.

Mrs. THURMAN. That $35 million that we talked about.

Mr. HUGHES. Exactly.

Mrs. THURMAN. That $35 million that was talked about, where instead of being taken away from us, it could actually be used.

Mr. HUGHES. Yes. And I support VERA strongly. I really do. I think it is going to help a lot.

Mr. STEARNS. Okay. Well, I appreciate your comments.

Yes, ma'am, come up.

STATEMENT OF DRU DOSHER

Ms. DOSHER. Good morning. I think you know me, Cliff.

Mr. STEARNS. Yes, good morning. How are you? State your name anyway for the record.

Ms. DOSHER. Dru Dosher from Ocala, FL. I had reason to testify before the Presidential committee on November 13 with regard to the Gulf War illness. As such, I had veterans call me, because I was on C-SPAN and CNN, from all over the Nation, and I have become a sudden spokesman for Gulf War illnesses.

My orchid for Easter came from a Gulf War veteran for me.

You only quoted figures up to 1990, which don't include the Gulf War illness.

Mr. STEARNS. That is true.

Ms. DOSHER. In December, I was here. I have a company that works with the mental health clinic, which, you all know, we were all told, and I am a victim of the illness too, we were all told it was in our head. I have seen sarcomas, neuromas. I have testimony from someone that the whole fifth floor of Shanns Hospital was full of dying vets, all under the age of 30, that only had one thing in common, and that was that they were Gulf War veterans.

There was no testing. There were funds given to the University of Florida, and there are two dynamic women over there working on the mycoplasma incognitus they can't seem to get any information out of Dr. Shin Lu in Washington at the Army College. He is a specialist in it, but he seems to keep things to his self.

I am finding more and more, since you don't dispense drugs and since it only takes a generic, doxycycline, to get hold of this illness, and believe me, I went through it, I know what it is. I have even had relapse with it.

I can't understand why the veterans are being turned away, and there is a lot of fear. Reservists particularly are the ones who have contacted me. They have no coverage. There is no formal accepting of them in the VA. And right now I am doing an article on Dr. B-

L-A-N-K's setting aside the American Red Cross's ban on blood donated, and I also have the statements of three doctors.

We are spreading this illness, and you are not taking care of it in VA hospitals. I don't know the answer to this, because I went to get the figures December 1, and the day before your committee was to meet here I got a message on my answering machine, which was either the total message or cut off, that from December 1 until now they were about to give me the figures of how many Gulf War vets they were taking care of here.

I am particularly alarmed, three top medical doctors have said that this is contagious. And I just buried another dog. I have lost two dogs and one cat. It is communicable between people, dogs, and cats. I couldn't even get the vet to put the dog to sleep because he didn't know whether there was a virus involved or not.

So I am worried about the vets not getting the treatment they need. I realize you are bringing more money in, and I know they have appropriated money purportedly to study this illness. But by the time they study it, we have more than 100,000 that are infected with it. Since they don't do outpatient medications, you put them in the hospital, you have got an enormous expense that you wouldn't normally have if you had an outpatient clinic.

So I really think what we need to do is find some funding for VA clinics just to do the gene splicing, to discover it. Because in 50 percent of the vets that were tested, that is what it was, mycoplasma incognitus, which they believe was a biological warfare agent used during the war.

So I know you didn't address that today, and I know I took my heart in my hand when I came up here to talk to you about it, but it needs to be addressed. And it was our youngest and our healthiest, and if they can do it to our youngest and healthiest, and I know the pressures in this hospital. You need a road map to get around it. I have been around it for the last 6 months, and I know the volume of people they take care of, and I also know the age group in there. But we are missing our young, under 30, and they need help.

I know you serve on the other veterans committee, Cliff, but we have got to do something about this. It is just getting worse by the day.

Mr. STEARNS. Thank you very much for your leadership on this, Dru. I think on the 16th we are having a hearing that I have scheduled on my committee to address some of the things you are concerned about.

Ms. DOSHER. In Washington?

Mr. STEARNS. In Washington.

Ms. DOSHER. Gee, if I can find somebody else to send me up there, I might go.

Mr. STEARNS. Let's talk to staff. We appreciate your bringing these ideas to the forefront.

Ms. DOSHER. The saddest part is, they don't seem to have a spokesman. I could not believe when I got back from Washington, and you were the last one I saw when I was up there, I got calls from all over the Nation. I got jammed up. I got calls a month later and said, God bless you for bringing this up. I brought it up because I got sick from it, and I just happened to be a mouthy

spokesman, and I made up my mind—if the President hadn't been in Hawaii, believe me, I would have been at the White House. But it is just the way I feel about it.

As you know, Cliff, since I have come back, I have just had so much input. So whether the Lord has led these people to me, and the young lady that was going to accompany me this morning has finally got an infectious disease specialist to address her problem, and she is getting all her documentation together and has to be there tomorrow morning. She called me last night and said, "Oh, will it hurt too much if I don't come?" I said, "No, I have never been at a loss for words," so I was sure I would be able to impart it to you.

But one of the saddest things she said to me was—I love this country, and I thought when I was in the Reserves, and she was with, not the Green Berets, the Delta Force, and she said, but a Reservist, and she said, "I just never thought they would do this to me." And her head pain is incredible. I am sure she has chemical sensitivity too, because I just received another big documentation from Garth Nicholson in California for some more information, and it is sad, because, I don't know, if we keep trying to get a volunteer army, how we are going to get them, after what happened here.

Mr. STEARNS. Dru, thank you very much.

Dr. Roswell.

Dr. ROSWELL. Thank you, Mr. Chairman. I feel very strongly about the subject that has just been introduced. One of the positions I hold in addition to being the VISN Director for the Sunshine Health Care Network, is I am privileged to serve as the Executive Director of the Persian Gulf Veterans Coordinating Board created in 1994 to coordinate activities between the Department of Defense, Health and Human Services, and Veterans Affairs.

Certainly, the points that have been brought up by our past speaker are very important points, because clearly there are a number of Gulf veterans who are suffering a variety of illnesses which we don't fully understand at this point.

I would, however, for the record, like to point out some of what is available to Persian Gulf veterans. In 1992, the Secretary for Veterans Affairs introduced legislation that makes priority health care available for all veterans of the Persian Gulf War. So since 1992, any veteran who served in the Gulf War is afforded care, free of charge, at our medical centers. In some cases they are asked to make a nominal $2 copayment for prescriptions, but medication, hospitalization and treatment is available through the Department of Veterans Affairs.

There has also been landmark legislation that provides priority disability compensation, even when the illnesses are undiagnosed, as long as those illnesses developed within a period following service in the Gulf War.

More recently, legislation was enacted which allows for the first time the Department of Veterans Affairs to actually contract to provide medical examination and evaluation, not only for veterans, but for their spouses and dependent children, because of concerns like we have heard this morning that veterans may be passing illnesses on to spouses and children.

I should tell you, though, that we have looked at mortality data. To date, we have not seen any increase in deaths of Gulf War veterans for illness. There has been a very slight increase in Gulf War veterans' death rates as a result of trauma in accidents, either vehicular accidents, suicide, trauma, that type of thing, similar to the Vietnam population. But we have not yet seen any increase in mortality in Gulf War veterans due to disease.

By the same token, we have not seen an increase in hospitalization rates due to medical illnesses for Gulf War veterans.

So while we fully recognize that almost 100,000 of the 700,000-strong force who served in the Gulf War have reported a variety of medical illnesses, they don't seem to be so severe at this point to be causing an increase in the death rate or an increase in the need for hospitalization.

With regard to an infectious etiology, certainly infectious diseases have been diagnosed in Gulf War veterans. However, an extensive effort has failed to identify widespread infectious diseases in this group of veterans.

Specifically, the Department of Veterans Affairs has over 185,000 employees in its 172 medical centers nationwide. We are unaware of one single employee who has contracted illness from Gulf War veterans. I myself have treated hundreds of Gulf War veterans, and I am privileged to have been able to provide that care. But I have not seen cases or been able to document cases where transmission of Gulf War illnesses occurred, either to family members or to VA health care professionals.

With regard to the individual you spoke of, Dr. Garth Nicholson, Dr. Nicholson is a microbiologist, he is not a medical doctor. He is a microbiologist who has put forth a theory that a mycoplasma, a special type of bacteria, may be responsible for at least some of the Gulf War illnesses.

This research, like any research, is something that the department encourages. Both the Department of Veterans Affairs and the Centers for Disease Control, in prevention, part of Health and Human Services, have asked Dr. Nicholson to participate in research. My understanding is as recently as a few months ago, he has declined to do that.

