EFFECTIVENESS OF COMMUNITY CARE CLINICS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

APRIL 24, 1996

Printed for the use of the Committee on Veterans' Affairs

Serial No. 104–20

U.S. GOVERNMENT PRINTING OFFICE

25–742 CC WASHINGTON : 1996

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-052962-X

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON VETERANS' AFFAIRS

BOB STUMP, Arizona, *Chairman*

CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
FLOYD SPENCE, South Carolina
TIM HUTCHINSON, Arizona
TERRY EVERETT, Alabama
STEVE BUYER, Indiana
JACK QUINN, New York
SPENCER BACHUS, Alabama
CLIFF STEARNS, Florida
BOB NEY, Ohio
JON FOX, Pennsylvania
MIKE FLANAGAN, Illinois
BOB BARR, Georgia
JERRY WELLER, Illinois
J.D. HAYWORTH, Arkansas
WES COOLEY, Oregon
DAN SCHAEFER, Colorado

G.V. (SONNY) MONTGOMERY, Mississippi
LANE EVANS, Illinois
JOSEPH P. KENNEDY II, Massachusetts
CHET EDWARDS, Texas
BOB CLEMENT, Tennessee
BOB FILNER, California
FRANK TEJEDA, Texas
LUIS V. GUTIERREZ, Illinois
SCOTTY BAESLER, Kentucky
SANFORD BISHOP, Georgia
JAMES E. CLYBURN, South Carolina
CORRINE BROWN, Florida
MIKE DOYLE, Pennsylvania
FRANK MASCARA, Pennsylvania

CARL D. COMMENATOR, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

TIM HUTCHINSON, Arkansas, *Chairman*

BOB STUMP, Arizona
CHRISTOPHER H. SMITH, New Jersey
MICHAEL BILIRAKIS, Florida
FLOYD SPENCE, South Carolina
JACK QUINN, New York
SPENCER BACHUS, Alabama
CLIFF STEARNS, Florida
BOB NEY, Ohio
JON FOX, Pennsylvania
MIKE FLANAGAN, Illinois

CHET EDWARDS, Texas
JOSEPH P. KENNEDY II, Massachusetts
BOB CLEMENT, Tennessee
FRANK TEJEDA, Texas
LUIS V. GUTIERREZ, Illinois
SCOTTY BAESLER, Kentucky
SANFORD BISHOP, Georgia
CORRINE BROWN, Florida
MIKE DOYLE, Pennsylvania

CONTENTS

Page

OPENING STATEMENTS

Chairman Hutchinson 1
Prepared statement of Chairman Hutchinson 29
Hon. Chet Edwards 2
Prepared statement of Congressman Edwards 31
Hon. Jack Quinn 3
Hon. Joseph P. Kennedy II 3
Hon. Michael Bilirakis 34
Hon. Luis V. Gutierrez 36
Hon. Sanford Bishop 38
Hon. Corrine Brown 39
Hon. Mike Flanagan 40

WITNESSES

Baine, David P., Director, Health Care Delivery and Quality Issues, Health, Education, and Human Services Division, U.S. General Accounting Office; accompanied by Paul Reynolds, Assistant Director, Health Care Delivery and Quality Issues, Health, Education, and Human Services Division; and Barry Bedrick, Associate General Counsel 4
Prepared statement of Mr. Baine 42
Kizer, Kenneth, M.D., M.P.H., Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs; accompanied by Mary Lou Keener, General Counsel; Jule D. Moravec, Ph.D., Chief Network Officer; Denis J. Fitzgerald, M.D., Director, Veterans Integrated Service Network #1; Sanford M. Garfunkel, Director, VA Medical Center, Washington, DC, and Y.C. Parris, Director, VA Medical Center, Amarillo, TX 15
Prepared statement of Dr. Kizer 59

EFFECTIVENESS OF COMMUNITY CARE CLINICS

WEDNESDAY, APRIL 24, 1996

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

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Tim Hutchinson (chairman of the subcommittee) presiding.

Present: Representatives Hutchinson, Smith of New Jersey, Bilirakis, Spence, Quinn, Edwards, Kennedy, Tejeda, Gutierrez, and Bishop.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. The hearing of the Subcommittee on Hospitals and Health Care will now come to order. the subcommittee meets this morning in its oversight role to hear testimony on efforts to improve access to primary care services to veterans. This is an issue critical to veterans and Monday I was able to witness this first-hand by chairing the subcommittee's first field hearing on this very issue in LaSalle, IL.

The veterans of LaSalle are very similar to veterans residing in my own district of Northwest Arkansas and, I suspect, many parts of our country. They are proud of their service to this country, they are aging, and they want access to VA health care services that is convenient.

As health care changes, so must the VA. In a bipartisan manner, the Committee on Veterans' Affairs has given the VA the ability to implement the VISN structure, which decentralizes decisionmaking and should ultimately translate into improved services to veterans.

In the last few months, I have been approached by a number of members on the issue of veterans' access to outpatient services. The interest on this issue was reinforced by the overflow crowd of veterans who jammed the LaSalle VFW hall to show their support for care in their community. Because of the intense interest in this issue, I asked the General Accounting Office to examine the establishment of access points and the long-term implications of these clinics on the practice of medicine and the potential budgetary implications of establishing numerous community care clinics.

Health care has entered a new paradigm of managed care, intense competition, and delivery of services as close to the consumer as possible. In this vein, the survival of the VA health care system is dependent on its ability to satisfy the diversified needs of the

veteran population. Traditionally, veterans seeking care have done so at one of 173 inpatient hospital facilities. As we are all aware, many VA hospitals are not always convenient nor are they the most cost-effective delivery site for the care of veteran patients. While local community care clinics may provide some answers to access problems faced by veterans, the random proliferation of hundreds of access points could place the VA in a difficult budgetary situation. Along with access points, the subcommittee must also examine the nagging question of eligibility to care and the mandated priority system and demands that service-connected veterans receive the highest priority for care.

I look forward to the testimony of the representatives of GAO and the Veterans Health Administration. I understand the difficulties of both groups who will present testimony this morning as we look for better ways to better serve our Nation's veterans.

[The prepared statement of Chairman Hutchinson appears on p. 29.]

Mr. HUTCHINSON. If we are not completed by 11 a.m., I'm going to have to excuse myself, but I think Representative Bilirakis will be here at that time to assume the chair.

I'd like to recognize my friend and ranking member of the subcommittee, Chet Edwards of Texas.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Thank you, Mr. Chairman, and thank you for calling this hearing on VA community-based care. VA health planners and veterans advocates alike have long struggled with the fact that most veterans who rely on the VA care live significant distances from VA facilities.

Typically, these veterans have low or very low incomes, and covering great distances, especially for outpatient treatment, often works special hardship on these patients and their family members.

Also, many veterans, including those with a high priority for VA care, simply do not avail themselves of their eligibility for VA medical services, often for the very reason that there's difficulty involved in traveling to the VA facilities.

Given these circumstances, Mr. Chairman, I'm pleased by the VA's efforts to expand veterans' access to ambulatory and primary care services. Early last year, as you know, the VA promulgated an interim policy encouraging its medical centers to establish so-called "new" access points within available resources.

This February, the General Accounting Office reported that veterans' access to VA health care could improve significantly if medical centers used all means at their disposal to expand access as VA policy encouraged.

GAO's testimony today raises several questions about VA plans, but personally I do not construe GAO to be retreating from support for policy which should improve convenience to the patient and provide more efficient, effective care delivery possible in existing facilities.

Ultimately, Congress holds the key to answering at least one of GAO's concerns. And next Tuesday, Mr. Chairman, I want to thank you for having this committee mark up H.R. 3118, a bill that would

clear up issues of veterans' eligibility for primary care and the VA's authority to contract those services.

I hope today's hearing will help foster continued expansion of community-based care as well as further the development of policies to assure that a veteran's ability to receive VA care should not vary significantly depending on the state or region in which that veteran resides.

Thank you again, Mr. Chairman, for convening this hearing.

Mr. HUTCHINSON. Thank you, Chet. I will now recognize members for their opening statements. Mr. Spence, do you have an opening statement?

Mr. SPENCE. No, Mr. Chairman. I just want to commend you for having this hearing, and welcome our witnesses and look forward to their testimony.

Mr. HUTCHINSON. Mr. Quinn.

OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman. And I'm looking forward to hearing the testimony, too. And I think as important as the expansion of the community-based service that Chet Edwards just talked about, is the expansion of the discussion that goes on between the GAO, for example, and the VA. Dr. Kizer is here this morning, we'll hear from him on the second panel. But I'm a strong believer that we need to continue to talk to each other about suggestions that you may have and others may have, the subcommittee may have, the full committee may have, that we can take back to the Secretary and his staff that we can implement.

There's no sense in having any kind of ideas in your own department or your own agency, so I, Mr. Chairman, welcome the opportunity to join you today to hear from various different agencies, and the key for me is that we continue to talk to each other. I think it's healthy and we'll get some great suggestions. Thank you.

Mr. HUTCHINSON. Thank you, Jack. Mr. Kennedy.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY II

Mr. KENNEDY. Thank you, Mr. Chairman. I want to just say how encouraging I think it is to see some of the changes taking place within the VA health care system, given the fact that we see so many veterans that are getting older and such a reduction in terms of the level of commitment that the Congress is making to actually providing the funding that's necessary to meet the complete quality care needs of all the veterans that are requiring greater and greater amounts of care and, given those pressures, it seems to me it only makes sense if we begin to reform exactly how the health care system throughout the country operates.

And the fact that Dr. Kizer and Dr. Fitzgerald are coming up with innovative and creative approaches to try and make sure that we decentralize, that we provide quality care and appropriate care for veterans at more convenient locations that is, in fact, taking place in the private health care system throughout the country, and we have tended to resist that within the VA health care system.

I remember the fight that we had, for instance, on the outpatient clinic in downtown Boston, which was a significant difficulty for a

long period of time, and yet I think at this point there are still some steps that we as a committee have to take, and that Congress has to take, in terms of eligibility reform which, as I understand, is one of the issues that the GAO brings up.

And I just would urge those that work within the VA to continue your efforts, and that those of you who have the attitude that we ought to be providing the best and most efficient quality care for the veterans regardless of what some outdated regulations that, for whatever reason, the Congress seems unwilling, or unable, or just inept at trying to help assist you in reforming, then I understand the concerns that the GAO might raise, but I nevertheless would encourage you to continue to go about your business and to do the best thing that you think is the right thing to do on behalf of the Nation's veterans.

I wish we could move, and I know the Chairman and the Ranking Member both have tried to take up this initiative, and I still don't understand completely why we can't get eligibility reform just done. If you have a comment you'd like to make on that, Mr. Chairman, I'd be happy to turn the rest of my time over to you.

Mr. HUTCHINSON. Mr. Kennedy, we're going to mark up eligibility reform next Tuesday, and the subcommittee and the full committee intends to move forward with that. And we put the same priority on it as I know you do. I think it is the major issue facing health care reform with the VA.

Mr. Tejeda, you are recognized for an opening statement.

Mr. TEJEDA. I have no opening statement, Mr. Chairman.

Mr. HUTCHINSON. Today, we will hear testimony from two panels. The first panel is composed of David Baine, Director, Health Care Delivery and Quality Issues, Health, Education, and Human Services Division of the General Accounting Office. That is a mouthful. That is quite a title to live up to. He is accompanied by Paul Reynolds, Assistant Director of Health Care Delivery and Quality Issues, and Barry Bedrick, Associate General Counsel.

I will ask that you summarize your comments in 5 minutes, and we will include all of your written testimony in the record, and then members will operate under the 5-minute rule. Mr. Baine, you are recognized.

STATEMENT OF DAVID P. BAINE, DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY PAUL REYNOLDS, ASSISTANT DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION; AND BARRY BEDRICK, ASSOCIATE GENERAL COUNSEL

Mr. BAINE. Thank you, Mr. Chairman, and good morning. We'd like to thank you for the opportunity to discuss the Department of Veterans' Affairs' efforts to improve access to health care.

Traditionally, almost all veterans seeking care have used VA-operated facilities. Veterans have frequently indicated that they do not use VA health care because they live too far from the nearest hospital and clinic.

To improve veterans' access to care, VA recently empowered network and hospital directors to employ all means at their disposal, within available resources, to establish new access points.

