

VA'S EXPERIENCE IN IMPLEMENTING PATIENT ENROLLMENT UNDER PUBLIC LAW 104-262

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTH CONGRESS
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VA'S EXPERIENCE IN IMPLEMENTING PATIENT ENROLLMENT UNDER PUBLIC LAW 104-262

THURSDAY, JULY 15, 1999

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

The subcommittee met, pursuant to call, at 10 a.m., in room 340, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Moran, Baker, Gutierrez, Evans, Doyle, Peterson, Snyder, and Shows.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Subcommittee on Health will come to order. In 1996, as part of a major reform of VA health care eligibility rules, Congress directed VA to establish a patient enrollment system. This enrollment or registration system was intended to give VA a tool to plan for providing care to a particular patient population.

The intent of the law was to ensure to the extent funding permitted that VA would enroll and treat those veterans who had the highest priority for care. The law specified that veterans with a service-connected disability rated 50 percent or more of the highest priority for enrollment.

Of the seven different priority levels established in law, Congress assigned the lowest priority to those veterans who have no special eligibility status and who have incomes above a statutory means test.

The law provided VA considerable flexibility in how to design an enrollment system. Importantly, Congress also directed VA to limit the scope of enrollment in any given year to, quote, "ensure that the provision of care to enrollees is timely and acceptable in quality," end quote.

Now, this eligibility reform law requires the Secretary to determine in light of available funding which groups of veterans may be enrolled in any year and what benefits veterans will be provided. Such decisions are to be based on regulation, which the Secretary is to issue.

My colleagues, nearly 3 years after the law's enactment, Secretary West has yet to publish final regulations. Although the VA did implement an enrollment system last year, it opened enroll-

ment to all veterans, inviting some 26 million to seek care from a system which had been serving fewer than 4 million. Many of us question the wisdom of such a nationwide enrollment decision which failed to take account of VA's already tight budget and the variability among VA's 22 networks.

Until last year, for example, many VA facilities had long denied care to veterans with the lowest priority, so-called Priority Group 7 veterans, because their eligibility is explicitly limited to the availability of funding.

It may make sense to permit individual network directors to open enrollment to all veterans if a network has the capacity to treat them, but it makes no sense to jeopardize the timeliness or quality of care provided to higher-priority veterans in order to treat those with the lowest claim on VA care.

Having opened enrollment last year to all veterans, VA now faces a real dilemma regarding its enrollment decision for the coming fiscal year. That challenge is compounded by the administration's fiscal year 2000 budget.

What is a concern for me and I think my colleagues is that the VA's proposed final regulations do not provide the flexibility VA would need to deal with the \$1.4 billion shortfall. And we can debate what this shortfall is—it might be higher—that would occur under the administration's budget.

Decisions regarding veterans' enrollment next year must be made soon. So our hearing today is very important and timely. I think we will learn that for many reasons, different networks have had very different experience under enrollment. We will also learn that a "meat ax" decision at the VA headquarters on who can and cannot be enrolled across the country can obviously create serious problems.

I think it is also troubling, I think we will learn, that, despite VA's use of a resource allocation system aimed at providing greater equity of access, veterans in some parts of the country continue to have far better access to VA care than others.

So, my colleagues, I hope today's hearing will improve our understanding of the important issue involved in patient enrollment and move the VA closer to grappling with those issues.

I particularly want to thank those network directors who have come some distance to be with us this morning. And obviously I look forward to their testimony.

Before calling up our first panel of witnesses, I want to recognize my friend and good colleague the subcommittee ranking member Luis Gutierrez for any opening comments he may have.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman. I would ask that my complete statement be included in the record.

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

Mr. GUTIERREZ. I guess last year the VA opened up enrollment to all veterans, just following up on the Chairman. And, as expected, this created discrepancy in delivery of care among VA's 22 VISNs. While some networks tried to attract new Category C patients to improve their operating efficiency, other networks already

working to capacity tried to minimize or avoid taking on these new enrollees.

The policy of enrollment for all veterans also created a dilemma due to the VA's budget constraints the Chairman just spoke about. Some networks experience long waiting times and high enrollment of Category C patients while others did not.

This situation is not expected to improve considering the woefully inadequate budget the Department of Veterans Affairs is likely to receive for the next fiscal year. A potential shortfall of \$1.4 billion under the President's budget would almost definitely require disenrollment of veterans in Priority Groups 5 and 6.

Mr. Chairman, some veterans tell us they were misled because they were told they would receive health care for life. Now Priority 7 veterans are receiving letters from Kenneth Clark, VA Chief Network Officers, which reads as follows, and I quote, "You are in Enrollment Priority Group 7. For this fiscal year through September 30, 1999, we are enrolling veterans in Priority Group 7. However, we cannot assure you that the VA will be able to continue your enrollment after September 30, 1999. For that reason, we strongly recommend that you retain any health insurance you may now have. In 2 or 3 months, VA will be making decisions about whether Priority Group 7 will be eligible for VA care for the next fiscal year, October 1, 1999 through September 30, 2000. We will notify you as soon as possible if we are unable to continue your enrollment," end quote.

Mr. Chairman, I believe we must establish clear definitions about who is and who is not eligible for VA health care. Veterans are being misled about what, if any, health care they will receive.

I will repeat, as I have stated time and time again, we have a moral obligation to adequately fund the VA budget for the upcoming fiscal year. Increasing the budget will ensure that all veterans receive the care that they were promised when they stepped into their uniform.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague.

Mr. Doyle, opening comments?

OPENING STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Thank you, Mr. Chairman. I want to extend my appreciation to you for convening this morning's hearing to discuss VA's experience in implementing patient enrollment and to more closely examine the intended and unintended consequences it has produced throughout the 22 VISN structure.

I also want to recognize the thoughtful approach that Chairman Stearns and Ranking Member Gutierrez have employed in the sequencing of and selection of subject matter for our subcommittee's hearing schedule this session. Not only have our subcommittee's hearings focused on the most critical issues confronting the VA health care system, but we have considered these issues in a deliberative and logical manner.

In many ways, the topic of enrollment embodies all of the complex questions that must be posed when one looks at the juxtaposition of the need for veterans' health care and the actual delivery of services.

In essence, this juxtaposition is reflective of the larger quandary of the level of funding that the VA health care system needs and the level of funding it receives. As I am sure we would all acknowledge, the future of the VA health care system is precarious. And in the absence of adequate funding, we will have to increasingly turn to planning tools, such as the enrollment system we have gathered to discuss this morning.

I would emphasize that in many respects, the enrollment system has turned out to be not so much a way in which to plan better to meet demands but a way in which to ration health care and further pit one veteran's needs against another's.

Fundamentally the very fact that discriminating enrollment decisions have to be made connotes the pressure to artificially establish a balance between VA health care supply and demand. In doing so, the delivery of health care services is not being determined on the merits of medical necessity but on cost.

Thus, enrollment decisions, more than any other indicator, clearly illustrate where the rubber hits the road in the system. And given the current debate surrounding the need to reform HMOs, I have to wonder when we might be discussing the need for a veterans' health care bill of rights.

I have been an advocate for providing adequate funding for VA health care. So I sympathize with those who must increasingly find creative needs by which to treat veterans with dwindling resources. But we must make certain that creative means are thoroughly thought out as well as implemented, monitored, and analyzed in a systematic and sound manner. We must, however, guard against number-juggling schemes that present themselves under this guise.

I am anxious to hear more about how the VA's enrollment decision relating to Priority 7 veterans fares against these concerns. I am looking forward to the testimony of our distinguished panelists and will reserve raising further concerns until members have had the opportunity to pose questions.

Thank you, Mr. Chairman.

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

Mr. STEARNS. I thank my colleague.

The gentleman from Kansas, Mr. Moran.

Mr. MORAN. Mr. Chairman, I have no opening.

Mr. STEARNS. Okay. Will the first panelists step forward: Mr. Stephen Backhus, Director of the Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division of the GAO; accompanied by Mr. Ronald Guthrie and Ms. Lisa Gardner. Welcome. I appreciate your coming this morning. Mr. Backhus, we would like your opening statement.

STATEMENT OF MR. STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY: MR. RONALD J. GUTHRIE, ASSISTANT DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE; AND LISA R. GARDNER, SENIOR EVALUATOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE

STATEMENT OF STEPHEN BACKHUS

Mr. BACKHUS. Good morning, Mr. Chairman, members of the subcommittee. We are pleased to be here to discuss VA's impending fiscal year 2000 enrollment decision. As you know, this decision is due approximately August 1.

You asked that, in that context, we evaluate the impact of VA's fiscal year 1999 enrollment decision on the demand for and timeliness of health care being provided to veterans, also to report to you on the challenges and the options that VA faces for fiscal year 2000.

My remarks are based primarily on our review of VA's budget planning and execution documents as well as, because data are somewhat limited, to surveys that we have conducted of all the 22 VISN directors.

With me are Ron Guthrie and Lisa Gardner. Both have participated extensively in this study.

As you know, the Eligibility Reform Act of 1996 requires VA to annually enroll veterans for which it has the resources to provide timely care. And for fiscal year 1999, as you mentioned, VA allowed veterans in all seven priority groups to enroll.

Our analysis of the year to date, which is the first 6 months of fiscal year 1999, indicates that health care expenditures for enrollment predictions are on track. That is to say four million veterans have been enrolled, which is approximately what the VA or close to what the VA predicted. And half of the money that was allocated for this fiscal year has been spent.

That is the good news. However, the system is showing signs of strain. And by that, I mean that all of the VISNs have reported an increase in demand for health care and that this increased demand appears to be negatively impacting on the timeliness of care.

Now, demand has increased for three reasons. Enrollment is one of those reasons, open enrollment, but also it has increased, the VISN directors tell us, as a result of the uniform benefit package, which enhanced services, and also as a result of an increased number of community-based clinics, which increases access. So demand has increased.

But here is what the VISN directors told us in terms of what the impact of that demand has been. Primary care waiting times have increased. Seventeen of the 22 VISN directors told us that. And those increases are up to 150 days to obtain follow-up care.

They have also told us that specialty care waiting times have increased. Sixteen of the 22 VISN directors told us that that has happened and up to 100 days to wait for specialty care.

The increased demand has also impacted on care for the higher priority veterans. By that I mean their waiting times have increased as well. Nine of the VISN directors have told us that already for this fiscal year, they have less than adequate capacity to treat all of the enrolled veterans. And five of them limited their outreach efforts at the beginning of this fiscal year because they feared that they would not be able to enroll everybody who wanted to or serve everybody who enrolled.

So what does that bode for the next fiscal year? Obviously VA is going to be severely challenged to serve all veterans seeking enrollment. Its ability to continue the current level of care is unlikely in our opinion because of overly optimistic assumptions that it is going to save \$1.4 billion through management efficiencies.

All of the VISN directors reported to us that they will have difficulty meeting demand in fiscal year 2000. So what that means to us, our interpretation of that, is if these efficiencies don't occur, the VA needs to use the tools that are available to them in the act. And that is to provide care to only those priority groups or subgroups for which it has those resources available, to modify the benefit, or some combination of both.

In the long run, it needs to expedite its efforts to increase efficiencies through improved medical care cost recovery activities or additional revenue, dealing with its infrastructure problems and other kinds of issues related to the allocation system.

So, Mr. Chairman, that concludes my statement. Mr. Guthrie, Ms. Gardner, and I will be glad to answer any questions you have.

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

Mr. STEARNS. Let me just ask a general question. Are you aware that the VA has not even promulgated regulations to implement its enrollment system? Were you aware of that—

Mr. BACKHUS. I wasn't until you mentioned it earlier.

Mr. STEARNS (continuing). Before my opening statement?

Mr. BACKHUS. No, I wasn't. I was not aware of that.

Mr. STEARNS. So you never ran across this at all? It is totally a surprise to you? Okay.

Mr. BACKHUS. Yes, it is.

Mr. STEARNS. When we go to look at the administration not promulgating these regulations, the question comes up: Well, what do we do? The VA's General Counsel believes that at this date, there might even be some thought of some regulations being instituted to set such limits.

You suggested that the VA could also find savings by limiting the benefits it provides enrollees. What do you mean by that?

Mr. BACKHUS. Well, clearly one of the options would be to modify the uniform benefit package to all of the veterans and all of the groups; in other words, not provide the same level of care throughout the system as is done now—there would be obviously some cost savings that would derive from that—and lower those budget requirements if there were less services provided.

Mr. STEARNS. What do you mean by "lower" the "budget requirements"?

Mr. BACKHUS. Well, a particular kind of care. Say there were some kind of limitation put on prescriptions, medications, the VA didn't have to provide medications. If there were a change like that made, a reduction in the benefit, then, of course, that would consume less. There would be less dollars that the VA would need for health care because the benefit would be reduced.

I reviewed that as one of the potential options that the agency, the VA in this case, is potentially going to have to consider.

Mr. STEARNS. Do you view the VA health care system with its budget shortfall sort of in a crisis situation?

Mr. BACKHUS. Absolutely.

Mr. STEARNS. I mean, tell me: How dire is this?

Mr. BACKHUS. I do view it as a crisis situation. And I think it is very unlikely that they are going to be able to achieve the savings through these management efficiencies that are necessary.

For example, \$1.4 billion in management efficiencies is needed. Of that, \$500 million, the VA says, they will achieve through personnel reductions, personnel savings. That is the equivalent of 8,500 employees just to achieve \$500 million in savings, one-third of what they need to achieve, one-third of the \$1.4 billion approximately.

The 8,500 employees are 3 times more than what they have ever achieved in a fiscal year before. For this fiscal year, 1999, I think they were estimating it was around 2,000 employees, 2,200 employees, that they would need to reduce by for their efficiencies for this fiscal year. And I think one number a year before was about 3,300 employees.

So we are talking about three times as many employees as ever before to achieve one-third of the amount of savings they have to achieve. The other two-thirds of the savings which they have to achieve comes from non-personnel kinds of items. That is things like medical supplies. It could be pharmaceuticals. It could be medical equipment. It can be travel. It can be all of these other kinds of things.

Well, you know that prosthetics and pharmacy costs and those kinds of things are increasing at rapid rates. We are talking about trying to find a billion dollars of reduction when cost items like these are growing so fast. It doesn't seem possible.

Mr. STEARNS. Considering what you just said, don't you think the administration should have gone ahead and developed enrollment regulations so it would have the necessary tools to deal with the contingencies that you are talking about?

Mr. BACKHUS. I think the kinds of things that we are talking about doing here, be it modify the benefit or limit eligibility for enrollment, as you have said, require regulations. And there isn't time at this point between now and around August 1, when the decision has to be made to promulgate those regulations. So it seems like that has definitely caused us problems.

Mr. STEARNS. So we have at this point to deal with this potential problem that you have identified and this severe shortfall. And they are not developing the enrollment regulations. How do you explain that? Was there anything that you ran across that would show you why they did that, why they delayed this important implementation of the enrollment regulations?

I think what you are saying is you don't think the administration, the VA, will actually make those cuts of 8,500 based upon past history. And the other things that are projected for savings you question.

So the enrollment regulations were absolutely necessary to enforce. And it is 3 years out. Nothing has been done. So the question is: Is there any reason that you might think why they haven't done it? Is there something that—

Mr. BACKHUS. I can only—

Mr. STEARNS (continuing). We are all missing here?

Mr. BACKHUS. I can speculate, but that is really all it is.

Mr. STEARNS. It is what?

Mr. BACKHUS. I can speculate.

Mr. STEARNS. Okay.

Mr. BACKHUS. That is really all it is. It is not based on a conversation or a review of any documentation on that topic.

Mr. STEARNS. Well, just your best hunch.

Mr. BACKHUS. I think that my best hunch is that the VA was of the opinion that there would be either some kind of a budgetary increase down the road or that they would have somehow the ability to find these efficiencies within their system to continue to enroll all seven priority groups.

They also I know factored into the budget their desire, their hope, their intent to be able to obtain funding from alternative revenue sources through Medicare subvention and those kinds of things have budgetary impacts, Medicare subvention hasn't happened yet. They are not able to collect from Medicare for services they provide. So that is a source of revenue that they don't have that they were counting on.