But certainly the Department of Veterans Affairs has set aside research money to fully investigate this. We now operate four national referral centers as well as three specialized research centers to begin to fully understand the impact.

It is a very high priority, but I can assure you that the department has been aggressive in both reaching out to Persian Gulf veterans, making priority care and disability compensation available to them, and also to exploring what factors may be responsible for the illnesses they now reported.

Mr. STEARNS. Thank you, Dr. Roswell.

The next gentleman? Good morning, just state your name.

STATEMENT OF REVEREND RON CHAPMAN

Rev. CHAPMAN. Good morning. I am Reverend Ron Chapman. I am not complaining about the hospital. I want to know from Mrs. Thurman, when are we going to get the $35 million? Because they need more staff here. They really do.

Mrs. THURMAN. I wish I had the power to disburse those.

Rev. CHAPMAN. I know this sounds funny, but I can tell you that I was in here a couple weeks ago, and they need more staff for cleaning, nursing, and the whole thing. I was laying in the bed there and I realized that. It is not the person's fault who is there, it is the people who is up above getting the right amount of people into it. I am not kidding, it is necessary.

That is all I wanted to say. I like the hospital and I like the people here. It is a matter of they need more help.

Mrs. THURMAN. Tell that guy behind you.

Dr. ROSWELL. Six million dollars alone in Gainesville.

Rev. CHAPMAN. I am not complaining. The people here are wonderful. They work on the veterans. But if they don't have the money to put that extra cleaner in there, that room is going to go dirty.

Mr. STEARNS. Yes, sir. Come on up. Just state your name.

STATEMENT OF ALBERT STRICKLAND

Mr. STRICKLAND. My name is Albert Strickland.

Mr. STEARNS. Mr. Strickland.

Mr. STRICKLAND. I am 100 percent service-connected. I have been with this hospital since ground-breaking. And over the years I worked for the University of Florida, and to cover my wife, I took out their insurance, State of Florida. It is a very good insurance. I still keep it.

I developed a policy when I had to have major operations to go outside the VA for as much as anything because I had the insurance and there wouldn't be the pressure on the administration hospital.

Some time back, I am now a member of the geriatric clinic, and one time when I came in for a visit, I got a billing from VA for $204, I believe it was. It went to my secondary insurance because, as I found out later on, medicare would not transfer money to the VA hospital. It has been going on ever since. I go every 2 months, maybe 6 months. Each time I get a billing. My hospitalization insurance takes care of it. But, VA gets no money.

I could turn around and come and have all this taken care of at the VA, but I don't think that is right, because the funds are so low. Therefore, I have spent in the past 5 years about $300,000 of medicare money. I had a back lamination, I have had a hip replacement, and my spine is now fused. All of this paid through medicare.

That money could have been done and handed over to the VA. I have done it in the VA. I live in Gainesville, so it is no problem. I am an outpatient. But it is troublesome to me to think that our money is paying huge prices to physical therapy on the outside, and I mean outside, because I have had $1,800 and $2,000 physical therapy bills by contracting physical therapy.

I am a beneficiary of the pool here each summer, and we wish it could be all year long, year-round. Their aquatic therapy has done me the world of good. I am anticipating next May finding the lifeguard, and I will be in there happily again.

But I understand this has been addressed already today, but I would like for it to be furthermore considered and put my word into it, too. Thank you.

Mr. STEARNS. Thank you.

Is there anyone else?

If not, then we will close this portion of the testimony. I would like to thank the administrator of this hospital, Mr. Randall, for the facilities. I would like to thank my colleague, Karen Thurman, for her participation, and Corrine Brown for sending a representative. I want to thank the staff, both on my side and the staff here at the hospital, and all the witnesses.

Let me just say in conclusion, I am very optimistic. I think VERA is the right step forward. But I want to make sure that we hear from the people, particularly in Central Florida, how they feel. That is why I scheduled the hearing.

I think it is important for leaders to get out of Washington, come into the grass roots, and hear from the people, both at the administrative level and the hospital, as well as the people who testified. This is part of what leadership is all about, is hearing from you, because obviously both Karen and I work for the people of Central Florida and this country.

So we will be available, both Karen and I, at noon. If there is anybody in the press who would like to speak to us, we will be available to answer any questions.

From this hearing, we hope to propose additional legislation that will make it better for the people of this area, this country, and particularly this State.

With that, any concluding comments?

Mrs. THURMAN. Just thank everybody for coming.

Mr. STEARNS. Thank you very much. That will conclude the hearing.

[Whereupon, at 12 p.m., the committee was adjourned.]

APPENDIX

BOB GRAHAM
FLORIDA

United States Senate
WASHINGTON, DC 20510-0903

COMMITTEES:
FINANCE
ENVIRONMENT AND PUBLIC WORKS
VETERANS AFFAIRS
SELECT COMMITTEE ON INTELLIGENCE
ENERGY AND NATURAL RESOURCES

Statement before the House Committee on

Veterans Affairs

Health Care Subcommittee

Senator Bob Graham

March 26, 1997

Mr. Chairman: I am pleased to have this opportunity to enter my statement into the Record. You are to be commended for convening this bi-partisan field hearing on the implementation of the Veterans Equitable Resource Allocation (VERA) system -- an issue that is critical not only to Florida's veterans, but to the entire VA health care system.

The VA health care system exists out of a sense of pride, honor, and respect for those who have served our Nation with distinction. The biggest challenge facing VA is how to pay these veterans back, long after they have served us -- a difficult task in light of the dramatic veterans population shifts we have seen over the last 15 years and will continue to see in the foreseeable future.

Mr. Chairman, I'd like to focus briefly on the demographic shifts our Nation's veterans population has undergone. In 1980, just over 28.5 million veterans were living in the United States, but, just fifteen years later, the veterans population had declined by almost 2.5 million, or just under an 8.5 percent decrease. According to U.S. Census estimates, over the next 15 years, the **veterans population will continue to decline, so that between**

1980 and 2010, the nation's veterans population will decline by a staggering thirty percent.

But this nationwide trend is not the pattern in all states. For instance, by 2010, New York's total veterans population will realize an aggregate loss of approximately 47 percent. Conversely, other states, mostly in the south and southwest, will absorb some of these population losses. For example, in 1980, Arizona represented just over 1 percent of the nation's total veterans' population. By 2010, Arizona's relative veterans population will almost double -- approaching two percent of the nation's veterans.

Florida will undergo a similar transformation -- in 1980, 4.7 percent of the nation's veterans resided in the State -- compared to U.S. Census forecasts of just over 6.8 percent residing in Florida by 2010.

For years, Senator McCain and I, along with others, have been attempting to move the VA from a system of incremental, facility-based budgets to one which responds to the actual demands placed on VA health care. The process has been a difficult one and we have faced opposition along the way. Inefficient VA facilities have fought change at every turn. Despite declining caseloads, these facilities have continued to ask for more money at the expense of veterans who need care desperately and deserve it.

When Senator McCain and I proposed our amendment to the 1996 Continuing Resolution, we were simply asking that veterans be treated equally regardless of where in the country they reside. Our colleagues agreed, and with the bi-partisan help of Chairman Stearns, Representative Karen Thurman and Senator Mack, we passed our amendment and preserved it in conference committee.

To its credit, the VA, under the leadership of Secretary Brown and Undersecretary Kizer, followed through on the intentions of our amendment and designed VERA, a system which fundamentally changes the way that VA does business. Because of VERA, veterans will finally be treated equally whether they live in Florida or New York, Arizona or Pennsylvania. Through the leadership of VISN directors like Dr. Bob Roswell, veterans across the country will begin to receive the access to care they deserve. Some networks will have to become more efficient. As private citizens' budgets have become tighter, we have asked them to make do with less. It is only fair that the government also learns to spend money more wisely.

By phasing in VERA, the VA has given Network Directors the time necessary to learn to become more efficient, as Arizona and Florida has been for years. New York's veterans will no longer receive $859 per capita in health care dollars compared to Florida's per capita spending of $504 in 1995.

But make no mistake -- no State's veterans will have to endure the shortages of VA health care that the Florida and Arizona veterans have had to tolerate over the last twenty years. For instance, VISN 3 in Brooklyn loses just over one percent of its funding in fiscal year 1997. The VA has ensured a smooth transition, by giving inefficient networks up to four years to adjust to changes.

While some VISNs will simply have to become more efficient over a period of time -- the tradeoff is equity for all of our Nation's veterans. Those who have spent their time defending the status quo will have to begin devoting their energy toward changing the way health care is delivered.