In using access points to restructure their direct delivery systems into integrated service-delivery networks, VA directors have considerable freedom to develop their own goals and objectives as well as their own implementation plans.

To date, nine hospitals have opened 12 new access points. Of those 12 new access points, VA staff operate four of them, and contract with county or private clinics to operate the remaining eight. As you mentioned, at your request, we have reviewed VA's efforts to establish these access points.

Mr. Chairman, in summary, in establishing new access points, VA has identified what we believe could be a very cost-effective way to enhance the availability of health care for current users, especially those residing in underserved areas. In this regard, VA's efforts to establish these access points could represent a defining moment in its health care system as it moves into the 21st century.

VA hospitals, over the next several years, could open hundreds of access points and greatly expand market share. There are over 26 million veterans and 500,000 private physicians who could contract to provide private care at VA expense.

VA's growth potential appears to be limited only by the availability of resources and statutory authority, that you mentioned before, new veterans' willingness to use the access points and then be referred to VA hospitals, and other health care providers' willingness to contract with VA.

VA should be commended for encouraging hospital directors to serve veterans using their facilities in the most convenient way possible. It has not, however, established the access points in conformance with existing statutory authority, that Mr. Kennedy mentioned. For example, it is not adhering to statutory limitations that currently govern what services VA may provide and who may be served.

As a result, veterans are receiving more services than current statutes allow. In our view, under the current statutes, new access points should be VA-operated or provide contract care only for those services or classes of veterans specifically designated under Section 1703 of title 38. That's the fee basis section of title 38.

While legislative changes are needed to authorize VA hospitals to provide primary care to veterans in the same manner as the new access points are now doing, such changes carry with them several financial and equity access implications that we have detailed in our written statement. For example, creating too many access points may attract more veterans than network and hospital directors can finance within their existing budgets.

Empowering local hospital directors to establish new access points provides an opportunity for VA to go a long way toward assuring that similarly situated veterans are afforded equal access to VA care. However, access inequities may continue, given that the directors are establishing these access points without a clear, consistent criteria for targeting new locations and populations to be served.

In addition, VA has not developed a plan to ensure that hospitals establish these access points in an affordable manner. If developed, such a plan could articulate the number of new points to be established, the populations to be served, the time frames to begin operations, related costs, and funding sources.

Given the uncertainty surrounding resource needs for new access points, such a plan could also articulate clear goals for the target populations to be served. Hospitals could be directed to provide care at the new clinics in accordance with statutory service priorities. If sufficient resources are not available to serve all eligible veterans expected to seek care, the new clinics that are established would serve, first, veterans with service-connected disabilities, and then other categories of veterans, with higher income veterans being served last.

Finally, this approach could provide for more equitable access to VA care than VA's current strategy of allowing local hospitals to establish the clinics to serve veterans on a first-come, first-served basis, and then rationing services when their resources run out.

We have discussed, Mr. Chairman, the results of our work with the Deputy Under Secretary for Health and several other VA officials. In general, they express disagreement with our assessment of the legal implications of the new access points, and we can discuss that perhaps during the question-and-answer session.

While they indicated a reluctance to develop a plan, they told us yesterday, and showed us a draft of a new policy on access points that maybe Dr. Kizer can elaborate on a bit when he testifies. Generally, this new plan is to guide the establishment of the new clinics, and it does include specifically the target populations to be served.

That concludes my summary, and we'll be happy to take your questions.

[The prepared statement of Mr. Baine appears on p. 42.]

Mr. HUTCHINSON. Thank you, Mr. Baine. I assume from your testimony that it's your feeling that there are not currently consistent criteria for establishing these access points, is that correct?

Mr. BAINE. Yes, it is, Mr. Chairman, and I believe—Dr. Kizer and I were talking just before the hearing and, to some extent, I think that that's a matter of timing. The VA's purpose was to establish a few of these access points, see how they work and so forth, and then as time goes on, to refine the criteria for the establishment of the access points.

But the ones that have been established so far, have been established at the local level, which is what VA wanted to do, but the criteria for establishment of the access points has varied all over the place in terms of the populations to be served and that kind of thing.

Mr. HUTCHINSON. So, what did you find in your study, that there might be, for instance, a hospital that would create an access point in order to generate a new service area to veterans in an area that perhaps the access point or the community clinic might only be a few miles from the inpatient hospital where perhaps in a rural area where a VA hospital had fewer resources but great needs in that rural area for veterans maybe 30, 40, 50 miles away, who had

no easy access, did not have the ability to establish that kind of clinic because of their budget, or that kind of situation?

Mr. BAINE. Basically, that's correct. There are some of the access points that have been opened, and keep in mind that there are, I believe, 12 of them opened, but that are currently attracting nearly all new users. There are a few that have established access points in a way to serve service-connected veterans first, and then they plan to expand it if they have the resources to expand it.

Paul Reynolds may be able to elaborate a bit on sort of the variability that we found when we went out into the field.

Mr. REYNOLDS. I think one of the criteria that we would most like to see is what VA's definition of "convenient access" is. It could be in miles or it could be in minutes. I think we prefer minutes. Some of the private sector people that we talked to do it in 20 minutes to primary care; for example, all primary care should be within 30 minutes. If that kind of clear criteria was given, then you would get some consistency both in the rural and in the urban areas.

Mr. HUTCHINSON. Is it your understanding that it is the VA's intention to establish that kind of criteria?

Mr. BAINE. The draft policy that we were given yesterday establishes, I think, more specific criteria than the February 1995 interim policy under which the first ones were established. For example, it specifically notes that service-connected veterans are to be targeted for the use of these access points, I believe. Is that right, Paul?

Mr. REYNOLDS. I would characterize our discussions with VA, at this point, that VA has expressed a reluctance to establish those kinds of targets.

Mr. HUTCHINSON. So, Mr. Baine, when you said it should be limited to those who are statutorily eligible, you found then that in the existing access points that have been established, that that was not being consistently enforced?

Mr. BAINE. That's correct.

Mr. HUTCHINSON. You mentioned in your testimony your concern that because these access points must be budgeted through the hospital, there is concern that it might create a budgeting situation where the demand for services would outstrip the funds available through that local hospital budget. What kind of impact do you see that could potentially have on service-connected care?

Mr. BAINE. It could potentially in our view, negatively impact service-connected care. The concern that we expressed in the statement—I should probably explain what our specific concern is.

There's a certain cost involved in establishing the access point itself. If that clinic is attracting new users, it is likely that those new users would be referred to the Veterans' Hospital, the parent hospital. That, in our view, would have a budgetary impact.

Currently, the VA has asked its hospitals to fund this out of their existing budgets, and they have done that through a series of management efficiencies which I think you'll probably hear about later.

I believe that the extent of the budgetary impact will probably not be known until somebody can lay out how many of these access points are going to be established over the long-haul, over what pe-

riod of time, how many per year, for how long, and the potential cost impact. But the budgetary impact is sort of a two-fold impact—the cost to open and run the access point itself, and then the referral cost of folks who get referred to the VA hospital. If that population is primarily new users, then you're going to have a call on the demand for the system that is not now there.

Mr. HUTCHINSON. Thank you. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Mr. Baine, in your comments, would you suggest that the VA should not open any new access points until we deal with some of these questions on equity of access, or are you not recommending that?

Mr. BAINE. No, I don't believe we're recommending that, sir. It's our understanding that there are some 58 of these clinics up for approval by the Appropriations Committee. I think all we're suggesting is the development of some criteria that would give the people that approve these access points from the congressional side, some sense that there's going to be an equity of access element to this, some sense of what the likely demand is going to be, and those kinds of things. And this, again, may be a matter of timing.

Mr. EDWARDS. I think you make some valid points on that. We want some basic standards of equity across-the-country, but my second and last question would be, how do you try to balance what could be an argument for total centralization of these decisions versus the VA's effort that's been applauded by most Members of Congress and most veterans' organizations, to try to decentralize management decisionmaking. How do we balance, in your mind, those two competing philosophies?

Mr. BAINE. I understand your question, Congressman Edwards, and I don't think we are in any way advocating a retrenchment to the centralized "everything ought to be run out of 800 Vermont Avenue".

As a matter of fact, I think it's our view that the decentralized approach to the delivery of health care through the VA system is the way to go. Having said that, it's our view that the people, like yourself and this subcommittee and the Appropriations Committees and so forth, need a certain amount of information to understand where the VA is going with this, and what are the likely implications of it. And I don't think that that's in conflict with the decentralized approach to the delivery of care.

Mr. EDWARDS. Very good. Thank you for your testimony.

Mr. BAINE. You're welcome, sir.

Mr. HUTCHINSON. Mr. Spence.

Mr. SPENCE. No questions.

Mr. HUTCHINSON. Mr. Kennedy.

Mr. KENNEDY. I'm just trying to understand the basic concerns that you have, Mr. Baine, with regard to—is your concern that if the VA were to have its way, that there would just be such a plethora of these clinics that would open, that we would just get far too many veterans that would be applying for these services than the VA could handle? Is that your most fundamental concern?

Mr. BAINE. That's a possibility, Mr. Kennedy, because I don't think it has been publicized what the endpoint of this plan is. And maybe it can't be, at the moment. This is a matter of timing. But

I think the potential demand on the system is an issue. The budgetary implications of that demand is an issue. And to the extent that the system can generate the efficiencies to finance the access points and take care of the demand—I mean, I think everybody would applaud that.

Mr. KENNEDY. But isn't the problem, though, if you're fair about it, you can sort of analyze the idea of decentralization and say, well, that can bring in more patients. The difficulty, of course, is that if you look at the existing system, you've got a system where the patients that are coming into the VA are getting older and sicker. We're not providing the current system with enough money.

If anyone were running this as a private health care system, they would say, well, look, there's a much more efficient way to do this, which is instead of having all these centralized, sort of larger facilities that end up providing much more in certain cases than is required because of other regulations, that what we ought to be doing is decentralizing and allowing much more appropriate care to be provided to the veterans.

And then what happens, of course, is that when they start in on a reform package like that, then somebody else does a study saying, well, listen, if you do that, the problem is that you're going to be increasing the awareness of the possibilities of service to the veterans, and so therefore more veterans are going to come in, and so therefore you can't do that either. And you sort of put the managers of the VA health system into kind of a "Hobson's choice", or sort of a Catch–22 where there is really no logical way to do it.

I sort of think at some point—you know, we look to the GAO for a lot of answers to a lot of different things and, generally, you do a very good job, but usually I find that people are pretty reasonable about trying to look at not only the specific job that you've been given, but you've also got a head on your shoulders and you can look at the existing system and say, well, that thing doesn't work either—right?

So, if you've got a choice between the two, can you make a judgment as to how you'd suggest they proceed?

Mr. BAINE. I believe I can.

Mr. KENNEDY. Thank you. Please do.

Mr. BAINE. I hope you didn't get the impression that we're all negative on this notion of establishing clinics. This is, in our view, the way to go. The system and the demand on the system, to be quite honest with you, has been constrained by the fact that there's only 173 hospital locations and 200 clinics or something, so far. And the notion of making VA primary care more accessible to the veteran population makes imminently good sense.

I think all we're saying is that this may have some implications in terms of the demand on the system and on what VA's market share of the veteran population would be, and what the potential cost implications of that would be. And our view is that if somebody has a notion of what that would be, you folks deserve to know it.

Mr. KENNEDY. That was a "wiggler", if you ask me, Mr. Baine.

Mr. REYNOLDS. If I could interject for a minute, I think that what our concern is that if there was enough money to make convenient access for everyone within the next 12 months, then we

would be all for that. But we're afraid that absent a plan and absent any dollar or price tag put on access points in making it more convenient, it appears to us that it may be unaffordable, or at least that it will take 5, or 7, or 10 years, a phased-in approach.

Fairness is what we were looking at, and we believe that the law has, in the rationing priorities, clearly indicated the priority order of care when there's not enough resources available, starting with the service-connected veterans at the highest, working their way down through the categories to the higher-income, nonservice-connected veterans.

I think that someone could make a good case for a way to go about an initiative like this where there might not be enough money available, or it may take a number of years to first target the places that have the most needy or highest priority veterans, and then work your way down in some manner like that. And that approach may avoid a situation where service-connected veterans in some parts of the country, for whatever reason, may still have to ride an hour, hour and a half, while nonservice-connected, high-income veterans in another part of the country have never used VA but now have care 20 minutes away. Those are the kind of concerns that we discussed.