Mr. STEARNS. All right. The ranking member, Mr. Gutierrez.

Mr. GUTIERREZ. Thank you very much.

The VA seems to differ with your assessment that treatment of Priority 7 veterans is one of the root causes of the problem VA is experiencing with waiting times and access to care. Will you comment on other factors you believe based on your survey of network directors are impacting veterans' demand for service and the VA's ability to meet this demand?

Mr. BACKHUS. Yes. I don't think we have characterized the Priority 7's as being the veterans exclusively who have caused this shortfall. What we are saying is that there are a number of factors that have increased the demand.

First is that there are and have been over the last few years increases in the number of access points for veterans through, as you know, the community clinics, more places for veterans to access the system. It is closer to them. It is more convenient. Build it, and perhaps they will come. So there is some of that that VISN directors have told us results in increases in demand.

The benefit package coming out of the Eligibility Reform Act expanded services for people. That clearly draws people to the system. It is attractive. It is comprehensive. That has a net effect of increasing demand. But they also did tell us that opening enrollment to all veterans also was a factor.

So in that sense, while there are some new users who are Priority 7's who are attracted to the system by this ability to enroll, they are not exclusively the reason. And we aren't suggesting that.

Mr. GUTIERREZ. Let me follow up. In your opinion, should the—this is just for your opinion on this issue—veterans' equitable resource allocation model accommodate Priority 7 veterans who require basic care?

Mr. BACKHUS. Well, it doesn't now, as you know. That is not a factor that is used in VERA. And should it or not? Well, I don't know that I have an opinion on that, really. You know, the VA now has the ability to collect revenue from the insurance companies of these Priority 7's, those who have insurance. So VERA started paying the VA for the care they provide to Priority 7's. It ought to be net of what the VA is able to collect. So there are a lot of those kinds of issues involved.

Mr. GUTIERREZ. Mr. Chairman, I don't have any other questions. It seems that we should—following up on what Mr. Doyle said, I think this is an excellent hearing to get this information.

I think it should help us later on this afternoon when we come back here to look at the millennium bill and look at some of the kinds of actions because, as Mr. Backhus has testified, it seems as though every time we pass legislation, making it more attractive and expanding the services and we do that by allowing the VA to care for more people and expand their range of services, that more people are going to come. They are going to say, "This sounds pretty good. Let me go access it." And that is going to be part of the problem.

So maybe we should be careful as we continue to open up access to more and more veterans for more and more services unless we have the money to go along with it. I think that is going to be a big problem.

It sounds like the VA is doing good. People are coming back. The problem is: Do they have the resources to take care of them?

Mr. BACKHUS. Right.

Mr. GUTIERREZ. Thank you very much.

Mr. BACKHUS. Sure.

Mr. GUTIERREZ. And thank you, Mr. Chairman.

Mr. STEARNS. Okay. And I thank my colleague.

The gentleman from Pennsylvania, Mr. Doyle.

Mr. DOYLE. Thank you very much, Mr. Chairman. You know, I just can't help notice you and the ranking member there. I feel like I am out of uniform. Did you guys coordinate your suits there today?

Let me start, Mr. Backhus, by thanking you for your articulate and thorough testimony. I am curious. In preparation of your testimony, I know you surveyed the effects of enrolling Priority 7 vets in all 22 VISNs. Is it possible for members of the Committee to get a copy of their particular VISN survey? Was it broken down by VISN? Can we get our hands on that?

Mr. BACKHUS. Well, you can, but there is one issue I need to bring to your attention. When we surveyed the VISN directors, several of them asked for confidentiality. They asked that their remarks not be reported individually but only in the aggregate with the others. So we have tried to respect that.

So I would leave that up to you. But do understand that I can't and could never guarantee them that that could be done. Okay? We could only explain that, to the extent that we can, we will mention this desire of theirs. We would, to the extent that we can, honor that request, but we couldn't necessarily guarantee that we could if, for example, members of the Committee wanted to see that information. So I need to leave that up to you.

Mr. DOYLE. Yes. I am inclined to respect their desires because if it gets them to finally say what needs to be said, we are finally hearing on this Committee what we have suspected and have been hearing from veterans and VSOs and employees at the veterans' hospital for a long time.

I am glad that VISN directors are also stepping forward and saying what reality is. And if providing them some confidentiality is the key to getting the message and the truth out, then I think we should respect that. And I will withdraw my request for information on my particular VISN.

I am curious. In the surveys, you found that all the 22 directors you surveyed said they anticipated having problems meeting veterans' demands for health care in fiscal year 2000. Can you tell me if having problems was broken down specifically beyond increased demand and longer waiting periods? Did they say what types of other problems they anticipate or—

Ms. GARDNER. Actually, when we talked to them about the problems, that was in the first survey, where we basically just had them check a box as a way to measure to what extent they would have a problem.

When we talked to them the second time, we called all VISN directors in May of this year and talked to them about what kind of problems they might have next year. Most of them attributed the problems to the budget. And they mostly attributed the types of problems they would have to increased waiting times.

I could go back in and review the surveys because it was all narrative responses from them, very open-ended questions on that. So I haven't aggregated that specific information, but I do recall that the main thing was the increase in waiting times. That would be the difficulty for them with the budget constraints next year.

Mr. DOYLE. Thank you.

Given the shortfall of at least \$1.4 billion that most of us here on the Committee agree will exist in fiscal year 2000 if the budget request is enacted, what priority groups would you foresee the VA being able to reasonably accommodate?

Mr. BACKHUS. If the rest of the year tracks expenditure-wise the first 6 months and assuming there is the entire \$1.4 billion shortfall that exists through next year, that would require VA to stop enrolling somewhere within the Priority 5 category. Now, that is the big unknown.

How much of the \$1.4 billion in efficiencies can VA realistically expect to achieve? That I don't know. I just don't know. I have seen a preliminary list of items, a list that sums up to \$1.1 billion.

Mr. DOYLE. Right.

Mr. BACKHUS. And some of these things are pretty significant in terms of actions that don't seem very likely to me. So we have talked about this a lot in terms of trying to figure out what is the

most likely number they are going to get and don't have a good answer for that. But it seems like it is going to have to be somewhere in the Priority 5's.

Mr. DOYLE. What do you think is the impact on the VA's ability to provide service to veterans? How would that be impacted by 8,500 less employees?

Mr. BACKHUS. Most of that reduction comes from a combination of consolidating services, integrating services. And in those cases, those are probably real efficiencies.

So you have not such a great impact on care, but a lot of the savings also comes from eliminating services. And there clearly is a direct impact on the care people get because there is less of it.

Mr. DOYLE. Thank you very much. Thanks, Mr. Chairman.

Mr. STEARNS. My colleague the gentleman from Kansas, Mr. Moran.

Ms. MORAN. Mr. Chairman, thank you.

Mr. Backhus, thank you for your testimony. The increased demand for services by veterans, how related is that to the providing of outpatient and community-based services?

Mr. BACKHUS. It is related very closely. As I mentioned earlier, the VA has embarked on a path to increase access points for veterans, to make it more convenient, to put these outpatient clinics closer to where the veterans live, to be more state-of-the-art. That all induces demand. So I think there is a direct link to that.

And, as you know, over the past several years, much like health care in the rest of the country, there is an effort to go from an inpatient setting to an outpatient setting, ambulatory care kind of environment. That also is a way of managing care that produces some increased demand, at least at that level.

Mr. MORAN. Are there cost savings associated with that type of providing care in that type of setting?

Mr. BACKHUS. That is the \$64,000 question. I think there obviously are, but I am in no position to quantify what that is.

Mr. MORAN. The experience I have had just that I can relate to is the opening of an outpatient clinic in my district. The estimate was 1,100 veterans being served by that clinic. The end result was about double that as a result of veterans who were unwilling to drive 3 hours, 4 hours, 5 hours to a VA hospital but were willing to access care when provided on a more local basis, willing or more able, perhaps able at all.

Is that typical that there is just a significant increase in demand when the services are more localized?

Mr. BACKHUS. I think so, yes.

Mr. MORAN. And, as I understood I think your response to Mr. Doyle's inquiry, even eliminating services for Category 7, if the \$1.4 billion is any place close to being accurate and there is not significant cost savings realized, Category 7 is insufficient to solve this problem.

Mr. BACKHUS. It is not even close. There is for 6 months of this year some \$275 to \$285 million spent on the Category 7 veterans.

Mr. MORAN. I am sorry? That number again?

Mr. BACKHUS. For 6 months of this fiscal year, about \$275 million have been spent on Priority 7 veterans. So double that, and you get \$560 million. That is about a third of what that budget

shortfall is of \$1.4 billion, not quite a third, but \$600 million. If you stop treating the Category 7 and incur \$600 million less cost, you still have a billion dollars approximately, \$800 million more, of efficiencies to gain.

But, you see, it is not even that much money because the VA has the authority to collect from the insurance companies that many of these Priority 7 veterans have. So by treating fewer Priority 7's, they do reduce their costs, but they also reduce their revenue collections.

So there is not a trade-off here. Although the numbers aren't perfect, you are just not going to get much from eliminating 7's.

Mr. MORAN. And Category 7 would be the most likely to be able to provide additional revenue——

Mr. BACKHUS. Correct.

Mr. MORAN (continuing). Through private insurance?

Mr. BACKHUS. Correct.

Mr. MORAN. Has the Veterans' Administration notified—do they have a plan beyond the consideration beyond not providing services to Category 7 to meet this need?

Mr. BACKHUS. Those are the management efficiencies that——

Mr. MORAN. Beyond management efficiencies, which may or may not be realized, is there a fallback plan that if they are not realized, we are talking Category 6,5?

Mr. BACKHUS. Nothing beyond perhaps I think there is discussion underway there about potentially modifying the benefit and there is a discussion occurring as to the possibility of eliminating some eligibility for part of the Priority 7 group. And that is all that I am aware of.

Mr. MORAN. Did you determine that the VA sees this and the circumstance that you describe as a crisis? Do they see it as a crisis?

Mr. BACKHUS. I think they are banging their heads. Yes, I do. I think that they are taking this seriously and are as confounded as we are as to what to do.

Mr. MORAN. Thank you, Mr. Backhus. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleagues. I just would call attention to all members. I have here utilization cost data which shows the extent to which veterans in each of the seven priority groups use VA care. And what we are talking about basically is that regulations identifying how VA would limit access to care within these groupings has not been implemented.

So I think it is important that all members at least get a copy to understand this so you could even take it to your case worker back in your district and so that he or she could have the profound understanding that with limited resources, that the VA indeed is taking a Priority 1 through 7 in veterans in all classifications.

The gentleman from Mississippi, Mr. Shows.

Mr. SHOWS. Thank you, Mr. Chairman.

I apologize for coming in late a while ago, but I think Mr. Moran asked the question I was interested in on the survey. How much new demand do you believe is attributable to the decision of an increase due to Priority 7 enrollment?

I mean, you said it was somewhere around \$600 million, but that is really hard to tell because they do participate on the private insurance. So it doesn't have that large an impact. Is that correct?

Mr. BACKHUS. That is correct.

Mr. SHOWS. So if you had a percentage, it would be——

Mr. BACKHUS. I think historically the VA has collected about one-third of what they have billed. So it would be a \$200 million offset——

Mr. SHOWS. Yes.

Mr. BACKHUS (continuing). If it holds, but they are getting better at that. So it could be a little higher even. Some people in VA suggest it is close to a one-to-one now.

Mr. SHOWS. Really?

Mr. BACKHUS. But I don't have data on that. Actually, we are now beginning the project to evaluate just how well the collections are going. We will have more of that information in September probably.

Mr. SHOWS. We would certainly like to see all veterans have ability to get benefits, but we also want to make sure we can afford to do it. I appreciate your testimony in helping us come to a decision. Thank you.

Mr. BACKHUS. Yes.

Mr. STEARNS. Mr. Baker from Louisiana.

OPENING STATEMENT OF HON. RICHARD H. BAKER

Mr. BAKER. I thank you, Mr. Chairman.

I am interested in the apparent difficulty in coming up with recommendations beyond the identification of the problem. It appears if we move only through Priority 5, we have about 12 percent approximately of utilization currently in 6 and 7. About 42 percent or so is in Priority 5. Even if someone made the unreasonable suggestion that 6 and 7 needs were unmet, that would be insufficient to meet the budget shortfalls you are identifying.

There doesn't appear to be any managerial steps that have been agreed upon that could be taken to mitigate the loss or the shortfall. Your view apparently is personnel reductions are not likely to occur in sufficient numbers to even significantly contribute. You haven't said it, but what are we looking at as additional money?

I mean, if that is your recommendation, you have built a very close box with no other doors out. I am trying to figure out: What are you telling us?

Mr. BACKHUS. I think what I would do first, obviously next year isn't going to be like this year. I don't think it can be exactly the same as this year because of all of these reasons that we stated, but perhaps the first thing I would do would be to proceed with enrolling all seven priority groups but make these people aware that enrollment in this case does not necessarily guarantee that they are going to get care next year and monitor very closely the——

Mr. BAKER. I have a question on that particular point——

Mr. BACKHUS. Okay.

Mr. BAKER (continuing). When prioritizing and telling an individual you are conditionally eligible. That relates directly to timeliness of care. If we were to prioritize those who are obviously in need of critical care first and then either make optional or further delay

the treatment of those who could afford the delay, is that something that exacerbates or has no effect on the shortfall.

I am trying to understand. If we have an individual with a 24-hour problem, you can't tell them to come back next week. If we are addressing those issues, does that have any contribution to the overall cost or is it not of consequence?

Mr. BACKHUS. I don't know that I have a good answer for that because I don't have that kind of detailed information. It conceptually seems to make sense, though, that could have a significant impact on how the money is managed and how much money is needed for the entire year.

Mr. BAKER. You would have no idea or ability at this moment to say of the medical procedures performed how many of those—I don't think any medical procedure is optional, but medical necessity versus good treatment protocol?

Mr. BACKHUS. No.

Mr. BAKER. Okay. I am sorry to interrupt. I just wanted to get that out.

Mr. BACKHUS. No. That is okay.

So I think perhaps I would suggest proceeding at this point with enrolling all seven priority groups but making it clear to them that that doesn't necessarily guarantee that they are going to get care next year, but it does preclude those who don't enroll from getting care for sure.

It will be a condition for the possibility of getting enrollment and then to see just how successful these management efficiencies are for the year assuming there is no additional money that is going to be appropriated than what is now anticipated and having to make decisions on a month-by-month basis as to what priority groups are going to be able to get care and at the same time begin this effort to get regulations out so that within, say, for the Priority 5 category, we can identify and have a plan for providing care to those who don't have insurance, that VA continues to function as the safety net for people most in need.

And potentially for those 4's and 5's who do have other insurance putting them into another subgroup where if you have to cut, if it absolutely becomes no other alternative, then at least those folks have other options.

Mr. BAKER. One further follow-up. Do you believe management currently has the data available on a month-to-month basis sufficient to make these decisions?

Mr. BACKHUS. We, the VA and the GAO, have a difference of opinion on this slightly. In the aggregate, yes, they probably do. But when it comes down to managing particular patients or particular types of benefits or trying to determine, for example, what the waiting times are, no.

Mr. BAKER. How can you make good medical judgments that are managerially competent without having your hands on that data?

Mr. BACKHUS. I agree. It is hard to do, yes.

Mr. BAKER. Thanks a lot.

Mr. STEARNS. I thank the gentleman.

The gentleman from Arkansas, Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. I appreciate you holding this hearing. I learned so much at the last hearing, as we discussed, I am going to vote for your bill this afternoon.

Mr. STEARNS. That sounds good.

Dr. SNYDER. So who knows where this hearing will lead.

Mr. STEARNS. Okay. That is good news.

I am sorry I am late. I apologize. I had wanted to ask. On Page 2, my staff told me that you talked about it a bit during your opening statement, but this issue of waiting times on appointments, which I guess is one of the details of this whole discussion we are having today, the line "Eighty percent of the directors we surveyed said that the waiting time to schedule primary and specialty care appointments has increased since the beginning of fiscal year 1999."

