

**STATEMENT OF THOMAS L. GARTHWAITE, M.D.
DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
OF THE
UNITED STATES SENATE
JULY 25, 1997**

Mr. Chairman and Members:

I am pleased to be here to discuss the array of bills being considered by the Committee. Included is S. 801, a bill that would make changes in procedures for resolving complaints of employment discrimination and sexual harassment, S. 999, a bill pertaining to setting standards for how frequently we should offer mammograms to women veterans, and a draft bill that would change our health care resource allocation system. You also asked that we comment on a bill making technical amendments to the eligibility legislation enacted last year, a bill extending a number of expiring authorities, a draft bill containing authorizations for constructions projects, and finally, S. 309, a bill pertaining to parking fees at a VA facility in Hawaii.

S. 801

S. 801 would establish a new statutory equal employment opportunity complaint system for the VA. It would create a new office charged with the responsibility of overseeing the discrimination complaint system. It would require employment of full-time EEO counselors, investigators, and would legislatively establish a cadre of Administrative Law Judges to render both procedural and substantive final agency decisions on all EEO complaints filed after a transition period following enactment.

We oppose enactment of S. 801 for several reasons. First, if enacted, this bill will remove the administrative flexibility needed by the Secretary to adapt to changing needs and circumstances that might arise as a result of any government-wide complaint processing changes that might be implemented by the EEOC, or changed circumstances within the Department.

Second, the bill singles out and subjects VA and its employees to a complaint process that grants fewer rights and would be quite different from the rest of the Federal government. For example, the bill denies VA employees the right to file EEO complaints concerning the most significant personnel actions that can occur in Federal employment, such as removals and reductions in grade. Other Federal government employees would still have the right to choose between the EEO complaint process and the MSPB's appeal procedures if they wished to challenge such actions. VA employees, on the other hand, would be restricted to

the MSPB's forum only. VA's employees should have the same rights as other Federal government employees to choose between the EEOC's procedures and the MSPB's procedures.

Third, the bill purports to eliminate the perception that the Department decides complaints against itself; that, in effect, "the fox is guarding the hen house." We doubt, however, that the bill would dispel this perception. The bill would still provide for the Department to accept, investigate, and decide complaints against itself. Although VA administrative law judges, rather than VA attorneys, would issue decisions under the bill, it is unlikely that VA employees "outside the beltway" would appreciate the distinction. The administrative law judges would still be viewed by the rank and file as VA employees who are controlled by the Department.

Finally, and perhaps most significant, most of the changes in the bill can be accomplished by an administrative reorganization. A legislative mandate will not be required. We can reach the same result administratively and we are committed to doing so.

DRAFT BILL -- HEALTH CARE RESOURCE ALLOCATION

Another draft bill being considered today would add a new section to chapter 73 of title 38, United States Code, directing the Secretary, in consultation with the Under Secretary for Health, to allocate health care resources to the Veterans Integrated Service Networks (VISN) on the basis of veteran population in each network. The proposed new statute would require the Secretary to annually develop a plan for resource allocation that includes four specific statutory requirements, and it would require an annual report to the Congress on VA's progress in carrying out the law. Finally, the draft bill would repeal a provision in VA's Appropriations Act for Fiscal Year 1997 which pertains to health care resource allocation.

The Department strongly opposes the enactment of this draft bill. As you know, earlier this year we submitted a health care resource allocation plan to the Congress in response to a statutory requirement imposed in our Appropriations Act for this fiscal year. That same requirement directed that we implement the plan not later than 60 days after its submission to Congress, and we have done that. We believe the resource allocation methodology we have implemented is at this time the best and most appropriate way to allocate resources throughout the Nation to ensure that veterans with similar eligibility priority have equal access to VA care. To alter the new allocation methodology by basing it on total veteran population, as this draft bill would do, would result in misallocation of resources, since veteran population is not an indicator of need or demand.

On the other hand, the Veterans Equitable Resource Allocation (VERA) model which we developed and have implemented is based on actual veteran usage of the VA system. Historical usage of the system is the only reliable information available at this time to determine how many veterans actually need and will use the system. In initially developing the VERA model, one option we considered was basing the system on veteran population in each VISN, but we rejected that option as inappropriate, for several reasons.

First, the use of total veteran population in each VISN would fail to protect VA's higher cost, special care programs, because it would result in allocating the same funding for veterans who receive their health care from non-VA sources as it would for current patients who depend on VA, such as those with spinal cord injuries.

Second, we would not be according priority in funding to those veterans with the highest priority for care, the so-called "category A" veterans, because we would be allocating resources to higher income veterans who have no service-connected disabilities on the same basis as allocations are made to category A veterans.

Third, funding would not be based on indicators of how many veterans are likely to use the VA, but rather on a population number that bears no historical relationship to actual use of VA health care. That would require distribution of medical care dollars to provide treatment to veterans whom we do not expect to come to VA.

Finally, there is no evidence that the total veteran population is a good predictor of future workload.