Mr. KENNEDY. I guess just in conclusion, Mr. Chairman, I would imagine that we will hear, when we hear directly from the VA, that they will, in fact, be taking into account some of those issues, and probably have given it some more logical thinking than that, instead of just a scatter-shot approach about building a clinic anywhere, anytime, anyhow. They are probably going to have some criteria about what makes sense, some of which might be screwed up because of the way we operate but, nevertheless, I think they'll probably have some logic in terms of which clinics they want to build first.

Mr. REYNOLDS. I believe that that's what they are now talking through and, with the draft policy they gave us, our concerns were based on the 12 access points we looked at, the ones we visited. In those, they were basically opening them up to all veterans, new users, current users, and they were enrolling them on a first-come, first-served basis.

They were establishing target limits like this access point would be funded for 500 people, or 400. If they reached 500 in the first 4 months, then the hospital director had a difficult choice. He could obviously enroll more, but he would have to find the money. But at some point, money would run out. But that's what we were really reacting to, was the first-come, first-served nature of it, and basically the access points we looked at—we looked at 1,200 veterans' individual circumstances, and 20 percent of them were service-connected—the majority were nonservice-connected—and there were some high-income, and so they were——

Mr. KENNEDY. Sometime, Mr. Chairman, I wish we had an opportunity to have, when we have a panel like this—it is very interesting about the reforms—that we also have the VA on the same panel so we have a chance to hear them respond to what Mr. Reynolds is saying and then hear Mr. Reynolds respond to them—I'll bet Dr. Kizer would like to respond right now—but anyway——

Mr. HUTCHINSON. I think you have a very good point. They're going to have their chance, but it would be interesting to have them point-counterpoint. Thank you, Joe. Mr. Tejeda.

Mr. TEJEDA. Thank you, Mr. Chairman. I'd like to ask Mr. Baine a question. You testified that the VA does not have a clear and consistent criteria for targeting new locations. What is determining the location of these facilities?

Mr. BAINE. Initially, Mr. Tejeda, the medical centers were asked, I believe, to make proposals for new access clinics. They did that. The VA submitted a list of the locations to the Appropriations Committee, which approved the first 15—is that correct, Paul?

Mr. REYNOLDS. Yes.

Mr. BAINE. And, again, this may be a matter of timing, as Dr. Kizer and I were talking about before, but it was a local initiative, and the ones that were submitted and have been submitted so far, have been initiated by the local hospital directors. And some of them, quite honestly, have been more aggressive in doing that than others.

Mr. TEJEDA. Let me just briefly ask once again, in your examination of the 12 new access points, did you find the shift resulted in savings or increased expenditures?

Mr. REYNOLDS. That's an interesting question. Initially, VA will spend more money to provide care to veterans over the short-term. This is because—an example we have in our written statement—they have primary care teams now in their hospitals, the ones that we visited. Those primary care teams would roughly handle 1,500 veterans. As they develop the access points, some of those veterans would be shifted to the remote location.

If they only did, say, three access points and had 500 veterans, then they couldn't get rid of the primary care team in the hospital. Once they had enough access points to where they had shifted 1,500 of the veterans now enrolled in the primary care team in the hospital, they could then reduce that primary care team. In the example I'm using, they had five teams and they eventually could go to four teams. That's where they would get savings.

At that point, the answer to the question would be that based on VA's cost analyses, it was cheaper to contract than it was to provide it with that primary care team in the hospital. So, on a longer-term basis, they would save money in the primary care.

What Mr. Baine was alluding to earlier was—and the great unknown in this is—that over time veterans will need to be referred to VA hospitals for specialty care and inpatient care. It's unknown yet the extent to which the veterans, especially the new ones, will accept referral and go to VA for care.

To the extent they do, the hospitals may incur increased costs, and those are the costs that will only be known—it was too short in only the year they've been doing this, to really see that. That's something that maybe in the third year or the fourth year you'll start to get some good data about what effect it actually has on the specialized care and the hospital care.

A long answer, but I hope it got to the point.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman. I ask unanimous consent that my opening statement be included in the record.

Mr. HUTCHINSON. Without objection.

[The prepared statement of Congressman Gutierrez appears on p. 36.]

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Mr. Baine, you stated that the VA directors are establishing new access points without clear consisting criteria for targeting new locations and populations to be served.

Can you give a few examples of the different criteria the directors have used at the 12 access points set up so far?

Mr. BAINE. Yes, sir. There are one or two of the access points that have specifically initially targeted service-connected veterans. So, their target was the service-connected veterans for service connected conditions. Some of those plan to expand, if they have the resources to expand, to others.

There was at least one where all the veterans who were enrolled at the access point were, I believe, new users—hadn't used VA in the past 3 years, or something like that.

So, those are two examples where the local initiatives targeted different segments of the veteran population.

Mr. GUTIERREZ. One was, they were targeting new people who had not used the VA, and the other one we're targeting only service-connected veterans.

Mr. BAINE. Yes. Those are sort of the two extremes, as I recall.

Mr. GUTIERREZ. Does anybody else have an example of different criteria?

Mr. REYNOLDS. One of them is only current users. So, they did not accept new users.

Mr. GUTIERREZ. So they didn't accept new users, whether they were service-connected or not.

Mr. REYNOLDS. Right.

Mr. GUTIERREZ. Mr. Baine, you stated in your testimony that most directors have concluded that it was more cost-effective to contract for care in the target locations, than operate new access points themselves. However, four out of the 12 new access points are run by the VA and not by private health care providers.

What made these four new access points that are run by the VA different, if anything, than the other eight clinics, and what can we learn from their unique situation, and what can these experiences teach us as we look to expand access points?

Mr. BAINE. I believe the answer to your question is the number of people that the access points intended to enroll. If the number was relatively small, then the hospital directors believed that it was less costly to contract with a rural health clinic or something, than it was to lease and run their own clinic.

If the veteran population were to be larger, the enrolled population were to be larger, then I believe the judgment was that it was more cost-effective to lease and run it themselves.

Mr. GUTIERREZ. So that the VA—in the four locations of the 12, the VA would run it because it was more cost-effective when there was a larger population? I'm sorry, I don't——

Mr. BAINE. There was a larger enrolled population in the VA-operated ones than there was——

Mr. GUTIERREZ. Than in the independent ones.

Mr. BAINE. Yes.

Mr. GUTIERREZ. So, as you get smaller populations, it's——

Mr. BAINE. Basically, that's correct. Plus, you've got to understand that some of these things are a long way from the parent hospital.

Mr. GUTIERREZ. And so there is a question of distance from the parent hospital.

Mr. BAINE. Absolutely.

Mr. GUTIERREZ. Thank you very much, Mr. Baine.

Mr. BAINE. You're welcome.

Mr. HUTCHINSON. I was intrigued by Mr. Kennedy's line of questioning regarding the whole issue of centralized control and how we establish fairness and equity in the service of veterans. I have the brochure from the Amarillo Veterans' Rural Health Clinic Network. Part of the brochure says—and it's italicized—"Current VA eligibility guidelines apply to all applicants for care". Did you find that this was typical of the 12, or not typical—atypical?

Mr. BAINE. I believe that it was pretty typical.

Mr. HUTCHINSON. The first-come, first-served basis of care, though would fly in the face of that statement, wouldn't it?

Mr. BAINE. Not necessarily, I don't think, but go ahead, Paul.

Mr. REYNOLDS. All the 26 million veterans are eligible for some care in the VA system now. The higher-income ones would have to pay co-payments, but if resources are available, they are eligible for diagnosis of new conditions. So, the question is not that any of the 26 million veterans that are eligible for nothing in the VA system, it's just a question that the way the eligibility rules are written, there are limitations.

And because this was a capitated situation, it made it very difficult for the contractors to differentiate who was eligible for what under the statutory authority. So, they basically were contracting for primary care, and the contractors were providing medically necessary primary care.

Mr. HUTCHINSON. But the point was, I think you found inconsistencies and therefore inequities in the way service is being offered.

Mr. BAINE. Right.

Mr. HUTCHINSON. How do we balance the effort toward decentralizing, allowing more of that local control, and the need to have some consistency across the system?

Mr. BAINE. In my view, it would not be out of the question for Dr. Kizer and his people here to lay out a set of guidelines that say, if you are going to establish access points—and they've done this in this draft policy—that you should target service-connected veterans first, in accordance with the eligibility rules that now prevail.

I think what Paul was saying before, Mr. Hutchinson, is correct. A lot of the eligibility rules have to do—and this goes back to your citation of that which was in italics—a lot of the eligibility rules have to do with what the veteran is eligible for, and which classes of veterans are eligible for what service and, as you know, that's sort of bizarre as it has evolved.

The VA could inform the hospital directors that it's the VA's intention to target particular categories of veterans and specify what

kinds of services, and that would go at least some of the way toward reducing some of the inequities that currently exist.

Mr. HUTCHINSON. Would those same kind of target guidelines be needed as far as what geographical areas should be allowed to establish these access points? I mean, if you have——

Mr. BAINE. In terms of geographic accessibility?

Mr. HUTCHINSON. Well, I'm thinking particularly about the subcommittee field hearing we had in LaSalle, IL, where it takes 45 minutes or so to get to a primary care facility, while some of the clinics that were established were within just a few minutes of a large hospital—it would seem to me you would have a fairness issue involved there as well, that the VA should establish some guidelines on.

Mr. BAINE. I guess our view is, Mr. Hutchinson, that the notion of geographic inaccessibility should be included in whatever criteria are provided to the field to establish these things. And perhaps the inaccessibility measurement should be in minutes to a primary care clinic. That's what happens essentially in the private sector. The major health care networks have essentially said that if somebody is within 30 minutes, or 35 or 40 minutes, of a primary care provider, that's sort of the parameters that the private sector has laid on their providers.

Mr. HUTCHINSON. But so long as that local hospital director has the autonomy to establish access points, as long as his budget permits it, you could continue to perpetuate those kinds of geographical inequities, or time sequence.

Mr. BAINE. Sure.

Mr. HUTCHINSON. Mr. Bishop, do you have any questions?

Mr. BISHOP. I will pass at this time, Mr. Chairman.

Mr. HUTCHINSON. Mr. Edwards? Anybody else?

Let me ask, did you find in your computing that there were cost savings relating to the travel costs that are eliminated because of those access points?

Mr. BAINE. I believe there are some cost-savings that are attributable to the establishment of—beneficiary travel costs, is that what you're referring to?

Mr. HUTCHINSON. Right.

Mr. BAINE. I believe there are. Some of the hospitals have found that there are some. I don't think they are major. We have heard numbers when we talked to the folks down at VA here, that beneficiary travel cost-savings may be in the hundreds of thousands of dollars. The real unknown in this, Mr. Hutchinson, is the extent to which the VA would incur beneficiary travel costs for those folks who are referred from the access point back to the parent hospital.

Mr. HUTCHINSON. So you may have additional costs that eat into whatever savings you might have.

Mr. BAINE. I believe that's correct.

Mr. HUTCHINSON. The VA, as a whole, is moving toward a capitated system. My understanding is that the access points, some of them, are operating under a capitation now.

Mr. BAINE. Yes.

Mr. HUTCHINSON. What kind of annual fee is paid per veteran, and what services are covered?

Mr. BAINE. I believe that the ones that are currently open—and Paul can elaborate on this—I believe that the annual fee is roughly from $190 to $360, and that pays for essentially three to four—a planned three to four visits by each veteran to the——

Mr. HUTCHINSON. Are they limited?

Mr. BAINE. No, sir, they are not limited. And to the extent that a veteran uses the services, VA, if they are insured, will bill the insurance company on a fee-for-service basis for each visit. I believe that's correct.

Mr. REYNOLDS. That's right.

Mr. HUTCHINSON. Are there any other questions of this panel?

[No response.]

If not, you are excused. We thank you very much for your fine testimony and the report.

Mr. HUTCHINSON. The second panel this morning is composed of Dr. Kizer, Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs. He is accompanied by Ms. Mary Lou Keener, General Counsel of the Department; Dr. Jule D. Moravec, Chief Network Officer for the Department; Dr. Denis Fitzgerald, Director of Provision No. 1; Mr. Sanford Garfunkel, Director of the Washington VA Medical Center, and Mr. Y.C. Parris, Director of the VA Medical Center at Amarillo, TX.