I wanted to ask: Is the increase in waiting times something you consider statistically significant? Are we talking about 2 additional days? Are we talking about how much additional time? And then also as part of that, did the numbers indicate a fair amount of variability?

For example, there is one hospital showing or VISN showing 1-day increase, but we have got others that are showing a month-long increase.

Mr. BACKHUS. The source of that information comes directly from the VISN directors——

Dr. SNYDER. Yes.

Mr. BACKHUS (continuing). As a result of two surveys that we conducted. We did not ask for specific data on the waiting times for them to try to calculate a report to us the exact change that has occurred for their location. We were fairly general in our request and asked them to comment for us on whether it had a large or small impact.

So it is not of a specific enough nature, the information is, for me to answer that question the way you asked it.

Dr. SNYDER. Yes. The reason I am interested in this is we have had some at times fairly heated discussions on this Committee. And there certainly has been a lot of concern amongst people on this Committee in a bipartisan way about the budget numbers for this coming budget that we are doing and the number that came out of OMB.

In my conversations with the folks at OMB and Mr. Lew, those of us on the Committee say: Well, there is data out there that says that waiting times are increasing significantly. And the folks at OMB tell me: Show us the numbers because they say they checked the information. The information they have is that the waiting times have not increased. And that is the gist of my interest here.

Is there a system? Is there a way that a member of Congress can call a phone number and say, "What are the current waiting times for primary care and specialty appointments at this VISN?" or——

Mr. BACKHUS. You might. Some of the VISNs collect that information and some don't.

Dr. SNYDER. But there is not any systematic reporting requirement on——

Mr. BACKHUS. But there is one in the works. There is one being planned, being tested right now.

Dr. SNYDER. Yes.

Mr. BACKHUS. And I am of the impression that sometime in the September time frame we will be starting to see for the first time reports on what waiting times are.

Dr. SNYDER. Okay.

Mr. BACKHUS. The only thing that is collected now that I am aware of nationally is how long a person sits in the waiting room to be seen by a physician, not how long it takes them from the time they try to make an appointment until they see the doctor.

Dr. SNYDER. I understand. This is a different kind of waiting time.

Mr. BACKHUS. Much different.

Dr. SNYDER. Thank you. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague.

The gentleman from Minnesota, Mr. Peterson.

Mr. PETERSON. Thank you, Mr. Chairman.

I am sorry I got here late. So I am not sure if I am going to ask something that is out of line here. One of the things that is kind of hard for me to understand, I have got a hospital in my area, not in my state, that we use. They built additional capacity, and then they never opened it up because apparently they don't have money. We have people on the waiting list that can't get in and so forth.

Did you look at that issue? Is that an anomaly or did that go on throughout the system?

Mr. BACKHUS. There are VISN directors who reported to us stories similar to that as you have just expressed it where they don't have the resources to meet the demand for care. And it could be either not having sufficient people or equipment or supplies, but it is a budgetary issue that they don't have resources they need to meet the demand that is out there.

That concern is increasing to the point where I think, if I recall, every VISN director told us that next year they think they are going to have difficulty meeting the demand. So your facility is certainly not alone.

Mr. PETERSON. When they prioritize who gets care, is this uniform across VISNs? In other words, do they always get down to the same level or do they run out of capacity at the same time? Did you look at that?

Mr. BACKHUS. No, no. That is not that way. The decision was made nationally last year to enroll all seven priority groups. There was a national outreach effort to inform veterans of this opportunity.

Then at the next level, the VISNs varied in how much outreach they did. And they tried to make that determination, engage that outreach effort based on an estimate of how much care they thought they could provide.

Some could afford to be aggressive in their outreach because they had plenty of capacity and were able to meet the demand, have been able to meet the demand this year. Others knew in the beginning or were worried in the beginning that they would be unable to meet the demand, didn't do outreach. They are at capacity already. They can't accommodate all of the veterans. So they are in a much different situation.

Mr. PETERSON. So we ended up in whatever enrollment process happened here. It is not necessarily even.

Mr. BACKHUS. It is not even. It is uneven.

Mr. PETERSON. And then did you look beyond that, beyond the enrollment, to what is actually happening in terms of how people are getting care in each VISN or didn't you look that far? Did you just look at the enrollment part of the process?

Mr. BACKHUS. Well, for this particular project, that has been the extent of it, to try to determine the best we could what the impact of this enrollment decision was for last year and what are the implications for next.

Mr. PETERSON. Has anybody looked at that that you are aware of in GAO, whether one VISN is covering priorities a lot further down than another because the——

Mr. BACKHUS. Well, that would be us.

Mr. PETERSON. (continuing). Historical way that the resources have been allocated and so forth?

Mr. BACKHUS. We have done a little bit of—yes and no. We have looked at the allocation system and tried to judge what effect that has had and the extent to which it is working. We reported on that last year, and we recognized in the report a lot of improvement in terms of greater or something closer to equitable resource allocation but recognized that within VISNs, there is still a lot of variability about how they divide the money. We will be looking at this in the future, the extent to which the waiting times have changed, probably be doing this concurrently with the VA efforts to try to measure it as well because that will also begin to show the extent to which care varies by priority group, I suspect.

Mr. PETERSON. Maybe you already testified to this, but is there some kind of a percentage difference that you came up with between the highest and lowest——

Mr. BACKHUS. Could I——

Mr. PETERSON. (continuing). Enrollment that happened in the VISNs? I mean, is there some kind of range about——

Mr. BACKHUS. My memory is not——

Mr. PETERSON. Have you got any estimate?

Mr. BACKHUS. My memory is not serving me well here. Can I provide that for the record?

Mr. PETERSON. Sure.

Mr. BACKHUS. Yes, I think we did show. We did in that report show what the rate of change and range of change were by VISNs.

Mr. PETERSON. Okay.

Mr. BACKHUS. The numbers aren't detrimental.

Mr. PETERSON. Okay. Thank you. I yield.

[The information follows:]

Total Enrollees Sorted by VISN, as of March 26, 1999			
VISN	Total Enrollees	New Enrollees	New Enrollees as Percentage of Total
1	184,233	26,151	14.2%
2	118,032	24,545	20.8%
3	229,079	49,634	21.7%
4	240,428	39,986	16.6%
5	100,453	9,570	9.5%
6	199,092	29,651	14.9%
7	228,938	31,203	13.6%
8	330,370	47,424	14.4%
9	180,362	14,768	8.2%
10	151,216	15,415	10.9%
11	160,954	17,783	11.0%
12	185,206	27,936	15.1%
13	97,361	12,660	13.0%
14	77,029	15,913	20.7%
15	154,697	19,077	12.3%
16	335,371	31,075	9.3%
17	172,757	22,740	13.2%
18	178,014	23,151	13.0%
19	111,227	17,365	15.6%
20	168,106	22,272	13.2%
21	172,027	26,797	15.6%
22	225,549	34,170	15.1%
unassigned	3,207	1,215	37.9%
National:	4,003,708	561,501	14.0%

Mr. GUTIERREZ. Thank you.

Just one last question. Do you have the VISNs ranked from best to worst?

Mr. BACKHUS. In terms of what?

Mr. GUTIERREZ. In terms of how long it is going to take me to wait?

Mr. BACKHUS. No.

Mr. GUTIERREZ. Can you do that?

Mr. BACKHUS. Well, I think we are—

Mr. GUTIERREZ. And who is being whether they are covering 1 through 7 and what capacity they are covering.

Mr. BACKHUS. We expect to embark on that evaluation probably after we complete this one and can certainly get back in touch with you on that.

Mr. GUTIERREZ. I just think it would be interesting. At least we could give it—at least if a veteran—I don't want to be sarcastic. At least if somebody came up to me, I could tell them where to go. Maybe they have got a relative in Arizona.

I am not saying that Arizona is the place to go, but maybe Chicago is. I don't know if Chicago is the place to go. It is kind of rough there. I am from there. So I wouldn't exactly recommend that anybody go there.

But it would be really good because I think it will help us in the future as this Committee begins to look at allocation of resources and where the people are at and where they are moving.

Thank you very much for all of your testimony as well.

Mr. BACKHUS. You are welcome.

Mr. STEARNS. Well, I thank the panel very much for your time and efforts.

Mr. STEARNS. We will now call up the second panel. My colleagues, we have a large group in the second panel. I think many of you know Dr. Garthwaite. He is Acting Under Secretary for Health, Department of Veterans Affairs. Of course, he has a prepared opening statement.

I would also like to have each of the network directors to provide an opening statement to the subcommittee, sort of an overview of the experience in your network under the new enrollment system and how you have coped with it.

And, particularly, of course, I want to welcome Dr. Robert Roswell, VISN Director for 8, the Sunshine Network. I just might point out to my colleagues that VISN 8 includes Florida and Puerto Rico. And since 1995, there has been a 27 percent increase in veteran using VA in Florida and Puerto Rico, at least, we are seeing a huge need for veteran services.

So I want to welcome the second panel. And, Dr. Garthwaite, you might want to introduce quickly everybody here and then your opening statement.

Dr. GARTHWAITE. Thank you, Mr. Chairman, members of the Committee.

Starting from my left, your right, Dr. Ted Galey of VISN 20. He is the Network Director. Dr. Robert Roswell, as you mentioned, is the Network Director in VISN 8. Dr. John Higgins is the Network Director in VISN 16, headquartered in Jackson, MS. Dr. Galey is from Portland, Oregon; Gregg Pane, Chief Officer for Policy and Planning; Walt Hall from the General Counsel's Office; Mr. Vincent Ng, who is our Network Director in VISN 14, headquartered in Lincoln, Nebraska; and Jim Farsetta, who has appeared here several times, from VISN 3 in New York City.

Mr. STEARNS. Thank you.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., ACTING UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY: GREGG A. PANE, M.D., M.P.A., CHIEF, OFFICE OF POLICY AND PLANNING, DEPARTMENT OF VETERANS AFFAIRS; MR. WALTER A. HALL, ASSISTANT GENERAL COUNSEL, DEPARTMENT OF VETERANS AFFAIRS; MR. JAMES J. FARSETTA, DIRECTOR, VISN 3; ROBERT H. ROSWELL, M.D., DIRECTOR, VISN 8; MR. VINCENT W. NG, DIRECTOR, VISN 14; JOHN R. HIGGINS, M.D., DIRECTOR, VISN 16; AND WILLIAM (TED) GALEY, M.D., DIRECTOR, VISN 20

STATEMENT OF THOMAS GARTHWAITE

Dr. GARTHWAITE. In lieu of a fairly formal opening statement, I thought I would make a couple of quick points. First of all, we believe that eligibility reform has been a very positive thing for veterans. We are able to tell veterans that we are going to take care of what they need. We are able to do that in a fashion that makes more sense than before eligibility reform was undertaken.

As we talk about some of the difficulties with regards to enrollment and the difficulties with regard to budget and a variety of

other things, behind all of this, there is a lot of good news. We are treating increasing numbers of patients in a comprehensive and coordinated manner.

And, as we look at problems, I would urge us not to forget all of the positives coming out of this. Enrollment in my view is a work in progress. We have issues of notification, of data, of equity, of marketing. We have issues of coordination of federal benefits across a broad spectrum. We have issues of collection of third party billings. We have issues of the complexity of the analysis of the data that we are beginning to generate.

We have not had this data before. We haven't had it for very long now. And we are spending a lot of time and effort with a lot of different people trying to understand it even better.

And I would just say that with regard to enrollment decisions, I promise you as open a dialogue as we can possibly have—this hearing being one step in that direction about how that decision is made for this year.

The second thing is that the VA system continues to be a large system in the middle of reinvention, reengineering, and transition. Not only are we in transition; all the health care around us is in transition.

We have reviewed with you in prior hearings many of the positives with regards to improvements in quality and access. I know you have been listening to the previous panel, but the waiting time issue is both good news and bad news.

The fact that people are lined up to get the quality health care that we are giving is in a sense good news. The fact that there are more veterans being able to access the VA health care system, probably half a million over the last 5 years, is good news. It is bad news when people wait inappropriately, and we totally agree with that.

I would say that there are many causes for waiting times. There is increased demand. We have obviously opened up more access. We have made the care more desirable. We give primary care. You get to know your doctor. That makes you want to come back.

So there are a lot of good things about improving the quality of care that makes people want to seek it, and that does cause us to need to adapt our system to take care of that demand.

Simultaneously with that, we have the issue of next year's budget. I have testified previously that next year's budget as originally proposed is a challenge. And I think that next year's budget has had a fairly paralytic effect on taking the kinds of actions this year that would have implications into next year.

And so our ability to meet the demand this year with the budget we have is I believe tempered by the fact that next year we need to be positioned for a proposed budget which requires very hard choices.

Then there is a whole host of process and local geographic issues which contribute to waiting times. A lot of waiting time issues are related to the way people are processed through clinics. We have a major initiative underway with the Institute for Health Care Improvement to sort that out. In a couple of VAs where we have piloted this approach, we have had dramatic effects on waiting time

by understanding the processes and the assumptions and the way people do their work from day to day.

Finally, I will just mention that—as I think was mentioned as well by the GAO—that our estimate at the current time is the Priority 7 veterans have not been a major burden, are not the main cause of any waiting time increases and that we would concur with their analysis that if we were to try to save money, elimination of Priority 7's would not save a significant amount of money.

I think that is all the points I would like to make at this time. I think overall, eligibility reform, although it is a new process for us and some difficult management challenges are there and remain ahead, that, by and large, for the vast majority of veterans, they are getting more coordinated care and more veterans are being served.

[The prepared statement of Dr. Garthwaite appears on p. 51.]

Mr. STEARNS. Well, I think maybe we will just start from my right and just move across. So, Dr. Galey, why don't you start, if you don't mind.

STATEMENT OF WILLIAM GALEY

Dr. GALEY. That is fine. Thank you, Mr. Chairman.

I appreciate the opportunity to testify on the important subject of enrollment in VHA and specifically for VISN 20. I had the privilege to address you back in February. So I won't go into a detailed description of VISN 20, but I will say that we are a network that covers a largely rural Northwest.

We have a few metropolitan centers, a few modestly sized towns, and a lot of rural territory to cover. If you look at Alaska, indeed, that is really a frontier where huge distances separates small cities and towns where our veterans reside.

It is important to understand the health care environment of the Northwest when considering enrollment and access to care for Northwest veterans. Large metropolitan areas in the Northwest are among the most highly penetrated competitive managed care markets in the United States.

Veterans in these managed care systems often experience high co-pays for anything but routine services, high co-pays for drugs, oftentimes \$10 to \$15—

Mr. STEARNS. Dr. Galey, could you just move the microphone a little closer to you?

Dr. GALEY. I am sorry.

Mr. STEARNS. That is fine.

Dr. GALEY (continuing). High co-pays for drugs, oftentimes \$10 to \$15 or more for a drug per month. And our veterans if you know about their demographics, they oftentimes have 10, 15, or more pharmaceuticals that they need. So they are into hundreds of dollars a month. They have limited access to mental health, rehabilitation, oftentimes no transplant service availability, oftentimes no long-term care benefits, all of these things being available in the veterans' health care plan. Oftentimes lifetime benefits for chronic diseases, of which our veteran population has many, are capped. So they run out of benefit, if you will.

They have learned very wisely to use the benefits of the VA in the Northwest along with those benefits from their managed health

care plans to manage their health care needs in a cost-effective way. They oftentimes come to us in the beginning for catastrophic care and for pharmaceuticals. And then as they age and have more chronic disease and run out of benefits, they come to us as well.

In many instances,—and we have heard some references to it today—we can bill third party carriers who have responsibility for these veterans. However, in the Northwest, we have a large number of HMOs, again one of the highest penetrations of HMO care in the country. They don't pay. They just won't pay. So we can't collect third party billings in many instances.

The non-metropolitan areas have a strong fee-for-service presence. There is an organized resistance to penetration of the managed care organizations. In fact, the marketeers from those organizations have told us that the environments are hostile, that the care delivering services in those areas simply will not take on their managed care patients when they need access to non-available subspecialty services, for instance.

