

ELIGIBILITY REFORM LIMITATIONS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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ELIGIBILITY REFORM LIMITATIONS

WEDNESDAY, JULY 19, 1995

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

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

Present: Representatives Stump, Bilirakis, Spence, Hutchinson, Everett, Quinn, Bachus, Stearns, Ney, Fox, Hayworth, Montgomery, Evans, Kennedy, Edwards, Clement, Filner, Tejada, Gutierrez, Bishop, Doyle, and Mascara.

OPENING STATEMENT OF CHAIRMAN STUMP

The CHAIRMAN. The meeting will please come to order.

Today's hearing on eligibility reform is the next step in what I hope will be a frank discussion on how best to fix the complicated rules determining which veterans receive VA care. The rules also determine the level of care the VA may provide.

The House had previously passed bills trying to improve outpatient care. During the 103rd, eligibility reform was made a part of the national health care package which was not enacted.

This committee reported a bipartisan provision because it was a vast improvement over the Administration's bill. Also last year, I introduced H.R. 4788 addressing eligibility reform in consultations with the veterans' service organization. We certainly want to continue working with the service organization, the VA and all other interested parties.

Additionally, Mr. Edwards has introduced a bill, and we appreciate his efforts.

The purpose of this meeting today is twofold. First, we need to understand the complexity of the problem. Second, we expect the testimony we hear today will help develop a bipartisan measure which will simplify the process, provide quality cost-effective care and ensure priority is given to the most deserving. At the same time, however, we are all well aware that the current budget climate will require caution on how best to proceed with reform.

I look forward to working with you to reach our mutually shared goal of improving access to quality care on a simplified basis. I particularly want to welcome Dr. Kizer today, the VA Under Secretary for Health.

In addition to the witness statements, Members have before them a chart depicting the complexity of the current eligibility rules and some possible changes. There should also be a Congress-

sional Research Survey of the history of health VA care eligibility and committee staff has prepared alternative discussion drafts which were handed out to your staff yesterday.

We have several panels today, so the committee would appreciate each witness summarizing their written statements and your statement, of course, will be included in the record in its entirety.

Since this is not a decision making point, general descriptions of your proposals and observations about other proposals would be most helpful.

Dr. Kizer, we welcome you here today, and you may proceed in any way you see fit.

Oh, I'm sorry, Dr. Kizer. Excuse me a minute. I'm almost forgetting my ranking member here. The Chair recognizes the gentleman from Mississippi.

OPENING STATEMENT OF HON. G.V. (SONNY) MONTGOMERY

Mr. MONTGOMERY. Thank you, Mr. Chairman.

I'd also like to welcome Dr. Kizer and Ms. Keener and our other witnesses.

Last year, as part of the Congress' work on national health care reform legislation, our committee adopted major changes to assure adequate funding for VA health care and to reform VA eligibility. As we all know, the national health reform did not have broad support. Though our legislation was not enacted, we thought it was good legislation we passed out of this committee.

The need for VA health care reform is ever more important today than it was at this time last year, and I commend you, Mr. Chairman, for making eligibility reform a priority.

There are several proposals before the committee, and I'm pleased to be an original and cosponsor of H.R. 1385 introduced by the ranking member of the Subcommittee on Hospitals and Health Care, Chet Edwards. It's a good bill. It simplifies eligibility and lets VA practice good medicine and reduce its cost. It treats veterans fairly, and I would like to say it gives the VA a potential source of new funding with which to expand VA outpatient health care.

This is an important hearing, Mr. Chairman, and I believe today's testimony will help us work out a bipartisan eligibility reform measure that all of our members can support.

Thank you.

The CHAIRMAN. Thank you.

Any others? Mr. Bilirakis.

Mr. BILIRAKIS. Are you discouraging opening statements?

The CHAIRMAN. No. If you could be brief, please, because we do have a long meeting. But proceed. Go ahead.

Mr. BILIRAKIS. All right. I just will ask unanimous consent to offer my statement into the record and I just wanted to apologize to you and the witnesses in advance. I'm chairing a Health and Environment Subcommittee hearing on Medicare reform, fraud and abuse over in the other building, and so I'm going to have to leave a little early and I wanted to apologize. Thank you.

The CHAIRMAN. There are other meetings going on as well as the Republican caucus.

[The prepared statement of Congressman Bilirakis appears on p. 55.]

Mr. EVANS. I'd like unanimous consent to insert into the record my opening statement.

The CHAIRMAN. Without objection.

[The prepared statement of Congressman Evans appears on p. 58.]

The CHAIRMAN. Others?

Mr. HUTCHINSON. Likewise, I ask unanimous consent to revise and extend and have my statement included in the record.

[The prepared statement of Congressman Hutchinson appears on p. 59.]

The CHAIRMAN. Mr. Quinn.

Mr. QUINN. Ditto.

The CHAIRMAN. Without objection.

[The prepared statement of Congressman Quinn appears on p. 64.]

The CHAIRMAN. Mr. Fox.

Mr. FOX. I'd like to ask consent to insert my opening within the record as well.

The CHAIRMAN. Absolutely.

[The prepared statement of Congressman Fox appears on p. 67.]

Mr. HAYWORTH. And I would follow suit, Mr. Chairman, with my own statement.

The CHAIRMAN. Mr. Hayworth, without objection.

[The prepared statement of Congressman Hayworth appears on p. 68.]

The CHAIRMAN. All right. Everybody is included.

Mr. MONTGOMERY. Mr. Chairman, Chet Edwards was trying to be here today since he is the ranking member on the subcommittee and I'd like to have his statement put in the record.

The CHAIRMAN. Without objection, it certainly will be.

[The prepared statement of Congressman Edwards appears on p. 69.]

The CHAIRMAN. Now, our first witness, Dr. Kizer, Under Secretary for Health, and he's joined also at the table today by Mary Lou Keener, the VA General Counsel. Dr. Kizer in his short tenure has shown his willingness to make a number of difficult decisions including eligibility reform which, by the way, is our highest priority here. Doctor, you may proceed in any way you see fit.

STATEMENT OF KENNETH W. KIZER, M.D., M.P.H., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MARY LOU KEENER, GENERAL COUNSEL

Dr. KIZER. Thank you, Mr. Chairman and members of the committee. I appreciate the invitation to be here this morning with you to discuss this very important topic.

Reforming the VA health care eligibility system is long overdue, and I'm pleased to be here this morning to participate in this general discussion of eligibility reform as well as to specifically discuss the Administration's proposal for eligibility reform.

With your permission—being cognizant of the congested agenda this morning—I will summarize my formal testimony, then respond to your questions.

As you know, reforming eligibility is a key step in restructuring the VA to provide state-of-the-art health care from the perspectives of both quality and efficiency.

VA's current eligibility criteria evolved in an era that emphasized inpatient care. Today, however, most health care is provided in outpatient settings. Unfortunately, the current statutes dictating VA eligibility require physicians to admit patients to the hospital even if their ailments could be treated more effectively, more efficiently and more compassionately on an outpatient basis.

Under the current Congressionally mandated system of different rules for hospital care, outpatient care, and long-term care, rules that depend on each particular veteran's service-connected status and income level, the ability of many veteran patients to receive adequate health care through the VA is a testament to the tenacity and perseverance of both the veterans seeking care and the health care professionals who provide that care.

As you know, last March we submitted a proposal to the Congress describing a comprehensive proposal to reorganize the management structure of the VA health care system. Although independent of eligibility reform, that reorganization is part of our strategy to ensure that VA can successfully meet the health care needs of veterans in the changing health care environment of today, as well as tomorrow.

Turning now to our eligibility reform proposal, Mr. Chairman, I would note that it was developed to achieve several important objectives: First, both patients and providers should be able to understand the eligibility system.

Second, the eligibility system should allow VA to furnish the most appropriate care and treatment that is medically needed, cost-effectively and in the most appropriate setting.

Third, veterans should retain eligibility for those benefits that they are now eligible to receive.

Fourth, VA management should gain the flexibility needed to manage the system effectively.

Fifth, the proposal should be budget neutral.

And sixth, the system should not create any new and unnecessary bureaucracy.

The most significant change in the Administration's proposal would be the complete elimination of the complicated and archaic eligibility rules governing the provision of outpatient care. This key feature would, in essence, allow us to provide the right care at the right place at the right time for the right price.

Our bill also includes important provisions to help us provide cost-efficient care to eligible veterans. Almost no provision is more important than the expansion of our ability to share resources with other community health care providers. This authority is essential for the VA to establish integrated systems of care, improve access and achieve the efficiencies of modern health care management techniques.

Other important provisions of our bill would permit the department to retain part of the funds collected from third-party insurers for care furnished to veterans, would allow us to place in temporary residential care certain veterans receiving hospital care who do not belong in an acute care hospital, and would improve the way

we obtain income and asset information needed to determine a veteran's eligibility for VA health care. Quite simply, we want to replace the current complicated procedure with a simpler test.

Mr. Chairman, pursuant to your request, I would now comment, in general terms, about some of the provisions and certain other legislative proposals which are before you today. First though, I would reaffirm that any proposal should meet the objectives I previously outlined.

Having participated in the preparation of our bill, I can understand how difficult it is to put together legislation of this nature.

The committee staff proposal and the other proposals all contain provisions with laudatory goals which we support, as well as some others which we can not. My formal written testimony comments briefly on some of these specific provisions. However, some of the proposals are still in draft, and we would defer our formal comments until the proposals are made final.

In general, we do not believe that the committee staff proposal goes far enough in simplifying eligibility rules. It contains various review and study proposals that are not needed, and it does not allow sufficient flexibility for VA to manage the system in the future.

Now turning to the bill offered by Mr. Edwards, H.R. 1385, I would note that it contains a number of provisions which are quite similar to our draft bill and, thus, we are generally supportive of those provisions. However, the bill also has some provisions that we do not support and those are discussed in my formal statement.

Mr. Chairman, you also asked that I comment on a proposal being developed by the veterans' service organizations who develop the *Independent Budget*. It's my understanding that the group is working closely with Senator Rockefeller and that its proposal will be introduced in the near future but is currently not available. From discussions with representatives of the veterans' service organizations, I gather that their bill would reform eligibility in a manner that is similar to the provisions of the Administration's proposal. However, we would need to review their final draft to be sure that it meets the criteria that I previously outlined before we comment more definitively.

Mr. Chairman, that concludes my opening statement. I'd be happy to respond to your questions at this time.

[The prepared statement of Dr. Kizer appears on p. 86.]

The CHAIRMAN. Thank you, Doctor. I appreciate you commenting on our draft proposal. Of course, that's what it is and we hope to later on through a bipartisan approach to be able to achieve a bill that is workable.

In your statement you said that you hope to retain part of the funds collected by third-party insurance. Would you also try or make an effort to collect Medicare funds for those patients we treat?

Dr. KIZER. Well, as I'm sure you know, we have proposed to do some pilot projects in that regard. There are a number of questions in that regard that need to be delineated in more detail. But ultimately it would be our goal, presupposing perhaps the outcome of these pilots, that Medicare would be among the payers that we would hope to retain payment from.

The CHAIRMAN. Mr. Montgomery.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

One of our biggest problems over the years is that we treat these veterans in our hospitals and Medicare won't reimburse us. I certainly hope we can make an effort now, Mr. Chairman, because this would certainly help our system if we could get Medicare to pay into our system which I believe would cost the taxpayers less in the long run since we can treat patients at a more reasonable rate than they can in Medicaid. Is that a correct statement, Dr. Kizer?

Dr. KIZER. I believe that there's a lot of truth in what you say. I believe that the way we need to view this is how the Medicare can be beneficial to the VA, and how the VA can be beneficial to Medicare. I think there are lots of mutually beneficial opportunities. We hope to be able to explore these in more depth and flesh out some of the details through the pilot projects that have been proposed. Ultimately, I see the VA as being able to provide as much benefit to the Medicare system as it, in turn, might provide to the VA.

Mr. MONTGOMERY. I don't want to get into this, but I was reading it in the *Albany Times* today what you worked out with the military, I guess it's called, Tri-care where you'll be taking military personnel on certain bases into the VA hospital system where the beds are available.

Dr. KIZER. That is correct, sir. At the end of June we signed a memorandum of understanding with the Department of Defense where the VA may be a bidder or be among the options that are potentially available to CHAMPUS beneficiaries under certain conditions. This is part of the "new VA," if you will, where we are looking to interface much more closely with DOD as well as other community providers where it makes sense to do that—and where we can provide quality and efficient care for veterans by sharing resources.

Mr. MONTGOMERY. DOD will pay into your system and you can take that money to run the VA hospital system.

Dr. KIZER. That would be correct under the provisions of the Tri-care Agreement.

Mr. MONTGOMERY. All these eligibility reforms, both what the Chairman is talking about and what Mr. Chet Edwards has introduced, that's moving more to outpatient clinic care eligibility changes.

Dr. KIZER. The biggest impediment for the VA system moving where health care is in the community is moving the current eligibility rules which have a number of barriers to providing care in the outpatient setting. As I've indicated, I believe I have commented before this group, and in other forums in the past, that our goal is to move the veterans health care system over the next 1 to 2 years from being a primarily inpatient centered health care system, as it is today, to one that is primarily outpatient based.

Mr. MONTGOMERY. You mentioned that there were some drawbacks, I believe, on H.R. 1385. It's in your full statement. Can you briefly mention what those were.

Dr. KIZER. Yes, sir. One of the provisions that is not understandable at this point is why the changes proposed would be limited to

3 years and then be revoked. We see no reason for that. Basically, as far as moving to outpatient care, that's where we need to go. We don't need to have a three year trial and then look at it at that point.

There are a number of other things in the bill such as requiring operating service networks and eliminating duplication within networks and assuring that networks provide core veterans with care that's comparable to what's available elsewhere that are conceptually similar to what we're proposing. However, we don't see any reason to have those things imposed or mandated by statutes if that's the direction that we are going. Having these things in statute unnecessarily complicates VA health care delivery.

Mr. MONTGOMERY. My time is about up. What is the biggest change that you're recommending in eligibility reform as far as inpatient/outpatient? What do you think is the major change we need to make here?

Dr. KIZER. To let doctors treat patients according to what they need. If they need to be admitted to the hospital, then they should be admitted to the hospital. If they can be taken care of in an outpatient setting, then they should be taken care of in an outpatient setting. If they need to go directly to a nursing home, then they should go to a nursing home. Instead of having all the present Byzantine rules about who can get what under what circumstances, you should allow those medical care decisions to be made by the physicians treating the patients so that we can achieve high quality and efficient care.

Mr. MONTGOMERY. Thank you very much.

The CHAIRMAN. Doctor, would any of those include statutory changes or are they all rules and regulations when you're talking about going from inpatient to outpatient, et cetera?

Dr. KIZER. Well, I think if they were rules and regulations, they would have been changed by now. They're all statutes.

The CHAIRMAN. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Well, to follow up because I had planned to go into that area also, this emphasis we've heard for quite some time now, even before this administration, on an outpatient care which I think we all agree with and I'm very pleased to see you emphasizing that. But you've also mentioned—you use the word obstacles and impediments to providing veterans that kind of care. You just made the comment about allowing medical decisions. Are there specific areas in the law that would preclude a doctor from making those kinds of decisions, specific areas in that law that would say that a veteran who could be treated on an outpatient basis must be hospitalized in order to receive care from the VA? There are specific areas in the law requiring that?

Dr. KIZER. There are myriad areas in the law that do indeed do that. This is the problem! Historically, while it may have been well intended and perhaps understandable in retrospect, these things were all put in statute. That is not consistent today with the provision of either quality or efficient health care.

Mr. BILIRAKIS. I see. Well now, staff has put out a—I'm not sure whether you have that—eligibility reform chart here which is good. I'm a former engineer so I always like to see these charts. But I haven't really had a chance to study this. I'm not sure though that

this sort of covers this particular area, so I think it's just critical. Staff is right here. But we've got to look into things such as that because, talk about obviously inefficient and costly, when we won't allow the medical doctor to make those kind of decisions. Just ridiculous, isn't it?

So anyhow, please help us to emphasize those areas, in addition to all the other changes that need to be made, Doctor. Thank you.

Dr. KIZER. We'll be happy to provide you whatever technical expertise we can.

The CHAIRMAN. Mr. Doyle, question?

Mr. DOYLE. I have no questions, Mr. Chairman.

The CHAIRMAN. Tim Hutchinson.

Mr. HUTCHINSON. Thank you, Mr. Chairman, and I commend you for calling this hearing and for your leadership on this subject.

Dr. Kizer, I certainly echo your support for allowing the VA to retain third-party collections and would hope that would include the Medicare payments. Recently, with bipartisan support from Mr. Montgomery and Mr. Edwards, I've introduced H.R. 1767 which would allow the VA to retain Medicare payments and give veterans a choice of where to use their Medicare eligibility. Current eligibility rules, while complicated and, as you said, Byzantine and arcane, are a pretty good deal for non-service connected veterans who fall below the income threshold. For instance, a veteran with three dependents is eligible for the full continuum of care should he or she make below \$27,302. The median household income for a family of four in my home State of Arkansas is \$23,893. So by this standard, over half of Arkansas's veterans would be eligible for full health care benefits while many service-connected veterans who do not meet the income threshold would be eligible for treatment only on ailments incurred during their time in the armed forces. I think that's a skewing of priorities in that in our eligibility reform we should not compound and exacerbate that.

One particular veteran, Mr. Chairman—speaking on firsthand knowledge—a person who had 100 percent service-connected condition, combat injured, triple amputee who is in need of heart surgery. Inexplicably, Dr. Kizer, this veteran was placed on a waiting list at #14 behind a number of non-service connected veterans. So the eligibility reform that I would envision would hopefully put that service-connected disability veteran at the top of the list and give him priority.

Now, under your liberalized treatment definition to furnish care and treatment in the most appropriate setting, how can you ensure and how can we ensure that the service-connected will receive priority care?

Dr. KIZER. I think the example that you point out goes to the heart of the complicated nature of and the difficulties with the current eligibility system. Certainly, as a matter of policy, we would agree that service-connected veterans should have priority; I guess we would want to know about instances where there were problems like what you describe where there seems to be an inequitable application of the eligibility statutes.

Mr. HUTCHINSON. Within the context of eligibility reform, should there be an effort to define some kind of standard benefits package to control costs for non-service connected care? At the present time,

a non-service connected veteran could be eligible for many more services than a service-connected veteran just by virtue of the fact that he or she is poor. So should we have some kind of a benefits package to ensure that resources are going to be there for the service-connected benefits?

Dr. KIZER. That's an issue which we need to review in much more detail particularly how that would apply and work with the population that is served by the VA. Certainly in the private sector, it has been found that if you want to compare apples to apples, i.e., or make price comparisons among different health care plans, then you need to first standardize what those plans are. Whether that is workable under the system that we have in the VA and the types of conditions that we are treating is something we need to explore in more detail.

Mr. HUTCHINSON. Dr. Kizer, if you take a kind of expansionist view of eligibility reform so that you open this up to a broader range of veterans, for instance, higher income veterans—do you see the VA system being able to attract them through our veterans health care hospital system apart from major infusions of money to improve facilities and the infrastructure of the system? Will we see a large influx by changing eligibility without making that kind of investment in the system?

Dr. KIZER. Well, let me note at the outset, I think given where the budget is and other things at this point, our major priority at this point is preserving services for those that we currently serve, who by and large don't fall into higher income brackets. So first and foremost, we would be looking at how to make the system better and more efficient for those that we currently serve.

In a general sense, our VA facilities are on a par with what would be found in the community and would be attractive to higher income veterans. That will vary according to where one is in the country. Some of our facilities are absolutely on par with anything you can find in the community. There are others that have a long way to go and need substantive improvements before they can provide the amenities, the privacy, and certain other things that most people view as customary in an inpatient setting.

Mr. HUTCHINSON. Doctor, if I understand the premise of the *Independent Budget*, it is that if you open up eligibility to a much broader range of veterans, that it's going to infuse the system with enough money, new money, to make it viable, and yet you used the budget as being the basis for saying that's not the direction we should go. So I'm gathering from that that you don't think they're all going to start using the system merely because they're eligible.

Dr. KIZER. I'm not sure that you interpreted quite what I was trying to say in the sense that that change, if you will, even as envisioned under the *Independent Budget*, is something that would take some time to occur. During the next year or two as we're transitioning the system to one in which the majority of care will be provided on an outpatient basis, versus an inpatient basis, our major focus is going to be on preserving care for those who we currently serve. In the long-term, it may well be that new veterans and people who are currently served by our facilities may bring insurance with them that would allow us to make some of those improvements, but that's not going to happen immediately.

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

The CHAIRMAN. Mr. Quinn.

Mr. QUINN. Thank you, Mr. Chairman. Welcome, Dr. Kizer, Ms. Keener. I want to echo what's been said already, Mr. Chairman. Your work and Representative Chet Edwards' and Mr. Montgomery's work is a beginning for some general discussion today.

Dr. Kizer, I also want to make a special—shifting gears here to talk about our women veterans for just a minute or two. I was pleased to see a section in Chairman Stump's proposal on women's health care. I've introduced legislation H.R. 882 which has over 50 or 60 co-sponsors right now to ensure that the VA meets requirements of the Mammography Quality Standards Act, and it's my understanding through some phone calls and letters to your office that the VA is in the process of prescribing quality assurance control for the performance and interpretation of mammograms and use of the equipment. I think it's important for the committee and for the secretary and most importantly for the facilities out across the country that the language we have in H.R. 882 is included in a section in this eligibility reform legislation that we're talking about. I think the timing is perfect for us to do that and I think it's important that each VA facility across the country is provided with the proper equipment, the facilities and the staff to provide women's health services including, of course, mammography. More and more female vets are coming to the VA for care and we must be able to meet their needs.

I also want to take this opportunity to thank Congressman Hutchinson who's been working with me and our staff, your staff, his staff on the subcommittee. I'm wondering if you might take a minute or two now to comment on what kind of progress you see in that area.

Dr. KIZER. Let me first say, as a disclaimer, I didn't come prepared to specifically talk about your bill, but as far as mammography in general, at last count I believe that 38 of our 39 mammography programs were either provisionally or fully accredited by the American College of Radiology and that the 39th was in the process of doing that. That is a process that does take some time and our facilities are well on the way to achieving accreditation. We intend that all of our programs will be so certified.

I would also add that this is a good example of where it makes sense and where it is advantageous to our women veterans to open the system up to additional users. One of the biggest difficulties in meeting the mammography standards in many of our facilities is the relatively low number of female veterans. These facilities have difficulty meeting the minimum number of cases per year that's required to assure quality. If we were able to have CHAMPUS users, or others, utilize the system, it would be much easier to not only meet those volume standards but also to maintain the proficiency of our radiologists and other staff in providing those services to our female veterans.

Mr. QUINN. Again, I agree entirely and I think the time is perfect, as you said, as we look, Mr. Chairman, at the whole eligibility question. This might be a perfect opportunity. Thanks, and your of-

fice has already responded to a telephone call from ours. Thank you.

The CHAIRMAN. Thank you. Mr. Fox.

Mr. FOX. Mr. Chairman, thank you for calling this hearing, and I just want to thank Dr. Kizer and Ms. Keener, and I have no questions at this time.

The CHAIRMAN. Thank you. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Doctor, some eligibility reform proposals, in my opinion, might actually work to restrict eligibility by lowering the income threshold, by making veterans with ratings below 20 percent discretionary and by freezing nursing home levels. Under the provisions of the committee's draft proposal, approximately how many veterans would lose their mandatory status?

Dr. KIZER. I'd have to get back to you with that figure. I don't have that on the tip of my tongue.

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

The Committee's draft proposal describes two alternatives. With respect to draft alternative #1, we understand the only "loss" of benefits such as you've asked about to be applicable to non-service connected veterans with incomes over 2 times pension but less than or equal to the current means test threshold. These veterans would no longer be mandatory for inpatient care. We estimate that approximately 98,088 current-user veterans would be effected by this provision.

In addition to the same effect as we described for alternative #1, alternative #2 would also change service-connected veterans rated less than 30 percent to the discretionary category for inpatient care. We estimate this additional group to be 506,157 current user veterans. So under alternative #2, an estimated total of 604,245 current user veterans would lose "mandatory" benefits.

Mr. EVANS. All right. The underlying premise of many of these eligibility reform proposals is that outpatient care is usually more efficient and more cost effective than inpatient care. Yet, it's clear that the VA's construction funding is going to be cut drastically. Do we really have the infrastructure in place to shift much of the caseload to outpatient settings or would it be forced to contract out for care?

Dr. KIZER. Over the last 2 or 3 years, there already has been a substantive shift to ambulatory care, and we expect that to continue. I think what we need most in this regard is the flexibility to look at options and, indeed in many cases, it may be that we don't need to build a new clinic, but instead we could lease a facility, or we could enter into a sharing arrangement with other providers. There are other ways of providing physical assets that are needed to take care of patients. We need to have the management flexibility that allows us to look at a full menu of opportunities to determine what will best serve the needs of our providers and our patients. We need the enhanced ability to enter into sharing and contractual arrangements.

Mr. EVANS. Any attempt to reform the eligibility criteria, of course, would involve some shifting of resources. Would the department be willing to fence funding for specialized services such as post-traumatic stress disorder counseling and treatment and prosthetics to ensure that they don't lose in this transition that we're making?

Dr. KIZER. I think a preferred way of dealing with those programs is to have clear outcome goals, policy directions, and per-

formance measures, and then hold our managers accountable. I think once you get into fencing funds—and I find that term somewhat objectionable—but if you have a designated funding stream, that generally works contrary to encouraging people to find the most efficient ways to provide services. There are lots of examples that we can point to in that regard. Again, the preferred way, I think, is to have clear policy and outcome expectations and then hold managers accountable for meeting them.

Mr. EVANS. The budget proposal that the House passed earlier this year recommended essentially freezing VA health care funding through 2002. What impact would this freeze have on the VA's ability to care for veterans regardless if we pass eligibility reform or not?

Dr. KIZER. Well, if you can guarantee that there'll be no further inflation during those 7 years, as well, then perhaps we can provide some semblance of the same degree of services. However, if inflation continues at the present rate, albeit a lower rate than historically, but if it continues at the rate that it has in recent years and our budget is frozen, that means we're going to have less funds. Even though we can achieve some efficiencies in the system, ultimately it will mean that we'll be treating less people.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Filner.