Dr. Kizer, we welcome you back. As always, we're delighted to have you, and you are recognized.

STATEMENT OF KENNETH KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL; JULE D. MORAVEC, PH.D., CHIEF NETWORK OFFICER; DENIS J. FITZGERALD, M.D., DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK #1; SANFORD M. GARFUNKEL, DIRECTOR, VA MEDICAL CENTER, WASHINGTON, DC, , AND Y.C. PARRIS, DIRECTOR, VA MEDICAL CENTER, AMARILLO, TX

Dr. KIZER. Thank you, sir. I know you have limited time this morning, so I'm going to forego much of my opening statement. I would just like to make a few points, however, I would just note that I wish we had had the opportunity to sit at the table with the GAO so you could have heard a point-counterpoint. I believe you may have been left with a different impression if you had had an opportunity to hear an actual dialogue.

Mr. HUTCHINSON. We'll work on that format.

Dr. KIZER. I'd like to underscore a couple points. One is that, as Mr. Baine has said, much of this is more an issue of timing than anything else. I believe it's safe to say that there is universal consensus that the VA needs to change, that it needs to proceed along a course towards becoming an ambulatory care-based system, to decentralize, and a number of other things. However, in doing that, and recognizing that this is the largest health care system in the country, we have to have a certain amount of latitude and flexibility as we make these very profound changes. Indeed, as we establish guidelines and policy for how these access points should operate, it is, in my judgment, prudent to have some experiential basis to support those guidelines.

We have indicated to the Appropriations Committees, and I think to this committee as well, going back a year or so, that we intended to develop more specific policy and guidelines as we gain some experience. With experience we will be able to answer questions such as who exactly are the likely new users, what would be the increased utilization from current users, and a whole lot of additional issues. Without any experience, or without any data, though, it is difficult to make sound policy.

As Mr. Baine referenced, there is a policy guidance document that has been in evolution for sometime as we have gathered this experience, and that we hope to issue within a few weeks. This policy document will provide more specific guidance than has been provided in the past.

In moving a system like this forward, although we all agree that we need to move it from a hospital bed-based system to an ambulatory care-based system, if we don't have any infrastructure, if we don't have clinics to move that patient's care to, we can't very well make that transition. So, establishing these community-based clinics in underserved areas is a critical step in transtioning of the VA. The criteria from the outset for all of these was that they would be sited in areas that are underserved. We have myriad places in the country where we have underserved populations.

So, we are trying to make that transition, to start developing the infrastructure we need to make the transition, and we also are gaining experience to make more informed and prudent policy as we go forward.

I'll end these brief comments with just a couple of specific patient examples. A veteran who has a below-the-knee amputation, and is 40 percent service-connected, might not be eligible for all types of care, but as he or she has gotten older, and developed diabetes, and as a consequence of their diabetes, he or she is starting to develop ulcers on their remaining good foot, while it would be against the law under the current eligibility rules to provide care for the person's diabetes. However, it would be morally and medically unethical not to treat the diabetes so the person would hopefully retain their one functional leg for as long as possible.

A second situation is illustrated by a new user of the system that Mr. Parris told me about a few moments ago. A patient who came in to one of the clinics that they've sited in an underserved area, had not been seen for medical care for 20 years; he basically didn't use health care. He developed abdominal pain and because the clinic was now accessible, he came into the clinic, and was found to have a large dissecting abdominal aneurysm. He certainly would have died if he had not had access to that care. If that clinic had not been there, he would have continued his practice of not seeking medical care.

Yes, it was a new user to the system, but it certainly seemed like, in that instance of saving his life, that that was an appropriate utilization of the clinic.

I think there are a whole host of questions that have been raised by the committee, and we'll be happy to respond to them as best we can.

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

Mr. HUTCHINSON. Thank you, Dr. Kizer. Has the VA established a definition for that underserved or for geographic inaccessibility?

Dr. KIZER. We have not developed a specific definition. In the new policy we talk about things like distance, inclement weather and traffic congestion. What may be inaccessible to one person, or conversely what may be accessible for one person, may be very inaccessible to somebody else. A disabled or elderly person may have difficulty negotiating traffic in Southern California, where someone who is younger and not disabled would not. Likewise, in some parts of the country in the winter, roads become very difficult to travel on and, while the distance may not be that great, the weather may be a factor.

Coming up with a "one size fits all" definition of underserved is problematic. We need to maintain a considerable amount of flexibility in how we approach this so that we can deal with the local needs that exist under some overarching guidance, for example, that they would serve underserved, that they would be targeted to Category A veterans, things of that type.

Mr. HUTCHINSON. I'm going to recognize Mr. Edwards, and I'm going to ask Mr. Bilirakis if he would assume the chair. Thank you, Dr. Kizer, and I regrettably must leave.

Mr. EDWARDS. Thank you, Mr. Chairman. You've touched on this, Dr. Kizer, but would you care to make any additional comments regarding the question I had asked Mr. Baine in terms of how you balance the need for some standardization at the national level, but still wanting to maintain the flexibility and local decisionmaking authority that we have asked you and encouraged you to implement in the VA.

Dr. KIZER. We're trying to strike that balance, and we're trying to do it through policy guidance. We would hope that that policy guidance will be based on solid data and on an evidentiary basis that indeed supports it. And in some cases, that policy is going to have to lag behind gathering some experience if, indeed, we are going to innovate and do things differently than things have been done in the past.

I don't argue or dispute much of what Mr. Baine and his folks have said about the need for some of these things. I would question, though, whether you can do it in a thoughtful manner up front, without any experiential base for your policy.

Mr. EDWARDS. Very good. One last question. Do you have any general ballpark number in terms of given today's limited resources for the VA, how many access points that you'd like to see opened over the next 2 to 3 years?

Dr. KIZER. Let me answer that in two ways. One is, all of our VISN directors, i.e., network directors have signed performance contracts with my office. As part of their performance contracts, they will be submitting a business plan—a strategic plan—by September 30th of this year.

After October 1 of this year, all new access points will have to be included within that annual business or strategic plan, and I think this addresses one of the concerns GAO had expressed. And I say this because at this point, not having received those plans, I'm not sure what the universe is.

I think that this year, if, indeed, we were authorized to move forward with the 58 that we have submitted to the Appropriations Committees for review, over the next couple of months it would not be unreasonable to think that another 30, or 40, or 50 or so may come forward. Over the next 2 to 3 years, somewhere in the range of 200 to 300 might be a reasonable sort of planning figure. Part of what I see as the headquarters challenge and, indeed, part of what's noted in the draft policy, is that we need to try to assure some equity of access from a national perspective. That's why VISN's are required to submit plans for new access points for review and concurrence before they site these, so that we can indeed make some judgment as far as maintaining that equity throughout the system.

Mr. EDWARDS. Thank you, Dr. Kizer, and I just would finish by saying thank you again, and I want to pay my respects to you for your creativity and innovation in trying to find ways with limited resources that we all recognize the VA has to try to reach out and provide outpatient care and other types of care to our veterans, and to bring the VA medical system into the latter half of the 20th century. Good luck.

Dr. KIZER. Thank you, and I look forward to working with you.

Mr. BILIRAKIS (presiding). The gentleman's time has expired. I thank the gentleman. Mr. Spence.

Mr. SPENCE. Thank you, Mr. Chairman, and thank you, Dr. Kizer, for all you're doing to help provide better care for our veterans. This might be a good time for you to respond to some of those things that Mr. Baine pointed out in his testimony. For instance, the VA is not adhering to statutory limitations that govern what services VA may provide and who may be served, the fact that this statute does not authorize VA to provide primary care through its access points, most veterans currently receiving care at access points do not have service-connected conditions and, therefore, do not appear to be eligible for all the care provided, those type things. If you could respond to those.

Dr. KIZER. Sure. I'll be happy to try to respond to as many of those points as I can. Let me start by saying the initial requirement for establishing any of these access points is that they would operate within existing legal authority. I understand that there may be some dispute between our General Counsel's Office and General Accounting Office's legal advisors on some of these, or exactly which category of legal authority they may fall under. It's not uncommon to have lawyers disagree.

From our perspective, though, all would be sited under existing legal authority, however constrained and limited that may be. Hopefully, as we move forward with some of the ideas that this committee has, we will have more logic and rationale in our legal authorities. Mr. Baine also raised concerns that VA may be exceeding what technically it could provide. Earlier, I used the example of a veteran who has a below-the-knee amputation, i.e., he has only one functional leg, and is 40 percent service-connected. Technically, under the law, the veteran may not be eligible for care for their diabetes that has developed as he or she has grown older. However, as a physician or as a caregiver seeing that patient, knowing they only have one leg, to not treat their diabetes in the hope of trying

to preserve their remaining leg, raises a whole host of other moral and ethical questions. Frankly, I would rather see our caregivers provide that care with the hope of allowing that veteran to maintain their functional leg because I think that should be our first priority.

Mr. BILIRAKIS. I thank the gentleman. Mr. Tejeda.

Mr. TEJEDA. Thank you, Mr. Chairman. Dr. Kizer, it's my understanding that the Amarillo, Texas VA Medical Center has established several small access points by contracting with rural health clinics. Has this program been successful? What lessons, good and bad, has the VA gained from this program, that can be applied elsewhere? And do you envision the VA establishing similar rural access points in other networks?

Dr. KIZER. Let me touch on a couple of points and then ask Mr. Parris, the Director of the Amarillo facility to respond. One of the things that I found gratifying in discussing the situation with him is that, for the first few months of the year, when typically their ICU is overcrowded and bursting at the seams, now it seems with the establishment of these several access points, for the first time that he can remember, their ICU was not "bursting at the seams" in the first few months of that year. And while we haven't quantitated yet what the actual savings are, there certainly would seem to be some cause-and-effect relationship there that will translate into saving considerable amounts of money.

With regard to your question about establishing rural access points in other networks, if we have the clear statutory authority and congressional direction to contract with whoever, we could in different areas. We see potentially doing this in rural areas.

We know that many veterans who live in rural areas are underserved, and don't get the care they should be getting. They just do not have reasonable access to care because of their geographic location. It's not fiscally reasonable to site VA clinics or hospitals in those areas, however, by establishing contractual relationships with private providers or with other government-funded providers we can better serve veterans in those areas.

Mr. PARRIS. Congressman, we found that—as you know, being from Texas, we're in the Panhandle—we cover 26,000 square miles, one facility and, for lots of our veterans to drive in, it's as much as 4 hours for health care.

We searched for a way that we could, within our own resources—and I think that's partially what a lot of this is about, is the resources—we've tried to look for a way within our resources to provide that care.

In looking at capitation, we found that we can go to a private provider in a community—we're not competing with him either now—we're working out of his office, with his staff. What we do do is we provide him with our computer, with the training of his clerk—we do credential and privilege that physician, by the way, so we guarantee quality, the same quality provided at the hospital.

Now we go with capitation, which is a lot less than we can provide the same service on the first floor of a hospital in an ambulatory care area. In our case, we've been lucky enough to negotiate contracts at $175 per year, per patient. If you go to a hospital, each visit runs us approximately $175. So you can see the difference.

The other part is, as Dr. Kizer alluded to, that because now we're giving preventative care and maintenance, we're seeing less hospitalizations—Amarillo is a good example of that. If you look from our access points since they've been established, our hospitalizations to date, we've reduced hospitalizations by 30 percent.

Mr. TEJEDA. Dr. Kizer, during this last congressional break that we had a couple of weeks, I went to Star and Zapata Counties in Texas, which are right on the Mexican border. They want accessible care. One of them has 800-plus veterans, the other one has 900-plus veterans. And the current clinics—the hospital, which is the Audie Murphy Hospital, is in San Antonio, TX, many hours away—the current clinics are between 40 to 80 miles away, depending upon which county it is.

I'm very concerned about the veterans that are there. They certainly want access and want to be helped so that they can attend some of either the local hospitals that are there, or perhaps the local clinics that are there, but there are no VA clinics, no VA hospitals anywhere around except for 40 to 80 miles, depending upon the county. Star and Zapata Counties. Have you heard of them, or have you looked at them, or have you discussed them with anyone?

