Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. fax	cover sheet, Molly Brostrom to Gordon Adams et al (partial) (1 page)	09/20/1995	P6/b(6)
001b. memo	Jeremy Ben-Ami et al to Peter Beach et al re Fall IVPG Meeting with Outside Groups (partial) (2 pages)	09/19/1995	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Molly Brostrom
OA/Box Number: 8398

FOLDER TITLE:
Joint Interagency Veterans Policy Group/VSOs [Veterans Service Organizations] Meeting, Oct 12, [1995]

2012-0326-S
kc787

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

07-Sep-1995 06:27pm

TO: Nancy-Ann E. Min
TO: Lee A. Satterfield

FROM: Molly Brostrom
Economic and Domestic Policy

CC: LeeAnn Inadomi
CC: Jeremy D. Benami

SUBJECT: Next IVPG Mtg

At the last Interagency Veterans Policy Groups, the veterans and military coalition groups asked that the next meeting be with agency representatives as well as White House reps. I wanted to get your reactions to our thoughts on how this meeting would be set up.

Invitees: the 19 veterans and military coalition groups we usually invite; representatives from OMB, VA, DOD, HUD, DOL, HHS, (NPR? OPM?), as well as the usual DPC, Cabinet Affairs, and OPL.

Discussion Format: Structure the discussion around two general categories that encompass the key issues that the groups have raised in the past--

*Health Care and Defense/Veteran community (would include Subvention, Tricare, other health care changes)

*Economic status of veterans (would include impact of base closure and mil downsizing, Empl&Training, homelessness).

Limiting the discussion to these areas would allow us to limit the agency reps required for responses. Other issues could be submitted in writing and followed up on in future meetings.

Ask each group to submit position papers ahead of time, and to limit remarks to set amount of time, giving agency reps opportunity to comment/respond.

Location: WH Conference Center (given size of meeting and bad acoustics in Indian Treaty Room)

Date: Early October

We hope to send out invitations next week, so please let me know if you have any thoughts/reactions soon.

-Rm for 50
- invites at last minute prior

? mtg
- date: end of Sept/at earliest/early Oct
- Simple, structured
- drop by from Pres.
→ WH letterhead

Interagency Veterans Policy Working Group

There are 19 organizations representing major VSO/Military Coalition interest.

It is recommended that the Catholic War veterans be dropped- non participation.

It has been proposed that a joint meeting be held with the 18 organization representatives and the federal agency representatives.

It is important that the principals from OPL, Cabinet Affairs and Domestic policy participate in a joint meeting.

The meeting must be structured and tightly controlled

A review of past (on going) issues reflects that the concerns fall generally into;

1. Health Care (VA/DOD)
2. Economic (federal/private)
3. budget (VA/DOD)

The meeting should not last more than two (2) hours

Indian Treaty Room OEOB is a marginal space for holding the meeting (acoustics/security)

The W.H. Conference center is the best location in terms of space and coordination. It does create difficulties for the participation of the principals.

W.H. conference center has been used before by the IAVPWG and Alexis Herman chaired the entire meeting.

Organizations should be required to provide written input prior to the meeting that is to be shared with all participants. Oral input should be a five minute summary of the written text.

Suggested flow

Welcome by W.H. Chief of Staff (talking paper jointly prepared)

remarks by the principals - meeting chaired by cabinet affairs

up date on civil service reform - OPM

up date on the budget - OMB

rationale:
- Momentum for QC → pos. response from some in pubs
build
- shore up
- continue to neutralize

(Nat'l Service)
NPR ?
OMB (2)

Organization comments — HUD - h'less

agency remarks → HHS, VA, DOD > income — Cab Aff, DPC

conclusion

Suggested issues — DOL, OPM > empl — OPL

1. Meeting the Health Care needs of the Defense/Veteran community
   - Subs
   - Trcare
2. Economic impact of base closure and military down sizing on veterans
   - E+T
   - h'lessness
   - mil. retired pay

- E-mail to Nancy Ann / OPL -
  DoD
  NPR ?
  HUD

c.c: JB
LI

- invite all IVPG

FAX COVER SHEET

TO:	Gordon Adams, OMB	
	Peter Beach, HHS	690-5672
	Leon Bechet, SBA	205-7292
	Gary Christopherson, DoD	703/614-3537
→	Dennis Duffy, VA	273-5993
	Jim Fish, OMB	
	Jeanne Fites, DoD	703/697-6691
	Toni Hustead, OMB	
	Janice LaChance,OPM	606-2264
	Jaquie Lawing, HUD	708-3336
	Bruce Miller, OMB	
	Nancy-Ann Min, OMB	
	Joel Slackman, HCFA	690-6994
	Preston Taylor, DOL	219-4773

FROM: Molly Brostrom
Senior Policy Analyst
Domestic Policy Council

PAGES (INCLUDING COVER): 4

DATE: September 22, 1995

If there is any problem receiving this fax please call Alexander Schrank at 456-2334.

THE WHITE HOUSE

WASHINGTON

September 19, 1995

MEMORANDUM FOR **Peter Beach, HHS**
Leon Bechet, SBA
Dennis Duffy, VA
Jeanne Fites, DoD
Janice LaChance, OPM
Jaquie Lawing, HUD
Nancy-Ann Min, OMB
Preston Taylor, DOL

FROM: Jeremy Ben-Ami, Domestic Policy Council
LeeAnn Inadomi, Cabinet Affairs
Lee Satterfield, Office of Public Liaison

RE: Fall Interagency Veterans Policy Group Meeting with Outside Groups

At their last meeting with us, the veterans service organizations and military coalition groups requested that agency members of the Interagency Veterans Policy Group participate in the fall meeting. This meeting is scheduled for **October 12, 1:00-3:00 pm, Truman Room of the White House Conference Center**. Your attendance is very important; please let us know as soon as possible if you cannot attend.

Because this will be such a large group, we are structuring the discussion around two broad areas -- health care and economic issues. As you can see in the attached draft agenda, we would like agency representatives to begin the discussion in each area by reporting on progress made on past IVPG agenda items.

To prepare for the October 12 meeting, we would like to have a pre-meeting with you on **Friday, September 29, 2:30-3:30 pm, Room 211 OEOB**, to discuss the status of issues and perhaps identify areas where further progress can be made prior to the meeting with groups. Please bring any staff to the meeting who are integral to the discussion.

The following is a list of the issues that have been raised on past IVPG agendas that fall in these two categories. Please come to the pre-meeting prepared to discuss these issues.

- Health Care: health reform, disability policy, eligibility reform and other VA REGO II initiatives, pilots for Medicare subvention at VA and DOD facilities, Tricare Prime and other changes to DOD health care system.

- Economic issues: DOL Advisory Committee on Veterans Employment and Training; employment impact on veterans and military of recont military downsizing and base closures; employment and training consolidation legislation and veterans programs; and homeless veterans.

Thank you. If you have questions, please call Molly Brostrom of the Domestic Policy Council (456-5561). We look forward to seeing you on Friday, September 29.

cc: Gordon Adams, OMB
Gary Christopherson, DoD
Jim Fish, OMB
Toni Hustead, OMB
Mark ~~Bruce~~ Miller, OMB
Joel Slackman, HCFA

Fall Interagency Veterans Policy Group Meeting
Truman Room, White House Conference Center
October 12, 1995, 1:00-3:00 pm

Draft Agenda

1:00 Welcome

1:10 Review of General IVPG Accomplishments

1:20 Discussion of Issues

1. Meeting the health care needs of the defense/veterans community

   -Agency Presentations on Progress Made

   -Comments from Groups

2:10 2. Economic issues affecting the defense/veterans community

   -Agency Presentations on Progress Made

   -Comments from Groups

3:00 Adjourn

FAX COVER SHEET

TO:	Jeanne Fites, DOD	(703) 697-6691
	Gary Christopherson, DOD	(703) 614-3537
	Norma St. Claire, DOD	(703) 696-8703
	Preston Taylor, DOL	219-4773
	Joel Slackman, HCFA	690-6994
	Dan Ermann, HCFA	690-8168
	Peter Beach, HHS	690-5672
	Jacquie Lawing, HUD	708-3336
	Nancy-Ann Min, OMB	395-7289
	Toni Hustead, OMB	395-6835
	Phebe Vickers, OMB	395-5722
	David Morrison, OMB	395-5722
	Jim Fish, OMB	395-5722
	Janice LaChance, OPM	606-2264
	Lynn Klein, OPM	606-1540
	Bill Truitt, SBA	205-7292
	Dennis Duffy, VA	273-5993
	Marcha Martin,VA	273-7090

FROM: Molly Brostrom
Senior Policy Analyst
Domestic Policy Council

PAGES (INCLUDING COVER SHEET) : 4

DATE: October 6, 1995

If you have a problem receiving this fax, please call Shyra Gregory at 456-2334.