In our view, the best predictor at this time, of expected workload is the number of veterans who have demonstrated a need for care and have chosen VA as their healthcare provider--that is, the historical user population. This system for predicting future workload in each VISN is much more valid than using total veteran population.

S. 999--MAMMOGRAM SCREENINGS

S. 999 would require the Department to provide mammograms to women veterans at the age and rate currently recommended by the American Cancer Society. We strongly oppose this bill.

The issue of mammogram screenings for women between the age of 40 and 49 rose to the forefront in January of 1997 when the National Institutes of Health Consensus Conference agreed with other experts (including the U.S. Preventive Services Task Force, The American College of Physicians, and the Canadian

Task Force on the Periodic Health Examination) that there was no strong evidence on which to base a recommendation that women aged 40 to 49 have routine mammograms. The Director of the National Cancer Institute subsequently convened a National Cancer Advisory Board to review the evidence. This board concluded that the evidence supported recommending that women in this age group have routine mammograms, i.e., every one or two years.

It is not uncommon for scientific and medical experts to reach differing conclusions based on their interpretations of the same evidence. At best, one can say that the question of whether women in this age bracket should receive annual or bi-annual mammograms is still being debated and is far from decided. It will take time for a consensus on this matter to develop in the relevant medical and scientific communities. Consequently, the American Cancer Society's recommendation cannot be said to establish the accepted national clinical standard on frequency of mammograms for this age group. Moreover, the American Cancer Society is not recognized by many experts as the entity able to alone establish such a standard.

As for VA's position in this debate, we are considering our policy on frequency of mammograms in light of this controversy. VA's current clinical guidelines on mammograms were issued before the controversy occurred in January of 1997; they recommend mammograms for women from age 50 to 69. However, in light of this controversy, our National Center for Health Promotion has been directed to study this issue and to revise, if and as appropriate, VA's guidelines for mammography in VA facilities. New mammography guidelines should be in place in six months. However, we underscore that we will only revise our policy on frequency of mammograms if, in our medical judgment, the evidence to date compels a revision. In the interim, we are confident that women veterans in this age bracket are receiving adequate mammography screenings. A direct inquiry of women veterans performed by the Center for Health Promotion recently revealed that 75% of women veterans between the ages of 40 and 49 reported receiving a mammogram within the past two years.

Clinical standards should not be established by statute. Such standards are, by their nature, ever changing. As medical knowledge advances, clinical treatments and standards are revised as necessary. In some cases, they are changed or replaced completely by a more suitable treatment protocol. Even when clinical standards are recognized and accepted by the medical profession, they must still be adapted to every individual patient's clinical needs. It is crucial these standards be flexible. For that reason, they must serve more as "guidelines" than rules for the practitioner.

DRAFT BILL -- TECHNICAL AMENDMENTS TO P.L. 104-262

Also before you today is a draft bill that would make a number of technical and relatively minor amendments to the eligibility reform law that Congress enacted last Fall. We reviewed all of the proposed changes and they appear to be warranted. Accordingly, we support enactment of the bill.

DRAFT BILL -- EXTENSIONS OF AUTHORITY

Another draft bill being considered today would extend the authority for several successful VA programs, including VA's homeless programs. Authority for all the affected programs will otherwise expire at the end of this calendar year.

HOMELESS PROGRAMS

The draft would extend authority for five VA programs for homeless veterans. First, it would extend for three years, VA's authority to contract for care, treatment, and rehabilitative services for alcohol and drug abuse and disabilities in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities. Second, it would extend for three years our demonstration program to provide compensated work therapy and therapeutic transitional housing to eligible veterans, and our authority to convey real property acquired under the Department's home loan guaranty program to nonprofit organizations, states, and local governments which agree to use the property solely as a shelter primarily for homeless veterans and their families.

The bill would provide a two-year extension of our authority to operate demonstration programs for the provision of comprehensive services to homeless veterans, and make grants and per diem payments to homeless providers who provide housing and services to homeless veterans. It also would extend for two years the Homeless Veterans Reintegration Projects Program, a Labor Department administered program authorized in the Stewart B. McKinney Homeless Assistance Act.

We strongly support extending these programs. As we have stated in past reports to Congress and in previous hearings, these programs have proven very successful in helping VA meet the medical needs of this very vulnerable population of veterans. However, as an alternative to simply extending some of these programs, we urge the Committee to consider a bill currently pending in the House which would consolidate, clarify, and codify in a new subchapter of chapter 17 of title 38, United States Code, authority for several of these VA homeless activities. The House Bill would, to some extent, replace the patchwork of currently existing programs, several of which are authorized in Public Laws, not in title 38, United States Code.