Dr. KIZER. I've discussed them in only a general sense. They really typify the situation that exists in many parts of the country. We do believe that we could service those communities either through contractual relationships with private providers or, in some cases, out-station VA personnel, in a very cost-effective way if, indeed, we had the authorities and congressional direction to do that.

Part of the challenge that we have as an organization, though, is that there are so many areas like that, and to try to achieve some sort of balance across-the-country so that they aren't all located in Texas, or Florida, or New York, or wherever is difficult. But philosophically, and programmatically, what you've described is exactly what we'd like to do. We'd like to take care of those folks.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman. Welcome again to Dr. Kizer and his staff. The 58 pending access points that are not evenly distributed around the country, is there a reason why so few of the proposed clinics are in the southeast, for example? Is it based on veterans population, or what is it based on?

Dr. KIZER. No, it's solely a function of timing. Let me just step back on the evolution of this. This concept of citing these antedated my joining the Department. It was put on hold for various reasons. I arrived. It was resurrected. We issued new policy last February, and people started preparing and gearing up to do this. There were some congressional concerns expressed by the appropriators, and essentially things were put on hold for another period of time. Some people proceeded with their planning and development ideas more aggressively than others, while we've been trying to work through the issues with Congress. After the initial fifteen were approved at the end of last year, people are now gearing up to site these.

So the fact that you see in the 58 that were submitted earlier this year, a considerable number in New York and some other places—Southern California, for example—is merely a reflection of

where those networks are in their planning. This should not be taken to mean anything other than they are perhaps a little further along in the development of their ideas and establishing their networks, than some other networks are. Over time, it will even out.

Mr. BISHOP. Wouldn't it be appropriate, though, to do it based on need rather than who perhaps has the most time, or who has apparently—the most opportunity probably means they are serving fewer veterans—and the people who need it the most apparently are the ones who are not necessarily getting it.

Dr. KIZER. I don't actually think that your perception is correct. All these areas are in need. There are a large number of others that people are developing. As I responded, I think, to Mr. Edwards earlier, that in the next 2 or 3 months, assuming these 58 are approved, we would expect to see a number of others be submitted from other networks that now are doing the developmental work. They will have had to have gone out and met with the private providers, and identified where their local pockets of need are. What you see now merely just reflects where we are in this early evolutionary process.

Mr. BISHOP. How long do you anticipate it will take to have it all completed, or have all of the service areas covered?

Dr. KIZER. Well, that's probably years down the road, but as I said before, each of the networks will be submitting a business and strategic plan by September 30. Establishing these new access points will be a part of those plans and must be included in those annual plans effective October 1. And so when we get those in and start looking at them, we'll get a better idea as to, in the long-term, what the total universe may be and what some of those implications are. Right now, we know there is such a huge unmet need and that there are so many opportunities that we're perhaps just addressing the most urgent ones early on.

Mr. BISHOP. But I thought you were saying those were not necessarily the most urgent, those are just the areas where they got ahead in their planning because, obviously, they didn't have anything else to do whereas some of the areas that are serving veterans and are overworked didn't have time to do the long-range planning and do that, and that holds for something.

Dr. KIZER. If that's what you took from my comments, I must have misspoke because that certainly wasn't what was implied. Some people have just been more aggressive in pursuing these opportunities at a faster rate than some of the other network directors. It certainly doesn't reflect a lack of or a shortage of work that needs to be done on their parts.

Mr. BISHOP. That means that the people in the southeast just weren't aggressive, even though they have probably as large a veterans population, as large a need, as other areas of the country.

Dr. KIZER. In some cases, I think they may have more difficult issues to deal with in working with the private sector and identifying opportunities. In some cases, it is simply more difficult. I don't know if Y.C. or some of the other network directors may want to comment on that.

Dr. MORAVEC. I'd like to comment on that. There are a number of network directors who are holding plans for the future develop-

ment of access points. One of the things that they are not doing is getting out into the communities, raising expectations, and causing people to think something is going to happen before we know that we can deliver. Because of the process that we are developing to plan and implement access points, their implementation has been slowed. I think that once this process is agreed to by all parties, we will see a flurry of activity throughout the country in establishing these access points.

Mr. PARRIS. Sir, also, the frustration of some of us in the field is that we started with this aggressively—in my case, we got two clinics up—and then because of some of the things that brought us to this hearing today, as Dr. Kizer said, we've been put on ice for over a year. And I think there are a lot of my colleagues in the southeast who are ready to go, but they have to have the authority to do that, and that's why we're here today.

Mr. GARFUNKEL. I can speak as a director who doesn't have an access point, that what was just said is exactly the case. We've done a fair amount of planning in the last year, but really have held off on any final recommendations because we know that the access points have been on hold for quite a while, and we are waiting to hear the go-ahead before we begin to finalize the plans and submit the application.

Mr. BILIRAKIS. The gentleman's time has expired. Oh, I'm sorry.

Dr. FITZGERALD. If I could just add, in New England we have six additional access points about to come into the chute. These are not included in the 53 that we're talking about here. And so the planning process is going on and, as has been said, there has been a dampening of network enthusiasm given the time frames and delay of approvals.

Mr. BILIRAKIS. I thank the gentleman. Dr. Kizer, first, I would ask unanimous consent that my statement and all statements of members might be made part of the record. Without objection, that will be the case.

[The prepared statement of Congressman Bilirakis appears on p. 34.]

[The prepared statement of Congresswoman Brown appears on p. 39.]

[The prepared statement of Congressman Bishop appears on p. 38.]

Mr. BILIRAKIS. Dr. Kizer, I want to apologize to you and your staff for my tardiness, but we've got so many things to do, and welcome you. Again, it's always good to see you, and welcome to all of your staff and, of course, I want to add my congratulations to Ms. Keener, on her recent marriage to Herschel.

I'm not going to, in my time here, get provincial about why there aren't any scheduled for Florida and all that. I suppose probably much of the response might be that the directors down there haven't seen fit to indicate a willingness towards that end, although I know that I had two town meetings, veterans town meetings, strictly veterans town meetings, in Florida this last Saturday, and we've talked to one of the directors there, and I think he's contemplating doing something like that in St. Petersburg.

Dr. KIZER. I know for a fact that there are a number of opportunities that are being considered down there, and many of the com-

ments that were just made about the process, up and down, has frustrated the efforts of our field folks to actually get these going.

Mr. BILIRAKIS. Well, let me ask you, though, Doctor, is it strictly—and I realize that the dollars, as I understand it, comes from the budget that that particular center now has, so we're not talking about new dollars. That's correct, isn't it?

Dr. KIZER. That's correct.

Mr. BILIRAKIS. There are no new dollars. And I appreciate the fact that you want to give flexibility to your directors and that sort of thing, but if a director decides he wants to put an access point in a particular location, does he have the authority to just go ahead and do it without going through you first, or do you review it and sort of determine yes, it's a good idea to put it there, or not a good idea?

Dr. KIZER. Well, it's not just us, but you do, too. We have a requirement that all these have to be reviewed and concurred in by VA Headquarters, but also, as part of the process, submit them to the Appropriations Committee's.

Mr. BILIRAKIS. Well, I see that, and that, of course, is the bottom line of the problem here. But it seems—and Mr. Bishop and Mr. Tejeda and others have asked questions about locations and that sort of thing. It seems if we're going to be able to be of any use, if anybody could be of much use, much realistic use for the Appropriations Committee in terms of trying to push these things, or endorse them, or whatnot, it seems like we should have maybe better reasons for particular locations than just the director decided to put an access point. I don't know. For instance, how good of a job can I do in pushing—it's already there.

There are, what, four medical centers in Chicago, in that area? And 8 miles away from at least one of them is an access point. And New York City, you've got, what, 58 new ones, 15 of them are scheduled for New York City. I realize I'm talking about a pretty big geographical area, but how many centers there are in New York City and we're talking about, what, 15 of these access points. I mean, just like we would expect you to believe in what you're a proponent of, we've got to maybe have some pretty darn good reasons for pushing these things with the appropriations people. I mean, off the top of my head—and I'll say this maybe not very diplomatic—but off the top of my head, my feeling generally is I'm very pleased with Dr. Kizer, from what I've seen so far, and we've encouraged you—Chet and I were just talking—we've encouraged you and VA to come up with imaginative ways to be able to better serve our veterans, considering the lack of dollar increases and things of that nature.

And so my first-blush thought would be, heck, if this is what the VA feels can do the job in a better way, certainly I would support it, but I do think that we're talking about some of the specifics we maybe need more rationale, if you will, more supporting ammunition, particularly with 15 in New York City. And I'm not concerned there aren't any in Florida. Mr. Bishop maybe should rightly be concerned that there aren't any—I don't know whether there are any in Georgia or not but, if there are, maybe not enough. Do you have any comment to all that?

Dr. KIZER. Well, a couple of things. One, I don't think 15 are in New York City per se. They are in New York, but I don't think they're all in the City. But that does actually raise one of the issues here, is that in a large, metropolitan area like that, and given the socioeconomic condition of many of the patients that we serve, transportation, whether it's 3 miles away, or 30 or 300 miles, really doesn't make a difference when they don't have their own transportation. And sometimes a shorter distance, with many of the people that we take care of, can be just as much of an impediment as having to drive 8 hours in a rural area. And that's why we need that sort of flexibility to address what the particular needs are in a given area.

To address the other point I would just repeat or reaffirm what I said at the outset—and I don't recall whether you were here then or not—but part of the reason that we have intentionally delayed issuing specific policy on this is that we wanted to gain some experiential basis and knowledge from the ones that were initially sited so that we could make that policy guidance as informed and as rational as possible. And since this was a new thing, had not been done before in the VA, without having that sort of experiential basis, policy guidance may not have necessarily been very prudent. I think, in this case, as we try to do something new and different, it's appropriate that we gain that experience, gain some knowledge, gain some real data, before we try to issue formal policy that will direct it in the long-term.

Mr. BILIRAKIS. But whatever that number is that you have now—what is it, eight?

Dr. KIZER. Twelve.

Mr. BILIRAKIS. The 12 that you have now is not adequate to give you that additional data before you go any further?

Dr. KIZER. Well, we're using that, and those have come on—again, understand that those are only approved 4 or 5 months ago. Those have all been sited in just the last several months. So, gaining an experiential base is not something that happens the day that they open the door. They have to get operational and see who's coming through the door, and this is a process that takes some time. These weren't approved until the end of last year.

Mr. BILIRAKIS. All right, sir. You personally, as head of the health care area of Veterans Affairs, personally endorse every one of these access points and their locations, is that right?

Dr. KIZER. I believe that our folks have put together a plan that works in their local areas. Actually, Jule has looked at these in perhaps more detail than I have.

Dr. MORAVEC. I'd like to provide a better understanding of the developmental process that goes behind any one of these. First, it's a shifting of dollars within a medical center, so there is a great deal of scrutiny, as you might expect, from the peers within the organization in terms of what's going on with the dollars, and are they being shifted out of my area. So that happens, and there's a thorough development at the local level. It's not a knee-jerk reaction by a medical center director.

Following that developmental process, it has to be elevated to the network. That was true at the onset with the first ones, and it has continued to be true, that the Network Executive Leadership Coun-

cil, the network director, and the medical center director, must agree that that's a good thing to do for that network.

If it happens to cross network lines, the adjoining network also has to agree that it's okay, it's a good thing. The proposal comes into Central Office. It's reviewed in my office. Dr. Kizer is apprised of what's going on before it ever comes over to the Hill. So, it's much more than a knee-jerk, it's a very deliberative, thoughtful, planning process. We simply want to improve on that and make it better than it has been.

Mr. BILIRAKIS. Well, Dr. Moravec and Dr. Kizer, et cetera, one thing we've sure learned the hard way up here over the years is—maybe I can't put it anymore diplomatically than this—you give people something and try to take it away. Now you're setting up these access points in locations, for the most part, where they are losing veterans—they are moving to Texas, to Florida, to Georgia, et cetera—and so the dollars are going to be decreased based on the capitation system that we talked about at the last hearing we had, so the dollars are probably going to be decreased in those particular areas, and dollars are going to be increased, we hope, in Georgia, and Texas, and Florida, and the areas where a lot of the veterans are moving down to. You know, we talk about veterans population decreasing—God knows that's not true in the south, the southern states, particularly the southeast and Texas, but they are certainly decreasing in the other areas.

