

**STATEMENT OF
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WASHINGTON HEADQUARTERS
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.
MARCH 29, 2006**

Mr. Chairman and Members of the Committee:

Thank you for requesting the views of the veterans service organizations that produce the annual *Independent Budget (IB)* on the question of VA's efforts to establish a demonstration project, now called "Healthcare Effectiveness through Resource Optimization" (Project HERO). This demonstration project was directed to be carried out by the Conference Report on VA's fiscal year 2006 appropriation, Public Law 109-114. The demonstration project is aimed at coordination of contract care for veterans eligible for outpatient or inpatient services at VA expense provided by private health care providers.

My testimony today is a compendium of the views of the *IB* organizations—AMVETS, Paralyzed Veterans of America (PVA), Veterans of Foreign Wars of the United States (VFW), and my own organization, the Disabled American Veterans (DAV). All of these organizations appreciate this opportunity to testify.

In general, current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. VA also has authority to contract for the services in VA facilities of scarce medical specialists. Beyond these limits, there is no general authority in the law to support any broad contracting for populations of veterans. The *IB* veterans service organizations (IBVSOs) agree and accept that VA contract care for eligible veterans should be used judiciously and only in these specific circumstances so as not to endanger VA facilities' ability to maintain a full range of specialized inpatient services for all enrolled veterans. We believe VA must maintain a "critical mass" of capital, human and technical resources to promote effective, high quality care for veterans, especially those disabled in military service and those with highly sophisticated health problems such as blindness, amputations, spinal cord injury or chronic mental health problems. We are concerned that in an open environment of mixed government and private providers with tight budgets, the contracted element (particularly if it were focused on acute and primary care to large populations) would inevitably grow over time, and place at risk VA's well-recognized qualities as a renowned and comprehensive provider. We believe such a distributed program would not

only become prohibitively expensive, but also could damage VA's health professions affiliations—the bedrock of VA quality care.

We believe the best course for most enrolled veterans in VA health care is VA's providing continuity of care in facilities under the direct jurisdiction of the Secretary of Veterans Affairs. For the past twenty-five years or more all major veterans service organizations have consistently opposed a series of proposals seeking to contract out or to “privatize” VA health care to non-VA providers on a broad or general basis. Specific incidences of such proposals have occurred in the states of Maryland, Minnesota, Oregon and Florida. Ultimately, these ideas were rejected by Congress or the Federal courts. We believe such proposals—ostensibly seeking to expand VA health care services into broader areas serving additional veteran populations at less cost, or providing health care vouchers enabling veterans to choose private providers in lieu of VA programs, in the end only dilute the quality and quantity of VA services for all veteran patients. Given the dire financial straits VA has experienced over several recent fiscal years, this is an important policy to sick and disabled veterans, and to those who represent their interests.

Mr. Chairman, aside from these concerns, we all observe that VA's contract workloads have grown significantly. VA currently spends \$2 billion or more each year on contract health care services, from all sources. Unfortunately, VA has not been able to monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most contract providers. VA has no systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health-care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

Twice in the *IB* we have recommended that VA implement a program of community contract care coordination that includes integrated clinical and claims information for veterans currently cared for by community-based providers. However, one small element of our concept is now in place. VA's currently authorized “Preferred Pricing Program” allows VA medical facilities to conserve funds when veterans (under the eligibility limitations enumerated earlier) find it necessary today to use non-VA medical services. In this program, VA receives negotiated network discounts through a preexisting preferred pricing program that is organized under contract with VA by HealthNet Federal Services, Inc. However, VA currently has no system in place to direct veteran patients to that network so that VA can:

- receive discounted rates for the services rendered;
- use a mechanism to refer patients to credentialed providers in that network; and
- exchange clinical information with non-VA providers.

Although preferred pricing has been available to all VA medical centers (VAMCs) for several years, if a veteran randomly uses one of HealthNet's preferred providers for care, some facilities have not taken advantage of the cost savings available from this arrangement. Therefore, in many cases, VA facilities have paid more for contracted health care than would be necessary under the HealthNet arrangement.

We are pleased that in response to this discovery pointed out by the IBVSOs, in October 2005, the VA made mandatory VAMC participation in the Preferred Pricing Program. In anticipation of full implementation, VA has reported potential savings of \$80 million in spending in fiscal year 2006 alone.