THE WHITE HOUSE

WASHINGTON

October 4, 1995

MEMORANDUM FOR PARTICIPANTS IN OCTOBER 12 IVPG MEETING WITH VSO'S AND MILITARY COALITION GROUPS

FROM: Molly Brostrom
Domestic Policy Council

RE: Agenda for Next Week's Meeting

Attached is a detailed agenda for the October 12 IVPG meeting with VSOs and Military Coalition groups, as discussed at the September 29 meeting. If you have questions about the agenda or your participation, please call to discuss. Otherwise, we will expect you to be prepared to give a brief presentation in the area(s) identified. For issues that involve multiple agencies, we will assume coordination on the presentation prior to the meeting, but the first agency listed on the agenda will be expected to present, with the other agencies available for questions or comments.

Your presentation should be brief (no more than 5 minutes), and should reference the fact that these are issues that the groups have identified for the IVPG,...here is progress made and the status.

Following are the attendees that I understand are attending/participating. If I have missed anyone or there are any substitutions, please let me know. Since the meeting is being held at the White House Conference Center, it is not vital for clearance reasons, but would be helpful for organizational purposes.

DoD: Jeanne Fites, Gary Christopherson, Norma St. Claire
DOL: Preston Taylor
HCFA: Joel Slackman, Dan Ermann
HHS: Peter Beach
HUD: Jacquie Lawing
OMB: Nancy-Ann Min, Toni Hustead, Phoebe Vickers/David Morrison, Jim Fish
OPM: Janice LaChance, Lynn Klein
SBA: Bill Truitt
VA: Dennis Duffy, Marsha Martin

Following are handouts that agencies have said will be made available at the meeting. Unless notified otherwise, I will assume you will bring copies for the groups (14 expected).

- Statement of Administration Policy on VA/HUD Appropriations (OMB)
- VA Appropriations tracking (OMB)
- Status Report on Development of VA Subvention Pilot (OMB)
- Status Report on Development of DoD Subvention Pilot (DoD/HCFA)

- One-pager on Tricare (DoD)
- VP Letter to Agencies (DoD)
- OPM Report on Civil Service hirings (OPM)

For those unfamiliar with the White House Conference Center, the address is 726 Jackson Place (across from Lafayette Park; between the Blair and Decatur Houses).

Thank you very much for your help in preparing and for your participation next week. Please call if you have any questions (456-5561).

cc: Jeremy Ben-Ami
LeeAnn Inadomi
Bob Jones
Lee Satterfield

Fall Interagency Veterans Policy Group Meeting
Truman Room, White House Conference Center
October 12, 1995, 1:00-3:00 pm

Detailed Agenda
(For Internal Use)

1:00 Welcome (DPC, Cabinet Affairs, OPL)

1:10 Review of General IVPG Accomplishments (DPC, Cabinet Affairs)

To include:
- Budget and Reconciliation (OMB)
- Homelessness (HUD, VA)

1:30 Discussion: Meeting the health care needs of the defense/veterans community

Agency Presentations (5 minutes each):
- VA Eligibility Reform, Other REGO II initiatives, VA health care reorganization, VA Client Services Report (VA)
- VA Subvention Pilots (OMB, VA, HCFA)
- DoD Subvention Pilots (DoD, HCFA, OMB)
- DoD Health Care Changes--VA/DoD collaboration, Tricare, Medicare managed care and base closures (DoD, HCFA, VA)

Comments from groups/New Issues

2:20 Discussion: Economic issues affecting the defense/veterans community

Agency Presentations (5 minutes each):
- VocRehab, Empl&Training Consolidation, Progress on Advisory Committee Recommendations (DOL)
- GI Bill, Responses to Downsizing (DoD)
- Civil Service hiring (OPM)

Comments from Groups/New Issues

3:00 Adjourn

DOL →
VocRehab
E+T consol
? Adv Comm

DoD: GI Bill
Downsizing

OPM: Civil Service hiring
* handout

Planning Meeting for
Fall Interagency Veterans Policy Group Meeting
(October 12, 1995, 1:00-3:00 pm)

September 29, 1995, 2:30-3:30 pm

Agenda

1. Background to October 12 Meeting -
   - Rpts on past + New
   - issues we anticipate - want to make sure the right pple + we're conf w/ rpts

2. Agenda Item Reports: Economic Issues

   * GI Bill
   * TAP

   - Budget Report (OMB) (GAO Rpt)
   - Homelessness (HUD)
   - HVRP (DOL) - Reauth'd + Carry in approps
   - ? Advisory Committee on Veterans Employment and Training (DOL)
   - Base closures/downsizing and veterans - concern that insuff't attn being paid to empl impact on veterans
   - * Employment and training consolidation legislation and veterans programs (DOL, VA) - don't want folded in w/o adequate vets repr → we headed off

   OPM Report

   * VocRehab → coord btwn VA + DOL → mem of agt

3. Agenda Item Reports: Health Care

   - Subvention Pilots
     - VA (HCFA, OMB, VA)
     - DoD (HCFA, OMB, DoD)
   - → VA Eligibility Reform/Other REGO II initiatives (OMB, VA)
     - submitted to Hill
     - Stump introd own pkge as part of Reconcil
   - DoD Health Care Changes (DoD) - under 65 mil. retirees + Tricare PRIME (copaymts →) - over 65 → can't enroll in Tricare Prime - w/ integr of trtmt facils into TP, will they lose access
   - Health Reform (HHS, OMB)
   - closing of Uniformed Services Med'l School

4. Other Issues

   - Transition ass prog issue (cut from $50 to 25M
     SMOCTA (empl prog) / DoD approps / DOL " / VA opposed
     Thurmond → $6.9M)

   - Vets Prefs
   - OPM → pol. apptees?

~~[illegible]~~ 0800

Budget
OMB: discuss SAP comments ⇒ handout: SAP
- open up with
Toni (discuss w/ Nancy - Ann)

overview
↓
~~Presidents~~ opposed to attempts to decrease

Reconciliation
- Senate + GI Bill → we've opposed

Homelessness
HUD not discrimin
- localities may

handout: Htrs + mmo's

- data on participants + survey
- t.a. (Subcomm on Empl of Pple w/ Disabs)

(JBA: Baltimore)
① Rpt on ICH Trace ⇒ Marsha Martin ② HUD
* H'lessness → Accplshmts

HVRP —

ACVETS
- Minority Empl'ment

⇒ *Accplshmts

Downsizing:
Jt Agt Stdy VA + DoD
Closure of hosp's
Trans Ass Prog

⇒ NSC → vets as recr'g pool

- Elig Reform – Duffy
- Subvention h'out → 1-pager
  → joint DOD, VA, HCFA, OMB
- DoD HE changes (DOD present, VA)
  - VA/DOD collabs - Tricare regs)
  - VP ltr to agencies (handout)
  - HCFA/DoD → info on Medicare mgd care
    brief closing
    (Dan, Gary)
- Reorg of VA HCare into VISNS (Duffy can mention)
- VA Client Services Rpt (h'out) – VA can mention
- SMOCTA – Thurmond included – ltrs from bus const
  – took $8M from claims adj op & expenses
- PSAs on # Veterans

Attendees

Gordon Adams, OMB
Karen Klure, HHS
Bill Truitt, SBA
Gary Christopherson, DoD
Irwin Pernick, VA
Jacquie Lawing?, HUD
Mark Miller?, OMB
Nancy-Ann Min, OMB
Al Borrego, DOL
Dan Ermann, HCFA

Name	Agency	Phone/Fax
LeeAnn Inadomi	Cabinet Affairs	62572 / 66704
~~Bob~~ James	OPL / VA	65178 / 273-4876
Al Borrego	DOL / VETS	219-8116 / 219-4723
Irwin Pernick	VA	273-1049
Mark Johnston	HUD	708-1226
Tom Lewis	OMB	53796
Karen Kluve / Dr. Broch	HHS	690-6156 / 690-5672
Norma St. Claire	DoD	703/696-8710 / fax 703/696-8705
Gary Christopherson	DoD	703-697-2111
Dan Ermann	HCFA	690 5456
Joel Slackman	HCFA	690-8258
Molly Boston	DPC	6-5541
JBA		
Lynn Klein	OPM	606-0800
		606-1540 (fax)
	Sonia Lach	606-1800 (tel)
		606-2264 (fax)