When the GAO visited us several years ago looking at CBOCs, when we started out doing CBOCs, they looked at areas below Portland in the rural communities and gave us forewarning that we would have much difficulty in penetrating those areas and if we did show up there, that we could expect an unwelcome welcome. We have actually found that to be true.

The sum and substance of the Northwest health services environment review is that wherever we open enrollment or access to veterans, they come. They like us a lot. We provide them not only additional catastrophic care and good prices for their pharmaceuticals, but they have found us to be a user-friendly, very robust health care package.

As of March 1999, we are seeing an actual increase in veteran users of over six percent as compared to March 1998. Most of those are in Priorities 5 and 7 with the Priority 5's predominating. We are traditionally strong finishers in the year. Rather than tailing off, I expect this percentage to increase to what we have been seeing in the last several years between seven and eight percent in new veterans.

Given this setting, my real concern relates, then, to fiscal year 2000. If VA receives a flat line or a small incremental increase in budget, VISN 20 will face a \$30 to \$50 million shortfall in the face of expected continued increases in veteran users in the Northwest.

And paired with the management actions that will be required to live within this type of a budget scenario, the inability to see veteran users in a timely way will exacerbate. This will affect not only Priority 7's but will involve Priority 5's significantly in my view.

From a VISN 20 perspective, then, in this type of cost containment environment, I would not be in favor of enrolling all veteran priorities.

Mr. STEARNS. I thank the doctor. Let me just ask each of you to pretty much summarize, if you could, and maybe not take your full 5 minutes so we can get the questions in.

Also, we are looking for dramatic facts here. We are looking for your opinions, deep, heartfelt opinion, because we are all here to work with and to help veterans. And so we are hoping that you can

say, "This is my problem. This is the help I need" or "We are doing okay," some really dramatic statements here that you could help us coalesce behind some kind of understanding on what to do.

So let me continue on.

STATEMENT OF ROBERT ROSWELL

Dr. ROSWELL. Thank you, Mr. Chairman. It is a pleasure to be here.

VISN 8, as you know, includes Florida and Puerto Rico. Since 1995, the year we became a VISN, we have had a 35 percent increase in users throughout Florida and Puerto Rico. It looks like this year alone we will have a full ten percent increase in the number of users, which I attribute partly to the impact of enrollment but probably more so to the suppressed demand for veterans' health care throughout the State of Florida as well as in the Caribbean and the U.S. Virgin Islands.

I think the important point I would make is that the new users we are seeing in my VISN are not Priority 7 veterans. They are Priority 5 veterans, those veterans who have lower income but without Service-connected disabilities.

For every Category 7 veteran we see, we see two or more Category 5 veterans. Those are the veterans who in my mind, in my heart, have the greatest need for VA health care and to whom we have the greatest obligation because they have served our country, they are indigent, and they need our care.

Their cost is high, too. In Florida and Puerto Rico, fully 93 percent of those veterans enrolling have already used VA for their health care needs. So there is a very, very high market penetration, which is part of the reason why our new user cost is higher as a percentage of our old user cost than many of the other VISNs. I think it reflects again a suppressed demand for much needed health care. And that is why they are utilizing VA for their health care.

You asked for heartfelt opinions. It seems to me that much of our deliberation is putting the cart before the horse. My understanding of Public Law 104-262 is that a determination of who shall be enrolled will be based upon resources available. And, yet, as the gentleman from the GAO pointed out earlier, the enrollment decision for next fiscal year must be made by approximately the 1st of August. And, yet, we will have no idea what the appropriations process will provide us for that same fiscal year until much later than that. That creates a very difficult challenge for us because the enrollment process has to be in place before the uncertainty of the budget is clarified.

I also wanted to comment partly as a physician, partly as a network director, on a couple of other suggestions that were either put forward or inferred previously. One suggestion was to modify the package of the covered benefit. A group is looking at that, but, quite frankly, the covered benefit to me is the crux of the whole eligibility reform enrollment legislation.

For years, we as physicians wanted to be able to treat the whole patient, not the Service-connected elbow or the Service-connected knee but the whole patient. And the covered benefit, the uniform benefit, in fact, represents the basic health care needs of veterans.

The suggestion to exclude pharmacy benefits is something that I as a physician would be very opposed to because most of our patients are indigent. By excluding pharmacy benefits, we are not transferring the cost of that prescription care elsewhere. We are eliminating that care. Then obviously compliance and the restoration of health suffer because they don't have access to medicines. They simply can't afford them. Therefore, they don't have them.

Another suggestion was to reduce the number of enrollees. Certainly I am one of those VISN directors who advocated or expressed concerns about enrolling Category 7's. And, in fact, I am one of those VISN directors who took actions to limit access to Category 7 veterans.

But I will tell you this, Mr. Chairman, that when I go out and speak to veterans throughout Florida today, their greatest concerns are now that they have enrolled, now that they are under care as a Category 7, they don't want to be cut off. And I would have great personal moral and ethical difficulties in trying to cease to care for those veterans whom we have already accepted enrolled in much needed, much deserved care.

Thank you, Mr. Chairman. It is a pleasure to be here.

Mr. STEARNS. Okay Thank you. Yes.

STATEMENT OF JOHN HIGGINS

Dr. HIGGINS. I am John Higgins, the Director for VISN 16, which is located in Jackson, MS. It includes Mississippi; Louisiana; Arkansas; Oklahoma; and Houston, Texas.

Like others, we are projecting a 15 percent growth in our total workload with the Category 5's or Priority Group 5's being the largest segment. Altogether we are looking at a projected increase of between 10 and 15 thousand veterans for next year.

Now our average cost for treating a veteran is about \$4,600 a year, but our average incremental cost, that is, the cost of adding a new veteran to the system, is about \$2,900 a year, about 60 percent of the average cost.

So we would project a need for \$29 to \$43 million a year in addition to what we currently have to meet the needs of new veterans. For the last 3 years, under the allocation process, we have received that much or more. So if the allocation process is similar to previous years under VERA, we would have enough money to continue our current services.

One of the real unknowns that we are grappling with, though, is while the actuarial data for numbers of new veterans has proven to be more accurate than I ever expected it to be, we don't have similarly good figures for our attrition rate. We know, for example, that World War II veterans are dying at very high rates.

We think that within next year or perhaps year after, the attrition rate will more or less balance the new patient rate and that if we don't bring in new patients to the system now, we will be looking at a down side beginning in 2 or 3 years.

We think in our VISN we can get through this interval period where we are actually treating more veterans before things level off. We always have to look at worst case scenarios. If we have a flat line budget, we will need to conduct a reduction in force of about 680 FTE. If, for example, we get an extra \$250 million na-

tionally, that FTE reduction would fall to 364. And with \$500 million extra, it would fall to 39. So we are trying to plan those scenarios.

I guess if I had to give you one of my most heartfelt emotions, as Bob said, it is really difficult to do the planning before you have the budget. We feel obligated in our VISN to do worst case scenario planning, which involves reductions in force, mergers between hospitals, mergers between service. It gets our employees very upset. It gets our patients and the Service organizations that represent them upset. It gets you a lot of extra calls that your case workers have to deal with.

And I guess my most heartfelt thing, in a perfect world, we would know what the budget is going to be early so we could plan our workload and all of the parameters to fit that budget.

Mr. STEARNS. I thank you, Dr. Higgins. We are going to take a break while we go vote. So the subcommittee will suspend, and we will be back shortly.

[Recess.]

Mr. STEARNS. The Subcommittee on Health will come to order again. I guess Mr. Vincent Ng, your opening statement, please.

STATEMENT OF VINCENT NG

Mr. NG. Okay. Thank you, Mr. Chairman. It is my pleasure to be here to testify to this subcommittee on enrollment.

I am the Director of the Central Plains Health Network. It encompasses three states: Nebraska, Iowa, and the western part of Illinois. I see the ranking Democrat member, Mr. Evans, is in attendance. Western Illinois is his district, which comprises part of this network.

This network experience with enrollment started with the national effort of informing veterans about the new eligibility system. We have made a moderate attempt in terms of advertising and information sharing with the veterans in that area in our marketing effort.

This network about 2 years ago or 2½ years ago had made a decision at that time not to take Category C or the Priority 7 veterans. So the opening of enrollment to all priorities was a welcome to the veterans in this network.

The network workload has increased tremendously with the effort on enrollment this year. Our workload has increased by 18 percent in terms of unique veterans served. The majority of the increases is in the Priority 7 veterans. We had experienced a 315 percent increase of the workload in that area, and in terms of the Priorities 1 through 6, we had a 7 percent increase.

Partially, the increase in Priority 7 can be attributed to the suppressed demand that, as I mentioned earlier, the network decided at that time not to take Priority 7 veterans 2½ years ago and that with the opening of the enrollment, that certainly has stimulated that demand.

The network and the veterans in terms of Priority 7 is helpful in Central Plains Network as the financial means test based eligibility 1 through 6 on income plus capital assets. As you know, Nebraska, Iowa, and the western part of Illinois has a lot of rural areas. A lot of the veterans, they are farmers. They have inherited

farms. They have high capital assets. But their income could be minimal. So when you count capital assets as part of the means test formula, a lot of our veterans fall into the Priority 7 category and not the Priority 1 through 6.

That is why I believe, and the veterans in that area believe, that opening up enrollment to all priorities is really helpful to providing health care to veterans that if capital assets are not counted, they would be Priority 1 through 6.

Also, in the rural areas, we face access problems and that the VA using community-based clinics and traveling provider teams has been able to provide health care to areas of veterans that normally may not have easier access.

We talked a lot about Priority 7. We talked a lot about budget earlier. I agree with my colleague that it is a very difficult decision in terms of timing when you do not rightfully know what your budget is next year to determine what priority level you are going to reach in enrollment.

A lot of veterans have mentioned to me when they knew that I was going to be here to testify about their concern of this enrollment, especially Priority 7. I see that it is our obligation to take care of them, and I will propose that if we are not going to take additional Priority 7, that the ones already in our system should be grandfathered in.

I would like to make one additional point in terms of volume. In my network, there are many small hospitals. In order to maintain competency of the medical professionals, volume is needed to maintain that competency.

The two biggest hospitals in my network are Iowa City and Omaha. Even those two hospitals are approaching some volume problems as we move a lot of the care to the outpatient areas. As you know, Iowa City has looked into maybe partnering with the university hospital, University of Iowa hospital and when we do analysis on it because of some of the concerns of volume and quality.

At this point, we feel that it is best that we maintain the care, patient care, in Iowa City because it is a hospital of quality and not enough savings could be achieved due to the high fixed costs.

Thank you for all the opportunity to testify, Mr. Chairman.

Mr. STEARNS. I thank you and welcome again James Farsetta.

STATEMENT OF JAMES FARSETTA

Mr. FARSETTA. Thank you, Mr. Chairman. It is always nice to come to Washington. It is probably nicer during the winter than during the summer.

The issue in VISN Number 3, the change in policy having to do with access, really did not have a dramatic effect on our network. Of course, historically our network has always taken care of all priority of veterans. Although we have seen an increase, a rather dramatic increase, the increase is the same as the other network directors have expressed, really, in Category 5 or Priority Level Number 5, versus Priority Level Number 7.

My increase has occurred in an environment where in real dollars, based upon a survey that was done by the General Accounting Office, our budget has decreased by approximately a little more

than \$200 million. And as we approach fiscal year 2000, we are looking at an additional decrease of approximately \$125 million.

The problem for my network is really not one of access, not one of the change in policy. It really is the budgetary challenges of fiscal year 2000. I think that Mr. Backhus really summed it up very well.

I am struggling with how one gets from where we are now to deal with the budgetary challenges that not only confront my network but confront the system. What we really haven't discussed, we talk about a RIF of 8,500 FTE. We really haven't discussed the cost of paying for that RIF. I mean, RIFs are not without cost. I think the estimate is about \$40,000 per employee. If you do the math to that, you can look at the dollars incurred in doing that.

One assumes that when you run a RIF, those employees would be off the rolls the beginning of the fiscal year. In order to achieve that, you really need about a 90-day window for that to happen. It appears that we are not going to be running any more RIFs this year. So we probably couldn't run a RIF until maybe the first, almost the second quarter of next year. One would be incurring those costs during the first 3 months of the fiscal year.

I think the challenge before us really is a budgetary challenge. Certainly within that challenge one could look at who we perhaps might want to disenroll. You can argue that you really don't want to make that decision until you have a budget. I would concur with that, but, by the same token, I think that some decision has to be made in the short term because I think the financial challenge presented to us I don't believe would be achievable if we don't begin to do something in the short term.

I can tell you that from my network, in order to achieve my projected budgetary reduction, I would have to RIF at least 2,000 employees. And I can tell you right now I do not know how I would be able to provide an acceptable level of care with 2,000 less employees. I have already eliminated 3,000 employees. So we would be looking at 5,000 employees. We would be looking at a net reduction in workforce of about 40 percent.

I don't know how I would do that without affecting major mission changes. I don't want to mention the word "closure," but you could look at major mission changes. Even major mission changes if you were to reduce wholesale services take time. Time for me gets translated into money. It also gets translated into reduced services for veterans.

I think the challenge for me certainly is really more financial than whether access impacts that, I think it may ultimately impact that, but I don't think it impacts that in the short run by any stretch of the imagination.

Mr. STEARNS. I thank you.

I will take five minutes for some questions. Dr. Garthwaite, I will start with you. I think you have heard the VISN directors indicate their feelings. And they seem to indicate that they have to cut into Priority Group 5 under the administration's budget. I guess my question is to you: Do you agree?

I think you have used the word "challenging" in your opening statement. I think that is a curious choice of terms considering

what I hear. What we feel here on the Committee is "challenging" is a euphemistic word, which could mean a lot of things.

I think the question is you have heard the VISN directors and what they have said. You have heard the CBO. What is your response to this? And what are you going to do?

Dr. GARTHWAITE. Clearly I would agree with the GAO's assessment and what you heard from the VISN directors that our system is stressed to provide quality care to all the veterans we see, especially as we look into the future. I don't think the budget we have this year is causing stress, but anticipation in being positioned for the projected budget for next year does cause significant stress.

To live with that budget, we will have to do business differently and make very significant changes. We have put forward some possibilities of how we might live with that budget, which includes how we buy supplies and services, how we do the process of care, how we manage our inventory. There are some new models out in the private sector which suggest we can save significant dollars.

I, with all due respect to GAO, will concur with them that achieving \$1.1, \$1.4 billion in savings is something that we have put forward that we believe we can achieve, but I can't promise you it is going to be an easy process or a painless process.

If those efficiencies aren't there, then the next real decision is: Do we provide care to fewer people? I think I would agree that we would have to cut farther than 7's to do that.

Mr. STEARNS. Really, what is on the horizon—and I think every member here as well as the administration understands what the problem is. Why is it taking you 3 years to implement/promulgate enrollment regulations?

Dr. GARTHWAITE. I think there have been a lot of complex discussions, a lot of complex issues, and maybe some procedural issues, hard issues about defining the term catastrophic, hard issues about the benefits package, a variety of different issues that we entertained a fair amount of debate internally that have slowed those processes down, and some things that I don't know that I can account for that delayed the process.

Mr. STEARNS. What was that last sentence? You what? You can't? What did you say, the last sentence?

Dr. GARTHWAITE. I said maybe other delays that I can't account for that I haven't been a part of.

Mr. STEARNS. Were you aware of this problem that the enrollment regulations were not being promulgated? Were you personally aware?

Dr. GARTHWAITE. I have been aware of difficulties in promulgating them at different times. It hasn't been solely on my plate in my previous job. I have taken a renewed interest in my new position.

Mr. STEARNS. Even with all of that, those proposed final regulations do not address the budget shortfall, do they?

Dr. GARTHWAITE. Walt, do you have a comment on that?

Mr. HALL. Not to the extent that they would authorize reduction in the categories of individuals we are taking care of beyond—

Mr. STEARNS. So the answer is no.

Mr. HALL. That is correct.

Mr. STEARNS. I assume you will be working until 4 o'clock in the morning on this, give some urgency to it. I think what the Commit-

tee is feeling is that there is just a sense of inertia in the administration here. We will be glad to help, and I think we are trying to do so through our efforts here. But we need to have a sense of urgency from you folks.