Mr. Chairman, in closing, VERA is the first step in ensuring that the VA is up to the challenge presented -- delivering quality,

cost-efficient health care to an increasingly mobile veterans population. It will enable us as a Nation to honor the commitments we made long ago when we asked our veterans to serve. They deserve no less.

STATEMENT OF REPRESENTATIVE CHARLES CANADY

for the

HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON HEALTH CARE

March 26, 1997

Thank you, Mr. Chairman.

I appreciate the opportunity to participate in this discussion of the unique and expanding heaith care needs of Florida's veterans. I have heard from many constituents from the 12th District, which I represent, about the lack of resources available to Florida's veterans through the Veterans Administration (VA). In fact, last week I met with members of the Disabled American Veterans (DAV) from my district. Each of these representatives expressed a frustration with the VA and also a sense of hope that the development and implementation of the Veterans Equitable Resource Allocation (VERA) system would provide much needed additional support for the 1.7 million Florida veterans. The health care needs of these men and women have put a tremendous drain on the limited resources of a state that ranks 45th in the nation in terms of access to health care on a per capita basis.

Mr. Chairman, this is a shame. For too long, citizens of this state who sacrificed for their nation have been overlooked and underserved. I am pleased that this will soon begin to change with the implementation of VERA; Florida veterans will finally begin to receive federal funding which is more in line with their needs. This new system will dramatically affect Florida's veterans by changing the funding allocation to ensure that funds are distributed according to the number and need of veterans. I am fully supportive of the implementation of this system of allocation.

However, this is only the first step in ensuring that Florida's veterans get the benefits they have earned. I am also in support of eligibility reform to guarantee that those veterans who most need care receive it in a timely fashion. With the passage in the 104th Congress of Public Law 104-262, the Congress has put eligibility reform near the top of its agenda for veterans. This law ensures that any veteran with a compensable service-connected disability

or who is unable to defray the expenses of necessary medical services is able to receive care. It is my hope that the 105th Congress can continue to offer increased access to VA medical facilities.

Along these lines, I would like to take this opportunity to express my full support for a proposal currently under consideration to open an outpatient care clinic in Bartow, Florida. Currently, many veterans living in the 12th Congressional District have to travel over 50 miles to receive treatment at the closest VA facility, the James Haley Veterans Hospital in Tampa. This represents an undue hardship on many older or disabled veterans. While this is a modest proposal--a few rooms in a closed wing at Polk General Hospital--this clinic would do much to improve access to quality health care for many of my constituents in Polk County.

Mr. Chairman, much is left to be done to ensure that each and every veteran who needs health care will receive it. I look forward to working with you and your subcommittee towards that goal.

Thank you again for allowing me this opportunity to submit testimony on this important issue.

Statement of Robert H. Roswell,M.D. before the

U.S. House of Representatives Veterans' Affairs Committee

Subcommittee on Health

April 3, 1997

Gainesville, Florida

Mr. Chairman, thank you for the opportunity to appear before the Subcommittee and provide information on how the Department of Veterans Affairs' new Veterans Equitable Resource Allocation process will improve access to high quality healthcare for more Florida veterans.

Although today's veteran population has declined to slightly more than 26 million nationwide, these men and women are older and often in need of more healthcare services than the veteran population of just a few years ago. Experience has shown that veterans over the age of 65 consume two to three times more healthcare resources than their younger counterparts. The geographic location of America's veteran population has changed as well, through significant migration to locales throughout the South and Southwest. This relocation of veterans coupled with their age-related increased requirement for healthcare services has created substantial demand for care that cannot always be met with existing resources.

Historically, the Department of Veterans Affairs has responded, in part, to increased demand for services through its major construction program. Building new medical centers coupled with the activation dollars to equip, staff, and operate them was the means used to provide some of the necessary resources to meet new healthcare needs.

This strategy is no longer appropriate primarily because of changes in how healthcare is delivered. Even if additional inpatient bed capacity were needed, a construction approach that required a 7 to 10 year time span to plan, seek authorizing and appropriation legislation, design and build new medical centers, would not be an effective means to meet additional veterans healthcare needs. The shift to community-based outpatient care, development of new healthcare technologies, and improvements in utilization management, in many cases make new construction no longer practical or desirable.

Due to the changes in veteran demographics and healthcare delivery, a high demand for care exists today in many areas where VA has no healthcare facilities, while other areas find themselves with an oversupply of hospital beds that are costly to operate and often poorly utilized. The end result is a need both to reallocate veterans healthcare dollars to under-served veteran populations by means other than hospital construction, and to discontinue funding mechanisms that distribute the VA Medical Care appropriation based on historical bed levels.

The Veterans Equitable Resource Allocation (VERA) program, which will be implemented on April 1, will accomplish this critical requirement. The VERA process will move healthcare dollars to those areas where increased demand for care exceeds VA's capacity to meet this need with existing resources and facilities. Reform of eligibility rules and new contracting authority included in legislation enacted last year will allow VA to utilize these resources to provide comprehensive veterans healthcare that will incorporate the purchase of necessary services, including hospitalization, in the local community when it is cost-effective to do so.

Florida and its veteran population typify the dynamic described above. Currently over 1.7 million veterans reside in the Florida-Puerto Rico Veterans Integrated

Service Network (VISN), and over 60 veterans relocate to Florida each day. The veteran population in the VISN increased by 23 percent between 1980 and 1996 (with a 26 percent increase in Florida alone). During this same period, the veteran population nation-wide decreased 10 percent. Over 41 percent of veterans in the VISN are age 65 and older, with that percentage expected to rise to more than 45 percent in the next five years.

The Florida-Puerto Rico VISN ranks first of the 22 networks in the number of veterans with service-connected disabilities rated at 50 percent or greater. This is significant because VA cost data show veterans with service-connected disabilities rated 50 percent or higher consume 40 percent more healthcare resources than other veterans. The VISN also ranks first in the number of veterans with serious mental health disorders and second in the number of veterans receiving care for AIDS.

The resulting demand for care exceeds our current capacity to meet this need. Of necessity, veterans with lower priority for care are denied the services they seek, including veterans who seasonally migrate to Florida and find that the care they receive in their home state is unavailable to them during their stay in Florida. Additionally, veterans in many parts of Florida find that healthcare is unavailable to them through the VA unless they are able to travel fairly long distances to seek the care they need.

When implemented next month, VERA will provide an additional $29 million dollars for healthcare in the Florida-Puerto Rico VISN during the remainder of FY 1997. This amount coupled with the $28 million in additional resources already programmed for the VISN as a result of the increase in the FY97 Medical Care appropriation, will add a total of $57 million over the FY96 funding level, for a total operating budget of approximately $1 billion. It is important to note that the

STATEMENT

Carlos L. Rainwater
Executive Director
Florida Department of Veterans Affairs

It would be redundant for me to go into detail and explain again that Florida's veteran population has grown at a rapid rate over the past twenty years and now stands at 1.7 million individuals. I was initially assigned to the US VARO in St. Petersburg in 1972 and from that time to the present I can testify from personal knowledge that veterans in Florida have not had the same level of access to VA's health care facilities as their fellow veterans in states where veterans population is declining. In my 33 years (from 1963 to 1996) with VA I worked at various times in VA offices in Georgia, Louisiana, Iowa, Colorado, and Pennsylvania. I had a view from the inside of the imbalance in the allocation of VA resources. I can assure you that there is a vast difference in the way VA delivers benefits and health care from state to state.

In my view, there are many reasons for the imbalance in resource allocation. Some of those reasons are internal to VA and some are the result of external forces over which VA had little or no control, but it serves no purpose here to go into the history of the situation. We are grateful that today, through the efforts of Senator John McCain of Arizona and our own Senator Bob Graham, supported by the entire Florida delegation, VA is mandated to allocate its health care dollars so that veterans have equal access to the system regardless of where they live.

It is troublesome to me that political interests in other states are working to prevent VA from reallocating its resources equitably. Obviously, we in Florida want nothing more than our fair share of VA's health care resources. There are several factors in computing that fair share such as:

- **Florida's veteran population is second highest in the U.S.**
- **Florida has a higher percentage of veterans with service connected disabilities than any other large state**

additional funds that this VISN is receiving for FY 1997 is only a part year allocation. In future years, although specific dollar amounts are not yet available, the additional funding from VERA will be significantly larger than the $29 million that we are receiving this year.

