

VA MEDICAL CARE BUDGET AND CONSTRUCTION PRIORITIES

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BEFORE THE
SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
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THURSDAY, MARCH 21, 1996

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

The subcommittee met, pursuant to call, at 11:30 a.m., in room 334, Cannon House Office Building, Hon. Tim Hutchinson (chairman of the subcommittee), presiding.

Present: Representatives Hutchinson, Smith, Bilirakis, Quinn, Ney, Flanagan, Edwards, Kennedy, Tejada, Gutierrez, Bishop, Brown, and Doyle.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. The subcommittee will come to order. And I will begin with an apology for being late. This is not the pattern for this committee and I regret it very much. We had a roll call. It almost makes one long for the days of proxy voting. But we're here.

The subcommittee meets today as part of its oversight responsibility to review and discuss the fiscal year 1997 medical care and major construction budgets. I would like to begin by stating that this has been a difficult year from the standpoint of the subcommittee having to formulate its views and estimates to the Budget Committee without the comparative benefit of the President's budget submission.

We did receive the administration medical care and construction submission Tuesday. Although it was somewhat late, I was heartened to see that the administration's medical care request was within a respectable range of the full Committee's recommendation to Mr. Kasich, the Chairman of the Budget Committee.

The full Committee's recommendation was an increase of \$505 million over the fiscal year 1996 conference levels. The administration's request is \$61 million less than the full Committee's recommendation, representing an increase to medical care of \$444 million.

Underscoring the importance of the VA research program, I question the administration's efforts to hold the research budget at the fiscal year 1996 level of \$257 million. I'm also concerned about the Department's efforts to fund new research initiatives and its commitment to the prosthetic and rehabilitative needs of aging veterans under a level that represents no inflationary or programmatic growth.

With the continued emphasis upon ambulatory care and VA's closure of 2,294 beds or the equivalent of 12 community hospitals in the last year, I can only register surprise at the inclusion of 2 hospital construction projects in the administration's fiscal year 1997 request.

Understanding the importance of eligibility reform as the key to reengineering the health care system, I am happy to report that H.R. 3118, the Veterans' Health Care Eligibility Reform Act of 1996, was introduced yesterday with the bipartisan support of Chairman Stump; Mr. Montgomery; my good friend and ranking member of this subcommittee, Chet Edwards; and myself.

Facing a compressed legislative schedule, we intend to move this bill as quickly as possible. I appreciate the support that your staff has provided in the ongoing negotiations with CBO and look forward to continued help as we work to make eligibility reform a reality for veterans.

It's been an especially difficult year for those of you who have had to manage under various continuing resolutions without a firm assurance of the final budget number.

Dr. Kizer, I commend your leadership and the dedication of the nearly 200,000 VHA employees who never wavered from the mission of serving the health care needs of veterans during the shut-down and throughout this time of fiscal uncertainty. Your accomplishments during your brief tenure have been impressive. And I have followed with interest the vision, reorganization, and the other innovations begun under your watch.

I would like to welcome Dr. Kizer, the Under Secretary for Health. He's joined at the witness table by Mr. Mark Catlett, Assistant Secretary for Management and Mr. Chuck Yarbrough, Associate Chief Medical Director for Construction Management.

The chair now recognizes the ranking minority member, Mr. Chet Edwards of Texas, for opening remarks.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Thank you, Mr. Chairman. I'll try to keep this brief and allow us to make the vote.

Mr. Chairman, I want to thank you for calling this important meeting and also for your leadership in pushing for introduction of health care eligibility reform for veterans. I think that's terribly important.

And I think members on our side of the aisle will work diligently with you and your staff. And we'll see in the short time we have left this year if we can push that priority, which I believe is the top priority of virtually every major veterans' service organization in America.

At a time when many Federal programs are taking deep cuts, I am pleased that the President is proposing to increase VA funding, and particularly VA medical and construction funding. The medical care budget, for example, would increase by nearly \$450 million. At the same time, though, I hope we look at these numbers soberly because this budget does have a gloomy side to it.

This funding increase does not guarantee or insure growth. In fact, it calls for reducing more than 5,100 full-time positions in the

VA health care system. For those who would call for change in the VA health care system, this plan would accelerate the pace.

Since 1993 the VA has reduced medical care staff by some 7,000 personnel. This plan would nearly double that number next year. In the last decade, the VA has also reduced the number of hospital beds that operate by 35 percent, from more than 78,000 to fewer than 51,000. Further decline should be expected.

I want to commend, Mr. Chairman, Dr. Kizer for the emphasis he's given to primary care delivery and the improved services veterans are getting in many VA hospitals. I'm hopeful that those improvements will continue as VA projects.

We cannot simply assume the VA can keep on doing more with less. And we cannot be sure that cuts of the magnitude proposed will not affect patient care delivery.

Mr. Chairman, we are, in fact, already beginning to read about reductions in force taking place at VA medical centers. I would urge that we monitor closely how those cuts are being carried out and what impact they have on the very vulnerable patient population the VA serves.

I hope members on both sides of the aisle, Mr. Chairman, will recognize the reality of our terrible budget deficit and the fact that we must work together to reduce that. At the same time, I hope we continue to keep a close eye on how these efforts to balance the budget are, in fact, affecting care to our betterment.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Edwards.

We've got about 10 minutes left on this vote. What I would propose to do is, with great apologies to these witnesses who have been sitting here 15 minutes waiting already, if we will go and vote quickly, we'll come back and allow members to make opening statements.

Mr. SMITH. Mr. Chairman, I'm in the middle of a mark-up, unfortunately, on international relations. If I could just make a very brief opening statement?

Mr. HUTCHINSON. We'll be glad to recognize—

Mr. SMITH. Thank you, Mr. Chairman.

Mr. HUTCHINSON (continuing). Mr. Smith for a brief statement.

OPENING STATEMENT OF HON. CHRIS SMITH

Mr. SMITH. Let me just say that I want to commend you, Mr. Hutchinson, for the exemplary job you have done in leading this subcommittee, whose work is so vitally important to our nation's veterans. These are indeed difficult transitional times. By all accounts, the VHA must make fundamental, systemic changes in the way it delivers services if it is to fully meet the vital mission that it has. Reforms that have been proposed by all sides would affect the most basic managerial structures that have been employed by the VHA for decades. Despite the fact that no one is satisfied with the current system, reforming of the status quo is always difficult. And again I want to thank you for the very fine work you're doing.

And I would ask that my full statement may be made a part of the record.

Mr. HUTCHINSON. Without objection.

[The prepared statement of Congressman Smith appears on p. 33.]

Mr. SMITH. I've read your testimony, Dr. Kizer. It's very fine. Again, I thank you for this time.

Mr. KENNEDY. Mr. Chairman?

Mr. HUTCHINSON. We have I guess a 5-minute vote after this. It looks like a series of at least two votes. I just wanted to remind you of that.

Mr. KENNEDY. Mr. Chairman?

Mr. HUTCHINSON. Yes, Mr. Kennedy?

Mr. KENNEDY. I apologize that, like Mr. Smith, I have a conflict that starts just after this next vote as well. I wondered if I could just share a couple of brief thoughts with—

Mr. HUTCHINSON. I'm a little concerned we're going to miss this vote.

Mr. KENNEDY. Well, you go ahead and—

Mr. HUTCHINSON. No. Go ahead and make your brief statement.

OPENING STATEMENT OF HON. JOE KENNEDY

Mr. KENNEDY. First of all, I want to welcome Dr. Kizer. I want to thank you, Mr. Chairman, for hosting this hearing this morning.

I want to just give encouragement to Dr. Kizer to try and continue along the lines of reforms that I think he has initiated at the VA, where we recognize, I think, finally that we're coming to grips with the idea that the resources that are coming to this committee are not going to be infinite. And, rather than hoping that we're going to end up with the pot of gold, we're trying to begin to make some reforms that deal not only with the eligibility requirements but also with the fundamental missions that we're going to be expecting each one of our VA hospitals to be able to take on.

As I understand your plan of creating separate regions, it will enable the VA to operate much more efficiently and effectively and perhaps at some point be able to provide some kinds of patient care that might go directly through the VA and might be able to actually have some of the patient care being done by other facilities as well that could end up funneling in a much more efficient and effective manner the kind of VA health care that I think ultimately will be best for our veterans and also maintain a separate VA system as a goal that I would like to share with you.

I really wish I could stay for your testimony later. And at some point maybe if you get a few minutes, we might be able to get together, either at your office or back at mine. All right? Thank you very much, Doctor.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Kennedy.

The subcommittee will stand in recess until 12 noon. And I promise you I'll come back, and I hope the committee can. Thank you, Dr. Kizer.

[Recess.]

Mr. HUTCHINSON. Dr. Kizer, I feel confident that there are going to be some more members returning. And they may want to make opening statements at a later time, but I would like the witnesses to go ahead. And if you'd go ahead and give your testimony, maybe that will expedite and make it a little easier on your schedule.

So thank you for being here, and I now recognize you. Dr. Kizer. Dr. KIZER. Thank you, sir. I'm sure that if they're not here in body, they're certainly here in spirit.

STATEMENT OF KENNETH W. KIZER, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY MARK CATLETT, ASSISTANT SECRETARY OF MANAGEMENT; C.V. (CHUCK) YARBROUGH, ASSOCIATE CHIEF MEDICAL DIRECTOR FOR CONSTRUCTION MANAGEMENT; AND W. TODD GRAMS, VHA CHIEF FINANCIAL OFFICER

Dr. KIZER. I am pleased to have this opportunity to initiate discussion with you on the fiscal year 1997 budget request for the VA medical care programs.

In addition to Mr. Catlett and Mr. Yarbrough, whom you were kind of enough to introduce, I would also note for the record that Mr. Todd Grams is sitting on my immediate right. He is the Chief Financial Officer for the Veterans Health Administration.

Mr. Chairman, in viewing the President's request for VA's medical care programs, I believe it's useful to first put the proposed \$448 million increase in context with the other two large Federal health care programs, Medicare and Medicaid, and with regard to inflation. In brief, the proposed increase in the VA's medical care budget represents a 2.7 percent increase. This contrasts with a proposed 7.1 percent increase for Medicare and an 11.3 percent increase for Medicaid. This continues the trend of recent years, where Medicare and Medicaid spending have increased at a rate of two to three times the rate of increase of VA health care spending.

Also, again, just to put this in some context, I would note that the projected Consumer Price Index increase in fiscal year 1997 is 3 percent and the projected medical CPI increase for 1997 is 5.2 percent. Again VA's 1997 Budget request continues the trend of VA funding increases that are about half the rate of medical care inflation.

I would also just note in the way of context, that it's important to understand that the VA is in a critical period of transition, in what some folks have called the most significant management restructuring of the medical care operation since inception of the program.

So there is a great deal of change going on in the system. And with the degree of change that is going on, it is difficult to sometimes achieve the degree of specificity in numbers that we would all like to have.

Certainly, as we continue with implementation of the integrated service network structure that we are putting in place, we're going to continue to emphasize improved and increased accessibility and quality of VA health care, increasing the efficiency with which the system provides care and heightening the accountability for outcomes and bottom line results.

You were kind enough to mention in your opening comments that there have been some promising changes and numbers that indicate the change that's underway. I would expect these efforts to significantly expand through the remainder of this fiscal year and into fiscal year 1997. Due to the time constraints on us this

morning I will not take the time to detail those things here, but I would certainly be happy to discuss them with you as the hearing continues.

I would also note that one of the assumptions underlying our plans for 1996, as well as beyond, was the enactment of eligibility reform. It is certainly heartening to hear what is happening with regard to your leadership in this regard and actions that are being proposed to move that agenda forward. It's absolutely critical to making the system go where I think we would all like to see it go.

I would also make a pitch for one other provision that we talked about last year and which would be very important in helping us move forward with VA's transition. I'm referring to having increased contracting flexibility and being able to enter into sharing arrangements with others to help us mold a system that's most cost-effective at the local level.

I would also note, just briefly before concluding these comments, that the budget does include important gain-sharing legislation that I believe your committee has endorsed in the past. This legislation would provide incentives for the VA to increase its collection of third party reimbursement and allow us to retain a portion of those funds to provide medical care.

You also asked that we comment on the allocation of resources in the VA system. I would certainly want to make clear for the record, as I have mentioned to you in prior discussions, that the historical means of allocating resources in the veterans' health care system has not proved to be equitable and has resulted in uneven distribution of resources in the system. We are trying to address that.

We believe that ultimately the best way to achieve equity in resource allocation is to operate on a prospective capitation model. However, to correct the inequities that currently exist in the system would require a shift of resources that would be so large that it would, we believe, disrupt ongoing patient care.

And so we have planned to phase this in over fiscal years 1996 and 1997. Hopefully by fiscal year 1998 we will be in a position to fully implement a capitation methodology. We have established work groups to develop this methodology.

Let me just conclude my comments now. We'll be happy to try to answer any questions that you and other members of the committee have at this juncture in these discussions.

[The prepared statement of Dr. Kizer appears on p. 41.]

Mr. HUTCHINSON. Thank you, Dr. Kizer.

We have a number of members who have joined us. So let me invite them if they have opening statements. Mr. Bilirakis, do you?

Mr. BILIRAKIS. Thank you, Mr. Chairman. I cast that vote and ran over here, trying to get here at least the same time as you. I don't know how in the world you made it before I did.

Mr. HUTCHINSON. A lot of practice.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. I commend you, sir, for scheduling this very important hearing and, of course, to add my commendations as well as Dr. Kizer and others for the great leadership you've shown on

the eligibility reform issue. And I welcome Dr. Kizer and his colleagues here.

The VA's medical care budget is obviously very important to all of us, Dr. Kizer, and I know it's important to you. Although I'm anxious to hear about the President's recommendations for the VA's 1997 budget and I guess we've heard most of that, I'm going to focus my remarks on an issue which is of particular concern to my state. And the good doctor addressed it somewhat here a couple of minutes ago. And that is resource allocation within the VA health care system.

Over the last several weeks, representatives from the various veterans' service organizations have visited me to discuss issues of importance to veterans. The number one concern has been, as you already guessed, the distribution of resources throughout the VA health care system.

It's not a new concern for our veterans. Since coming to Congress, I've heard from many that moved to Florida and were denied care at the VA. Prior to moving, these veterans were able to receive care from their local VA medical facilities. However, once they moved to Florida—in other words, in their old facility, they were able to receive care. Once they moved to Florida, which has one of the lowest rates of non-mandatory care in the country, they're turned away from the VA because they've fallen into the discretionary care category.

It's very hard for these veterans to understand. We try to explain it to them. It's hard for them to understand how they can lose their VA health care simply by moving to another part of the country. I share their frustrations, and I'd like to think all of us do.

Many of them are forced to move back home to get the care to which they're accustomed. Otherwise, others simply give up in despair.

Unfortunately, the situation only appears to be getting worse. I found just last week that the West Palm Beach Medical Center announced that it will no longer accept new patients classified as Category C because of budgetary constraints.

The West Palm facility is the second Florida medical center to implement this policy this year in January. The Dade Pines Medical Center also began restricting Category C veterans in their access to care in order to treat those who have a higher priority.

Mr. Chairman and Dr. Kizer, my veterans also raised concerns about the impacts of snowbirds. And when we get to talking about the capitation-based system, I'd like to really go into detail with you on that.

The snowbirds have in their ability access to the VA health care system. During the winter months, Florida veterans are literally crowded out of the system by individuals who travel south to enjoy our warm weather. I certainly can't blame anyone for wanting to escape the snowy north. There's no denying that the snowbirds have a devastating impact on Florida's veterans.

I also have a hard time explaining to Floridians why they have to wait 120 days, 120 days, for an appointment with the Orthopedic Clinic in the Gainesville Medical Center or 65 days for an appointment with the Cardiology Clinic in the Dade Pines Medical Center when at the same time medical centers in other parts of the coun-

try are advertising for patients. I believe that information is correct, literally advertising for patients.

Several recent GAO reports highlight the funding disparities among VA health care facilities across the country. Three years ago the Department of Veterans Affairs put in a system known as RPM, resource planning and management, which was supposed to, Mr. Chairman, give veterans better access to health care, regardless of where they lived. However, according to the GAO, the Department has made only minimal changes in funding allocations for facilities during the two budget cycles in which RPM has been used.

The maximum loss to any one facility was 1 percent, 1 percent, of its past budget. And the average gain was also about 1 percent. In fiscal year 1995 Florida facilities continued to have the highest number of applications and highest statistics, the highest number of applications for medical care by service-connected veterans in the nation. And, yet, the VA expenditures for medical services administration for Florida continues to lag behind states, such as California and New York and Texas, which have fewer applications for service-connected care.

The VA implemented the RPM system to correct this very inequity. And, yet, the problem persists. I hope that Dr. Kizer will address this issue. Possibly he may think the capitation based might do it. I don't know.

So with that, Mr. Chairman, I will conclude my statement, which is longer than usual, but I really wanted to make it. Thank you for giving me the opportunity because it's just so very, very critical that we solve these problems. Thank you very much.

Mr. HUTCHINSON. Thank you, Mr. Bilirakis. We were just discussing maybe the possibility of prohibiting those northerners from going south at all. I don't know how Mr. Gutierrez might feel about that.

Mr. BILIRAKIS. Well, when we use the term "snowbirds," we use that term fondly. We don't want to—

Mr. HUTCHINSON. Mr. Tejada.

Mr. TEJEDA. Thank you, Mr. Chairman. I'd just like to welcome Dr. Kizer and the others. I do have some questions, but they'll come along when we go into it. Thank you very much for being here and for the information.

Mr. HUTCHINSON. Mr. Gutierrez.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Good morning, Mr. Chairman. I'd like to thank you once again for holding this important hearing to discuss medical care and construction priorities for the upcoming fiscal year.

Dr. Kizer, once again I welcome you to these chambers. I would like to commend you for your perseverance in these tough times. The VA's medical program, as you point out, is undergoing a significant restructuring to expand the outpatient accessibility and provide more efficient care for our nation's veterans.

However, Congress hasn't exactly been helpful with this task. Many times budget rhetoric and budget cuts have placed unfair constraints on the ability of this committee and the Department of

Veterans Affairs to follow through with plans for an improved veterans' administration.

The delays in enacting a fiscal year 1996 budget have certainly added to uncertainty at the VA. Dr. Kizer, I was pleased to hear you mention the responsibility of Congress to pass eligibility reform this session.

We made a pledge to our nation's veterans and to your agency to aid in the overdue restructuring plans of the Veterans' Administration. Without the outpatient eligibility reform you mentioned, this cannot happen according to the plans your agency and this Congress have approved.