Mr. FILNER. No questions.

The CHAIRMAN. Mr. Mascara.

Mr. MASCARA. Thank you, Mr. Chairman, and thank you for calling this hearing. Dr. Kizer, I would like to paraphrase you. I'm not certain how you said it about in-care, inpatient hospital care, that we should avoid that if we can and rather have inpatient care at home. I've heard that before and I heard it in Medicare where they were discouraging the elderly from being placed in hospitals when they could be cared for in-home, and that made a lot of sense. But what concerns me now is that we're making cuts in reimbursements for in-home care patients. It seems like it's an oxymoron somehow saying these people shouldn't be in hospitals and we should care for them in their home and then cutting the funding for in-home care. I mean can we look for that in the VA that somehow if we have those people home that in the future we'll cut funding for them in the in-home setting?

Dr. KIZER. No. Actually, what we're requesting is the ability to provide that care when it makes sense, both medically and fiscally, in a setting other than an acute care hospital. One of the complicating factors in many of our patients is that they have no home, so we also need to look at other options. Certainly, the intent is to have the flexibility to manage patients in a way that makes good medical sense and good fiscal sense.

Mr. MASCARA. I think you did say that if they need to go in a hospital, we'll put them in a hospital. If they need to be in a home or a nursing home, whatever it might be. But I'm just drawing on my experience with Medicare that said, "Let's take these people out of the hospitals, put them into their home. We can care for them in their home." And then they cut the funding for in-home care. That somehow is a contradiction and I don't want that to happen

if we're going to be sending veterans home and then cut off the funding to take care of them in the home.

Dr. KIZER. I appreciate your comment, and that is not what is envisioned.

Mr. MASCARA. Thank you, Dr. Kizer.

The CHAIRMAN. Mr. Bachus.

OPENING STATEMENT OF HON. SPENCER BACHUS

Mr. BACHUS. Thank you, Mr. Chairman. First of all, I'd like to compliment you, Dr. Kizer, for your speech at the opening of the Claude Harris Facility in Tuscaloosa and I'm going to introduce for the record because of time my comments about eligibility reform. I don't think there's a more important issue. We've had sort of incremental, piecemeal adjustments to eligibility requirements and I think that's caused problems and we do need comprehensive eligibility reform. I want to compliment Mr. Stump, Mr. Montgomery, Mr. Edwards and the entire committee for moving in that direction.

Because of your speech at the Claude Harris Facility, I want to mention to members of the committee and ask Dr. Kizer's comments on one thing. I learned any time you visit a facility, you're there for 4 or 5 hours and you talk with the faculty, you sometimes get an insight and that facility is treating people with dementia, Alzheimer's disease and as veterans grow older, we're basically having—I don't know if a flood is the right word to say, but we're having a number of these patients, by the hundreds, arriving at VA and these conditions, I guess, are all non-service related or a good many of them percentage-wise are non-service related. I just ask you to comment on how the eligibility requirements will affect these people, if at all, and any comments you'd like to make on the number of veterans we're seeing with Alzheimer's disease and dementia, if you would.

Dr. KIZER. I will respond to your questions in reverse order, if I could, sir. The number of veterans who will be in need of long-term care, whether it be for Alzheimers disease or some other debilitating condition in the future, is going to increase dramatically in the next 10 to 15 years, and the VA, at this time, does not have the fiscal capability to provide care for the anticipated large influx of patients. That again underscores our need to achieve some flexibility in how we provide options to our veteran patients who may need long-term care or other care because of their debilitating condition.

Under the eligibility reform proposal, we would see this continuing as it currently is as a discretionary program that would be limited by the availability of funds.

Mr. BACHUS. I think this is an area where there isn't going to be treatment anywhere else if the VA doesn't provide it, and it's a very important service of the VA, especially when some people say that these people could get treatment elsewhere, they certainly are not thinking about this group of veterans. And I think that from all I saw and heard at the VA Facility in Tuscaloosa, I think the VA in this area does a better job than the private sector in caring for these people. I think it's a real success story. If you'd like to comment on it.

Dr. KIZER. I would just add as a former clinician and practitioner, there's more than one instance that I'm aware of personally where we had somebody with severe brain injury or other condition, and the preferred place to send them for treatment was the VA, as opposed to one of the private hospitals. It was often impossible to place these individuals in private sector facilities simply because they didn't have the capability or the technical know how to take care of them.

Mr. BACHUS. I appreciate that. I want to compliment you on the efforts of the VA in treating these mental conditions of our elderly veterans.

The CHAIRMAN. Mr. Bishop.

Mr. BISHOP. Thank you very much, Mr. Chairman. As the ranking member, I certainly want to thank you for your hard work in this area continually over the years on the subcommittee and I want to commend you for scheduling this hearing. I think it's very, very timely. And I want to welcome Dr. Kizer. I just have a couple of questions for you, Dr. Kizer.

The first one, some members of Congress have discussed legislation to create a VA Realignment Commission modeled after the Base Closure Commission. That proposal would appear to deprive the VA of authority to carry out mission changes, program changes and other realignments. Given the budget problems that you face and your plans to restructure the VA health care system and to reform the way that the VA delivers care, what do you believe would be the impact of such a proposal?

Dr. KIZER. A big waste of taxpayer dollars. I would note that I think a commission of this type is unnecessary and that we would be categorically opposed to it. We have in place a plan to restructure the VA. We have structures in place to solicit the type of outside input that is necessary for the plans to work and be responsive to their communities. There is no need for a commission, and it would only delay efforts to move the system to where it needs to be.

Mr. BISHOP. Thank you. Would you comment on the concerns that have been expressed by the GAO that eligibility reform could significantly increase the demand for VA health care services.

Dr. KIZER. If you make the system rational, more people will probably use it because it provides better service. That increase is a potentiality. We just have to have in place a management structure that can address that and have the appropriate utilization review mechanisms in place, not unlike what occurs elsewhere, so that we manage within our budget. And it's something that is very doable. I'm confident it can be done. That's not to say that there won't be greater demand, but if we only have a certain amount of funds to provide care, then we'll provide care as efficiently and as well as we can within that budget. But then we will probably not satisfy all the demand that may be out there. That's not different from what VA has been doing for years.

Mr. BISHOP. Let me just posit this sort of hypothetical to you. I've heard it discussed that under some of the proposals for eligibility reform, if, for example, a young veteran or a young servicemember were stationed in Germany and got a pass and went into town and was involved in an automobile accident and be-

came a paraplegic, that under some of the provisions, unlike current law, that soldier would be treated, stabilized, then discharged from the service without the complete commitment of health care, without the counseling services, without all of the other support services that are now provided under current and existing law and because that was not service-connected, the accident, he was actually on a pass, then it would be left up to that individual's family to care for that individual for the rest of his life. Is that the practical effect of what some of these proposals in changing to the service-connected requirement?

Dr. KIZER. I think Secretary Brown has spoken quite eloquently in this regard and has expressed the Administration's opposition to taking away benefits that servicemembers are currently entitled to. That benefit package was part of the contract that they entered into when they joined the service and the Administration would oppose measures that would take away care such as you outlined in that scenario.

Mr. BISHOP. Those are contained in some of the proposals for eligibility reform?

Dr. KIZER. Those topics have been discussed in various forms. I'm not sure they're specifically in eligibility reform legislation, but again we haven't seen final copies of some of them. But the issue has certainly been discussed.

Mr. BISHOP. I'm really just trying to understand the application of eligibility rules that would disqualify an individual in that circumstance. What would have to occur in terms of eligibility to disqualify a young soldier that experienced that unfortunate circumstance?

Dr. KIZER. Well, it would just have to be made explicit that that was not to be covered. Most of the discussion so far has been centered on budget resolutions that have included language to that effect, but there would have to be an explicit prohibition of that for that to occur.

Mr. BISHOP. So we would have to do something in the Authorizing Committee to make it specific, even though the budget resolution sort of alludes to it in a general sense. Is that what you're saying?

Dr. KIZER. Yes. The discussion to date has been centered around language that's in the budget resolution.

Mr. BISHOP. Thank you very much.

The CHAIRMAN. Mr. Stearns. Mr. Gutierrez.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman. I'd like to ask unanimous consent to have this opening statement inserted into the record.

The CHAIRMAN. Certainly.

Mr. GUTIERREZ. Thank you very much.

[The prepared statement of Congressman Gutierrez appears on p. 82.]

Mr. GUTIERREZ. I guess my basic concern, Doctor, is that people with lower income levels probably have additional risks to their health due to their income and because of income, they probably have less of an opportunity to get a full range of comprehensive preventative kinds of services and that they would probably be more likely than not, than others to need more acute care, whether

it's in an inpatient or outpatient basis. So I say all of this because one of the reasons, it seems, under the proposal that we're going to have a group of lower income veterans who are making between \$16,000 and \$20,000 suddenly told that their care will be mandated by the VA. Can you tell me what is likely to happen to these people?

Dr. KIZER. Well, sir, as you acknowledge, health status is, and has been known for centuries to be, related to income and whether one has a job, an education, and a number of other variables that are unrelated to medical care per se. The population that the VA serves is sicker and has more problems than you would see in the general population at large. One of the provisions in the measure that we are advancing makes it clear that disease prevention measures and services would be included among what is called health care and that we would put a higher priority on health promotion and disease prevention than has been the case in the past. Likewise, independent of eligibility reform but another of the efforts being pursued in the department is to shift our resource allocation methodology to a capitation basis. This would provide a number of incentives to provide those services and to keep people as healthy as possible.

Having said all that, going back to your specific question, if those individuals that are of low income are not able to receive services or get health care services through the VA, it is likely that they will not get services, certainly in a timely or convenient manner, if at all. This would put further stress on an already over-stressed publicly funded health care system at the local level, including county hospitals where those facilities exist. Unknown and a complicating variable here is the impact of possible cuts in Medicaid and Medicare. There is a significant interface between these systems of care and VA. If they're all being ratcheted down at the same time, the net effect is that a lot of people are not going to be getting health care that formerly were.

Mr. GUTIERREZ. Thank you, Doctor. I have no further questions, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Tejada.

Mr. TEJEDA. Thank you, Mr. Chairman.

I just have one question. I again thank you very much for being here. My question is how would the Veterans Integrated Service Network's proposal be affected by the eligibility reform proposals that are being discussed today?

Dr. KIZER. Our proposal would provide VISN's with the flexibility needed to transition care from inpatient to outpatient settings and other goals that are enumerated in the *Vision for Change* document. As I indicated when that measure was introduced, while it is independent of eligibility reform and while it can function and improve the system independent of eligibility reform, the goals that I believe everybody supports will certainly be easier to accomplish and the performance of the system will be enhanced if eligibility reform is added to the new management structure.

Mr. TEJEDA. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, sir. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman. Before asking Dr. Kizer a question, if I could just thank you for holding these hear-

ings. I don't think there is any issue more important before this committee this year than eligibility reform, and thank you for your and Mr. Hutchinson's focus on this issue.

I apologize for being late. This is a tough day for me. I've testified on impact aid funding for the children of military families this morning and now in a few minutes I've got to go to Waco hearings. Waco is my home town and frankly, those aren't as important as the issue before this committee but, because it's the district I represent, my home town, I want to and need to be there to see how those hearings are going.

But the bill that Mr. Montgomery and I introduced, I'd like to say, was designed to be a first step and not the last step in this process. We certainly look forward to looking to you, Mr. Chairman and Mr. Hutchinson's committee to work together on a bipartisan basis to develop a bill that this committee can support that is affordable and is good for our veterans.

Dr. Kizer, I appreciate very much your forward looking vision and aggressive approach toward reforming the VA health care system. I think we either have to reform it or we're going to have serious problems in the future, and your focus on putting more resources into outpatient care I think makes absolute sense. Clearly, that's what's happened in the private sector and the VA has fallen behind in that area, and I thank you for your leadership on that.

I would like to ask you if the infrastructure in place today is going to be a serious problem in terms of shifting care from inpatient to outpatient care. Is that going to make this transition over the next 2 or 3, 4 years extremely difficult to carry out in the real world or can you use the facilities that are already out there, just shift them somehow more toward outpatient care?

Dr. KIZER. Let me respond to that in just a moment. I would just preface my response by saying that we do want to work with you on the bill and while there are some parts of the bill we do not support, we'll look forward to working with you on that.

Specifically in response to your question, if we're given the tools to manage the system, all of these problems are manageable. In some areas, there will be more or less difficulty depending on the availability of VA assets, as well as what is available in the private sector for sharing or what may be available with the Department of Defense or with others that we may be looking to joint venture with us on projects in the future. There are clearly marked problems in providing health care in rural areas and in other areas that are independent of the VA. We're going to share in some of those difficulties as we move forward just like everybody else has problems in these areas.

But basically, if we have the tools and the managerial flexibility, I think that these are all things that can be managed and that we can move the system forward quickly.

Mr. EDWARDS. Good. Could I also ask. You made general reference in your opening statement to the problems of the present system. Could I ask you to give the committee and for the record some specific examples of where the present system simply is irrational, where veterans, whether it's hypertension or other cases whether a veteran has to get in such bad shape that he has to go into the hospital for 3 days to get the care he could and should

have gotten on an outpatient basis. Can you give us any specific examples of where the present system simply doesn't serve the veterans rationally?

Dr. KIZER. I suppose one could cite a lot of examples. Just to give you a couple, a veteran may be receiving care for their amputation that's service connected and in the process they're noted to have hypertension that's out of control, or maybe diabetes or any number of other conditions. Because they are not service-connected for that condition, they're not technically eligible to receive care for that. However, if they were to leave the facility and have a stroke because of their hypertension, or any number of other complications from other diseases, then the system could take care of them. But instead of providing timely care to prevent the stroke, or other untoward effect or outcome, we would be precluded from doing it under the current eligibility rules. That just doesn't make any medical sense, and it doesn't make fiscal sense either because it's going to be more expensive to treat them in the ICU after they've had a stroke than to put them on appropriate anti-hypertensive regimen.

The case that's been used in other settings, and I think it also graphically illustrates the problem is where an individual falls down and sprains or breaks his or her ankle. That patient could be casted quite appropriately in the outpatient department but to provide them crutches, which are a prosthetic device, they would have to be admitted to the hospital under the current rules. Obviously that makes no sense. Other examples could be pointed out that are just as egregious.

Mr. EDWARDS. Thank you, Dr. Kizer. Mr. Chairman, thank you. I'll submit my other questions for the record in writing. Thank you.

The CHAIRMAN. Thank you, Mr. Edwards, and thank you for the bill that you introduced and all the work you've done in this area, too.

Mr. Clement.

Mr. CLEMENT. Thank you, Mr. Chairman. First of all, I'd like my statement to be accepted into the record.

The CHAIRMAN. Without objection.

[The prepared statement of Congressman Clement appears on p. 72.]

Mr. CLEMENT. Mr. Secretary, a pleasure to have you here today. Some critics suggest that eligibility changes alone won't change the way doctors practice medicine and that whatever we do, many veterans will still be hospitalized inappropriately. Would you please address that view?

Dr. KIZER. Well, what we can do with the eligibility reform would certainly be a big blow for freedom, liberty and moving the system in the right direction. It's true that any measure such as this can't ensure that there will be no inappropriate admissions, but the same applies in the private sector. You have to have an overall system to address this. Indeed, we are putting that in place, but currently the incentives of the system are such that it favors inpatient care because of the eligibility requirements and other things. We have to change that to put the appropriate incentives in place that will then drive the system to not only provide the highest technical quality care but also the most efficient care.

Mr. CLEMENT. It's been proposed that we enact a statute to limit the number of nursing home beds VA operates. Do you agree with that?

Dr. KIZER. No, sir.

Mr. CLEMENT. Why?

Dr. KIZER. Well, because I don't think it makes sense to put in place that type of statute. I think we have measures underway, some of which we have talked about before, where we are looking at how we can work with the private sector in providing more community-based care. We have special needs that may not be available in the community where putting an arbitrary mandate on the number of beds just doesn't make sense. Obviously, any construction or other things that we may do in the future as far as physical assets is going to be constrained by the budgets, so we're going to be looking real carefully at that. I just see no reason to put that type of mandate in place. Indeed, those types of mandates are why we're in this hearing today. We need to have the right incentives in the system and to hold the managers accountable for running the system efficiently, but we don't need laws and mandates that have arbitrary numbers in them.

Mr. CLEMENT. So you think VA has the capacity to meet the demand for nursing home care posed by World War II, Korean War veterans and others?

Dr. KIZER. No, sir, I don't. As I mentioned earlier, with our current assets, as I look down the road 10 to 15 years, the VA does not have. However, if we are given the tools to manage the system, we can certainly make the types of arrangements, sharing arrangements and others, that would provide us with that, recognizing, of course, that this is a discretionary area and what we would provide would be limited by the budget.

Mr. CLEMENT. Have you run the numbers to determine how many additional beds we would have to have?

Dr. KIZER. We have folks actually that are looking at that now.

Mr. CLEMENT. When would we have that information?

Dr. KIZER. We can make it available as soon as I have it.

Mr. CLEMENT. Okay. Thank you.

The CHAIRMAN. Thank you, Mr. Clement.

Doctor, is it not true though that by your own figures that the VA from 1990 to 2015 will lose about 26 percent of the veterans population or about seven million people? I mean I grant that some of these may become old and may have to be replaced, but are you saying that you would see a need for additional hospitals to be built?

Dr. KIZER. No, sir. That's not at all what I said. What I'm saying is that in the next 10 or 15 years our need for services, both for acute care as well as long-term care, is going to increase even though we have a diminishing population of veterans just because they're going to be older. This is particularly true as we look at the oldest old, those over 85; this population is increasing dramatically. The need for services in that population is many times higher than it is in a younger population. At a certain point in time, 15 years down the road, that trend will start to decrease. What we're talking about here is having tools so that we can share and joint venture with others to obviate the need for building some of the facilities

that historically has been the way the VA has approached this business. What we'd like is to be able to have sharing arrangements with community nursing homes, community hospitals, Department of Defense health providers or others when our managers determine that such arrangements are the best way to provide services to our patients. If it indeed makes sense in the short- and long-term basis to entertain a construction project, then that would be an option as well. But I want to make sure that we have the array of options that our managers need to run the system efficiently.

The CHAIRMAN. Thank you, Doctor.

Are there others? Yes, but first let me remind the members that we do have four more panels, so if you'd be brief, we'd appreciate it.

Mr. HUTCHINSON. Mr. Chairman, I thank you for your indulgence. I just wanted to follow-up one question that Mr. Bishop asked concerning the suggestion of an alignment commission and Dr. Kizer's response. I think you said that it would be a waste of time and money and that you were unalterably opposed. So let me follow-up. First of all, as one who has suggested that it might be time for such a commission, let me suggest that I think there's some misunderstanding if there's any inference that we who think that a commission might be advisable would use that commission to interfere or obstruct or slow down your efforts on reorganizing the VA. In fact, I think that you will acknowledge that our committee and our subcommittee has been quite supportive of your efforts on reorganization, that they're not mutually exclusive at all.

I would also suggest that the real reason it may be time for such a commission is not a lack of expertise in the VA as to what should be done but because Congress has too often exerted political influence in the alignment of the veterans' system. I think that's a historic reality. We control the purse strings and because we control the purse strings, it is very easy for Congress to interfere in how the veterans' health care system looks in its alignment. The whole idea of a commission is to take that undue political influence out of the kind of decisions that you might want to make. Whether that political influence comes from the administration and whether that political influence come from Congress, politics ought to be out of what should be our goal, and that's providing the best possible health care for our veterans.

So if such a commission can take that politics out and improve the health care that we're providing to our veterans, it would seem to me that ought at least to be something that we're open to or that we would look at. I suggest also that if you go back to Dick Armye when he first came in and suggested to the Base Closure Committee, that was exactly what he heard: it's a waste of time and money, and everybody's unalterably opposed to it. Yet many of those same people there think, you know, it was a pretty good idea, it's worked out pretty good.

So my question is, would you leave just a crack of an opening—Dr. Kizer, I have seen you as a voice of change and as one who is open to some new ideas, so I would just ask that you have a little openness on this idea until the specifics might be looked at more closely.

Dr. KIZER. Well, sir, I thought you told me that you were going to take politics out of this decision making process in the future. On a serious note, my comment was premised on what I currently understand the commission goals to be and how it would function. We're always willing to talk and to discuss things.

The CHAIRMAN. Thank you. Mr. Everett, I apologize. I should have gone to you before I started the second round.

Mr. EVERETT. No questions.

The CHAIRMAN. All right. Are there any other questions?

Mr. MASCARA. Mr. Chairman, I move that the prepared statement I prepared for today's hearing be accepted for the record.

[The prepared statement of Congressman Mascara appears on p. 74.]

The CHAIRMAN. It certainly will be.

Doctor, thank you. I'm sure you're familiar with the *Independent Budget* that the veterans' service organizations put together. In the interest of time, I do have some questions that I would like to ask you with respect to that budget. They do a valuable service to us and at least I think most of them on this committee look to that for help and I would like to submit some questions to you if you would answer for the committee, please.

Dr. KIZER. I'd be delighted to, sir.

The CHAIRMAN. Thank you.

If we could proceed now with this next panel. This morning we'd like to welcome Mr. David Baine, Director of Federal Health Care Delivery at the Health, Education and Human Service Division of GAO. He is joined by Mr. Jim Linz and Mr. Paul Reynolds, Assistant Directors.

GAO has conducted numerous studies in VA health care and we welcome you this morning, Dr. Baine. And if you would summarize, we would appreciate it. Your entire statement will be made part of the record. You may proceed in any way you see fit.

STATEMENT OF DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JAMES LINZ AND PAUL REYNOLDS, ASSISTANT DIRECTORS

Mr. BAINE. Thank you, Mr. Chairman and members of the committee. We, as usual, appreciate the opportunity to be here today as the committee considers reforms of veterans' eligibility for health care. With the Congress and VA facing increasing pressures to limit VA health care spending as part of government-wide efforts to reduce the budget deficit, eligibility reform presents a formidable challenge. Veterans' eligibility for health care has evolved over time, both in terms of the types of veterans eligible for care and the services they are eligible to receive.

VA has gone from a system that primarily provided hospital care to veterans with war-related injuries to a system covering a wide array of hospital and other medical services for both war time and peace time veterans. In the process, eligibility for VA care has grown increasingly complex including multiple coverage groups of veterans whose eligibility is based on such factors as periods of

service, presence and seriousness of service-connected disabilities and income.

For most veterans, however, eligibility continues to be conditioned on the need for hospital-related care. Veterans' benefits differ from benefits under a typical private health insurance policy in two important ways. First, private health insurance policies are easy for both policy holders and providers to understand and administer because they all have uniform benefits that apply to everybody who happens to have that policy. In private plans, benefits are typically defined in terms of specific medical services that are covered. In VA, however, benefits are not defined in terms of such medical services. Rather, they are defined in terms of disabilities.

One category of veterans, primarily those with service-connected disabilities rated at 50 percent or more, is eligible to receive any medical service needed to treat a disability, regardless of the cause or severity of that disability. But for veterans in other categories, the services they are eligible to receive on an outpatient basis depends on the types of disabilities for which they are seeking care.

Veterans are eligible to receive any needed medical service for treatment of a service-connected disability regardless of the severity of that disability but are eligible for treatment of other disabilities only if it will obviate the need for hospital care or as a follow-up to hospital care. For example, women veterans can obtain treatment for complications related to a pregnancy but can not obtain routine prenatal care or delivery services through the VA health care system.

The second major difference between VA and public and private insurance is that there are no guaranteed VA benefits. Under insurance programs, policy holders are essentially guaranteed coverage of all their medically necessary services in their benefit package. Under the VA system, however, even veterans that the law says shall or must be provided certain types of health care services can get those services only if resources are available. This is because the VA system is funded through a fixed annual appropriation and when funds run out, VA's obligation to provide care runs out with it.

VA's eligibility provisions create problems for veterans and providers alike. Generally, they create uneven and uncertain access to VA care and limit VA's ability to meet veterans' health care needs. Veterans with similar medical needs, service status and incomes may get treated or turned away, depending on what type of care they seek, where they seek it and when they seek it. This creates frustrations for veterans who can not understand what services they can get from VA and for VA providers who have to interpret subjective eligibility provisions.

Because the provision of VA services is conditioned on the availability of space and resources, VA's medical centers have developed policies and procedures for rationing care. These procedures vary as does the sufficiency of resources and, as a result, many medical centers turn away veterans for care while others serve all the veterans who apply for care. Frequently, this results in a veteran receiving care at one medical center while another veteran with a comparable condition and coverage status is denied care in a different center.

Mr. Chairman, the Congress faces many difficult choices in trying to reform eligibility provisions to address these problems. Some questions that might be raised as part of the discussion of eligibility reform include: Should the current eligibility distinctions based on factors such as presence and degree of service-connected disability, period of service and income be changed? If so, how should coverage groups be structured? Should the restrictions on access to outpatient care be altered or removed? Should a uniform benefit package be developed for one or more benefit coverage groups and what benefits should be included for each group? Should the availability of benefits be guaranteed for one or more of the coverage groups, and how much should veterans be expected to contribute to the cost of expanded benefits?

Obviously, the cost of eligibility reform will depend on answers to those kinds of questions. For example, a lower cost alternative might be first to maintain existing coverage groups. Second, provide uniform benefits for coverage groups with a more limited benefit package for certain groups such as higher income veterans with no service-connected disabilities. Third, increase the cost sharing requirements for some veterans, and fourth, maintain the existing space and resource constraints on the availability of care. That is, to guarantee no particular benefits. Such an alternative would address some of the problems caused by VA's current eligibility provisions but would not fully address others such as uneven availability of care.

In contrast, a higher cost alternative might first establish a single coverage group for all veterans. Second, expand coverage to include a uniform benefit package of all medically necessary services. Third, provide for guaranteed availability of benefits for all veterans, and fourth, maintain or decrease veterans' cost sharing. In choosing among the available alternatives, the Congress faces, in our opinion, a difficult policy dilemma. If the first approach is followed, either appropriations will have to be increased to accommodate the expected increases in demand or many veterans, including some who are currently being served, will be turned away because of resource limitations. If the second approach is followed and the availability of benefits is guaranteed, Congressional control over VA health care spending will be largely relinquished.