Jim 5-3776 → 5-55
395-5722

Rm 211
OEOB

FAX COVER SHEET

TO:	Jeanne Fites, DOD	(703) 697-6691
	Gary Christopherson, DOD	(703) 614-3537
	Norma St. Claire, DOD	(703) 696-8703
	Preston Taylor, DOL	219-4773
	Joel Slackman, HCFA	690-6994
	Dan Ermann, HCFA	690-8168
	Peter Beach, HHS	690-5672
	Jacquie Lawing, HUD	708-3336
	Nancy-Ann Min, OMB	395-7289 395-9119
	Toni Hustead, OMB	395-6835
	Phebe Vickers, OMB	395-5722
	David Morrison, OMB	395-5722
	Jim Fish, OMB	395-5722
	Janice LaChance, OPM	606-2264
	Lynn Klein, OPM	606-1540 * 0927
	Bill Truitt, SBA	205-7292
	Dennis Duffy, VA	273-5993
	Marcha Martin,VA	273-7090

FROM: Molly Brostrom
Senior Policy Analyst
Domestic Policy Council

PAGES (INCLUDING COVER SHEET) : 4

DATE: October 6, 1995

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59119

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[001a]

R = sending representative to meeting √ = confirmed will attend

FAX COVER SHEET

Confirmations for Sept 29, 195

Confirmations for Oct 12, 195

TO:

? Planning	Gordon Adams, OMB		
R	Peter Beach, HHS - Karen Klure	690-5672	
√	Leon Bechet, SBA	205-7292	
√	Gary Christopherson, DoD	703/614-3537	
R	Dennis Duffy, VA - Irwin Pernick	273-5993	
R	Jim Fish, OMB - send S.O.		
√	Jeanne Fites, DoD	703/697-6691	
√	Toni Hustead, OMB		
X	Janice LaChance, OPM	606-2264	
(?)	Jaquie Lawing, HUD	708-3336	
? Mark	~~Bruce~~ Miller, OMB		
√	Nancy-Ann Min, OMB		
√	Joel Slackman, HCFA	690-6994	
√	Preston Taylor, DOL	219-4773	

P6/(b)(6)

Confirmations for Oct 12, 195: ? - Out of town; R - Bill Truitt; √; √; (?); (?); √

Possible replacement

FROM: Molly Brostrom ⇒ 456-5561
Senior Policy Analyst
Domestic Policy Council
('Alexander Schrank 456-2334)

PAGES (INCLUDING COVER): 4

DATE: September 20, 1995

If there is any problem receiving this fax please call Alexander Schrank at 456-2334.

Gordon Adams = planning on attending Sept 29.
Peter Beach = Will send intern Karen Klure P6/(b)(6) for Sept 29.
Beach is out of town on Oct 12.
Leon Bechet = Will send Bill William Truitt P6/(b)(6) on Oct 12.
Gary Christopherson = Will call back for Oct 12. (we'll decide @ 9/29 mtg)
Dennis Duffy = Will send Irwin Pernick P6/(b)(6) (Tel 273-5993)
for Sept 29

⇒ Jim Fish = out until Oct 2. Left message for David Morgan / possibly Tom Lewis } Someone else will attend: Will call back to give names of repla

~~Jeanie LaChance = Will call back~~

Jaquie Lawing = Back on Sept 25. ~~Will call back~~ P6/(b)(6) Penciled her in, but she can't confirm for sure.

Mark Miller = Unsure: schedule him in, but he is busy with reconciliation.

Nancy-Ann Min = Unsure for Oct 12.

~~Joel Slackman = Back on Monday, Sept 25~~ ~~left message~~

Preston Taylor = ~~Back on Monday, Sept 25~~ May send a replacement on Sep

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[0016]

Irwin Pernick 273-5993 DOB P6/(b)(6)

Phebe Vickers-Agency 3 in place of 6 Agency
David Morrison

P6/(b)(6)

THE WHITE HOUSE

WASHINGTON

intern Karen Klusse DOB

call for Both

September 19, 1995

Bill William Truitt SS# DOB P6/(b)(6)

will call back

MEMORANDUM FOR **Peter Beach, HHS** → will not be in town until Oct 11, 12
Leon Bechet, SBA → will call to confirm Oct 12.
Dennis Duffy, VA + DOB → can't make it on 29 will send someone else
Jeanne Fites, DoD
Janice LaChance, OPM → Y on Oct 12; no on 9/29
Jaquie Lawing, HUD → out of M Sept 25; will call back
Nancy-Ann Min, OMB → on congress.
Preston Taylor, DOL → back on Monday

FROM: Jeremy Ben-Ami, Domestic Policy Council
LeeAnn Inadomi, Cabinet Affairs
Lee Satterfield, Office of Public Liaison

box

RE: Fall Interagency Veterans Policy Group Meeting with Outside Groups

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confirm

Because this will be such a large group, we are structuring the discussion around two broad areas -- health care and economic issues. As you can see in the attached draft agenda, we would like agency representatives to begin the discussion in each area by reporting on progress made on past IVPG agenda items.

To prepare for the October 12 meeting, we would like to have a pre-meeting with you on **Friday, September 29, 2:30-3:30 pm, Room 211 OEOB**, to discuss the status of issues and perhaps identify areas where further progress can be made prior to the meeting with groups. Please bring any staff to the meeting who are integral to the discussion.

The following is a list of the issues that have been raised on past IVPG agendas that fall in these two categories. Please come to the pre-meeting prepared to discuss these issues.

- Health Care: health reform, disability policy, eligibility reform and other VA REGO II initiatives, pilots for Medicare subvention at VA and DOD facilities, Tricare Prime and other changes to DOD health care system.

[0016]

- Economic issues: DOL Advisory Committee on Veterans Employment and Training; employment impact on veterans and military of recont military downsizing and base closures; employment and training consolidation legislation and veterans programs; and homeless veterans.

Thank you. If you have questions, please call Molly Brostrom of the Domestic Policy Council (456-5561). We look forward to seeing you on Friday, September 29.

call for 29th only

cc: Gordon Adams, OMB planning on attending Jeane Cites knows.
Gary Christopherson, DoD ~~[redacted]~~ → carrying
Jim Fish, OMB Out of office Oct 2 Monday 395-3884 David Morison
Toni Hustead, OMB
Mark ~~Bruce~~ Miller, OMB → schedule mtg reconciliation.
Joel Slackman, HCFA → back on Monday; left message on voice mail, 690-8258

P6/(b)(6)

Molly
D. Duffy's Tel# 2735033

1 - Create Fax cover sheet + send fax to recipients

2 - send copies inside mail to JBA, LI, LS (original to me)

3 - on Friday, plse call to confirm attendance + get DOBs for any missg

Thanks! - Molly | 6-5561 Rm 207

Draft 10/10/95

MEDICARE DEMONSTRATION: MILITARY MANAGED CARE DEMONSTRATION

The Department of Defense (DoD) has proposed to the Health Care Financing Adminstration (HCFA), Department of Health and Human Services (DHHS), a demonstration where the Medicare program would treat the DoD and its Military Health Services System (MHSS) as a risk-type health maintenance organization (HMO) for dual-eligible Medicare/DoD beneficiaries. Under this arrangement, the DoD would continue to maintain its current level of effort in terms of financial commitment to caring for the dual eligible population. Medicare would pay for dual-eligibles receiving care from the DoD managed care program.

The Health Care Financing Administration (HCFA) and Department of Defense (DoD) are currently working through the agreement necessary for the Military Managed Care Demonstration. As one step in this process, the two agencies, working with the Office of Management and Budget, agreed on legislative language that would authorize such a demonstration. HCFA and DoD are jointly examining issues to establish the demonstration's feasibility. This involves analysis of DoD and HCFA data to assure that this demonstration does not increase the total federal cost of both programs. Both Departments are working with OMB to assure that is of mutal benefit to both agencies, as well as the beneficiary populations served.