I'm hopeful this committee, which has worked to produce bipartisan eligibility reform in the past, will get the job done right away. I would also like to take this time to raise my concerns about funding levels for VA medical programs and how these will affect the restructuring of the system.

As you know, this past Wednesday the Washington Post ran an article about the budget with the headline "VAs Lay Off 10,000 Workers Next Year." I'm extremely concerned about all the overall provisions and quality of Federal services to the 2.9 million individuals the VA expects to treat in this fiscal year, especially with this headline.

With the veteran population rapidly aging, I believe the VA must become more efficient without diminishing its capacity to adequately serve older veterans' population. I'm concerned that the impending staff cutbacks and the possible closure of facilities alluded to in yesterday's article in the Washington Post undoubtedly would hamper the VA's the ability to do the things we know it needs to do.

I'm sure that Dr. Kizer and Assistant Secretary Catlett will have plans to address this issue. So, Mr. Chairman and Mr. Edwards, I look forward to today's hearing and working with you to ensure that Congress makes good on its commitment to our nation's veterans. And I will look forward to presenting my questions, as my other colleagues, later on.

Thank you very much, Mr. Chairman, for allowing me the opportunity to give this opening statement.

Mr. HUTCHINSON. Thank you, Mr. Gutierrez. Mr. Ney.

OPENING STATEMENT OF HON. BOB NEY

Mr. NEY. Thank you, Mr. Chairman. I want to thank you for holding the hearings. I apologize in advance. I'm juggled between two engagements.

I just wanted to tell you about one thing. Last week in Steubenville, OH, the VA Director from Pittsburgh, Steve Young, combined with Mr. Macio, Veterans' Service Officer, Jefferson County, came down. I think they do this every 6 weeks. They donate their time and come to the VA, where they set up kind of a health fair, take problems on the spot, the veterans have, in spite of a day's work.

I just want to tell you the VA has done an admirable job of Saturday visits around Pennsylvania and Ohio and I guess just to stress, too, that downsizing, whether it's from previous budgets or whatever is going to occur out of Congress at this point in time, I think we've got to be cognizant that this is the local level, to peo-

ple out there across the country, whether it's in your organization or ours, because I do think they're real people and you want to listen to them, not have a glazed-over look, thinking, "When is this going to end?" but actually listen to what they do on the front firing line. I believe we're going to learn a lot. It works out here in the Federal Government, too.

Sometimes when we're in a change—and I'm going to submit some questions to you later, correspond with your office, but I also think that the big issue is the third party recovery and what you can be able to have with that and to be able to continue health care. I think we're going in the direction that we should be in a sense of looking at as much as possible a base. I'd like to thank you for that.

Also one ongoing item that I think we've always got to be cognizant of as technology gives here, talking about computerization, what we can do with that, and I think that can save a lot of money, also take a lot of aggravation, whether it's the snowbirds—we'd like to keep them north, believe me, but no matter where you're at in the country, to be able to have high-tech ability in terms of veterans, that will be an ongoing process we've got to come to terms with, spend our money wisely on that end.

Again, I appreciate you working with us.

Mr. HUTCHINSON. Thank you, Mr. Ney. Mr. Doyle.

OPENING STATEMENT OF HON. MIKE DOYLE

Mr. DOYLE. Thank you very much, Mr. Chairman, and thank you for holding this hearing today. Let me start by apologizing for not being here and for the fact I'm going to have to leave. I'm testifying over in the Science Committee. But, like many members running back and forth, I do want to give a brief opening statement.

I would like to begin by thanking Secretary Brown, Dr. Kizer, and everyone who works for the Department of Veterans Affairs for doing their utmost during the budget battles and shutdowns to see that the services we guaranteed for our veterans were delivered as best as could be expected considering the circumstances.

Throughout the Pittsburgh area and all of western Pennsylvania, an area with one of the largest veteran populations nationwide, the impact of veterans' services was felt. But I believe there was a general recognition that DVA was doing everything possible to minimize the problem. And hopefully we won't have to go through that again.

As we begin to look at the fiscal year 1997 veterans' budget, I hope there's a better recognition here in Washington that we should not be targeting the DVA budget as a source of savings. While there are undoubtedly areas we can look to for improved efficiency, that effort should not serve as an excuse to eliminate essential programs that are in our jurisdiction.

I just want to go on record today as expressing my gratitude to the administration for continuing with the environmental improvements at the University Drive VA Hospital in the Oakland section of the City of Pittsburgh. Although this facility is not in my district, it serves many veterans that I represent. This is a long overdue initiative to get back to a base level of patient care quality in what could become an obsolete and somewhat unsafe facility. I

want to point out to the members of this committee, too, that this project has been the subject of extensive analysis and is one of the highest priorities in the Pennsylvania veterans' community.

With that, Mr. Chairman, I want to thank you very much for this time for an opening statement. And thank you for holding the hearing today.

Mr. HUTCHINSON. Thank you, Mr. Doyle. Mr. Bishop.

OPENING STATEMENT OF HON. SANFORD BISHOP

Mr. BISHOP. Thank you very much, Mr. Chairman, ranking member. I'm pleased to be with you today. And I'm hopeful that this year will be a good one for our veterans in need of health care.

I would like to take the time to welcome Dr. Kizer and the representatives who are testifying here today. I send my best regards to Secretary Brown.

I'm very pleased with the \$17 billion appropriated in the administration's fiscal year 1997 budget for health care for veterans, but I am concerned with the VA's proposed downsizing causing the loss of 10,000 jobs that would serve veterans' needs, as referred to by my colleague Mr. Gutierrez.

I understand that the VA budget calls for overall increases of \$1 billion, but our concerns center around the Department's plan for the new VA, splitting the VA hospital system into 22 regions. Many of our veterans would be adversely affected if the transformation is not done properly.

Our veterans deserve the highest priority, with adequate health care being the number one concern. It is my hope that the fiscal year 1997 budget will continue to allow us to reach the goals of: one, providing America's veterans with access to a full continuum of health care services; two, operating the VA hospitals more efficiently; and, three, funding construction needs at the VA hospitals.

Again, I want to take the time to thank you, Dr. Kizer, and the Department of Veterans Affairs, all of the employees, for the great job that you do. While many agree that the VA can use even more funding, especially for medical care, this budget does move the Department forward in its commitment to provide the best possible health care services for America's veterans in the most efficient and cost-effective way, although we must be sure that quality of care does not decline.

Thank you very much.

Mr. HUTCHINSON. Thank you, Mr. Bishop. Mr. Flanagan.

OPENING STATEMENT OF HON. MIKE FLANAGAN

Mr. FLANAGAN. Thank you, Mr. Chairman.

I, like Mr. Doyle, have 32 other pressing things to do today, but I'm happy to come and give a brief statement and listen to some of the testimony of Dr. Kizer. And, again, I have certainly read your statement. It is a good one.

I would like to join my colleagues on this committee and welcome you, Dr. Kizer and also the Department of Veterans Affairs, Mr. Mark Catlett, Assistant Secretary of Management in the Department of Veterans Affairs; Mr. Chuck Yarbrough, Associate Chief Medical Director for Construction Management. Thank you for tak-

ing the time to come before this subcommittee today with the fiscal 1997 budget request for the VA medical programs.

I would also like to thank you, Mr. Chairman, for your leadership in holding this hearing today.

It is imperative that we work together to ensure veterans improved quality and accessibility of health care. I am eager to work throughout the upcoming year to pass reforms that will assist the VA in providing America's veterans with the quality health care that they have earned.

I think we all recognize the dramatic role our veterans have played in shaping our history. It's kind of a remarkable fact that we forget here occasionally, but not once did any of these veterans debate the potential cost of their service. I think it is our duty to provide them with the best health care and most efficient health care facilities possible. They have earned our continuing attention and support.

I look forward to it. I believe in the end, as Mr. Bishop has observed, Mr. Gutierrez has as well, veterans will receive the highest priority we can provide in Congress. And certainly health care has to be number one among that.

Thank you again, Mr. Chairman, for these hearings today. Thank you, Dr. Kizer, for coming.

Mr. HUTCHINSON. Thank you, Mr. Flanagan.

I'm going to ask us to abide by the 5-minute rule in our questioning, rather than 10, just because we're starting so late. And we'll give an opportunity to go around a second time if there are questions still remaining.

Dr. Kizer, let me begin by picking up on I think what Mr. Gutierrez mentioned. I think Mr. Bishop may have mentioned this and others. And that's the headline that appeared regarding the 10,000 positions that could be RIFed.

My understanding is that in the last year the management of 17 hospitals was merged and that you have asked for and received from the Secretary authority to RIF up to 10,000 positions.

Could you describe for the subcommittee how large a reduction you actually expect under that authorization that you have received and what types of positions will be targeted in the RIF? And in your opinion will this reduction necessitate the closing of any hospitals?

Dr. KIZER. I will address as much of that as I can. At the outset I would note that the budget assumes that our FTE level will drop about 5,000 in fiscal year 1997. I'm not exactly sure of the genesis of the figure that was headlined in *The Washington Post* since I was not at the event that generated that figure. We have previously discussed our needs in this regard with the Office of Management and Budget and with the Secretary. As we restructure and redirect our workforce, we have used a figure of between 5 and 10 thousand as a planning figure, if you will, of the potential number of employees that might be affected.

Now, in many cases this involves what we consider workforce tailoring. As we move to managed care or primary care, in many cases what we need are more primary care givers, generalist physicians, nurse-practitioners, physicians' assistants, as opposed to specialist

types of positions that we currently have. So we need to change the mix.

As we have merged facilities and as we expect to consolidate or integrate additional facilities in the upcoming year, we find that there are redundancies in both administrative personnel and in some cases clinical services. We no longer need the same number of individuals in those categories that we did before. And so if we can save some funds by having one service chief manage the service at two facilities, then we're reinvesting those funds in clinical care.

We're looking at the complete array of VA staff. At this time it is not possible to give you a precise depiction of either the number or the specific breakdown of personnel categories.

But as we transition the system to a primary care, ambulatory care-based system and as we merge management, try to eliminate redundant administrative positions and turn them into care givers, there is going to be a flux in our workforce.

The number that was given represents what I would consider an outside parameter, for what may occur in fiscal year 1997.

Mr. HUTCHINSON. And do you anticipate that it will necessitate closing any hospitals?

Dr. KIZER. The number per-se would not be a factor that I would consider as necessitating closure of a hospital. It is quite possible that we may come forward with proposals to close facilities, but that would be based on finding better ways of meeting those health care needs. And so the number of FTE per-se would not be the driving force in the proposal to close a facility.

At this time there is no specific proposal on the table. But I certainly would not rule that out in the future.

Mr. HUTCHINSON. I guess this should be addressed to Mr. Yarbrough. Please describe the major construction priorities for fiscal year 1997 and how the Department arrived at that list of priority projects. Anybody like to address that?

Mr. YARBROUGH. There is a fairly well-established, long established prioritization methodology, which until last year included some program emphasis weights that added more emphasis, as the title would describe, to certain projects that were considered by the Under Secretary and the Secretary to be important. We stopped doing that and now compete the projects within modernization, patient environment and ambulatory care categories.

It's quite a detailed methodology. It's a model. It's not perfect. I don't think anybody that is familiar with it and uses it believes it's perfect. And, of course, it does cull some projects out and leave some in.

Mr. HUTCHINSON. Let me get this question asked before that red light comes on. There are two major hospital projects that are included in the fiscal year 1997 request, Travis and Brevard. In light of the bed closures, which I think were 2,294, the cumulative drop in beds system-wide during the last 15 years, about 40 percent, the whole effort to move toward ambulatory care, what's the justification for 2 major hospital projects?

Dr. KIZER. Those two projects reflect the Administration's view of the need for those facilities in those geographic areas. I don't think that our move towards ambulatory care is in any way af-

ected by the fact that we're also looking at constructing a couple of inpatient institutions, one of which is a replacement hospital.

I would also note that while we closed 2,309 beds last year, in the first quarter of this year we will have closed another 2,070 beds. So clearly the trend and the direction of movement towards ambulatory care is not only continuing, but it has accelerated.

Now, you could compare our proposal to a private sector example: Kaiser Permanente, which is often held out as the gold standard for frugality in hospital construction. They currently are building or have just finished four new hospitals in the State of California. They are indeed a model, if you will, for ambulatory care. But as they try to address the needs of their beneficiaries, they find they also need inpatient capacity in some areas.

In the Community of Roseville, CA, for example, which is near where I'm from, the Roseville Community Hospital or the Community of Roseville is building a new hospital that is within a mile of a new Kaiser Permanente Hospital. So you have two hospitals in a relatively small community.

Or take a town like Las Vegas. Las Vegas has three new hospitals under construction at this time, probably because of the shift in population that's occurring there. In Phoenix, which has a hospital bed occupancy rate in the private sector of 58 percent the Mayo Clinic is building a new hospital. And in Chicago, certainly not viewed as being under-bedded, Northwestern University is building a new \$700 million hospital.

So the fact that we are, as is the private sector, moving rapidly towards an ambulatory care-based system does not mean that we don't because of population shifts or replacement needs, have the need for some hospital beds as well.

Mr. HUTCHINSON. We might follow that up another time. Thank you, Dr. Kizer. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman. Dr. Kizer, thank you, and the others, for being here today.

I'd like to ask the question: If you assumed we didn't change the eligibility rules for VA medical care—and I hope we will, and I will be working with the chairman to try to do that—if you assume we didn't, can you tell me over the next 5 years or so how the combination, perhaps the decreasing number of veterans with the increasing number of aging veterans, affects the total demand for health care services?

It seems we always compare this year's budget to last year's budget, and to inflation rates. And that's important, but we also ought to compare our budgets to whether the demand is in net effect decreasing or increasing. How far into the future can we see? And what does that future look like to you, Dr. Kizer?

Dr. KIZER. Everybody's crystal ball for the future of health care is cloudy. But, having said that, I would just note that often the connection is made between the number of veterans; i.e., the decreasing number of veterans, and the needs of the veterans' health care system.

That comparison overlooks the fact that most veterans aren't eligible for care in the VA in the first place. Indeed the majority of veterans functionally are not eligible for care in the VA.

So the reality is that the decreasing number of veterans is not connected to the demand for care in the VA. The demand for care in the veterans' health care system continually goes up. Each year for the past several years we have seen an increased number of patients served.

Eligibility today is confined to essentially service-connected individuals and poor folks. The VA has become essentially a key component of the Federal safety net. That demand certainly is increasing as the existing veteran population ages.

If we look just at health care in general, the demand for services as the population ages, as it goes from, say, age 65 to 80, the demand for services typically will go up 4 to 9 times.

So if we look at our veteran population, in fact, by shortly after the year 2000, 40 percent of our beneficiaries will be over the age of 65. Clearly the demand for both acute care services as well as long-term care services is going to substantially increase.

Mr. EDWARDS. Knowing that it takes subjective assumptions, have you tried to project that out into the future for 4 or 5 years using some sort of numbers?

I mean, as this committee tries to plan how much is enough for health care, if we could assume accurately the demand was going down and a frozen budget would actually be increasing perhaps, care for captive, the demand, in the contrary, is actually going up significantly because of the fact, as you mentioned, that we're going to have to look very carefully at how we define those resources.

Dr. KIZER. Well, we've tried to do some of that. It's complicated. And based on other health care systems that I've worked with, there is nothing that compares to the VA because we have these very byzantine and arcane rules about providing care in predetermined settings.

It would be vastly easier if the intent and the policy of the Congress were that the VA should provide care for whatever the described or prescribed population were in the most cost-effective setting that's clinically appropriate.

If we had that type of policy and guidance, it would be much easier to do projections as to exactly how you could structure dollars to provide the most amount of care in outpatient settings, home settings, day care, and a variety of other venues. We could then tailor our services to provide just the right amount of care at the right time in the right setting for the right cost.

Mr. EDWARDS. Very good. Can I ask you also: Where are we now in the consolidation process? And have you had enough time to start to evaluate whether that process has impacted for better or for worse VA medical care?

Dr. KIZER. Last year we initiated the consolidation of 18 facilities into 8. One of those is fully completed at this point: the Palo Alto and Livermore consolidation. With the initial consolidation, there was something like 42 positions that were identified immediately as being redundant, which translated into a cost savings of about \$2.2 million. The expectation is that as that consolidation or integration matures, that there will be significant further savings identified.

In upstate New York, where another consolidation or integration is rapidly progressing, they have been able to identify a similar fig-

ure of redundant positions, which equated in that case to a savings of about \$1.5 million. That was then redirected to patient care.

We're seeing similar sorts of experiences elsewhere, although the exact numbers may change. Clearly one of the things that we have to do as we move forward is to identify these integration opportunities, where we can manage two or three or more facilities with one management structure and in doing so eliminate redundant positions, and translate the savings from those excess personnel into more clinical care.

Mr. EDWARDS. Thank you. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Edwards.

If I could just follow up on one thing Mr. Edwards brought up about declining or you mentioned, declining veterans' population? I understand there are many factors in the aging and the need for more acute services that would affect the budget part.

But even among the eligible veterans, your projections are that there would be a decrease in the number of eligible under current eligibility rules. Is that correct?

Dr. KIZER. The gap between the number that we currently serve and the total eligible is so wide that functionally they're not dependent.

Mr. HUTCHINSON. It might be debatable what relationship there is, but if those currently eligible—which is what? 2.6, the vets using the VA?

Dr. KIZER. It's about 9.5 million.

Mr. HUTCHINSON. Are eligible?

Dr. KIZER. They are the service-connected and/or low-income veterans.

Mr. HUTCHINSON. But your projections would be that that number would be decreasing?

Dr. KIZER. That number is decreasing as well, yes.

Mr. HUTCHINSON. Mr. Bilirakis.

Mr. BILIRAKIS. I thank you, Mr. Chairman.

Yes, that number is decreasing as well, but if we go to particular geographic areas, we don't find that number decreasing. Isn't that true? Obviously I'm referring to states like Florida.

Dr. KIZER. Sir, as you were kind enough to note already, and as I pointed out in my opening comments—and this is where I believe you're going—the resource allocation methods that have been used in the past have not been equitable.

I inherited a system that the VA recognized it was inequitable. It tried to make some changes. It hasn't worked out the way that some would hope. We are now putting in place a new allocation methodology that I believe will address your situation. The potential shifts in resources are considerable.

Since we don't want to disrupt care for those who are currently receiving care in other areas, we are phasing the new methodology in over a 2 to 3-year transition period to get to where we think it would represent an equitable allocation of the funds that we have.

Mr. BILIRAKIS. Doctor, I intended to commend you before I even asked that question or any question and certainly also to express how I just know, I really believe very strongly, you have a darn tough job. If anybody doubted that, all they have to do is take a look at this quote in the newspaper, in the *Post*, when if you were

asked if the VA would consider closing hospitals, you said, "The real question is not whether the VA will do it but whether Congress will let the VA do it." That kind of says it all. There's no question about that.