In conclusion, Mr. Chairman, as you are all painfully aware, enacting an eligibility reform proposal in a constrained resource environment will be a very tricky proposition. We, of course, will be happy to work with you and other committees as specific proposals are put forward and to try to help you analyze those proposals both in terms of the benefit package and cost implications. We'll be more than happy to take your questions, sir.

[The prepared statement of Mr. Baine appears on p. 93.]

The CHAIRMAN. Thank you, Mr. Baine.

Mr. Bishop.

Mr. BISHOP. Thank you, Mr. Chairman, and welcome to you, Mr. Baine.

Current eligibility provisions require that VA provide hospital care to Category A veterans while restricting access to outpatient care. A number of studies have found that a substantial percentage of veterans receiving acute hospital care can more appropriately be

cared for in a less costly setting. Assuming changes in both the veterans' health system management and eligibility law such as is proposed in H.R. 1385 and the Administration proposal, would you not agree that a very substantial savings can be realized just from shifting much of the care from an inpatient to an outpatient basis?

Mr. BAINE. Mr. Bishop, I think it's been our experience as we've done studies around the country of the VA health care system that while some of the eligibility provisions contribute to probably greater lengths of stay in hospitals and contribute toward a trend toward inpatient care, it really has been the management philosophy of the medical center directors that has contributed most toward the bent toward inpatient care. And part of the reason for that, and I think this is an important issue, is that the budget incentives that the VA has set up for allocating resources to the medical centers have traditionally largely been based on the inpatient work load and the number and the lengths of stay and the inpatient days in particular medical centers. Some of that is changing with the new resource allocation system that VA has come up with, but I think it's fair to say that the culture of the VA medical system has been an inpatient culture. Dr. Kizer—and we've talked to him on several occasions about this—is trying very, very hard to change that culture and believes that some of the eligibility provisions need to be changed as part of the culture change.

Mr. BISHOP. And that cause for change then would be consistent with what's happening in other areas of our health care delivery system.

Mr. BAINE. Absolutely.

Mr. BISHOP. And has been proven in many instances to promote better overall health care. Is that correct?

Mr. BAINE. Yes, sir.

Mr. BISHOP. One of your major concerns seems to be that we might, as a Congress, enact legislation which could give veterans false expectations of the benefits that they can get from the VA. None of the veterans' organizations that regularly testify before this committee seem to be worried about it. Why is it that you're worried about it?

Mr. BAINE. I believe one of the reasons that we are concerned about that is that some of the proposals that we've seen for eligibility reform state that VA must and shall do several things in terms of various categories of beneficiaries. It's going to be very difficult, in our opinion, if there's a statute written that says VA must do this and shall do that for various categories of beneficiaries for the Congress to not make good on the appropriations that stand behind that must and shall. I think it's going to put the Congress in a very tough position when there are eligibility provisions that are written in such a way that veterans expect to receive care and they show up at a medical center that does not have the resources to take care of those things. The problem, as we see it, is that provisions continue to have space and resources available constraint in them in addition to the must and shall provisions.

Mr. BISHOP. Don't you think that's our responsibility?

Mr. BAINE. Absolutely, sir.

Mr. BISHOP. And if in fact our veterans have fulfilled their responsibilities and have been promised really as an entitlement that

they would get these services and we as a Congress and the Authorizing Committee say these services shall be granted, don't you think that that puts the U.S. Government in the position of allowing our veterans to be in a position of mandamusing the Congress to appropriate what needs to be appropriated to carry out that mandate?

Mr. BAINE. Yes, and that's a decision, sir, that the Congress is going to have to make year-to-year if, in fact, the eligibility provisions that say VA shall do this for these categories of beneficiaries are enacted and the Congress—I'm not saying that the Congress won't or they will. Our concern is that in an era of budgetary constraints, it's going to put a lot of pressure on this institution to appropriate the money, notwithstanding what the demand might be.

Mr. BISHOP. Isn't that our responsibility?

Mr. BAINE. Absolutely.

Mr. BISHOP. We're the Authorizing Committee and we're supposed to set the standard and if we do that and it is the will of the Congress to pass legislation that sets those standards, then doesn't that appropriately put the pressure on the budgetary arm of the Congress to follow through?

Mr. BAINE. Yes, sir. The question is whether they will or not.

The CHAIRMAN. Thank you. Mr. Tejada.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. Baine, I guess you had the opportunity to review these eligibility reform proposals that we're discussing today?

Mr. BAINE. We've had the opportunity to look at them, sir. We saw one Monday night and one prior to that, but we have not analyzed them in great detail.

Mr. TEJEDA. What you have seen of them, do they address many of the concerns that you have?

Mr. BAINE. Yes, sir, they address several of the concerns that VA has raised over the years about eligibility. I think I would say to you, as I responded to Mr. Bishop, that the financial implications of the eligibility reform proposals in our view need to be analyzed thoroughly. I wonder if Mr. Linz or Mr. Reynolds might want to comment on that.

Mr. TEJEDA. Let me just follow up with this and perhaps you can incorporate. Can these proposals expand care given the current resources without forcing the rationing of care?

Mr. BAINE. My own personal opinion is no, they can not. We did a fair amount of work a year or so ago about whether the VA is rationing care now. They, in fact, are rationing care because of resource constraints at particular medical centers. We found that about two-thirds of the medical centers were rationing care and about one-third of the 158 medical centers were not. If rationing is an issue, I mean I believe it's going on now.

Mr. LINZ. I think the extent to which VA can expand services without additional resources is going to depend largely on the extent to which they are successful in shifting care out of inpatient hospitals and into outpatient settings. Our basic concern there is that we think they've had the authority since 1973 to shift that care to an outpatient setting and it's primarily management inefficiencies, not the law, that's the barrier. And so we're hesitant to count those savings not knowing whether or not they will really

materialize. Dr. Kizer is trying to do things to expedite that shifting. I think that shifting can take place without eligibility reform.

Mr. TEJEDA. Thank you.

The CHAIRMAN. Mr. Clement.

Mr. CLEMENT. Mr. Baine, you warn that eligibility reform could significantly increase demand for VA health care services and force VA to turn away increasing numbers of veterans. Yet only 2 months ago in testifying before the Committee on Government Reform and Oversight, you questioned the viability of the VA health care system in light of your dire predictions about a continuing decline in patient work load. Are we damned if we do and damned if we don't?

Mr. BAINE. I believe our testimony before the other committee, sir, was primarily emphasizing the inpatient portion of the VA health care system. Secondly, with regard to the comment on whether the demand for VA care would be increased under an eligibility reform proposal, our sense is that the demand would be increased, primarily if the benefit is a no or low cost option. As VA tries to increase their points of access, as Dr. Kizer is trying very hard to do through these community service clinics, the demand for VA care in the outpatient area will increase significantly. Our comments before the other committee related primarily to the fact that VA has been traditionally and largely an inpatient driven system and with the rest of the health care market going increasingly to outpatient care, that leaves VA pretty far behind in terms of being able to turn its system around to be a real competing provider in the health care market.

Mr. CLEMENT. In your testimony, you cite determining eligibility for veterans suffering from ailments they believe to be linked to their service in the Persian Gulf. As one of the members who drafted legislation opening the VA to such individuals, I would be interested in hearing your thoughts on this issue. What are some of the problems and suggestions?

Mr. BAINE. I'm sorry, sir.

Mr. CLEMENT. Concerning the veterans of the Persian Gulf, you cite determining eligibility for veterans suffering from ailments they believe link to their service in the Persian Gulf.

Mr. BAINE. It's my understanding that under the chairman's proposal, Persian Gulf veterans would be eligible for care in VA facilities for a period of time, I believe it's 3 years—no 2 years.

Mr. CLEMENT. That's correct. I didn't know whether you had any follow-up. I know you mention that in your testimony.

Mr. BAINE. Yes. Jim.

Mr. LINZ. If I could comment on that. It's included in the testimony more as an example of another one of the administrative tasks that VA has to go through that you wouldn't see in administering a typical private health insurance plan. It's one of the additional questions that VA physicians and administrative staff have to answer.

Mr. CLEMENT. Okay

Mr. BAINE. But we are aware that that provision is in the committee's draft proposal.

Mr. CLEMENT. Thank you.

The CHAIRMAN. Mr. Everett

Mr. EVERETT. No questions.

The CHAIRMAN. No questions. Mr. Baine, I do have a couple of questions with respect to the *Independent Budget* and at the time I will submit them to you. If you would answer them in writing for the committee, please.

Mr. BAINE. We'll be more than happy to, sir.

The CHAIRMAN. If there are no other questions, we thank you gentlemen very much, and let's proceed very rapidly with the third panel, Veterans' Service Organizations.

Good morning. Our third panel today is Mr. David Gorman, Disabled American Veterans, Mr. Greg Bessler, Military Order of the Purple Heart, Jim Magill of the VFW and Mr. Gordon Mansfield of the Paralyzed Veterans of America. We thank you very much for appearing before us today and I apologize for the short number of members, and you may proceed in any fashion you want. I guess, Mr. Gorman, if you'd like to start off.

STATEMENTS OF DAVID W. GORMAN, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; GREGORY A. BRESSER, NATIONAL SERVICE DIRECTOR, MILITARY ORDER OF THE PURPLE HEART; JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS; AND GORDON H. MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

STATEMENT OF DAVID W. GORMAN

Mr. GORMAN. Thank you very much, Mr. Chairman. My written testimony is a part of the record and I would hope that it would be included in the record.

The CHAIRMAN. All of your testimony will be entirely included in the record.

Mr. GORMAN. Thank you. Having said that, let me digress from that written testimony a little bit if I can for my oral remarks based on a lot of the things we've heard this morning.

First, if I could preface it and digress from the issue of eligibility reform specifically and say, Mr. Chairman, that a lot has been said about funding, a lot has been said about service-connected versus non-service connected eligibility. I want you to know that we realize there's a lot of things coming from other committees and other sources other than the Veterans' Affairs Committee, who we've always viewed as addressing veterans' issues in a bipartisan manner. But I need to say that any proposal—and there certainly are a number of them out there, real ones and ones being talked about and perceived—that takes away benefits and services for service-connected disabled veterans is going to meet the stiffest opposition from the Disabled American Veterans that we can muster. Whether it be from the Appropriation Committee as far as incompetent veterans, as much as we acknowledge the fact and we've come to this committee talking about the need for eligibility reform, if eligibility reform is going to be attempted to be accomplished by taking away service-connected disabled veterans' benefits to pay for it, then we will oppose that. I just wanted to say that as a preface, and I appreciate Mr. Hutchinson's remarks in that respect, too, as far as the priority that must be accorded to service-connected veterans be-

fore you can go ahead and start taking care of the non-service connected veteran.

There's a couple of premises that are in our testimony. One is that the Nation has an obligation to care for service-connected disabled veterans and we're fearful that that obligation is being diminished. If you agree with that premise and you also agree with the second premise that the VA should be the primary Federal provider of benefits and services to service-connected disabled veterans. If we start from there, then I think we can take today's subject and today the issue of eligibility reform will move forward. There are parts of both your proposal, Mr. Chairman, and Mr. Edwards' that the DAV is totally supportive of. There are things in there that we've been talking about as the authors of the *Independent Budget*. There are things that we oppose.

Having said that, however, I think a prime example has come forward that has not been specifically talked about yet this morning and that's the North Chicago, Illinois VA Medical Center has moved into, I think starting in October of 1993, with an HMO type primary care model which has shown tremendous benefits, not only to VA but to the patients they serve. They've been able to increase the enrolled veterans in their program fivefold. They've been able to reduce inpatient admissions and hospitalizations up to 98 percent. They've eliminated from five acute care wards down to three wards. That's a 63 percent reduction in the number of acute care beds. There's a potential annual savings of over \$15 million by doing it that way. They've saved and redirected FTE doing it under that model. It makes no sense to us why one facility can be doing that so successfully and it can't be replicated through the system. I think it's basically because of the very issue that we're talking about, and that is this bed-base model VA has been locked into for years.

There's a proposal that the *Independent Budget* has put forward for a number of years. It's again before the committees this year. That is the model that we believe will move the VA forward in a direction it needs to be. I would say also that Dr. Kizer's proposal, his *Vision for Change*, is supported by the DAV. We think it's the way to go. We agree somewhat with what GAO had to say as far as moving in the right direction in trying to do these things. We don't agree that the VA has the authority under the law right now to provide outpatient care to Category A veterans. Even if they did, the perception out there among hospital directors is there's no way they would do that because they'll be visited by the IG or the GAO for that matter probably and get slapped on the wrist again.

So we need to wipe the slate clean, we need to start anew, we need to define specifically who's entitled to care, what they get, and how it's going to be funded. All those things are part of the *Independent Budget* proposal.

Mr. Bishop mentioned a couple of things as far as the commission that's been talked about by Mr. Hutchinson. I think the DAV, for one, independent to my statement there's a copy of a letter that was authored by the *Independent Budget* as well as the Blinded Veterans, Jewish War Veterans, and the Military Order of the Purple Heart signed on to it, that basically says the establishment of a commission at this time, we believe, is premature. First, you

can't go out and look at facilities when you don't know who you're going to treat and what you're going to treat them for. You don't know about other entire health environment as far as Medicare and Medicaid what changes may be made, what impact that's going to have. However, that's not to say that at some time in the future that kind of a look at the VA system in that fashion may not be advisable.

However, we think the evolutionary process that Dr. Kizer envisions is going to largely take care of that. We are not opposed, the DAV is not opposed, to major mission and facility changes in the VA's physical plant. If facilities have to be consolidated or whatnot in order to provide the best care to the most number of eligible veterans, then we say that's the way the VA needs to go. I want to repeat that because I think it bears repeating that we're not opposed with these kinds of major mission changes that the VA may probably have to make in the future in order to accommodate the veterans they're charged to take care of.

I see my time is fast approaching, Mr. Chairman, so I'll close on that basis and be happy to respond to any questions you may have.

[The prepared statement of Mr. Gorman, with attachments, appears on p. 109.]

The CHAIRMAN. Thank you, sir. I think we'll go through the panel and then go back to the questions. Mr. Bresser.

STATEMENT OF GREGORY A. BRESSER

Mr. BRESSER. Mr. Chairman, committee members, good morning. Before I begin, I'd like to take this opportunity to thank you for the opportunity of this hearing. I'd like to also reaffirm who and what the Military Order of the Purple Heart is. The Military Order of the Purple Heart is an organization composed entirely of veterans who are Purple Heart recipients, the combat wounded.

Mr. Chairman and committee members, veterans have been asking for eligibility reform for years. The forum you are holding today will have a dramatic effect on the course of eligibility reform for all perfectly eligible veterans. The actions taken by your committee regarding eligibility reform could improve the access to full continual health care and improve the efficiency of services delivery. The American people have recognized that Purple Heart recipients, the combat wounded, are a special category of veterans and therefore must be placed with veterans with special eligibilities.

Legislation defining the core group veterans must include specific language identifying the combat wounded Purple Heart recipients as meeting core group veterans criteria without reference to percentages. Legislation that would ignore the combat wounded as a recognized special group would trivialize the intent of the American people. The American populace recognizes sacrifices of men and women who have served in combat and any legislative initiative to deny special eligibility status to combat wounded would outrage the American public.

Mr. Chairman, the DVA is the Nation's largest Federal health care provider. Studies available to Congress and at DVA effectively show that DVA medical centers provide a more comprehensive and cost-effective health care than comparable counterparts. Take, for example, HMOs. They are profit driven. In other words, when sub-

scribers get sick, HMOs lose money or pass the costs on to subscribers. On the other hand, the DVA provides acute, long-term care services that subsidize Medicare and Medicaid programs at a great savings to the Medicare Trust Fund and the state taxpayers. The DVA provides a wide range of specialized services not available in the private sector, tailored to the unique needs of the combat wounded veterans.

Decentralizing the DVA's management operations can improve efficiency. Local directors understand the needs of veterans' community. They serve decentralization, can increase responsiveness of local facilities. Deregulating of contracting, resource sharing and personnel management functions could increase efficiency and would be more cost effective. Funding the DVA is also in need of reform. Discretionary funding for DVA health care has failed to keep pace with medical inflation and, as a result, DVA has been forced to deny medical services to eligible combat wounded veterans and other service-connected disabled veterans.

Congress must make DVA health care accounts non-discretionary. Congress must provide for alternative funding sources such as third-party reimbursements and Medicare payments for the non-service connected treatment and allow the DVA to retain those funds in the local facilities that provide those services.

On behalf of John C. Loper, our National Commander for the Military Order of the Purple Heart, I want to thank you for the time and your attention.

[The prepared statement of Mr. Bresser appears on p. 122.]

The CHAIRMAN. Thank you.

Mr. Magill.

STATEMENT OF JAMES N. MAGILL

Mr. MAGILL. Thank you. As you know, the VFW has supported eligibility reform for many years and, in fact, just the past few years we have it listed as one of our priority goals and for that reason, the VFW is very appreciative of you for holding these hearings this morning.

In your opening statement, I think you mentioned two key things that we are in total agreement with. First, is that any reform proposal must reduce the complexity of the system as it exists today and also it should improve the veterans' access to VA.

As you know, before us there are several proposals and I would first like to address the draft that was submitted by the committee. After reviewing this draft, we do not believe that it does reduce the complexity of the system and we don't believe that it improves access. In fact, our concern in several cases for veterans who are eligible now may not be in the future but reduced more to a discretionary basis.

For those two reasons and, of course, the reasons that I listed in my prepared statement, that in its present form we can not support the draft proposal.

With respect to H.R. 1385 introduced by Mr. Edwards and Mr. Montgomery, the VFW is more receptive to those provisions. We do have some concerns. We do not like the three year date. We don't look at eligibility reform as being a pilot project, if you will. Also,

we would like to see zero percenters included in a reform proposal that will be advanced.

With respect to the administration, I just received that very late yesterday afternoon. There are some provisions that we can support and some provisions that we can't, and I would like to have a little bit more time if I could to give a detailed review of it and then submit that to the committee to be a part of the record.

The CHAIRMAN. Certainly.

Mr. MAGILL. Okay. Thank you.

The next proposal is the *Independent Budget*. You, of course, are aware of it. You've been supplied a copy of the budget. It's my understanding that the language now has been put into legislative form and that it will soon be submitted to CBO for a cost. We would hope that once it is costed out and we find that it is affordable and then have it introduced, that it would receive the full attention of the Congress. We think that if we're going to advance anything, it's got to have broad support. This has been brought up in staff and we totally agree. I think there is broad support for the thrust of the *Independent Budget* and again, we would hope that once this is put before the committee that we can review it again at that time.

I would also in closing just like to comment on the commission that has been brought up with Mr. Bishop. We, too, think that while there may be a need for it at some time, this is not the time now and that we would hope that Dr. Kizer will be able to continue with his plan, and that concludes my statement. I'll be happy to answer any questions.

[The prepared statement of Mr. Magill appears on p. 124.]

The CHAIRMAN. Thank you.

Mr. Mansfield.

STATEMENT OF GORDON H. MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman.

I'm going to be very simplistic and go back to square one. In the Constitution of the United States which I have before me, it says here that Congress has the power to declare war, grant letters of mark reprisal and make rules concerning captures on land and water. It also has the power to raise and support armies, to provide and maintain a Navy, to make rules for the government regulation of the land and naval forces.

When we talk about resources, I get concerned that we are perhaps lumping a fundamental constitutional responsibility which this Congress has in with other programs which may have a lesser connection with the Constitution of the United States. What we have here is citizens' service to the country and the country's contract based on that service to provide care. I would refer you, Mr. Chairman, to your far right to those flags that are on the dais and point out that those battle streamers, each and every one, represent members of the armed forces who have gone into battle and each one of those battle streamers represents people who have been killed, people who have been wounded, people who have come home as veterans.

The reason we're in the position we're in is because this committee has been attempting to limit care to meet constrained resources

since the late 1970s through the 1980s and into the 1990s. We recognize that. The VSOs, I think, have been realistic in attempting to work with the committee to find a reasonable solution.

Last year in the context of national health care reform, the veterans' service organizations, the VA and others, came up with a plan for inclusion had that legislation gone forward which acknowledged \$3.3 billion of unfunded necessities in that system. The need to expand the system, the need for geographic response to the needs of the veterans. I would suggest to you, Mr. Chairman and members, those needs have not gone away in the past year. They have probably gotten worse.

We would like to thank you for recognizing the issue. This hearing is timely and needed. PVA wants to make the point that we intend to work with you to find an answer that is both fair to the veterans and realistic in terms of the resources needed. We would point out that, in our view, real world medicine has evolved to outpatient care. The VA can not provide treatment as the other medical models are doing because of this web of statutes which result in rules and regulations which define how they can do it. We've got a situation where the HMOs are considered right now to be the most cost conscious method of treatment, but right now I would suggest that the VA, although to some degree considered a national HMO, in effect is a backward HMO.

One of my fellow testifiers made the point that HMOs limit costs by enrolling people who are not sick and limiting treatment. I would suggest to you the reason the VA has got people in their system is because they are sick and they do need treatment and that has to be recognized. What we think is needed is a realistic and simple system that's simplifies rather than complicates things. We would like to see a system where the VA can concentrate on medical issues and put their FTEs and resources into medical care and not a backlog of paperwork and administrative issues to determine what part of what veteran on what day in what specific VA medical center they might be able to treat after they send them down the hall, whether or not there's a bed there or a doctor there or a nurse there or treatment facilities there.

PVA has had a chance to review the drafts and proposals, not in the detail that we would like. I also would like to have the opportunity to submit further testimony to the committee. We would like to point out that in your proposal and the other proposals, we do see elements that we like. We also see elements that we don't like. I would suggest again though that what we're looking for is something that the doctors and nurses and the patients can understand and that this Congress can find the money to pay for it. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Mansfield appears on p. 127.]

The CHAIRMAN. That was one of the two points—simplicity. Gentlemen, thank you. Of course, this is a draft. We appreciate working with you. We appreciate your comments. We welcome additional statements from you for that purpose.

Mr. Gorman, you commented on the success of North Chicago. Do current eligibility rules prevent that from being duplicated in other areas?

Mr. GORMAN. I'm not quite sure, Mr. Chairman. I'm not fully acquainted with all the things that they're doing up there. Sometimes it's better to do the right thing and seek forgiveness rather than ask permission, so I'm not altogether sure. But I would think that if the majority—I know our reading over the years, I think shared by many on the committee and the committee staff, is that there is preclusion to a full continuum of care for a veteran who needs it. As Dr. Kizer said, a physician should be able to provide care to a veteran who's in the core group and found eligible to what they need for medical services and treatment rather than a hodge-podge, and that's exactly what goes on today and there's no question about that. I don't think anybody denies the fact that rationing of care is existing.

There are two comments as far as the outpatient aspect that I would like to make the GAO referred to and I would like to argue against. First, is that they thought the demand would increase significantly in an outpatient basis. We maintain that it would simply shift. It would shift from an inpatient basis and work load to a much less costly outpatient basis, therefore, averting or saving, if you will, the system, the *Independent Budget* estimates, \$2 billion a year simply by the major fact of doing that alone.

Second is the false expectations that GAO feels may be created. If there were ever false expectations on the part of veterans, they're existing today and they're met every day by virtue of them trying to seek medical care and being told you can get this but you can't get what you really need. We think that's a travesty. As Mr. Mansfield pointed out, that's what needs to be corrected.

The CHAIRMAN. Thank you. I do have some other questions, if you would submit for the record those answers, but in the essence of time we're going to move right along.

Mr. Bishop.

Mr. BISHOP. Thank you very much, and let me thank you all for your testimony. You've reinforced some thoughts that I think I've had on these questions. Would you—and this is addressed to any or all of you who care to comment. I will have limited time. But would you agree that the most confusing and the irrational aspects of our current eligibility law are in the provisions that are governing the eligibility for outpatient care? And I think you've referenced that, several of you, in your testimony. Either of you can comment on it.

Mr. MANSFIELD. Mr. Bishop, I would wholeheartedly agree with you. And again, if you go back to the *Independent Budget* project that the veterans groups put together and forwarded and furtherance in testimony just given here, the whole purpose of shifting from inpatient/outpatient care is to be able to save the money within the system to treat the people that are there, so we would agree.

Mr. BISHOP. So you think it would be more efficient?

Mr. MANSFIELD. Definitely more efficient.

Mr. MAGILL. I would agree with that, but I would also add that it's not only confusion in the outpatient but it's also in the inpatient, too. The whole system has got to be revamped and then it would be much more effective and less costly.

Mr. BISHOP. I'll admit confusion in terms of the eligibility criteria.

Mr. MAGILL. Yes, sir.

Mr. BRESSER. The cost just for inpatient care is anywhere from \$700 to \$900 a day. The cost of outpatient care is approximately \$85 and for that \$85, if you broadened the eligibility for outpatient care, made it less restrictive, you would serve more veterans, you would turn less veterans away and you would also save money.

Mr. BISHOP. The GAO's testimony dwells pretty heavily on the possibility—and you touched on this—that eligibility reform could significantly increase the demand for VA health care and it would require that the VA perhaps have to ration its care. Do you feel that that risk is sufficient to suggest the desirability of either imposing co-payments on VA hospital and outpatient care or (2) cutting back on who's eligible for care or (3) doing nothing?

Mr. BRESSER. I think—

Mr. GORMAN. I was just going to comment that co-payments exist right now for both inpatient and outpatient care for some veterans. I think I've commented, we don't agree. The work load may increase but it could be met by VA with current resources. Back in 1986 when the category of shall first came into being, the current category A were mandated or shall be provided inpatient care, I think the same fear was brought up. The gates are going to open. There'll be a flood of veterans. And that hasn't occurred. I think there's going to be an increased work load by more veterans, but that's as it should be because they are rationing care now to veterans who are otherwise eligible for care. I think if the cry is that the veterans' organizations and the VA are continually asking for more and more resources and more and more money to fund this system, if you're going to maintain the system in its current form, you need more and more resources. If you change the system, and that's the whole premise of reform. The system is broken, it's inefficient. If you change in a manner in which I think the *Independent Budget* has proposed and others agree to including the committee—and the legislation you marked up last year is a cost avoidance and you can take care of more veterans with the quality of care second to none and equals the community for the same amount of resource and you don't have to hear this constant budget battle of more and more resources.