Of this $57 million, almost $28 million will be needed to cover increased costs resulting from inflation and personnel salaries and benefits. Activation of new or expanded clinic facilities in Mayaguez and San Juan, Puerto Rico and in Ft. Myers, Gainesville, and Port Richey, Florida, as well as much needed improvements in our telecommunications and computer infrastructure will consume another $15 million.

The remaining $14 million plus additional resources made available through improved efficiency in procurement, contracting, and delivery of healthcare services will allow almost 8,000 additional veterans to receive healthcare through Florida and Puerto Rico facilities this year. With the additional funding in FY97, waiting times for both primary care and specialty clinic appointments will be reduced and patients will be able to access services through telephone referral and consultation programs at all medical centers.

Considerable care will be provided through new, more accessible community-based outpatient clinics located in leased space in Homestead, Sarasota, Bartow, and Brevard County, Florida. Additional primary care services will be provided to veterans through VA's 14 existing Vet Center locations operated by the Readjustment Counseling Service in the Florida-Puerto Rico VISN. Telemedicine systems will link VA Medical Centers and clinics throughout the VISN so that specialty consultation can be obtained without lengthy waits for appointments and the need for veterans to travel to large, metropolitan medical center locations. This same system will also improve access to benefits claims

services provided by the Veterans Benefits Administration.

The VERA plan is particularly well suited to meet today's veterans healthcare needs because the plan will distribute federal dollars in a capitation-like manner. This process involves determining the number of category A veterans (primarily those veterans with service connected disabilities, or whose income falls below a particular threshold) who have received care from the VA over the proceeding three-year period. The actual annual cost of this care is then divided into the total number of veterans who received care to develop a national reimbursement rate. Each of the 22 VISNs then receives an allocation equal to the number of veterans treated in that VISN times the national reimbursement rate.

A similar process is utilized to reimburse care provided to veterans with specialized needs that result in the utilization of large quantities of healthcare resources such as those who require organ transplantation, or who suffer with AIDS, spinal cord injuries, visual loss, or other catastrophic needs. Important additional aspects of the plan include provisions to fund VA's medical education and research missions, adjust for locality-based variations in salary costs, and provide for equipment and non-recurring maintenance needs.

Ultimately, the VERA plan will reallocate federal veterans healthcare dollars to those areas where veterans reside and depend upon the VA for their medical care. The plan will give the VA much needed flexibility to respond to changing healthcare needs in a timely manner. More importantly, it will assure that veterans seeking VA healthcare all across our country have comparable access to a comprehensive continuum of care, both now and in the years ahead.

Mr. Chairman, thank you for the opportunity to appear before the Subcommittee and share my views on the VERA plan. I strongly believe that the future of

- Florida's veterans are, on an average, older than veterans in any other state
- The majority of Florida's 1.7 million veterans have come here from those very states where the opposition to reallocation is most vocal

The illustrations we have provided were derived from VA's own data base. The information clearly demonstrates that there are more veterans in Florida than almost anywhere in this country and they are more in need of health care than most other veterans because of their ages and the seriousness of their disabilities. There is no reason why a veteran in Florida should have to wait longer for medical treatment than his brother or sister veteran in another state.

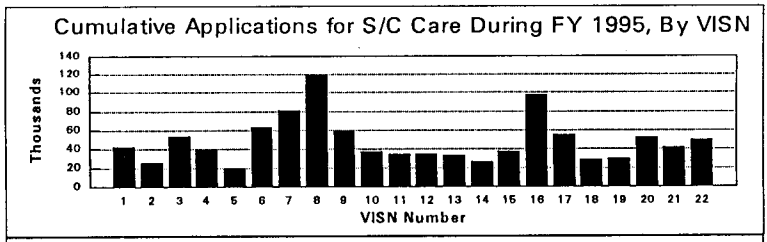
In summary, the veterans of Florida now have hope that they will be able to access VA's excellent health care system at the same level as veterans in other states. VA managers and their dedicated employees in Florida have for years struggled to provide adequate benefits and health care to veterans in an environment of underfunding and understaffing. I know because I was one of those managers for many years. The VERA model has the potential to change that environment and all of us who work for veterans are obligated to do everything we can to ensure that Florida's veterans get their fair share.

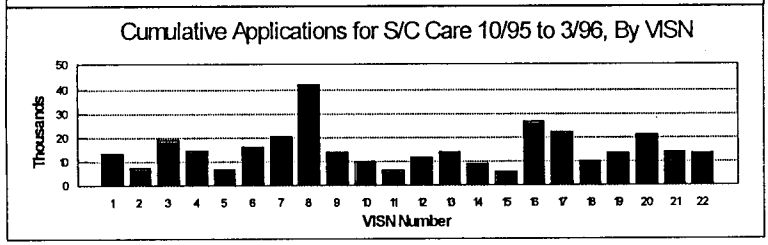
VA, under the leadership of Dr. Kizer, is rapidly moving into the current mode of delivering health care, that is through expanded access points and the primary care method. The emphasis is now on preventing in-patient admissions and programs of managed care. However, for the new approach to health care to work in Florida, the VERA model must be put into operation as outlined by VA.

Finally, we ought to view the level of services that government provides veterans as a "litmus test" as to how well government is working. Veterans are a special group clearly deserving of a high level of service from government. For us to fail to provide adequate services to veterans is simply not acceptable.

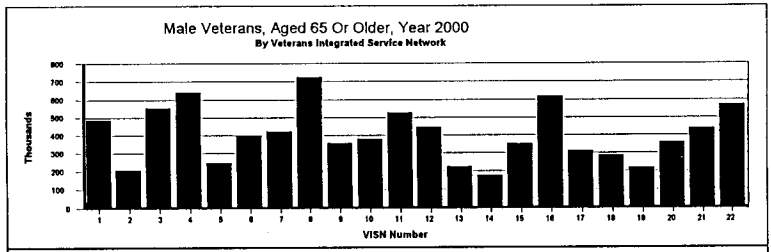
Florida veterans' healthcare is dependent upon the successful implementation of this program. I will be happy to answer any questions you or the other members may have.

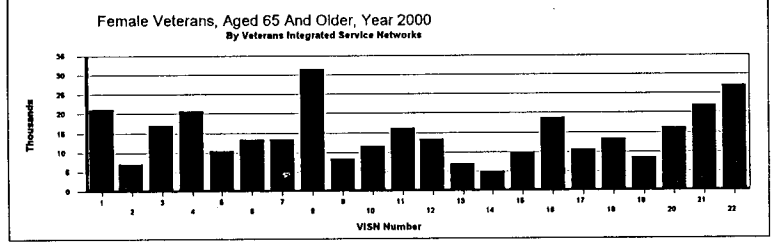
Where Do Service-Connected Disabled Veterans Live?