Dr. KIZER. What's the answer? [Laughter.]

Mr. BILIRAKIS. Coming from Florida, I would let you do it. I have no idea whether those would take place elsewhere, but I also can understand. We all are fending for our veterans. We are fending for our congressional districts. We're fending for our veterans.

And a veteran in New York State, Pennsylvania, et cetera, et cetera, where they have an awful lot of vacancies generally in their facilities, is just as important as a veteran in Florida. And I realize that.

And I commend you for coming up with this idea of this capitation system. I remember a few years ago the VA came up with the DRG concept. And that was supposed to solve this problem. Then we have this resource-based concept. And that was supposed to solve the problem. And now we hopefully will have the capitation base.

You say that will be in place by 1998. Do you mean fiscal 1998?

Dr. KIZER. Our goal is to have it in place by fiscal year 1998.

Mr. BILIRAKIS. Well, now, why couldn't we have it in place at the latest by fiscal year, by the start of fiscal year, 1998? I mean, what are the problems? You know, I guess if you share those types of problems with us, maybe we can understand a little better why it might take a little bit longer than we sometimes think it should.

Dr. KIZER. Well, we had set this out as a target in fiscal year 1995 and then made some assumptions about what our budget would be in fiscal year 1996. Because we have to make real world spending decisions based on what our budget will be in fiscal year 1996, we're still not sure as we continue to operate under a series of continuing resolutions.

And so that's one factor that complicates our decisions for fiscal year 1996. We don't know exactly what we're going to spend this year. It makes it harder to actually shift funding.

Mr. BILIRAKIS. Get the President to sign the bills, sir. Then we wouldn't have these—

Dr. KIZER. I imply nothing other than the facts.

Mr. BILIRAKIS. I know politically the problems that would take place there, but we're talking about shifting the resources when you talk about capitation.

When you refer to capitation, you mean true capitation. In other words, I mentioned the snowbirds, very fondly the snowbirds, in my opening statement. So those people taxing the facilities in Florida, the Florida facilities then would receive credit for it.

Dr. KIZER. You hit upon one of a number of nuances that, frankly, we're having to write the textbook on. If you're in a managed care program, capitation means you have a body that you're responsible for. And a certain amount of money goes with that. And you know what your service area is and what your facilities are, et cetera.

The snowbirds are a good example of where funds may be allocated or they may come from an area in the Northeast, where ultimately they end up part of the year getting their care in the South-

east. How do you capitate or allocate funds in a way that addresses that behavior, which is quite different than what is the basis for capitation in private sector managed care?

We also have some other things that make it more difficult in the sense of some of our special populations or special service needs that are very high risk, high utilization. How do you come up with an appropriate capitation rate for them, even though numerically they're a relatively small part of the overall service population? How do you achieve the balance and equitably fund those, support those services, which are critical to the VA, but at the same time address the special needs that go with those service populations?

So we're wrestling with some issues that, frankly, the private sector has not yet addressed.

Mr. BILIRAKIS. Well, sir, if we're talking about true capitation, I guess basing it on the prior years that statistics in terms of allocating the dollars would be—well, let me go into the third party reimbursement.

How much money does the VA—I guess my time has expired, hasn't it? I'll stick around for another round. Thank you.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Bilirakis. Mr. Tejada.

Mr. TEJEDA. Thank you, Mr. Chairman.

Currently, Dr. Kizer, the VA is authorized to collect co-payments from veterans and reimbursement from insurance companies for veterans, non-service-connected cases. The collections are deposited in the U.S. Treasury and are not available to the VA to expand and improve health care.

It's my understanding that the gain-sharing proposal, which would require a legislative change, would enable the VA to retain 25 percent of the collections for Category A veterans; that is, service-connected veterans, and 100 percent for Category C veterans; that is, non-service-connected veterans, after a baseline level of collections are achieved.

The question I have is: Will the individual facilities be able to retain all or a majority of the monies they collect above the baseline?

Dr. KIZER. We haven't come to final closure on that issue. Certainly the intent would be that the bulk of those funds would stay with the facility. Again looking at it from a national system point of view, some places or some facilities would have much more opportunity to capitalize on those funds than others because of the local demographics of the population that they serve.

And one of the issues that comes up that we've not, as I say, come to final closure on is: How can we somehow both reward the facilities for being aggressive and going after as much of that as possible but at the same time try to achieve some balance or equity in a system for those other facilities, i.e., other parts of the country that would not have the same opportunity to recover funds just because of the local circumstances.

So we, as I said, would want the bulk of those funds to go to the facility making the collection. Exactly what the mix might be is something that we have not come to closure on.

Mr. TEJEDA. Thank you.

The proposed increase in health care funding does not cover, in my opinion does not cover, inflationary and payroll increase. How do you envision the VA making up for the shortfall?

Dr. KIZER. Well, that goes to the heart of many of the things that we are trying to do in restructuring the system. We need to achieve as much efficiency as possible because your observation is quite correct. The medical CPI is projected to be 5.2 percent in 1997. And the increase in medical care appropriation is 2.7 percent. We're at half of what inflation will be. And so we're going to come out on the short end of the stick.

Indeed that has been the case for many years in the VA. So we need to achieve efficiencies wherever possible. If we can merge the management of facilities and, in doing so, redirect funds from excessive or redundant management personnel to clinical care, we need to do that.

If we can save money in how we handle our pharmaceutical products through things like the consolidated mail-out pharmacy programs we need to do that. We have now been able to demonstrate about \$1.25 savings per prescription, which on the 11 million prescriptions that they will mail out this year, equates to about a \$13.75 million savings. As we finalize our prime vendor program this year, we hope to achieve about a \$20 million in savings there.

We hope to achieve as many efficiencies as possible to try to maintain the level of care or the number of patients that we're taking care of. You have hit the nexus of the problem. How do we do that? We're trying to do it through better management.

Mr. TEJEDA. One last question. And that is: At facilities that have already derived significant savings through integration, do you envision those facilities having to find additional savings to maintain their current level of service?

Dr. KIZER. In some cases that's quite possibly going to have to happen. With the implementation of the VISN management structure with the concept of an integrated service network, instead of those decisions being facility-based, which often skews how you would make your decision, we are looking at how a population can best be served by a number of facilities and not just individual facility based impacts.

If we can integrate those facilities and the personnel pool our resources and allocate them in a way that best serves the needs of the overall population that has to be served we can minimize those impacts on our patients.

Mr. TEJEDA. Thank you, Mr. Chairman. Thank you, Dr. Kizer.

Mr. HUTCHINSON. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

Dr. Kizer, I've learned through conversations with veterans in my district that Chicago area VA hospitals are deliberating the possible shutdown of inpatient substance abuse treatment programs. In particular, I've received letters concerning the possible shutdown of the West Side VA Inpatient Substance Abuse Center. The center now aids 380 veterans on an inpatient basis and more than 500 veterans in its outpatient facility annually.

I understand the VA's proposal of eliminating functions in the VA hospitals sharing a similar geographic base. I also recognize the VA's intending to shift many of its functions from an inpatient to

an outpatient basis. However, I'm very concerned about these potential cuts.

So could you offer this committee some insight into the future of the VA's substance abuse programs, given the restructuring of the VA in general? And can you describe the situation in regards to how it will affect the Chicago area hospitals? And is it true that the VA has such plans?

Dr. KIZER. Currently, at our facilities in Chicago as well as elsewhere, we're discussing those sorts of things. The real issue is the outcome. Is the outcome that is achieved from inpatient substance abuse treatment better than the outcome that's achieved through outpatient substance abuse treatment as measured by recidivism rates, return to employment, et cetera, et cetera?

The science, or the data to date, suggest that there really is no difference in outcome between inpatient and outpatient substance abuse treatment programs. So the question is: How can we provide for the needs of those folks who have substance abuse problems that need treatment? In some cases they don't have housing or other things. And the question is: Do we need to provide them a bed in an acute care hospital to do that or could we do it through some other arrangement?

And this same sort of question is being asked with PTSD programs and others. And if you can't demonstrate that there is clearly a therapeutic advantage to the inpatient program, and you know that those inpatient programs cost markedly more than outpatient programs, how can we then provide the same therapy but also address some of the other needs and go forward?

That's why we're looking at: How can we increase our hoptel or hotel capability? How can we increase our residential care capacity?

Indeed one of the issues in the eligibility reform legislation—right now we're precluded from having residential care. It may be that, instead of putting somebody in a \$500 a day hospital bed you can put them in a \$50 a day house bed and provide for their housing need. At the same time they're getting their therapy for their substance abuse or PTSD or whatever it may be. So we achieve the savings there and still provide the treatment.

Mr. GUTIERREZ. So, if I understand you correctly, they are looking at restructuring the outpatient and the inpatient and how that's allocated? But you're finding better, more efficient ways to take care of those veterans who do need inpatient care but maybe not in the hospital setting?

Dr. KIZER. That's correct. We're looking at the opportunities for doing that. In some cases we need to renovate wards or whatnot into what may be viewed as hotel capability—i.e., self care units. In other cases—I'm talking now from a national perspective—we're looked at things such as just renting hotel rooms or having hotels or motels designate certain space that would be available.

We're looking at everything from Ronald McDonald Houses to Fisher Houses, to the whole panoply of options where when patients need housing or accommodation, but they don't need acute hospital care, how can we provide for those needs but without the expense that goes with a bed in a hospital?

Mr. GUTIERREZ. Very good. Wednesday's article that I alluded to in my opening statement mentioned that the VA's restructuring may also affect open heart surgery programs offered by three Chicago area hospitals. Has the VA already developed plans to restructure these programs in Chicago? And, if so, could you provide me with the information on those plans?

Dr. KIZER. No, we don't have definite plans at this point, but it is something that is being looked at not only in Chicago but elsewhere. Certainly the experience in the private sector has shown that quality of care, and heart surgery in particular, often goes up with higher volume. We obviously understand why that might be the case.

If we can provide the service in the Chicago area at one facility or two facilities and in doing so meet the needs but not have the expense of having it at three facilities, that would make good management sense.

So the issue is not taking care away, but: Can we consolidate it at one or two facilities and, in doing so, both improve quality and reduce costs?

Mr. GUTIERREZ. Because of the time, I'm just going to hand my third question over to Dr. Kizer. And he can just respond in writing.

Thank you very much, Dr. Kizer. Thank you very much, Mr. Chairman. I'll give you Question Number 3 here to your staff. Thank you very much.

Mr. HUTCHINSON. Thank you, Mr. Gutierrez. Mr. Bishop.

Mr. BISHOP. Thank you very much.

Dr. Kizer, let me ask you your understanding of the 1997 health care priorities. Does it allow for the funds that you feel are necessary to accelerate prioritizing resources towards better health care for veterans?

Dr. KIZER. Let me try to answer. I'm not sure I totally understand your question.

Mr. BISHOP. I just want to know whether you think that the budget as it's being offered gives budget priorities, budget priorities for health care are funded well enough under the proposed budget.

Dr. KIZER. I've learned a couple of things over the years. One is that you can always spend more on health care, no matter who you are in what setting. I think that the budget that has been proposed recognizes and has made a good judgment in trying to balance the needs of both providing health care and sustaining the system while at the same time recognizing the needs to address the Federal budget deficit and those issues.

We are also, as has been discussed some here today and in other settings, trying to move as rapidly as we can to make the VA as efficient a provider as possible. We believe there are significant efficiencies that can be achieved. We don't know at this point what the entire extent of that will be. But we're certainly going to try to move the system as quickly as possible so we both provide high-quality care as well as very cost-effective care.

Mr. BISHOP. The article that we've alluded to indicating the possible reduction of 10,000 workers raises the question in my mind and I'm sure raises the question in the minds of a lot of veterans and their families as to whether or not this type of cut is really

going beyond trimming fat and actually cutting down to the bone to the extent that it will compromise services that veterans need in order to have quality health care. I don't know the answer to that. I'm asking you that, and I'd like you to address it.

Say that you will lose 10,000 employees across the veterans' health care system that now are providing services to veterans, which would be, even as we speak, not adequate. To cut 10,000, it seems to me that that's going to really be cutting into some vital organs in the body of the health that we're delivering to.

Dr. KIZER. Again, as I mentioned before, I wasn't present at the setting where the question was asked and the answer given the other day. What we have talked about in the past is the need to tailor our workforce as we move forward and do some things differently that may result in the need for RIFing or reducing 5 to 10 thousand people. But in that regard, I would add that the net loss would not be that much.

For example, as we move towards primary care and if we need some more general internists or nurse-practitioners or physician assistants and we don't need some subspecialists or specialists, we may have to RIF or restructure our workforce. However, we would be bringing others on board to accommodate the new VA health system needs so that the net loss would be less than the number RIFed.

Mr. BISHOP. What you're suggesting is a reallocation. While it may on paper appear to be that 10,000 jobs have been lost, you're saying that, in point of fact, you don't anticipate that it would be 10,000.

Dr. KIZER. No. In fact, we have budgeted for a reduction of about 5,000.

Mr. BISHOP. Which is half of—

Dr. KIZER. Which is significant, yes.

Mr. BISHOP. Instead of the whole heart, just taking half of the heart.

Dr. KIZER. We do think there are significant staff efficiencies that can be achieved without a decrement in care. And we're moving in that direction.

Mr. BISHOP. The other line of questioning I would like to deal with is the community-based services, homebound services for veterans, which could eliminate the cost of some inpatient services. What do you do in situations where veterans are not physically located near a VA facility?

Dr. KIZER. What has been done historically is they either went without care or they traveled long distances to get the care.

Mr. BISHOP. Do you have anything in the budget that would provide for additional transportation or to help the VSOs because they provide transportation for their members? Since you're going to be downsizing and since you're going to be cutting back and you want it to be community-based, somehow there's got to be some transportation I would think modes in there somehow.

Dr. KIZER. There are a number of things that can be done. As we begin to review our operations from the concept of the integrated service network, we will be looking at how we can outstation personnel to those areas that are currently underserved, and site community-based clinics; and how we could, with increased con-

tracting authority, contract with local private sector or government providers, to enhance our presence.

Right now the VA is far too inaccessible. It has just too few points of access for veterans to get care in a convenient manner. We can, we believe, site a large number of additional community-based clinics or access points, as we call them, to make the system much more accessible, much more user-friendly, and at the same time much more cost-efficient. Care in those settings is far less costly than hospital care.

We sited 15 new access points last year. There are 58 currently before Congress for concurrence. We could see siting as many as 200 more this year. That's really contingent upon congressional approval.

Mr. BISHOP. Thank you very much.

Mr. HUTCHINSON. Thank you, Mr. Bishop.

And, Dr. Kizer, if you'll just help us with the appropriators on all those new access points, convince them that that saves us money and not costs us money, we'll be glad to help you on that.

Dr. KIZER. I have made that argument repeatedly, sir.

Mr. HUTCHINSON. Ms. Brown.

Ms. BROWN. Thank you. Mr. Chairman, I would like for my opening statement to go in the record and as well as my question and answer.

Mr. HUTCHINSON. Without objection, so order.

[The prepared statement of Congresswoman Brown appears on p. 38.]

[The attachment appears on p. 54.]

Ms. BROWN. First of all, Dr. Kizer thank you for being here. I do, however, find it odd that we are meeting about the fiscal year 1997 when fiscal year 1996 has not been finalized and signed into law. Despite the fact that we didn't get full funding last year for the Brevard County Hospital that VA had requested, an additional \$42.6 million has been requested for this year. I see we have a future request of \$104 million in the out years, which brings the total to \$171 million to complete a new medical center in North Central Florida.

Obviously the administration supports that hospital. You must have some reason to believe that this hospital is still needed. Can you speak to that and also a little about the care the veterans are receiving in North Central Florida?

Dr. KIZER. I think Mr. Catlett was going to address part of that. I would just say that the administration's position is that there is still substantial unmet need in that area that this facility would address. As far as the funding in the out years, Mark, do you want to—

Mr. CATLETT. Ms. Brown, I was just noting that the 1997 request is for \$42 million. The \$104 million is in future years.

Ms. BROWN. So that brings the total to \$171 million. Can you speak to that? The legislature in their wisdom did not fund this last year. And I'm hoping that they look very closely at it, but I'm wondering. And I very much support the administration position. But can you explain to me a little bit more as to why we're still requesting it?

Mr. CATLETT. Well, that's what Dr. Kizer just spoke to. The need for beds is still evident although the system has continued to focus on outpatient care. This is a service area that's underserved in terms of the beds as well as the outpatient capacity.

Ms. BROWN. Because of the growth in the area?

Mr. CATLETT. Yes.

Ms. BROWN. Let me say one other thing. I am hoping that the President doesn't sign the VA budget when it gets to his desk. I just want to state that for the record. I haven't called him recently on it, but I will call him and ask him not to sign.

(Subsequently, Ms. Brown submitted the following additional statement for the record:

The President has submitted his fiscal year 1997 budget in good faith. It is now in the hands of Congressional Appropriators. If they decide to decimate the veterans' budget again this year and shortchange our veterans, I will recommend a presidential veto.

Mr. HUTCHINSON. Thank you, Ms. Brown.

Dr. Kizer, could you describe the Department's position on long-term care? Last year's budget, as I understand it, proposed nearly 95 percent of the long-term care funds for institutional care, contrary to the national trend of providing non-institutional alternatives to long-term care. Does the Department have a position on the mix of institutional to noninstitutional or alternatives to traditional nursing home care and were you to go in that direction?

Dr. KIZER. Well, I'd certainly like to see us do more in the noninstitutional care setting. And it would certainly be helpful if the laws were changed that would allow us to move more in that direction as far as the eligibility statutes that would provide us more flexibility in that regard.

Mr. HUTCHINSON. Mr. Edwards. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Doctor, Mr. Tejada sort of touched on my area that I started to question you on: Third party insurance. How much does it cost the VA to collect that money? Is there an additional cost, would you say?

Dr. KIZER. An additional cost to what?

Mr. BILIRAKIS. Third party insurers.

Dr. KIZER. Well, the medical care cost recovery program is totally self-supporting. So there is no appropriation to support that program. The costs come out of what is recouped. And, of course, the vast amount of it is recouped and turned back into the Treasury.

Mr. BILIRAKIS. "The vast amount of it" meaning amount over and above the costs to recover it. Is that right?

Dr. KIZER. Eighty percent.

Mr. BILIRAKIS. All right. Do we know how much we bill third party insurers for medical care?