So, now with those dollars being decreased and the veterans population being decreased, are we contemplating that there might be a closing down of some of these access points sometime in the near future? I mean, my gosh, there's going to be a firestorm out there if you close down a veterans facility. Have we taken all that into consideration? Are we just looking at today insofar as needs are concerned, and not taking into consideration the near future?

Dr. KIZER. No, we certainly are looking at the future. Indeed, the scenario that you've described makes me wonder—or I would think you would certainly endorse the approach that's being taken because, if we are entering into a contractual relationship with a private provider that does not rely on any VA expenditure for capital assets, if that's a contract that can be adjusted up or down depending upon the volume of patients that are being seen, that provides the most flexible and, I think, the fiscally most prudent way of dealing with a changing population.

Mr. BILIRAKIS. Well, all right, I can't argue with that, except that you and I know there's a mood out there. You're still closing down—if you shut down that contract, you're still closing down a veterans facility, access for veterans in that particular area. And you try to explain to them that, hey, you know, we've had a reduction in funding here as a result of capitation, reduction in the number of veterans being served in this area and, therefore, we're closing this facility. That's going to be pretty tough. I mean, what we run into on the bases, and there are facilities up north that are not being used anywhere near capacity, as you know, but try to shut those down and shift those dollars someplace else, you're going to get the Member of Congress particularly in an uproar as far as that's concerned.

Dr. KIZER. I don't know if the reaction will be that great.

Mr. BILIRAKIS. I've given you an awful lot of credit, and I think you deserve it in terms of coming up with imaginative ways and that sort of thing, but I do think that if we're going to help you out—I'm only speaking for myself—if we're going to try to help out with the Appropriations Committee on these—and I'm not saying that should even be necessary because they are not due dollars, but apparently it is necessary because of the way it's being addressed by Appropriations—I think we need maybe a little more, and I'd appreciate—I wasn't here for the first hour of the hearing—but let me ask very quickly here—I know my time is probably either up or close to being up—is there much of a distinction between maybe a small type of outpatient clinic and these access points? I know that outpatient clinics vary in size, and so there would be quite a distinction, I guess, as against a large one, but are we, in effect, talking about maybe outpatient clinics, so to speak, modified type of outpatient clinics?

Dr. KIZER. We're talking about small outpatient clinics, and we're talking about doctors' offices.

Mr. BILIRAKIS. Well, an outpatient clinic which is contracted out, but, yeah. Okay.

Dr. KIZER. And in some of the cases—and Mr. Parris or others may want to comment on the specific arrangements—but, for example, if we have an arrangement with a private physician that they will, under their contractual relationship, provide care for 500 patients at a capitated rate on an annual basis—and just to go back to the scenario that you described a minute ago—if that population of veterans should change in that area so that this year there is only a need to contract for 300 as opposed to 500, that private provider is still going to be there. Nothing is going to be closed down, it's just that the terms of the contract may be renegotiated because at 300 patients versus 500 patients, they may want a different rate.

So, I'm not sure that the problem that you perceive is a serious problem under this scenario.

Mr. BISHOP. Would the gentleman yield?

Mr. BILIRAKIS. Except that ultimately that need might decrease to the point where you would actually shut down the access point all together. I'd be glad to yield. My time will be up after his statement.

Mr. BISHOP. Will you answer me whether or not, for example, you take a ward on a hospital, say, someplace in the northeast where the population is declining. You turn that ward into several smaller access points for examining patients, which means you're going to transfer some capital expenditures and do the renovations necessary to do that. You've put that into the building, into the capital expenditure or the renovation cost for redesigning that ward into access points, and now you have a declining population, and you decide that, well, we don't need this anymore.

You've poured all that money into the physical facility. Now you've got your need down in Georgia or Florida.

Dr. KIZER. I think—perhaps we should spend some more time chatting about this—but the scenario you're describing is exactly what we're trying to prevent with the access points because we are not taking that money and doing capital construction or renovat-

ing. Indeed, we are investing it in existing private providers or other facilities that exist so that we don't have new capital investment requirements.

Mr. BISHOP. I guess I misunderstood because I thought there were some instances where you were taking wards in existing VA facilities, and taking those wards and constructing smaller examining clinics for—was I misinformed there?

Dr. KIZER. That's a different thing. We are indeed, as we've been able to close wards and change our delivery mode, renovating some of our hospitals to convert those into clinics and ambulatory surgery, et cetera, but those are different than the access points and the community-based clinics which we are discussing.

Mr. BISHOP. I thought they were being counted as access points also.

Dr. KIZER. Not at all.

Mr. BILIRAKIS. Any further questions? Mr. Tejeda? Mr. Edwards?

[No response.]

That being the case, I thank you, Dr. Kizer. It's always great to be here with you. I hope that you will—you know, I can only speak for myself—but I like to think we're not being negative about this. I haven't seen that. Again, I commend you and your people for coming up with creative ways to try to get the job done, considering the resources that will be available over the next few years, but if you want our help, maybe you've got to give us a little more ammunition.

Dr. KIZER. Well, I appreciate that, and your comments in general, and I would also just say that we are more than happy to come and spend some time talking with any or all of you on the specific issues here. There are some fundamental shifts in how the VA is approaching this care, and I can understand how, indeed, it may be confusing at times.

Mr. BILIRAKIS. Maybe one final thing, maybe going back to Mr. Bishop's concerns. Are we basically saying that if there are no access points on this list for Georgia, it's because none of the Georgia directors have seen fit to request—suggest or request access points?

Dr. KIZER. What it simply means is that at the point in time that that was sent to Congress some weeks ago, they did not have their preparatory work done, but I essentially can guarantee you that they have thought about it, that they are doing it, and I would be amazed if they did not have, at this point, plans or thoughts on actually submitting new access points. It's really, again, a timing issue as opposed to something that has more significance.

Mr. BILIRAKIS. And the same thing is true with Florida and others.

Dr. KIZER. I know there are a number being considered in Florida and Georgia.

Mr. BILIRAKIS. Mr. Smith.

Mr. SMITH OF NEW JERSEY. Not at this point.

Mr. BILIRAKIS. Not at this point. Well, we're finishing up. This is the hearing.

By unanimous consent, any opening statement you have will be made a part of the record. Thank you very much, Dr. Kizer.

[Whereupon, at 11:37 a.m., the subcommittee was adjourned.]

APPENDIX

Statement of Chairman Tim Hutchinson
Subcommittee on Hospitals and Health Care
Hearing on Community Care Clinics
April 24,1996

The Subcommittee meets this morning in its oversight role to hear testimony on efforts to improve access to primary care services to veterans. This is an issue critical to veterans and Monday I was able to witness this firsthand by chairing the Subcommittee's first field hearing on this very issue in LaSalle, IL. The veterans of LaSalle are very similar to veterans residing in my own district of Northwest Arkansas. They are proud of their service to this country, they are aging, and they want access to VA health care services that is convenient.

As health care changes, so must the VA. In a bipartisan manner, the Committee on Veterans' Affairs has given the VA the ability to implement the VISN structure, which decentralizes decision-making and should ultimately translate into improved services to veterans.

In the last few months, I have been approached by a number of members on the issue of veterans' access to outpatient services. The interest on this issue was reinforced by the overflow crowd of veterans who jammed the LaSalle VFW hall to show their support for care in their community. Because of the intense interest in this issue, I asked the General Accounting Office to examine the establishment of access points and the long-term implications of these clinics on the practice of medicine and the potential budgetary implications of establishing numerous community care clinics.

Health care has entered a new paradigm of managed care, intense competition, and delivery of services as close to the consumer as possible. In this vein, the survival of the VA health care system is dependent on its ability to satisfy the diversified needs of the veteran population. Traditionally, veterans seeking care have done so at one of 173 inpatient hospital facilities. As we are all aware, many VA hospitals are not always convenient nor are they the most cost effective delivery site for the care of veteran patients. While local community care clinics may provide some answers to access

problems faced by veterans, the random proliferation of hundreds of access points could place the VA in an untenable budgetary dilemma, threatening the viability of specialized and other programs unique to the VA. Along with access points, the Subcommittee must also examine the nagging question of eligibility to care and the mandated priority system and demands that service-connected veterans receive the highest priority for care.

I look forward to the testimony of both the representatives of GAO and the Veterans Health Administration. I understand the difficulties of both groups who will present testimony this morning as we look for ways to best serve our Nation's veterans.

Opening Statement
for
Honorable Chet Edwards
Ranking Member
Subcommittee on Hospitals and Health Care

Hearing on the Effectiveness of Community Care Clinics

April 24, 1996
Room 334, CHOB

Mr. Chairman, I'd like to thank you for calling this hearing on VA community-based care.

VA health planners and veterans' advocates alike have long struggled with the fact that most veterans who rely on VA care live significant distances from VA facilities. Typically, these veterans have low or very low incomes, and traveling great distances, especially for outpatient treatment, often works particular hardships on these patients and their family members. Also, many veterans, including those with a high priority for VA care, simply do not avail themselves of their eligibility for VA medical services – often because of difficulties involved in traveling to VA facilities.

Given these circumstances, I have been pleased by VA's efforts to expand veterans' access to ambulatory and primary

care services. Early last year VA promulgated an interim policy encouraging its medical centers to establish so-called "new access points" within available resources. This February the General Accounting Office reported that veterans' access to VA health care could improve significantly if medical centers used all means at their disposal to expand access, as VA policy encouraged.

GAO's testimony today raises several questions about VA plans. But I do not construe GAO to be retreating from support for a policy which would improve convenience to the patient and provide more efficient, effective care-delivery than possible in existing facilities.

The Congress holds the key to answering at least one of GAO's concerns. Next Tuesday, this Committee will be marking up H.R. 3118, a bill which would clear up issues of veterans' eligibility for primary care and VA's authority to contract for those services.

I hope today's hearing will help foster continued expansion of community-based care as well as further the development of

policies to help assure that a veteran's ability to receive VA care should not vary significantly depending on the state or region in which the veteran resides.

Again, I thank you for convening this hearing, Mr. Chairman.

THE HONORABLE MICHAEL BILIRAKIS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
APRIL 24, 1996

EFFECTIVENESS OF COMMUNITY CARE CLINICS

THANK YOU, MR. CHAIRMAN.

FIRST, LET ME COMMEND YOU FOR SCHEDULING THIS HEARING ON COMMUNITY CARE CLINICS. I WOULD LIKE TO WELCOME THIS MORNING'S WITNESSES AND I LOOK FORWARD TO YOUR TESTIMONY.

AS A REPRESENTATIVE FROM A STATE WITH A LARGE VETERANS POPULATION, I AM ALWAYS INTERESTED IN CHANGES WHICH MAY IMPROVE ACCESS TO THE VA HEALTH CARE SYSTEM. JUST LAST WEEKEND, I HELD SEVERAL TOWN MEETINGS ON VETERANS ISSUES. THE QUESTION MOST FREQUENTLY ASKED BY MY CONSTITUENTS WAS WHY DO VETERANS IN FLORIDA HAVE SUCH A HARD TIME GETTING VA MEDICAL FACILITIES?

AS I HAVE MENTIONED IN SOME OF OUR PREVIOUS HEARINGS, FLORIDA HAS THE HIGHEST NUMBER OF APPLICATIONS FOR SERVICE-CONNECTED CARE IN THE COUNTRY. BUT MANY OF OUR VETERANS ARE UNABLE TO RECEIVE TREATMENT IN VA MEDICAL FACILITIES -- PARTICULARLY IN THE WINTER WHEN THERE IS A LARGE INFLUX OF VETERANS FROM THE NORTH.

THEREFORE, I AM ANXIOUS TO HEAR WHAT THE VA HAS TO SAY ABOUT ITS EFFORT TO INCREASE THE NUMBER OF "ACCESS POINTS" BY ESTABLISHING COMMUNITY-BASED AND OUTREACH CLINICS. I WOULD ALSO LIKE TO HEAR ANY SUGGESTIONS THE VA AND THE GOVERNMENT ACCOUNTING OFFICE MAY HAVE ON WAYS IN WHICH THIS SUBCOMMITTEE CAN ASSIST THE VA IN ITS EFFORTS TO IMPROVE ACCESS TO ITS HEALTH CARE SYSTEM.

MR. CHAIRMAN, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE ON THE ISSUES BEFORE US TODAY.