Almost every VISN director has pointed out heartfelt concern about these shortfalls. Has the administration done a worst case scenario based upon \$1.4, \$1.9, \$3 billion shortfall?

Dr. GARTHWAITE. We have gone out to the networks and asked for specific plans of how they would deal with various levels of appropriations, including the essentially flat line or the balanced budget agreement projections for this year.

Mr. STEARNS. Does it include laying people off? I heard Mr. Farsetta indicate it costs \$40,000 an employee, and that turns out to be \$340 million if his math is right. Mr. Farsetta, I am just wondering where we are going to get the money to even lay off the 8,500 people.

First of all, do you agree it is going to cost \$40,000 a person to lay a person off, just "Yes" or "No"?

Dr. GARTHWAITE. Yes. There are significant expenses. I don't know if they are 40,000, but it is in that range. There is a cost of doing a RIF.

Mr. STEARNS. Okay. Is there any intention to try and consolidate and to lay off these people or do you agree that we should lay them off? Just "Yes" or "No," do you think we should lay off 8,500 people?

Dr. GARTHWAITE. Well, obviously we don't believe we should RIF our employees if at all possible. There are probably a few places where downsizing makes some sense, but there are times when it doesn't make good sense.

Mr. STEARNS. Well, that is obvious.

Dr. GARTHWAITE. Right.

Mr. STEARNS. So you don't agree with the 8,500?

Dr. GARTHWAITE. I don't think we intend to log-off 8,500.

Mr. STEARNS. But do you have a number yourself? Do you have a number? Does the administration have a number itself that they think they should RIF to consolidate to save money ultimately to give more money to veterans? Is there any number you have on the table?

Dr. GARTHWAITE. We put forward in the budget the number of people, not necessarily RIF, that we would come down in total FTE to fall within the President's budget this year.

Mr. STEARNS. How many was that?

Dr. GARTHWAITE. That was the 8,000 number, I believe.

Mr. STEARNS. Okay. So do you intend to do that under this fiscal year? Under the next fiscal year?

Dr. GARTHWAITE. If that is the budget we get, yes.

Mr. STEARNS. So your answer is yes, you intend to RIF——

Dr. GARTHWAITE. No, not RIF.

Mr. STEARNS. To? What is your word?

Dr. GARTHWAITE. Decrease.

Mr. STEARNS. Decrease.

Dr. GARTHWAITE. Yes, or downsize, just reducing employment level by that amount.

Mr. STEARNS. Well, what is the difference between reducing employment level and RIFing?

Dr. GARTHWAITE. The bulk of our reductions over the past 5 years of 20,000 or so has been through attrition. People normally retire, and you just—

Mr. STEARNS. So you expect 8,500 in attrition, then?

Dr. GARTHWAITE. Well, I don't know whether it would all be attrition because attrition doesn't necessarily occur where you would like to try to gain the efficiencies and reengineer the processes.

Mr. STEARNS. Well, my time is expired, but I just hope that you are dreaming at night of some way to make this system superb and supreme and excellent. You know, I don't think you can be wishy-washy. I think you are going to have to be bold and you are going to have to take some political capital and you are going to have to do something because you are just drifting along. And you can blame it on Congress. I mean, that could be a strategy, what you are doing.

But it seems to me you have had 3 years to promulgate these regulations. You haven't done it. Your budget that came forward has been short. We are trying to get more money. One party wants more. We are trying to—even our leadership is reluctant to give us what we want. We want more.

So we understand the circumstances. But I think you have, so to speak, this Veterans' Affairs and you have all the resources to make this superb. And the budget is about \$48 billion a year total. That is a lot of money. And you are the CEO, so to speak, the administration.

So you can go in and do lots of enterprising things. I think if you invest the time and effort and tell the veterans, I don't think you are going to worry about the flak because the veterans and Congress, the administration want to make this system better, much better than it is today.

So a lot of us get a little frustrated to hear these sort of diffident cautious comments. I mean, we want something out of you folks to solve these problems. The VISN director out of Florida and Puerto Rico said 35 percent, you said the increase has been. How long can that go on? And how long could he not have enough services?

Let me welcome the ranking member, Mr. Evans. He left. He is gone. So I didn't get him quick enough. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

Dr. Garthwaite, I don't know whether to congratulate you or offer my condolences on your appointment to Acting Under Secretary of Health. And I hope you are not going to have any surprise announcements for us in the next couple of months.

I want to ask a number of questions. Your department's 1999 VERA report, the executive summary states that there was a September 1997 GAO report which indicated the VA needs to develop more timely and detailed indicators of changes in key workload measures and medical care practices to maintain VERA's ability to equitably allocate resources in the future and help ensure that veterans receive the most appropriate care.

Here we are July of 1999. It seems like we are still having some of the same problems with the collection of basic data, such as pri-

mary and specialty clinic appointment waiting times. Why is that? And what is being done to address that continuing problem?

Dr. GARTHWAITE. Well, I think we have lots more data and lots better data than we have ever had. The fact that there still are some gaps, there are millions of things to measure, and we don't measure everything yet or maybe even should we try to measure everything.

I think, as GAO mentioned, we have in place in our pilot testing a better measurement of waiting times. We used to estimate our waiting times by looking at our computer systems and seeing how long it was until there was a blank appointment.

It turned out that that wasn't as accurate as we had hoped. We found out that there were just a lot of technical reasons why that wasn't accurate. So we have gone back to the drawing boards to get more accurate data.

So it is not true we haven't measured waiting times, but through more scrutiny of the process and caring more about those waiting times and trying to take measures to address that, we became aware of some insufficiencies in that data. I think that is the way it is.

As we look at each piece of data and begin to use it to make decisions, we often find that it is somewhat lacking in its quality. And we have to go back and then reestablish the quality of the data. We have been hard at work in doing that and I think have made considerable progress.

I think the actuarial projections for enrollment were based on some real hard work that Dr. Pane and his folks did with the actuaries. And the fact that they were accurate I think is testimony that we are getting better at being able to project and to use data for decisionmaking.

You can ask any of the network directors here if they don't feel like they are barraged with data, but that is what we rate and rank them on and that is what we grade them on every year. We have very clear data standards that we think we are using to guide the system.

Mr. DOYLE. I am looking at your bureau brochure here, and it says "Network allocations are no longer based on historical funding patterns but on validated patient workload and adjustments for variances in labor costs, research, education, equipment, and NRN." Do you think that is an accurate statement?

Dr. GARTHWAITE. Well, yes. I think it is fairly accurate in the aggregate that we continue to try to perfect the VERA system as we learn more about it, but it is based on workload in the big sense of the number of veterans served in the basic categories of illness that they have.

We think there are ways to improve it, and we have continuous review and monitoring. And I think we have made some subtle improvements over the last couple of years.

Mr. DOYLE. In Dr. Kizer's well-known budget memo to Secretary West, the focus on managing the health care crisis was placed on the authority to right size and to do it sooner, rather than later. In your view, beyond increased funding levels—and let me just say that a lot of this responsibility sits with the Congress, too.

I, for one, am for breaking these goofy budget caps and putting more money into the budget. Now, that I don't think is a majority view on the House, unfortunately.

But putting increased funding levels aside, what other strategies do you think are most important for the VA to pursue if we are going to have a viable system in the future?

Dr. GARTHWAITE. I think we have been clear in the way we have tried to reengineer the VA health care system. We believe that we can't be totally dependent on our appropriated funds because of the pressures that the Congress faces in trying to balance the budget.

So we have asked for the opportunity to bring in additional resources, whether that is through the medical care cost recovery process or third party billings, whether that is partnering with the Department of Defense or whether that is seeing patients and receiving some reimbursement from the Medicare trust fund for care they choose to get at the VA, as opposed to another Medicare provider.

I think all of that begins to then align our ability to produce quality health care with reimbursement, which is a fairly common assumption that quality and funding should go hand in hand here in America. I think it would help very much with incentivizing the system in a proper direction.

Mr. DOYLE. How does the upcoming decision on Priority 7 fit in in the scheme of things?

Dr. GARTHWAITE. I think if you look farther down the road and if you said that a portion of our revenues come from reimbursed care, that people come to us because they choose to come to us and they bring money along with them, that the long-term health of the health care system depends critically on having those who can opt to see us, see us. It gives us the volume to see the patients who don't have the option. And I think that ends up being a critical piece. To run a health care system to serve the most needy, we must have the volume of patients needed to assure quality care when they come in.

So I think we do need both, even though our first priority must be to the ones who have no other choice or who come to us from entitlement as Service-connected veterans, but Mr. Ng's, comment I think is very well-taken in that regard. I think that maintaining volume is a key piece of that Priority 7 decision.

Mr. DOYLE. I see that my time is up. Thank you, Mr. Chairman.

Mr. STEARNS. The gentleman from Arkansas, Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman.

Dr. Higgins, since you represent the region that I am from, I just wanted to ask you a couple of questions. We spent a lot of time over the last several months using this amount of time that it takes a veteran to get an appointment as being almost like the key factor for how we are judging how you all are doing. Is that a fair measure? Are we making too much of that time?

For example, if I know as a veteran that it is going to be 3 months before I see a family doctor but it has been explained to me that any problems at all I had before then I can—a call would come in, go to the emergency room. Maybe that is not a big deal in the grand scheme of quality care. It is certainly something we hear about. I don't think waiting times should be very long, but is

it a fair assessment of how well you are doing for us to look at these waiting times?

Then the second thing is: What comments do you have about how difficult it is with regard to accurately assessing waiting times, waiting periods to get appointments? How difficult is that for your hospitals to do?

Dr. HIGGINS. Sir, it is very difficult. You are quite right. Sometimes when we have an intake examination for a new veteran who is not acutely ill, we will say, "Fine. Here are your prescriptions. We will see you back in 90 days," which will inflate our rate.

We also have always had the ability for a given doctor to get on the phone and call the cardiology clinic or the orthopedic clinic and say, "I have got a veteran who is really ill and needs your help right away." And he would be worked in.

Nevertheless, we do realize that from time to time in different clinics at different hospitals, we do experience delays. And we monitor that monthly.

I noticed between January and June of 1999, we have slightly increased in the percent of veterans who have to wait more than 30 days from 20 percent to 22 percent. I am not certain if that is a statistically significant increase, but it is one that is of concern to us.

We have also experienced some bolus types of effects. Last year our prosthetic orders in just a short period of time rose by 25 percent. In response to that, we fell behind and had an increase in our delays. It took us about 3 months to re-equilibrate.

That is what you see going on at all of the hospitals. I know at Little Rock, they were having trouble with the eye clinic and worked with the university to add an extra ophthalmologist, which I think has solved that problem. But next week it will be orthopedics or urology. It is something we just have to keep after.

I think one of the things where we are probably not very good is explaining to the veterans, "Look, I am going to make your ophthalmology appointment 6 months from now, but that is fine. That is consistent with your medical needs. You don't have any urgent problems." So I think maybe communications with the veterans is one of the key things we need to improve on.

Dr. SNYDER. And, Dr. Garthwaite, I wanted to ask about some of the process for the budget. You and I have talked before. I don't think anybody has been very satisfied with how this whole budget process has gone this year.

The Chairman acknowledged that once this number is set and the number comes out here, then it is very difficult even for the leadership of his party that runs the place to somehow adjust that number because once the President's number is set—do you have any specific suggestions about how our process might be done differently so we don't have to repeat this experience next year?

I am convinced that we are going to do the best we can with adding money to the number, but we would just as soon not have to go through such a wrenching experience to get there.

For example, the August number seems to be problematic for you. Are there things that we should be changing to make it easier while we are going through this budget process or have you thought that through much?

Dr. GARTHWAITE. I can't say I have thought it through exceptionally well. I think, at least internal to the administration, I have already taken some steps to try to improve our communication early on with the Office of Management and Budget so that we have substantive discussions as early as possible.

I don't know whether that will help, but I don't think it can hurt. It is usually the press of time and lack of getting to the common understanding that is the hardest thing to do.

Dr. SNYDER. This wouldn't really be with regard to the specific processes, but I think the Committee members always find it helpful to have a panel of either VISN directors or hospital administrators. Does anyone at OMB have that kind of a sit-down session? I would guess that they probably don't.

Dr. GARTHWAITE. I don't know that we have done that specifically with OMB.

Dr. SNYDER. That may be one of those worthwhile things to do——

Dr. GARTHWAITE. Yes.

Dr. SNYDER (continuing). When you all go meet with them to stake in some people where rubber meets the road so they can hear some of those discussions. My impression is that everybody in town now wants to do something different. It is just: How do you get to do that once the numbers have been set and we have got a budget resolution? We ought to try to head that off in the future.

Thank you all for being here today.

Mr. STEARNS. I thank my colleague.

You know, Dr. Garthwaite, in your opening statement, you talked about good news and bad news. The good news is we are having more patients, we are taking care of them. Of course, you acknowledge the fact that we have a shortfall.

But if you are going to be in this position, I submit that you are going to have to create a clarion call for more money and you are going to have to be a motivating impetus. We on the Congress side will do it, but we have to work together to get more money for veterans. We can't give politically correct answers all of the time. We are going to have to reach out and do something and just can't let this thing wander on.

Your word "challenging" I think is too euphemistic. I think we have a serious problem here that all of you should be concerned about. And you are all getting paid. You are all executives.

Fortune magazine had an article on CEOs that failed their corporation and their stockholders. One of the problems was these CEOs did not execute. They knew the problem. They knew what to do, but they just didn't do it.

And so I call on you this morning, all of you, to have in place a scenario for a shortfall and to try to make the hard decisions because if you don't make them now, they are going to get harder and harder and harder.

So I think my closing comments are that there has been some failed leadership here, to plan adequately for these potential serious budget shortfalls. GAO has testified that in that contingency, VA must move quickly to use the enrollment system. But there are no regulations in place and the proposed final regulations do not

provide the flexibility the Congress gave the VA to use enrollment carefully, to minimize its potentially harsh impact.

Mr. Backhus suggested ways that that could be done, but VA's proposed final regulations do not address the budget shortfall contingencies at all.

So I think what we have here this morning is a problem. We need leadership. You have to have the contingency plans in place. And if Secretary Togo West says, "We are going to take care of all of the veterans" and all of you VISN directors say, "Oh, yes, we are going to do it," it is a game. Nothing is going to get done. You are not going to take them. You don't have the funds. So why are we all kidding ourselves?

I mean, the veterans can figure this out. The public can figure this out. So we have got to come together here with some real creative solutions and work together, instead of just saying it is challenging and that we will take care of it, no matter what the shortfall is. You have got to have the contingency plan in place.

You have got to implement the enrollment regulations. And you have got to come back to us and push us. I mean, that is your job, Dr. Garthwaite. If I were in your position, I would be pushing Congress, asking for stuff all the time. Do you know what I mean? I wouldn't be sitting there saying the word "challenging." I mean, I would really be involved, you know.

You have got a lot of education. You are a smart man. You can't just sit in a corporation and just let this boat just float out to sea and nothing happen and everybody says, "There is no problem." There is a problem. We have got to come about. We have got to get this thing engaged and working. So that is just my way of saying that I think we have got to work harder for veterans.

I thank all of you for your time. You are very kind to come here this morning and patient. I appreciate your opening statements, and I thank my colleagues. The subcommittee is adjourned.

[Whereupon, at 11:41 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. LUIS GUTIERREZ

Thank you, Mr. Chairman. I am pleased that we are here today to discuss the patient enrollment system in the Department of Veterans Affairs. I am eager to hear the testimony from our witnesses and I thank them for joining us. I would also like to extend a special welcome to Dr. Garthwaite, who appears before us for the first time in his new capacity as Acting Under Secretary for Health.

In 1996, as part of a major reform of VA health care eligibility rules, Congress directed VA to establish a patient enrollment system to give VA the ability to gauge the size and composition of the patient population it could serve with appropriated funds. The Veterans' Health Care Eligibility Reform Act of 1996 was enacted to equip VA with ways to provide veterans with medically needed care in an equitable manner, to the extent funding permitted, by enrolling and treating those veterans who have the greatest need for care. Veterans were classified in one of seven "Priority Groups."