The Military Managed Care Demonstration is intended to respond to Medicare/DoD dual-eligible beneficiaries who have asked that they be more able to use the Military Health Services System as their Medicare provider. In order to overcome concerns with previous legislative and demonstration proposals, the current demonstration proposal differs in that DoD agrees to maintain its level of effort, subject to overall Defense Health Program budget changes. Further, to address a concern over budget rules, the demonstration expends DoD's dual-eligible beneficiaries' dollars first and then turns to HCFA to cover additional DoD/Medicare beneficiaries wanting to enroll in DoD's TRICARE Prime.

The goal of this effort is to improve access to needed health services for this dual-eligible population while assuring that the demonstration does not increase the total federal cost of both programs. DoD has proposed the following framework.

- MHSS enrolls Medicare dual-eligible beneficiaries and maintains level of effort (subject to appropriate reductions due to reduced budget for the Defense Health Program) for dual-eligible beneficiaries.
- Medicare authorizes the MHSS to enroll, provide health services, and be reimbursed (after level of effort is achieved) for dual-eligible beneficiaries (who enroll in TRICARE Prime) similar to a Medicare private HMO.
- MHSS and Medicare appropriately share the financial burden for these dual-eligible beneficiaries. All DoD covered services not covered by Medicare are covered by DoD. Similarly, all Medicare covered services not covered by DoD are covered by Medicare.
- DHHS and DoD will develop an appropriate payment system and approaches to quality assurance that are mutually agreeable.
- The demonstration would be for a limited period of time (e.g. three years) covering selected geographic areas.
- The demonstration would be evaluated by a mutually acceptable evaluator.

MEDICARE DEMONSTRATION:
MILITARY MANAGED CARE DEMONSTRATION

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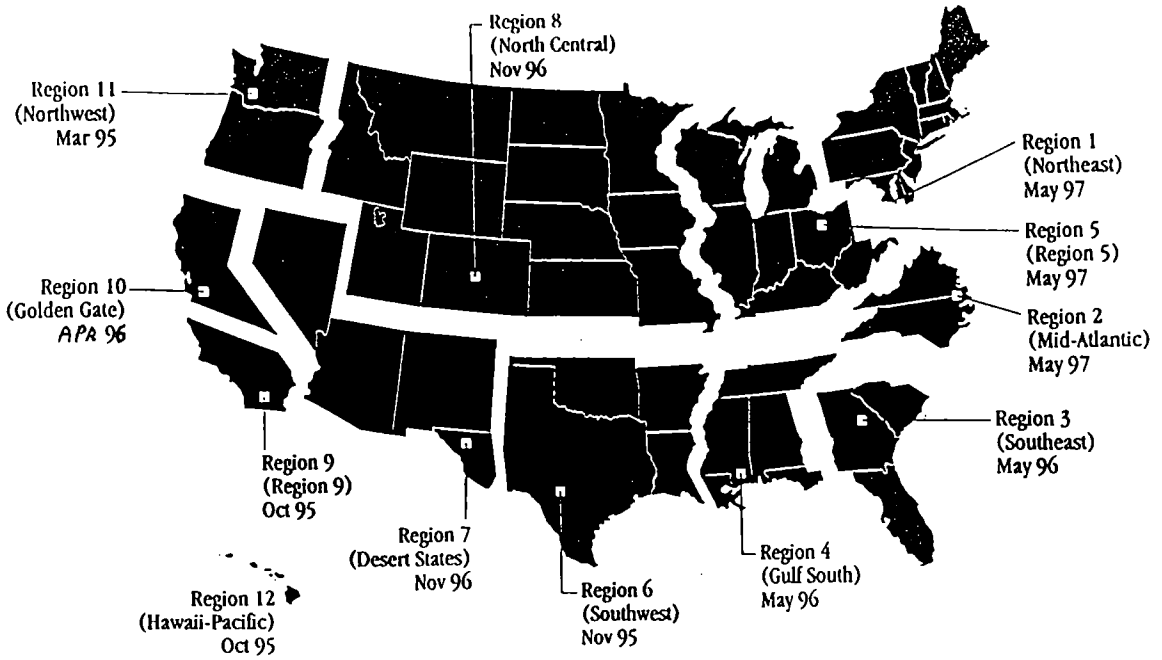
TRICARE will be coming to your Region in the near future. Beneficiaries in the States of Washington and Oregon now have the opportunity to participate in TRICARE. If you live in another state, check the map at right for the start-up date in your Region.



TRICARE

Quality Care for the Uniformed Services

Welcome to TRICARE!

TRICARE is the new Department of Defense health care pro-gram. We have combined the best features of the Army, Navy, Air Force and CHAMPUS health care programs to create the TRICARE triple option - health care plan.

This brochure is designed to give you a general overview of the three TRICARE options from which you can choose— Prime, Extra and Standard. However, it is not intended as a complete description of coverage.

OPTION I

TRICARE Prime–*beneficiaries may enroll in TRICARE Prime which features:*

- ★ Lower Costs—*no annual deductible and reduced copayments.*
- ★ Improved Access—*enrollees have timely access to health care services. This includes a twenty-four hour Health Care Finder who can assist you in quickly obtaining health care services.*
- ★ Enhanced Benefits—*preventive health care benefits to keep you and your family healthy.*
- ★ Less Paperwork—*usually there are no claim forms to file.*
- ★ A Primary Care Manager—*you select a Primary Care Manager (PCM) who will provide and/or coordinate all your health care needs.*
- ★ Point of Service—*the TRICARE Prime benefit also includes a new point of service option which allows enrollees to retain freedom of choice to use providers without an authorization from the PCM, but at significantly higher cost sharing than TRICARE Standard.*
- ★ A Quality Provider Network—*access to a network of quality doctors, hospitals and other health care providers usually near your home or work.*
- ★ No Balance Billing—*TRICARE network providers accept the negotiated rates and your copayment as payment in full.*

How can you enroll in TRICARE Prime.

Active duty personnel are automatically enrolled in TRICARE Prime and will continue to receive most of their care in military treatment facilities. Active duty family members, retirees and their family members and survivors can easily enroll in TRICARE Prime, for a minimum of one year, by filling out an application and agreeing to receive their health care services coordinated through their TRICARE Primary Care Manager.

MEDICARE-ELIGIBLE BENEFICIARIES

At this time, Medicare-eligible beneficiaries will not be able to enroll in TRICARE Prime. If the Department of Defense is permitted by Congress to obtain reimbursement from the Medicare system for providing health care services to Medicare patients, we will then offer Prime enrollment. Until then, Medicare beneficiaries will be able to use military treatment facilities on a space-available basis. In addition, Medicare beneficiaries will be able to use the Health Care Finders who can provide them a list of health care providers in their area who accept Medicare payments.

Do you have to pay any enrollment fees or copayments in TRICARE Prime.

Active duty personnel and their family members pay no enrollment fees. Retirees, their family members and survivors will be required to pay an enrollment fee (see costs chart). If a non-active duty patient receives care from the civil-ian network they will pay a small copayment (see costs chart).

OPTION 2

TRICARE Extra - if you choose not to enroll in TRICARE Prime, you may still take advantage of cost savings by using the TRICARE Extra option. The TRICARE Extra option offers the following features when you use our TRICARE Network Providers:

- ★ Lower Costs—*once the deductible has been met, your cost share will be 5% less than TRICARE Standard rates. You will also be able to take advantage of lower negotiated network provider rates.*
- ★ No Enrollment Fees—*unlike TRICARE Prime you do not have to enroll, but you can still use the network health care providers on a case-by-case basis.*
- ★ Less Paperwork—*usually there are no claim forms to file.*
- ★ Choice—*you have the choice of selecting your own health care provider.*
- ★ No Balance Billing—*network providers accept the negotiated rates and your cost share, after the appropriate deductible is met, as payment in full.*

OPTION 3

TRICARE Standard has been traditionally known as Standard CHAMPUS. This option offers our beneficiaries maximum choice in choosing their health care provider, but at the highest out-of-pocket cost to the beneficiary.