Mr. MANSFIELD. Mr. Bishop, as a follow-up, in the *Independent Budget* one of the things that we project is that you will be able to take care in an outpatient setting three times as many patients as you would in an inpatient system. So the increase would have to be more than three times before you ever start getting into the question.

And the other point, too, I would make in the submission of the *Independent Budget* this year is a follow-up to Mr. Gorman's comments. The VSOs have proposed a way for this Congress to save some dollars. That has been, I think, a fundamental shift in the way that the veterans' service organizations that make up the *Independent Budget* approached this goal back to last fall and presented a scenario with the shift from inpatient to outpatient, some other changes, getting additional dollars and keeping them in the system where we can help you with that resource question.

Mr. BISHOP. I certainly want to commend you for your creativity and your desire to help us to be more efficient and at the same

time to serve more veterans and deliver the services that you are certainly entitled to have.

Mr. Chairman, I yield the balance of my time.

The CHAIRMAN. Mr. Tejada.

Mr. TEJEDA. Thank you, Mr. Chairman, and thank you very much for your service to our veterans and certainly to our VSOs.

I know you have not had the opportunity to do a detailed analysis of the draft proposal or H.R. 1385 and I know there's some concerns with the draft and you were a little more receptive of H.R. 1385. So let's just stick to H.R. 1385, what you have read of it, what you have looked at. How would you improve upon the bill? And that question is for everyone. How would you improve upon the bill, that which you have had the opportunity to look at?

Mr. MAGILL. IF I could start, as I mentioned in my statement, we would like to see all service-connected be included and to include the zero percent. I think that would be a good step. It was also brought up that the bill would have—I believe it was a three year date on it. This has got to be permanent. What we have to do if we're going to advance something, this has got to be the way we go, not a trial that in 3 years we're going to go back and take a look at it. That would be my comments.

Mr. GORMAN. I think that H.R. 1385 is a good step in the right direction and encompasses a lot of things that the *Independent Budget* has put forward. I'm not clear specifically from the ability of the VA under this proposal of their contracting authority, and I think that needs to be looked at and needs to be strengthened. I think as far as you get into the issue of nursing home care, how you can provide more nursing home care without bricks and mortar, whether it be through enhanced use, leasing or whether it be going out in the community and contract more, plus the VA to be able to be a provider of care for fair dollar return from the private sector. I think there's a lot of capability out there so long as veterans aren't displaced in the process. It's an additional revenue source to VA that needs to be explored, and I'm not sure that's specifically addressed in that detail in that piece of legislation.

The CHAIRMAN. Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman.

I'm trying to understand the priority lists for outpatient care as they exist today and whether or not any of you feel that they make any sense. I mean if you had to devise—obviously Category A veterans and that type of thing are going to be in a separate category of not only need but also expectation in terms of where they get their benefits, but in terms of how the outpatient care works, does it make any sense, given the priorities of the VA today?

Mr. BRESSER. Not with respect to medical needs. Not when you have to go to a hospital for 3 days when you can get taken care of in 2 hours.

Mr. KENNEDY. Right.

Mr. BRESSER. That's not only inconvenience for the staff, the hospital and the government. It's a major inconvenience for the veteran and his family.

Mr. MANSFIELD. The only sense it makes right now, Congressman, is that loyal, hard working VA employees out there are making the damn system work by forcing people through it and they're

having to jump through hoops to do it. There's X number of people being treated and they're being treated today while we sit here and they'll be treated tomorrow because they made the system work. What we're saying is the system can work a lot easier, those people can get better care, more continuous care and probably cheaper care and the resources needed would be less if we did it the right way.

Mr. KENNEDY. Right. I couldn't agree with you more. You're confirming what my instincts have been for several years with regard to this whole issue of eligibility. It seems that this becomes as much politics as it does good health care policy. As people that have followed this committee understand, we have passed some eligibility reform. Not all of us have felt that it went far enough. You could debate that, but it's died in the Senate because they don't feel that the VA essentially can handle the system changes and the financial burdens that would shift as a result. It seems to me that if you're saving money by not having someone go into a hospital and you can shift them into outpatient care, that's a savings to the system if it's run properly. I don't know whether that's going to prove out to be true, and it might end up meaning that we have to look at finding additional resources.

I wonder whether or not if, in fact, we continue to run up against the same kinds of buzz saw politics of this that we've seen in times past whether or not you feel that administratively these kinds of changes could, in fact, begin to take place. We've seen them take place in the private sector. In other words, when we talk about, for instance, the difference between—we have in Massachusetts more people that have signed up for HMOs, PPOs than any other State in the country. They have reduced the amount of inpatient care in hospitals dramatically and reduced the number of hospital beds, therefore, dramatically. I could see a situation where administratively the VA begins to make some decisions. If the VA were left to just make the decisions within the confines of how they have to do it today, could, in fact, the system change dramatically? Are they just bumping up against the hard rules and regulations that the Congress has set out so that they have run out of flexibility? Anybody.

Mr. GORMAN. The current structure is constraining, Mr. Kennedy. There's no question about that. You talk about two different things. If you're talking about a priority of care versus who's eligible now and what priority they then fall into for care, that's one issue. The other issue, which is the broader issue that we need to discuss is who is going to be eligible for the care and what kind of care are they going to be eligible for? You talk about putting a person in an inpatient bed versus treating them on an outpatient basis. The VA has always been what I refer to as a sick system. When you're sick, you come to them, and that's the only time the VA sees you. There's no preventive care or preventive medicine being delivered in VA right now. Very, very little because there's very little authority to do that. There's a way to go to keep people not only out of the hospital but out of the crowded outpatient clinics, if you can provide that kind of model which everybody would, I think, agree to is a cost effective way to go. But more importantly, from a delivery of medical care, it's the preferred way to go.

Mr. KENNEDY. Mr. Gorman, just to follow up with that, are you saying that—for instance, let's say you're running the Boston VA in Jamaica Plains or something. The rules that we have set out do not allow you to, for instance, provide people with the kinds of standard preventative health medicine that we would allow in any other health system in this country?

Mr. GORMAN. I believe that's an accurate statement. In my view it is. Yes.

Mr. KENNEDY. And there's nothing administratively that you feel that the VA can do. Mr. Chairman, if you have an opinion, I'm happy to listen to what you have to say.

The CHAIRMAN. I would agree with that. I would agree.

Mr. KENNEDY. And would you say—and I appreciate, Mr. Mansfield, your notions that the VA is, as I've found always the case, that the VA personnel themselves are trying to make what appears to be kind of a broken system work. But is there anything that you feel that administratively the VA can do right now that could make this process just work more smoothly? Are there any changes that we could expect? I think that fellow Kizer is trying to do some of those changes. I don't know whether or not you feel that there's anything more they could do or whether they're just sort of bumping up against the very rules and regulations that we set out.

Mr. BRESSER. I think one of the things, the VA employees right now, the managers in the VA hospitals, the outpatient clinic directors and managers, nurses and doctors, they're bending every regulation so they can provide the services necessary. When it comes to the law, it's black and white. They can not do anything that violates the law. They can bend rules, but they can't violate laws, and that's what they're up against.

Mr. MANSFIELD. There's two parts to this in my mind, Mr. Kennedy. First is, let's face it, the VA is some 250,000 people and it's a big bureaucracy. Bureaucracies have some inefficiencies built into them. The other point I would make is I get a little bit nervous when you put me in between this committee or the Congress of the United States and the Secretary or the people over there and give them a chance to say, Go do what you want. There are some other sanctions built into appropriations language and budget language where if they did some things, they're liable to be—not before this branch, the other courts. That's something that has to be worried about.

I think I would say that Dr. Kizer, I think we can generally say here, the veterans' service organizations feel that Dr. Kizer is bringing a breath of fresh air and ideas in and he is pushing forward and we support him to the fullest and we'll continue to support him.

The other part of the problem here though is you're talking about eligibility reform and you're talking about the patient. The other part of the problem is getting paid for treating that patient. And I know up in Jamaica Plains and West Roxbury, there's problems up there because even if they bend the rules and get the patient in there and take care of them, if they can't get the resources within the budget for that medical center, then that medical center director is answering to Washington, DC. Why did you go over budg-

et and spend more money than we appropriated for you? And that's the other side of the problem that you have to deal with.

Mr. GORMAN. The one thing they can do right now, I think, administratively, and they have a proposal in the works, is to open up additional points of access for veterans to come into to get care, not only to the VA itself, but in the community. I think they've identified upwards of 200 of those across the country where they can go out and say to the veterans in that community, Don't drive 100 miles to the VA hospital. Come to us. We'll provide you outpatient care. That, I believe, can be done administratively and with no cost.

Mr. KENNEDY. Mr. Chairman, do you have any thoughts that you want to share with us about what happens. I know that you've put out a bill for some general discussion which I think it's obviously getting, but even if we get some compromise between you and Sonny in terms of what the actual eligibility reform might look like, do you have a feeling that you're sending a bill over to the Senate to again die in the Senate graveyard over there or what?

The CHAIRMAN. If I thought that was true, I wouldn't be wasting my time, Mr. Kennedy. I really think that since this is our number one priority and that we are very sincere in what we're trying to do and we're going to bring some unbelievable pressure over there if we don't get some cooperation from them.

Mr. KENNEDY. Good. Thank you very much, Mr. Chairman.

The CHAIRMAN. Gentlemen, thank you very much, and we welcome your additional remarks as you requested. It would be my hope to continue on through the next panel. Hopefully, most of the questions have been asked and we can proceed very rapidly.

We go to Panel 4 please continuing with the VSOs. The fourth panel is comprised of Mr. Frank Buxton, American Legion, Mr. Larry Rhea, Non Commissioned Officers Association, and Kelli West of the Vietnam Veterans of America. Welcome. Your statements, of course, will be printed in the record in their entirety. We would appreciate if you would summarize. You may proceed, Mr. Buxton, please.

STATEMENTS OF FRANK C. BUXTON, DEPUTY DIRECTOR FOR VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION; LARRY D. RHEA, DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS, NON COMMISSIONED OFFICERS ASSOCIATION; AND KELLI R. WILLARD WEST, DEPUTY DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

STATEMENT OF FRANK C. BUXTON

Mr. BUXTON. Good morning, Mr. Chairman and members of the committee. The American Legion certainly appreciates this opportunity to comment on the eligibility reform for veterans' health care.

Mr. Chairman, any approach to reforming eligibility guidelines is a tight rope walk, and we understand that fact. The necessity to remain budget neutral while improving access to VA health care for our Nation's veterans is clearly a give and take balancing act. As an organization dedicated to mutual helpfulness for our veter-

ans, we trust giving rather than taking from veteran patients would be the thrust of any legislation. Health care delivered on the basis of funds available rather than the health care needs of our veterans is not good health care.

The American Legion has consistently advocated a fair system of access to VA health care and this access, coupled with adequate appropriated funding and sustained by other means of fiscal support would play a major role in creating a sensible and fair system.

Mr. Chairman, certain of the bills under consideration limit or revoke the care of veterans with a noncompensable disability. I'd just like to comment on the fact that this limitation affects 37.3 percent of our service-connected veterans. Limiting care to veterans with 10 and 20 percent service-connected disability ratings affects another 35 percent. This is not good, and we have concerns about that.

Mr. Chairman, we have for years said that several elements must be present in any eligibility reform package. One of those elements was the expansion of the population of veterans served by VA. We would expect service-connected veterans to receive care with appropriated funds and non-service connected veterans allowed access to the system with payment by a third-party reimbursement. Several of the bills under consideration such as the chairman's discussion draft and H.R. 1385 allow VA to retain certain monies received as third-party reimbursement over the CBO baseline. We commend this step forward. We do have some concerns, however, that the increased collections are presumed to come from the same population of veterans presently treated in the system. These are the veterans that are least able nor obligated to pay for care. Discretionary veteran patients must be encouraged to use the VA health care facilities and bring their third-party dollars with them to cover the cost of their care.

We also understand that this legislative language should prod the VA into being more efficient in collecting the third-party payments. Moving this collection process to a contracted service could be a next step if such stimulation fails to produce results. Most of the bills under discussion such as H.R. 1385, the chairman's draft and the VA proposal, also expand the provision of outpatient services to a larger veteran population which is certainly a step toward more responsible, appropriate and cost-effective care delivery. This is a major improvement and a move away from the expensive inpatient care. Congress must be careful, however, not to stifle this initiative by withholding construction funds for ambulatory care projects.

Regardless of the way any legislation is designed, Mr. Chairman, we must be assured that our veterans requiring specialized care such as blind rehab, prosthetic services, treatment of spinal cord dysfunction, long-term psychiatric care and other specialized services receive that care and we applaud the bills that require this continued provision of service.

Mr. Chairman, any bill which moves the VA into a managed care arena, provides for the decentralization of management authority and promotes the regional oversight as we see in Dr. Kizer's *Visions for Change*, is an excellent step toward such a move. The

chairman's draft, H.R. 1385, and the VA's proposal all speak to these changes and we encourage that.

Mr. Chairman, we also lend our support to the comprehensive proposal put forward by the organizations comprising the *Independent Budget* and, as most know, the American Legion is not part of the *Independent Budget*. Mr. Chairman, the American Legion is also in its final stages of crafting a VA health care plan which will espouse all of what we think is good for veterans health care while promoting cost effectiveness, expanding accessibility and moving a VA into a fiscally responsible, modern health care delivery arena. This plan is nearly in its final development phase and we will be requesting your support and Mr. Montgomery's support in having this proposal costed by CBO as expeditiously as possible so that we can then garner the support from all Congressional quarters which would be essential to moving this legislation forward.

We also wish to comment briefly on the commission to study VA as proposed. We think a study while the VA is in such a major state of flux would only be shooting at a moving target. Let's let the VA position itself under the visions for change, let the eligibility criteria changes settle in and then, in several years perhaps, we can study away, Mr. Chairman. That concludes our statement.

[The prepared statement of Mr. Buxton appears on p. 135.]

The CHAIRMAN. Thank you, Mr. Buxton. Mr. Rhea.

STATEMENT OF LARRY D. RHEA

Mr. RHEA. Thank you, Mr. Chairman. The Non Commissioned Officers Association, like everyone else, is pleased to be here today and we commend you for holding this full committee hearing. We would be remiss if we did not extend a special word of thanks to both the majority and the minority staff for their efforts and candor in the discussions preliminary to today's hearing.

I think we've learned one thing this morning, Mr. Chairman, if we didn't already know it. That is, two things. We're dealing with a complex issue and the solution is not going to be easy. So we took a slightly different approach in our testimony than some of the other organizations. Rather than support or not support provisions of various bills, we looked for some common ground. I think out of what we've heard this morning and in the discussions that we've had over the past several weeks, there's some common ground amongst all interested parties that eligibility reform, in whatever finality it takes, should allow the VA to deliver care to an eligible veteran on the basis of the clinical need, whether that be outpatient or inpatient, and that that should probably be determined by the attending VA physician rather than a set of lawyerly rules that we've crafted.

But if the goal, or at least a portion of the goal, that we're seeking is fairly clear, the pathway to get there is probably equally unclear. There are significant divergences between the various proposals that we've been talking about. So what we tried to do, we tried to find the common ground, and we think there is some common ground, that irrespective of whatever else happens, Mr. Chairman, we believe that it should be moved on rather quickly because

we sense that there's a certain urgency to the matter that's before us today.

First, Mr. Chairman, NCOA thinks that if today's hearing results in nothing more than the introduction and passage of a simple piece of legislation that would repeal to obviate the need language, then we will have taken a major step forward. Closely second, let's remove the legal hurdles that VA physicians must overcome in the delivery of care. Once eligibility has been established, and we can debate what the groups of eligible veterans are later, but even operating under the current system, once eligibility has been established, VA physicians should only be confronted with the question of how best to deliver that care. If it's ambulatory care that would satisfy the patient's need, then we should do it. If in the opinion of the VA physician, hospitalization is required, then we should do it. The fact that 40 percent of inpatient care is for non-acute reasons should be argument enough for us to abandon the rules that we now operate under.

NCOA's third point is that of certifying VA as an authorized Medicare provider and allow VA to recover the cost for care provided to Medicare eligible patients.

We made one other point in our testimony, Mr. Chairman, and I'm also compelled to mention it here in my opening comments. It deals with the category of veterans that is really all too often overlooked, forgotten or outright ignored in the VA system. Probably as well as anyone else here today, NCOA understands the mission and the obligation of the VA. Above all else and without question, there is the obligation to the service-connected veteran. But it's also clear to the NCOA that military retiree veterans served under a promise believing it also to be an unalterable obligation that guaranteed them medical care. And it is that guarantee and belief, Mr. Chairman, that concerns NCOA with the recently signed memorandum of understanding between DVA and the Department of Defense. Under that agreement, DVA medical centers can apply for and be certified as eligible providers under DOD's managed care contract on program. But that agreement treats the Federal DVA facility the same as any other private sector provider and the cost of these retiree veteran beneficiaries for treatment in a VA hospital is the same as if that care had been provided by the private sector.

We believe that to impose any out-of-pocket cost on this group of eligible retiree veterans for treatment in a Federal facility, even if that facility is managed by the Department of Veteran Affairs, is an abrogation of a core obligation, just like we incurred it with the service-connected, that it's an abrogation of a core obligation that the Federal Government has to those retiree veterans. It is our position that the treatment of these folks and these veterans in the DVA should not require CHAMPUS co-payments just like any other civilian facility. We're hopeful that DOD and DVA will address this issue and we've asked them to do so, but I raise this point with the committee and specifically with you, Mr. Chairman, in the hope that the committee members will use their influence to see if we can't get these co-payments waived for those retirees that were promised their health care. That concludes my comments

and we appreciate your inclusion of our prepared testimony in the record.

[The prepared statement of Mr. Rhea appears on p. 138.]

The CHAIRMAN. Thank you, Larry.

Ms. West, I'm going to give you a choice. If you want to do it in about 3 minutes or otherwise wait about 10 minutes until I can run over and vote and come back.

STATEMENT OF KELLI R. WILLARD WEST

Ms. WEST. I would be happy to be very brief. I'm losing my voice anyway, so I'll try to keep my remarks very short.

Mr. Chairman, VVA appreciates the opportunity to present views on one of the most complicated and critical issues facing American veterans today. We understand that this hearing is aimed to set the stage for further discussion when the CBO cost figures and analysis of VA's proposal are available. As a single generation organization, VVA has a unique perspective on VA health care. This is a sandwich generation caught between the concerns of raising families and contemplating the problems of aging. Vietnam veterans currently represent the largest sub-group of the veterans population.

VVA is proud to collaborate with our VSO colleagues in the partnership for veterans health care reform. This unprecedented unity among the VSOs is a testament to the commonalities and the needs of the veteran population and to the necessity of change. VVA believes that service-connected disabled veterans and low income veterans should always remain VA's highest priority. Greater efficiencies through emphasis in outpatient care should logically allow VA to provide more outpatient services. We believe that the core group veterans would not necessarily get more care but simply more efficient care. VA will likely have an increased capacity to provide care with an outpatient emphasis. Just as non-service connected higher income veterans can currently access the VA when resources permit, eligibility reform should provide the same opportunities for these veterans who wish to pay for that care.

VHA should be allowed to retain a portion of the monies collected for services to discretionary veterans and these funds can then be reinvested to improve services for all veterans. Facility enhancements, equipment purchases and the addition of services and access points could be accomplished with these new funds. This is the basic premise behind the VSO's analysis detailing that eligibility reform could increase services while still reducing VHA's reliance on Federal tax dollars. By bringing new sources of funding into the VA and increasing efficiency, VHA could make some of these improvements without tapping into annual Federal appropriation. In this budget climate, access can not be expanded, even for core group veterans, without new sources of funding.

I recognize you need to run to vote, and I'll close my remarks there. Thank you, Mr. Chairman.

[The prepared statement of Ms. West appears on p. 144.]

The CHAIRMAN. Thank you, and I apologize. I have about 4 minutes to go vote, and my apologies to you. I will submit some questions to you, and my apologies to the fifth panel. I will be back shortly, if we take about a 10-minute recess. Thank you very much.

[Recess.]

The CHAIRMAN. The hearing will come to order. Our fifth and final panel consists of Dr. Robert Keimowitz, Dean of Academic Affairs, George Washington University, representing the Association of American Medical Colleges, and Lynna Smith, President of the Nurses Organization of the VA. If you could come forward, please, and we apologize. I appreciate your patience, and you can have as much time as you desire pending that next vote. Welcome to both of you. The floor is yours.

STATEMENTS OF ROBERT I. KEIMOWITZ, M.D., DEAN FOR ACADEMIC AFFAIRS, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND LYNNA C. SMITH, MN, RN, CS, ARNP, PRESIDENT, NURSES ORGANIZATION OF VETERANS AFFAIRS

STATEMENT OF ROBERT I. KEIMOWITZ, M.D.

Dr. KEIMOWITZ. Thank you, sir.

Mr. Chairman, members of the committee, I am Dr. Robert Keimowitz, the Dean for Academic Affairs at the George Washington University School of Medicine and Health Sciences. I'm pleased to appear today to share my views and those of the Association of American Medical Colleges on reform of the rules that determine a veteran's eligibility to receive health care services through the VA health system.

The AAMC represents 125 accredited United States medical schools, nearly 400 major teaching hospitals, including 74 VA medical centers, over 90 academic and professional societies, and the Nation's medical faculties, students and residents. Together, the members of the AAMC work to improve the Nation's health through the advancement of academic medicine. As we near the 50th anniversary of the first affiliation between a VA medical center and a medical school, academic medicine looks back with great pride on its record of service to our Nation and to our Nation's veterans. Likewise, we look forward to continuing this very productive and mutually beneficial relationship over the next 50 years and beyond.

Since the Hines VA Medical Center and Northwestern University entered into the first collaboration in 1946, affiliations between medical schools, other health professions schools and VA medical centers have contributed to attaining the goals set forth in the VA policy memorandum that still guides the affiliations today. That is, affording the veteran a much higher standard of medical care that could be given with a wholly full-time medical service.

Nearly 10,000 faculty from these academic affiliates direct or provide care for veteran patients and teach residents and students at VA medical facilities. Today, 130 of the 171 VA medical centers are singly or jointly affiliated with 105 of the Nation's 125 medical schools.

The AAMC applauds this committee for embarking on a thorough review of the VA eligibility standards. Academic physicians are well aware that the current eligibility criteria hamper VA health professionals' efforts to provide appropriate medical care to

veterans. These criteria have evolved around the model of health care delivery that emphasized inpatient hospital care. Today, however, as others have said, most health care providers and organizations are moving away from that model to a delivery style that focuses on primary and preventive care in outpatient settings. While most policy experts believe this new model is more efficient and substantially more cost effective than the traditional hospital-based system, the current eligibility criteria preclude many veterans from receiving both outpatient and inpatient care.

Many of the veteran patients my colleagues see at the Washington VA Medical Center have conditions or diseases that could be treated more effectively if the patients had access to outpatient care. Eligibility rules currently in place, however, require physicians to admit many veterans to a VA hospital, even if their ailments could be treated less expensively and more appropriately on an outpatient basis. With different rules for hospital care, outpatient care, and long-term care, rules that depend on each particular veteran's disability status, their special classification and their income level, the ability of most veteran patients to receive adequate health care in the VA health system is a testament to the tenacity and perseverance of both the veterans who seek that care and the physicians and health professionals at the VA who provide the care.

Before I proceed further, let me say that like many of today's witnesses, the AAMC is concerned about the seven year freeze on funding for VA medical care assumed by the Congressional budget resolution for fiscal year 1996. With level funding, inflation will continue to erode the VA's power to provide veterans with appropriate health care services. The effects of this erosion will most likely be manifested in a gradual diminution of the VA's notable yet expensive services in the areas of spinal cord dysfunction medicine, rehabilitation of the blind, prosthetics and orthotics, and post-traumatic stress disorder treatment.

Eligibility reform, however, provides this Congress with an opportunity to adopt health policy that makes sense both medically and fiscally. For instance, the fiscal year 1993 *Independent Budget* estimates that the VA could save \$2 billion by diverting inpatients to more appropriate outpatient or long-term care settings. The AAMC believes eligibility reform can enable Congress to allocate limited Federal resources more effectively, yet maintain its commitment to those who have borne the battle on our Nation's behalf.

The AAMC would prefer to withhold its comment on the specifics of the eligibility reform proposals being offered by you, Chairman Stump, Representative Edwards and the Clinton administration, until we have had an opportunity to review and compare all of the proposals thoroughly and carefully. However, I'd like to elucidate three general principles on which the AAMC and its member institutions believe eligibility reform should be based.

First, the new criteria must not inhibit health professionals and administrators from making appropriate clinical decisions on how best to care for patients or on the most appropriate venue for such care. Congress should allow all eligible veterans to qualify for a full and comprehensive continuum of care including outpatient care,

hospital care, long-term care and the outstanding specialized services that are the hallmark of the VA health system.

Second, the new eligibility criteria should identify and clearly define the population of patients to be served and should allow the VA to concentrate its efforts on that population. In today's fiscal climate, this Congress may have to make difficult choices about what veterans to serve with the VA's limited resources. However, determining a distinctly identified cohort of entitled patients will enhance the VA's ability to balance its resources and capabilities with the needs of its constituents.

Third and lastly, Congress's package of eligibility reforms should not distract the VA from its efforts to create a more rational and effective system through which to deliver health care to its patient population. As set forth in our April testimony before the Subcommittee on Hospitals and Health Care, the AAMC supports the general principles underlying the VA's *Vision for Change*. We believe that Under Secretary Kizer and his colleagues should be given a full opportunity to implement their proposed reorganization and we urge the committee to allow the Department of Veterans Affairs to focus on reorganization without the additional burden of new missions or programs that might drain resources and talent away from the restructuring efforts.