This law specified that veterans with a service-connected disability rated fifty percent or more had the highest priority for enrollment and were placed in Priority Group 1. Veterans placed in Priority Groups 2 through 6 had lesser service-connected disability or were still eligible due to other circumstances such as income or exposure to radiation or Agent Orange.

Last year, VA opened enrollment to all veterans. As expected, this created discrepancies in the delivery of care among the VA's twenty-two VISNs. While some networks tried to attract new Category C patients to improve their operating efficiency, other networks already working to capacity tried to minimize or avoid taking on these new enrollees.

The policy of enrollment for all veterans also created a dilemma due to the VA's budget constraints. Some networks experienced long waiting times and high enrollment of Category C patients while others did not. This situation is not expected to improve considering the woefully inadequate budget that the Department of Veterans Affairs is likely to receive for the next fiscal year. A potential shortfall of approximately \$1.4 billion under the President's budget would almost definitely require disenrollment of veterans in Priority Groups 5 and 6.

Mr. Chairman, some veterans tell us they were misled because they were told that they would receive health care for life. Now, Priority 7 veterans are receiving letters from Kenneth Clark, VA Chief Network Officer, which read as follows:

"You are in enrollment Priority Group 7. For this fiscal year (through September 30, 1999), we are enrolling veterans in Priority Group 7. However, we cannot assure you that VA will be able to continue your enrollment after September 30, 1999. For that reason, we strongly recommend that you retain any health insurance you may now have . . . In two to three months, VA will be making decisions about whether Priority Group 7 will be eligible for VA care for the next fiscal year (October 1, 1999, through September 30, 2000). We will notify you as soon as possible if we are unable to continue your enrollment."

Mr. Chairman, I believe that we must establish clear definitions about who is and who is not eligible for VA health care. Veterans are being misled about what, if any, health care they will receive. I will repeat, as I have stated time and again, that we have a moral obligation to adequately fund the VA budget for the upcoming fiscal year. Increasing the budget will ensure that all veterans receive the care they were promised when they stepped into uniform.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. MICHAEL F. DOYLE

Thank you Mr. Chairman. I want to extend my appreciation to you for convening this morning's hearing to discuss VA's experience in implementing patient enrollment and to more closely examine the intended and unintended consequences it has produced throughout the 22 VISN structure. I also want to recognize the thoughtful approach that Chairman Stearns and Ranking Member Gutierrez have employed in the sequencing of, and selection of subject matter for, our Subcommittee's hearing schedule during this session. Not only have our Subcommittee's hearings focused on the most critical issues confronting the VA healthcare system, but we have considered these issues in a deliberative and logical manner.

In many ways, the topic of enrollment embodies all of the complex questions that must be posed when one looks at the juxtaposition of the need for veterans' healthcare and the actual delivery of services. And in essence this juxtaposition is reflective of the larger quandary of the level of funding that the VA healthcare system needs and the level of funding it receives. As I am sure we would all acknowledge, the future of the VA healthcare system is precarious and in the absence of adequate funding we will have to increasingly turn to "planning tools" such as the enrollment system we have gathered to discuss this morning. But I would emphasize that in many respects the enrollment system has turned out to be not so much a way in which to plan better to meet demands, but a way in which to ration healthcare and further pit one veterans' needs against another's.

Fundamentally, the very fact that discriminating enrollment decisions have to be made connotes the pressure to artificially establish a balance between VA healthcare supply and demand. In doing so, the delivery of healthcare services is not being determined on the merits of medical necessity, but on cost. Thus, enrollment decisions more than any other indicator clearly illustrate where the rubber hits the road in the system. Given the current debate surrounding the need to reform HMO's, I have to wonder when we might be discussing the need for a veterans' healthcare bill of rights. I have been an advocate for providing adequate funding for VA healthcare, so I sympathize with those who must increasingly find creative means by which to beat veterans with dwindling resources. But we must make certain that creative means are thoroughly thought out, as well as implemented, monitored, and analyzed in a systematic and sound manner. We must however, guard again number juggling schemes that present themselves under this guise. I am anxious to hear more about how the VA's enrollment decisions relating to Priority 7 veterans fares against these concerns.

I am looking forward to the testimony of our distinguished panelists and will reserve raising further concerns until members have the opportunity to pose questions.

Again, thank you Mr. Chairman.

Statement of
LANE EVANS
Ranking Democratic Member
House Committee on Veterans Affairs

Subcommittee on Health
VA's Experience with Enrollment
July 15, 1999

Mr. Chairman, thank you for holding this important hearing today. VA has now had about a year's experience with enrollment and our goal today is see how it's going. But it's more than that...it's about budget priorities and the future direction of a unique veterans' health care system. Decisions about which veterans the system enrolls and treats are at the core of this debate.

About a year ago, VA advised my staff that the Under Secretary for Health had decided to enroll Priority 7 veterans for health care for FY 1999. At that time we had little information about how VA had reached this important decision and it represented a fairly radical departure from the way VA had previously granted discretionary veterans access to the system. Up until that point VA allowed the various medical centers to decide if they had space or resources available to treat these veterans. Many medical centers had made the decision not to treat what statute defines as "discretionary" veterans.

A couple of months later, armed with more information, but still unclear about the basis for the decision, Chairman Stump and I asked the General Accounting Office to determine how VA had made its choice and whether, in light of scarce resources, it was the right one to make. Few important decisions are ever clear cut and I don't believe that VA's decision about whether to treat Priority 7 veterans in fiscal year 1999 was an easy one. After a year of deliberation, I still don't know whether VA made the right choice, but I do know that there have been consequences—both good and bad—because of it.

I represent a district in Western Illinois that is predominantly rural. For many of the veterans in my district, a significant travel time to VA health care has been routine. Many veterans travel to Iowa City VA Medical Center which is part of one of the smallest and most rural networks in the country, Central Plains Network, to acquire services. I asked Chairman Stearns to invite my friend, Vincent Ng, who is that network's director, to discuss his perspective on enrolling Priority 7 veterans in that network. I appreciate the Chairman's willingness to do

so. I suspect that Mr. Ng and other directors in rural parts of the country may share my concern that VA needs larger veterans' populations that include discretionary veterans in order to maintain viable VA health care facilities. This is true in some areas now and, as veterans age, it will be true in more areas in the not-too-distant future.

On the other side of the argument, the VA's budget has had no real growth in the last four years. If VA is compelled to deal with the budget that's been proposed for FY 2000, it will be hard pressed to treat even the veterans in higher priority groups. We have already seen indications that the system is under stress—waiting times have grown unreasonable in some areas and some VA clinicians allege that certain treatments are already being rationed and the quality of care overall is being compromised because of staffing and other resource shortages. We have seen drastic reductions in some types of care, particularly long-term care and mental health services. Any Economics 101 student understands that in a world of limited resources you must control supply or demand. In VA, this means, it must either reduce services or reduce the demand for them by limiting those VA enrolls for a full package of health care benefits.

Most veterans want VA to continue offering care to all veterans, and I share their desire. After all, these veterans served their country honorably in war and in peace. I would like to preserve VA enrollment as an option for Priority 7 veterans, including myself! I do believe veterans in this group should be willing to reimburse VA for their care, rather than relying on scarce appropriated dollars to fund it. Right now VA is likely eroding the value of appropriations to serve these lower priority veterans. VA clearly could make vast improvements in obtaining accurate insurance information from veterans, and in billing and collecting for this care. If VA could collect the same amount of dollars for VA's care for higher priority veterans that it spends for the care it delivers, it might be possible to offer them care without compromising higher priority veterans' access to care. VA has certainly not maximized its opportunity in this regard.

In the past, VA has argued that its costs of delivering this care were marginal. If that was the case in earlier years when VA had more staff, more beds, and fewer veterans to treat, it certainly does not seem to be now. We will hear testimony from the General Accounting Office that indicates that many network directors believe they have reached the limits of their capacity and that all have experienced new demand due to changes, not only in enrollment, but to Community Based Outpatient Clinics and the impact of eligibility reform. It seems clear that they may be stretched to the limit in many places.

If limited resources compel VA to decide between maintaining a system that can deliver a full-continuum of high-quality health care services to fewer veterans or offering queues, rationing and substandard care to many, I would choose the former. I hope Congress and VA can collaborate on this matter to find a creative solution to best meet the needs of veterans and the system. I look forward to the candid statements of our expert witnesses this morning.

Opening Statement of Congressman Howard P. "Buck" McKeon

July 15, 1999

Mr. Chairman, I am pleased to speak today on this extremely important topic. The enrollment issue facing our Veterans, the Department of Veterans' Affairs (VA), and also Congress are among the most important that we must address in the coming months and years.

I think it is important that I begin by explaining that I was made aware of this problem, not by the VA, but instead by a constituent who informed me that he was told that his benefits were either going to be cut drastically or not offered at all. He then went about telling me how he was a priority seven veteran and that he was told this by the VA. Finally, he explained to me that his benefits were being cut because Congress instituted the "reform" legislation and now were not following through on the funding side of the issue. This was also told to him by the VA.

I found this interesting and decided to check it out further. I was informed by the Health Subcommittee staff that indeed this was possible that my constituent's concerns could be correct that his benefits could either be drastically reduced or eliminated as a priority 7 veteran. They explained that indeed Congress did create "reform" legislation about the classification of veterans. However, this seemed to be where the stories of the VA and the Committee stopped.

The Committee then went on to explain the VA's actions on the implementation of the enrollment reform. To begin with the VA was required to establish regulations on implementing this enrollment. To date, the Secretary has not. Furthermore, the VA was required to consider enrollment with an eye toward the budgetary concerns. The VA's response was to open enrollment to all veterans without concern of actually paying for it.

As such, the debate about enrollment in fact is all about the budget. I find it interesting that the VA is claiming to many veterans that they are not going to be able to afford to provide benefits because Congress is not appropriating enough funding for the VA. Either the VA has a short memory span or they are misleading veterans or they are misleading Congress, but make no mistake, the VA is not telling someone the truth. For it was not Congress that has recommended a flat lined budget for the VA. In fact, only two members of Congress seemed to support the proposal of flat lining the budget for the VA. No, it was the President who offered this budget and it was the Secretary of the VA who testified in support of this budget. Now it seems that the VA has either realized in five months that their own Department will be between \$1 and \$3 billion below what is needed for Veterans or they are either misleading Congress or veterans or both.

However, make no mistake about it, Mr. Chairman, the VA is not explaining the truth. I voted for a budget earlier this year that called on an increase of \$2 billion for America's Veterans. I chose to vote against the President's flat line option. However, the VA apparently wants to have its cake and eat it too. They want to tell the Veteran that they want to provide him or her the benefits they deserve, but they don't want to have to bring to the table a legitimate offer of how to pay for it. Instead, they would rather tell the Veteran its anyone's fault but their

own and get them to blame their Representative for something that is clearly not true.

Mr. Chairman, its high time that the VA stand up and take some responsibility. Its time the Secretary of the VA explained to the American Veterans that in fact it was the VA that have not promulgated the regulations for enrollment. Furthermore, it is time that the VA stand up and explain to the Veterans that it is not Congress that opened the doors of enrollment without any thought to being able to provide the benefits they were promising. It is also time that the VA start talking straight to the veterans of this nation and inform them of what they have asked for in terms of budgetary needs. Finally, it is time for the VA to bring about rules for this program, implement the program to the intent that Congress had requested.

Mr. Chairman, I have enclosed a number of questions for the record that I would appreciate an answer by the witnesses that have come before this Committee. I thank you and the Ranking Member for holding this hearing and I look forward to future hearings on this matter. If the past is any indication of the future with the development of the Millennium Health Care Act, I am certain that we will see the needed legislative solution to this problem.

Questions (directing to any or all witness who cares to answer):

1. Has the Secretary of Veterans' Affairs actually promulgated the rules as required under the enrollment reform legislation?
2. Did the Department of Veterans' Affairs enrollment decisions factor into the budgetary request made by the President earlier this year?
3. Does the Department of Veterans' Affairs have plans to promulgate rules in the near future?
4. Did the Department of Veterans' Affairs consider the view point of the VSN directors when they were enrolling veterans and also considering their budgetary needs in light of this enrollment?
5. Is the Department of Veterans' Affairs tell veterans that their benefits were going to be cut if Congress did not allocate more funding? If so, why has the Secretary repeatedly told Congress that the President's request for a flat lined funding will adequately cover all veteran needs? If not, are the veterans who are contacting me are not telling an accurate statements when they say the Department of Veterans' Affairs are telling veterans that their benefits will be cut if Congress does not increase the VA budget?
6. If the Department of Veterans' Affairs continues to enroll veterans at the pace they are now without promulgating rules and also Congress allocates anywhere between \$1.5 and \$2 billion in increased funding for the Department of Veterans' Affairs, will the Department still be able to offer either priority 7 veterans benefits or continue to offer the current level of benefits to the other priority levels? In essence, a best case scenario of funding for the Department would require how much of an increase in funding to continue to offer the same level of benefits to veterans if enrollment remains the same?

GAO**United States General Accounting Office****Testimony**

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

For Release on Delivery
Expected at 9:30 a.m.
Thursday, July 16, 1998

VA HEALTH CARE**Progress and Challenges
in Providing Care to
Veterans**

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division



GAO/T-HEHS-99-158

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) new system for enrolling veterans for health care. Historically, VA's health care system was a network of hospitals established to provide specialty care to veterans with injuries or conditions directly resulting from their military service. Over time, eligibility was expanded to provide both inpatient and outpatient care to low-income veterans for conditions not directly resulting from military service—establishing VA's role as a safety net provider for indigent veterans. VA typically provided inpatient hospital care to these veterans and restricted outpatient care by linking it to inpatient admissions. VA also had different eligibility rules for care, based on veterans' degree of injury or condition directly resulting from military service.

The Veterans' Health Care Eligibility Reform Act of 1996 was enacted to equip VA with ways to provide veterans with medically needed care in a more equitable and cost-effective manner. The act required VA to establish a system for enrolling veterans for health care and to use this system for managing delivery of services. VA is to annually enroll veterans according to seven priority groups established by the act—with the highest priority given to veterans with significant service-connected disabilities. VA is also required by the act to enroll only those veterans for which it has sufficient resources to provide timely health care. For fiscal year 1999, VA decided that it had adequate resources to enroll veterans in all seven priority groups; by August 1, 1999, VA will decide which veterans it will enroll in fiscal year 2000.

A number of stakeholders, including Members of this Subcommittee, have raised concerns about VA's basis for offering enrollment to veterans in all seven priority groups and whether VA's budget was sufficient to provide care to these veterans. These stakeholders also raised concerns about the basis that VA would use in deciding which veteran priority groups to enroll in fiscal year 2000. To the extent data are available, you asked that we evaluate the effect of VA's decision to enroll all veteran groups in fiscal year 1999 on veteran demand for health care and the timeliness of that care. You also asked us to identify the challenges and options VA has in making its fiscal year 2000 enrollment decision. My remarks today are based on information we received from VA headquarters, contractors, and Veterans' Service Organizations as well as surveys of all 22 directors of VA's Veterans Integrated Service Networks (VISN).

In summary, since implementing its enrollment system at the beginning of fiscal year 1999, VA has enrolled about 4 million veterans and, according to VA's latest enrollment data, its health care expenditures for these enrollees are on track with VA's projections.¹ However, each of the 22 VISN directors we surveyed told us that demand for care has increased in fiscal year 1999 and that this increase has affected the delivery of timely care to veterans in some VISNs. Eighty percent of the directors we surveyed said that the waiting time to schedule primary and specialty care appointments has increased since the beginning of fiscal year 1999. While 18 of the 22 directors told us that enrollment was a factor to some extent in the increased demand, 13 cited the expansion of health care benefits and 12 cited additional VA outpatient clinics as other factors contributing to this increased demand. In addition, 8 of the 22 VISN directors reported that VA's decision to open enrollment to all veterans has negatively impacted access to care for veterans in higher priority groups to some extent. Nine told us that they had less than adequate capacity to meet the increased demand, and five directors, believing that their VISN's capacity to deliver health care was limited, chose to limit outreach efforts that would attract new veterans into the VA health care system. This, in turn, has created uneven access to care by making care available to veterans in some locations but not in others.