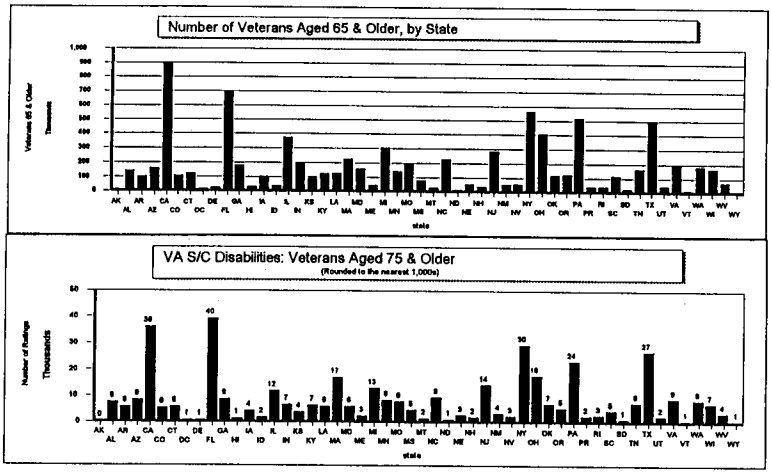


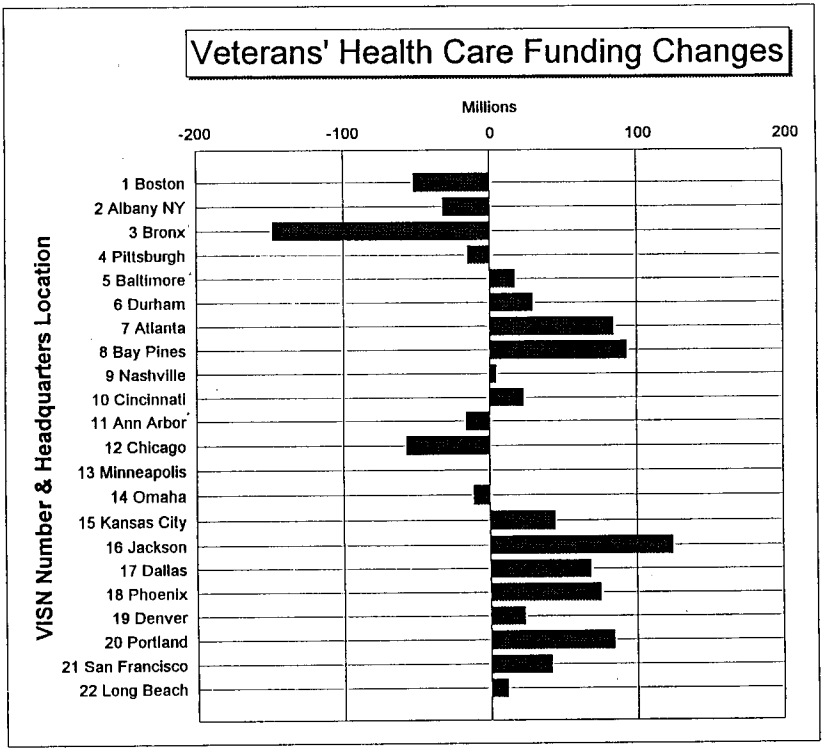
WhereWill Older Veterans Live in The Year 2000?





Where Do Older Veterans Live Now?




Veterans' Health Care Funding Changes
Millions
-200
-100
0
100
200
VISN Number & Headquarters Location
1 Boston
2 Albany NY
3 Bronx
4 Pittsburgh
5 Baltimore
6 Durham
7 Atlanta
8 Bay Pines
9 Nashville
10 Cincinnati
11 Ann Arbor
12 Chicago
13 Minneapolis
14 Omaha
15 Kansas City
16 Jackson
17 Dallas
18 Phoenix
19 Denver
20 Portland
21 San Francisco
22 Long Beach

CARLOS L. RAINWATER
EXECUTIVE DIRECTOR
FLORIDA DEPARTMENT OF VETERANS' AFFAIRS

On April 1, 1996, Carlos L. Rainwater was nominated by Governor Lawton Chiles and his Cabinet for the position of Executive Director of the Florida Department of Veterans' Affairs, to serve the 1.7 million veterans in Florida. He was confirmed by the Florida Senate on May 3, 1996.

Mr. Rainwater served in the U.S. Navy with the 6th Fleet during the Korean Conflict. He served aboard Patrol Craft and Fleet Tankers as a Radar Electronics Technician. After military service, he earned a Bachelor's Degree in Management under the G.I. Bill at Georgia State University. He went on to earn a Law Degree following completion of undergraduate work. He is a graduate of the Federal Executive Institute, Charlottesville, Virginia.

Mr. Rainwater joined the U.S. Department of Veterans Affairs (then known as the Veterans' Administration) in 1963. He was promoted to positions of increasing responsibility at Regional Offices in Atlanta, New Orleans, Des Moines, Denver, St. Petersburg, and again in Atlanta. From 1980 to 1995, he was Director of VA's largest Regional Office, St. Petersburg. From 1995 to 1996, he was Director of the Atlanta Regional Processing Office. He retired from the VA in 1996. In 1992, he was awarded the rank of Meritorious Senior Executive by President George Bush. Upon retirement from the VA he was awarded the Exceptional Service Award by Secretary of Veterans Affairs, Jesse Brown.

His volunteer activities have included membership on the Board of Directors of Pinellas United Way and Chairmanship of the Pinellas Combined Federal Campaign. He was a Board member and Chapter Chairman of the Tampa Bay Suncoast Chapter of the American Red Cross. From 1990 to 1995, he served on the National Board of Governors of the Red Cross.

He has done extensive volunteer work with the Seminole Tribe of Florida, the United Southeastern Tribes, and the National Congress of American Indians.

Mr. Rainwater also has done extensive work in the fields of Total Quality Improvement, Strategic Planning, and Empowered Employee Work Teams. He chaired VA's Southern area Quality and Planning Council and was instrumental in implementing the Quality Program in the 13 Regional Offices in the Southeast. He is a guest lecturer in Total Quality Concepts.

STATEMENT OF
ALBERT H. LINDEN, EXECUTIVE DIRECTOR
DISABLED AMERICAN VETERANS, DEPARTMENT OF FLORIDA
BEFORE THE HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON HEALTH
GAINESVILLE, FL.
MARCH 26, 1997

On behalf of the more than 87, 000 members of Florida's Disabled American Veterans and it's Auxiliary, I would like to take this opportunity to thank you for this hearing and to present our general views on the issue of Veterans Health Care and our specific views regarding access to the VA Health Care Facilities in the State of Florida. Also, my comments are on behalf of Florida Joint Veterans Planning Group of which I am the moderator.

On March 23, 1989, I testified before a field hearing of the U.S. Senate Veterans Affairs Committee concerning Veterans Health Care in Florida. Not much has changed except it has gotten worse as was predicted then. The Veterans Equitable Resources Allocation (VERA) model for the allocation of veterans health care resources brings hope that the future will improve for Florida's disabled veterans.

Florida is the place to retire, thousands of individuals move to Florida each month and most of these individuals are in the category of senior citizens.

A 1989 survey conducted by the U.S. House of Representatives showed by the VA's own account that it would take an additional $45 million dollars and an additional 1,600 personnel to meet VA health care 1989 work load levels. It would not meet the total needs of Florida's current or future veterans.

As you know, Florida has the oldest veteran population in the nation. The veteran's median age in Florida is 60 years old. Florida, according to the VA also has the most severely disabled veterans in the country. These VA statistics show that 61% of the VA outpatient care in Florida was for conditions directly related to a veterans' military service while 46% was the nation wide average.

While these statistics do not provide all the answers, they clearly indicate that Florida is not receiving it's fair share of federal VA resources and more importantly, that these statistics show Florida veterans do not have the same access to VA health care as veterans in other areas of the country. Given the older and more disabled veteran population of Florida, more long term health care is required.

From 1980 to 1990, Florida experienced a net increase of 349,451 new resident veterans, while the State of New York lost 357,394 of its resident veterans during this period. Because Florida is a retirement area, it retains its unique standing and will for sometime be a " growth state", particularly in terms of military veterans. Florida now has the second largest population of veterans in the U.S. it is second only to California. The Department of Veterans Affairs statistics

show than Florida has more 100% service connected disabled veterans than any state. In addition, Florida has more 60% through 90% disabled veterans, making Florida the home to the largest population of the most seriously disabled veterans in the Nation.

It is unbelievable, but true, that Florida ranks 41st in terms of VA hospital beds per 1,000 veterans. Further, in the early 1980's Congress directed the VA to specifically assess veterans' health care needs in Florida. That mandate resulted in the publication entitled, "30-Year Study of the Needs of Veterans in Florida". This study determined that Florida ranked among the top four of all VA Medical Districts and exceeded the VA predetermined indicators of suppressed demand. Simply put, the VA concluded that Florida's veterans substantially lacked access to VA facilities. This problem was so severe that veterans had simply stopped asking for VA health care.

Since this report was published, Florida's veterans population has grown rapidly and only one VA Medical Center has been constructed, adding but 400 of the 1483 VA hospital beds cited as necessary in the early 1980s.

In any discussion of the resources needed to properly fund this demand for VA health care, consideration must be given to the number of veterans seeking treatment for their illness. But, when such a discussion is attempted, the number of real-time applications for VA care made by veterans who the VA has determined as having service-connected disabilities is an obvious factor to consider. Again, as published in the VA's 1995 Summary of Medical Programs, Florida leads the Nation (again, including California with a much larger population) in terms of absolute number of requests for VA health care made by veterans with service-connected disabilities.

Perhaps the next index of "need" should be seen as the relative percentage of veterans who requested VA outpatient care for service-connected disabilities in each state.

In a relatively recent turn of events, Maine (at 63%) now pinpoints where the highest level of service-connected outpatient care is provided, while Florida ties for a ranking of second (at 61%) with Hawaii and New Hampshire. (Until recently, Florida usually far exceeded almost all other locations as providing the highest level of service-connected outpatient care.) Conversely, these are also the areas where discretionary VA outpatient health care is least available (e.g., the VA is required to provide services for service-connected conditions), therefore, when an overall higher incidence of service-connected care is indicated over time, then a lower incidence of discretionary care was possible. Stated otherwise, the VA's high frequency of required health care in these areas utilizes most of their available resources and guarantees that discretionary care will be restricted.