- ★ Flexibility—*you can use Standard or take advantage of cost-saving benefits under TRICARE Extra.*
- ★ Continuity of Care—*no need to change providers if you have established a relationship with a TRICARE Standard provider.*
- ★ No Enrollment—*with your military I.D. card, you can easily enjoy the benefits of TRICARE Standard or Extra.*

TRICARE Triple Option Costs

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductibles:			
• *Families of E-4 and Below*	*$0*	*$50/$100*	*$50/$100*
• *Other Active Duty Families*	*$0*	*$150/$300*	*$150/$300*
• *Retirees and Others*	*$0*	*$150/$300*	*$150/$300*
Annual Enrollment Fees:			
• *Families of E-4 and Below*	*$0*	*$0*	*$0*
• *Other Active Duty Families*	*$0*	*$0*	*$0*
• *Retirees and Others*	*$230/$460*	*$0*	*$0*
Civilian Provider Copays:			
• *Families of E-4 and Below*	*$6*	*15% of negotiated fees*	*20% of allowed charges*
• *Other Active Duty Families*	*$12*	*15% of negotiated fees*	*20% of allowed charges*
• *Retirees and Others*	*$12*	*20% of negotiated fees*	*25% of allowed charges*
Civilian Inpatient Cost Shares:			
• *Families of E-4 and Below*	*$11 per day*	*$9.50 per day*	*$9.50 per day*
• *Other Active Duty Families*	*$11 per day*	*$9.50 per day*	*$9.50 per day*
• *Retirees and Others*	*$11 per day*	*$250 per day plus 20% of negotiated prof fees*	*$323 per day plus 25% of allowed charges*

Note: This chart does not display all cost-sharing amounts.

MEDICAL CARE FOR BENEFICIARIES IN BASE REALIGNMENT AND CLOSURE (BRAC) AREAS

BACKGROUND: The approved base realignment and closure (BRAC) lists (1988, 1991, 1993 & 1995) will result in the closure of 31 military treatment facilities (MTFs) and an additional number of health clinics in the continental United States. In the past, when an MTF closed, residual beneficiaries used either the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Medicare for their health care needs. That no longer is the situation. With strong Congressional support for the Department of Defense (DoD) to do more for beneficiary populations affected by base closures, we have enhanced our planning and programs to specifically address their needs. DoD eligible beneficiaries remaining in areas affected by BRAC actions will be provided with alternative health care delivery options after their local MTF closes. The Department's actions to lessen the medical impact include transitional health care programs, managed care initiatives, retail pharmacy networks, a mail service pharmacy demonstration, and meetings with beneficiaries at affected BRAC sites.

CURRENT STATUS: The Military Services are charged to develop transition medical plans for their MTFs scheduled for closure. These in turn are reviewed by a joint working group at the DoD level to ensure a consistent and integrated approach to the identification of resource requirements, allocation, and access at closure sites.

Our goal is to have TRICARE, the Department's managed care program, implemented throughout the United States by 1997. This initiative provides a uniform, triple option set of benefits for eligible beneficiaries and will offer stable, comprehensive, health care coverage, improved beneficiary access and choice while containing overall DoD health care costs. Once TRICARE is implemented, the managed care support contractor will be able to develop networks of providers for those locations having a sufficient density of eligible beneficiaries. In the interim, we are including in our fiscal intermediary CHAMPUS claims processor contracts the requirement for development of preferred provider networks in BRAC areas. This will provide our beneficiaries an optional network of health care providers, reduce cost, and eliminate claims paperwork.

A retail pharmacy benefit is also included in each location where a provider network is developed. This program for CHAMPUS-eligible personnel will also be available to military Medicare-eligible beneficiaries residing within former BRAC catchment areas or those who relied upon a now closed facility for pharmacy services within twelve months of its closure.

In addition, the Department is conducting a two year mail order pharmacy demonstration project which began service on November 1, 1994. This project involves two multi-state regions that include Florida, Georgia, South Carolina, Pennsylvania, Delaware, and New Jersey. At the end of two years, a Report to the Congress is required which will evaluate the project and recommend future deployment of the program. Additionally, on September 1, 1995, mail service was extended to 12 BRAC sites. As with the retail pharmacy benefit program, the mail service pharmacy benefit is also available to Medicare-eligible beneficiaries residing within former BRAC catchment areas or those who relied upon a former facility for pharmacy services within twelve months of closure. Additional BRAC sites may be added to the mail order service contract as future closures progress.

Our BRAC Health Care Beneficiary Working Group is composed of representatives of each Military Service, Health Affairs, and an independent member appointed from among private citizens qualified to represent all personnel entitled to military health care. Since May 1993, selected members of the Working Group have visited many of the installations scheduled for closure. They have met with beneficiary organizations, local officials, Congressional representatives and their staff, base personnel, and retired personnel at each of the closure sites. Town meetings were held at each site and attendance has averaged approximately 200 - 600 people.

The group has gained valuable insight into specific health care issues and concerns affecting beneficiaries who remain after a base medical facility has closed. Information gathered during these visits will be the basis for future recommendations to the ASD (Health Affairs) and the Congress concerning health care delivery systems within affected BRAC sites.

Military Hospitals Due to Close as a result of BRAC

Installations with Inpatient Hospital Facilities

Army

Presidio of San Francisco, CA
Fort Ord, CA
Fort Devens, MA
Fort B. Harrison, IN
Fort McClellan, AL
Fitzsimons Army Medical Center, CO
Fort Lee, VA
Fort Meade, MD

Navy

NH Long Beach, CA
NH Orlando, FL
NH Philadelphia, PA
NH Oakland, CA

Air Force

Pease AFB, NH
Homestead AFB, FL
Eaker, AFB, AR
England AFB, LA
George AFB, CA
Myrtle Beach AFB, SC
Wurtsmith AFB, MI
Williams AFB, AZ
Bergstrom AFB, TX
Carswell AFB, TX
Chanute AFB, IL
Loring AFB, ME
Castle AFB, CA
Griffiss AFB, NY
K.I. Sawyer, AFB, MI
Plattsburgh AFB, NY
March AFB, CA
Reese Air Force Base, TX
McClellan AFB, CA

Dr. Stephen C. Joseph and Dr. Kenneth W. Kizer

DoD and VA Joint Efforts -- Of Mutual Benefit

On June 29th, a significant event in the history of the Departments of Defense (DoD) and Veterans Affairs (VA) joint efforts took place. Not with a lot of fanfare but with a sense of common purpose, the Assistant Secretary of Defense (Health Affairs) and the Under Secretary for Health, Department of Veterans Affairs signed a memorandum of understanding. Under this agreement and for the first time, the DoD is making VA Medical Centers eligible to be reimbursed for care under Defense's new TRICARE program.

This newest effort, operating through Defense's TRICARE program, has the potential of giving DoD's CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) beneficiaries another choice, in addition to military and private sector providers serving them today. While beneficiaries can continue to use military treatment facilities and private sector providers, many may have one more option -- a VA Medical Center. Beneficiaries who prefer care from a VA Medical Center can choose to use one, as long as it meets the requirements of TRICARE and its managed care support contractors. Costs to beneficiaries will be the same as when they use a private sector provider.

With this new agreement, VA Medical Centers wishing to participate in TRICARE would apply to DoD's regional managed care support contractors and must meet the cost, access and quality criteria used by the contractors. Those VA Medical Centers striking agreements with TRICARE contractors would then be available to DoD's beneficiaries in the same way that private sector providers will be available. While this agreement does not automatically treat VA Medical Centers as TRICARE providers, for the first time it makes them eligible to apply through managed care support contractors to become TRICARE providers. This new effort with the VA will be phased in over the next two years.

This VA and DoD agreement, in the form of a memorandum of understanding, and the mechanisms it creates become the primary vehicle for VA Medical Centers wanting to provide care to DoD's CHAMPUS beneficiaries.

Why is this agreement so important? Very simply, it exemplifies the way that DoD and VA are approaching joint efforts now and into the future. The key is that VA and DoD joint efforts be of mutual benefit.

In this case, VA Medical Centers will benefit because they have the opportunity to attract not only more paying patients, but more paying patients who have much in common with the veterans already being served, yet present a more diverse set of medical conditions. At the same time DoD and its beneficiaries will benefit as beneficiaries have another option for receiving health care, in addition to Military Treatment Facilities and private sector health care providers. The more attractive, in terms of cost, access and quality, that VA Medical Centers become for DoD beneficiaries, the more DoD beneficiaries will choose VA Medical Centers.

DoD and VA are working cooperatively at all levels. The above agreement is just one example of cooperation at the highest level between the Under Secretary for Health in Veterans Affairs and the Assistant Secretary of Defense (Health Affairs). Many joint efforts have been operational for some time and many of those efforts reflect cooperation at all levels of both agencies. More joint efforts, as are described below, will come in the future.

Dr. Custis, in his June 1995 column in U.S. Medicine, points out that many joint efforts are already in place. For years, VA and DoD at all levels have engaged in a wide range of sharing arrangements built on the principle of joint efforts for mutual benefit. For example, VA and DoD have collaborated in research projects, such as traumatic brain injury, post-traumatic stress disorder, alcoholism, AIDS, spinal cord injury and sensory impairments and, most recently, illnesses that may be related to service in the Persian Gulf War.