¹Prior to fiscal year 1999, VA did not enroll veterans in its health care system. Therefore, VA tracked only the number of patients it served, not those that might seek care in the future.

As VA nears its fiscal year 2000 enrollment decision, VA's ability to continue its current level of care—or to enroll more veterans—is unlikely, primarily because its fiscal year 2000 budget request is based on, in our view, an overly optimistic assumption that it will realize \$1.4 billion in management efficiencies. In prior testimony before this Subcommittee, some VISN directors stated that they will have difficulty achieving these management efficiencies; all of the 22 directors we surveyed told us that they anticipate having problems meeting veteran demand for health care in fiscal year 2000. If VA does not have the resources available to continue to enroll veterans in all priority groups in fiscal year 2000, it will need to consider limiting health care eligibility to only those veteran priority groups or subgroups to which VA can provide timely care, as the act requires; modifying the benefits it offers to all enrollees; or both. VA may have difficulty determining the financial effect of these options because its data on treatment costs and veteran income levels are insufficient. Although VA has efforts under way to improve its data, it is unlikely that these improvements will occur in time for VA's fiscal year 2000 enrollment decision.

BACKGROUND

The Eligibility Reform Act was enacted to help VA improve its management of care and provide this care in more cost-effective ways; it also sought to increase veterans' equity of care. To improve cost-effectiveness, the act allowed VA to provide needed hospital care and health care services to veterans in the most clinically appropriate setting—including care for conditions not directly resulting from military service. To administer this care locally, VA established, in fiscal year 1996, 22 regional VISNs to serve as the basic budgetary and decisionmaking units for how best to provide services to veterans within these VISNs' geographic boundaries.

To improve VA's management of health care, the act required VA to establish and implement a national enrollment system. VA is to use this system as a tool to manage veterans' access to care through the seven priority groups established by the act; each year, VA must decide which of these priority groups it can afford to enroll so that it can provide timely care. VA is also required to maintain capacity for veterans with special disabilities, including spinal cord injury, blindness, amputation, and mental illness. If VA decides it cannot enroll veterans in all priority groups, veterans in the lowest groups—beginning with priority group 7—would not be offered enrollment. Table 1 summarizes the seven veteran priority groups.

Table 1: Seven Veteran Priority Groups

Priority group	Eligibility criteria
1 (highest)	Veterans with service-connected conditions resulting in disability of 50 percent or more
2	Veterans with service-connected conditions resulting in disability of 30 to 40 percent
3	– Veterans with service-connected conditions resulting in disability of 10 to 20 percent – Former prisoners of war – Veterans discharged from active duty for a disability incurred or aggravated while on active duty – Veterans with special eligibility classification
4	– Veterans receiving aid and attendance or who are housebound – Veterans with catastrophic disability
5	Veterans with incomes below the means-test threshold (currently, \$22,361 for single veterans and \$26,824 for veterans with one dependent)
6	– World War I and Mexican-border veterans – Veterans receiving care for radiation or toxic substance or environmental hazard exposures
7 (lowest)	All other veterans who agree to pay established copayments (that is, veterans who have non-service-connected disabilities and/or noncompensable 0 percent service-connected disabilities above the means-test threshold)

Note: Groups 1 through 6 were covered under VA's former health care system. Veterans under group 7 were only covered when space and resources were available. Under the new enrollment system, VA has offered care to all veteran priority groups for fiscal year 1999.

To ensure that all enrolled veterans have access to the same level of health care, VA has expanded its health care benefits by offering a comprehensive and uniform benefits package to all enrollees. VA's 22 VISNs administer these benefits, and each has the flexibility to decide where and how medical care is provided—through in-house services, contracts, or other arrangements. Through this benefits package, enrollees are eligible for any medically necessary outpatient or inpatient care that (1) will promote, preserve, or restore health; (2) has been prescribed by a VA clinical care provider; and (3) is consistent with generally accepted standards of clinical practice. Once enrolled, veterans can receive care, regardless of their priority group.

The act specified that, after October 1, 1998, VA may not provide hospital care or medical services to veterans unless they are enrolled in VA's health care system. VA began accepting applications for enrollment in October 1997, as a test period, and officially began enrolling veterans on October 1, 1998, as mandated by the act. Veterans who had used the VA health care system in the previous year were automatically enrolled.² Further, veterans who meet the following criteria do not need to enroll: (1) veterans with a service-connected condition of 50-percent disabled or more; (2) veterans seeking care for a service-connected condition; and (3) veterans

²VA defines these veterans as "past" enrollees, since they have used VA health care since 1996. In contrast, veterans who have not used VA health care since 1996 are defined as "new" enrollees.

discharged from active duty for a disability within the prior 12 months but who have not yet received a disability rating from VA.

Veterans may enroll in person or through the mail. When completing the one-page enrollment application, veterans choose a primary care provider employed by VA. Once enrolled, veterans receive a letter from VA confirming their enrollment. VA uses a "rolling" enrollment system, meaning that veterans may submit an application for enrollment at any time and are generally enrolled for the duration of the fiscal year.

In making its decision to offer enrollment nationwide to veterans within the seven priority groups for fiscal year 1999, VA estimated the number of veterans who would enroll, their need for services, the portion of services they would seek from VA, and VA's expenditures to provide these services under its Uniform Benefits Package. VA then compared its estimated expenditures for the Uniform Benefits Package to the anticipated funding and concluded that it could afford to offer enrollment to veterans in all priority groups.³

VA'S FISCAL YEAR 1999 ENROLLMENT DECISION AND OTHER FACTORS INCREASED VETERAN DEMAND FOR CARE AND WAITING TIMES IN SOME LOCATIONS

Since implementing its enrollment system, VA has expanded its health care services and locations of care to increasing numbers of veterans. Halfway through the fiscal year 1999 enrollment year, VA is generally on track with its projections of enrollee demand for health care and its expenditures on these enrollees at the national and VISN levels; VA has spent about half of its \$14.1 billion available to fund the Uniform Benefits Package. Table 2 shows VA's most recent data on the number of enrollees and users and the associated costs for each by priority group for the first 6 months of fiscal year 1999.

Table 2: Number of Enrollees and Users and Associated Costs by Priority Group, October 1998 Through March 1999

Priority group	Total number of enrollees	Number of users	Cost per user ^a	Total costs
1	443,134	362,240	\$4,514	\$1,635,117,425
2	297,480	205,256	2,394	491,465,728
3	532,913	329,059	2,216	729,292,271
4	120,398	94,786	11,733	1,112,088,333
5	1,378,924	1,047,098	2,679	2,805,336,809
6	58,678	27,095	1,542	41,767,687
7	486,260	243,080	2,629	316,213,510
Unprioritized	685,921	141,253	1,991	281,186,735
Total	4,003,708	2,449,867	\$3,026	\$7,412,468,498

^aTo determine the cost per user, VA divided the total costs by the number of users.

Source: VA's Office of Policy and Planning.

³VA is required by the Eligibility Reform Act to report on its experience in implementing certain sections of the act, including management of health care. Although the report for fiscal year 1999 was due by April 1, 1999, VA expects to issue this report by July of this year.

VISN directors told us that, during this time, veteran demand for health care services has increased in all 22 VISNs. While 18 of the 22 directors told us that the decision to offer enrollment to all veterans was a factor in the increased demand, 13 directors cited the expanded health care benefits and 12 noted the additional VA outpatient clinics as factors contributing to this increased demand.⁴ One VISN recently applied for and was granted supplemental funding from VA's National Reserve Fund, in part, to help meet veteran demand for health care.⁵

VA conducted activities at a national level to inform veterans about enrollment. After VA made its decision to offer enrollment to all veterans, however, several VISNs expressed concerns about potentially excessive demands on capacity.⁶ Similarly, 9 of the 22 VISN directors we surveyed told us that given their present level of demand, the facilities within their VISN had less than adequate capacity to meet this demand. Over two-thirds of the 22 VISN directors told us they made moderate efforts to inform veterans about enrollment, but 5 directors made small or little to no effort—believing they had less than adequate capacity to meet the increased veteran demand for health care. By making care available to veterans in some locations but not in others, access to care is uneven.

The Eligibility Reform Act requires VA to ensure that enrollees receive timely health care. However, 17 directors told us the waiting times to schedule primary care have increased since the beginning of fiscal year 1999, and 16 directors told us that the same had occurred for specialty care appointments. In addition, VA's guideline states that new patients wanting routine care—that is nonemergent and nonurgent—and specialty care patients will receive appointments within 30 days. However, information we obtained from two VISN directors suggests that VA is not always meeting these timeliness standards. For example, one VISN director told us that veterans have to wait 150 days to obtain a follow-up appointment with a primary care provider and that the waiting time for specialty care appointments exceeds 30 days on average. Another VISN director told us that some veterans must wait more than 40 days to obtain primary care and between 50 and 100 days to obtain specialty care. Further, 8 VISN directors told us that VA's decision to offer enrollment to veterans in all seven priority groups has reduced access to care for higher priority veterans (priority groups 1 through 4) to some extent.

In addition to surveying VISN directors, we also spoke with representatives of Veterans' Service Organizations, such as the Paralyzed Veterans of America and Disabled American Veterans, to obtain their views on the timeliness of veterans' health care. Like some VISN directors, these representatives expressed concerns about increased waiting times for veterans—especially those waiting to see specialty care providers. For example, according to a representative of the Paralyzed Veterans of America, veterans had to wait 3 to 5 months to obtain orthopedic or urology appointments at one VA medical center.

⁴To enhance primary care access, VA has over 1,000 primary care teams at large medical facilities and opened over 183 outpatient clinics. These clinics provide primary care closer to veterans' homes, especially those living in underserved areas. Currently, VA plans to open 272 community clinics in fiscal years 1999 and 2000 and expects to open about 200 more by fiscal year 2003.

⁵This fund was established to provide a source of funds during each fiscal year for unanticipated needs in VISNs or in headquarters-administered programs. The initial source of these reserve funds is the annual appropriation to the Medical Care account.

⁶Department of Veterans Affairs: Veterans Health Administration, Office of Communications: VA Eligibility Reform, VISN Outreach Programs and Initiatives, Survey Report, prepared by Loudon Associates, Inc.; Jan. 3, 1999.

Currently, VA does not gather and track information on primary and specialty clinic appointment waiting times. However, it is designing a system to collect this information and testing is under way at four medical centers. VA expects to install software for this system at all of its medical centers by the end of August 1999 and to generate its first report on waiting times by September 1999. We plan to monitor VA's efforts to measure veteran waiting times.

BUDGET AND OTHER CHALLENGES CONFRONT VA IN MAKING ITS FISCAL YEAR 2000 ENROLLMENT DECISION

To provide timely notification to veterans, VA must decide soon who it will enroll in fiscal year 2000. VA is facing budget constraints for fiscal year 2000 that may limit its ability to enroll and fully serve all priority groups, as it did in fiscal year 1999. Recognizing this potential dilemma and its need to realize savings in the short-term, VA is exploring two options to manage the delivery of health care within its proposed fiscal year 2000 budget request: (1) limit health care eligibility to only those veteran priority groups or subgroups for which VA can provide timely care or (2) modify the benefits it offers to all enrollees. However, VA may have difficulty calculating the cost savings it could achieve through these options due to some data limitations. Further, VA will not know what its fiscal year 2000 appropriation will be until after it makes its enrollment decision in August.

VA's Budget Dilemma in Fiscal Year 2000

As we testified in April 1999, VA will be severely challenged to serve all veterans seeking to enroll in fiscal year 2000 within its proposed budget.⁷ This is primarily because the budget is based on, in our view, an overly optimistic assumption that VA will realize substantial savings through management efficiencies in fiscal year 2000. In addition, VA may have underestimated the cost of treating veterans with hepatitis C.

VA estimates that it will need \$19.23 billion—\$870 million more than its estimated fiscal year 1999 spending level of \$18.36 billion—to maintain current service levels in fiscal year 2000 if no management efficiencies were realized. This \$870 million difference primarily involves payroll increases for existing employees, inflation, and other mandatory rate changes. In addition to these increases, VA plans to use another \$525 million to enhance services provided to veterans. In total, VA will need to reduce other expenditures by nearly \$1.4 billion to effect these increases.

In general, VA estimates that it could save about \$514 million of this \$1.4 billion in personal services savings. To reach this level of personal services savings, using VA's average cost of \$60,236 per full-time equivalent, VA would need to reduce its employment level by 8,529 full-time equivalents. This is significantly higher than the reduction of 3,606 that VA achieved in 1998 and the 2,518 reduction that VA expects to achieve in 1999. Further, VA needs to achieve the employment reduction of 8,529 before fiscal year 2000 starts, less than 3 months from now. If VA does not achieve this reduction until after the beginning of fiscal year 2000, it will have to eliminate even more positions in order to meet its savings goal. VA estimates that the remaining \$876 million in efficiencies will be achieved through savings in nonpersonal services, such as prosthetics and pharmaceuticals. This, too, could prove challenging, given the rapid increases in demand for these services. If VA is unable to meet its employment reduction goal, it will have to increase nonpersonal services savings beyond this target level.

Although all VISNs have prepared a plan indicating the strategies and actions they may have to take to realize management efficiencies, some VISN directors have expressed concern about their ability to achieve these required efficiency savings. At a hearing

⁷Veterans' Affairs: Progress and Challenges in Transforming Health Care (GAO/T-HEHS-99-109).

before this Subcommittee in February 1999, two VISN directors stated that these efficiency savings in VA's fiscal year 2000 budget would require significant furloughs of employees. Further, two VISN directors told us that they believe that the cost savings achieved from transitioning care from costly inpatient hospital settings to less costly outpatient settings are approaching their maximum and that many VISNs have exhausted their efficiency options. All 22 VISN directors told us that they will have difficulty meeting veteran demand for health care services in fiscal year 2000 if VA continues to offer enrollment to all veterans. As a result, VA may not be able to offer the same level of care to veterans in fiscal year 2000 as they have been providing. Nonetheless, 11 VISN directors told us that they are generally in favor of offering enrollment to all veterans again in fiscal year 2000, for varying reasons.

Further, VA's fiscal year 2000 budget submission may have underestimated the cost of treating veterans with hepatitis C. For example, VA's budget submission included \$135 million to expand treatment of veterans who have hepatitis C, based on an assumed prevalence rate of 5.5 percent among the veteran population. However, VA's most recent estimate of the prevalence rate is 8 to 10 percent. According to a VA official, if an 8-percent prevalence rate proves accurate, it may cost VA \$100 million more than it previously estimated to provide services to veterans with this disease.

VA Enrollment Options and Information Challenges

Recognizing the potential budget dilemma for fiscal year 2000 and its need to realize short-term financial savings, VA is exploring two principal options to manage the delivery of health care. The first option is to limit health care eligibility to a subgroup of veterans by dividing priority group 7 into two subgroups: (1) those veterans who have a service-connected condition but receive no compensation for their disabilities and (2) all other priority group 7 veterans. VA is contemplating discontinuing enrollment to veterans in the second subgroup as a way to reduce its costs. Using VA's preliminary cost data for the first half of fiscal year 1999, veterans in this second subgroup represent about \$284 million of VA's total health care expenditures of approximately \$7.4 billion. However, priority group 7 veterans typically have other health insurance that VA can bill; thus, VA's net cost for these veterans is generally small, and any savings it could achieve by no longer enrolling them would also be small.

If VA does not realize the \$1.4 billion it plans to save in management efficiencies from personal and nonpersonal services, it may have to consider cutting deeper into the priority groups. As shown in table 2, according to VA's preliminary cost data, it has spent \$2.8 billion (about 38 percent) of its expenditures on veterans in priority group 5. Since its role has been defined as providing a safety net for veterans in this group—who are generally lower-income—VA would have difficulty discontinuing care to these veterans. However, if this were unavoidable, VA may need to identify those veterans who do not have sources of health care other than VA and continue offering enrollment to these veterans.