Once again, the AAMC and its member institutions appreciate your willingness to tackle eligibility reform and look forward to working with you to disentangle the current eligibility criteria and create a system that encourages appropriate and efficacious medical care for our Nation's veterans. However, eligibility reform is one of several strategies and changes in policy that are critical to the health of the veterans and the future of the VA. While it considers eligibility reform, the committee should also consider allowing the VA to retain third-party collections, including Medicare payments, and thereby increase its funding base and reduce its reliance upon Federal appropriations; should continue to urge appropriators to provide adequate funding for VA medical care and, in addition, VA health research which supports the study of conditions that directly affect veterans and provides incentives for top physicians and scientists to choose VA careers; and should allow VA medical centers to treat non-veteran patients as long as the high quality of care for eligible veterans is not compromised and the VA is reimbursed properly for all care provided to non-veterans.

Thank you for allowing me to present the views of the Association of American Medical Colleges on reform of the VA's eligibility standards. I'd be delighted to answer any questions.

[The prepared statement of Dr. Keimowitz appears on p. 150.]

The CHAIRMAN. Thank you, Doctor.

Ms. Smith.

STATEMENT OF LYNNA SMITH, MN, RN, CS, ARNP

Ms. SMITH. Thank you very much, Mr. Chairman and members of the committee. I'm Lynna Smith, a nurse practitioner at the American Lake Seattle VA Medical Center. As president of the Nurses Organization of Veterans Affairs, I'm testifying on behalf of NOVA and I speak for more than 40,000 VA professional nurses. It's an honor and privilege for me to represent NOVA today.

This testimony will focus on the effect eligibility rules have on the health care of veterans and on the ability of VA nurses to provide quality health care. NOVA strongly supports the VA as an independent health care system providing a full range of services to all veterans. This care must be enhanced by education and research programs benefitting both veterans and the Nation. To achieve this goal, eligibility reform is essential and VA nurses are pivotal in decreasing the fragmentation of health care.

NOVA believes confusing eligibility regulations impede quality health care. VA nurses cite needless admissions to fit prosthetic appliances, difficulty getting prosthetic appliances following outpatient surgery while readily available for inpatients. Another situation describes a veteran who was prepared for outpatient surgery when the staff received a call to say that the veteran was ineligible. The surgery was completed in any case. However, the veteran did receive a bill.

We believe that empowering the VA medical centers to tailor programs to meet the needs of veterans in their catchment area is essential for effective care.

NOVA agrees with the *Independent Budget* recommendations. We'd like to share an example of a veteran with catastrophic disability which may be helpful in understanding their need for health care. A 70 year old veteran with a frontal sinus tumor was not treated by a community physician because he was too old to do anything about the tumor. One year later, he came to the VA because of severe pain and required extreme surgical intervention resulting in the loss of an eye, his frontal sinuses and his nose. He also required follow-up radiation. A year later, he is functioning well and he's now being fitted with a prosthesis to make his appearance more socially acceptable.

In reviewing H.R. 1385, NOVA agrees with expanding outpatient care, decreasing duplication of services, inclusion of preventive health services, prosthetic appliances and home care, and in providing for specialized treatment and rehabilitative needs for disabled veterans. NOVA believes any veteran with a service-connected disability should be included in the core group. We also believe the percentage of collections made available to medical centers should be increased to at least 50 percent. Consideration of Medicare reimbursement should again be discussed.

Veterans in the tri-care program tell us that the DOD bills HMOs for services and medical visits with DOD. The HMO then bills Medicare and then reimburses the DOD. One of my veterans suggested that the VA follow this same procedure and, in thinking about this, we believe this just provides an extra administrative layer. Also shows creativity. We really need to consider when we're considering reimbursement.

Some comments on the draft legislation. The delivery of care to veterans based on clinical or treatment need is critical in defining delivery of health care. The eligibility criteria in this proposal still remain quite complex. The pension amount cited is much less than the income currently used for the means test, and we do not support this change. The change in prosthetic services, devices and appliances is commendable. However, NOVA recommends removing hospitalization requirements for all core veterans. The Medical Ad-

visory Commission is very interesting and NOVA recommends nursing representation on the commission.

The nursing home care recommendations are excellent. However, the veteran population is aging and NOVA recommends that we not place arbitrary limits on nursing home care beds. Let this be flexible. The pilot programs. Before instituting new programs, we need to evaluate current rural health clinics and mobile clinics that are already functioning. Veterans who live at a great distance from the VA may have their own community physicians but may travel to the VA for the cost of medications, to receive their medications. Many of these veterans have multiple health care problems and medications may cost them \$200 to \$300 or even more a month. On an income of \$800 to \$1,000 a month, this is truly prohibitive. The National Survey of Veterans showed that cost and unique therapy were major reasons for choosing VA health care services.

Regarding reimbursement, the current collections program is working very well. There's been a steady growth of collections over time. Contracting out these services may precipitate a delay in the program and if it's done for a three year period, it may result in the loss of experienced personnel.

Mr. Chairman, NOVA is pleased to have your leadership and skill in our mutual effort to ensure quality health care for veterans. To quote Mr. Montgomery, "We have asked much of our fighting men and women. Remembering is what Memorial Day is for and what gives it meaning is how each one of us remembers the great sacrifices which have made possible the blessings we share as Americans today."

We'd like to thank you for this opportunity to share with you VA nurses' concerns on eligibility reform, and we thank you for your ongoing support of nursing and pledge to continue to work with you.

[The prepared statement of Ms. Smith appears on p. 155.]

The CHAIRMAN. Thank you, Ms. Smith. We thank you for your input, for your testimony. We have heard more than once today that the draft is still too complex and, believe me, be assured we will readdress that.

Doctor, let me ask you. If we are successful in going from an inpatient to an outpatient care mode, would that significantly impact our association and relationship with the medical schools?

Dr. KEIMOWITZ. No. Medical schools in this country increasingly recognize our obligation to train students in an environment that's appropriate to what they will be doing in their future lives. Outpatient care is a very important component of education and we at GW and many medical schools are increasingly moving the educational venue out of the hospitals and into offices, clinics, and other sites for outpatient experiences for students. So that would not pose a problem.

The CHAIRMAN. Let me ask you one other quick question. Would you further explain your association's proposal for inclusion of non-veterans into the VA system?

Dr. KEIMOWITZ. I think the association which composed this testimony from the input of lots of people with lots of expertise across the country was looking at ways of saying to this Congress that we understand the financial limitations, that we are looking for ways

of maintaining something that is of quality and of real value to the veterans and, to be frank, to the medical centers, as well. But we need to not simply request everything. I presume that the inclusion of that statement was to look for new sources of revenue, recognizing that the likelihood is that there will be a cohort of patients that the VA concentrates on but that if that facility has elastic potential, that non-VA patients be included as long as they are not displacing appropriate veterans and as long as funding is available.

The CHAIRMAN. Thank you, and let me thank you both again, and thank you for your patience. We are grateful for your appearance here today. Thank you very much. We may have some questions from members or staff that we would like to submit to you, if you would please. Thank you very much for coming today.

Dr. KEIMOWITZ. Thank you.

The CHAIRMAN. No other business. The meeting stands adjourned.

[Whereupon, at 1 p.m. the committee was adjourned.]

A P P E N D I X

STATEMENT OF HON. BOB STUMP

HEARING ON ELIGIBILITY AND HEALTH CARE DELIVERY REFORM

JULY 19, 1995

TODAY'S HEARING ON ELIGIBILITY REFORM IS THE NEXT STEP IN WHAT I HOPE WILL BE A FRANK DISCUSSION ON HOW BEST TO FIX THE COMPLICATED SET OF RULES DETERMINING WHICH VETERANS RECEIVE VA CARE.

THOSE RULES ALSO DETERMINE THE LEVEL OF CARE THE VA MAY PROVIDE.

THIS IS NOT A NEW TOPIC.

THE HOUSE HAS PREVIOUSLY PASSED BILLS TRYING TO IMPROVE OUTPATIENT CARE.

THE VA DID QUITE A LOT OF WORK ON ELIGIBILITY REFORM DURING THE 102ND AND 103RD CONGRESSES.

DURING THE 103RD CONGRESS, ELIGIBILITY REFORM WAS MADE PART OF THE NATIONAL HEALTH CARE REFORM PACKAGE, WHICH WAS NOT ENACTED.

THIS COMMITTEE REPORTED A PROVISION ON A BIPARTISAN BASIS BECAUSE IT WAS A VAST IMPROVEMENT OVER THE ADMINISTRATION'S BILL.

HOWEVER, I COULD NOT HAVE SUPPORTED THE BILL ON THE FLOOR BECAUSE OF THE PRINCIPLES IT WAS FOUNDED UPON,

INCLUDING THE UNDERLYING CONTEXT OF THE
VETERANS PROVISIONS.

ALSO LAST YEAR, I INTRODUCED H.R. 4788,
ADDRESSING ELIGIBILITY REFORM IN
CONSULTATION WITH VETERANS SERVICE
ORGANIZATIONS.

WE CERTAINLY WANT TO CONTINUE WORKING
WITH THE SERVICE ORGANIZATIONS, THE VA
AND ALL INTERESTED PARTIES.

ADDITIONALLY, MR. EDWARDS HAS
INTRODUCED A BILL AND WE APPRECIATE HIS
EFFORTS.

THE PURPOSE OF THIS HEARING IS TWO-FOLD.

FIRST, WE MUST BEGIN BY UNDERSTANDING
THE COMPLEXITY OF THE PROBLEM.

SECOND, WE EXPECT THAT THE TESTIMONY WE HEAR TODAY WILL HELP US DEVELOP A BIPARTISAN MEASURE WHICH WILL SIMPLIFY THE PROCESS, PROVIDE QUALITY COST-EFFECTIVE CARE, AND ENSURE THAT PRIORITY IS GIVEN TO THOSE MOST DESERVING.

AT THE SAME TIME, HOWEVER, WE ARE ALL WELL AWARE THAT THE CURRENT BUDGET CLIMATE WILL REQUIRE CAUTION ON HOW BEST TO PROCEED WITH REFORM.

I WELCOME THE WITNESSES COMING BEFORE US THIS MORNING TO PROVIDE THEIR IDEAS ON THIS CRITICAL ISSUE.

I LOOK FORWARD TO WORKING WITH YOU TO REACH OUR MUTUALLY SHARED GOAL OF IMPROVING ACCESS TO QUALITY CARE ON A SIMPLIFIED BASIS.

I PARTICULARLY WANT TO WELCOME DR. KEN KIZER, THE VA UNDER SECRETARY FOR HEALTH.

WE ARE ALL GETTING TO KNOW DR. KIZER BETTER AND APPRECIATE HIS THOUGHTS AND IDEAS ON THIS MATTER.

IN ADDITION TO WITNESS STATEMENTS, MEMBERS SHOULD HAVE BEFORE THEM A CHART DEPICTING THE COMPLEXITY OF CURRENT ELIGIBILITY RULES AND SOME POSSIBLE CHANGES.

THERE SHOULD ALSO BE A CONGRESSIONAL RESEARCH SERVICE SUMMARY OF THE HISTORY OF VA HEALTH CARE ELIGIBILITY.

COMMITTEE STAFF HAS ALSO PREPARED ALTERNATIVE DISCUSSION DRAFTS WHICH

WERE HANDED OUT TO YOUR STAFF
YESTERDAY.

THESE ARE MORE INCREMENTAL THAN OTHER
PROPOSALS BUT SHOULD HELP IN DISCUSSING
OPTIONS AND COST.

WE HAVE SEVERAL PANELS, SO THE
COMMITTEE WOULD APPRECIATE EACH
WITNESS SUMMARIZING THEIR WRITTEN
STATEMENT.

SINCE THIS IS NOT A DECISION-MAKING POINT,
GENERAL DESCRIPTIONS OF YOUR PROPOSALS
AND OBSERVATIONS ABOUT OTHERS WOULD
BE MOST HELPFUL.

**THE HONORABLE MICHAEL BILIRAKIS
THE HOUSE COMMITTEE ON VETERANS AFFAIRS
JULY 19, 1995**

"ELIGIBILITY REFORM INITIATIVES"

THANK YOU, MR. CHAIRMAN.

FIRST, I WANT TO COMMEND YOU FOR SCHEDULING THIS HEARING ON ELIGIBILITY REFORM INITIATIVES. I WOULD ALSO LIKE TO TAKE THIS OPPORTUNITY TO WELCOME TODAY'S WITNESSES TO THE COMMITTEE.

THE VA'S ELIGIBILITY RULES HAVE EVOLVED GRADUALLY OVER THE LAST 65 YEARS. TODAY'S COMPLEX AND CONFUSING CRITERIA REPRESENT A CONTINUING SOURCE OF FRUSTRATION FOR BOTH VETERANS AND VA PERSONNEL.

MOREOVER, IT IS OFTEN AN IMPEDIMENT TO PROVIDING VETERANS WITH THE KIND OF HEALTH CARE THEY REALLY NEED. MANY TIMES, A VETERAN WHO COULD BE TREATED ON AN OUTPATIENT BASIS MUST BE HOSPITALIZED IN ORDER TO RECEIVE CARE FROM THE VA. THIS IS OBVIOUSLY INEFFICIENT AND ADDS UNNECESSARY COSTS TO THE DELIVERY OF HEALTH CARE.

AS MOST HEALTH CARE PROVIDERS MOVE TOWARD A NEW MODEL OF CARE THAT EMPHASIZES PRIMARY AND PREVENTIVE CARE IN OUTPATIENT SETTINGS, THE VA MUST ALSO SHIFT ITS FOCUS FROM INPATIENT TO OUTPATIENT CARE. WITHOUT MEANINGFUL ELIGIBILITY REFORM, IT WILL BE EXTREMELY

DIFFICULT FOR THE VA TO REMAIN A VIABLE HEALTH CARE PROVIDER.

UNDER CURRENT LAW, ELIGIBILITY FOR CARE IS DETERMINED BY TWO MAJOR FACTORS -- THE DEGREE OF SERVICE-CONNECTION AND THE INCOME LEVEL OF THE VETERAN APPLYING FOR CARE. BASED ON THESE FACTORS, VETERANS ARE DIVIDED INTO TWO ELIGIBILITY CATEGORIES AND CLASSIFIED AS EITHER MANDATORY FOR CARE OR DISCRETIONARY.

I OFTEN HEAR 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.

CLEARLY, ELIGIBILITY REFORM IS LONG OVERDUE. I AM ANXIOUS TO LEARN OF ANY RECOMMENDATIONS OUR WITNESSES HAVE FOR REFORMING THE CURRENT ELIGIBILITY RULES.

MR. CHAIRMAN, MY SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT IS CONDUCTING A HEARING ON WASTE, FRAUD AND ABUSE IN THE MEDICARE PROGRAM RIGHT NOW. THEREFORE, IT MAY BE NECESSARY FOR ME TO LEAVE BEFORE THE HEARING CONCLUDES. LET ME APOLOGIZE IN ADVANCE TO OUR WITNESSES. I WILL CERTAINLY REVIEW YOUR WRITTEN TESTIMONY IF I DO HAVE TO LEAVE EARLY.

AS ALWAYS, I LOOK FORWARD TO WORKING WITH YOU AND THE OTHER MEMBERS OF THE COMMITTEE ON ANY SUGGESTIONS THE WITNESSES MAY HAVE ON THE ISSUES BEFORE US TODAY.

THANK YOU, MR. CHAIRMAN.

VA HEALTH CARE ELIGIBILITY REFORM

Hon. Lane Evans
07/19/95

Mr. Chairman:

Thank you for holding today's hearing. VHA's current eligibility system is broken and must be fixed.

VA's health care system is the nation's largest and many of its services and facilities are among the best in the nation, but the fact remains that only a small percentage of veterans actually can and do use the system.

Veterans may think that they're entitled to VA health care services, but they're wrong. The government has built a system that treats veteran's health care services as a privilege rather than a right. Services are delivered on a resource available basis and subject to annual appropriations. And as long as this is the case, thousands of deserving veterans will be denied health care every year.

While the doctors, nurses, and staff who serve veterans are dedicated, caring individuals, the system is arbitrary and capricious. Veterans never know what to expect. It is not uncommon for veterans to be denied services at one VA facility and granted the same services at another VA facility or for a vet to be denied care on day and deemed eligible the next.

As long as VA health care is not considered an entitlement and eligibility determinations are based on hospital budgets, veterans will continue to be denied vital care. And don't fool yourself, the cuts that this House voted for when it passed the budget resolution earlier this year will simply make a bad situation worse. The Republican budget will cut nearly \$6.4 billion from VA's budget by FY 2002.

VA's original health care mission was to care for the service connected injuries of war veterans. Today, it is charged with doing much more. Congress has expanded VHA's mission and charged it with caring for both service-connected and non service-connected veterans. This has led to perpetual underfunding for VHA and confusing eligibility criteria for veterans.

Veterans deserve better. The system may have evolved beyond its original mission, but veterans should not have to pay for Washington's folly. We expanded VHA's mission and promised veterans that they could count on the system in their time of need. It is only fair that we live up to that promise.

VHA's eligibility criteria need to be reformed, but in an honest and meaningful way. I am concerned that many of the provisions in the proposals under consideration would actually be a step backwards. Changing the status of service connected veterans rated at 20% or less and decreasing the income criteria by almost 20% could knock over a million veterans off the VHA's roles.

This is wrong. The eligibility criteria should not be "simplified" at the expense of any veteran.

As we enter this debate, I encourage you to remember the courage and sacrifice of our veterans. This debate should not be about money or about politics. It should only be about the provision of quality health care to veterans.

STATEMENT OF REP. TIM HUTCHINSON
COMMITTEE ON VETERANS' AFFAIRS
HEARING ON ELIGIBILITY REFORM
JULY 19, 1995

Thank you, Mr. Chairman, for your leadership on this very important issue. The nation's veterans deserve a more streamlined approach to health care eligibility, and your commitment to fixing the current system is to be applauded.

As Chairman of the Subcommittee on Hospitals and Health Care, I view eligibility reform not as an expansionist effort, but rather as a golden opportunity to revamp the system so that service-connected and needy veterans can receive health care in a variety of venues without worrying about arcane rules and complicated regulations.

Current eligibility rules, while complicated, are a pretty good deal for nonservice-connected vets who fall below the income threshold. For instance, a veteran with three dependents is eligible for the full continuum of care should he or she make below \$27,302. The median household income for a family of four in my home state of Arkansas is \$23,893. By this standard, over half of Arkansas' veterans would be eligible for full health care benefits, while many service-connected veterans who do not meet the income threshold would be eligible for treatment only on ailments incurred during their time in the armed forces. This skewering of priorities should not be compounded and exacerbated in eligibility reform.

Many of today's witnesses have worked long and hard on the Independent Budget. I have met

with you on a number of occasions and applaud the hard work you have done. However, I am concerned about eligibility expansion at the expense of those who are most deserving -- service-connected veterans.

I am particularly dismayed when I hear the personal accounts of veterans. Allow me, Mr. Chairman, to speak of my firsthand knowledge of a 100% service-connected veteran -- a combat-injured triple amputee who was in need of heart surgery. Inexplicably, this veteran was placed on a waiting list at #14 -- behind a number of nonservice-connected vets. The eligibility reform I envision would put this brave veteran -- and those like him -- first. The VA will continue to be chastised by thousands of veterans if the practice of placing service-

connected veterans down on the list of priorities continues.

Eligibility reform will not be easy. The tendency of any centralized bureaucracy is toward excessive, even non-sensical, regulations. But modernizing and simplifying eligibility is an essential and fundamental component in ensuring the viability of the VA.

Eligibility reform should not be viewed as a cure-all for the VA. While we must move expeditiously on the eligibility issue, this effort must not preclude other reforms like reorganization and realignment from moving ahead simultaneously. Reform must be premised on a strategic vision for the VA that will guarantee that it is an integral part of our health care delivery system in the 21st century.

Mr. Chairman, thank you for calling this very important hearing. I look forward to hearing the testimony of each of our witnesses.

The Honorable Jack Quinn
Full Committee Hearing on Eligibility Reform
July 19, 1995

Mr. Chairman, I want to thank you for calling the hearing this morning. Also thank you to everyone who is here, I appreciate your taking the time to come testify this morning. I am certain it will prove invaluable to our discussions.

I know eligibility reform is a large issue and this is just the first step in a series of examinations on how we can best serve our veterans. Whether their care is required due to a service-connected injury or because they do not have the financial resources to seek care on their own.

I think the three Congressional proposals - Chairman Stump's proposal and possible alternative and H.R. 1385, the Veterans Health Care Reform Act introduced by our colleagues Reps. Edwards and Montgomery - will serve as a strong basis for our discussion. The Administration's proposal will also play an important role in determining where we want to go.

Currently, care is subjected to consideration of scope, mandatory or nonmandatory, service-connected status, degree of the service-connected disability, income, specific wartime service, and resource availability. All of

these factors are required by current law to determine if, when and where a veteran may receive care.

This Committee must take the current eligibility system, which can be confusing and often nonsensical, and turn it into something more predictable.

Our nation's veterans and their families deserve it. VA employees will appreciate it.

I was pleased to see a section on women's health care in Chairman Stump's proposal. I have introduced legislation, HR 882 which has over 50 cosponsors, to ensure that the VA meet the requirements of the Mammography Quality Standards Act. It is my understanding that VA is in the process of prescribing quality assurance and control for the performance and interpretation of mammograms and the use of mammography equipment.

I think it is important, however, that the language contained in HR 882 is included in a section of the eligibility reform legislation regarding Health Care Services for Women. The Secretary should ensure that each VA facility is

provided with proper equipment, facilities and staff to provide women's health services - including mammography.

More and more female veterans are coming to the VA for care and the VA must be able to meet their needs. VA facilities should offer quality services to all veterans.

I appreciate the willingness Rep. Tim Hutchinson, who serves as Chairman of the Subcommittee on Hospitals and Healthcare, has shown to work with me on this.

Once again, thank you Mr. Chairman and I look forward to the discussion this morning.

STATEMENT OF CONGRESSMAN JON D. FOX
COMMITTEE ON VETERANS AFFAIRS
ELIGIBILITY REFORM HEARING - JULY 19, 1995

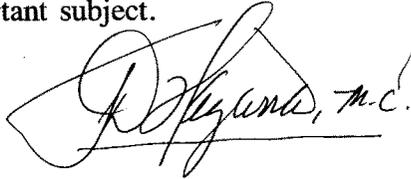
MR. CHAIRMAN, MR. MONTGOMERY, THANK YOU FOR YOUR LEADERSHIP IN CONDUCTING THESE HEARINGS. I AGREE WITH YOU THAT WE MUST ADDRESS THE PRESSING ISSUE OF ELIGIBILITY REFORM WITHIN THE VA HEALTH CARE DELIVERY SYSTEM. I WOULD ALSO LIKE TO RECOGNIZE THE VALUABLE CONTRIBUTIONS TO THIS DIALOGUE WHICH HAVE BEEN MADE BY THE MONTGOMERY/EDWARDS BILL, CHAIRMAN STUMP'S DISCUSSION DRAFT, AND THE INDEPENDENT BUDGET PLAN.

I AM PLEASED TO HAVE THE BENEFIT OF THE EXPERIENCE AND EXPERTISE OF OUR DISTINGUISHED WITNESSES TODAY, AND I THANK THEM FOR THEIR VALUABLE TESTIMONY BEFORE THIS COMMITTEE.

I LOOK FORWARD TO WORKING TOGETHER SO THAT WE CAN MAINTAIN QUALITY HEALTH CARE FOR OUR VETERANS, EXAMINE COST EFFECTIVE SOLUTIONS, ENHANCE OUTPATIENT CARE, PROTECT WOMENS' HEALTH AND IMPROVE THE EFFICIENT DELIVERY OF SERVICES.

I REMAIN COMMITTED TO ENSURING THAT WE HONOR OUR OBLIGATION TO CARE FOR OUR VETERANS. THANK YOU.

Mr. Chairman, thank you for the opportunity to participate in this important hearing today. I think most of the members of this committee agree that the current eligibility laws are complex and confusing and have been in need of repair for some time. This Congress must heed the long-standing call for "eligibility reform". It is my hope that these panels will help us formulate the best policy for our nation's veterans'. I thank the witnesses in advance for their participation and look forward to hearing their testimony on this important subject.

A handwritten signature in black ink, appearing to read "J.D. Hayworth, M.C.", with a horizontal line underneath the name.

J.D. Hayworth
statement for
record
7/19/95

Opening Statement
Rep. Chet Edwards
Hearing on VA Health Care Eligibility Reform Proposals
July 19, 1995

Mr. Chairman, I want to commend you for calling this hearing on VA health care eligibility reform and for your commitment to changing these eligibility rules. We need to revise these rules not just because they are confusing and even inconsistent, but because they often prevent VA from providing appropriate, needed care to veterans. Under current eligibility laws, veterans with similar health problems and similar service backgrounds may get hospital care in some VA facilities, outpatient care in others, and be denied care elsewhere. We owe it to the veteran, and to the taxpayer, to make substantial changes.

I wonder, actually, how many members of this Committee could outline the eligibility criteria which VA must administer.

To give you some indication of how complex and irrational current law is, consider a few illustrations:

-- only veterans who are 50% or more service-connected disabled are eligible for the kind of routine health care coverage

most of us get under our medical insurance;

-- a non-service-connected veteran is not eligible for routine outpatient treatment to keep his hypertension under control; only if that condition deteriorates and he gets really sick is the VA outpatient clinic open to him;

-- because prosthetic devices can generally be furnished to veterans only in connection with hospital care, a veteran under treatment in a VA outpatient clinic may be refused a hearing aid

-- it's questionable whether VA can lawfully do cataract surgery on an outpatient basis as is commonly done in the private sector.

I think these examples make clear the urgency of enacting reforms. There may be many options open to us, but we should be clear on how to proceed. In that regard, I hope this hearing will make it clear that at a minimum, we must eliminate the statutory barriers that restrict veterans from getting routine VA outpatient care. Secondly, I believe we must change eligibility in a manner that establishes a clearly defined population to be served without reducing eligibility of current beneficiaries, that

bases eligibility on clinical need, and that assures those eligible of a basic continuum of care. Thirdly, I believe we must protect the integrity of potentially vulnerable specialized programs on which profoundly disabled veterans depend.

With these principles in mind, I developed legislation which was introduced earlier this year as H.R. 1385, co-sponsored by Sonny Montgomery. I'm pleased that H.R. 1385 is being considered in today's important hearing. I believe that bill is a step in the right direction and hope to work with the Committee leadership in crafting a strong bipartisan measure that all members can support.