Dr. KIZER. Well, what we know is how much has gone back to the Treasury in recent years. It's about \$560 million to \$580 million. We do believe that there is more that could be achieved in that regard. But, in all candor, with all the other things that our facility directors are focusing on and all the changes underway, there's no incentive for them to devote attention to an activity that has no direct impact on their operations. There's no incentive for

them to go after all of these dollars since it costs them resources and time to do it and they don't have—

Mr. BILIRAKIS. Should there be?

Dr. KIZER. That's why we're proposing the gain-sharing legislation. I think if certainly the incentive were there to retain some or all of the funds, that would increase the attractiveness to go after it.

Mr. BILIRAKIS. All right. Now, \$560 million to \$570 million is gone to the Treasury. That is net over and above actually what's collected. Some of it went into cost, I suppose, I guess. Is that right? In other words, we had collected more than that, but only—

Dr. KIZER. Todd has those numbers.

Mr. GRAMS. In 1995, total collections were around \$580 million, as Dr. Kizer said. Costs of the program were around \$100 million.

Mr. BILIRAKIS. I see.

Mr. GRAMS. So we turned over to the Treasury, to help reduce the deficit, almost \$500 million.

Mr. BILIRAKIS. How much did we bill those third party insurers? I guess I'm getting now to the uncollectible, to get to your point, Dr. Kizer, or maybe give some incentives.

Mr. GRAMS. I don't have that information here with me.

(Subsequently, the Department of Veterans Affairs provided the following information:)

MCCR

Amount of Insurance Billed and Collected

The following table illustrates the VA's collection experience with inpatient and outpatient Medigap and non-Medigap insurance plans. As the table demonstrates, the VA's collection record is distorted by the Medigap collection activity. In FY 1995, inpatient Medigap policy payments were capped at \$716. This equated to approximately 16% of the average established receivable. Similarly, the outpatient Medigap policy paid approximately 20% of the average established receivable.

	FY 1995 Medigap	FY 1995 Non-Medigap	FY 1995 Total
Inpatient Third Party			
Amount Billed	623,364,242	415,576,161	1,038,940,403
Amount Collected	99,738,277	256,415,400	356,153,677
% Collected	16.00%	61.70%	34.28%
Outpatient Third Party			
Amount Billed	254,443,237	169,628,824	424,072,061
Amount Collected	50,888,647	115,779,913	166,668,560
% Collected	20.00%	68.25%	39.30%
Total Amount Billed	877,807,479	585,204,985	1,463,012,464
Total Amount Collected	150,626,924	372,195,313	522,822,237
% Collected	17.16%	63.60%	35.74%

VA's collection experience with other insurers, that are non-Medigap insurers, is much better. In the case of other insurers, VA's collection rate for an average inpatient care claim is 61.7% and for an average outpatient care claim is 68.25%.

As the chart above illustrates the combined average collection rate for Medigap and non-Medigap for inpatient and outpatient claims are 34.28% and 39.30%, respectively.

Collection experience for the VA is different for VA than for most private sector medical centers.

The dollar value of the receivables established (Amount Billed) by VA medical centers does not reflect the actual recovery potential of the MCCR program. There are a number of factors that contribute to the overstatement of receivables outstanding. These include:

- * About 60% of veterans having health insurance, who are treated by VA, are over 65. Most of these insurance plans are Medicare supplemental plans. In FY 1996, they cover only \$736 of the cost for the first 90 days of inpatient care in a 365 day period. Outpatient benefits are limited to 20% of the outpatient charge. Consequently, an insurance claim for full care is established, e.g., \$10,000, yet only \$736 is expected in recoveries. (Worth noting is the fact that while representing 60% of all insurance billings, the over 65 age group represents only 40% of patients treated by the VA.)
- * Significant outstanding receivables on the books represent unpaid Medicare supplemental claims. VA pursued litigation with three Blue Cross companies to force payment of Medicare supplemental policies. Although VA won the litigation, a number of payers are still contesting the right of VA to recover payments for Medicare supplemental policies.
- * Not all services provided by the VA are covered by third party insurance. Some services are only partially covered and other services have limited coverage authorized per year. Psychiatry services are an example. Most policies either exclude or limit psychiatric care to acute days and limit the number of billable days per year or in a lifetime. Also, unlike the private sector, costs not covered by an insurance carrier are NOT passed on to the patient for payment.
- * Not all policies billed are reimbursable. Many facilities bill HMO and PPO plans in an effort to establish documentation of care provided in case HMOs change their rules and pay at a future date. In most instances, HMO and PPO plans only reimburse for emergency care.
- * Receivables must be established for the billing period using approved VA per diem rates. Consequently, receivables are overstated in cases such as the Medicare supplemental example cited above and in the case of

outpatient care where our claim for \$205 may receive a reimbursement of \$41 for an office visit.

- * Most health care contracts include patient copayments and deductibles which VA does not require patients to pay. Consequently, claims for reimbursement of the costs of care and actual payments differ by at least the copayment and deductible requirements of the policy.
- * VA recoveries from third party payers are limited to the terms of the contract between payer and insured. In most instances, policies limit payments to some percentage of customary and reasonable charges. For example, traditional policies may cover 80% of customary charges and providers rely on self pay by patients to recover the remaining 20%. VA does not require veterans to pay the outstanding balance (balance billing.)
- * By law, insurance payers may pay VA based on what the VA bills or upon usual and customary charges. This means that payers have control of the value of the service provided. In the outpatient area, as many as 25% of outpatient claims lacked adequate coding of the care provided. The absence of detail results in payers assigning the lowest valued office visit rate to the care.
- * Due to the recent release of new software functionality, VA medical center finance offices have not had the opportunity to fully implement the software which allows for insurance claims tracking and accounts receivable functions that identify insurance category, estimate net recovery potential, and support timely contract adjustments.

Mr. BILIRAKIS. You don't?

Mr. GRAMS. I believe we collect around 60 percent or so of what we bill. One of the major problems we run into with our older veteran population is Medigap insurance plans that they have. We cannot bill Medicare. We cannot collect from Medicare. We are fighting Medigap plans, the Blues and others, to get a legal record established so that we can collect from those plans.

Mr. BILIRAKIS. In other words, because we can't collect from Medicare, they use the argument that, therefore, it also includes Medigap?

Mr. GRAMS. Yes, sir.

Mr. BILIRAKIS. Interesting. Do we have any idea how much we conceivably could get from Medigap if we had a law that will allow us to do that?

Mr. GRAMS. I don't have that figure with me today. We can certainly provide it to you.

Mr. BILIRAKIS. Could you do that?

Mr. GRAMS. I believe it is substantial.

(Subsequently, the Department of Veterans Affairs provided the following information:)

MCCR

Recoveries from Medigap Insurers

In the early years of the MCCR program, VA met with serious resistance from Medigap insurers who argued that since VA could not bill Medicare, their Medigap policies were not required to pay VA for care provided. In three separate litigation cases against Blue Cross Medigap Insurers in Alabama, Maryland and Pennsylvania which were pursued by the Department of Justice, VA established its right to recover from these insurance plans. Currently, VA faces a court challenge from several large commercial Medigap insurers requesting VA to provide the equivalent of the Remittal Advice and the Explanation of Benefits normally prepared by a Medicare Carrier or Fiscal Intermediary to identify the Medicare obligation for each episode of Care. VA is working to resolve the issue.

Amount that we could recover from Medigap insurers

Our estimate for FY 1995 is that we recovered nearly \$100 million from Medigap insurers. Two factors contribute to the difficulty in projecting potential recoveries from Medigap insurers: (1) the actual number of veterans covered by Medigap Supplemental insurance and (2) the determination for those patients covered by Medigap Insurance that the treatment provided by VA was nonservice-connected.

Since these two variables can only be approximated, it is impossible to accurately estimate the full collection potential VA may have from Medigap Insurance.

Mr. BILIRAKIS. Basically I guess what I'm getting at is, resources being what they are, none of us are happy with the money that is available for the VA to spend for the veterans. But we want to try to help you.

I know I speak for the chairman and for the ranking member of the committee if we have that information and it costs you about \$100 million of that \$580 million to come to make the collection.

How—and this is a very sensitive subject because we play Medicare general senior citizen versus veteran who is also elderly. How much could we expect to receive if we, in fact, allow the billing to Medicare?

Dr. KIZER. I don't know if I could give you a number that I would firmly endorse. I've heard numbers that range everywhere from \$1 or \$2 billion to \$3 or \$4 billion. It's clearly a substantial amount of money.

And I guess, if I may, sir, just to digress one moment, as someone coming into this system as well as a taxpayer, it always surprises me why the Medicare program doesn't look more favorably, indeed more aggressively, upon the VA as a provider of service for them if we can believe what GAO says and indicates that Medicare is paying 30, 40, 58 times as much for surgical dressings as what the VA pays, if we know that they're paying 2 to 3 times what the VA pays for oxygen therapy, if we know that we're 25 to 50 percent lower on pharmaceuticals, recognizing that Medicare doesn't cover much in the way of pharmaceuticals but someone is paying for that, recognizing that our physician salaries are lower.

If you start adding these things up, the average urban hospital last year made 6.6 percent profit off of Medicare. Medicare managed care programs are making significant profits. I would think that if you're trying to stretch that taxpayer dollar, stretch that Medicare dollar as far as possible, one might start looking at the VA as potentially a very viable option.

Mr. BILIRAKIS. If you're talking about not taking away from quality of service—and I believe you would be because I, frankly, think very highly of the quality of service in our VA facilities on a relative basis—the concern always is: Are you shifting Medicare dollars that could be available for Medicare to the VA system?

And, of course, we also have problems as far as, as you know, with Medicare right now the fact that it's forecast to go broke by 2002 if something is not done, that sort of thing. So you've always got to play all of these things.

Looking at it from your standpoint where you're talking about the same quality or better service and for less cost to the taxpayer, maybe we should take more serious looks at the overall picture.

Thank you very much, Doctor.

Mr. HUTCHINSON. Thank you, Mr. Bilirakis. Ms. Brown.

Ms. BROWN. Yes. Psychiatric care is one area that I'm concerned about. And I understand that many Florida veterans are currently being shipped out to states closely surrounding Florida for some long-term care. What are we doing to address this problem?

(Subsequently, the Department of Veterans Affairs provided the following information:)

The proposed new hospital for Brevard County includes 230 psychiatric beds to address the needs of Florida veterans for psychiatric care.

Dr. KIZER. Overall the VA provides long-term care in VA facilities through the state home program and through a contract nursing care program. VA nursing homes are typically 95 to 98 percent occupied, which is functionally about as full as you can keep them.

And if we look at the needs down the road, there's clearly going to be a lot more need. That's part of what we're restructuring. How can we stretch those dollars that we have to provide more care, in this case long-term care?

We currently, as you may know, are looking at the contract care program. On any given day in the VA, there are approximately 9,000 patients who are maintained in the community. Historically the contracts for that care have been provided on a facility basis such that under the current time we have 3,200 contracts to manage those 9,000 patients.

That seems a little excessive in the number of contracts in my mind. And so we did put a bid out some months ago to see if we couldn't consolidate the number of long-term care contracts that we were having to manage. Those bids came in. They're currently being evaluated. And hopefully within a few weeks we'll be able to announce what the results were.

No, we're not going to be able to achieve complete coverage, but if we can start making some inroads in that regard and reducing the number of contracts that have to be managed, then that's going to result in more dollars being able to take care of patients.

Ms. BROWN. Just one other question. For the 1996 budget, on the construction side, can you tell me what were the final cuts for hospital construction in the House and Senate bill?

Mr. YARBROUGH. Cuts from the 1997 budget or the 1996?

Ms. BROWN. No. 1996, 1996. That's the one.

Mr. YARBROUGH. I don't understand the question.

Mr. CATLETT. The House proposal eliminated funding for the replacement facilities at Brevard County, Florida and Travis, California. The Senate proposal eliminated all of the construction of all major projects proposed by the Administration except for one small cemetery project.

Ms. BROWN. So it's about the same for the 1996 year?

Mr. CATLETT. In the overall total.

Ms. BROWN. Okay. These are just the priorities?

Mr. CATLETT. Yes.

Mr. HUTCHINSON. Do you have any other questions, Ms. Brown? Any other members have questions? Mr. Edwards? [No response.]

Dr. KIZER, let me take this opportunity to thank you for your candor and the forthrightness of your answers today and for the job you're doing. Many members have already complimented you, but we do appreciate it. I think you're in a difficult job, difficult position, and with a lot of competing interests. And you do an outstanding job.

Before you leave today I'm going to present you the first copy of H.R. 3118 on eligibility reform with the hope and prayer that it becomes law.

If there are no other questions, this subcommittee meeting is—oh, there are a number of members who have mentioned they would like to submit questions. Is there any assurance of how promptly we could expect answers? And I'm asking that at the request of other members who would hope that we could get expeditious responses.

Dr. KIZER. We will respond as expeditiously as we can, sir. And I thank you for your kind comments as well as the copy of the bill. And we will get you expeditious responses.

Mr. HUTCHINSON. The subcommittee stands adjourned.

[Whereupon, at 1:29 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. CHRISTPHER H. SMITH

Thank you Mr. Chairman.

I would like to thank Chairman Hutchinson for all you have done in leading this subcommittee, whose work is so vitally important to our Nation's veterans. These are difficult, transitional times. By all accounts the VHA must make fundamental, systemic changes in the way it delivers services, if it is to fully meet its vital mission. The reforms, that have been proposed by all sides, would affect the most basic managerial structures that have been employed by the VHA for decades. Despite the fact that no one is satisfied with the current system, reforming the status quo of such long duration is still a complicated task. So again I want to thank the chairman for walking passed through this mine field.

Dr. Kizer, I also thank you for being here today. Like the chairman, I commend you and the 200,000 VHA employees you represent for the extraordinary commitment to our veterans. By remaining steadfast to your mission to serve veterans—even during a time of great financial uncertainty—the VA employees do a great service to our country that we should *all* be grateful for. I know personally from conversations I've had with veterans from my State are very appreciative of this exemplary level of professionalism that was shown.

I've read your testimony Doctor Kizer. While I am concerned that some of the Admistrations funding proposals are not adequate, there is also much that is commendable in what you have to say including: your emphasis on a continued shift from a hospitalization model to an ambulatory care model for health care delivery; better targeting of VA medical resources; and enhancing the VA's incentive to collect revenue from third party insurers.

THE HONORABLE MICHAEL BILIRAKIS
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
MARCH 21, 1996

HEARING ON VA MEDICAL CARE BUDGET AND CONSTRUCTION PRIORITIES

THANK YOU, MR. CHAIRMAN.

FIRST, LET ME TAKE THIS OPPORTUNITY TO COMMEND YOU FOR SCHEDULING THIS IMPORTANT HEARING. I WOULD ALSO LIKE TO WELCOME DR. KIZER TO THE SUBCOMMITTEE. I LOOK FORWARD TO HEARING YOUR TESTIMONY.

OBVIOUSLY, THE VA'S MEDICAL CARE BUDGET IS EXTREMELY IMPORTANT TO ALL OF US. ALTHOUGH I AM ANXIOUS TO HEAR ABOUT THE PRESIDENT'S RECOMMENDATIONS FOR THE VA'S 1997 BUDGET, I AM GOING TO FOCUS MY REMARKS ON AN ISSUE WHICH IS OF PARTICULAR CONCERN TO MY STATE -- RESOURCE ALLOCATION WITHIN THE VA HEALTH CARE SYSTEM.

OVER THE LAST SEVERAL WEEKS, REPRESENTATIVES FROM THE VARIOUS VETERANS SERVICE ORGANIZATIONS HAVE VISITED ME TO DISCUSS ISSUES OF IMPORTANCE TO VETERANS. THEIR NUMBER ONE CONCERN HAS BEEN THE DISTRIBUTION OF RESOURCES THROUGHOUT THE VA HEALTH CARE SYSTEM.

THIS IS NOT A NEW CONCERN FOR FLORIDA'S VETERANS. SINCE COMING TO CONGRESS, I HAVE HEARD FROM VETERANS WHO HAVE MOVED TO FLORIDA AND BEEN DENIED CARE AT THE VA.

PRIOR TO MOVING, THESE VETERANS WERE ABLE TO RECEIVE CARE FROM THEIR LOCAL VA MEDICAL FACILITY. HOWEVER, ONCE THEY MOVE TO FLORIDA, WHICH HAS ONE OF THE LOWEST RATES OF NON-MANDATORY CARE IN THE COUNTRY, THEY ARE TURNED AWAY FROM THE VA BECAUSE THEY FALL INTO THE DISCRETIONARY CARE CATEGORY.

IT IS HARD FOR THESE VETERANS TO UNDERSTAND HOW THEY CAN LOSE THEIR VA HEALTH CARE SIMPLY BY MOVING TO ANOTHER PART OF THE COUNTRY. AS THEIR REPRESENTATIVE IN CONGRESS, I SHARE THEIR FRUSTRATIONS.

MANY OF THEM ARE FORCED TO MOVE BACK HOME TO GET THE CARE TO WHICH THEY ARE ACCUSTOMED. OTHERS SIMPLY GIVE UP IN DESPAIR.

UNFORTUNATELY, THE SITUATION ONLY APPEARS TO BE GETTING WORSE. I FOUND JUST LAST WEEK THAT THE WEST PALM MEDICAL CENTER ANNOUNCED THAT IT WILL NO LONGER ACCEPT NEW PATIENTS CLASSIFIED AS "CATEGORY C" BECAUSE OF BUDGETARY CONSTRAINTS.

THE WEST PALM FACILITY IS THE SECOND FLORIDA MEDICAL CENTER TO IMPLEMENT THIS POLICY THIS YEAR. IN JANUARY, THE BAY PINES MEDICAL CENTER ALSO BEGAN RESTRICTING CATEGORY C VETERANS' ACCESS TO CARE IN ORDER TO TREAT THOSE WHO HAVE A HIGHER PRIORITY.

MY VETERANS ALSO RAISED CONCERNS ABOUT THE IMPACT "SNOWBIRDS" HAVE ON THEIR ABILITY TO ACCESS THE VA

VETERANS ARE LITERALLY CROWDED OUT OF THE SYSTEM BY INDIVIDUALS WHO TRAVEL SOUTH TO ENJOY OUR WARM WEATHER. ALTHOUGH I CERTAINLY CANNOT BLAME ANYONE FOR WANTING TO ESCAPE THE SNOWY NORTH, THERE IS NO DENYING THAT SNOWBIRDS HAVE A DEVASTATING IMPACT ON FLORIDA'S VETERANS.