THANK YOU, MR. CHAIRMAN.

Statement of Rep. Luis V. Gutierrez
Subcommittee on Hospitals and Health Care
April 24, 1996

Good Morning.

Mr. Chairman, I would like to thank you for holding this important hearing to discuss the GAO report on efforts to improve veterans access to primary care services and VA access point policy.

Community care clinics will provide veterans with opportunities they have been denied for too long. As Mr. Baine points out, 50 percent of veterans live more than 25 miles from a VA hospital.

Community care clinics, similar to the VET CENTERS, provide needed services where veterans live, where they work and where they raise their families. This is important for veterans who, like the rest of us with private insurers, must balance competing demands on their time.

Beyond convenience, outpatient care is more amenable to focusing on preventive medical treatment that is more cost-effective.

Mr. Baine, I would like to commend the efforts of the GAO in this area. You point out a number of issues that the VA and this committee will have to address, in particular statutory, financial and equity-of-access concerns surrounding VHA access point improvements.

This committee has discussed VHA restructuring previously. I find that one issue always stands out above the others. Mr. Paine mentions it in his testimony and Dr. Kizer has often stated the need for it at recent budget hearings before this committee. What these gentleman point to, and what we all know must be accomplished is comprehensive eligibility reform.

Eligibility reform that enables the VHA to provide convenient, efficient outpatient and ambulatory care.

Eligibility reform that promises veterans more, not fewer, opportunities to receive a full continuum of VA health services.

If Mr. Baine is right, if the VA is not adhering to statutory limitations that govern what services the VA may provide and who may be served, it is not entirely the VA's fault.

This Congress promised veterans and promised those responsible for providing health services to veterans, that it would pass eligibility reform that complimented VA plans to expand outpatient treatment.

As we know, the budget battle stopped attempts last year for passing eligibility reform. This year we have another chance. I am hopeful that we can make good on our promises and commitments to the millions of veterans who depend on the VA for their health care.

Mr. Chairman, once again thank you for calling this hearing. I look forward to working with you to enable the VA to provide veterans with the most convenient and best quality care available.

Thank you.

PREPARED STATEMENT OF HON. SANFORD D. BISHOP, JR.

Good morning, Mr. Chairman and Ranking Member.

I would like to take this time to welcome our distinguished panels of witnesses who are taking time to testify before this subcommittee this morning.

In today's competitive health market, our veterans deserve a health care delivery system that is responsive to their needs, understanding that health care is driven by local market conditions.

I am very supportive of a structure that will afford maximum flexibility and accessibility in the delivery of health care services.

Over the years this committee has on a bipartisan basis worked to ensure veteran's health care remains a priority. This hearing is one opportunity to again assure veterans that the we are working as a committee to ensure that delivery and quality of health care to veterans is improved, to increase the efficiency with which we provide it, and to establish accountability for bottom-line results.

Again, I want to take this time to thank the witnesses on each panel.

HEARING:

Effectiveness of Community Care Clinics

STATEMENT BY
CONGRESSWOMAN CORRINE BROWN

Thank you, Mr. Chairman, for holding this important hearing. There may be no subject of greater importance to our nation's veterans than this: How do we deliver health care to those who need it?

We are here today to hear from GAO and the Undersecretary of Veterans Affairs on how we can best utilize our precious VA dollars to best serve veterans who seek medical care. I look forward to hearing from our witnesses today.

Statement of Rep. Michael P. Flanagan of Illinois
VA Hospitals and Healthcare Subcommittee Hearing
Community Care Clinics
April 24, 1996
10:00 AM 334 CHOB

Opening Remarks

Thank you Mr. Baine, Dr. Kizer and all of you for coming here today to testify before this Subcommittee regarding the effectiveness of Community Care Clinics. I would like to join my colleagues on this Committee in welcoming all of you to Washington, DC today. We all certainly appreciate your dedication and commitment to our veterans and are happy to have you here with us today.

Accessible healthcare is essential to our nation's veterans. Unfortunately, many of our veterans have a difficult time gaining access to the VA Medical facility system. This Subcommittee held a field hearing in LaSalle, Illinois on Monday, April 22, 1996 related to the lack of accessibility to VA Medical Facilities for thousands of veterans in the Illinois Valley. Unfortunately, there are many veterans in the country who are experiencing similar difficulties. Community based care is the most cost effective and accessible means of extending VA healthcare to all veterans.

I am pleased that we are holding this hearing today as it is imperative that our veterans who are not able to receive treatment from VA facilities receive the attention they deserve.

We all agree that America's veterans deserve priority healthcare. They honored their commitment to the United States by serving, it's time that we honor our pledge to our veterans.

Quality and accessibility of veterans' health care is a priority of Chairman Hutchinson and the this Committee as a whole. We must to ensure that our veterans receive the very best in health care, in a timely, efficient and effective manner, regardless of their geographic location.

The commitment this nation made to its veterans has to be honored. This Committee is dedicated to fulfilling our obligation to our nation's veterans. look forward to working with the Committee to achieve these goals in a bipartisan manner.

I look forward to hearing and reviewing the testimony of Mr. Baine and Dr. Kizer and working on this Subcommittee to address the necessity for accessible, effective, efficient healthcare for ***ALL*** of America's veterans. Thank you Mr. Chairman.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Hospitals and Health Care, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, April 24, 1996

VA HEALTH CARE

Efforts to Improve Veterans' Access to Primary Care Services

Statement of David P. Baine, Director,
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division

GAO/T-HEHS-96-134

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) efforts to improve veterans' access to health care. VA operates one of our nation's largest health care systems, including 173 hospitals and 220 clinics. Last year, VA spent about $16 billion serving 2.6 million veterans.

Traditionally, almost all veterans seeking care have used VA-operated facilities. VA's hospitals and clinics, however, are often located hundreds of miles from each other. As a result, about half of all veterans live over 25 miles from a VA hospital, including 6 percent who live over 100 miles away; and over a third live more than 25 miles from a VA clinic. Veterans have frequently indicated that they do not use VA health care because they live too far from the nearest hospital or clinic.

To improve veterans' access to health care, VA recently empowered network[1] and hospital directors to employ all means at their disposal, within available resources, to establish new access points. VA defines an access point as a VA-operated clinic or a VA-funded or -reimbursed private clinic, group practice, or single practitioner that is geographically distinct or separate from the parent facility. In general, access points are to provide primary

[1]VA realigned the 173 hospitals into 22 service networks, each consisting of between 5 and 12 facilities.

care to all veterans and refer those needing specialized services or inpatient stays to VA hospitals.

In using access points to restructure their direct delivery systems into integrated service-delivery networks, VA directors have considerable freedom to develop their own goals and objectives as well as their own implementation strategies. To date, 9 hospitals have opened 12 new access points. Recently, VA notified the Congress that 47 hospitals (including 5 of the original 9) are ready to open an additional 58 access points. Another 200 are under development and could be operating by this December.

Of the 12 new access points, VA staff operate 4 and contract with county or private clinics to operate the remaining 8. Contract access points are paid an annual fee per patient in advance to serve enrolled veterans according to an agreed-upon benefit package.[2] Most have encouraged all veterans currently receiving VA health care to enroll in new access points along with veterans who have not previously received care. However, some have limited enrollment to only veterans with service-connected conditions or current VA users. To date, the 12 access points have enrolled nearly 5,000 veterans.

---

[2]VA patients are generally a fraction of the total patient population these providers serve.

At your request,[3] we have reviewed VA's efforts to establish access points and will provide you with a report this summer. Today, we would like to discuss some legal, financial, and equity-of-access issues facing VA managers as they strive to establish new access points. Finally, we will highlight several options to address these issues.

Our comments today are based on visits to 3 VA hospitals that operate 6 new access points; interviews with 115 veterans now using them; and discussions with officials of the other 6 hospitals that are now operating new access points. We also reviewed a wide range of records and documents provided by these facilities. We have discussed the results of our work with the Deputy Under Secretary for Health as well as other VA officials and representatives of veterans' service organizations.

In summary, in establishing new access points, VA has identified what could be a cost-effective way to enhance the availability of health care for current users, especially those residing in underserved areas. Doing this, however, has raised some important issues that VA has not yet adequately addressed. For example, VA is not adhering to statutory limitations that govern what services VA may provide and who may be served. As a result, veterans are receiving more services than current statutes

[3]Subsequently, Senator Bond, Chairman of the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations, also asked us to examine VA's efforts.

allow. Also, creating hundreds of new access points may attract more veterans than network and hospital directors can finance within their existing budgets.

Empowering local hospital directors to establish new access points provides an opportunity to ensure that similarly situated veterans are afforded equal access to VA care. However, access inequities may continue, given that directors are establishing new access points without clear, consistent criteria for targeting new locations and populations to be served.

INAPPROPRIATE STATUTORY AUTHORITY
BEING USED TO IMPROVE PRIMARY CARE ACCESS

Historically, the Congress has limited VA's authority to provide medical care to veterans, expanding it in a careful and deliberate manner. Although VA's authority has increased significantly over the years, important limitations have not been recognized by VA in establishing and operating new access points.

At the access points we visited, many veterans receive primary care contrary to applicable statutory limitations and priorities on their eligibility for such services. As authority for operating contract access points, VA relies on a statute (38 U.S.C. 8153) that permits it to enter into agreements "for the mutual use, or exchange of use, of specialized medical resources when such an

agreement will obviate the need for a similar resource to be provided" in a VA facility. Specialized medical resources are equipment, space, or personnel that--because of cost, limited availability, or unusual nature--are unique in the medical community.

VA officials assert that primary care provided at access points is a specialized medical resource because its limited availability to veterans in areas where VA facilities are geographically inaccessible (or inconvenient) makes it unique. One significant aspect of VA's reliance on this authority is that it effectively broadens the eligibility criteria for contract outpatient care, thus allowing some veterans, who would otherwise be ineligible, to receive treatment.

In our view, this statute does not authorize VA to provide primary care through its access points. Nothing in the statute suggests that the absence of a VA facility close to veterans in a particular area makes primary care physicians unique in the medical community. The purpose of allowing VA to contract for services under the specialized medical resources authority is not to expand the geographic reach of its health care system, but to make available to eligible veterans services that are not feasibly available at a VA facility that presently serves them. Furthermore, contracting for the provision of primary care at

access points does not obviate the need for primary care physicians at the parent VA facility.

VA has specific statutory authority (38 U.S.C. 1703) to contract for medical care when its facilities cannot provide necessary services because they are geographically inaccessible. This authority could be relied upon to authorize contracting for the operation of access points. However, contract care provided under this authority is available only for specified services and classes of veterans that are more restrictive than those under 38 U.S.C. 8153 upon which VA relies.

For example, under 38 U.S.C. 8153, a veteran who has income above a certain level and no service-connected disability is eligible for pre- and post-hospitalization medical services and for services that obviate the need for hospitalization. But under 38 U.S.C. 1703, that same veteran is not eligible for pre-hospitalization medical services or for services that obviate the need for hospitalization.

If access points are established in conformance with 38 U.S.C. 1703, VA would need to limit the types of services provided to all veterans except those with service-connected disabilities rated at 50 percent or higher (who are eligible to receive treatment of any condition).

All other veterans are generally eligible for VA care based on statutory limitations (and to the extent that VA has sufficient funds). For example, veterans with service-connected conditions are eligible for all care needed to treat those conditions. Those with disabilities rated at 30 or 40 percent are eligible for care of non-service-connected conditions at contract access points to complete treatment incident to hospital care. Furthermore, veterans with disabilities rated at 20 percent or less, as well as those with no service-connected disability, may only be eligible for limited diagnostic services and follow-up care after hospitalization.

Most veterans currently receiving care at access points do not have service-connected conditions and, therefore, do not appear to be eligible for all care provided. VA is to assess each veteran's eligibility for care on the merits of his or her unique situation each time that the veteran seeks care for a new medical condition. We found no indication that VA requires access point contractors to establish veterans' eligibility or priority for primary care or that contractors were making such determinations for each new condition.

Last year, VA proposed ways to expand its statutory authority and veterans' eligibility for VA health care. Several bills have been introduced that, if enacted, should authorize VA hospitals to establish contract access points and provide more primary care

services to veterans in the same manner as the new access points are now doing.