Mr. Chairman, I look forward to today's testimony and to working with you on this issue in the days ahead.

STATEMENT OF THE HONORABLE BOB CLEMENT
JULY 19, 1995

Mr. Chairman, since its creation in 1930, the VA system has been **like none other**. Unfortunately, the phrase "**like none other**" has taken on an altogether different meaning recently.

For many years this phrase symbolized the pride and purpose associated with the VA and its facilities. Now, it is more suggestive of the problems associated with the issue before the members of this committee today -- the provisions governing eligibility for care in VA facilities are truly **like none other**.

Unlike the benefits packages utilized by a majority of Americans, today's veterans benefits are the result of sixty-five years of legislative additions, deletions, revisions, and interpretations. Consequently, what began as a simple system in 1930 has evolved into a complex and confusing system which frustrates veterans, VA physicians, VA staff, and a fair number of congressmen.

It would be wrong to try to determine who's to blame because I don't think there is any single individual or entity at fault. I am certain that each time the criteria was changed, adjusted, or tinkered with in some fashion that there was merit to doing so. But, after you add all these seemingly harmless ingredients together you're left with a really strange brew.

Mr. Chairman, I want to commend you, Mr. Montgomery, Mr. Edwards and Mr. Hutchinson for taking on this issue. This is going to be quite a formidable task.

Frankly, I am a little skeptical that we can adopt meaningful reforms which the veterans can support in light of the current budgetary constraints. Nonetheless, I agree that eligibility reform is an important issue which must be addressed and I remain committed to working with you and the other members of this committee to bring about much-needed changes.

STATEMENT BY CONGRESSMAN MASCARA
VETERANS HEARING ON ELIGIBILITY REQUIREMENT
JULY 19, 1995

GOOD MORNING MR. CHAIRMAN. I AM PLEASED TO BE INVOLVED THIS IMPORTANT HEARING. IT IS MY HOPE THAT IT WILL ULTIMATELY SPUR US FORWARD WITH A STRONG EFFORT TO REFORM VETERANS' HEALTH CARE ELIGIBILITY REQUIREMENTS.

READING OVER THE TESTIMONY FOR TODAY'S HEARING, I WAS STRUCK THAT EACH AND EVERYONE OF THE WITNESSES THAT WILL TESTIFY AGREE THAT THE CURRENT ELIGIBILITY REQUIREMENTS ARE COMPLEX AND CONTRADICTORY.

PROVIDING CARE BASED SOLELY ON THE NOTION OF AVOIDING A HOSPITAL ADMISSION, DOES NOT LEAD TO RATIONAL MEDICINE.

I AGREE WITH THE WITNESSES WHO SAY THE SITUATION MUST BE CHANGED, AND CHANGED QUICKLY, SO THAT VA DOCTORS CAN BEGIN TO

TREAT VETERANS LIKE PATIENTS, NOT LIKE ANSWERS TO A COMPLICATED RIDDLE.

THE VETERANS GROUPS THAT WILL APPEAR HERE TODAY HAVE BEEN ADVOCATING A SWEEPING REFORM OF THE VA HEALTH CARE SYSTEM FOR SOMETIME. THEY KNOW ALL TOO WELL THAT WHAT IS AT STAKE IS THE CONTINUED EXISTENCE OF THE VA HEALTH CARE SYSTEM AS AN INDEPENDENT BODY. WE CAN NO LONGER IGNORE THEIR URGENT PLEAS.

I AM PLEASED THAT VA HAS BEGUN ITS OWN REFORM EFFORTS AS RESULT OF THE VICE PRESIDENT'S PUSH TO REINVENT GOVERNMENT. THE INTEGRATED SERVICE NETWORKS IT IS DEVELOPING SHOULD HELP MOVE THE VA TOWARD MORE PRACTICAL OUTPATIENT CARE AND BETTER COORDINATE THE SERVICES AVAILABLE TO ALL VETERANS.

I WAS IMPRESSED WITH THE TESTIMONY THAT WILL BE PRESENTED DISCUSSING THE SUCCESSFUL SYSTEM BEING DEVELOPED AT THE NORTH

CHICAGO VA FACILITY. I WOULD ENCOURAGE THE VA TO DUPLICATE THESE EFFORTS WHERE EVER POSSIBLE.

FINALLY, I MUST SAY I CONCUR WITH THOSE WHO WILL TESTIFY THAT ANY ELIGIBILITY REFORM THIS COMMITTEE CONSIDERS MUST AVOID AT ALL COSTS CUTTING OFF CARE TO THOSE BEING TREATED FOR INJURIES AND ILLNESSES RESULTING FROM THEIR SERVICE TO OUR COUNTRY.

INSTEAD OF RESTRICTING CARE, I SHARE THE VIEW OF THOSE WHO ADVOCATE OPENING UP THE VA SYSTEM AND ALLOWING IT TO PROVIDE CARE TO A BROADER CATEGORY OF VETERANS.

IF THE VA CAN RECEIVE THIRD-PARTY REIMBURSEMENT INCLUDING MEDICARE PAYMENTS, I THINK IT WILL HELP IT BECOME A STRONG AND VIABLE SYSTEM CAPABLE TO PROVIDING NEEDED AND SPECIALIZED HEALTH CARE SERVICES TO VETERANS WELL INTO THE NEXT CENTURY.

THANK YOU MR. CHAIRMAN. I LOOK FORWARD
TO LISTENING TO OUR WITNESSES.

--THE END--

OPENING STATEMENT
Representative Mike Doyle [PA-18]
Committee on Veterans' Affairs
Hearing on Eligibility Reform
July 19, 1995

I want to express my sincere thanks to Chairman Stump as well as the Ranking Member and former Chairman, Mr. Montgomery, for holding this very timely hearing today.

In the coming weeks, Members of the House of Representatives will be considering next year's funding for the Department of Veterans' Affairs. This discussion will be taking place at a time of enormous pressure to find savings in all areas of the federal budget. This pressure is due not only to the need to address our budget debt, but in order to foot the bill for an enormous tax cut we cannot afford.

Regardless of the reasons why we are in the financial predicament, it will be up to the members of this Committee to ensure that our nation's veterans continue to receive what was promised to them when they put their lives on the line to defend our country. Targeting veterans' programs as a priority for savings is unacceptable, and in my first six months in Congress, I admit to be disappointed at the willingness of some who never served to offer up veterans' compensation as part of a 'quick fix' to our budget problems.

One of my paramount areas of concern is the quality of veterans' health care. From my personal observation and from numerous conversations with those in the veterans' health care field, there is a need to undertake eligibility reform. Furthermore, it is my sense that this effort could, if undertaken responsibly, result in both significant savings to the taxpayer as well as more responsive and higher-quality care.

I look forward to hearing from the witnesses today in order to achieve a greater understanding of the specifics of eligibility reform. My greatest concern is that, once we begin the process of eligibility reform, we will set an arbitrary goal that is based purely on the need to achieve a certain level of financial savings, regardless of the impact on veterans. It is up to us on the Veterans' Affairs Committee, who have the greatest understanding of these programs, to make sure that the need for eligibility reform is not used as a tool for deconstructing the veterans' health care system.

Again, I thank the Chairman for his attention in this matter and look forward to today's hearing.

STATEMENT OF THE HONORABLE SPENCER BACHUS
JULY 19, 1995

Mr. Chairman,

Thank you for holding a hearing on one of the most important topics facing the veterans' health care system today - eligibility reform. I commend your leadership on this issue and I believe that it is one where all members of this Committee and the veterans' community can find common ground. Without doubt, incremental adjustments to VA eligibility rules over the years have created a complicated and confusing system that ignores and excludes the needs of many veterans. In addition, the existing criteria ignore current health care trends which, in many cases, are more efficient and effective than the methods of yesteryear. New eligibility criteria encourages the VA to look to non-institutional treatment alternatives and preventive care.

I supported eligibility reform in the 103rd Congress and I will proudly support eligibility reform in the 104th. Mr. Stump, I believe that your proposal is an important first step in clarifying and simplifying the eligibility criteria. I am anxious and eager to work with you, Mr. Montgomery, Mr. Edwards and the rest of the Committee to bring much needed reform to the VA eligibility criteria. Our veterans deserve no less.

STATEMENT OF THE HONORABLE CLIFF STEARNS
COMMITTEE ON VETERANS' AFFAIRS
HEARING ON ELIGIBILITY REFORM
JULY 19, 1995

THANK YOU, CHAIRMAN STUMP, FOR HOLDING THIS VERY IMPORTANT HEARING. I WOULD ALSO LIKE TO THANK OUR DISTINGUISHED PANEL OF WITNESSES THAT WE HAVE HERE WITH US TODAY.

THE QUESTION OF ELIGIBILITY AS IT RELATES TO VETERANS RECEIVING MEDICAL CARE HAS BEEN THE SUBJECT OF AN ONGOING DIALOGUE FOR THE PAST SEVERAL YEARS .

HOW DOES THE VA'S TREATMENT OF PROVIDING HEALTH CARE DIFFER FROM THE PRIVATE/PUBLIC SECTOR? UNDER THE VETERANS PROGRAM, ELIGIBILITY IS DETERMINED IN TERMS OF DISABILITIES, RATHER THAN IN TERMS OF SPECIFIC MEDICAL SERVICES AND THE ABILITY OF THE VETERAN TO PAY. IN OTHER WORDS, ELIGIBILITY TO RECEIVE CARE IS DIRECTLY LINKED TO INCOME.

ANOTHER SIGNIFICANT DIFFERENCE IS THAT THERE ARE NO "GUARANTEED" BENEFITS UNDER THE VA HEALTH CARE SYSTEM.

THE OBVIOUS BENEFIT OF ELIGIBILITY REFORM IS THAT IT COULD MAKE HEALTH CARE ACCESSIBLE TO THOSE VETERANS WHO DO NOT HAVE ANY OTHER HEALTH CARE OPTION. HOWEVER, WE MUST NOT LOSE SIGHT OF THE FACT THAT IN MAKING CHANGES AND

EXPANDING ELIGIBILITY WITHOUT THE NECESSARY FUNDING COULD PRODUCE FALSE HOPES AND RESULT IN TURNING AWAY VETERANS FROM VA FACILITIES.

CURRENT LAW GOVERNING ELIGIBILITY FOR VA HEALTH CARE DELIVERY IS COMPLICATED AND OFTEN CONFUSING. HOPEFULLY, TODAY'S HEARING WILL SHED SOME LIGHT ON THE MYRIAD OF RULES AND REGULATIONS IN THE VA HEALTH CARE SYSTEM THAT MAKES IT ALMOST IMPOSSIBLE TO SERVE OUR NATION'S VETERAN. WE MUST FIND A SOLUTION TO ENSURE THAT THIS PROGRAM CAN CONTINUE TO DELIVER ON ITS PROMISE TO OUR NATION'S VETERANS THAT THOSE WHO SERVED WOULD HAVE THEIR NEEDS MET BACK HOME.

AGAIN, THANK YOU ALL FOR BEING HERE TODAY. I LOOK FORWARD TO HEARING YOUR IDEAS CONCERNING ELIGIBILITY REFORMS.

Statement by Mr. Gutierrez
July 19, 1995

Mr. Chairman, I'll keep my comments brief and to the point.

I'm pleased to be here this morning. I think it's important to get something accomplished in this area-- and the sooner the better.

Like most people in this room, I believe that it's important to reform eligibility criteria because, frankly, the way VA eligibility is currently determined is quite confusing.

But, I have to admit-- when I hear some of the proposals that are floating around, proposals that supposedly reform eligibility, I get even more confused.

I am confused because I simply can't imagine that the best way to reform eligibility is to cut more people out of the system, or to limit their access to services that we know they need.

I am confused when I try to look at the big picture, at what else is going on in Washington. And when I do that, I get confused hearing members of this Congress try to justify their idea of the appropriate relationship between the government and people of different income levels.

Let's remember: earlier this year, some of our colleagues said that people who earn two hundred thousand dollars a year are the "middle class"-- and therefore, the government owes them a tax cut.

And, today I have to sit here and hear that there's a proposal that says that people-- veterans!-- who earn anything above sixteen thousand and seventy-four dollars a year (\$16,074) are "higher income veterans", and therefore, the government can tear up parts of its previous policy with them. We no longer have to give them inpatient hospital care unless under certain, specific circumstances.

I hope you can understand why I am confused after hearing those two arguments.

Mr. Chairman, like all members of this committee, I have no interest in injecting partisanship in an area that could be addressed in a bipartisan basis.

And, I raise this point not to score political points. I do it because, I think that's our job, our duty. That's our obligation-- to our constituents, and to each other.

My job, Mr. Chairman, here at the committee level, is to let you and all the members of the committee realize what lays ahead for these kinds of proposals, before they leave this room, before they reach the House floor.

And what you should know is that there is going to be a hard road ahead for any piece of eligibility reform that simply makes more people ineligible.

I'm sure that is no one's intention, Mr. Chairman. Not yours. Not the VA's.

But, if that's the result-- even if it's an unintended, circumstantial result, one that might not affect more than a mere handful of veterans-- then I'm going to have to raise some serious concerns.

Having said that, I hope you will believe me when I say that I have an open mind on this subject. But it's an "open" mind that won't allow us to shut the doors in the faces of veterans who served us.

Thank you, Mr. Chairman.

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Representative Michael P. Flanagan

Committee on Veterans' Affairs
Hearings on Eligibility Reform
July 19, 1995

Opening Statement

Thank you, Mr. Chairman. The issue of eligibility reform within the Department of Veterans' Affairs deserves the highest attention of this Committee. Given the importance of providing our nation's veterans with health care in return for the sacrifices they have made for us, I look forward to considering legislation that will enhance the VA's ability to service our veterans' health care needs.

As we move forward in consideration of eligibility reform legislation, I am interested in better serving our veterans with more cost-effective and efficient services that bring the VA up to date with private health care alternatives and simplify the eligibility criteria for all veterans' benefits. However, reform to the standards of eligibility must remain consistent with our commitment to serving those veterans in the greatest need of VA health care services. Given that the VA cannot operate like private hospitals in that it receives a limited annual budget, we must guarantee the highest priority access of VA medical resources to those veterans with service-connected health care needs and low income veterans without private or public health care alternatives.

I commend Chairman Stump, Representative Edwards and ranking member Montgomery for their concern and attention to eligibility reform. I look forward to moving forward on this issue and to working in the bipartisan spirit of this Committee.

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

July 19, 1995

Mr. Chairman and Members of the Committee:

Reforming the VA healthcare eligibility system is long overdue. I am pleased to be here this morning to participate in the general discussion of eligibility reform and to specifically discuss the Administration's proposal for eligibility reform.

As you know, reforming eligibility is necessary to restructure VA to provide state-of-the-art healthcare from both the quality and efficiency perspectives.

VA's current eligibility criteria evolved in an era that emphasized inpatient care. Today, however, most healthcare is provided in outpatient settings. Unfortunately, current VA eligibility rules require physicians to admit veterans to the hospital even if their ailments could be treated more efficiently and compassionately on an outpatient basis.

Under the current system which has different rules for hospital care, outpatient care, and long-term care -- rules that depend on each particular veteran's service-connected status and income level -- the ability of most veteran patients to receive adequate healthcare through the VA is a testament to the tenacity and perseverance of both the veterans seeking care and the healthcare professionals who provide that care.

As you know, last March we submitted a proposal to the Congress describing a comprehensive proposal to reorganize the

management structure of the VA healthcare system. Although independent of eligibility reform, that reorganization is part of our strategy to ensure that VA can successfully meet the healthcare needs of veterans in the changing healthcare environment of today and tomorrow.

Turning now to our eligibility reform proposal, Mr. Chairman, I would note that it was developed to achieve several important objectives.

- First, the eligibility system should be one that both the persons seeking care and those providing the care are able to understand.
- Second, the eligibility system should ensure that we are able to furnish our patients the most appropriate care and treatment that is medically needed--cost effectively, and in the most appropriate setting.
- Third, veterans should retain eligibility for those benefits they are now eligible to receive.
- Fourth, VA management should gain the flexibility needed to manage the system effectively.
- Fifth, the proposal should be budget neutral.
- And sixth, the system should not create any new and unnecessary bureaucracy.

Specifically, our proposal would provide that the Department "shall" furnish a specified core group of veterans with needed "healthcare." This would include hospital care, outpatient care, disease prevention services, pharmaceuticals, medical equipment, and prosthetic equipment and devices.

Persons in the core group would generally be those veterans commonly referred to today as category A veterans: those with service-connected disabilities, former prisoners of war, World War I veterans, and nonservice-connected veterans with incomes below the current means test income threshold. The Department would retain authority to furnish those veterans with other types of healthcare, including nursing home care, as resources allow. We also would retain authority to furnish all healthcare to veterans not included in the core group, as resources allow. We would furnish all care in accordance with five priority groups set forth in the bill. Finally, the bill would continue in place the current copayment structure, and would retain, essentially unchanged, the Agent Orange, Radiation, and Persian Gulf treatment authorities.

The most significant change in our proposal would be the complete elimination of the complicated and archaic eligibility rules governing the provision of outpatient care. This key feature will allow us to provide the right care at the right place and the right time for the right price.

In addition to undertaking basic eligibility reform, our bill would also "clean up" chapter 17 of title 38. It would consolidate and realign a number of sections in that chapter, eliminating outdated language and unnecessary provisions. These changes would make chapter 17 more sensible without making substantive changes in authority to furnish benefits.

Our bill also includes important provisions to help us effectively furnish care to eligible veterans. No provision is more important than the expansion of our ability to share resources with other community healthcare providers. Our proposal would allow sharing of all types of healthcare resources, with all types of healthcare providers in the community. This authority is essential for VA to establish

integrated systems of care, improve access, and achieve the efficiencies of modern healthcare management techniques.

Another important provision in our bill would permit the Department to retain part of the funds collected from 3rd party insurers for care furnished to veterans. Those funds are now turned over to the Treasury. The Department does a good job of collecting these funds; however, this new "gainsharing" authority will provide VA medical centers with additional important incentives to increase these collections.

Our bill also contains new provisions which will allow us to place in temporary residential care, certain veterans receiving hospital care who do not belong in an acute care hospital. As you know, we have patients who have no home to return to when their hospital care is completed. We need the ability to place these veterans in a medically appropriate setting that is less expensive than a hospital.

Finally, our bill would improve the way we obtain income and asset information needed to determine a veteran's eligibility for VA healthcare. We want to replace the current complicated procedure with a simpler test.

Mr. Chairman, pursuant to your request I would now comment, in general terms, about some of the provisions in certain other legislative proposals which you are reviewing today. First, though, I would reaffirm that any proposal should meet the objectives that I previously outlined.

Having just participated in preparation of our bill, I can understand how difficult it is to put together legislation of this nature. The Committee staff proposal contains provisions with laudatory goals which we support, and others which we

cannot. The proposal seeks to review or study various innovations that do not need further study.

Also, the Committee draft reduces the eligibility of nonservice-connected veterans for VA care. We do not believe veterans should be asked to give up benefits which they are now eligible to receive.

We also do not believe that provisions of the Committee draft bill eliminate the complexity of the current eligibility system. It is that complexity which has caused the need for today's hearing.

We believe that enactment of our proposal will significantly augment efforts already underway to restructure the VA health system in ways that assure it provides high quality and cost-effective care. We do not need another advisory commission to provide the Department with guidance on appropriate medical practices, and to review resource allocation methodologies.

We have consulted extensively with all of our stakeholders in developing our plans to restructure VA healthcare. There have been numerous reviews and reports concluding that eligibility rules need reform. We intend to continue to consult with all of our stakeholders and outside experts, as well as the relevant Committees of Congress, as we reinvent the VA health system. Our own reorganization plan now being reviewed by Congress, and which I hope we will soon be able to implement, includes a detailed process for obtaining the type of input the proposed commission would provide. We urge you to give the green light to our proposal and provide us with the management flexibility needed to make improvements in the veterans healthcare system.

The draft proposal would also direct VA to implement a pilot program to contract for 3rd party collection services, services

now provided well by our Medical Care Cost Recovery Office. As part of our reinvention of government effort, we will be taking a close look at privatizing a variety of functions, and we believe we have the authority to contract for the types of services contemplated in this pilot program.

The draft bill also contains a provision like one in our bill which would allow the Department to retain amounts that it collects from insurance companies that are in excess of amounts planned for in the budget. We, of course, support the goal of this proposal, but prefer the provision in our own bill, which will both benefit the VA and reduce the Federal deficit.

As a final matter, it is unnecessary to have a provision such as that contained in section 10 of the proposal which would not allow VA to implement eligibility reform provisions until after providing an implementation plan to Congress, and then waiting 60 days.

Now turning to the bill authored by Mr. Edwards, H.R. 1385, I would note that it contains a number of provisions which are similar to our draft bill, and thus, we are generally supportive of those provisions; however, the bill also has provisions that we do not support.

This bill would, much like our bill, reform eligibility primarily by providing that VA shall furnish care to a core group, generally category A veterans, and by simplifying outpatient care eligibility. It would eliminate the limitation which allows the Department to furnish outpatient care to many veterans only when the care is needed as pre-hospital care, post-hospital care, or to obviate the need for hospital care. The eligibility reform in the bill is characterized, however, as a program that would expire after three years. We see no basis for making the reforms time limited.

Other provisions in H.R. 1385 would direct VA to operate service area networks, eliminate duplication within networks, assure that all networks provide core veterans with similar services, and require VA to increase outpatient care capacity. We are pursuing all of these goals; however, we believe it is unnecessary to have them imposed by statute.

Mr. Chairman, you also asked that I comment on a proposal being developed by the veteran service organizations who developed "The Independent Budget." It is my understanding that the group is working closely with Senator Rockefeller, and that its proposal will be introduced in the near future. From discussions with representatives of the veterans service organizations, their bill would reform eligibility in a manner that is similar to the provisions of our Administration proposal. We would need to review their final draft to be sure it meets the criteria that I outlined earlier before commenting further.

Mr. Chairman, this concludes my formal testimony. I and my colleagues would be pleased to respond to your questions.

GAO

United States General Accounting Office

TestimonyBefore the Committee on Veterans' Affairs,
House of Representatives

For Release
on Delivery
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VA HEALTH CARE**Issues Affecting Eligibility
Reform**

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



GAO/T-HEHS-95-213

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss issues affecting eligibility reforms at the Department of Veterans Affairs (VA) health care program. VA has a budget of about \$16.2 billion to provide health care services to America's 26.4 million veterans. Eligibility reform would present a significant challenge even with unlimited resources. But with the Congress and VA facing increasing pressures to limit VA health care spending as part of governmentwide efforts to reduce the budget deficit, this challenge has become even greater.

Over the past several years, we have conducted a series of reviews that have detailed problems in administering VA's outpatient eligibility provisions; compared VA benefits and eligibility to those of other public and private health benefits programs; and assessed VA's role in a changing health care marketplace. My comments this morning are based primarily on the results of those reviews.¹

Specifically, we will discuss

- the evolution of VA health care eligibility;
- differences between eligibility for VA health care and eligibility under typical public and private health insurance programs;
- the problems VA's current eligibility provisions create for veterans and providers;
- various approaches for reforming VA eligibility; and
- options for offsetting the costs of eligibility expansions.

In summary, veterans' eligibility for VA health care has evolved over time both in terms of the types of veterans eligible for care and the services they are eligible to receive. VA has gone from a system primarily covering hospital care for veterans with war-related injuries to a system covering a wide array of hospital and other medical services for both wartime and peacetime veterans and both veterans with and without service-connected disabilities. In the process, eligibility for VA care has grown increasingly complex. Where VA once had two services--hospital and domiciliary care--available to all eligible veterans, it now has multiple categories of veterans with eligibility based on such factors as period of service, presence and seriousness of service-connected disabilities, and income. For most veterans, however, eligibility continues to be conditioned on the need for hospital-related care.

VA benefits differ from benefits under a typical private health insurance policy in two important ways. First, private health insurance policies are easy for policyholders to understand and providers to administer because they have uniform benefits that apply to all policyholders. In private plans, benefits are typically defined in terms of specific medical services that are covered. In VA, however, benefits are not defined in terms of specific medical services. Rather, they are defined in terms of disabilities. One category of veterans--primarily those with service-connected disabilities rated at 50 percent or more--is eligible to receive any medical service needed to treat a disability, regardless of the cause or severity of the disability. But for veterans in other categories, the services they are eligible to receive on an outpatient basis depends on the types of disabilities for which they are seeking care. Veterans are eligible to receive any needed medical service for treatment of a service-connected disability regardless of the severity of the disability, but are eligible

¹A list of related GAO testimonies and reports is in appendix I.

for treatment of other disabilities only if it will obviate the need for hospitalization or is needed in preparation for or as a follow-up to hospital care.

For example, a low-income veteran can receive a tetanus shot at a VA clinic for treatment of a puncture wound that, if left untreated, might result in a serious infection requiring hospital admission for treatment. The same veteran, however, could be denied care if he or she sought a tetanus shot at a VA clinic as a preventive health measure. Similarly, women veterans can obtain treatment for complications relating to a pregnancy, but cannot obtain routine prenatal care or delivery services through the VA health care system.

The second major difference between VA and public and private insurance is that there are no "guaranteed" benefits under the VA health care system. Under insurance programs, policyholders are essentially guaranteed coverage of all medically necessary services in their benefit package. Under the VA system, however, even veterans that the law says "shall" or "must" be provided certain types of health care services can get care only if resources are available. This is because the VA system is funded through a fixed annual appropriation. When funds run out, VA's obligation to provide care ends as well.

VA's eligibility provisions create problems for veterans and providers. Generally, they create uneven and uncertain access to VA health care and limit VA's ability to meet veterans' health care needs. Veterans with similar medical needs, service status, and incomes may get treated or turned away depending on what type of care they seek and where and when they seek care. This creates frustration for veterans who cannot understand what services they can get from VA and for VA physicians and administrative staff who have to interpret the subjective eligibility provisions.

Because the provision of VA services is conditioned on the availability of space and resources, VA medical centers have developed policies and procedures for rationing care. Medical centers' policies vary, as does the sufficiency of resources, and, as a result, many medical centers turn away veterans for care, while others serve all veterans applying for care. Frequently, this results in a veteran receiving care at one medical center while another veteran with a comparable condition and coverage status is being denied care at a different center. Most veterans turned away obtain needed health care from other sources or obtain care during a subsequent trip to a VA facility. But of a group of 198 veterans we tracked, 15 percent did not obtain the needed health care.