In the area of sharing health care resources, Public Law 97-174, "The Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," was specifically enacted in 1982, to promote cost-effective use of federal health care resources by minimizing duplication and underuse of health care resources while benefiting both VA and DoD beneficiaries. As a result of this legislation, the Economy Act (Title 31 USC) and administrative action, the two Departments have shared health care resources.

Since the 1982 legislation, facility-level resources sharing agreements, ranging from major medical and surgical services, laundry, blood, and laboratory services, to unusual specialty care services, have shown continued annual growth. In 1984, there were a combined total of 102 VA and DoD facilities with sharing agreements. By 1995, that number had more than doubled to 284. In two years between FY1992 and FY1994 shared services increased from slightly over 3,000 to more than 4000.

In addition to the hospital-to-hospital agreements, many education and training agreements exist between VA Medical Centers and military medical reserve component units. Under a typical agreement, a VA Medical Center provides space for weekend training drills. In return, reserve personnel serve as supplemental staff. For example, the VA Medical Center in Tampa, Florida, has training agreements with Army, Navy, and Air Force Reserve units. An average of 25 reservists train at Tampa on weekends while simultaneously supplementing VA staff. Reservists training at Tampa include physicians, nurses, and medical technicians. Training occurs in medical services, shock trauma, aeromedical evacuation, disaster preparedness, surgery, psychiatry, pathology and administrative services.

Also, for several years, the two Departments have pursued a program of joint venture construction and operation of hospitals. The first of these was the facility at Kirtland AFB in Albuquerque, New Mexico. In this joint undertaking, the Air Force is operating a wing in the Albuquerque VA Medical Center. The Air Force also operates a comprehensive health care clinic and dental clinic adjacent to the hospital. Through this sharing effort, the Air Force avoided approximately $10 million in construction costs and is producing additional savings through multiple sharing agreements within the facility.

Another joint effort is the new 129-bed hospital at Nellis AFB. The $75 million FY 1990 Federal Medical Facility which replaced the old Nellis Air Force Base Hospital opened in July 1994. The Air Force is operating the facility, but VA is staffing its 52 beds. The Air Force and the VA estimate annual savings of almost $24 million and approximately $7 million respectively.

At the same time, VA and DoD are working together on other potential joint ventures at sites such as Travis AFB (California), Elmendorf AFB (Alaska), East Central Florida, Fort Sill (Oklahoma), Fort Bliss (Texas) and Tripler Army Medical Center (Hawaii).

How are we approaching future joint efforts? DoD and VA have decided the best strategy is to link our two networks wherever their is substantial mutual benefit. We are aggressively fielding that strategy and will continue to do so for the foreseeable future.

While this may appear obvious, not everyone seems to agree that the criteria should be mutual benefit. However, to do otherwise causes problems. There are problems if VA and DoD were to pursue joint efforts when one of the agencies and its beneficiaries may see no benefit. There are greater problems with pursuing joint efforts when both agencies and their beneficiaries may see no benefit. Neither of these latter two criteria is in the best interest of our beneficiaries or taxpayers. Instead, since there are more than enough opportunities offering mutual benefit to DoD, VA and their beneficiaries, we apply the mutual benefit criteria and focus on those opportunities meeting that criteria.

To provide a better idea of what that portends for the future, it is helpful to cite another recent agreement reached between DoD and VA. Under this informal agreement, the two agencies laid out those areas which offer the best possibility for mutual benefit. As can be seen from the following list, future joint VA and DoD efforts cover significant territory.

PRIORITIES FOR JOINT DOD/VA EFFORTS

Health systems development

- DoD and VA will develop and operate shared facilities and joint venture sites.
- DoD and VA will carry out joint planning on medical facility construction that impacts both DoD and VA beneficiaries.

Readiness

- DoD and VA will carry out joint planning for and the development of:
  - The flow of patients (injured active duty troops) within the continental U.S.
  - Specialized care for specific types of conflict-related injuries, e.g. spinal cord injury, traumatic brain injury.

Provision of Care

- DoD and VA will sign the appropriate agreements and take the necessary steps which enable the provision of medical care to DoD beneficiaries by VA Medical Centers under the CHAMPUS managed care support contracts. (Signed June 29, 1995)
- DoD and VA will work together to develop arrangements whereby DoD beneficiaries can receive appropriate specialized care (e.g. head trauma, rehabilitative care) from VA Medical Centers.

Post-deployment epidemiology, research, evaluation and care

- DoD and VA will continue their close cooperation on post-deployment (including Persian Gulf Illness) research, epidemiology, and clinical care.

Technology/Information Systems

- DoD and VA will develop joint and coordinated efforts with regard to a) developing telemedicine as a means to improve readiness and patient care, b) improving interoperability and interconnectivity between VA and DoD services, and c) providing information management support for joint ventures.

With this as our joint strategy for the future, let us return to the issue of how our two networks should be linked. In this, we share the caution put forward by Dr. Custis. As he stated, "this is not to propose a single monolithic Federal Medical Service." On that point we concur. So what are we not only proposing, but actually implementing?

Paralleling what the DoD is doing within its own Military Health Services System, the VA and DoD are moving forward jointly on the development of their respective health care systems. Each agency is heavily involved in reinventing their health care systems.

For VA, that means the activation of the Veterans Integrated Service Networks (VISNs) along with a sweeping reorganization of the VA headquarters. Beginning in October of this year, the structure of both the field and headquarters of the Veterans Health Administration (VHA) will be significantly changed, In the field, the former four-region structure will give way to 22 smaller, more cohesive VISNs. These networks were chosen according to existing patient referral patterns, and groupings of facilities and patients sufficient to provide comprehensive services. The facility directors will collaborate with the VISN director to provide cost-effective care and improved patient services, and to pool resources to expand access of care to veterans. Each VISN will be headed by a director, who will have operational control, strategic planning and budgetary responsibility over all the patient care facilities and service providers in the network.

Commensurate with this decentralization of day-to-day decision making authority will be a re-engineering of VA headquarters, which will shift its focus to systemwide issues and the important function of governance of the system. This reorganization of VHA will improve efficiency, boost accountability and enhance customer service.

For DoD, reinvention, in part, means the development of TRICARE. TRICARE is DoD's regionalized managed care system, serving active duty troops and their families and retirees and their families. Moving away from the traditional workload based system, TRICARE moves toward capitation. Under capitation, the system will focus on funding Military Treatment Facilities and managed care support contractors per enrolled beneficiary rather than on the number of visits or bed days. With that change, the incentives change for military providers and the private sector, as managed through the managed care support contractors. Providers will need to be concerned about the total care of a beneficiary, not just for this current episode and not just for current year, but potentially for year after year. Preventing illness and injury becomes very important. Beneficiary satisfaction with access, cost and quality become more important. More cost-effective management of the Military Health Services System and its Military Treatment Facilities becomes more important.

DoD made a fundamental decision as to how to bring about this change. This change was to result from a joint effort of the Army, Navy, Air Force and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)). "Joint" is the key term. After all, that is how DoD carries out its military missions. That is how DoD is carrying out its health mission. Under the joint approach, the Military Services and the OASD(HA) retain their respective missions, identities, cultures, and strengths. Whenever it is to their mutual benefit, as is the case with the new TRICARE program, they join forces and work side-by-side.

So it is with the VA and DoD. They have joined forces and are working side-by-side. Both retain their identity and culture. Both play to their strengths. Both carry out their assigned mission. Both must be responsive to the American taxpayer. Both ensure that their respective beneficiaries are cared for.

Again, joint efforts are best built on the principle of maximizing mutual benefit. For DoD, VA and their beneficiaries, joint efforts have been and will continue to be of mutual benefit.