I ALSO HAVE A HARD TIME EXPLAINING TO FLORIDIANS WHY THEY HAVE TO WAIT 120 DAYS FOR AN APPOINTMENT WITH THE ORTHOPEDIC CLINIC AT THE GAINESVILLE MEDICAL CENTER OR 65 DAYS FOR AN APPOINTMENT WITH THE CARDIOLOGY CLINIC AT THE BAY PINES MEDICAL CENTER WHEN, AT THE SAME TIME, MEDICAL CENTERS IN OTHER PARTS OF THE COUNTRY ARE ADVERTISING FOR PATIENTS.

SEVERAL RECENT GAO REPORTS HIGHLIGHT THE FUNDING DISPARITIES AMONG VA HEALTH CARE FACILITIES ACROSS THE COUNTRY. THREE YEARS AGO, THE DEPARTMENT OF VETERANS AFFAIRS PUT IN PLACE A SYSTEM KNOWN AS RPM (RESOURCE PLANNING AND MANAGEMENT) WHICH WAS SUPPOSED TO GIVE VETERANS BETTER ACCESS TO HEALTH CARE REGARDLESS OF WHERE THEY LIVE.

HOWEVER, ACCORDING TO GAO, THE DEPARTMENT HAS MADE ONLY MINIMAL CHANGES IN FUNDING ALLOCATIONS FOR FACILITIES DURING THE TWO BUDGET CYCLES IN WHICH RPM HAS BEEN USED. THE MAXIMUM LOSS TO ANY ONE FACILITY WAS ONE PERCENT OF ITS PAST BUDGET AND THE AVERAGE GAIN WAS ALSO ABOUT ONE PERCENT.

IN FISCAL YEAR 1995, FLORIDA FACILITIES CONTINUED TO HAVE THE HIGHEST NUMBER OF APPLICATIONS FOR MEDICAL CARE BY SERVICE-CONNECTED VETERANS IN THE NATION. YET, VA EXPENDITURES FOR MEDICAL SERVICES AND ADMINISTRATION FOR FLORIDA CONTINUES TO LAG BEHIND STATES SUCH AS CALIFORNIA, NEW YORK AND TEXAS, WHICH HAVE FEWER APPLICATIONS FOR SERVICE-CONNECTED CARE.

THE VA IMPLEMENTED THE RPM SYSTEM TO CORRECT THIS VERY INEQUITY. YET, THE PROBLEM PERSISTS. I HOPE DR. KIZER WILL ADDRESS THIS ISSUE DURING HIS TESTIMONY TODAY.

SO WITH THAT, MR. CHAIRMAN, I WILL CONCLUDE MY STATEMENT. AS ALWAYS, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THE SUBCOMMITTEE ON THE ISSUES BEFORE US TODAY.

THANK YOU, MR. CHAIRMAN.

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**Congress of the United States
 House of Representatives
 Washington, DC 20515**

CORRINE BROWN
 3D DISTRICT, FLORIDA

OFFICE**WASHINGTON OFFICE:**

450 LONGWORTH BUILDING
 WASHINGTON, DC 20515
 (202) 225-6122
 Fax (202) 225-1394

DISTRICT OFFICES:

314 PALMETTO BLVD
 JACKSONVILLE, FL 32202
 (904) 846-1822
 Fax (904) 846-1731

75 HAWKEYE BOULEVARD
 GAINESVILLE, FL 32604
 (352) 872-0866
 Fax (352) 872-8782

551 SE 3RD PLACE
 SUITE 104
 GAINESVILLE, FL 32601
 (352) 378-4882
 Fax (352) 378-4888

Orlando Office, Florida
 Title Page
 (407) 254-2014

HEARING:

**VA MEDICAL CARE BUDGET AND CONSTRUCTION PRIORITIES
 SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
 COMMITTEE ON VETERANS AFFAIRS**

**OPENING STATEMENT BY
 CONGRESSWOMAN CORRINE BROWN**

Mr. Chairman, thank you for holding this important hearing today. Today we will hear from Dr. Kenneth Kizer, Under Secretary for Health at the Veterans Health Administration of the Department of Veterans Affairs. I am so pleased to welcome Dr. Kizer here today.

Thank you for being here today to discuss with us the VA's budget for Medical care and Construction. The President has just released his proposed budget for FY97 and I am happy to see that comprehensive medical care and the construction of new facilities for growing areas -- like North Central Florida -- remain a priority of this Administration.

As you know, Florida's veterans population has grown substantially in the last few years. The nearly 2 million Florida veterans are concerned about what will happen to them when they get sick and need medical care. According to some estimates, 100 veterans move to Florida each day.

The President knows that we must never forget about the sacrifices of our veterans. In our quest to pass a responsible budget, it would be wrong to do this by cutting back on health care for our veterans, who have made this country what it is today. So I commend President Clinton and VA Secretary Jesse Brown for responding to veterans' needs with such strong advocacy.

Thank you again for being here, Dr. Kizer. I'm looking forward to hearing the VA's plans for our nation's veterans.

Statement by Rep. Gutierrez
Subcommittee on Hospitals and Health Care
March 21, 1996

Good morning.

Mr. Chairman, I would like to thank you once again for holding this important hearing to discuss the Medical Care and Construction priorities for the upcoming fiscal year.

Dr. Kizer, once again I welcome you to these chambers.

I would like to commend you for your perserverance in these tough times. The VA's Medical Programs, as you point out, are undergoing a significant restructuring to expand the outpatient accessibility and provide more efficient care for our nation's veterans.

However, Congress hasn't exactly been helpful with this task. Budget rhetoric and budget cuts have placed unfair constraints on the ability of this committee and the Department of Veterans Affairs to follow through with plans for an improved VHA.

The delays in enacting a fiscal year 1996 budget have certainly added to uncertainty at the VA.

Dr. Kizer, I was pleased to hear you mention the responsibility of Congress to pass eligibility reform this session. We made a pledge to our nation's veterans and to your agency to aid in the overdue restructuring plans of the VHA.

Without the outpatient eligibility reform you mention this cannot happen according to the plans your agency and this Congress approved.

I am hopeful that this committee, which has worked to produce bipartisan eligibility reform in the past, will get the job done right away.

I would also like to take this time to raise my concerns about funding levels for VA Medical Programs and how these will affect the restructuring of the system.

As you know this past Wednesday the Washington Post ran an article about the budget, with the headline "VA May Lay Off 10,000 Workers Next Year." I am extremely concerned about the overall provision and quality of medical services to the 2.9 million individuals the VA expects to treat in the fiscal year 1997.

With the veteran population rapidly aging I believe that the VA must become more efficient without diminishing its capacity to adequately serve the older veterans population.

I am concerned that impending staff cutbacks and the possible closure of facilities alluded to in yesterday's article undoubtedly would hamper the VA's ability to do so.

I am sure that Dr. Kizer and Assistant Secretary Catlett have planned to address this issue.

So, Mr. Chairman, and Mr. Edwards, I look forward to today's hearing, and to working with you to ensure that Congress makes good on its commitments to our nation's veterans. I will look forward to presenting my questions later.

Thank you.

Statement of Rep. Michael P. Flanagan of Illinois
VA Committee Hospitals and Health Care Subcommittee Hearing
Budget Request for VA Medical Programs
March 20, 1996
11:30 AM 334 CHOB

I would like to join my colleagues on this Committee in welcoming Dr. Kenneth Kizer, Under Secretary for Health, Veterans Health Administration at the Department of Veterans Affairs, Mr. Mark Catlett, Assistant Secretary of Management, Department of Veterans Affairs, and Mr. Chuck Yarbrough, Associate Chief Medical Director for Construction Management, Department of Veterans Affairs. Thank you for taking the time to come before this Subcommittee today with the Fiscal 1997 budget request for VA Medical Programs. I would also like to thank you, Mr. Chairman, for your leadership in holding this Hearing today.

It is imperative that we work together to ensure veterans improved quality and accessibility of health care. I am eager to work throughout the upcoming year to pass reforms that will assist the VA in providing America's veterans with the quality health care that they have earned.

We all recognize the dramatic role our veterans have played in shaping our history. Not once did any of these veterans debate the potential cost of their service. It is our duty to provide them with the best health care and most efficient health care facilities possible. They have earned our continuing attention and support.

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

MARCH 21, 1996

Mr. Chairman and Members of the Subcommittee, I am pleased to have this opportunity to discuss with you the Fiscal Year 1997 budget request for VA Medical Programs.

Mr. Chairman, in viewing the President's request of \$17.9 billion for VA's Medical Programs it is important to remain cognizant of the fact that we expect to continue to restructure and re-engineer the veterans health care system along the lines we have previously outlined to Congress. With the full activation of the 22 Veterans Integrated Service Networks (VISNs), we will continue to emphasize improved accessibility and quality of VA health care, providing care with increased efficiency, and heightened accountability for outcomes and bottom-line results. We have already seen promising change, and I expect these efforts to significantly expand throughout the remainder of this fiscal year and in 1997.

An important assumption underlying our plans for 1996 and beyond was that Congress would enact budget neutral outpatient eligibility reform, and also provide much needed additional sharing and contracting flexibility. These pragmatic authorities are very much needed if VA is to restructure its delivery system to provide state-of-the-art and cost effective health care.

If we are to transition the VA from a hospital-based, specialty focused system to a more efficient ambulatory care-based system, then we must have the basic authorities to allow full use of outpatient care and to allow us to establish community networks of caregivers that are more accessible to our patients. We appreciate your Committee's efforts and the House action in this

regard last year, and we will continue to work with you this year to accomplish meaningful reform of the VA eligibility rules and our basic operating authorities.

The budget also includes important gainsharing legislation that your Committee has endorsed in the past -- to allow the VA to retain a portion of third party recoveries beyond an established collection goal. Allowing VA to retain a portion of collections above the goal will increase the incentive to collect from third party insurers. Specifically, the Administration is proposing that VA keep 25 percent of collections for Category A veterans and 100 percent for Category C veterans after a baseline level of collections are achieved. VA's share of these funds would be re-invested in the system to provide care to eligible veterans.

Mr. Chairman, you have requested that I comment on our plans to change the method by which resources are allocated to VA medical facilities. First, it is important to acknowledge that, at present, resources are not equitably allocated to our various facilities, and there is a need to target VA's medical care resources better. We cannot afford to perpetuate historical funding imbalances. To correct these problems we plan to implement a capitation-based system in 1998. The capitation methodology will be tailored to provide incentives for the use of the most appropriate cost-effective care setting while fully supporting VHA's missions and special programs. Because an immediate shift to capitation would so significantly change funding that it would disrupt ongoing care, this year and again in 1997, we will use a blended-rate methodology that will incrementally shift resources and prepare the system for fully capitated budget allocation in 1998.

The following is a brief summary of the Administration's request:

Medical Care

The 1997 medical care budget request of \$17.0 billion represents a \$448 million increase over the 1996 Conference Report level. This amount should support the treatment of 2.9 million unique patients in a restructured and more efficient veterans health care system.

Medical and Prosthetic Research

The request of \$257 million for VA's medical and prosthetic research program will allow for continued support of most currently approved research projects and direct a more focused research effort towards specific research priorities.

Medical Administration and Miscellaneous Operating Expenses

VHA's headquarters office has been streamlined through an unprecedented staff reduction of 25 percent. This RIF was completed in February. These employment reductions were integrated with the previously planned headquarters restructuring. The Medical Administration and Miscellaneous Operating Expenses (MAMOE) request of \$62 million supports a 610 FTE level in 1997 which includes a transfer of 10 FTE from the Department's Information Resource Management (IRM) Office to establish an Agency Chief Information Office.

Medical Care Cost Recovery

A total of \$119 million is requested in Medical Care Cost Recovery (MCCR) to collect an estimated \$729 million in third party payments, copayments and receipts. Collections are estimated to increase by \$87 million over the 1996 level. As mentioned earlier, legislation is being proposed to allow VA to retain a portion of third party recoveries to direct to patient

Construction

The Administration requests construction funding of \$439.1 million in FY 1997. This construction request includes \$249.9 million for the Major Construction program and \$189.2 million for Minor Construction. The Major Construction request emphasizes ambulatory care and patient privacy and environmental improvements, as well as increased access to VA health care for thousands of veterans.

The FY 1997 Minor Construction program includes \$154.1 million for Veterans Health Administration projects. Of this amount, \$34.8 million is targeted for outpatient improvements that will enable VA to continue its commitment to provide primary and preventive care. Additionally, \$44.1 million will be earmarked for projects that will improve patient environment. In this regard, I should also mention that legislation is also being proposed to increase the limit on minor construction projects from \$3 million to \$10 million.

Mr. Chairman, I look forward to working with you and the members of this subcommittee to meet the many challenges we face. This completes my prepared comments, and I will be pleased to answer any questions the Committee might have.

Committee on Veterans Affairs
 Subcommittee on Hospitals and Health Care
 March 21, 1996 Hearing
 Followup Question for
 Kenneth W. Kizer, MD
 Under Secretary for Health
 from Honorable Chet Edwards, Ranking Member

Question 1: Please expand on the data offered by Dr. Kizer in his opening remarks at the March 21 budget hearing so as to include comparable data for FY 96. Specifically, please contrast by fiscal year -- as to both funding for Fiscal Year 1996 and proposed funding in the budget for 1997 - the percentage increases provided for the VA medical care account vs. the Medicare and Medicaid programs, respectively, and vs. the CPI and medical CPI for those years.

Answer: The increase in outlays for FY 1996 and FY 1997 for Medicare and Medicaid are provided below:

	<u>1996</u>	<u>1997</u>
Medicare	+11.1%	+ 7.1%
Medicaid	+ 6.5%	+11.3%

In contrast the budget for Medical Care increased as follows during these same years:

	<u>1996</u>	<u>1997</u>
Medical Care	+ 2.6%	+ 2.7%

The economic assumption percentage increase for General and Medical Consumer Price Indexes follow:

	<u>1996</u>	<u>1997</u>
CPI	+ 2.7%	+ 3.0%
Medical CPI	+ 4.5%	+ 5.2%

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 2: Is the General Accounting Office on firm ground in testifying recently before Senate appropriators (based on its view that VA has overstated its resource needs and has not factored into its resource assessments the "potential magnitude of future efficiency savings") that a VA medical-care "operating goal of \$16.2 billion a year may be achievable"? If not, please discuss the flaws in GAO's analysis.

Answer: The GAO report overstates the magnitude of potential management saving available to VA. As the GAO report states, our estimate of 5% annual inflation is reasonable and conservative. Assuming the 5% compound annual inflation requirement, VA medical care would have to be 40% more efficient in order to operate at the straightlined 1995 level of \$16.2 billion level in 2002. Over a seven year period, 1996 - 2002, this equates to a cumulative shortfall of over \$25 billion from a 1995 appropriation level adjusted by 5% inflation per year. These additional savings would be over and above the \$10.5 billion in savings that have resulted from the VA medical care budget increasing at a rate less than the Medical Consumer Price Index over the period from 1980 through 1995.

Even though we disagree with GAO's conclusion on the level of achievable saving through the year 2002, we recognize the future will require innovative management in order to succeed in our mission of providing quality health care in an era of limited resources. The Veterans Health Administration (VHA) has recently taken the following actions to promote future efficiency and savings:

- The establishment of 22 VISNs,
- The restructuring of VHA Central Office,
- The increase in the number of unique users while there was a reduction of 2,409 operating beds and a reduction in staff of 3,436 FTE,
- The merger of the management of 18 facilities into 8,
- The elimination of 887 redundant forms,
- An increased number of sharing agreements with DoD,
- An additional 15 access points,
- The implementation of primary care,
- An increase in ambulatory care surgery,
- Pharmaceutical improvement to include formularies for each VISN with a national formulary to come, and
- More products being looked at for volume discounts.

VHA has also been focusing on:

- Development of a set of operating indicators and performance measures,
- Development of Network Director performance contracts,
- New criteria for allocation of FTE, and
- Innovations in nursing practices.

An important assumption underlying our plans to live with constrained resources after 1996 is that Congress will enact budget-neutral outpatient eligibility reform and provide additional sharing and contracting flexibility. These new authorities are critical to our efforts to restructure the VA to provide state-of-the-art health care. If we are to transition the VA system from a fragmented hospital-based specialty-oriented delivery system to a more efficient ambulatory care-based system, then we must have the basic supporting authorities to allow full use of outpatient care and to allow us to establish community networks of care providers that are more accessible to our patients.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 3. Dr. Kizer, you've emphasized primary care delivery in VA. But will VA continue to need to provide acute hospital care in the future? Please provide any projections VHA has made regarding the number of acute care hospital beds VA should be operating in the outyears.

Answer: VA will continue to need to provide acute hospital care in the future. Primary care and use of managed care principles have been emphasized only recently. These will reduce our need for acute hospital beds. However, it would be premature to provide projections of acute hospital bed requirements at this time.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 4: Please provide the total cost of construction associated with the most recently compiled National Major Project Inventory for major medical construction, to include all projects, without regard to their priority score. Of the projects on that list, what is the total cost of all pending projects in those areas which the Department characterizes as its highest construction priorities (which, as we understand it, include ambulatory care and patient environment). In that regard, please identify what those priority categories are.

Answer: The total cost of VA's pending major project inventory is approximately \$5,000,000,000. The highest construction priorities are Ambulatory Care \$890,500,000; Patient Privacy \$1,315,000,000; and Infrastructure \$820,700,000.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 5: How many FTE are needed to activate construction projects coming on line in FY 1997? Why are there no funds provided in the budget to support the opening of those new projects? Where will the dollars come from - the medical facility itself? The VISN director?

Answer: The FY 1997 Medical Care request does not include "line item" requests for the activation of any specific project. The Networks are expected to activate projects from within the level of resources provided in their total Medical Care prospective workload budget allocations. However, during this transition period management level reviews at the Networks and Central Office levels will be performed for each project.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 6: What is the status of development of the "performance measures" discussed in VHA's "Vision for Change"? What process or mechanism is now being used to further develop or refine these measures? What specific steps are being taken to win maximum support for these measures, particularly from those to be "measured" and those concerned with the outcome of those measurements?

Answer: The performance management system involves the development of performance measures that are integrative and outcome oriented. This approach will more closely relate resource distribution to the provision of actual services, and will focus on the functions of our 22 networks.

VHA is currently reviewing proposed measures and assessing its data and data tracking mechanisms for these measures. The measures will be valid and relevant to our mission and vision. This collaborative effort will lead to performance plans this year for network directors and other leaders, initially using a relatively small number of measures in such areas as patient satisfaction, organizational development and reduction of operating costs.