The Congress faces many difficult choices in trying to reform VA's eligibility provisions to address these problems, such as:

- Should current eligibility distinctions based on factors such as presence and degree of service-connected disability, period of service, and income be changed? If so, how should coverage groups be structured?
- Should the restrictions on access to outpatient care be altered or removed?
- Should a uniform benefit package be developed for one or more coverage groups? What benefits should be included for each coverage group?
- Should the availability of benefits be guaranteed for one or more of the coverage groups?
- How much should veterans be expected to contribute toward the

costs of expanded benefits?

Obviously, the cost of eligibility reform depends on the answers to those questions. For example, one lower cost alternative might (1) maintain existing coverage groups, (2) establish more limited benefit packages for certain coverage groups such as higher income veterans with no service-connected disabilities (hereafter referred to as nonservice-connected veterans), (3) maintain existing space and resource constraints on the availability of care, and (4) increase the cost-sharing requirements for some veterans. Such an alternative would address some of the problems caused by VA's current eligibility provisions, such as the uncertainty about covered services, but would not fully address other problems, such as the uneven availability of care.

In contrast, a higher cost alternative might (1) establish a single coverage group for all veterans, (2) expand coverage to include all medically necessary services, (3) provide for guaranteed availability of benefits for all veterans, and (4) maintain or decrease veterans' cost sharing.

In choosing among the available alternatives, the Congress faces a difficult policy dilemma. It seems inevitable that either (1) many veterans--including some who currently use VA services--will be turned away because of resource limitations if benefits are not guaranteed or (2) congressional control over VA health care spending will be relinquished if the availability of benefits is guaranteed.

BACKGROUND

The VA health care system was established in 1930, primarily to provide for the rehabilitation and continuing care of veterans injured during wartime service. VA developed its health care system as a direct delivery system with the government owning and operating its own health care facilities. It grew into the nation's largest direct delivery system.

VA now provides a wide range of inpatient, outpatient, and long-term care services to veterans both with and without service-connected disabilities. VA has gradually shifted from a system primarily providing treatment for service-connected disabilities incurred in wartime to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. Similarly, VA once treated an almost exclusively male veteran population but is now striving to meet the health care and privacy needs of an increasing number of women veterans.

For fiscal year 1996, VA is seeking an appropriation of about \$17 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA facilities are expected to provide inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics are expected to handle 25.3 million outpatient visits. The recently approved Congressional Budget Resolution, however, would essentially freeze the VA medical care appropriation at the fiscal year 1995 spending level--\$16.2 billion--for the next 7 years.

ELIGIBILITY FOR VA HEALTH CARE HAS EVOLVED

Eligibility for VA health care has undergone a gradual evolution since the 1930 establishment of VA. Initially, the only veterans eligible for VA care were those (1) with injuries incurred during wartime service or (2) incapable of earning a living because of a permanent disability, tuberculosis, or

neuropsychiatric disability suffered after their wartime service. Initially, eligibility was for hospital and domiciliary care only.

Eligibility for hospital care was later expanded to include veterans injured during other than combat duty and subsequently to all veterans without service-connected disabilities. Certain veterans, commonly referred to as "mandatory care" veterans, continued to have the highest priorities for care and are entitled to free VA hospital care. These mandatory care category veterans include those who

- have service-connected disabilities,
- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
- are former prisoners of war,
- were exposed to toxic substances or ionizing radiation,
- served in the Mexican border period or World War I,
- receive disability compensation,
- receive nonservice-connected disability pension benefits, and
- have incomes below the means test threshold (as of January 1995, \$20,469 for a single veteran, \$24,565 for a veteran with one dependent, plus \$1,368 for each additional dependent).

For higher income veterans who do not qualify under these conditions, VA may provide hospital care if space and resources are available. These discretionary care category veterans, however, must pay a part of the cost of the care they receive.

When outpatient care was added to the VA system, eligibility was initially limited to veterans with service-connected disabilities. It was not until 1960 that VA was first authorized to treat nonservice-connected veterans on an outpatient basis. In that year, P.L. 86-639 authorized outpatient treatment for a nonservice-connected disability in preparation for, or to complete treatment of, hospital care. So concerned was the then Administrator of Veterans Affairs about the potential implications of this change that he wrote

"The possible adverse effects of the proposed legislation should also, I believe, be considered. This bill would for the first time mean that non-service-connected veterans would be receiving outpatient treatment even though we have endeavored to make revisions which would relate this only to hospital care. The outpatient treatment of the non-service-connected might be an opening wedge to a further extension of this type of medical treatment."

Thirteen years later, the Veterans Health Care Expansion Act of 1973 (P.L. 93-82) further extended outpatient treatment for nonservice-connected veterans, authorizing outpatient treatment for any disability to "obviate the need of hospital admission." Although there have been a number of further revisions to outpatient eligibility since 1973, most veterans' eligibility for ambulatory care services continues to be restricted to hospital-related care.

Appendix II contains a detailed description of VA eligibility requirements.

DIFFERENCES BETWEEN VA AND OTHER HEALTH CARE PROGRAMS ARE SIGNIFICANT

Despite the expansions in VA eligibility that have occurred over the last 65 years, VA continues to focus primarily on treatment of disabilities that would ordinarily require hospitalization. Eligibility for care under the VA health care

system differs from eligibility under a typical public or private health insurance program in two key aspects:

- VA does not have a uniform benefit package. Because public and private insurance policies generally have a uniform benefit package, both policyholders and providers know in advance what services are covered and what, if any, limitations apply to the availability of services. By contrast, the services a veteran is eligible to receive from VA vary depending on such factors as the presence and degree of service-connected disability, income, and the veteran's period of service.

The uniform benefit package under public and private insurance programs frequently covers preventive health services, such as routine physical examinations and immunizations. By contrast, the VA system is focused on the provision of medical services needed for treatment of a "disability." For example, a woman veteran could obtain treatment for the complications of pregnancy but could not obtain prenatal care or delivery services for a routine pregnancy through the VA health care system.

- The availability of covered services is not guaranteed under the VA health care system. The terms eligibility and entitlement have different meanings under the VA health care system than under other health benefits programs. For example, all beneficiaries who meet the basic eligibility requirements for Medicare are entitled to receive all medically necessary care covered under the Medicare part A benefit package. Similarly, those Medicare beneficiaries who enroll for part B benefits are entitled to receive all medically necessary care covered under the part B benefit package. Medicare spending increases as utilization increases, creating guaranteed access to covered services.

Under the VA health care system, however, neither being eligible for nor being entitled to health care services guarantees the availability of needed services. The VA health care system is funded by a fixed annual appropriation; once appropriated funds have been expended, the VA health care system is not required to, and in fact is not allowed to, provide additional health care services--even to veterans "entitled" to VA care. Although title 38 of the U.S. Code contains frequent references to services that "shall" or "must" be provided to mandatory care group veterans, in practical application the terms mean that services "shall" or "must" be provided if adequate resources have been appropriated to pay for the care. Being "entitled" to care essentially gives veterans a higher priority for treatment than merely being "eligible."

VA ELIGIBILITY PROVISIONS FRUSTRATE
VETERANS AND LIMIT VA'S ABILITY
TO MEET VETERANS' HEALTH CARE NEEDS

VA's complex eligibility and entitlement provisions are a source of frustration for veterans, VA physicians, and VA's administrative staff:

- Veterans are often uncertain about what services they are eligible to receive and what right they have to demand that VA provide them.
- Physicians and administrative staff find the eligibility provisions hard to administer.
- Veterans have uneven access to care because the availability of covered services is not guaranteed.

Because of these problems, veterans may be unable to consistently obtain needed health care services from VA facilities.

Veterans Uncertain About What Services Are Covered

Veterans are often confused by VA's complex eligibility and entitlement provisions. The services they can get from VA depend on such factors as the presence and extent of any service-connected disabilities, their incomes, their periods of service, and the seriousness of their conditions. Table 1 demonstrates the complexities of VA eligibility.

Table 1: Eligibility for and Entitlement to VA Health Care Benefits

Veteran category	Hospital care	Outpatient care	Nursing home care
Service-connected: 50-100%, for any condition	Entitled	Entitled	Eligible
Service-connected: 0-40%, for a service-connected condition			
Discharged for disability			
Service-connected: 30-40%, for a nonservice-connected condition	Entitled	Entitled, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible
Pensioner or income under \$12,855			
Injured in VA			
Prisoner of war	Entitled	Eligible	Eligible
World War I & Mexican War veterans			
Pension with aid and attendance			
Service-connected: 0-20%, for a nonservice-connected condition	Entitled	Eligible, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible
Nonservice-connected with an income of \$12,855-\$20,469 (no dependents)			
Agent Orange, radiation, Medical-eligible			
Nonservice-connected with income over \$20,470	Eligible, with copayment	Eligible, with copayment, limited to pre- and post-hospitalization and to obviate the need for hospital care	Eligible, with copayment

Source: Independent Budget for Veterans Affairs Fiscal Year 1996.

To further add to veterans' confusion about what health care services they are eligible to receive at VA, title 38 of the U.S. Code specifies the types of medical services that can be provided on an outpatient or ambulatory basis. These services include provision of wheelchairs, crutches, eyeglasses, and hearing aids for veterans eligible for comprehensive outpatient services. For other veterans, however, such services are not covered unless they are needed to obviate the need for hospital care. Similarly, there are special eligibility provisions that apply specifically to dental examinations and treatment.

Outpatient Eligibility Requirements Are Difficult to Administer

Veterans are not the only ones confused by VA eligibility and entitlement provisions. Those tasked with applying and enforcing the provisions on a day-to-day basis--VA physicians and administrative staff--express similar frustration in attempting to interpret the provisions. Although the obviate the need for hospitalization criterion is most often cited as the primary source of frustration, VA administrative staff must also enforce

a series of other requirements, which add administrative costs not typically incurred under other public or private insurance programs.

VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. Guidance to medical centers says that eligibility determinations

"shall be based on the physician's judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated would reasonably be expected to require hospital care in the immediate future. . . ."

To assess medical centers' implementation of this criterion, we used medical profiles of 6 veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations.² At these 19 centers, interpretations of the criterion ranged from permissive (care for any medical condition) to restrictive (care only for certain medical conditions). In other words, from the veteran's perspective, access to VA care will depend greatly on which medical center they visit. For example, if one veteran we profiled had visited all 19 medical centers, he would have been determined eligible by 10 centers but ineligible by 9 others.

Officials at VA's headquarters and medical centers agreed that the "obviate the need of hospital admission" criterion is an ambiguous and inadequately defined concept. A headquarters official stated that because the term has no clinical meaning, its definition can vary among physicians or even with the same physician. A medical center official noted that the criterion

"...is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation. . . . Having no clear policy, we have no uniformity. The same patient with the same condition may be denied care by one physician, only to walk out of the clinic the next day with a handful of prescriptions supplied by the doctor in the next office. . . ."

With thousands of VA physicians making eligibility decisions each working day, the number of potential interpretations is, to say the least, very large.

In addition to interpreting the "obviate the need" provision, VA physicians or administrative staff must evaluate a series of other eligibility requirements before deciding whether individual veterans are eligible for the health care services they seek. For example, they must

- determine whether the disability for which care is being sought is service-connected or aggravating a service-connected disability because different eligibility and entitlement rules apply to service-connected and nonservice-connected care;
- determine the disability rating for service-connected veterans because the outpatient services they are eligible for and entitled to depend on their rating;
- determine the income and assets of nonservice-connected veterans because their eligibility for (and priority for receiving) care depends on a determination of their ability to pay for care; and

²VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

- determine whether their disability may have been related to exposure to toxic substances or environmental hazards during service in Desert Storm or Vietnam, in which case care may be provided without regard to other eligibility provisions.

Having to make such determinations on a case-by-case basis adds to the frustration of VA physicians and administrative staff.

Availability of Outpatient Care Is Uneven

Because the provision of VA outpatient services is conditioned on the availability of space and resources, veterans cannot be assured that health care services are available when they need them. Even veterans "entitled" to care are theoretically limited to health care services that can be provided with available space and resources. If demand for VA care exceeds the capacity of the system or of an individual facility to provide care, then health care services are rationed.

The Congress established general priorities for VA to use in rationing outpatient care when resources are not available to care for all veterans. VA delegated rationing decisions to its 158 medical centers; that is, each must independently make choices about when to and how to ration care.

Using a questionnaire, we obtained information from VA's 158 medical centers on their rationing practices. In fiscal year 1991, 118 centers reported that they rationed outpatient care for nonservice-connected conditions and 40 reported no rationing. Rationing generally occurred because resources did not always match veterans' demands for care.³

When the 118 centers rationed care, they also used differing methods. Some rationed care according to economic status, others by medical service, and still others by medical condition. The method used can greatly affect who is turned away. For example, rationing by economic status will help ensure that veterans of similar financial means are served or turned away. On the other hand, rationing by medical service or medical condition helps ensure that veterans with similar medical needs are served or turned away.

The 118 medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within centers. For example, higher income veterans frequently received care at many medical centers, while lower income veterans or those who also had service-connected disabilities were turned away at other centers. Some centers that rationed care by either medical service or medical condition sometimes turned away lower income veterans who needed certain types of services while caring for higher income veterans who needed other types of services.

Some Veterans' Health Conditions Go Untreated

In a 1993 review, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it.⁴ Through discussions with 198 veterans turned away at 6 medical centers, we learned that 85 percent obtained needed care after VA medical centers turned them away. Most obtained care outside the VA system, but some veterans returned to VA for care, either at the same center that turned them away or at another center.

³GAO/HRD-93-106, July 16, 1993.

⁴VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD-93-123, July 14, 1993).

The 198 veterans turned away needed varying levels of medical care. Some had requested medications for chronic medical conditions, such as diabetes or hypertension. Others presented new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could be ultimately life threatening, such as high blood pressure or cancer. In other cases, the conditions were potentially less serious, such as psoriasis.

FINANCIAL IMPLICATIONS OF ALTERNATIVE
APPROACHES FOR RESTRUCTURING VA
HEALTH CARE ELIGIBILITY

A number of approaches could be used to address the problems we just discussed. For example

- the restrictions on access to ambulatory care could be eliminated,
- a uniform benefit package could be created,
- veterans' entitlement to free care could be expanded,
- funding of veterans' health care could be changed from discretionary to mandatory, or
- a combination of these approaches could be used.

Such reforms, however, would likely generate significant new workload and could potentially cost billions of dollars. While retaining the discretionary nature of VA health care funding would theoretically give the Congress more control over VA spending, it would, in our opinion, be extremely difficult for the Congress to control the growth in VA appropriations if other changes generate increased workload.

Eliminating the restrictions on access to ambulatory care would simplify administration of health care benefits because VA physicians would no longer need to determine whether a patient would likely end up in the hospital if not treated. Eliminating the restrictions would also promote greater equity by reducing the inconsistencies in eligibility decisions. Finally, eliminating the restrictions would make benefits more understandable by essentially making veterans eligible for the full continuum of inpatient and outpatient care.

Eliminating the restrictions on access to ambulatory care would likely generate significant new workload because over 26 million veterans would be eligible to receive services that previously were reserved primarily for the approximately 465,000 service-connected veterans with disabilities rated at 50 percent or higher. Even many veterans who rely on other health care coverage for most of their needs are likely to take advantage of added VA benefits such as eyeglasses, contact lenses, and hearing aids not typically covered under other health insurance. Another area where workload would likely increase dramatically is prescription drugs. Medicare does not cover outpatient prescription drugs, making VA an attractive alternative. Medicare-eligible veterans already make significant use of VA outpatient prescriptions even with the current eligibility limitations.⁵ Removing the restrictions on access to ambulatory care would likely significantly increase demand for outpatient prescriptions.

One way to control the increase in workload would be to develop a uniform benefit package patterned after public and

⁵Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

private health insurance. This would narrow the range of services veterans could obtain from VA, allowing workload reduced by the eliminated services to offset the workload from increased demand for other services. VA could adjust the benefit package on a yearly basis based on the availability of resources.

Creating a uniform benefit package could result in some veterans receiving a narrower range of services than they receive now while others would receive additional benefits. This approach would essentially take some benefits away from service-connected veterans with the greatest disabilities and give additional benefits to service-connected veterans with lesser disabilities and to nonservice-connected veterans.

One option for addressing this problem would be to establish separate benefit packages for different types of veterans. For example, veterans with disabilities rated at 50 percent or higher might continue to be entitled to any needed outpatient service, while a narrower package of outpatient benefits--perhaps excluding such items as eyeglasses, hearing aids, and prescription drugs--could be provided to higher income nonservice-connected veterans.

The impact of eligibility reforms on VA workload will also depend on the extent to which concurrent changes are made in the accessibility of VA health care services. As it strives to make the transition from a hospital-based system to an ambulatory-care-based system, VA is attempting to bring ambulatory care closer to veterans' homes. Because distance is one of the primary factors affecting veterans' use of VA health care, actions to give veterans access to outpatient care closer to their homes, either through expansion of VA-operated clinics or through contracts with community providers, will likely increase demand for services.

Neither eliminating the restrictions on access to ambulatory care nor creating a uniform benefit package would address the uneven availability of VA health care services caused by resource limitations and inconsistent VA rationing policies. In fact, the increased demand for care generated by such changes would likely heighten the problems VA already faces in trying to equitably distribute available resources.

Eligibility reform that would remove the space and resource constraints would, however, essentially turn VA into an open-ended entitlement program like Medicare. Currently, about 465,000 veterans with service-connected disabilities rated at 50 percent or higher are entitled to free comprehensive outpatient services from VA. Removing the resource constraints and expanding VA entitlement to free comprehensive health care services to all veterans currently eligible for free care (about 9 million to 11 million veterans), as proposed by the Clinton Administration last year, could add billions of dollars to VA's health care budget.

We are also concerned, however, about the practicality of expanding entitlement while retaining current resource constraints because this might force rationing of care to veterans in the mandatory care group. Expanding entitlement to free care while retaining current resource constraints would make it exceedingly difficult for the Congress to set resource levels for the VA health care program that would not fully fund services for veterans in the mandatory care categories. In other words, if the eligibility reforms result in demands for care that exceed available resources, can the Congress realistically be expected to restrict VA's health care funding and tell VA to ration care to veterans entitled to such care? We think that is unlikely.

OPTIONS FOR OFFSETTING THE COSTS
OF ELIGIBILITY EXPANSIONS

Several options exist for offsetting the costs of eligibility expansions. First, the use of veteran cost sharing could be increased. For example, VA might be authorized to provide veterans any available health care service without changing veterans' existing eligibility for free care. In other words, veterans could purchase, or use their private health insurance to purchase, additional health care services from VA. Such a change would not, however, significantly strengthen VA's safety net role because lower income, uninsured veterans would likely be unable to pay for many additional health care services even if VA were authorized to provide them.

Similarly, VA could be authorized to increase cost sharing for nursing home care--a discretionary benefit for all veterans--either through increased copayments or estate recoveries. Recoveries could be used to help pay for benefit expansions.

Cost sharing could also be increased by redefining the mandatory care group. In other words, the income levels for inclusion in the mandatory care category could be lowered or copayments imposed for nonservice-connected care provided to veterans with 0- to 20-percent service-connected disabilities.

A second option for paying for eligibility expansions would be to authorize VA to recover from Medicare the costs of services VA facilities provide to Medicare-eligible veterans. Several proposals have been made in the past several years to authorize VA recoveries from Medicare either for all Medicare-eligible veterans or for those with higher incomes. Such proposals appear to offer little promise for offsetting the costs of eligibility expansions. First, many of the services, such as hearing aids and prescription drugs, that Medicare-eligible veterans are likely to obtain from VA are not Medicare-covered services. Second, allowing VA to retain recoveries from Medicare without an offset against VA's appropriation would create strong incentives for VA facilities to shift their priorities toward providing care to veterans with Medicare coverage. VA facilities would essentially receive duplicate payments for care provided to higher income Medicare beneficiaries, unless recoveries were designated to fund services or programs for which VA did not receive an appropriation.

Finally, authorizing VA recoveries from Medicare could further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs regardless of whether VA is allowed to keep all or a portion of the recoveries. Such an action would essentially transfer funds between federal agencies while adding administrative costs.

One argument frequently used to promote the need for eligibility reform is that the "obviate the need" provision prevents VA from providing care in the most cost-effective setting. The presumed "savings" from removing the restrictions on access to ambulatory care services would then be used to offset the costs of expanded benefits.

We agree that significant savings can accrue from shifting a sizable portion of VA's inpatient workload to other settings. We do not believe, however, that current eligibility provisions prevent VA from shifting much of its current inpatient workload to ambulatory care settings.

The same "obviate the need" provisions discussed earlier as making it difficult for VA physicians to determine whether to provide outpatient care for certain conditions, make it clear that care can be provided to any veteran, regardless of income or other factors, if it would prevent a hospital admission. The

eligibility provisions, for example, allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care. Accordingly, we do not believe it would be appropriate to assume that the management inefficiencies that have prevented VA from effectively implementing the "obviate the need" provision and shifting care to outpatient settings for over 20 years will be eliminated and the planned savings actually realized.

CONCLUSIONS

The VA health care system was neither designed nor intended to be the primary source of health care services for most veterans. It was initially established to meet the special care needs of veterans injured during wartime and those wartime veterans permanently incapacitated and incapable of earning a living. Although the system has evolved since that time, even today it focuses on meeting the comprehensive health care needs of only about 465,000 of the nation's 26.4 million veterans. As a result, few veterans can count on VA as their only source of health care coverage.

Fortunately, 9 out of 10 veterans have other public or private health insurance that meets their basic health care needs. For such veterans, VA eligibility reform might provide an additional option for health care services or additional services not covered under their public or private insurance. For those veterans who do not have other health care options, however, eligibility reform is more important. It could provide them access to comprehensive health care services, including preventive health care services, they currently lack. In other words, they would no longer need to allow their medical conditions to deteriorate to the point where they would qualify for care under the "obviate the need" criterion.

Eligibility reform could significantly increase demand for VA health care services, putting pressures on the Congress to increase VA appropriations and on VA to develop rationing policies that would ensure that limited resources are directed toward those veterans with the highest priority for care and the greatest need for VA health care--those without other public and private health insurance. At the same time, VA would need to ensure that funds needed to provide specialized services, such as treatment of spinal cord injuries, not available through other programs are not diverted to pay for outpatient services for veterans who could get those services through other programs.

The Congress faces many challenges in designing eligibility reforms that will be budget neutral and that will not give veterans false expectations of what services they can obtain from VA. Expanding eligibility without providing adequate funds to pay for the expected increase in demand could increase the number of veterans turned away from VA facilities. We will be glad to work with this Committee and others in analyzing specific proposals as they are introduced.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions that you or other Members of the Committee may have.

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110. Terry Saiki, Evaluator-in-Charge, and Paul Reynolds, Assistant Director, also contributed to the preparation of the statement.

RELATED GAO PRODUCTS

VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-213, May 9, 1995).

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

Veterans Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Reform (GAO/HEHS-95-14, Dec. 23, 1994).

Veterans Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS-94-205FS, July 15, 1994).

Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148, May 5, 1994).

Veterans' Health Care: Most Care Provided Through Non VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

Veteran Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD 93-123, June 30 1993).

ELIGIBILITY FOR AND ENTITLEMENT TO
VA HEALTH CARE

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under other than dishonorable conditions is eligible for VA medical care benefits. The amount of required active duty service varies depending on when the person entered the military, and an eligible veteran's entitlement to medical care offered by VA depends on such factors as the presence and extent of a service-connected disability, income, and period or conditions of military service.

Persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed 2 years of active duty or the full period of their initial service obligation to be eligible for benefits. Veterans discharged at any time because of service-connected disabilities and those discharged for disabilities unrelated to their military service or because of personal hardship near the end of their service obligation are not held to this requirement. Also eligible are members of the armed forces' reserve components who were called to active duty and served the length of time for which they were activated.

Although all veterans meeting the above requirements are "eligible" for VA medical care, VA uses a complex priority system--based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed--to determine which veterans receive care within available resources.

HOSPITAL AND NURSING HOME CARE

Priority for receiving VA hospital and nursing home care is divided into two categories--mandatory and discretionary. VA must provide hospital care, and if space and resources are available, may provide nursing home care to certain veterans with injuries related to their service or whose incomes are below specified levels. These mandatory care category veterans include those who

- have service-connected disabilities,
- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
- are former prisoners of war,
- were exposed to certain toxic substances or ionizing radiation,
- served during the Mexican border period or World War I,
- receive disability compensation,
- receive nonservice-connected disability pension benefits, and
- have incomes below the means test threshold (as of January 1995, \$20,469 for a single veteran, \$24,565 for a veteran with one dependent, plus \$1,368 for each additional dependent).

For higher income veterans who do not qualify under these conditions, VA may provide hospital and nursing home care if space and resources are available. These discretionary care category veterans, however, must pay a part of the cost of the care they receive.

OUTPATIENT CARE

VA provides three levels of outpatient care:

- comprehensive care, which includes all services needed to treat any medical condition;

APPENDIX II

APPENDIX II

- service-connected care, which is limited treating conditions related to a service-connected disability; and
- hospital-related care, which provides only the outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

VA must furnish comprehensive outpatient care to veterans who have service-connected disabilities rated at 50 percent or more. VA may provide comprehensive outpatient care to veterans who (1) are former prisoners of war, (2) served during the Mexican border period or World War I, (3) are housebound or in need of aid and attendance, or (4) are participants in VA rehabilitation programs.

VA must furnish service-connected outpatient care to any veteran for the treatment of conditions related to service-connected disabilities regardless of the veterans' disability rating. VA must also provide all outpatient services needed to treat medical conditions related to injuries suffered as a result of VA hospitalization or while participating in a VA rehabilitation program.

VA must furnish hospital-related outpatient care to veterans (1) with service-connected disabilities rated at 30 or 40 percent and (2) whose annual incomes do not exceed VA's pension rate for veterans in need of regular aid and attendance.