VA'S ABILITY TO FINANCE ACCESS POINTS WITHIN EXISTING RESOURCES

VA hospital directors are likely to face an evolving series of financial challenges as they establish new access points. In the short term, hospitals must finance new access points within their existing budgets; this will generally require a reallocation of resources among hospitals' activities. Over the longer term, VA hospitals may incur unexpected, significant cost increases to provide care to veterans who would otherwise not have used VA's facilities. These costs may, however, be offset somewhat if access points allow hospitals to serve current users more efficiently.

So far, VA hospitals have successfully financed access points by implementing local management initiatives, unrelated to the access points, which allow the hospitals to operate more efficiently. For example, one hospital director estimated that he had generated resources for new access points by consolidating underused medical wards, at a cost savings of $250,000.

To date, most directors have concluded that it was more cost-effective to contract for care in the target locations than operate new access points themselves. Essentially, they have found that it

is not cost-effective to operate their own access points for a relatively small number of veterans. For example, one hospital that targeted 173 veterans for an access point concluded that this number could be most efficiently served by contracting for care. By contrast, private providers seem willing to serve small numbers of veterans on a contractual, capitated basis because they already have a non-VA patient base and sufficient excess capacity to meet VA's needs.

The longer-term effects of new access points on VA's budget are less certain. This is because VA has not clearly delineated its goals and objectives; nor has it developed a plan that specifies the total number of potential access points, time frames for beginning operations, estimates of current and potential new veterans to be served, and related costs. Of these, key cost factors appear to be the magnitude of new users and their willingness to be referred to VA hospitals for specialty and inpatient care. Costs could potentially vary greatly depending on whether VA hospitals' primary objective is to improve convenience for current users or to expand their market share by attracting new users.

In theory, VA hospitals could improve access for all current users within their existing budgets. Through careful planning, it appears that hospitals' staffing costs can be reduced in proportion to the costs of new access points. For example, one hospital

employs five primary care teams that, on average, each spend about $300,000 a year to provide primary care to about 1,500 veterans. This hospital can reduce the number of teams to four once it enrolls 1,500 veterans at new access points closer to their homes. These newly established access points could be cost-effective if their total costs are the same or lower than the VA hospital's costs--$300,000 or less in this case.

VA hospitals, however, could experience significant budget pressures if new access points modestly increase VA's market share. For example, VA currently serves about 2.6 million of our nation's 26 million veterans. To date, 40 percent of the 5,000 veterans enrolled at VA's 12 new access points had not received VA care within the last 3 years. Most of the new users we interviewed had learned about the access points through conversations with other veterans, friends, and relatives or from television, newspapers, and radio.

VA's access points may prove more attractive to veterans in part because they overcome barriers such as geographic inaccessibility and quality of care. About half of the veterans who have used VA health care in the past, and a larger portion of the new users, said that it matters little whether they receive care in a VA-operated facility. In fact, almost two-thirds of the new users indicated that if hospitalization is needed, they would choose their local hospital rather than a distant VA facility.

Veterans will also generally benefit financially by enrolling in new VA access points. For example, prior VA users will save expenses incurred traveling to distant VA facilities as well as out-of-pocket costs for any primary care received from non-VA providers; most said that they use both VA and non-VA providers. New VA users will also save out-of-pocket costs, with low-income veterans receiving free care and high-income veterans incurring relatively nominal charges.

Also, about 80 percent of the new users have alternative health care coverage, and most of the rest said that they paid for their own primary care. Most prior VA hospital users also have alternative coverage that they may use to obtain primary care from non-VA providers. Based on our interviews with veterans using new access points, we learned that 70 percent of the veterans had Medicare coverage, 50 percent had private insurance coverage, and 7 percent had Medicaid coverage. VA will act as an intermediary and bill private insurers to recover the cost of providing care. Previously, the insurers would have paid the local providers directly, but now VA pays the contract provider a capitated rate and then bills the insurer to recover its costs on a fee-for-service basis.

The combination of these factors could lead to VA attracting several hundred thousand new users through its access points. This may force VA to turn veterans away if sufficient resources are not

available, or it may cause VA to seek additional appropriations to accommodate the potential increased demand.

Currently, VA is to provide outpatient care to the extent resources are available. When resources are insufficient to care for all eligible veterans, VA is to care for veterans with service-connected disabilities before providing care to those without such disabilities. Furthermore, when VA provides care to veterans without service-connected disabilities, it is to provide care for those with low incomes before those with high incomes.

Presently, most of the nine hopsitals encourage current and new users to enroll in their new access points. For example, the 3 hospitals we visited had enrolled 1,250 veterans in new access points. Of the 1,250, about 20 percent had service-connected disabilities, including about 4 percent rated at 50 percent or higher. Of the remaining 80 percent, most had low incomes, including about 10 percent who were receiving VA pensions or aid and attendance benefits.

CREATING NEW ACCESS POINTS CAN ADDRESS LONG-STANDING EQUITY CONCERNS

Inequities in veterans' access to VA care have been a long-standing concern. For example, about three-fourths of veterans (both those with service-connected conditions and others) using VA

clinics live over 5 miles away, including about one-third who live over 25 miles away.

Establishing new access points gives VA the opportunity to reduce some of these veterans' travel distances. Although VA provided general guidance, it left the development of specific criteria for targeting new locations and populations to be served to network and hospital directors. Directors have several options when targeting new locations and populations to be served. For example, they could target those current users or potential new users living the greatest distances from VA facilities.

VA's 12 new access points operate in a variety of locations, including 3 areas that are more than 100 miles from a VA facility; 6 areas between 50 and 100 miles from a VA facility; and 3 areas less than 50 miles from a VA facility (including 1 large urban area located 8 miles from a hospital). Most have improved convenience for existing users and attracted new users as well. However, two new access points have served only current VA users, while another one has served only new users.

CONCLUDING OBSERVATIONS

VA's plans to establish access points could represent a defining moment for its health care system as it prepares to move into the 21st century. On one hand, VA hospitals could use a

relatively small amount of resources to improve access for a modest number of current or new users, such as those living the greatest distances from VA facilities or in the most underserved areas.

On the other hand, VA hospitals could, over the next several years, open hundreds of access points and greatly expand market share. There are over 26 million veterans and 550,000 private physicians who could contract to provide care at VA expense. VA's growth potential appears to be limited only by the availability of resources and statutory authority, new veteran users' willingness to be referred to VA hospitals, and other health care providers' willingness to contract with VA hospitals.

Although VA should be commended for encouraging hospital directors to serve veterans using their facilities in the most convenient way possible, VA has not established access points in conformance with existing statutory authority. In our view, under current statutes, new access points should be VA-operated or provide contract care for only those services or classes of veterans specifically designated by VA's geographic inaccessibility authority. While legislative changes are needed to authorize VA hospitals to provide primary care to veterans in the same manner as the new access points are now doing, such changes carry with them several financial and equity-of-access implications.

In addition, VA has not developed a plan to ensure that hospitals establish access points in an affordable manner. If developed, such a plan could articulate the number of new access points to be established, target populations to be served, time frames to begin operations, and related costs and funding sources. It could also articulate specific travel times or distances that represent reasonable veteran travel goals that hospitals could use in locating access points.

Given the uncertainty surrounding resource needs for new access points, such a plan could also articulate clear goals for the target populations to be served. Hospitals could be directed to provide care at new access points in accordance with the statutory service priorities. If sufficient resources are not available to serve all eligible veterans expected to seek care, new access points that are established would serve, first, veterans with service-connected disabilities and then, second, other categories of veterans, with higher income veterans served last. Finally, this approach could provide for more equitable access to VA care than VA's current strategy of allowing local hospitals to establish access points that serve veterans on a first-come, first-served basis and then rationing services when resources run out.

- - - - -

Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other Members may have.

For more information, please call Paul Reynolds, Assistant Director, at (202) 512-7109. Michael O'Dell, Patrick Gallagher, Abigail Ohl, Robert Crystal, Sylvia Shanks, Linda Diggs, Larry Moore, and Joan Vogel also contributed to the preparation of this statement.

(406103)

STATEMENT
OF
KENNETH W. KIZER, M.D., M.P.H.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

APRIL 24, 1996

Mr. Chairman and Members of the Subcommittee:

I am pleased to have this opportunity to continue our discussion of VA's plans to restructure itself from primarily a hospital-based to an ambulatory-based system of care, including our need to establish community-based and outreach clinics, or new access points as we have called them.

Mr. Chairman, during 1995 we took a number of steps to restructure how VA provides health care services to veterans.

- In March 1995 we forwarded our *"Vision for Change"* to Congress. This document layed out our general plans for changing the VA system, including our basic objectives to achieve improved access to care, more customer satisfaction, improved efficiency and higher quality of care.

- We directed that all of our facilities implement primary care programs for all patients by the end of FY 1996. Last fall, a survey of our facilities showed that about 40 percent of patients were then enrolled. Many more have been since then.

- We forwarded our proposal for eligibility reform and expanded contracting authority to Congress in September 1995. Our program changes and those in your bill, along with appropriate contracting authority, would provide clear direction and supporting authorities that VA is to provide cost-efficient care in whatever setting that is clinically appropriate and that VA may partner with whoever might be needed at the local level.

- Consistent with our *"Vision for Change"* we provided policy direction to the field in February 1995, encouraging the activation of access points for veterans health care. To date, we have received Congressional concurrence for 15 new access points, and we have a proposal for siting 58 more pending before the Appropriations Committees.

The creation of additional points of ambulatory care access within coordinated community networks of care is needed as part of the transition of the VA health system from a hospital-based to an outpatient-oriented system of care. We have to create the capacity to provide outpatient services before we can move our patients from the more expensive hospital-based centers of service.

We have other problems such as resource allocation methods, and we are taking steps to address those as quickly as possible. We are also adjusting our access points policy as the need arises. For example, concerns have been raised that these new access points may attract a higher percentage of non-mandatory workload than exists now. I have instructed the VISN Directors to carefully review these workloads to be sure that the level of discretionary workload remains consistent with other VA points of service. And, I would emphasize that a basic condition of establishing an access point is that it will be operated within existing resources.

Access points have to be established using the limited legal authorities that we now have; they must operate within existing resources; and they are intended to serve underserved areas or populations of service-connected, special category and low income veterans. We require a proposal to establish an access point be submitted to Headquarters as part of the review and notification process; the proposal must include a demographic analysis of the clinics' catchment area; an evaluation of ability to provide needed care through existing facilities and resources; a delineation of the services to be provided; an analysis of the alternatives considered including their cost; a listing of internal and external sources of funds and FTE; an implementation plan; and a statement of stakeholder involvement and support. The policy allows for maximum flexibility for the VISN and the medical center, and provides the Network Director the authority to establish access points in accordance with local needs, pending VHA Headquarters and Congressional notification and concurrence. Our policy also delegates authority to VISN Directors to activate, deactivate and realign clinics in their jurisdiction consistent with availability of funds and legal authority, and for approval of proposed access points with total annual recurring costs of up to $1 million, where the lease does not exceed $300,000.

Mr. Chairman, we believe that our emphasis on transitioning the system to an ambulatory care based system is beginning to show results. In 1995, we increased outpatient visits by 2.9 million while reducing operating beds by over 2,400. We expect this trend to continue for the foreseeable future. In fact, during the first quarter of 1996 an additional 2,070 operating beds were closed.

Mr. Chairman, you also requested testimony concerning GAO's recent review of our efforts to improve access to outpatient services; however, we have not had the

opportunity to fully review and analyze their final report. Thus, we would be pleased to provide our analysis of their report to the Committee for the record.

To conclude, I believe that the VA health system must be restructured if it is to be a patient responsive and cost-effective system in the future. We have undertaken an aggressive agenda of change, including the development of new mechanisms to better allocate our resources to our Networks. As I mentioned earlier, improving veterans access to community-based primary care is a critical first step in restructuring VA health care. We are beginning to make progress toward this goal, however, we need Congressional support. VA's statutory authorities are simply inadequate to support modern, cost-effective health care. With the enactment of the program reforms that we have proposed, and that your Committee has endorsed, along with appropriate contracting reforms, our VISN directors will be able to fully restructure how we provide services to veterans and achieve improvements in services to our patients, as well as increased value for the resources that we employ.

Thank you for the opportunity to be here today, and I will be happy to try to answer your questions now.

○

25-742 (68)