Florida's veteran population is, relatively speaking, known to have greatest objective need for VA health care services, as defined by demographics data. **The best way to guarantee equity of access to VA health care across the Nation is to guarantee that all VA discretionary health care services are equally available and equally utilized by all similarly situated veterans.** The provision of disproportionately high levels of resources to one area versus another amount to little more than a discretionary creation of a welfare-like health care capacity for

veterans in that locality. As our Nation has been defended equally by veterans living in all parts of it, there exists no justification for federal policies which would allow for such casual allocation of these high-cost, life-sustaining public resources.

Another fact is that Florida ranks 42nd among all the states with VA hospital beds available at the rate of 1.9 beds per thousand veterans. Massachusetts, for example, has almost one half as many veteran residents as Florida but slightly more VA hospital beds (2795 beds in Florida compared to 2893 beds in Massachusetts). This gives the veteran in Massachusetts twice the chance of receiving treatment as the veteran in Florida has.

Is "VERA" or Veterans Equitable Resource Allocation" the answer to Florida inequitable treatment?

In an early analysis of VERA's impact on Florida and other locales with similar (albeit less dramatic) concern, it appears to be a very significant improvement over past practice. In fact, **VERA could reasonably be regarded as the single most meaningful and fundamental enhancement in the way health care is provided to veterans.** This characterization is certainly accurate from Florida's point-of-view.

Does VERA offer everything Florida veterans would have asked for? No, it does not. Several important elements of our dream solution are missing. What would those missing elements have done? They could have recognized that both the State of Florida and its veteran population have been unfairly penalized by local VA health care shortages which have been uniquely evident for so long. Florida's taxpayers have had to foot the bill for many years for health care needed by our medically-indigent veterans who would have been treated by the VA if only they lived elsewhere. It is contended that Florida has been denied several billion dollars in federal health care funds over the past few decades. This circumstance could have been recognized in VERA. Instead, **Florida is given hope by VERA that it will be more fairly treated in the future,** and, that perhaps the past should be forgotten. With that said, VERA is a major improvement over what we have endured for many years and it holds the promise that circumstances may continue to improve.

Does VERA offer Florida the absolute promise of complete fairness? No, it does not. Several of the elements of the formula used to determine funding for each VISN in the VERA plan could be criticized. For example, allegations of high labor costs in certain areas which have typically received inordinately generous allocations of VA health care resources have been accepted as accurate and grounds for special consideration. This decision has mitigated reductions in health care funding which otherwise would have been more significant. Just how concerned should Florida be about reportedly high labor costs in such areas? Who voiced concerns about the innumerable financial and human consequences Florida's 1.7 million veterans have endured (as well as the State's taxpayers who supported the VA) when no comparable level of services were available?

The really important outcome is that the VA seems to be making a genuine effort to at least begin to concentrate on what is important - that similarly situated veterans receive similar

treatment. VERA is a step in that direction. That is and should remain our focus. As circumstances permit, we can build on that foundation.

According to the initial briefing document on VERA, VISN #8, which encompasses most of the State (except part of the panhandle), VA health care facilities in Florida should receive an immediate increase of $57 million throughout the remainder of the current federal fiscal year. An additional $93 million is scheduled to follow next year. On top of those new dollars to fund care for Florida veterans we should also expect new resources from VISN #16 to fund additional services for veterans in the panhandle of the state - at present we have no idea how much or in what form.

In any event, Florida must regard VERA as a positive step but not as evidence that the needs of our veterans have been resolved. We have, however, made significant progress in that direction. Moreover, it was the Florida Delegation that made that difference. Members from other states, however, have made various public comments about VERA and their intention to prevent the loss of resources in their home states - apparently without regard to the lack of merit in their plans. Florida seeks no advantage while we continue to urge fair allocations of VA resources. It seems quite likely that the motives of others will become crystal clear to everyone involved in the debate to come. Any public debate where the facts are known will overwhelmingly favor our position.

If ever there was case when "the angels are on our side," this is it. It is impossible to imagine what constituency (e.g., military veterans) has a more legitimate claim to fair treatment from our federal government. Even less likely is that Florida's 1.7 million veterans would find themselves with a stronger argument for that fair treatment!

Hardly a day goes by when a veteran does not stop by our headquarters which is located 15 miles from the Gainesville VA Medical Center and state that he was unable to have his health care needs met.

However, let me state that it is not the fault of the Gainesville VA Medical Center. They and other VA facilities in Florida are doing an excellent job with the resources they have available to them. The problem is they do not have enough resources to meet the demand for services and this lack of resources has been happening in Florida now for over twenty years.

An often repeated message by many of Florida's disabled veterans' is that " I will die before I will receive VA health care in Florida," This is not the fault of the VA employees in Florida but the lack of placing the resources where the veterans who need health care are located. As long as the new VERA allocation model plus the eligibility reform legislation PL104-262 is given an opportunity to work the situation for Florida's disabled veterans will improve. Thank you for the opportunity to participate and thank you for holding the hearing in Florida. I would be happy to answer any questions you may have.

STATEMENT
WILLIAM R. KIRSOP
ADJUTANT/QUARTERMASTER
VETERANS OF FOREIGN WARS OF THE U.S.
DEPARTMENT OF FLORIDA

As a stakeholder in VA Healthcare System, we appreciate the opportunity to appear today and provide testimony on the crucial issues of the Health care needs of veterans in the State of Florida, including the Reallocation of Resources and the Veterans Equitable Resource Allocation plans (VERA).

We understand one of the purposes of Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, is to improve the cost effectiveness of and simplify rules for providing health care to veterans. With over 81,000 Veterans of Foreign Wars members residing in the State of Florida we are genuinely concerned with any plans that will affect how VA health care is managed in this state.

Many of our veterans moved to Florida from other states and put roots down in particular areas because of the VA health care facilities available in those areas. Statistics show within VISN 8 during FY 1995, 120,000 applications for service connected care alone were received in the area's VA hospitals and clinics.

Under the recently announced VERA, Veterans Equitable Resource Allocation, this VISN will receive 57 million dollars in additional funding over the next three years. That translates to a 4.7% increase in each VA medical facility's budget. Ladies and Gentlemen, this reallocation of funding is long overdue. On behalf of Florida's Veterans of Foreign Wars of the United States, we thank you.

On the other hand, we have some genuine concerns about the future of VA healthcare as it will affect our membership and all veterans as well. Will the demands of our ever-increasing veteran population exceed the supply of funding and health care? There does not seem to be any indication veterans choosing Florida as a home will decrease and, in fact, as the statistics show, they will increase significantly.

There are more male and female veterans over the age of 65 in Florida than in any other state. By the year 2000 it is predicted that VISN 8 will have over 1 million veterans aged 65 and older. These statistics point out within three years this VISN, and particularly Florida, will have more retired veterans aged 65 and older than any other state.

As I said before, we have over 81,000 members of the Veterans of Foreign Wars residing in the State of Florida. Because of membership we are genuinely concerned with any proposals or plans that will change/alter how VA health care is delivered and received by all the veterans in Florida. We do not approve of any action that will reduce/combine or otherwise result in a degradation of available services/benefits to our veterans.

We applaud the efforts of the VISN who are working toward providing linked communication and information systems between facilities and down to the physician/care giver level, a procedure that is long overdue in providing care givers with the latest information available on veterans.

We also applaud the VISN's aggressive efforts to insure outside stakeholders such as the Veterans of Foreign Wars are invited and included in Management Assistant Councils and Service Evaluation and Action Teams (SEAT). We have a representative on both.

We appreciate the funding for the expansion of VA health care facilities within the State of Florida. The new West Palm Beach hospital and proposed clinic expansions and constructions will help a great deal. Again, with the ever increasing veteran population here this is long overdue.

STATEMENT
WILLIAM R. KIRSOP
PAGE 2

At the present time, within VISN 8 there are plans proposed to realign hospital and clinic facilities. One example is the proposed integration involving the Gainesville and Lake City medical centers.

While we understand the need to eliminate duplication in management functions and applaud those efforts, we vehemently oppose any reduction in care available at either facility.

We do agree with the consolidation of heads of offices that duplicate the efforts in administrative, fiscal and clinical areas within VA facilities that are in close proximity. We can understand and appreciate the savings that would be realized with that type of consolidation.