THE WHITE HOUSE

WASHINGTON

Joint Meeting of the
Interagency Veterans Policy Group and
Veterans Service Organizations and Military Coalition Groups

White House Conference Center, Truman Room,
October 12, 1995, 1:00-3:00 pm

Agenda

1:00 Welcome

- Alexis Herman, Assistant to the President for Public Liaison
- Kitty Higgins, Assistant to the President and Secretary to the Cabinet
- Carol Rasco, Assistant to the President for Domestic Policy

1:15 Overview of IVPG History and Updates

- Budget and Reconciliation
- Homelessness

1:30 Meeting the health care needs of the defense/veterans community

- Agency Presentations
- Discussion

2:20 Economic issues affecting the defense/veterans community

- Agency Presentations
- Discussion

3:00 Adjourn

THE WHITE HOUSE

WASHINGTON

Joint Meeting of the
Interagency Veterans Policy Group and
Veterans Service Organizations and Military Coalition Groups

White House Conference Center, Truman Room
October 12, 1995, 1:00-3:00 pm

Administration Participants

White House
Alexis Herman
Assistant to the President for Public Liaison

Kitty Higgins
Assistant to the President and Secretary to the Cabinet

Carol Rasco
Assistant to the President for Domestic Policy

Jeremy Ben-Ami
Deputy Assistant to the President for Domestic Policy

LeeAnn Inadomi
Special Assistant to the President for Cabinet Affairs

Bob Jones
Special Assistant to the Secretary, Department of Veterans Affairs/OPL

Molly Brostrom
Senior Policy Analyst, Domestic Policy Council

Office of Management and Budget
Nancy-Ann Min
Associate Director for Health and Personnel

Toni Hustead
Branch Chief, Veterans Personnel

Jim Fish
Program Examiner, National Security Division

Department of Defense
Jeanne Fites
Deputy Undersecretary of Defense

Norma St. Claire
Director, Information Management for OUSD Personnel and Readiness

Gary Christopherson
Senior Health Advisor

Al Giambone
Principal Director for Program Policy and Coordination

Department of Housing and Urban Development
Jacquie Lawing
Deputy Assistant Secretary for Economic Development

Mark Johnston
Acting Director, Program Mgmt. Division, Office of Special Needs Assistance

Department of Labor
Preston Taylor
Assistant Secretary for Veterans Employment and Training

Department of Veterans Affairs
Dennis Duffy
Assistant Secretary for Policy and Planning

Marsha Martin
VHA Coordinator for Homeless Initiatives

Irwin Pernick
Associate Deputy Assistant Secretary for Policy

Health Care Financing Administration, HHS
Dan Ermann
Office of Legislation and Intergovernmental Affairs

Joel Slackman
Special Analysis Staff

Office of Personnel Management
Janice LaChance
Director, Communications

Leonard R. Klein
Associate Director, Employment

Small Business Administration
Bill Truitt
Assistant Director, Office of Veterans Affairs

THE WHITE HOUSE

WASHINGTON

Joint Meeting of the
Interagency Veterans Policy Group and
Veterans Service Organizations and Military Coalition Groups

White House Conference Center, Truman Room,
October 12, 1995, 1:00-3:00 pm

VSO and Military Coalition Group Participants

Michael Schlee
The American Legion

Bob Carbonneau
AMVETS

Hector DeLeon
American G.I. Forum

Tom Miller
Blinded Veterans Association

Ron Drach
Disabled American Veterans

Howard Metzger
Jewish War Veterans

Greg Bresser
Military Order of the Purple Heart

Wallace Williams
National Association for Black Veterans

Sharon Barnes
National Association for Uniformed Services

Chuck Schreiber
National Guard Association

Dick Johnson
Non Commissioned Officers Association

Doug Vollmer
Paralyzed Veterans of America

Col. Walker Williams
Reserve Officers Association

Jim Adams
The Retired Enlisted Association

Jim Magill
Veterans of Foreign Wars

Bill Crandell
Vietnam Veterans of America

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Agenda

1:00 Welcome

- Alexis Herman, Assistant to the President for Public Liaison
- Kitty Higgins, Assistant to the President and Secretary to the Cabinet
- Carol Rasco, Assistant to the President for Domestic Policy

1:15 Overview of IVPG History and Updates

- Budget and Reconciliation
- Homelessness

1:30 Meeting the health care needs of the defense/veterans community

- Agency Presentations
- Discussion

2:20 Economic issues affecting the defense/veterans community

- Agency Presentations
- Discussion

3:00 Adjourn

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Administration Participants

White House
Alexis Herman
Assistant to the President for Public Liaison

Kitty Higgins
Assistant to the President and Secretary to the Cabinet

Carol Rasco
Assistant to the President for Domestic Policy

Jeremy Ben-Ami
Deputy Assistant to the President for Domestic Policy

LeeAnn Inadomi
Special Assistant to the President for Cabinet Affairs

Bob Jones
Special Assistant to the Secretary, Department of Veterans Affairs/OPL

Molly Brostrom
Senior Policy Analyst, Domestic Policy Council

Office of Management and Budget
Nancy-Ann Min
Associate Director for Health and Personnel

Toni Hustead
Branch Chief, Veterans Personnel

Jim Fish
Program Examiner, National Security Division

Department of Defense
Jeanne Fites
Deputy Undersecretary of Defense

Norma St. Claire
Director, Information Management for OUSD Personnel and Readiness

Gary Christopherson
Senior Health Advisor

Al Giambone
Principal Director for Program Policy and Coordination

Department of Housing and Urban Development
Jacquie Lawing
Deputy Assistant Secretary for Economic Development

Mark Johnston
Acting Director, Program Mgmt. Division, Office of Special Needs Assistance

Department of Labor
Preston Taylor
Assistant Secretary for Veterans Employment and Training

Department of Veterans Affairs
Dennis Duffy
Assistant Secretary for Policy and Planning

Marsha Martin
VHA Coordinator for Homeless Initiatives

Irwin Pernick
Associate Deputy Assistant Secretary for Policy

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The Retired Enlisted Association

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Veterans of Foreign Wars

Bill Crandell
Vietnam Veterans of America

THE WHITE HOUSE

WASHINGTON

SEP 19 1995

MEMORANDUM

TO: Executive Directors:

American Legion
AMVETS
American G.I. Forum
Blinded Veterans Association
Disabled American Veterans
Jewish War Veterans
Military Order of the Purple Heart
National Association for Uniformed Services
National Association of Black Veterans
National Association of State Directors for Veterans Affairs
National Guard Association
Non Commissioned Officers Association
Paralyzed Veterans of America
Reserve Officers Association
The Retired Enlisted Association
The Retired Officers Association - no
Veterans of Foreign Wars
Vietnam Veterans of America

FROM: Robert L. Jones
Office of Public Liaison

SUBJ: Interagency Veterans Policy Working Group

The White House Domestic Policy Council, Office of Public Liaison and Office of Cabinet Affairs created an Interagency Veterans Policy Working Group consisting of representatives from federal agencies responsible for veterans policy in order to provide a forum to address veterans needs, coordinate efforts and to foster communications. This group provides representatives of Veterans Service Organizations and the Military Coalition an opportunity to provide input into emerging veterans policy issues.

We cordially invite you to participate in a joint meeting of the Interagency Veterans Policy Working Group. The meeting will be held on Thursday, October 12, 1995 from 1:00 p.m. to 3:00 p.m. in the Truman Room in the White House Conference Center on Jackson Place. Please confirm your participation by contacting Mr. Bob Jones at (202) 273-4836. Due to space limitations organizations are limited to one representative each.

Federal agency representatives will provide an oversight of their activities concerning issues previously raised by the addressees in two broad areas: 1) Meeting the health care needs of the defense/veterans community, and 2) Economic issues affecting the defense/veterans community. Following each overview there will be an opportunity for discussion.

Addressees are invited to provide an issue paper that raises additional concerns outside the two general discussion topics. These papers are not to exceed 10 type-written letter-sized pages. These organization issue papers will be utilized to establish future agenda items. You are requested to provide at least 15 copies of your issue paper to Mr. Jones by October 3, 1995.

cc: Lee Satterfield, OPL
LeeAnn Inadomi, Cabinet Affairs
Molly Brostrom, Domestic Policy

INTERAGENCY VETERANS POLICY
TRUMAN ROOM IN THE WHITE HOUSE
CONFERENCE CENTER ON JACKSON PLACE
WORKING GROUP
OCTOBER 12, 1995
1:00 3:00 PM

Organizations	Attendees
* The American Legion	Michael Schlee
AMVETS	Bob Carbonneau
American G.I. Forum	Hector DeLeon
Blinded Veterans Association	Tom Miller
Disabled American Veterans	Ron Drach
Jewish War Veterans	Howard Metzger
Military Order of the Purple Heart	Greg Bresser
National Assoc. for Black Veterans	Wallace Williams
National Assoc. for Uniformed Services	Sharon Barnes
National Guard Association	Chuck Schreiber
Non Commissioned Officers Asso.	Dick Johnson
Paralyzed Veterans of America	Doug Vollmer
Reserve Officers Association	Col. Walker Williams
* The Retired Enlisted Association	Jim Adams
* Veterans of Foreign Wars	Jim Magill
* Vietnam Veterans of America	Bill Crandell

White House Staff	
Lee Satterfield, OPL	OPL
LeeAnn Inadomi, Cabinet Affairs	Cabinet Affairs
Molly Brostrom, Domestic Policy	Domestic Policy

* Submitted input for meeting

Veterans Activities
White House Conference on Aging

Conference Resolutions

There were two primary outcomes from the July 10 meeting with representatives of Veterans Service Organizations which affected the resolutions from the Conference:

1. **Two additional resolutions were added** to the synthesized resolutions, including the veterans' resolution on choice in health care. The two added delegate-introduced resolutions had garnered significant support from the delegates and ranked 11th and 12th among the delegate introduced resolutions. Previously, only the top 10 delegate-introduced resolutions (those receiving "yes" votes from a majority of the delegates) had been included.