Specifically, the House bill would provide new authority to replace existing law authorizing VA's contract program for treating veterans with drug and alcohol abuse disabilities in halfway houses and community-based facilities, but leave the program entirely unchanged. It would also continue and improve VA's Compensated Work Therapy/Transitional Residence Program (CWT/TR). It would consolidate existing reporting requirements into one annual report addressing all of the homeless programs. Finally, it would codify authority for VA's program for Homeless Chronically Mentally Ill Veterans (HCMI), a program that we note you did not extend in your bill, but which we believe should be extended unless you act favorably on the House bill.

NONINSTITUTIONAL ALTERNATIVES TO NURSING HOME CARE

Another provision in the draft bill would extend VA's Pilot Program for Noninstitutional Alternatives to Nursing Home Care. VA currently uses this authority to furnish many veterans with health related services through contracts with appropriate public and private agencies. This enables many veterans to continue living in their homes when they would otherwise have to receive care in much costlier nursing homes. We support continuation of this authority which provides an alternative means for providing veterans with a full continuum of care.

SCHOLARSHIP PROGRAM

Another provision in the draft bill would extend through December 31, 2000, VA's authority to award scholarships under VA's Health Professional Scholarship Program. This program has assisted VA in recruiting and retaining various health professionals, most notably nurses, physical therapists, occupational therapists, nurse anesthetists, and respiratory therapists. Under the program, VA furnished students in the above professions with scholarships during the final year or two of their education program. In return the student agreed to work for VA for a specified period of obligated service.

Although we do not oppose extending this authority, it is unnecessary as VA no longer uses the authority. VA made its last award under this program at the end of 1995. Since then, we have not funded this program and we do not expect to fund it in the future. We are now placing the last scholarship recipients in jobs.

We view this centralized program as unable to meet the Department's needs at a time when more and more program responsibilities are being de-centralized to the field. Moreover, the costs of the program increased significantly over time, mirroring the rising costs of tuition and training, and the program yielded fewer and fewer benefits to VA.

ENHANCED USE LEASING

Another provision in the draft bill would extend for three years, VA's authority to enter into enhanced-use leases of VA real property. Under the highly successful enhanced-use leasing program, the Department enters into leasing arrangements with private sector entities to obtain resources beneficial to both parties. In return for long-term leases, the Department is able to obtain goods, cash, or services, such as space in a building built by the lessee.

We strongly support continuation of this valuable program, but we want to point out that current workload indicates that the existing cap on the number of enhanced-use leases could be reached in the next fiscal year. The Administration is working on a proposal to improve the current authority.

S. 309 -- PARKING FEES

S. 309 would amend section 8109 of title 38, United States Code, to prohibit the VA Secretary from establishing a schedule of parking fees for any parking facilities used in conjunction with a medical facility operated jointly by the Secretary and the Department of Defense under an agreement or contract entered into pursuant to section 8111 of title 38.

There is a unique situation in Hawaii where VA built a parking garage at a DOD facility. The garage is jointly used by VA and DOD personnel as well as veterans and others visiting the facility. DOD does not charge for parking at its facility, but VA must charge in the parking garage it built. It is very difficult to operate a garage with this situation, and not particularly cost-effective. This legislation would exempt the VA from having to charge for parking in this facility. We have no objection to the legislation.

DRAFT BILL -- AUTHORIZATION OF MAJOR VA MEDICAL FACILITY PROJECTS AND LEASES

The final draft bill on today's agenda would authorize VA to carryout a major medical facility construction project and to enter into major medical facility leases. We support the enactment of the bill.

First, it would authorize the construction of a seismic corrections project in Memphis, Tennessee, in the amount of \$107,600,000. It would allow the major medical facility project to be deemed fully authorized if the amount of funds appropriated for fiscal year 1998 or 1999 for design and partial construction is less than the amount required to complete the construction of the project as authorized and if the Secretary obligates funds for such construction of the major medical facility. Such authorization shall cease to have effect at the close of fiscal year 2002.

The draft bill would also authorize seven leases. Two of the leases are for information resources management field offices. One would be in Birmingham,

Alabama, in an amount not to exceed \$595,000. The second would be in Salt Lake City, Utah, in an amount not to exceed \$652,000. The other five leases are all for satellite outpatient clinics. They include a clinic in Jacksonville, Florida, in an amount not to exceed \$3,095,000; a clinic in Boston, Massachusetts, in an amount not to exceed \$5,215,000; a clinic in Canton, Ohio, in an amount not to exceed \$735,000; a clinic in Tulsa, Oklahoma, in an amount not to exceed \$2,112,000; and a clinic in Portland, Oregon, in an amount not to exceed \$1,919,000.

The draft bill would authorize for appropriation for fiscal years 1998 and 1999, \$34,600,000 for the construction project, and \$14,323,000 for the leases. It would also allow the construction to be carried out by 1) using funds appropriated for fiscal year 1998 or fiscal year 1999 consistent with the authorization of appropriations in the bill; 2) using funds appropriated for major construction projects for a fiscal year before fiscal year 1998 that remain available for obligation; and 3) funds appropriated for major construction projects for fiscal years 1998 or 1999 for a category of activity not specific to a project.

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