In developing and selecting these measures we have solicited widespread input from clinicians, administrators and program managers. In the case of performance measures for the special programs we have also solicited input from the many stakeholder constituencies. We anticipate using a negotiation process to arrive at the final performance contract measures.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 7: With respect to Dr. Kizer's testimony to the effect that VHA's budget plans assume the enactment of "much needed. contracting flexibility," please clarify specifically whether this is a reference to amending provisions of law other than 38 USC sec. 8153. If so, please specify (1) what other provisions require amending, (2) the "inflexibilities" they create, (3) the precise barriers they erect to contracting, (4) the specific impact of such inflexibility, and (5) the proposed statutory remedy.

Answer: Dr. Kizer's testimony was in reference to VA's proposal that amends sections 8151-53 Title 38 to expand VA's sharing authority.

Committee on Veterans Affairs
Subcommittee on Hospitals and Health Care

Question 8: Dr. Kizer testified as to the importance of VA's providing "hotel" service as a less costly way of overnight lodging of veterans in connection with provision of medical services than lodging the veteran in an acute care bed. Section 601 of H.R. 1468 (104th Cong) would amend the definition of the term "medical services" to include "overnight lodging in Department facilities when necessary for the provision of services on an outpatient basis." Whether or not this language fully meets the goals described in testimony, is there not at least a serious question whether VA has clear authority to provide "hotel" services in its facilities?

Answer: We agree, the VA does not have clear authority to provide the "hotel" services that Dr. Kizer referred to.

Questions by Congresswoman Brown

Question 1: Can you tell me a bit about how patients are being served in North Central Florida. In particular, I want to know about the care of those veterans who need psychiatric care.

Answer: There are two VA medical centers in North Central Florida: Gainesville and Lake City. VAMC Gainesville has satellite outpatient clinics in Jacksonville and Daytona Beach; VAMC Lake City has a satellite outpatient clinic in Tallahassee. The Orlando OPC, located in East Central Florida, is administered by VAMC Tampa.

VAMC Gainesville provided hospital treatment to 8,924 inpatients in FY 1995, 15.4 percent of whom received psychiatric care. During this same period, 5,782 hospital inpatients were treated by VAMC Lake City; 13.9 percent received psychiatric care. As shown below, fewer patients were hospitalized in FY 1995 than in FY 1994 as more VA care is provided on an outpatient basis.

	Facility	Total Inpts <u>Treated</u>	Med Inpts* <u>Treated</u>	Surg Inpts <u>Treated</u>	Psych Inpts <u>Treated</u>
FY95	Gainesville	8,924	3,684	3,868	1,372
	Lake City	5,782	3,735	1,246	801
FY94	Gainesville	9,604	3,905	4,292	1,407
	Lake City	6,059	3,883	1,420	756

* Includes medical, intermediate and neurology inpatients treated.

Gainesville and its satellite clinics provided 249,499 outpatient visits in FY95; 59,546 (23.9 %) of these visits were for psychiatric care. During this same period, Lake City and its satellite clinic provided 96,761 outpatient visits, 13,079 (13.5 %) of which were for psychiatric care. Each facility provided more outpatient care in FY95 than in FY94, as shown below:

	VAMC	Visits	OPC	Visits
FY95	Gainesville	154,399	Jacksonville	51,925
			Daytona Bch	43,175
	Lake City	62,881	Tallahassee	33,880
			Orlando	135,617
FY94	Gainesville	133,146	Jacksonville	48,017
			Daytona Bch	38,128
	Lake City	59,544	Tallahassee	30,076
			Orlando	113,727

An inventory of mental health services in Florida show the following programs available at North and East Central Florida facilities:

Questions by Congresswoman Brown

Mental Health Program	G'ville	Jacks	D.Bch	L.City	T'hassee	Orlando
Inpt Gen Psych	Yes	---	---	Yes	---	---
Inpt Subs Abuse	Yes	---	---	Yes	---	---
Inpt PTSD Unit	---	---	---	---	---	---
Inpt Sustained Tx	---	---	---	---	---	---
Geropsych Unit	---	---	---	Planned	---	---
MH Clinic	Yes	Yes	Yes	Yes	Yes	Yes
Subs Abuse Clinic	Yes	Yes	Yes	Yes	Yes	Yes
PTSD Clinic Team	Yes	---	---	---	---	---
Outpt Day Tx	---	Yes	Yes	---	---	Yes
Intensive Comm Care	Yes	---	---	---	---	---
Voc Rehab	Yes	---	---	Yes	---	---
Comp Work Therapy	Yes	---	---	---	---	---
Vet Center	---	Yes	---	---	Yes	Yes
Residential Care	Planned	---	---	---	---	---
Transitional Housing	---	---	---	Yes	---	---

Additional psychiatric programs are planned for veterans in East Central Florida (assuming a facility in Brevard County is established).

Question 2: Despite the fact that we didn't get full funding last year for the Brevard County Hospital, the VA has requested a total of \$42.6 million for the Brevard County Hospital and Nursing Care Facility. And I see that there is a future request for 104.3 million for a total of 171.9 million dollars to complete the new Medical Center in North Central Florida. Despite the fact that Congress appropriated \$25 million for an outpatient clinic last year, you must still believe that a hospital is needed in Brevard County.

Answer: Yes. We strongly believe that the hospital proposed for Brevard county is needed to meet the health care needs of veterans in East Central Florida and psychiatric hospital care needs of veterans throughout Florida. The proposed project will provide area veterans with access to VA health care services currently not available. These comprehensive services, organized in a managed care environment, will include outpatient care, nursing home care, and long term psychiatric care as well as inpatient medical service.

Questions by Congressman Tejada

Question 1: Gainsharing: Will the individual facilities be able to retain all or a majority of the moneys they collect above the baseline?

Answer: Our intention is to have some of funds collected above the baseline returned to the individual facility. However, there are some system-wide issues to be considered and we have not come to closure on these issues.

Question 2. Capitation: Please explain the blended rate methodology to be used in FY 1997. Will this direct more resources to areas that have greater veteran populations and higher percentages of service-connected veterans?

Answer: The Veterans Health Administration has implemented a new workload pricing approach called "blended rates" for allocating the Fiscal Year 1996 budget. The blended rates workload pricing is intended to target resources on the basis of expected patient care workload and efficiency. Blended rates is a method to set prices for prospective VA medical care workloads. Under blended rates, a unit price for expected workload is established by adding together a percentage of the individual facility's unit price, the peer group average price (MCG), the geographic area average price (VISN) and the VA national average price. The unadjusted proportions add up to 100 percent. For example, as applied in the fiscal year 1996 budget allocations, the blended rate has been constructed from a blend of 70 percent of the facility's price, 5 percent of the Medical Center Group (MCG) unit price, 5 percent of the VISN unit price, and 20 percent of the national unit price. The objective of blending is to promote efficiency and more equitable access to care by veterans across the Nation and to transition VA to a capitated method of resource allocation in FY 98 or FY 99.

We will also use blended rates to allocate the FY 1997 Medical Care Appropriation to the Veterans Integrated Service Networks (VISNs). Decisions about the blending factors for FY 1997 budget allocations have not been finalized. Consideration is currently being given to potential adjustments to the blending factors used in FY 1996 and structuring greater financial support for shifting from inpatient to ambulatory care. The volume of workload, the number of unique persons adjusted to reflect expected utilization, is determined through projections of historical workloads. Veteran populations and counts of service-connected veterans are being explored as variables for use in capitation allocations scheduled for FY 1998 implementation.

Question 3. Capitation: Does the VA intend to go to a full capitation based system in FY 1998? If so, how will the capitation rate be determined?

Answer: We hope to. VHA has chartered a new work group, the Capitation Advisory Panel, to assist in the development and implementation of a capitation-based resource allocation system for Fiscal Year 1998. This panel will also further refine and implement the blended rates for Fiscal Year 1997 as a bridge to the capitation-based resource allocation system. The development of VHA's capitation-based resource allocation system will take into consideration VA's special programs and other unique patient

Questions by Congressman Tejada

populations. With capitation, VISN budgets will be based on the number of veterans that the VISN is expected to take care of for a unit price that considers the risk profile of the patients, including age and casemix, geographic costs and standardized prices. The Capitation Advisory Panel will be exploring various ways for determining the capitation rates; this will include options such as having VHA price standards that consider casemix, geographic costs and veteran population dynamics as well as price standards from outside of the VA. At this time, it is premature to specify what the ratio will be.

Question 4: The proposed increase in health care funding does not cover inflationary and payroll increases. How do you envision the VA making up this shortfall? RIFs?

Answer: The restructuring and streamlining of VA's health care system will provide the framework to operate successfully within the requested resources. Our strategy is to fully implement the Veterans Integrated Service Network (VISN) management structure and provide the VISNs with considerable latitude to be part of the solution in achieving efficiency of operations within resource targets. I expect some RIFs.

We have also clarified contracting authority for the field; provided criteria for program review and potential realignment; adopted a "blended rate" resource allocation model this year to target resources on the basis of expected patient care workload and efficiency; and approved the integration of 24 facilities into 11 entire facility consolidations and expect more of these and numerous functional consolidations to occur this year.

In addition, we will continue to emphasize our Primary Care initiative to improve the management of our patients' care, and we will continue to ask Congress to pass budget neutral eligibility reform and provide additional contracting and sharing flexibility so that we have the tools to provide modern day clinical care to our patients, and manage their care in the most appropriate setting from both a quality and efficiency standpoint.

With the management flexibility that we have provided and with the added flexibility that would come from Eligibility Reform legislation, we will expect our VISN Directors to manage services to veterans in a way that reflects innovation and creativity in the delivery of quality health care to veterans.

Whether or not Reductions-In-Force (RIFs) are required for any specific VISN will depend upon the VISN director's evaluation of the local situation. The RIF option is available to each VISN director if necessary to achieve quality and efficiency goals.

There are a number of important considerations which could require us to use RIFs to restructure our health care system under the VISN arrangement. Some of these involve shifting of resources to support facility activations, restructuring staff at integration sites, and consolidation of functions across facilities. We simply do not have the right mix of personnel at many of our locations to respond to changing healthcare demands. While we will make every effort to provide opportunities for our employees to develop new skills, it will almost certainly be necessary to abolish a number of positions throughout the field and

Questions by Congressman Tejada

to use those resources to fill positions for which there is a more critical need. In each instance, the VISN director will determine whether these restructuring requirements will necessitate a RIF.

Question 5. At facilities that have already derived significant savings through integrations, do you envision those facilities have to find additional savings to maintain current level of services?

Answer: All VA medical care facilities will be expected to seek and implement further management improvements that enhance the quality of care and the cost effectiveness of their operation.

Questions by Congressman Gutierrez

I believe that the administration's budget proposal is generally sound. However, I do have some concerns with it. Many of my concerns are related to the rapidly aging veterans population and the VA's ability to adapt to their demands. About one-third of all veterans are from the World War II era. Their median age is around 70. Another one-third of the veterans population hails from the Vietnam era. Their median age is around 50. Obviously, the veterans population, for the next quarter century or more, will be increasingly afflicted with those chronic diseases that afflict the elderly.

In the administration's budget, it has been pointed out to me that the funding support for nursing home construction grants has been reduced by 17 percent. Given the graying of our veteran population, these programs like the construction of national cemeteries, should experience greater funding level

Question 1: How do you reconcile these demographics with this large cutback in the amount allocated for the nursing home account?

Answer: This program, like most Federal programs has been impacted by the availability of scarce discretionary funding. At the budget level requested, however, we will be able to make significant expansions in veterans long-term care. This request provides for an investment of approximately \$40 million in grants to states for new or renovated long-term care facilities. We also expect to be converting many acute care beds to long term care beds over the next several years.

Questions by Congressman Hutchinson

Question 1. GAO recently released a report entitled *Facilities' Resource Allocations Could be More Equitable* which was critical of the resource allocation methodology; could you describe

- a) how resources for FY 97 will be allocated and
- b) what percent of the total VHA budget will be subject to the RPM allocation process?
- c) What attempts will be made to better adjust resource needs to ensure that resources are allocated more equitably?

Answer: a) The Veterans Health Administration has implemented a new workload pricing approach called "blended rates" for allocating the Fiscal Year 1996 budget. The blended rates workload pricing is intended to target resources on the basis of expected patient care workload and efficiency. Blended rates is a method to set prices for prospective VA medical care workloads. Under blended rates, a unit price for expected workload is established by adding together a percentage of the individual facility's unit price, the peer group average price (MCG), the geographic area average price (VISN) and the VA national average price. The unadjusted proportions add up to 100 percent. For example, as applied in the fiscal year 1996 budget allocations, the blended rate has been constructed from a blend of 70 percent of the facility's price, 5 percent of the Medical Center Group (MCG) unit price, 5 percent of the VISN unit price, and 20 percent of the national unit price. The objective of blending is to promote efficiency and more equitable access to care by veterans across the Nation and to transition VA to a capitated resource allocation methodology in FY 98 or FY 99.

We will also use blended rates to allocate the FY 1997 Medical Care Appropriation to the Veterans Integrated Service Networks (VISNs). Decisions about the blending factors for FY 1997 budget allocations have not been finalized. Consideration is currently being given to potential adjustments to the blending factors used in FY 1996 and structuring greater financial support for shifting from inpatient to ambulatory care. VHA has chartered a new work group, the Capitation Advisory Panel, to assist in the development and implementation of a capitation-based resource allocation system for Fiscal Year 1998. This panel will further refine and implement the blended rates for FY 1997 as a bridge to the capitation-based resource allocation system. The development of VHA's capitation-based resource allocation system will take into consideration VA's special programs and other unique patient populations.

b) VHA has undertaken a comprehensive review of Non-RPM funding -- the funds controlled by corporate headquarters committees during the year. Our goal is to shift more resources into the RPM model, that is, funds distributed at the beginning of the year directly to the field based on projected workload. In Fiscal Year 1997, VHA plans to increase the RPM pool of dollars that go directly to the field in the initial budget allocations by approximately \$1.7 billion over the comparable 1996 distribution. This will have the effect of reducing the amount of funds in the Non-RPM category by almost 50% and put 90% of the Medical Care budget under RPM in Fiscal Year 1997.

Questions by Congressman Hutchinson

c) As noted above, VHA is moving towards a capitation-based resource allocation system for FY 1998. The development of VHA's capitation-based resource allocation system will take into consideration VA's special programs and other unique patient populations. Capitation means paying a provider a flat fee in advance to take care of a set number of patients' health care needs during a defined period of time, according to an agreed upon benefit package. For VHA, the provider network is made up of 22 VISNs. The VISN is the locus for management, planning and budget in the Network geographic area. With capitation, VISN budgets will be based on the number of veterans that the VISN is expected to take care of for a unit price that considers the risk profile of the patients including age and casemix, geographic costs and standardized prices.

Question 2. Many Members of this Committee, especially those representing Sun Belt states believe that sufficient resources are not moved to facilities with growing patient workloads. Please describe how you intend to move resources from one area of the country to another?

Answer: Using blended rates in FY 1996, almost \$150 million dollars was redirected. This is compared to \$10 million shifted in the Fiscal Year 1994 budget allocations, and \$20 million shifted in the FY 1995 budget allocations; shifts in FY 1994 and FY 1995 were identified by the unit cost outlier adjustment process that was replaced in FY 1996 by blended rates. The further refinement and implementation of blended rates for Fiscal Year 1997, and the capitation-based resource allocation system to be implemented in FY 1998, will continue to shift resources on the basis of expected patient care workload and efficiency.

Question 3: Understanding that VA operates 172 hospitals, and that utilization rates vary widely among the facilities, what should be the acceptable utilization range or rate for a particular facility. In the private sector an 85% occupancy rate for bed utilization is considered the standard. Is this appropriate for VA facilities and if not, why?

Answer: Yes, although occupancy rates in private hospitals today average about 65% compared to 72% in VA.

One of VHA's strategic objectives is to shift more resources from inpatient care to outpatient care, as is occurring in the private sector. This shift requires that inpatient beds be closed and that freed resources be applied to expanding outpatient capacity. Closing beds will also have the effect of raising the average occupancy rate.

Question 4. Under RPM, what percentage of funds do you expect to shift this year (FY 96)? In its report, GAO states that overall workload in some facilities has increased by as much as 15% but the average loss or gain of resources to any facility was about 1%. My initial reaction would be that this hardly seems fair.

Questions by Congressman Hutchinson

Answer: Based on current estimates of budget allocations for FY 1996, some networks will receive an increase of approximately 5%, while other networks will be frozen at the 1995 level. The FY 1996 RPM allocations moved over \$150 million through the use of a national pricing system (blended rates). In general, resources have moved to the facilities with increasing workloads and away from those with decreasing workloads. The 1996 facility workload targets will be adjusted to reflect final budget levels. Revised workload targets are being developed at the Agency marginal rate and will be provided to facilities as soon as the full year 1996 medical care funding is settled. The revised workload targets will treat facilities equitably with respect to matching workload expectations with available funding.

Question 5. Originally the RPM system was designed to include a review and evaluation element that could provide feedback to managers on how facilities performed compared with their expected workloads and costs. It is also intended to better link cost data quality indicators. Have these goals been met, and if not, why?

Answer: There is an extensive historical review and evaluation component to the RPM system. As part of the documentation of the Medical Center allocations, every VA Medical Center receives historical analysis of its performance along with a number of comparisons relative to the nation, its Network and peer group. The allocation process also results in budgets that reflect the Medical Center's performance in both cost efficiency and workload. VHA is working on establishing linkages between cost, workload and quality indicators in performance contracts with Network Directors and key Agency officials.

Question 6: Understanding that VISNs are expected to function as that basic budgetary and planning unit for a network of facilities, what is the status of the implementation of these networks? When do you expect the budgetary process to be in control of the VISNs?

Answer: To date (5-8-96), 20 Networks are fully operational. This means that line authority now extends through the Network director to the medical centers. All 22 Networks should be fully operational by the end of May, 1996.

On February 6, 1996, VHA distributed the FY 1996 Target Allowances to the 22 VISNs from a "roll-up" of their VA Medical Center-specific allocations. The FY 1997 Medical Care Appropriation will be distributed to the Veterans Integrated Service Networks (VISNs), based on VISN-specific workloads and blended rate pricing rather than Medical Center-specific allocations. For VHA, the provider network is made up of 22 VISNs. The VISN is the locus for management, planning and budget in the Network geographic area. With VISN performance standards and a fixed amount of resources for expected workload, the Network Directors have the flexibility and expectation to be creative and innovative in their respective operations.

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Question 7: I was notified about the RIF underway at the Ft. Lyon, Colorado VA Medical Center. Can you explain why the costs at that facility were so high?

Answer: The Fort Lyon, VA Medical Center is relatively expensive to operate because it has an unusually high percentage of indirect patient care costs to direct care patient cost. These indirect costs are related to maintaining operations such as wastewater and fresh water treatment, grounds and road maintenance and fire department services. Also, Fort Lyon has increased beneficiary travel costs and employee training/education travel costs due to Medical Center isolation and transportation difficulties.