2. Those **delegate-introduced resolutions which received more "yes" votes than "no" votes** from the delegates were included in the proposed report. These 26 resolutions are referred to as delegate supported resolutions.

Post-conference Events

The Department of Veterans Affairs (VA) and Paralyzed Veterans of America (PVA) are actively involved in several types of post-conference activities. Two events focusing on implementation of the Conference resolutions (one held in September in Charleston, SC and another planned for later this month in Brockton, MA) have been coordinated by VA. For the forum on independent living planned for November, staff from both VA and PVA serve on the steering committee and PVA has contributed funds to underwrite the forum. One of the model programs for keeping people independent to be spotlighted at the forum is from VA.

NCOA

Non Commissioned Officers Association of the United States of America

225 N. Washington Street · Alexandria, Virginia 22314 · Telephone (703) 549-0311

August 15, 1995

Mr. Robert B. Blancato
Executive Director
1995 White House Conference on Aging
501 School Street, SW (8th Floor)
Washington, DC 20024

Dear Mr. Blancato:

I appreciated greatly the proposed report on the WHCOA which was just shared with the nation's governors. The inclusion of Resolution 132 as an official resolution was especially noted! The inclusion of all other delegate introduced resolutions where the conference yes votes exceeded the no votes was also most appropriate as we had previously discussed.

Appendix 3 listed 51 adopted resolutions 40 IRDS, 10 delegates introduced resolutions, and the post conference IRDS resolution which should have been Resolution 132. However, I did not recognize Resolution 132 title "Giving older veterans choice in health care and permitting the DVA to retain third party reimbursements, including Medicare," or any variation thereof. Perhaps when the Governor's comments are presented later this month, an appropriate editorial change could be incorporated into the final report.

Thanks for your leadership in this matter.

Please call upon me if I can be of further assistance to facilitate any of the Conference objectives or goals.

Sincerely,

Richard C. Schneider
National Director of State/Veterans Affairs

INDIVIDUALS WHO PARTICIPATED IN MEETING RE: VETERANS ISSUES
July 10, 1995

Manuel Auerbach
Delegate to Conference from Silver Spring, MD
(301) 589-0248

Leo Avila
American GI Forum of the United States
(209) 847-6841

Fred Cowell
Paralyzed Veterans of America
Also a delegate to the Conference
(202) 872-1300

R.G. Fazakerley
Blinded Veterans Association
Also a delegate to the Conference
(703) 548-2607

Carroll M. Fyffe
Military Order of the Purple Heart
Also a delegate to the Conference
(602) 458-9228

General Earl G. Peck
Florida Dept. of Veterans Affairs
Also a delegate to the Conference
(813) 893-2440

Carol Rutherford
American Legion
Also representing Barbara Kranig, delegate from Wisconsin
(202) 861-2700

Richard C. Schneider
Non-Commissioned Officers Association of the USA
Also a delegate to the Conference
(703) 549-0311
Steve Smithson
Intern at the Non-Commissioned Officers Association
(703) 549-0311

Harold M. Serven
Veterans of Foreign Wars of the U.S.
Also a delegate to the Conference
(202) 543-2239

Also participating were John Hanson, representing the Dept. of Veterans Affairs; Theresa Forster, representing Chairman Pryor; Bob Blancato; and WHCoA staff.

FROM GOVERNORS REPORT

Resolutions from the Conference

Most resolutions adopted by the delegates at the White House Conference on Aging (WHCoA) originally were numbered in an order corresponding with the four issues (comprehensive health care including long-term care, economic security, housing/support service options and options for a quality life) and their subissues. Once the resolutions were synthesized, the Advisory Committee chose to re-number them in order according to the number of votes each received at the Conference. When two or more resolutions were synthesized, the order was determined by the one receiving the higher number of votes. The number(s) in parentheses indicate the source resolution(s) for the resulting resolutions.

Advocacy groups have raised concerns about the voting threshold at which a delegate introduced resolution was considered to be formally adopted. Because of the level of support some resolutions garnered, the WHCoA determined that two additional resolutions would be included in the list of Conference resolutions.

1. Keeping Social Security sound, now and for the future (7.1, 78)
2. Reauthorizing and preserving the integrity of the Older Americans Act (4.7, 4.8, 121)
3. Preserving the nature of Medicaid (3.1, 3.2, 4.2, 82, 145)
4. Alzheimer research (70)
5. Ensuring the future of the Medicare program (2.4, 4.1, 77, 145)
6. Ensuring the availability of a broad spectrum of services (2.4, 3.1, 77, 145)
7. Preserving advocacy functions under the Older Americans Act (4.8)
8. Financing and providing long-term care and services (3.2)
9. Expanding and enhancing opportunities for older volunteers (20.1)
10. Assuming personal responsibility for the state of one's health (1.1)
11. Strengthening the federal role in building and sustaining a well-trained work force grounded in geriatric and gerontological education (1.1, 5.2, 5.3)
12. Expanding, coordinating and targeting necessary services (16.1)
13. Reforming the health care system (2.2, 2.3, 2.4, 77, 145)

14 Promoting innovative strategies to encourage new models supportive housing, particularly housing which facilitates long-te care services (14.2)
15 Expanding coverage of existing food programs (9.1, 79)
16 Meeting mental health needs (21.2, 65)
17 Maintaining personal choice and autonomy (2.1, 3.1, 82)
18 Preventing crimes against older persons (17.1)
19 Prevention/wellness throughout one's lifespan (1.2)
20 Preventing elder abuse, exploitation, and neglect (17.2)
21 Expanding training and employment opportunities for older workers (6.2, 78, 79)
22 Designing housing to maximize independence (12.1)
23 Providing services in a full range of locations th encompasses: institutional care; home care/foster hom care; community-based services (4.4)
24 Increasing federal funding for research in the areas of th mechanisms of aging, diseases of older people, long-term ca systems and services, and special populations (1.2, 5.1)
25 Developing alternative options for funding long-term care (4.6)
26 Providing oversight and ensuring greater public and private pensio coverage, solvency, portability, enforcement and vestment (8.1, 79)
27 Setting ground rules for guardianship (22.1)
28 Support for caregivers (3.3)
29 Enhancing community participation (21.1)
30 Maximizing transportation choices (15.3)
31 Ensuring the availability of appropriate care, services, an treatment (2.3)
32 Preserving and expanding federal and state elderly housing programs (13.1, 80)
33 Encouraging policies that support and reward the development of suitable and safe communities (14.1)
34 Providing health care coverage that addresses basic needs, prevention, and chronic disease concerns (4.3, 4.6, 77, 82)
35 Strengthening and coordinating the delivery of legal assistance to older persons (83)
36 Ensuring quality care, services and treatment (2.2)
37 Promoting positive images of aging by sensitizing society to the value of older adults (19.1)

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38 Expanding programs to assess and address malnutrition across generations (9.3)

39 Addressing issues related to grandparents raising grandchildren (20.3)

40 Targeting Social Security and Supplemental Security Income benefits for frail elderly women (7.3, 79)

41 Protecting the rights of older citizens and legal residents against discrimination (11.1, 79)

42 Encouraging development and ensuring implementation of advance directives, e.g., living wills (18.1)

43 Advocating for children (20.2)

44 Defending and advancing critical public policies (76)

45 Giving older veterans choice in health care; and permitting the Department of Veterans Affairs to retain third party reimbursement, including Medicare (132)