We do not concur with the elimination of or downsizing of any facility that affects the care available to be received by eligible veterans. We do not agree with the premise veterans would prefer to travel to another facility 35 or more miles from his/her home for treatment when the same treatment had previously been available in the local VA facility. Some present proposals would eliminate some of that availability creating a possible hardship on our veterans, especially the elderly ones.

As of October 1996, the VISN's published report on 'Hospital Bed Changes' (copy attached) shows an overall reduction of 426 hospital beds. With the veteran population increasing by approximately 200,000 per year it does not seem prudent to be reducing available beds. During the same period outpatients treated amounted to 2,081,192 visits. We understand there has been a major shift of resources from inpatient to outpatient. In the short term, perhaps for the next couple of years, this will prove workable. When the veteran population in Florida exceeds two million, will the funds be there to support them?

We reiterate our concerns for how this reallocation of resources, overall, will affect the average Florida veteran who is 65, or close to it, on a limited income and depends upon the VA for health care.

What does the future hold for them?

William R. Kirsop and the Department of Florida, Veterans of Foreign Wars have never received any federal grants or contracts.

HOSPITAL BED CHANGES - FINAL UPDATE
VISN 8 - Through FY 1996

From FY90 through FY95, the average operating beds at VISN 8 hospitals declined by **11** percent, from 3,338 to 2,970 (-368 beds), although hospital patients treated declined by only **3** percent. During the same time period, outpatient visits at VISN 8 facilities increased **21.3** percent, from 1,563,052 to 1,895,326 (+332,274 visits).

FY95 hospital bed changes are shown below. Excluding West Palm Beach, which was activated June 26, 1995, hospital operating beds were reduced by **161**, and authorized beds were reduced by **238**, in FY95 alone.

Facility	Authorized Bed Change	Operating Bed Change	Sept. 30, 1995 Auth/Oper Beds	
Bay Pines	-99	-59	522	522
Gainesville	-54	0	419	349
Lake City	-9	-6	296	266
Miami	-76	-65	590	563
San Juan	0	0	692	584
Tampa	0	0	581	512
West Palm	+400	+137	400	137
TOTAL	+162	-24	3,500	2,933

During **FY96,** and additional **416** operating beds were reduced, or **14.2** percent of hospital beds in the Network, as shown below. At the same time, hospitalized patients treated declined **8.2** percent. Outpatients treated increased by a somewhat higher percentage **(9.8%)** in FY96 to 2,081,192 visits.

Facility	Authorized Bed Change	Operating Bed Change	Sept. 30, 1995 Auth/Oper Beds	
Bay Pines	-28	-57	494	465
Gainesville	-102	-75	317	274
Lake City	-62	-46	234	220
Miami	-100	-100	490	463
San Juan	-150	-42	542	542
Tampa	-150	-111	431	401
West Palm	-130	+15	270	152
TOTAL	-596	-416	2,778	2,517

VA WORKLAOD: VISN 8
FY96 versus FY95

Facility	Hosp Pls Tx		NH Pls Tx		Dom Pls Tx		Outpt Visits	
	FY95	FY96	FY95	FY96	FY95	FY96	FY95	FY96
BAY PINES	10,539	9,990	497	468	558	502	226,312	225,941
Ft. Myers							58,178	55,225
GAINESVILLE	8,924	7,480	164	131			154,399	174,358
Daytona Beach							43,175	42,968
Jacksonville							51,925	51,092
LAKE CITY	5,782	5,224	285	395			62,881	72,919
Tallahassee							33,880	37,508
MIAMI	10,718	8,661	404	397			238,289	251,570
Key West							7,507	8,358
Miami							11,164	15,853
Oakland Park							85,899	88,753
SAN JUAN	12,354	11,068	266	314			275,174	265,007
Mayaquez							51.015	47,599
Ponce							48,782	46,662
St. Croix							4,646	4,973
St. Thomas							3,126	2,978
TAMPA	12,550	10,426	486	497			249,338	265,646
Orlando							135,617	156,126
Port Richey							37,214	38,419
WEST PALM	715	3,981	63	179			116,803	229,237
VISN TOTAL	61,582	56,830	2,165	2,381	558	502	1,895,324	2,081,192

West Palm Beach VAMC was activate June 26, 1995

WILLIAM R. KIRSOP
ADJUTANT/QUARTERMASTER
VETERANS OF FOREIGN WARS OF THE U.S.
DEPARTMENT OF FLORIDA

On June 24, 1995, William R. Kirsop was elected to the position of State Adjutant/Quartermaster, Department of Florida Veterans of Foreign Wars. He was re-elected to the position June 22, 1996.

Mr. Kirsop served in the United States Air Force from July 11, 1960 to February 1, 1981. He retired in the grade of Master Sergeant. The majority of his career was in administration and personnel. During his Air Force career he completed two tours of duty in Southeast Asia and a tour with the Defense Attache System, Sofia, Bulgaria. Mr. Kirsop was awarded two (2) Meritorious Service Medals, four (4) Air Force Commendation Medals, a Joint Service Commendation Medal and the Vietnam Service Medal.

Mr. Kirsop joined the Florida Division of Veterans Affairs in 1981 and worked as a Veterans Service Officer for seven (7) years. He was the Veterans of Foreign Wars Service Officer from 1988 to 1995. In these past two positions Mr. Kirsop received no awards, just a lot of satisfaction for helping Veterans.

Mr. Kirsop's volunteer activities include the American Legion, AMVETS and the Benevolent Protective Order of the Elks. During his military career at McDill Air Force Base he was recognized for having over 4,000 military members register to vote in the 1980 election.

Mr. Kirsop has completed extensive training in Veterans Affairs. He attended Proficiency Training Sessions taught by the Department of Veterans Affairs and the VFW Washington Office. He is currently a voluntary member of New Business Development Committee for VISN 8, Department of Veterans Affairs.

Statement of Dyke Shannon, Adjutant
The American Legion Department of Florida
Before the House Veterans' Affairs
Subcommittee on Health.
March 26, 1997

Mr. Chairman and Members of the Subcommittee:

The American Legion Department of Florida appreciates the opportunity to comment on VERA and its impact on VA health care in the sunshine state. My comments today will reflect the Florida American Legion's position and not necessarily The American Legion's official position.

We are hopeful that the implementation of VERA will correct the historical imbalance of VA medical funding in Florida. VERA should greatly assist our regional VISN Director with the means to administer an improved veterans' health care package to include improved access, quality of care, and a wider spectrum of services.

Florida currently has (approximately) 1.7 million veterans -- second only to California. Florida has more veterans 65 years of age and older who have a service connected disability than any other state. Many of these veterans have migrated from the northeast and Midwest to establish a residence here because of the

attractive climate, southern hospitality, and the perceived veterans health care availability. Florida ranks 41st in the nation with VA hospital beds available with only 1.3 beds per 1,000 veterans.

The constant influx of veterans into Florida and other Sunbelt states, coupled with the below average per capita funding provided for VA health care services (Florida currently ranks 42nd) has created a continual, significant shortfall in many types of veterans health care services in VISN 8. This shortfall is further compounded when considering that Florida has the second largest population of veterans with a service connected disability and leads the nation with the number of veterans who are 100% service connected. In addition, a large contingents of military retirees (162,000 plus) have chosen Florida to be their permanent residence. With the cutback of Department of Defense appropriations and corresponding base closure programs it is expected that many of these retirees will be looking to VAMC and outpatient clinics for health care services.

The American Legion National Headquarters is generally supportive of VERA, not withstanding the fact that for some regions to improve their capability to provide improved veterans health care, other regions will realize a corresponding reduction. The American Legion has formed a *Management and Resources Committee* to assess the impact of this quid-pro-quo on its three million veterans, and to monitor VERA during its 3-year

implementation. The Legion's bottom line is that an eligible veteran should never be denied VA health care, regardless of where he or she resides.

We must all realize that health care in America is going through a Renaissance Period not only in the Private Sector, but in the Public Sector, and the VAMC as a whole. We would offer the notion that in three years the entire VA Medical System will be reorganized and serve a more diverse client base. It is our opinion that VERA, and the VISN concept, may only be the beginning of a new and improved health care delivery system.

As a key to success of a commercial business, the paramount element is "location, location, location." A key to the success of the VA Health Care will be accessability, accessibility, accessability." It is our hope that the shift of funds will give the VISN opportunities to fulfill this desired access for veterans.

Veteran health care is a federal issue, not a state or regional problem. Congress must take a holistic approach to the care of those who have defended our freedom. We realize that a reduction in funding for any government agency has political ramifications.

Congress must focus on what is best for the veterans, not what is best for the politician's career.