The positions eliminated with the reduction-in-force are predominantly administrative and were identified through a reorganization plan. The reorganization plan includes streamlining of patient processing and support activities, expanding treatment alternatives so that patients receive the best care at reasonable costs, and creating interdisciplinary teams to address the comprehensive needs of each patient. The plan will bring costs at Fort Lyon in line with other VA facilities and will not compromise the level of patient services currently provided.

Question 8: Please describe the percentage increase for Medical Care over the FY 96 Conference level. In your view, what will be the impact on the system?

Answer: The \$17 billion requested for Medical Care in 1997 represents a 2.7% increase over the 1996 Conference level. The request will allow VA to maintain services to the current level of veterans being treated. We expect to treat 2.9 million unique individuals in both 1996 and 1997. VA will continue to shift workload from inpatient to outpatient care where medically appropriate. Outpatient visits are expected to increase by 1.6 million to 32.7 million while inpatient episodes are projected to decline by 57,000 to 948,000.

Question 9: Please describe the specific management improvements required by the Office of Management and Budget and what impacts they will have on direct delivery of health care services. Are these improvements actually service reductions?

Answer: The current fiscal climate requires significant attention to management improvements. However, there are no OMB directed efficiency adjustments to our FY 1996 budget. The restructuring of the VA's health care system will provide the framework to incorporate management improvements within daily operations. This restructuring will make medical care services and management less centralized, more efficient, and more patient-centered. Each Network director will be responsible for the efficient delivery of health care to veterans. We expect all VISNs will consider consolidation and realignment of facilities, and other strategies to maximize the use of human resources, and to ensure delivery of quality health services through VA or non-VA providers and other actions necessary to provide appropriate and timely care. During FY 1997, we expect to maintain the current level of high priority veterans being treated.

In addition, VHA has already made the following accomplishments:

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- The establishment of 22 VISNs, resulting in \$9.3 million recurring savings;
- The restructuring of VHA Central Office, resulting in \$8.7 million one-time savings;
- The increase in the number of unique users while there was a reduction of 2,309 operating beds and a reduction in staff of 3,436 FTE;
- The merger of the management of 18 facilities into 8;
- The elimination of 887 redundant forms;
- A 10% increase in the number of sharing agreements with DoD;
- Siting an additional 15 community based access points;
- The implementation of primary care, with over 40% of patients now enrolled;
- An increase in ambulatory care surgery;
- Pharmaceutical improvement to include formularies for each VISN with a national formulary to come; and
- More products being looked at for bulk purchasing or other volume discounts.

VHA has also been focusing on:

- Development of a set of operating indicators and performance measures.
- Development of Network Director performance contracts,
- New criteria for allocation of FTE, and
- Innovations in nursing practices.

Question 10: What is the current VHA equipment backlog and how much funding will be allocated to relieve the equipment backlog? What are the equipment funding priorities for FY 97?

Answer: For many years equipment backlogs were used as a basis for estimating Capital budget requirements. However, the validity of the backlog numbers was the subject of much debate and controversy. A new field based method for determining capital requirements is being developed and will be used in future budget processes. As VHA restructures its capital requirement methodologies, the distinction between replacement and additional equipment is no longer used. The Veterans Integrated Service Network (VISN) will manage the available equipment resources to assure that total equipment requirements receive appropriate priority ranking. A new group has been chartered within VHA to develop a capitation allocation system and this group will also be considering how to integrate capital needs into the capitation methodology.

Question 11: Please describe the status of new activations. How many are planned for FY 1997 and where are they located? What is being done for facilities who in the past have never received an adequate share of activation funds, such as West Palm Beach?

Answer: The FY 1997 Medical Care request does not include "line item" requests for the activation of any specific project. The Networks are expected to activate projects from within the level of dollars provided in their total Medical Care Budget allocation. However, during this transition period, management level reviews at the Networks and Central Office levels will be performed for each project.

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Activation funds in the amount of \$121 million had been requested in previous years budgets for the new West Palm Beach Medical Center. Through March 31, 1996, \$118 million has been allotted.

Question 12: Understanding that Hawaii offers limited universal health insurance to its residents, and that DoD has instituted TRICARE for its beneficiaries in this region, what is the rationale for the priority ranking of this project? It would appear that other areas of the country such as Sunbelt states would have a greater need for such a facility. How many unique veterans does the projected outpatient workload of 92,303 veterans represent?

Answer: VA has proposed projects from only four high priority categories (New Hospital, Environmental Improvements, Modernization -- both ambulatory care and environmental improvements, and Seismic) out of a possible 20 categories of projects. VA considers the New Hospital category projects a very high priority because of VA's long standing commitment to provide equity of access to health care for America's veterans irrespective of residence. This category includes the project in Hawaii. It is second in priority to the new Medical Center in Brevard County, FL, which is also being proposed in this budget. The 2005 projected estimate of unique veterans using outpatient services in Hawaii is approximately 14,100.

Question 13: It appears from your submission that you are proposing to change the definition of a minor construction project from the current level of \$3 million to \$10 million. Under this expanded definition what would be the oversight role of the Office of Construction Management and how would this new level affect the construction prioritization process?

Answer: The Office of Facilities Management does not have an oversight role in the minor construction program. This role is handled by the Office of Assistant Secretary for Management. The Office of Facilities Management does anticipate providing technical support to the VAMCs and VISNs for these projects upon request. The Consulting Support Office within Facilities Management is staffed by a cadre of senior technical professionals who respond to VAMCs requests for assistance on a broad range of construction problems. It is expected that this office will be called upon more frequently to assist the VAMCs and VISNs with the new level minor construction projects. For those medical centers who determine they do not have sufficient resources to handle projects of that magnitude, FM is prepared to continue to manage these projects. The projects between \$3M and \$10M are currently given priority scores utilizing the Major Construction Prioritization System methodology and compete with all other major projects in their category nationwide for resources. Under the proposal, projects between \$3M and \$10M would be given priority scores utilizing the prioritization methodology for minor category construction projects and compete with other minor projects nationwide for resources.

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Question 14: What is the amount that the Department estimates it will spend on Contract Care during FY 97? What is it expected to spend during this Fiscal Year (96)? What are the ambulatory contract care costs for Hawaii estimated to be for FY 97?

Answer: The chart below provides the estimated contract care costs for FY 1997 and FY 1996. The total FY 97 estimated ambulatory care contract costs for Hawaii is \$6,200,427. This includes fee-dental, fee-medical, scarce medical specialist and consultants.

1997 Estimated Contract Care		1996 Estimated Contract Care	
Description	(\$000)	Description	(\$000)
Community Nursing Home	\$383,436	Community Nursing Home	\$365,888
Contract Hospital	\$182,076	Contract Hospital	\$173,673
Outpatient (Fee)	\$280,278	Outpatient (Fee)	\$266,496
1997 Total	\$845,790	1996 Total	\$806,057

Question 15: It is my understanding that there are approximately 700 non-service connected, non-indigent patients in VA nursing homes who pay approximately \$6,000 a year for care that costs VA over \$40,000 to provide. What is the VA policy on the operation of these nursing home beds and who has priority for placement in these beds? It would appear that an inequity exists among non-service connected veterans. Most non-service connected veterans are limited to 6 months contract care, how is the VA placement of this particular group of non-service connected veterans justified?

Answer: Assuming that the number 700 is approximately correct, this represents 2.1% of patients receiving care in VA nursing homes. This care is justified according to priorities established by law. At a particular facility, a non-service-connected veteran in need of hospital based nursing home care can be admitted to a VA nursing home care unit when space and resources are available and an application for VA nursing home care from a service-connected veteran is not pending on a waiting list.

Service-connected veterans receive a higher priority for placement in VA nursing home care units. The priorities for care follow:

- a) Any veteran who has a service-connected disability and who requires nursing home care for any condition;
- b) Any veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in the line of duty and who requires nursing home care for any condition;
- c) Any veteran who, but for a suspension pursuant to 38 U.S.C. 1151 would be entitled to disability compensation, but only to the extent that such veterans' continuing eligibility for such care is provided for in the judgment or settlement described in such section and who requires nursing home care for any condition;
- d) Any veteran who is a former prisoner of war and who requires nursing home care for any condition;

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- e) Any veteran who served in Vietnam during the Vietnam era and who may have been exposed to Agent Orange or to other toxic substance and who needs care for a condition possibly related to such exposure, and to veterans who were exposed while on active duty to ionizing radiation from nuclear testing or participation in the American occupation of Hiroshima and Nagasaki following World War II and who are in need of nursing home care for a condition possible related to such exposure;
- f) Any veteran of the Spanish-American War, the Mexican Border Period, or World War I, for any condition that requires nursing home care; and
- g) Any non-service-connected veteran who is in receipt of VA pension or whose income is below the means test threshold amount.
- h) Any non-service-connected veteran eligible for VA hospital care whose income exceeds the means test income threshold amounts if the veteran agrees to pay the applicable copayments for the care rendered by VA.

It is possible to have a service-connected veteran on a waiting list at a facility which has a vacant bed, but the vacant bed does not meet the medical care level required by the service-connected veteran. In this case, a non-service connected veteran requiring the available level of care may be admitted. Most VA nursing home care units currently have waiting lists, however, there are a few that do not.

Question 16: Please describe the impact of the FY 97 Research Budget request on the research program. Will there be an increase or decrease in the number of grants funded? What are the research priorities for this coming fiscal year? Looking at research funding across the government, in your opinion, how has the VA fared in the last 2 years when compared to NIH?

Answer: Research programs will be maintained in the areas of highest importance to the Department. A committee of experts from both within the VA and outside the VA are reviewing the research portfolio to advise me regarding future areas of research.

There will be a decrease in the number of projects funded due to (1) a decrease in the Department of Defense funding transferred to VA (98 fewer projects) and (2) a stable budget without a current services increase (47 fewer projects)

In addition to the ongoing priorities in disorders associated with aging, schizophrenia, PTSD, Persian Gulf related illness, spinal cord injury, rehabilitation, AIDS, and health service; research will focus additional resources on outcomes research, nursing research, diabetes research and occupational and environmental hazards research.

For the years 1995 through 1997, the appropriations and the percent change by years for VA and NIH research are as follows:

	FY 95	% Changed From Prior	FY 96	% Changed from Prior Year	Proposed FY 97	% Changed From Prior Year

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Agency	\$ Millions	Year	\$ Millions		\$ Millions	
VA	251	0	257	.12	257	0
NIH	11,322	3.5	11,939	5.40	12,435	4.2

Question 17: As I mentioned in my opening remarks, I am concerned about the FY 97 request for the Research program. Specially describe how the Department can maintain a current services level under the proposed request of \$257 million.

Answer: An appropriation of \$257 million will not maintain a current services level, but research of the highest importance and the most meritorious, as determined by the peer review process, will be continued.

Question 18: In your view, will the Department be able to fund all priority one grants in FY 97?

Answer: No, our funding request for the Veterans State Home Grant program will not be sufficient to fund all priority one grants. Thirteen of 46 priority one applications will receive funding in fiscal year (FY) 1996; one project will receive partial funding. A total of 32 priority one projects will not be funded in FY 1996. The cost to fund the balance of the one partially-funded application and the 32 other grants is estimated at \$96 million. The estimated backlog assumes that no State will withdraw its application. In addition, the backlog estimate does not take into account new applications that will be received between August 1995 and August 1996 for prioritization on the August 15, 1996 priority list.

Question 19: As part of your budget proposal you have included a pilot program called the Franchise Fund. Describe the proposed operation of this program and what interface, if any, it would have with the Medical Care Cost Recovery program (MCCR)? How does it differ from the Medical Sharing program? What are the projected revenues and would its expanded patient/consumer base, in reality, be non-veterans?

Answer: Franchise Fund: Under Public Law 103-356, the Government Management Reform Act of 1994, the Department of Veterans Affairs was chosen as a pilot Franchise Fund agency, beginning in FY 1996. Beginning in FY 1997, the department is proposing to formally establish the Franchise Fund as a revolving fund.

The Franchise Fund is a revolving fund which will be used to supply common administrative services. Beginning in FY 1997, six activities (Austin Automation Center, Austin Finance Center, Security and Investigations, Law Enforcement Training Center, Neosho Records Depository, and ADP and Adaptive Training) will have annual billings of approximately \$55 million and 445 employees. In order to initiate the fund in FY 1997, VA proposes that General Operating Expense (GOE) funds that directly funded the Service Activities be moved to the customers to become part of their operating base. In addition, funds from current reimbursement agreements will continue to be paid to Service Activities through the Fund. Rates and service levels are set by a Board of Directors on

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an annual basis, in conjunction with the budget cycle. Competition with vendors outside VA (within the Federal Government and from outside contractors) is expected to lower costs and improve customer service.

The Franchise Fund does not interface with the Medical Care Cost Recovery program. The "gainsharing" legislation proposal does impact MCCR and Medical Care and is described below:

Gainsharing: Legislation is being proposed to allow the Department to retain a portion of third party recoveries above a defined collection goal. VA currently has the authority to collect from third-party insurers for the treatment of non-service connected conditions. However, all recoveries in excess of administrative expenses are returned to Treasury. Under this new "gainsharing" proposal, once the Department exceeds the goal defined in legislation, additional collections will be shared with VA retaining 25 percent of collections from Category A veterans and 100 percent of collections from Category C veterans. It is estimated that this will result in an additional \$3,439,000 to be transferred to Medical Care from the Medical Care Cost Recovery Fund in Fiscal Year in 1997.

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Question 1: In FY95, Florida facilities continued to have the highest number of applications for medical care by service-connected veterans in the nation. Yet, VA expenditures for medical services and administration for Florida continues to lag behind states such as California, New York and Texas which have fewer applications for service-connected care and smaller veterans populations. Can you explain this discrepancy?

Answer: The Department shares the concerns about the unevenness in the access to care across the nation. VHA's goal with capitation budgeting is to implement a system that allocates resources in a more equitable manner. The FY 1996 budget allocations to VA Medical Centers were made based on where veterans received care, and on forecasts of future counts of patients treated (workload) and costs for each VA medical center. The facility workload for Florida is lower than the workload for California, New York and Texas. Veteran populations and counts of service-connected veterans are being explored as variables for use in capitation allocations scheduled for FY 1998 implementation.

Question 2. One of the most frequent complaints I receive from my veterans is the impact "snowbirds" have on their ability to receive care at VA facilities. During the winter months, Florida veterans are being denied care because our limited resource are being used by non-Florida residents. Does the VA's resource allocation methodology include any type of mechanism to factor in the winter migration of veterans?

Answer: The FY 1996 budget allocations to VA Medical Centers have been made based on where veterans receive care. The current allocation system has a process for allocating individual patient resource consumption to the treating facility by a mechanism called "Pro-rated Person" (PRP). If a facility provides all of a patient's VA health care, the facility is credited with that patient's full 1.0 PRP. If the patient receives care at more than one VAMC, each facility is credited with a pro-rated share of the patient's PRP, based on costs. If a patient's total annual health care cost was \$10,000 and VAMC #1 provided \$2,500 of care, it would receive .25 PRP for the patient, with VAMC #2, which provided \$7,500 of care, receiving .75 PRP for that patient. The national sum of all Pro-rated Persons equals the total number of unique patients treated nationwide (unduplicated count) during any given fiscal year. "Snowbirds", or patients treated in both the North and the Sun-belt, are counted in the base workload numbers and projections of each facility providing care. In the allocation process, the treating facilities are allocated resources in proportion relative to the care provided by the PRP component of the RPM process. Therefore, Florida facilities receive equitable funding for "Snowbirds".

Question 3. Recent reports by GAO found that "while considerable number of veterans have migrated to southeastern and southwestern states, there was little shift in VA resources." Can you tell me why VA resource have not been shifted to reflect the migration of the veterans population?

Answer: This is a historical problem which we are trying to address. Based on current estimates of budget allocations for FY 1996, some networks will receive an increase of

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approximately 5%, while other networks will be frozen at the 1995 level. Using blended rates in FY 1996, almost \$150 million dollars were redirected within the VA health care system. This is compared to \$10 million shifted in the Fiscal Year 1994 budget allocations, and \$20 million shifted in the FY 1995 budget allocations; shifts in FY 1994 and FY 1995 were identified by the unit cost outlier adjustment process that was replaced in FY 1996 by blended rates. The further refinement and implementation of blended rates for Fiscal Year 1997, and the capitation-based resource allocation system to be implemented in FY 1998, will continue to shift resources on the basis of expected patient care workload and efficiency. With capitation, VISN budgets will be based on the number of veterans that the VISN is expected to take care of for a unit price that considers the risk profile of the patients including age and casemix, geographic costs and standardized prices.

Question 4: Earlier this year, two Florida VA Medical Centers (Bay Pines and West Palm Beach) announced they will not accept new patients classified as "Category C" because of budgetary constraints. Yet, I've been told that in other parts of the country, medical centers are advertising for patients. What is the VA doing to address these inequities?

Answer: Most VAMCs across the country have placed some restrictions on the acceptance of Category C patients. Nationwide, only about 4 percent of VA workload is from Category C patients. I know of no VA facility that is advertising for patients.

In response to the unevenness in veteran's access to care, VA is moving towards a capitation-based resource allocation system by FY 1998. Besides being more understandable to clinicians, managers and stakeholders, a capitation-based resource allocation system will allow for more equitable funding throughout the country when decisions are based on veteran population needs. In the interim, VA will implement a blended rate pricing methodology in FY 1996 and 1997. Further explanation of this transformation in resource allocation follows:

Blended Rates: The Veterans Health Administration (VHA) has implemented a new workload pricing approach called "blended rates" for allocating the Fiscal Year 1996 budget. The blended rates workload pricing is intended to target resources on the basis of expected patient care workload and efficiency. It is a method to set prices for prospective VA medical care workloads. Under blended rates, a unit price for expected workload is established by adding together a percentage of the individual facility's unit price, the peer group average price, the geographic area (VISN) average price, and the VA national average price. Before a blended rate is computed, each VA Medical Center's expenditure base and workload is adjusted for research, training, special programs and special salary rates. These funding adjustments recognize the inherent differences in VA Medical Centers and make the comparisons more valid and supportable.

Shifting Resources from Non-RPM to RPM in 1997: VHA has undertaken a comprehensive review of Non-RPM funding -- the funds controlled by corporate headquarters committees during the year. Our goal is to shift more resources into the

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RPM model, that is, funds distributed at the beginning of the year directly to the field based on projected workload.