Despite the significant savings that have been achieved through Preferred Pricing Program (more than \$53 million since its inception), several major improvements could be made to improve access, quality, and cost of non-VA care. The Preferred Pricing Program is the foundation upon which a more proactively managed VA contract care program could be established that not only would save significantly more money in the purchased care programs, but, more important, would provide the Veterans Health Administration (VHA) a mechanism to fully integrate veterans' community-provided medical care into the VA health care system. By partnering with an experienced contractor, VA could define a care management model with a high probability of achieving its health-care system objectives: integrated, timely, accessible, appropriate, and quality care purchased at the best value for taxpayers. The IBVSOs believe the program's features should include:

- Customized provider networks complementing the capabilities and capacities of each VAMC. Such contracted networks should address timeliness, access, and cost effectiveness of their care. Additionally, the care coordination contractor should require providers to meet specific requirements, such as providing timely and complete clinical information to VA, timely submission of reimbursement claims, use of standardized electronic claims, meeting established VA access standards, and complying with overall VA performance standards.
- Customized care management to assist every veteran and each VAMC when a veteran must receive non-VA care. By matching the appropriate non-VA care to the veteran's medical condition, the care coordination contractor could address appropriateness and continuity of care. The result could offer veterans a truly integrated, seamless health care delivery system.
- Improved veteran satisfaction; and
- Optimized workload for VA facilities and their academic affiliates while cost for non-VA care is reduced.

Currently, many veterans are disengaged from the VA health care system when receiving medical services from private nonparticipating physicians at VA expense. Additionally, VA is not fully optimizing its resources to improve timely access to medical care through coordination of private contracted community-based care.

Prior to the completion and full implementation of the Capital Asset Realignment for Enhanced Services (CARES) plan, it will be crucial for VA to develop an effective care

coordination model that achieves VA's health care and financial objectives. A care coordination contractor could be used to ensure successful implementation of CARES plans in local VA facilities whose inpatient missions are changing, thereby preventing unexpected backlogs. Developing an effective care coordination model would improve patient care quality, optimize use of VA's increasingly limited resources, and prevent overpayments when eligible veterans utilize community contracted care.

Mr. Chairman, the information expressed above is the basis for the *IB* recommendation on coordination of community care. We cannot testify today that, based on our current knowledge of VA's pending demonstration project called "HERO," that VA is developing our recommended model into that demonstration. Both at the Industry Forum hosted by VA in February to announce its plans for HERO and in more recent meetings with VA officials we have expressed concern about the lack of specificity of the shape, scope, size, depth and duration of the coming demonstration. We do not have even a clear sense of the goals of HERO. Within the past week, we have learned the proposed geographical sites for this demonstration (Veterans Integrated Service Networks [VISNs] 8, 16, 20 and 23); however, we have not been briefed on the status of any industry proposals that may be shaping VA's planned solicitation of bids. The IBVSOs are united that whatever emerges from that industry, we believe as representatives of millions of enrolled, sick and disabled veterans, that the VHA needs to coordinate with our community any proposed decision-making on the HERO initiative.

Several times VA has indicated that, in HERO, it is implementing our *IB* community care coordination recommendation. As indicated earlier, we believe we stated our intent clearly—that VA's unmanaged programs in community care were not only expensive and growing but were entirely discontinuous from VA's excellent internal health care programs and were absent the numerous protections and safeguards that are the hallmarks of VA health care today. We believe that more proactive management of fee and contract services by VA can provide greater continuity of care for veterans, better clinical record-keeping, higher quality outcomes and reduced expense to the Department.

We are concerned that in developing this new HERO model, the Department has strayed far off course from the intent of the *IB*'s recommendations for fee and contract care management. Mr. Chairman, as you and other members of this Committee well know, our organizations will strongly support and defend what is recommended in the *IB*; however, until our concerns are allayed about the true nature and goals of HERO, that demonstration project should not be attributed to, or justified by, our recommendation in the *IB*. Based on what we know and considering all that we do not know about HERO at this point, we do not conclude that HERO is consistent with our goals.

It is our hope that the Department will shift the focus of HERO to achieve the goals of the *IB*. We pledge to work with this Committee and with the Under Secretary for Health to secure that goal.

Mr. Chairman, this concludes my testimony, and I will be pleased to consider your questions on this important topic.