

Statement of

VIETNAM VETERANS OF AMERICA

Submitted for the Record

By

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And

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Before the Subcommittee on Oversight and Investigations

House Committee on Veterans Affairs

Regarding

The VA's Medical Care Collection Fund and related issues

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Mr. Chairman and other distinguished members of the Committee, Vietnam Veterans of America (VVA) is pleased to have this opportunity to provide our comments for the record on our concerns regarding the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF) and contracting issues within the VA.

As you know, in 1986 Congress authorized the VA to begin receiving third-party payments from insurers who covered non-service connected veterans. In 1990, Congress subsequently expanded the VA's authority to bill for medical care provided to insured service-connected veterans, provided the treatment was for a non-service connected condition. The Balance Budget Act of 1997 further revised the system to allow the VA to retain all third-party reimbursements, and created a specific fund for this purpose, the Medical Care Collection Fund (MCCF). MCCF monies can be used to fund both medical care collection activities and to provide health care services to veterans. Through the MCCF, the VA is allowed to bill insurers at market rates.

The VA has, as part of its overall strategic plan, repeatedly told the Congress that it has a goal of generating at least 10% of its funding from "alternative revenue streams," a euphemism for the MCCF and the deductibles and co-payments charged to Category 7 veterans. The VA has never reached this goal due to a number of factors.

First, VA has an abysmal track record of collecting from private insurers. As GAO reported in 1999, VA collections from insurers declined in every fiscal year from 1995 through 1999 (the last date for which VVA has figures). From a peak of \$532 million in 1995, VA third-party collections declined to roughly \$400 million by the end of fiscal year 1999. VA has even had to retain a private contractor to help it collect on delinquent bills. This is clearly a case of gross mismanagement at the VA, and we sincerely hope that today's hearing will serve as a wake up call for senior VA leaders where this aspect of the MCCF problem is concerned. Although collections to MCCF this year are up significantly, the cost of collecting these payments still makes this a marginal source of revenues. Part of the problem is that it is clear that the Office of Management & Budget (OMB) "discounts" the Veterans Health Administration budget request by the amount in collections anticipated, making the collections a wash in terms of bringing more revenue into the health care system.

Additionally, VA's shift from an inpatient-based to an outpatient-based health care model has dramatically reduced the number of opportunities to bill insurers for medical services; outpatient treatment episodes are almost always less costly than inpatient encounters. GAO reported in September 1999 that the annual number of VA inpatient episodes dropped by more than 250,000 between 1995 and 1998, while the number of outpatient episodes climbed by nearly 7 million.

VVA does not at present have figures on the numbers of outpatient encounters involving over-65 veterans. We would suggest to the committee that this is an area requiring further study and investigation, because another key problem facing the MCCF—and one completely outside of the VA's control—is the aging veteran population. An increasing number of veterans are over

65 and thus Medicare eligible. At present, however, there is no Medicare subvention program available to the VA through which the VA could bill Medicare for veteran's health care. Because the VA is not an authorized provider under any existing HMO plan, VA cannot bill those plans for services provided to veterans.

This issue is becoming more acute due to the VA's Capital Asset Realignment for Enhanced Services (CARES) process. In essence, CARES serves as a vehicle for the VA to shut down aging medical centers, shift functions and services to more modern facilities, and expand the number of community based outpatient clinics (CBOCs) within the VA system. We have testified before the full committee on previous occasions about our growing concerns over the decline in access to VA health care for hundreds of thousands of veterans across America.

On September 17, VVA filed comments with the VA opposing their proposed CARES-driven reorganization of VISN 12 primarily because of the VA's refusal to contract for medical service for veterans living in regions not within an easy drive of a VAMC. Similarly, the VA's inability to bill Medicare for services compromises health care for elderly veterans by tying over-65 veterans to VAMCs that are often hours from their homes. These issues are closely linked, and as such require a comprehensive Congressional response.

Reestablishing effective health care for veterans is VVA's number one legislative priority, and to that end, we would like to offer our suggestions on how the Congress should approach the MCCF issue in the broader context of veteran's health care.

To help deal with the immediate problem of inadequate management oversight of the MCCF overdue bill account, the Congress should mandate that the Secretary of Veterans Affairs provide an annual report on the status of overdue bills. Moreover, Congress should pass legislation that levies a \$10,000/day fine on any insurer who is more than 90 days in arrears to the VA. We are confident that such punitive measures would quickly incentivize private insurers to settle their accounts with the VA.

Secondly, the VA must do a better job of collecting insurance information from veterans in order to properly charge for services billed. GAO has repeatedly found the VA deficient in this area, and only strong management action will likely correct the problem.

Third, it appears that at least some insurers continue to use exclusionary clauses denying payment for care given at VA facilities. Our understanding is that there is no legal basis for any insurer to make such stipulations, and accordingly, Congress should pass legislation to ban such practices by insurers and to institute severe financial penalties for insurers who attempt to continue such practices.

Fourth, the VA must be compelled to make its diagnostic and billing systems compatible with those used in the private sector. Too often, GAO has reported that insurers have denied payment because of questions about the medical necessity of VA procedures; some of these denials are the result of the VA providing inadequate billing details to the insurer. The VA must

be brought into compliance with the wider health care industry where billing issues are concerned if these problems are to be eliminated and recoveries increased.

Fifth, the Congress must examine the MCCF issue in the broader context of veterans' declining access to quality health care. Although Medicare subvention for VA might address some of these issues in the short to medium term, a recent Department of Defense (DoD) Medicare subvention pilot project offers some insight into potential problems and limitations that any VA Medicare subvention program might encounter.