Development of a Capitation-Based Resource Allocation System: Capitation means paying a provider a flat fee in advance to take care of a set number of patients' health care needs during a defined period of time, according to an agreed upon benefit package. For VHA, the provider network is made up of 22 VISNs. The VISN is the locus for management, planning and budget in the Network geographic area. With capitation, VISN budgets will be based on the number of veterans that the VISN is expected to take care of for a unit price that considers the risk profile of the patients including age and casemix, geographic costs and standardized prices. The benefits to improved management of resources are significant. With VISN performance standards and a fixed amount of resources for expected workload, the Network Directors will have the flexibility and expectation to be creative and innovative in their respective operations. VHA's goal is to implement a system that allocates resources in a more equitable manner, encourages the use of the most appropriate setting for each episode of care, and supports VA's special programs.

Question 5: How much money have Florida medical centers requested for the treatment of service-connected veterans and how much have they actually received?

Answer: The VA request for budget resources in the past has been based on forecasts of future counts of patients and costs for each VA medical center. Veteran populations and counts of service-connected veterans are being explored as variables for use in capitation allocations scheduled for FY 1998 implementation.

Question 6: Can you give me a monthly breakdown of the workloads for each of the Florida medical centers for the past two years.

Answer: VA medical centers in Florida treated 49,553 hospital inpatients in FY 1995; this is 2,046 (-4%) fewer hospital inpatients treated than in FY 1994, when 51,599 were hospitalized. This reduction in hospitalized patients is indicative of the continuing shift from inpatient to outpatient care. A monthly breakdown of hospital inpatients treated at Florida VAMCs is attached.

VA medical centers in Florida (including their satellite outpatient clinics) provided 1,512,581 outpatient visits in FY 1995; this is 169,131 (+12.6%) more visits than in FY 1994, when 1,343,450 visits were provided. Again, this increase in outpatient workload demonstrates the changing emphasis in the VA from a hospital-based system to one providing more care on an outpatient basis. A monthly breakdown of outpatient visits at Florida facilities is attached.

Question 7: How much contracting for medical care services does the VA use in Florida.

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Answer: In FY 1995, Florida VA medical centers spent \$92,896,268 (11.7%) of their total medical care budget (\$791,356,111) on medical care services contracted from the community. As shown below, contracted care ranged from a high of 17.2 percent at VAMC Bay Pines to a low of 8.3 percent at VAMC Lake City.

Med Care

Budget	B.Pines	G'ville	L.City	Miami	Tampa	WPBch
Total	\$158,695,841	\$133,500,087	\$62,528,100	\$181,053,282	\$176,535,851	\$79,042,950
Contract	\$27,263,407	\$16,591,765	\$5,202,456	\$17,887,800	\$18,943,069	\$7,007,771
% Contract	17.2	12.4	8.3	9.9	10.7	8.9

Bay Pines has a higher percentage of contracted care because it operates the Clinic of Jurisdiction (VA health care facility assigned fee basis outpatient jurisdiction over the geographic area in which the veteran has established residency) for fee-basis programs in Florida. West Palm Beach was not activated until June 26, 1995, and includes activation dollars for new equipment, so its percentage of contracted care may be higher in the future.

Question 8: What is the status of pending construction projects in Florida? Where do these projects currently rank on the VA's priority list?

Answer: The projects listed below have been identified by the VA Medical Centers as viable major projects for their facilities. These projects are included in the 1996 National Major Project Inventory (used for the FY 1997 budget cycle). The FY 1997 budget includes projects that reflect VA's priorities of improving ambulatory care and the patients' environment. Those projects below not in these priority categories were not considered for funding in FY 1997. Of those that do fall into the ambulatory care or patient environment category, their project score precluded them from consideration within the requested budget level.

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East Central Florida aside, the remaining projects will be considered for the earliest budget request consistent with resource constraints and competing priorities. With the FY 1996 appropriation of \$17.2 million and the currently available \$7.8 million, Congress has provided \$25 million for the construction of an outpatient clinic in Brevard County. VA, however, included a request for partial funding (\$42.6 million) for a new medical center and nursing home in the FY 1997 budget request.

VA Medical Center	Project Title	Total Estimated Cost	Project Score
BAY PINES	Expand Ambulatory Care	\$15,900,000	4.21
EAST CENTRAL FL.	Brevard Co. New VAMC/NHCU	\$171,900,000	7.96
GAINESVILLE	120 Bed NHCU (30 Bed SCI)	\$24,900,000	7.24
LAKE CITY	Ambulatory Care Expansion	\$16,900,000	5.79
	Renovate/Expand Patient Wards	\$20,000,000	9.44
MIAMI	Clinical Addition	\$23,000,000	5.11
	Research & Education Addition	\$8,000,000	4.29
	Central Plant Addition	\$13,000,000	4.75
	Psychiatric Addition	\$17,600,000	5.89
	Renovate 5AB/6ABCD	\$9,000,000	6.11
	Renovate 11ABCD/12ABCD	\$10,400,000	6.11
	Renovate 9ABCD/10ABCD	\$10,600,000	6.11
	Renovate 7ABCD/8ABCD	\$10,800,000	5.94
PALM BEACH	Construct Addl. 120 Bed NHCU	\$9,700,000	10.00
TAMPA	SCI Building/Central Plant	\$50,200,000	7.18
	Renovate Surgery	\$18,900,000	4.39
	Clinical Addition	\$19,900,000	5.19
	Parking Garage	\$14,000,000	5.26
	Ambulatory Care	\$27,300,000	6.75

Question 9: In FY 1986, the Port Richey VAOPC had a total number of outpatient visits of 7,153. The Clinic's projected number of visits for FY 1996 is 40,000. Does the VA have plans to expand the Port Richey VAOPC? If so, I would like some information on the VA's proposal.

Answer: The Port Richey OPC was activated in September 1985 in 4,550 net square feet of leased space. The Clinic provided 7,153 outpatient visits in FY 1986, the first full year of operation. By FY 1987, Port Richey had provided 11,869 visits, necessitating an expansion of the leased space to 11,000 net square feet. The following year (FY 1988), workload increased to 21,661 visits. Some modular buildings were added in FY 1994, but these provided only an additional 1,000 net square feet. The workload has continued to grow in spite of the space constraints; visits increased from 27,410 in FY 1989 to 37,214 visits in FY 1995.

Approved workload allocations for 2005 at Port Richey total 54,100 visits. A space package was approved in December 1994 for expansion of the Port Richey OPC. Expansion plans call for 23,822 net square feet, or 30,492 occupiable square feet of space. Additional staff work is currently underway to insure that this amount of space is

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adequate. Advertisement for new leased space by VA Real Property is scheduled for May 1996. In the meantime the current lease, which expires in June 1996, has been extended for a 30-month period to allow time for acquisition of new leased space.

Question 10: On March 8, 1996, Deputy Inspector William Merriman testified before the Senate Appropriations Subcommittee regarding the VA's medical operations and functions. At that time, he testified that the VA needed to develop and implement performance criteria for the allocation of personnel in order to correct the variances in staffing at VA medical centers which have resulted in inequitable distribution of resources. Is the VA acting on the IG's recommendation? If so, what action are you planning to take?

Answer: The Veterans Health Administration (VHA) agrees with the Inspector General's conclusion that variances in resources allocated to medical centers have developed over time. VHA is already addressing the issue through several management initiatives which we believe meet the intent of the Inspector General's recommendation. These management initiatives will link staffing resources with work performed, and will allow VA to assess allocation of these resources among medical centers in meeting workloads. These initiatives focus on three broad goals: (1) capitated funding, (2) decentralized operational management at the VISN level, and (3) performance based oversight.

The changes VHA envisions will address concerns about resource allocation inequities. As evidence of this, as part of a 5-year plan, VISNs will evaluate the type and level of services needed at each facility. This will require an assessment of staffing resources. VHA is also exploring development of a system under which physicians will be paid based on performance and productivity.

Performance-based measurement and accountability are an important part of the VHA's current restructuring efforts. We plan to develop and use performance measures (including economic measures) in the management of all levels of VHA operations. When this restructuring is fully implemented, performance measures will be in place to help assure that VHA provides quality services, in the most appropriate setting, in a cost efficient manner.

To help better assure efficient production of services and to manage relative costs of services, we are working to better identify clinical production units, to define and account for work outputs, and to account for resource inputs assigned to production units. As we gain a better understanding of VHA's productivity status, we will work to improve productivity and to reallocate resources as feasible. As noted in the response to Question 4, in FY 1996 and FY 1997, VHA will be using an allocation methodology called blended rates to target resources on the basis of expected patient care workload and efficiency. The blended rate methodology is a transition step toward implementing a capitation based resource allocation system in FY 1998 which will further shift resources on the basis of expected patient care and workload efficiency. At the same time, we will continue to ensure that we measure not only productivity, but also quality of care, patient satisfaction,

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and other appropriate qualitative indicators. We will include performance information that better identifies and accounts for cost differences attributable to case mix, severity of illness, complexity of services provided, special programs and inefficient practices. We will also have better accounting for the costs of activities other than direct patient care, such as research and medical education.

The Decision Support System will be important to our management information efforts. DSS can generate comparative performance data for individual practitioners and production units, and can aggregate information at the facility, VISN and national levels, using a variety of qualitative and economic indicators. When implemented systemwide, we plan to make full use of DSS.

Question 12: Both GAO and the IG have testified at the Senate hearing that the VA could achieve substantial savings if the Department adopted Medicare fee schedules. Is the VA acting on these recommendations?

Answer: Yes. VA adopted Medicare's Diagnosis Related Group (DRG) payment methodology for inpatient non-VA hospital claims in mid-FY 1992. We estimate that through FY 1995 cumulative savings from that decision have totaled \$300 million.

We have made a decision to adopt Medicare's outpatient payment system at the earliest possible date. The new VA outpatient fee schedule will be based on the payment methodology established by the Department of Health and Human Services (HHS), Health Care Financing Administration (HCFA), under the Medicare Program Fee Schedule for Physicians' Services, also referred to as the Resource-Based Relative Value Scale (RBRVS). VA has been working with HCFA for the past year on developing software to accomplish VA's needs nationwide. Currently, VA is developing regulations in consultation with General Counsel to implement the RBRVS program. VA is planning on implementing and distributing to the field the 1996 Medicare Fee Schedule software by early Summer.

Questions by Congressman Bilirakis

Question 13a: How much money does the VA currently bill third party insurers for medical care cost recovery? How much money does the VA actually collect?

Answer: MCCR Third Party Recoveries (36_5014)

Inpatient Third Party	FY 1994	FY 1995
Amount Billed	\$1,005,829,550	\$1,038,940,403
Amount Collected	\$366,818,315	\$356,153,679
% Collected	36.47%	34.28%
Outpatient Third Party		
	FY 1994	FY 1995
Amount Billed	\$348,507,148	\$424,072,062
Amount Collected	\$139,337,685	\$166,668,560
% Collected	39.98%	39.30%
Total		
Total Amount Billed	1,354,336,698	1,463,012,465
Total Amount Collected	\$506,156,000	\$522,822,239
% Total Collected	37.37%	35.73%

The dollar value of the receivables established (Amount Billed) by VA medical centers does not reflect the actual recovery potential of the MCCR program. There are a number of factors that contribute to the overstatement of receivables outstanding. These include:

- About 60% of veterans having health insurance, who are treated by VA, are over 65. Most of these insurance plans are Medicare supplemental plans. They cover only \$736 of the cost for the first 90 days of inpatient care in a 365 day period. In addition, such policies can cover 20% of VA's physicians charges, along with additional co-payments of \$184 per day for inpatient care from the 61st through the 90th day of an inpatient stay. Furthermore, if not previously used up, lifetime reserve payments of \$368 per day may be available for the 91st through the 150th day of inpatient care. Outpatient benefits are limited to 20% of the outpatient charge. Prior to this fiscal year, software did not exist that allowed billing staff to identify this policy type. Consequently, an insurance claim for full care is established, e.g., \$10,000, yet in many cases only \$736 is expected in recoveries. (Worth noting is the fact that while representing 60% of all insurance billings, the over 65 age group represents only 40% of patients treated by the VA.)
- Significant outstanding receivables on the books represent unpaid Medicare supplemental claims. VA pursued litigation with three Blue Cross companies to force payment of Medicare supplemental policies. Although VA won the litigation, a number of payers are still contesting the right of VA to recover payments for Medicare supplemental policies. Furthermore, VA is presently in litigation on Medicare supplemental issues with United Services Automobile Association and other commercial carriers.

Questions by Congressman Bilirakis

- Not all services provided by the VA are covered by third party insurance. Some services are only partially covered and other services have limited coverage authorized per year. Psychiatry services are an example. Most policies either exclude or limit psychiatric care to acute days and limit the number of billable days per year or in a lifetime. Also, unlike the private sector, costs not covered by an insurance carrier are NOT passed on to the patient for payment.
- Not all policies billed are reimbursable. Many facilities bill HMO and PPO plans in an effort to establish documentation of care provided in case HMOs change their rules and pay at a future date. In most instances, HMO and PPO plans only reimburse for emergency care.
- Receivables must be established for the billing period using approved VA per diem rates. Consequently, receivables are overstated in cases such as the Medicare supplemental example cited above and in the case of outpatient care where our claim for \$205 may receive a reimbursement of \$41 for an office visit.
- Most health care contracts include patient copayments and deductibles which VA does not require patients to pay. Consequently, claims for reimbursement of the costs of care and actual payments differ by at least the copayment and deductible requirements of the policy.
- VA recoveries from third party payers are limited to the terms of the contract between payer and insured. In most instances, policies limit payments to some percentage of customary and reasonable charges. For example, traditional policies may cover 80% of customary charges and providers rely on self pay by patients to recover the remaining 20%. VA does not require veterans to pay the outstanding balance (balance billing.)
- VA lengths of stay exceed community standards. Insurance payers disallow unauthorized days of care and evoke penalties for facility failure to pre-certify inpatient admissions.
- By law, insurance payers may pay VA based on what the VA bills OR upon usual and customary charges. This means that payers have control of the value of the service provided. In the outpatient area, as many as 25% of outpatient claims lacked adequate coding of the care provided. The absence of detail results in payers assigning the lowest valued office visit rate to the care.
- VA practice patterns differ from the community. Care provided in an inpatient setting within the VA is often performed in an ambulatory care setting in the private sector. Payers deny payment for outpatient care performed in an inpatient setting (an example is cataract surgery). This, of course, is due to VA's antiquated eligibility laws.

Questions by Congressman Bilirakis

- Due to the recent release of new software functionality, VA medical center finance offices have not had the opportunity to fully implement the software which allows for insurance claims tracking and accounts receivable functions that identify insurance category, estimate net recovery potential, and support timely contract adjustments.

Question 13b: How much does it cost the VA to collect this money?

Answer: MCCR contracted with Birch & Davis, Associates, Inc. for an MCCR Cost of Collections Study. The Final Report was made available to the MCCR program office on November 21, 1995. The study analyzed the costs incurred to bill and collect third party inpatient and outpatient claims; first party means test and prescription copayments; claims for ineligible care; and claims for humanitarian care. (Data follows which was extracted from Exhibits 3 & 4 and from the table on page 12 of the Birch study on Collections.)¹

The Birch study examined the nature of the MCCR costs and identified a number of factors which impact MCCR's cost to collection ratio. The study provides detailed explanations of these factors which are summarized in the following Table.

Differences Between VA and Private Sector Costs to Bill and Collect²

Department of Veterans Affairs	Private Sector
<ul style="list-style-type: none"> • Patients have no incentive to report health insurance. 	<ul style="list-style-type: none"> • Patients report health insurance to lessen personal liability.
<ul style="list-style-type: none"> • Must bill by exception --NSC/SC --HMO 	<ul style="list-style-type: none"> • Bill is created for everyone
<ul style="list-style-type: none"> • Precertification, recertification (continued stay reviews), and appeals are included in the cost to collect computation. 	<ul style="list-style-type: none"> • Only precertification costs are included in the cost to collect computation.
<ul style="list-style-type: none"> • Limited EDI interface and automation. 	<ul style="list-style-type: none"> • Full automation and EDI interface.
<ul style="list-style-type: none"> • Lower collections base (i.e. lower potential receivables established) --Flat fee billing --Medicare supplemental 	<ul style="list-style-type: none"> • High collection base --Fee for service billing --Collects on Medicare and supplemental
<ul style="list-style-type: none"> • Limited resources for account follow-up 	<ul style="list-style-type: none"> • High level resources applied to account follow-up
<ul style="list-style-type: none"> • Includes overhead costs 	<ul style="list-style-type: none"> • Generally does not include overhead costs

¹ "Medical Care Cost Recovery Cost of Collections Study, Final Report", Birch & Davis Associates, Inc., November 21, 1995, pp. 10 - 15. (Henceforth, "Collections")

² "Collections", p. 22.

Questions by Congressman Bilirakis

The study determined that “the associated cost to collect ratio for all third party claims is estimated to be \$0.118 per dollar collected --\$0.056 for inpatient claims and \$0.279 for outpatient claims. The higher cost and higher cost-to-collect ratio for outpatient claims is due primarily to the following factors:

- Higher volume
- Lower collections base
- Greater reliance on paper based records to generate claims
- Time spent by MCCR staff in gathering all the information needed for billing”³

The Birch & Davis study notes that “First party claims are generated automatically, for the most part, at the time a patient receives care or a prescription.” The study found that there were “nearly equal cost-to-collect ratios” for prescription copayments (\$0.384) and for means test copayments (\$0.401). Birch finds that “for both types of first-party claims, MCCR staff spend most of their time and effort in responding to patient questions or complaints related to the charges and in receiving, depositing and posting payments.”⁴

While the overall cost to recover has been relatively constant over the five years of the program’s existence, the nature of the work and the volume of workload has not been constant. The MCCR program was challenged with rapidly increasing copayment activity and subsequently with the challenge of processing major refunds and adjustments following legislation exempting a large number of veterans less than two years into the program.

Similarly, little workload in the outpatient third party arena was being performed in the first several years of the MCCR effort. This was due primarily to the manual nature of outpatient record keeping, coding and claim generation. Today, nearly a third of all third party recovery dollars are derived from outpatient claims. Each of these outpatient claim dollars are recovered at approximately five times the cost of an inpatient dollar. The VA health care system has been eliminating Category C patients from its service roles as a result of limited resources. Category C patients as a group have the highest insurance coverage of all VA patients. The health care system is also in transition from inpatient care to outpatient care. To replace each recovery dollar lost due to inpatient reductions, five times the effort and cost must be expended to process outpatient claims just to keep recovery dollars constant.

² “Collections”, p. 22.

³ Birch, “Collections”, p. iv.

⁴ Birch, “Collections”, p. iv.

³ Birch, “Collections,” p. iv.

⁴ Birch, “Collections”, p. iv.