The Florida American Legion last week, had to defend the shift of funds at a national meeting in Washington, D.C. Fellow

legionnaires from New York, Pennsylvania and Ohio were very upset at the losses they anticipate experiencing.

Once the issue was discussed, it was recognized by all Legion representatives that the increased veterans health care in VISN 8, resulting from VERA, will be available for the large veteran transient contingent who resides for up to half of each calendar year in the Sunbelt region.

The American Legion will watch carefully that any reduction from any VISN will have a corresponding increase in other VISN's equal to the reduction. There must be a check-and-balance system to insure these funds are for direct delivery of health care and do not disappear in special projects initiated by the Central Office of the Veterans' Administration.

In conclusion, the veterans in Florida will be much better served with the implementation of VERA. We have not taken up a lot of time in this testimony to expound on the problems Florida veterans have experienced for the past 20 years. We would refer you to Appendix 1 that is a summary of demographic issues facing Florida veterans.

We wholeheartedly support this initiative, and sincerely hope that it will not become a political football in the next few years. We commend Senator Graham and Congressman McCollum for this realistic approach to veterans health care. We also thank the Florida Congressional Delegation for their support

of the passage of the monumental legislature. Not only is VERA right and fair for all veterans -- it is right for this country's veterans.

Disclosure Statement

The American Legion Department of Florida, Inc. has not received a Federal Grant or Contract relative to this testimony, during the current or previous two fiscal years, from any witness or organization.

Appendix 1

Demographic Issues Supporting an Increase for Florida Veterans Health Care Funding (Source: Florida Department of Veterans Affairs Congressional Delegation Briefing Book - 1997).

1. During the period of 1980 - 1990 nearly one-half (47%) of all veterans who relocated to another state moved to Florida.

2. Over the past two decades (1970-1980-1990) the rate of net growth in Florida's veteran population exceeded 102 veterans per day.

3. During the period of 1980-1990, the veteran growth in Florida out paced the next fastest growing population by nearly 400%.

4. During this period, Florida had a net increase of 349,451 new resident veterans, while the state of New York lost 357,394 of its resident veterans to other states.

5. Florida has the second largest population of veterans with a service connected disability (178 thousand). California has 191 thousand service connected veterans with a much larger vet population (approximately 2.8 million vets).
6. Florida leads the nation with 12 thousand 100% service connected vets. California is second with 11 thousand service connected vets, even though California has more than one million more veterans.

7. Florida leads the nation with those vets who have a 60 to 90% service connected disability (19 thousand). California is third with 16 thousand.

8. Florida has more veterans who are 65 years of age and older and have a service connected disability than any other state.

9. Florida has approximately 162,000 plus military retirees who are residents, second only to California with 210,000.

10. Florida ranks 41st in the nation for VA hospital beds with only 1.3 beds per 1,000 vets.

11. Florida ranks 1st in the nation for vets with a service connected disability requesting health care.

12. Florida ranks 42nd in the nation for per capita funding provided for VA health care services.

STATEMENT

Donald W. Priem, Jr., President
County Veterans Service Officers
Association of Florida &
Lake County Veterans Service Officer

On behalf of the County Veterans Service Officers Association, State of Florida and the 30,000 Veterans of Lake County, I want to thank the House Veteran's Affairs Subcommittee for allowing me the opportunity to address you today.

As I am sure you are aware Florida is home to the second-largest, fastest growing, oldest median-age and most severely serviced-connected disabled population of veterans. Furthermore, Florida has the third largest percentage of it's veterans who have served during a declared wartime period. No other state has so many demographic characteristics competing for VA resources. No other large state has a greater percentage of its population who are Military veterans. Florida's aging veteran population dictates the need for consideration of all alternatives for treatment of those ailments normally associated with aging.

We are hopeful, through the efforts of this subcommittee, that formal procedures will be adopted by the VA to reallocate desperately needed medical care funding, to properly care for Florida veterans.

I would like to take a few moments to share with you examples of the current

inadequacies which exist in Florida due to the current funding shortfalls:

1. Florida residents who are considered as (NSC) non-service connected veterans, and in many cases, are in fact, in receipt of VA pension, have not or are not able to receive medical care on a continuous basis. In most cases when they have attempted to seek care, they were assessed in triage by a cursory exam, may see a PA, prescribed a 30 day supply of medication and told to find a private physician for follow-on care due to the lack of VA funding and the current workload.

Note: When comparing those NSC veterans from other states to Florida veterans, we find the same category of veteran receiving full care in their home of record VAMC.

2. As Veterans Service Officers we are constantly reminded by veterans which relocate to Florida for six months out of the year, that the medical care they receive in their home of record far exceeds that available in the state of Florida.

3. Veterans from other states go to County Service Officers throughout the State of Florida, complaining about the lack of medical service availability. I have seen on many occasions copies of solicitation letters from VAMC in the northern states, which were sent to the veteran indicating that they had not been in for treatment for several years. The letter suggested that the veteran call and make an appointment for a complete exam.

Note: Florida veterans are not extended such privileges and access to medical

care.

4. VAMC's in northern states are more liberal in issuing fee basis cards. Note: Florida does not possess the funding, and therefore, limits fee basis cards dramatically.

We, the County Veterans Service Officers of Florida, recommended several years ago, that a possible solution to this situation would be, that the VA establish a credit card system whereby, a veteran treated in Florida, when presenting this card would generate a transfer of funds from the veterans home of record to the treating facility.

We continue to support the need to properly fund the VA medical system in the State of Florida. The DVA should take the appropriate action necessary to insure adequate funding is established for treatment of all veterans.

I was fortunate to have the opportunity to attend the VERA proposal presented in Gainesville recently. We support the full integration option recommended by the independent consulting firm. We believe that the integration would enhance the health care delivery system in the north central area.

In closing, I would again like to thank the committee for allowing me the opportunity to address you.

April 15, 1997

To: Members of the Veteran's Committee

On November 13, 1996 I gave testamony in person before the Presidental Advisory Committee on Gulf War Veterans' Illnesses. It was a very illuminating morning.There was a vet whose testamony revealed he had,since his Gulf excursion, had his spleen removed, his lymph nodes and various contributions to bone marrow. His diagnosis? Gulf War Illness but not associated with the Gulf War! A member of the committee said "Say that again! He did and the facts did not change. He was particularly upset with the Armed Forces Institute of Pathlogy which "collected the parts and secured them at their facilities and did not inform him of the "collection" and he accidently learned of their possession. Please review the testamony of Arquelio Martinez 11/13/96 so you may assuage any fears you may have that my statements are erroneous. Which brings me to ask you these questions at this time that this "inquiring mind"wants to know.

(1) Dr. Shyh Ching Lo is the recognized authority on MICOPLASMA FERMENTANS (INCOGNITUS STRAIN) and is located at the Department of Infectious Desease at the Armed Forces Institute of Pathology in your backyard in D.C. and he is NOT communicating with any other scientists or physicians...WHY? Who is allowing new the destruction of a segment of our population.

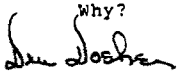
(2) Why was Jonathan B.Tucker dismissed from the President's official investigation into G W Illness and ordered not to interview certain persons and researchers that have been the target also for termination by the government agencies that

have information relevant to the illnesses.

(3) Why is Dr. Garth Nicolson who has given recent testamony before Representative Dicks committee drummed out of the M.D. Anderson Cancer Center in Texas for refusing to be silent on the "strain"(that Dr. Lo has knowledgeof)Dr. Nicolson 's work was dismissed at a recent meeting in Gainesville, Florida of the Veteran's Health Committee and he was referred to by Robert H. Roswell M.D of the VETERANS HEALTH ADMINISTRATION as just a scientist who was refusing to work with certain doctors. Check that for truth!

(4) After many faxes to the American Red Cross(Mrs. Dole)about J.William Costello's affadavit on the collection of Gulf Veterans blood which he deemed contaminatedand Mrs. Doles refusal to respond to me. I ask why General Blanck lifted the ban,why Costello was released from his job for philosophical differences. The ARC recently issued a statement that said they should not have accepted more than 35,000 donations dueto other reasons but made no mention of all the violations of their own donor procedures with regard to Gulf veterans blood.

(5) Why there is NO lab that can do GENE SPLICING to reveal the presence or absence of the mycoplasma microorganism.Why there is no help on coming just rhetoric...meetings & more meetings the rankest form of job protection...The military have a saying " if you're not a part of the solution, you are part of the problem. Which committe are you currently a part of? Why?



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