When it began its Medicare subvention pilot program in 1998, DoD had no experience dealing with the guidelines established by the Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration or "HCFA"). It took DoD more than a year to actually get the program off the ground; once the program was in place, however, it was generally successful at all of the demonstration sites, according to GAO.

DoD officials involved in the pilot projection admitted to GAO that HCFA/CMS standards forced participating sites to improve their medical record keeping and adopt some important "best practices" from the private sector. Accordingly, there is reason to believe that the VA could benefit in a similar fashion from such a program.

At least one problem encountered in the DoD Medicare subvention pilot—military medical staff turnover and deployments—would not in all likelihood affect the VA system. Other problems—such as the reluctance of providers to accept rates that are lower than the out-of-network rate they could otherwise receive—would likewise plague a VA Medicare subvention effort. Additionally, veterans may still face problems of distance to providers for certain specialized services even under a subvention scheme.

Our view is that the true solution to reestablishing effective health care for veterans requires a) adequate funding for the existing VA health care system, and b) effective use of contract medical services for veterans living in rural or other remote submarkets. In our comments to the VA regarding its proposed reorganization of VISN 12 via the CARES process, we noted that as there is no VAMC in the region between Iron Mountain and Tomah, we found it incomprehensible that the VA would select options that do not *mandate* medical service contracting for the nearly 100,000 veterans who live in these two markets. We are certain similar situations exist across the country, and that therefore the need for contract medical services is real and growing.

Sixth, Vietnam Veterans of America (VVA) is concerned about the strong-arm collections techniques used on veterans who have legitimate claims that have been pending for years at the Veterans Benefits Administration. VVA knows of specific instances where veterans have withdrawn from needed treatment because of the seizure of tax refunds and damage being done to their credit rating. In the instances cited, VBA subsequently granted the claim, but the damage was already done. Not even an apology was forthcoming from VA.

Mr. Chairman, VVA suggests that Committee work with the VA to devise a way to truly develop and expedite claims where there is an MCCF payment problem that may well cause the veteran to drop out of vitally needed treatment. While we know that improving the quality and reducing the time a veteran has to wait for a fair and accurate determination on that veteran's claim is important, we have a very long way to go in many geographic area. In the meantime, it is clear that some sort of forbearance and expediting combination of actions is needed, if VA is to truly live up to the Secretary's mandate of "One VA."

Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these extremely important issues, and we look forward to working with you, Mr. Chairman, and your distinguished colleagues on this Committee to address and resolve these and other important matters of concern to our nation's veterans.

VIETNAM VETERANS OF AMERICA
Funding Statement
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Vietnam Veterans of America (VVA) is a national non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

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Philip A. Litteer, Esq. has served as Chair of VVA's National Government Affairs Committee since April 1998. He has also variously served as an officer, director, delegate, and committee member in VVA at the national, state, and local levels since 1988. Mr. Litteer is a life member of VVA, and a member of the American Legion.

A lifelong resident of western New York state, Mr. Litteer has served in his community as an elected official, and maintains an active role in community affairs, in addition to his work on veterans issues.

Mr. Litteer is employed as the Principal Law Clerk to a Supreme Court Justice in Rochester, N.Y. He holds Bachelors and Masters degrees from the State University of New York and graduated from the Syracuse University College of Law in 1988. He and his wife Theresa, a former Army nurse who he met in 1968, have two grown sons—one, a computer software engineer who is an Army Reserve Captain; the other, a research chemist in Madison, Wisconsin. Phil and Theresa—who have recently become grandparents—reside in Rochester, New York.

Patrick G. Eddington
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Patrick G. Eddington was an award-winning military imagery analyst at the CIA's National Photographic Interpretation Center for almost nine years. He received numerous accolades for his analytical work, including letters of commendation from the Joint Special Operations Command, the Joint Warfare Analysis Center and the CIA's Office of Military Affairs.

During his tenure at CIA, Eddington worked a wide range of intelligence issues. His analytical assignments included monitoring the break-up of the former Soviet Union; providing military assessments to policy makers on Iraqi and Iranian conventional forces; and coordinating the CIA's military targeting support to NATO during Operation Deliberate Force in Bosnia in 1995.

Eddington received his undergraduate degree in International Affairs from Southwest Missouri State University in 1985. While at the CIA, Eddington took a one-year sabbatical to attend Georgetown University, earning a master's degree in National Security Studies. Eddington spent eleven years in the U.S. Army Reserve and the National Guard in both enlisted and commissioned service.

Currently, Eddington serves as Associate Director of Government Relations for Vietnam Veterans of America. Eddington's opinion pieces have appeared in a number of publications, including the *Washington Post*, *Los Angeles Times*, *Washington Times*, *Fort Worth Star-Telegram*, and the *Army Times*, among others. Eddington is a frequent commentator on national security issues for the Fox News Channel, MSNBC, SKYNews, CNN, and other domestic and international television networks. His first book, *Gassed in the Gulf*, was featured on the September 20, 1997 edition of CSPAN's "About Books" program.

Eddington is a member of the Authors Guild and Amnesty International. He also serves on the board of directors of the James Madison Project, a Washington, D.C.-based nonprofit advocacy organization focusing on 1st Amendment issues as they relate to national defense, foreign affairs, intelligence, and veterans policy. He and his wife Robin live in Alexandria, Virginia.