The second option VA is considering is to modify the benefits it now offers to all enrollees. VA has established a task force to explore possible changes to these benefits to reduce costs, and it plans to use the results of this task force in making its fiscal year 2000 enrollment decision. In our discussions with VISN directors, nine suggested that they believe VA should consider modifying the existing Uniform Benefits Package.

Calculating the cost savings VA could achieve through these options may be difficult, however, due to insufficient data on treatment costs and veteran income levels.

- Currently, VA's data systems do not fully track treatment-specific costs, making it difficult for VA to determine the exact cost savings it could realize by discontinuing care to some veterans or reducing benefits. Recognizing this

limitation, VA hired an actuarial firm to project the total number of veterans that might enroll for health care and forecast their utilization of VA health care and associated costs for fiscal year 2000, similar to its fiscal year 1999 decisionmaking process. Further, VA is developing a database—the Decision Support System—to capture patient- and treatment-specific cost data. This database is being implemented throughout VA's medical facilities, but according to VA officials, it will not fully replace VA's existing database until September 2001.

- To determine if veterans are above or below a particular income level (means test) and to place them into one of the seven priority groups, VA needs veteran income data. However, many veterans do not have information on their income status readily available to complete the enrollment application form when arriving at a medical facility. As a result, almost 686,000 of the 4 million enrollees (or about 17 percent) were not assigned to a priority group, as of March 26, 1999. To address this problem, VA recently verified the income of about 436,000 of these veterans and placed them in appropriate priority groups. Further, VA officials are planning to annually send enrollment applications to each veteran's home, allowing the veteran to complete the application in the home setting and send it back to VA.

These limitations restrict VA's ability to reliably determine its cost savings under these options. Although VA has efforts under way to improve the data, it is unlikely that these improvements will occur in time for VA's fiscal year 2000 enrollment decision.

CONCLUSIONS

The Eligibility Reform Act required VA to establish an enrollment system and, through the seven priority groups, to manage and provide timely health care within its resources. While at this time it appears that VA has the funding available in fiscal year 1999 to offer health care to veterans in each of the seven priority groups, it may not be providing timely care to enrollees in some areas of the country. Before the next annual enrollment period begins—less than 3 months from now—VA must decide whether it will continue offering enrollment to veterans in all seven priority groups. In the event that VA cannot realize the \$1.4 billion in management efficiencies it needs to operate within the President's fiscal year 2000 budget, we believe it will need to find other ways to realize significant savings within a very short period of time. If this is the case, VA will need to use the enrollment system as the tool the Congress intended and only enroll veterans in those priority groups for which it has sufficient resources to provide timely care, or it will need to modify the benefits it currently offers to all enrollees, or both. Regardless, VA may have difficulty calculating the cost savings it could achieve through these options due to insufficient data.

Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgments

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**Statement of
Thomas L. Garthwaite, M.D.
Acting Under Secretary for Health
Department of Veterans Affairs
On
VA's Experience in Implementing
Patient Enrollment under Public Law 104-262
Before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives**

July 15, 1999

Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to provide an overview of the Department of Veterans Affairs' (VA) experience in implementing patient enrollment under § 104 of Public Law 104-262. Appearing with me today are Dr. Gregg Pane, Chief Officer, Policy and Planning; Mr. James Farsetta, Director of Veterans Integrated Service Network (VISN) 3; Dr. Robert Roswell, Director of VISN 8; Mr. Vincent Ng, Director of VISN 14; Dr. John Higgins, Director of VISN 16; Dr. Ted Galey, Director of VISN 20; and, Mr. Walt Hall, Assistant General Counsel.

The Veterans Eligibility Reform Act of 1996, Public Law 104-262, fundamentally realigned access to VA health care. It eliminated the distinctions between eligibility for inpatient care and eligibility for outpatient care, expanded the spectrum of health-care services available to eligible veterans, and based care delivery on patient need. The Eligibility Reform Act also established an enrollment process as the primary tool by which VA manages access to health care within its limited resources and specified seven categories of veterans in order of their priority for enrollment.

VHA can now provide health care in the most appropriate setting – inpatient, outpatient, or in-home – and has an enhanced ability to provide care through contracts and sharing authorities, which improves veterans' access to care in communities closer to where they live. VHA also has expanded authority to provide preventive care, primary care services, and prosthetic and orthotic devices.

Under eligibility reform, emphasis has shifted from what care a patient is eligible to receive, to what care an enrolled patient needs. We have defined "need" as any treatment, procedure, supply, or service that is considered medically necessary when, in the judgment of the patient's clinical care provider and in accord with generally accepted standards of clinical practice, it will promote, preserve, or restore health.

To promote consistency in the services available to eligible veterans and allow for more clinical flexibility in treating patients, we developed a benefits package, known as the uniform benefits package. Each VISN must make this benefits package available to all enrolled veterans, but has the flexibility to decide where and how the care will be provided. For example, VISNs may make arrangements to provide care directly or by contract, at only one or a limited number of sites, or, when necessary, in another VISN. In addition, certain highly specialized programs, such as transplants, may be provided at only a few sites nationwide. The uniform benefits package helps to ensure that all veterans will receive a consistent level of care and services regardless of the VISN providing the care or where the veteran lives. It also enhances our ability to project the resources required, as well as the number of veterans for whom care can be provided. Some veterans may also be eligible for types of care that are not included in the uniform benefits package. These include nursing home care, domiciliary care, non-VA hospitalization or medical services, dental care, readjustment counseling services, adult day health care, homeless veterans programs, and sexual trauma counseling and treatment.

VA began accepting applications for enrollment on October 1, 1997, the beginning of FY 1998. This was a trial year for the VA enrollment process. An automatic application for VA health care enrollment was created for all veterans who had received care from October 1, 1996, through January 1998. Any veteran who was not enrolled automatically could apply for enrollment at any VA medical facility at any time. Enrollment officially began October 1, 1998.

On July 10, 1998, we published the proposed regulations implementing the enrollment provisions of Public Law 104-262, including the categories of veterans to be enrolled, the enrollment and disenrollment process, the definition of "catastrophically disabled," and the contents of the uniform benefits package. After considering the several comments received in regard to this proposal, we have submitted a draft of the final rule for departmental review.

To ensure that all veterans were well-informed about changes in the VA health care system and what they must do to receive VA care, VA developed a communications strategy. Communications products, including radio and television public service announcements, an enrollment brochure for veterans, and an enrollment brochure and handbook for VA employees have been widely used by VA health care facilities.

In June 1998, VHA established the Veterans Enrollment Service Center (or Call Center) to ensure that all veterans would have a single point of access for requesting assistance and information on eligibility reform policies and enrollment. This center has a national toll-free telephone number, 1-877-222-

VETS (8387), and is operated by a contract vendor, with oversight provided by offices within VHA. In its first year of operation, the Call Center handled nearly 254,000 calls, processed 49,000 requests for information brochures, and sent 58,000 enrollment applications to veterans.

After an initial application for healthcare and enrollment is processed at the veteran's local VA healthcare facility, the Health Eligibility Center (HEC) is responsible for verification of the veteran's enrollment and income information, assignment of the enrollment priority, and disposition of the enrollment application. Updated eligibility and enrollment information is automatically transmitted to VA facilities involved in the veteran's care. The HEC generates a letter that provides the veteran with notification of enrollment in the VA's health care system, general enrollment information, and, as applicable, their eligibility for income-based healthcare benefits. To date, the HEC has generated 3.8 million enrollment letters. The HEC will also facilitate the re-enrollment process. It will mail enrolled veterans in the income-based priority categories a VA Form 10-10EZ prior to the expiration of the annual enrollment period. Veterans will be asked to review and update the form and return it to the HEC for processing. Veterans will be notified by letter of their re-enrollment and priority status.

Enrollment Data

As of April 26, 1999, VHA had processed or received enrollment applications from 4,055,397 veterans. This number includes 210,888 veterans who died subsequent to being enrolled, 4,692 who ultimately declined enrollment, and 16,500 who have been found ineligible. Thus, as of April 26, 1999, there were 3,823,317 veterans who were currently enrolled or who had an application on file. Past user enrollees, defined as those who used the system at some point during FYs 1996, 1997, or 1998 (the three FYs immediately prior to the official beginning of enrollment on October 1, 1998), make up 84.6 percent (3,233,873) of current enrollees/applicants. The remaining 15.4 percent (589,444) are new enrollees, 45% of which are estimated to be Priority 7 veterans. The unprioritized group is largely due to veterans not having a current means test on file.

The following table shows the breakdown of total enrollees/applicants according to priority groups.

Total Enrollees (as of April 26, 1999)	
<u>Priority Group</u>	<u>Number</u>
Unprioritized	516,326
Priority 1	416,711
Priority 2	286,429
Priority 3	515,469
Priority 4	105,341
Priority 5	1,354,671
Priority 6	56,928
Priority 7	571,442
Total	3,823,317

Not all enrollees are users (patients) in the VA health care system. As of April 26, 1999, there were 2,549,835 enrollees who have been users since the beginning of FY 1999. Distribution of enrollee patients across priorities is shown in the following table:

FY 1999 Enrollees who have been patients (as of April 26, 1999)	
<u>Priority Group</u>	<u>Number</u>
Unprioritized	138,010
Priority 1	370,428
Priority 2	212,543
Priority 3	342,446
Priority 4	96,816
Priority 5	1,087,891
Priority 6	28,038
Priority 7	273,663
Total	2,549,835

Recently updated actuarial projections through FY 2004 indicate that the number of enrollees is projected to increase through FY 2000 and then steadily decrease. The following table shows the projections as of the end of the FYs indicated:

Projected Enrollees through FY 2004 (as of July 2, 1999)	
FY	Enrollees
FY 1999	3,738,393
FY 2000	3,804,694
FY 2001	3,787,461
FY 2002	3,693,321
FY 2003	3,597,647
FY 2004	3,503,081

Enrollment Determinations

Public Law 104-262 requires that VA "establish and operate a system of annual patient enrollment" in accordance with the seven specified priorities. In designing and managing its enrollment system, VA must ensure that it provides health care that is "timely and acceptable in quality." For FY 1999, VA projected the demand for enrollment and the utilization and cost of projected enrollees. While the lack of current data necessitated complex sensitivity analyses around uncertain parameters, VA found no quantitative or qualitative reason not to open the system to all priorities for enrollment in FY 1999. Based on data and experience to date, it appears that, actuarially, VA is on target with the initial projections for FY 1999.

In making a determination for enrollment in FY 2000 VA will, as was done last year, use both an internal VA model and an external actuarial model to make projections about the number of enrollees we might expect, their utilization, and costs. An enrollment level decision paper will integrate findings from both models and will be provided to senior management in the near future. These analyses will allow VA to assess the enrollment priority level supportable for FY 2000 in light of budgetary expectations.

Priority 7 Veterans

Although concerns have been expressed concerning our decision to enroll all veterans in FY 1999, so far this year we have been able to serve these veterans without significant impact on the system. I regret that we cannot report to you specific costs, today. The Administration is still discussing these figures. I can report, however, that through the second quarter of FY 1999, the cumulative cost of all new users, including Priority 7s, has been less than half of the average of all enrollee patients. Further, veterans who are in Priority 7 bring in revenue from co-payments and third-party payments, and we currently are examining the extent to which this revenue offsets the costs of Priority 7 users.

Finally, VHA believes it treats Priority 7 veterans at the margin – i.e., less than the average cost, depending on location, because of fixed investments. We are examining this issue, as well.

Patient Waiting Times

In the last 4 years, VHA has seen the beginnings of an unprecedented transformation of VA health care services, of which eligibility reform and enrollment are important parts. Since 1995, VHA has made significant progress in transitioning from a disease-oriented, hospital based, professional-discipline focused health care system to a system that is patient centered, prevention-oriented, community based, and which has universal primary care as its foundation. As you know, our re-engineering efforts are continuing.

As has been discussed, numerous factors are affecting the system's ability to provide care to enrollees. As we have improved services, increased the number of access points into the system, and generally improved the overall quality of VA health care, we have seen increased demand. In addition, coupled with ambitious budget targets, unforeseen clinical requirements, new technologies and new treatments for diseases, an infrastructure and processes not conducive to rapid change, and transition to outpatient primary care situations are challenges that, taken as a whole, have contributed to less than desirable access and waiting times in some areas.

Concerns have also been expressed about increased waiting times, both in specialty care clinics and primary care clinics. Anecdotally, the increases have been thought to be the result of enrollment. I am aware that some sites have reported an unanticipated increase in demand as a result of eligibility reform. The recent actuarial data suggest that these increases are initial reactions to the new eligibility criteria and will level off or decrease over time. Further, it should be noted at the outset that there are no data by which to compare current waiting times, with or without association to veteran priority, with waiting times prior to eligibility reform.

Waiting times for appointments in both primary and specialty care clinics vary across the system and within VISNs. Delays in obtaining appointments are due primarily to three circumstances: 1) a transition to universal primary care; 2) unanticipated increases in demand for care in some areas; and 3) processes that restrict our ability to promptly respond to infrastructure and human resource needs. Specialty care waiting delays are also affected by the need to recruit appropriate numbers of specialists in locations where they are needed; this was true prior to eligibility reform.

Recently, VHA sought to obtain estimates of local waiting times for primary care. These data are preliminary based on an informal survey, and we

are still examining it to assess its accuracy. Additionally, they represent "point in time" information and thus may not be representative. The most important issues raised by this preliminary data are: 62% of patients nationally can obtain a primary care appointment within VHA's 30-day goal; and there is much variation among VISN's in waiting times. The preliminary data show that six VISNs have all of their patients scheduled for the first primary care appointment in 30 days or less, while two VISNs have not provided primary care appointments to any patients within the 30 day goal. As we continue to analyze this data and other data on waiting times, we will keep you informed and share our information with you. Clearly our goal is to achieve 100% compliance with this measure. In the near-term, however, we are especially cognizant of the need to reduce waiting times in areas that are experiencing particularly long waits, and we have several initiatives underway (described below) to address this matter.

As we have implemented primary care and the care management it implies, we have faced the challenges of concurrently restructuring VA health care and taking other actions to generate the resources needed for this effort. These efforts are hampered by an infrastructure and processes not conducive to rapid change. We have also experienced difficulty in recruiting in some areas of the country in which recruitment is particularly challenging because the area is either not attractive for recruitment or the competition is particularly keen. Some sites also continue to have problems obtaining non-physician providers, who could increase primary care capacity and free physicians.

To meet the current challenges regarding waiting time, VHA:

- has a plan in place to monitor waiting times for specialty clinics and is piloting a data collection methodology for gathering such waiting times (data validation is expected to be complete in July with software installed at all facilities by September);
- has provided and is refining detailed guidance to networks regarding development of strategic plans;
- is sending a team into one network that has established waiting lists in order to assess its fiscal needs, quality issues, and re-engineering progress, and VHA will do so with other networks as indicated;
- has established a work group to assess and analyze discretionary resource management approaches being used in the system and to recommend national guidance and policy; and

- has initiated a breakthrough improvement strategy to reduce waits and delays at all healthcare facilities in collaboration with the Institute for Healthcare Improvement (IHI), which is expected to produce the same profound reductions in delays across the system over the next 12 months that IHI has successfully achieved elsewhere.

Conclusion

Thus far in FY 1999, we have maintained our ability to provide acute inpatient, outpatient and in-home care to all veterans, as medically indicated, and we have been able to meet the health care needs of all enrolled veterans. Nonetheless, we continue to monitor changes in access, outcomes, utilization, expenditures, and capacity of the system to provide the specialty and rehabilitation services, as well as enhanced primary and preventive care services. Above all, we are committed to providing the right care, in the right way, at the right time, in the right place, and for the right cost.

As I indicated earlier, we will be reviewing our total experience with enrollment, the level of resources that will be available in FY 2000, and other impacts on VA health care. We will be recommending an enrollment decision to the Secretary in the late summer. As the Congress, the Administration, VSOs, and other stakeholders know, VA's medical care budget is challenging.

Mr. Chairman, this concludes my opening statement and I would be pleased to answer any questions you or the members of the subcommittee might have.