VA may, to the extent resources permit, furnish limited hospital-related outpatient care to veterans not otherwise entitled to outpatient care, providing they agree to pay a part of the cost of care. Most veterans, about two-thirds of all eligible veterans according a 1990 VA survey, fall into this discretionary category.

STATEMENT OF
DAVID W. GORMAN
DEPUTY NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
JULY 19, 1995

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, may I say how genuinely appreciative we are for the opportunity to appear before the committee today. Your letter of invitation solicited our views regarding "various proposals to reform the VA's eligibility system."

Mr. Chairman, for the purposes of our statement we will discuss the three known initiatives that now exist to address reform of the VA's health care delivery system. First, H.R. 1385, the "Veterans' Health Care Reform Act of 1995," introduced by the Ranking Minority Member of the Subcommittee on Hospitals and Health Care, Mr. Edwards; a draft legislative proposal, dated July 11, 1995, offered by yourself, Mr. Chairman; and, the eligibility reform proposal as developed by the co-authors of the Independent Budget (IB).

At the outset, Mr. Chairman, it is our belief that the series of hearings, over the years, regarding the status of the VA health care delivery system and its need for reform, have laid a solid foundation and, in many ways, set the stage for today's hearing. Also, we would offer the opinion that there is virtually no one who would attempt to convincingly argue that the Veterans Health Administration (VHA) need not change.

Quite the contrary. The entire movement screaming for reform of VHA is motivated by the singular recognition that it is an inefficient system in its current form. In many ways, VA has not yet entered the era of contemporary medical care delivery. Certainly, this is not by VA's own choice or doing. We all recognize the numerous constraints placed upon the system as concerns its ability to provide care to eligible veterans, as well as corresponding financial and administrative restraints. It is for these reasons reform is so critical.

Mr. Chairman, our call for reform of the current system has been predicated upon two basic philosophical premises: first, obligation of the nation and the federal government to care for those disabled as a result of honorable military service; and second, the maintenance of an independent federal entity, the Department of Veterans Affairs, to meet this obligation.

Having agreement with both premises, we may then engage in the debate of how best to accomplish these goals.

Mr. Chairman, as an introduction to our testimony, I would take this opportunity to briefly describe the membership of the Disabled American Veterans (DAV) and the constituency whom we represent and speak for. As stated in Article 3 of the DAV's National Constitution, eligibility for membership is defined as:

Any man or woman, who was wounded, gassed, injured or disabled in line of duty during time of war, while in the service of either the military or naval forces of the United States of America, and who has not been dishonorably discharged or separated from such

(2)

service, or who may still be in active service in the armed forces of the United States of America is eligible for membership in the Disabled American Veterans. Others, who are disabled while serving with any of the armed forces of any nations associated with the United States of America as allies during any of its war periods, who are American citizens and who are honorably discharged, are also eligible.

Mr. Chairman, it therefore follows that our first duty as an organization is to assist the wartime service-connected disabled veteran to ensure they, above all other veterans, receive the benefits and services they require and are entitled to.

From that purpose we will not waver. We will oppose, Mr. Chairman, with all our might and vigor any and all attempts to deny, diminish or terminate benefits and services provided by the Department of Veterans Affairs to service-connected disabled veterans. They are, after all, the defenders of our nation and preservers of our rights and our freedoms.

It is these men and women who have given and sacrificed so much of themselves for the good of the nation. The very reason for VA being created and the essence for its continuance is to recognize the nation's obligation to care for those disabled as a result of their service.

H.R. 1385
"Veterans Health Care Reform Act of 1995"

Mr. Chairman, as described, H.R. 1385 represents an initial step toward comprehensive revision of VA's health care eligibility criteria. This bill proposes a framework for restructuring VA's health care delivery system so as to provide hospital and outpatient care to a core group of veterans. Such care would be provided not on the currently existing complex, confusing and archaic eligibility criteria but on clinical need. This is as it should be.

The intent of this measure is to accord those veterans with the highest priority for care the most appropriate care in the most appropriate venue without diminishing eligibility for other deserving veterans.

Mr. Chairman, the bill's key elements include:

- * Defining a "core group" of eligible veterans whose care would be provided in the most appropriate setting, hospital or outpatient care. The "core group" would consist of veterans with compensable service-connected disability; who were discharged from service for a compensable disability incurred or aggravated in the line of duty; those found eligible for benefits under section 1151, Title 38, U.S.C.; former POWs, World War I veterans, and those deemed unable to defray the cost of care;
- * Operating VA facilities in a manner that reduces duplication of services and, realigns services and programs; expanding its capacity to provide outpatient care;
- * Allocating resources to VA facilities so as to provide veterans reasonably comparable access to care;
- * Providing health care services to "non-core" veterans in accordance with current applicable provisions of law;

(3)

- * Maintaining its capacity to provide specialized treatment and rehabilitation programs;
- * Expanding the authority to procure health care services;
- * Establishing treatment priorities and an enrollment system to manage care;
- * Providing for new funding sources through the collection and retention of funds from third party collections above the defined level of the Congressional Budget Office baseline; and
- * Ensuring that veterans with service-connected disabilities will continue to be provided all VA health care benefits to which they are entitled under existing law.

Mr. Chairman, the DAV is supportive of the tenets embodied in H.R. 1385. We feel it makes a positive statement and fosters a movement that will permit VA to chart a course away from its traditional bed-based model of care and into an era of expansion of outpatient ambulatory care capabilities.

Also, and importantly, funding mechanisms are identified that would permit, as we understand it, this kind of healthy reform to be accomplished within current funding levels and creates additional funding streams through retention of certain third-party reimbursements.

Most importantly, Mr. Chairman, H.R. 1385 accomplishes significant enhancements in the way VA is permitted to deliver health care, without diminishing services to currently eligible service-connected disabled veterans.

**CHAIRMAN'S DRAFT LEGISLATIVE PROPOSALS AND
DISCUSSION DRAFT SUMMARY, DATED JULY 11, 1995**

Mr. Chairman, we have been provided, on Thursday, July 13, 1995 a package representing your draft legislative proposal to reform the eligibility and delivery of health care within the VHA.

I would state here, Mr. Chairman, because of obvious time constraints, we may not as of yet fully comprehend your entire set of proposals and their intent. However, there are aspects of the proposal that DAV is pleased to be able to offer our support for. Also, there are clearly segments of the proposal that prompt concern on our part and, others that we view as damaging to service-connected veterans, as well as VA, and, therefore, we will oppose them.

Mr. Chairman, with the understanding that the record will remain open for additional comments and clarification, we would offer the following comments on the draft proposal. First, we are pleased to be supportive of the intent creating authority for VA to provide cost-effective delivery of health care services in the most appropriate clinical setting and changing the system from a bed-based one to one that encourages greater use of ambulatory care services.

We are pleased to see the area of prosthetic services addressed in a meaningful way wherein the defined "core group" of veterans would be eligible to receive needed prosthetic services without regard to the current constraining eligibility. Also, we are encouraged by the concept of pursuing the most cost-effective non-institutional alternatives for those veterans in need of nursing home care. Additionally, we agree

(4)

with the concept of authorizing "core group" women veterans access to an array of needed preventive and wellness services.

Mr. Chairman, we are pleased to see the inclusion and are supportive of the reimbursement mechanism cited that would permit VA's retention of certain third-party dollars for use within the system. Also, because we believe there may be potential for enhanced reimbursements and thus additional operating expenses, by the contracting out of collection efforts, we are supportive of the proposed three-year pilot program.

Mr. Chairman, we are unalterably opposed to language that would terminate current service-connected disabled veterans, to include severely disabled combat veterans, and preclude future service-connected disabled veterans from mandatory eligibility to VA health care services.

The proposed eligibility change to define a "core group" of veterans has two alternatives. Alternative one, in part, would define, as a "core group" veteran, those veterans with service-connected conditions rated at 50% or greater. This, by our reading, would preclude the 2.1 million veterans with service-connected disabilities rated 0% through 40% from accessing the VA health care system except for treatment of their service-connected disability(ies).

Alternative two likewise changes the eligibility for inpatient care for the 1.2 million veterans with service-connected disabilities rated 10% through 20% from a mandatory eligibility status to a space-available, discretionary eligibility. The DAV totally and adamantly opposes both alternatives

Mr. Chairman, under alternative one, as we understand it, a combat disabled veteran, who has had his leg amputated below the knee as a result of combat-incurred wounds would be effectively excluded from obtaining VA medical care except that care necessary for the amputated extremity. At the same time, however, a non-service-connected disabled veteran with the same disability, but whose leg was amputated many years following service for reasons unrelated to service would enjoy eligibility and access to the full array of VA health care services.

More objectionable would be the situation of a nonservice-connected disability less disabling but entitling the veteran to a full array of VA health care services.

Mr. Chairman, this is fundamentally wrong. The proposal would very clearly provide nonservice-connected disabled veterans with VA health care services that would not be available to the wartime service-connected combat disabled veteran. This is wrong and the DAV totally and adamantly opposes such a change.

Mr. Chairman, we see no useful purpose to establish an independent advisory commission to provide advice and guidance to VA on appropriate medical practices. Such decisions belong within VA. We know of nothing to suggest VA is incapable of making such decisions nor that an outside entity is in a better position to make decisions.

Likewise, we oppose the provision to maintain the current limits on nursing home care beds and requiring VA to maintain their current capacity levels. In an era when the veteran population is aging and the need for long-term care services is clearly increasing, such a proposal is not understood.

(5)

We would also oppose, as currently drafted, the suggestion that a veteran, who has eligibility for health care services from other sources must utilize their other eligibility first. We believe the health care needs of service-connected disabled veterans is a responsibility to be borne by the federal government and not shifted to other sources.

Mr. Chairman, the proposal to create pilot programs and allow for VA to contract out the care for eligible core veterans geographically distant from a VA facility can not be supported as currently constructed.

While we agree conceptually that VA needs broadened authority to enter into contractual arrangements and sharing agreements with other health care providers, it must be done in a balanced manner. This proposal, as currently written and understood merely sets the stage, in our view, for the mainstreaming of VA health care services. This is a concept which we are in total opposition to.

Finally, Mr. Chairman, we are opposed to using savings generated from programs affecting service-connected disabled veterans to be used to finance health care reform.

FISCAL YEAR 1996 INDEPENDENT BUDGET

Mr. Chairman, as you and the members of the committee well know, the IB contains a comprehensive, reasoned and credible approach to meaningful reform of the VA health care system. The proposals and initiatives we espouse have been put forward for years. The IB's co-authors have testified before this committee on many occasions. We have had in-depth, ongoing discussions with staff. Realistically, this year's IB proposal does not differ significantly from what we have proposed and supported in the past.

Mr. Chairman, simply stated it is our position that all current Category A (core group veterans) who use the VA system should have access to the full continuum of care--from primary through nursing home care--in the most appropriate treatment venue. This would also include all catastrophically disabled veterans.

Also, that care should be delivered in the most appropriate, efficient, state-of-the-art delivery system available. VA must move from a bed-based system to an ambulatory care system. VA must have the authority to create additional points of access that would allow veterans who are now geographically distant from existing VA facilities to utilize VA care. The authority for VA to contract for care and for the sharing of services must be expanded to include authority allowing VA to be a contractual provider of services.

Mr. Chairman, we support the concept that VA should care for dependents of veterans so long as veterans are not denied or displaced from needed care. There are vast opportunities available for VA to create additional funding streams from such arrangements. So long as veterans are not compromised in the process, we believe and encourage VA to move in that direction.

The final broad tenet is that VA should be allowed the authority to collect and retain certain third-party reimbursements without corresponding appropriation offsets.

Mr. Chairman, the IB is indeed the prescription for change for the VA health care delivery system. Our proposal creates a system that enables VA to be in line with the rest of the medical community. It would allow VA to move from the antiquated, inefficient, costly bed-based model to one of

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providing care in an ambulatory setting. By opening points of access, more veterans would receive quality health care services in an efficient and timely manner. Also, no veteran now eligible for care would be denied care. Rather, their care would be enhanced.

Clearly, Mr. Chairman, the above discussion points to a system that would be beneficial for veterans and the VA system. The added ingredient is one of funding. Our proposal, if enacted as a package, would create overall cost savings approaching \$2 billion annually. This point bears repeating. The proposal advanced by the IB has the potential to save \$2 billion annually.

Rather than continue to tinker with existing eligibility rules, we offer a package that remedies the situation and at the same time saves the taxpayers \$2 billion a year. Mr. Chairman, what could be better for veterans and the American taxpayer?

The DAV is certainly not wed to the current system, neither programmatically, nor its physical plant. If eligibility reform, as described by the IB occurs, and as the VA implements its currently proposed field reorganization, we believe a close hard look at the VA's physical plant should be undertaken.

The DAV is not automatically opposed to looking at the system with an eye toward major changes. There is little doubt that major mission changes of existing VA facilities need to occur and they should. However, it cannot be done prematurely nor short-sighted. In this respect, I am appending to my statement a letter dated July 10, 1995 to the Honorable Tim Hutchinson, Chairman, Subcommittee on Hospitals and Health Care, from the co-authors of the Independent Budget and certain endorsers of the IB.

Mr. Chairman, I believe the committee needs to be aware of the reality surrounding the whole discussion of eligibility reform and its implications for VA and veterans, as well as the American taxpayer.

As we have stated, VA is not now totally flexible in creating the venues in which health care is delivered. It is this flexibility that is contemplated by the IB.

However, one VA facility in particular sticks out and deserves discussion. The North Chicago, Illinois VA Medical Center has implemented an HMO-based model of health care delivery to strengthen its position amid health care reform. I am appending to my statement information regarding this effort and its positive affect on both the VA and veterans.

Briefly, Mr. Chairman, the North Chicago experience has yielded data that shows since October, 1993 the number of veterans enrolled in their managed care plan increased five-fold. In less than ten months, the number of acute days of hospital care/per year/per one thousand enrollees fell by 85 percent. This was due to a reduction in the consumption of acute hospital resources due to:

- * 50% reduction in hospital stays;
- * 90% reduction in the need for acute hospitalization for nursing home care unit patients; and
- * 98% reduction in acute hospitalization for detoxification resulting from a shift from inpatient medical evaluation of these patient to an outpatient medical evaluation.

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The facility was able to reduce from five to only two the number of acute hospital wards, representing a 63 percent reduction in beds. The medical center estimates realizing nearly a tripling of their efficiency. Quality of care was maintained while their operating costs were reduced dramatically. It is projected that annual potential savings could exceed \$15 million. Also, the realignment of services allowed for a reduction of 170 full-time positions.

Clearly, the concept of managed care is cost-effective. A primary care model represents overall efficiency and enhanced quality of care realized by the patient. In combination, such a health care delivery model is the preferred choice. One need only consider the North Chicago experience and it becomes rather clear of what could be replicated throughout the system. Also, this data tends to buttress the position of cost savings of \$2 billion annually if the IB's reform package is realized.

Mr. Chairman, I would conclude my testimony with these major themes:

- * VA must remain as an independent system and be the responsible federal provider of care to eligible veterans;
- * A voucher system that mainstreams VA care must not occur;
- * Eligibility reform as proposed by the IB must proceed rapidly;
- * No service-connected disabled veteran should have their benefits diminished or terminated; and
- * Appropriate changes and alterations to the existing physical plant of VA must be made but in a reasoned strategic process.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you or members of the committee may have.

July 10, 1995

Honorable Tim Hutchinson
Chairman
Subcommittee on Hospitals
and Health Care
Committee on Veterans Affairs
U.S. House of Representatives
1005 Longworth House Office Building
Washington, DC 20515-0403

Dear Mr. Chairman:

Thank you very much for taking time from your schedule to meet with the Veterans' Service Organizations (VSOs) creating an open and frank dialogue regarding the future direction of the Department of Veterans Affairs (VA), Veterans Health Administration (VHA).

We have had the opportunity to review and discuss the draft summary of your proposed legislation creating the "Commission on the Strategic Direction and Alignment of VA Medical Resources."

Mr. Chairman, the VSOs are in clear agreement with your vision that the VA health care system must evolve and assume a flexibility allowing evolutionary changes to continue if a viable, top quality health care system will be in place to provide care for veterans into the next century. However, we believe that the imposition of a Commission as described in your proposed legislation, would be premature at the present time.

A restructuring of the existing, complex and often times inefficient system is not, however, a new or revolutionary idea. The *Independent Budget (IB)* has advocated such changes for years. The *IB's* Fiscal Year 1996 recommendations, continuing the theme of change, would provide quality care in a more efficient manner to greater numbers of veterans. Add to that a projected savings of some \$2 billion and we have our prescription for change and system viability. The Partnership for Veterans Health Care Reform, representing ten major veterans organizations and nine million veterans, has developed and advocated congruous recommendations and strategies as well.

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The need for the system to undergo major change is also addressed in Department of Veterans Affairs own proposal, Vision for Change, a Plan to Restructure the Veterans Health Administration, as proposed by the Under Secretary for Health, Kenneth W. Kizer, M.D., M.P.H. The proposal calls for a concerted and evolutionary course for VA to redesign its structure, budget mechanisms and service delivery systems to meet defined localized service area requirements. Certainly, the major reductions in VA health care spending in the budget proposal for FY 1996 and the dire hard freeze in VA health care budgets for the next seven years approved by the House and Senate, if implemented, will put the greatest incentive and burden of action on the Department itself to move swiftly to reinvent how it is going to meet Congressional requirements to provide health care for veterans. If allowed to follow its natural course and progression, we believe the VA's evolutionary process will emerge addressing where, how and to what extent veterans will receive care based on local demographics, utilization, availability of other public and private health services, system requirements and patient demand. This process will surely address physical plant requirements as well.

Any effort to scrutinize the existing system now with the goal of restructuring to the proportions perceived in the draft bill, absent consideration and enactment of eligibility reform legislation, is doomed to fail. The population to be served and the breadth of services provided must be a defined and known entity prior to changes being contemplated. Likewise, the major changes in Medicare coverage and Medicaid allocation currently contemplated by the Congress, as well as private sector provider and insurer reaction to those changes at the national and state level, could have untold effects on VA utilization and service requirements which would be difficult, if not impossible, to forecast at any time in the near future. All of these variables need to be defined at the local level before any realistic assessment can be made to realign the structure and availability of VA resources. That information does not exist at the present time.

Mr. Chairman, the issue seems to be one of timing. It is our firm and collective belief that the creation of a new, formalized commission is premature. The creation of a separate Commission now with a three-year reporting deadline, would, in our view, preclude VA from moving forward on its own with its existing reorganization plan. The net effect would force the system to operate in ways that are not representative of the delivery of contemporary health care and are certainly not in the best interest of veterans or the American taxpayer.

Mr. Chairman, we certainly agree with you that a close, hard look at the VA system desperately needs to occur. But we believe it must be done only after the question of

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eligibility reform has been addressed. Dr. Kizer's restructuring plan, which will bring needed changes to improve health care for our nation's veterans, must be allowed to proceed without delay. Freezing the system in place as it is now for the foreseeable future under the onus of severe long-term budget reductions would be devastating.

We could support the concept you envision for the creation of a formal Commission once eligibility reform and implementation of Dr. Kizer's plan are behind us. Then, and only then, can a logical, reasoned approach be utilized to address the concerns you have raised. In such a way the Commission would be a partner in this process, building on the data and experience of VA's own reorganization and providing political impetus for needed long-term, but appropriate, change in the best interest of the veteran population.

Mr. Chairman, we want to thank you for sharing your views with us and for your continued interest in doing what's right for veterans. We want to assure you of our continued pursuit of the same goal and our pledge to work with you toward that end.

Sincerely,

American Veterans of WWII, Korea and Vietnam (AMVETS)
Disabled American Veterans
Paralyzed Veterans of America
Veterans of Foreign Wars of the United States

Endorsers of the *Independent Budget*

Blinded Veterans Association
Jewish War Veterans of the USA
Military Order of the Purple Heart of the U.S.A., Inc.

North Chicago VA Medical Center has implemented an HMO based model of health care delivery to strengthen its position amid health care reform. Representatives from each department were chartered to develop a plan to implement the vision developed by management. This team redesigned the medical center's organizational structure around patient centered, process oriented programs rather than departments. Clinical services were reorganized under the auspices of three components: Comprehensive Medical Service, Substance Abuse/Domiciliary Services, and Mental Health/Behavioral Sciences Services which now provide health care for all patients. The medical center's organizational structure, support systems, and infrastructure were reengineered to facilitate the process orientation. Most importantly, the Primary Care Program developed at the medical center laid the foundation for this health care system and provided patients with their own personal team of health care providers. Surgical services were reactivated to meet the needs of the medical center's patients. The Substance Abuse programs were streamlined into one comprehensive program.

These changes in health care delivery have dramatically reduced acute care operating costs while maintaining quality of care. This has resulted in nearly a tripling of efficiency. The potential savings associated with these changes are estimated to exceed **\$15,000,000.00** annually. With only two components activated, the full impact of these changes will become more evident as Mental Health/Behavioral Sciences Services and Long Term Care are incorporated. The visionary leadership fostered by these empowered individuals has transformed the chaos introduced by health care reform into a health care organization capable of meeting the challenges ahead.

"North Chicago VA Medical Center is a Caring Community Working Together to Anticipate Your Needs and Exceed Your Expectations"

Challenged with fulfilling this vision statement, representatives from each department were called together resulting in the formation of one of the most effective and innovative teams ever assembled at this medical center. This multidisciplinary team defined "anticipating your needs..." as recognizing patients as "customers" and making customer satisfaction the number one priority. To ensure customer satisfaction, the team asked, "How do we increase access to quality health care services and ensure timely delivery of those services – while improving cost effectiveness?" The common denominator that linked every major issue was *financial accountability*. Accordingly, the team defined "...exceeding your expectations" as becoming fiscally responsible at all levels throughout the medical center. To achieve this, realignment and improved utilization of resources was mandatory.

North Chicago VA Medical Center recognized the urgency and importance of adopting a managed care approach to health care delivery with the key to success being patient satisfaction. Realizing these decisions would potentially impact every service and department at this medical center, the importance of maintaining a total quality management (TQM) progressive environment as well as empowering individuals at all service levels was essential to successfully implementing change.

Development of a primary medical care program to provide comprehensive medical services was pivotal in laying the foundation of managed care. Primary Care is recognized as the entry point of most patients into a health care system. A prototype multidisciplinary primary care team was designed and placed in operation in April 1993. Concomitantly, other services were recognized as essential for primary care to flourish. Of paramount importance was the development of an informational infrastructure to enable cost accounting and other essential fiscal/workload information. A task force was organized to implement such a system to monitor the effectiveness of our managed care program. Other essential support services such as surgery were absent. The absence of surgery was identified as adversely affecting the overall quality of care, timeliness of care, and cost effectiveness. Access to surgical care was considered pivotal if we were to expand enrollment in our managed care program and improve access to care and control costs. Surgical services were secured by reopening an ambulatory surgical service at North Chicago VA Medical Center and developing a collaborative clinical partnership for tertiary surgical support with another VA facility. The prototype primary care team expanded its coverage of outpatient to inpatients and finally nursing home care unit patients. Two additional teams became operational in April 1994, resulting in full implementation of primary care.

A comprehensive plan for reorganization of a Substance Abuse Service was developed. A multidisciplinary TQM team was empowered to reorganize the fragments of the various Substance Abuse programs into one comprehensive service. A multidisciplinary substance abuse team was designed and placed in operation in January 1994.

A departmental based model of health care delivery was transformed into a managed care program organized around strategic business units. Operational responsibility of each unit has been given to each program director. An advisory council, comprised of chiefs of services identified with each unit, provides the degree of "joint ownership" necessary to ensure *participatory management* (Attachment 1). Three specific units, Mental Health/Behavioral Sciences, Substance Abuse/Domiciliary, and Comprehensive Medical Services, collectively comprise the

Multispecialty Group. Comprehensive health care for all patients is managed and coordinated by the Multispecialty Group. The impact of activating only two segments of managed care, Substance Abuse/Domiciliary and Comprehensive Medical Services, have already had dramatic consequences on productivity.

Since October 1993, the number of enrollees in our managed health care plan increased fivefold. In less than ten months (from October 1993 to July 1994) the number of acute days of hospital care/per year/per 1000 enrollees fell by 85%. This remarkable reduction in consumption of acute hospital resources was due to:

50% reduction in hospital stay

90% reduction in the need for acute hospitalization for Nursing Home Care Unit residents

98% reduction in acute hospitalization for detoxification resulting from a shift from inpatient medical evaluation of substance abuse patients to an outpatient medical evaluation.

The impact upon medical center resources has been profound. In January 1994 there were five acute hospital wards. As of July 1994, there are only two. Three wards with 85 acute hospital beds were taken out of service, representing a 63% reduction in the number of beds necessary to meet the demands of a workload which has increased by 15%. The medical center realized nearly a tripling of efficiency. Quality of care was maintained and the cost of operating the acute care facility dramatically reduced. The annual potential savings associated with taking three wards out of service is estimated to exceed \$15,000,000. This realignment of services has allowed for a reduction in FTEE of 170 positions over the past year. The full impact of the changes underway at North Chicago VA Medical Center will become evident as managed care incorporates Mental Health/Behavioral Sciences Services into the Multispecialty Group and other strategic business units become operational. The visionary leadership fostered by these individuals to empower health care teams to operate as "profit centers" has transformed the chaos introduced by health care reform into a health care organization capable of meeting the challenges ahead.

Statement of Gregory A. Bresser, National Service Director, Military Order of the Purple Heart

MR. CHAIRMAN & MEMBERS OF THE VETERANS AFFAIRS COMMITTEE:

Good Morning! Before I begin, I would like to thank you for this opportunity to present our concerns regarding eligibility reform and reaffirm who the Military Order of the Purple Heart is.

The Military Order of the Purple Heart is an organization composed entirely of veterans who are Purple Heart recipients, **THE COMBAT-WOUNDED!**

Mr. Chairman, and committee members, veterans have been asking for eligibility reform for years. The forum you are holding today will have a dramatic effect on the course of eligibility reform for all currently eligible veterans. The actions taken by this committee regarding eligibility reform, could improve the access to a full continuum of care and improve the efficiency of services delivered.

The American people have recognized that Purple Heart recipients (combat-wounded) are a special category of veterans and therefore, must be placed with veterans of special eligibilities.

Legislation defining **core-group veterans** must include specific language identifying the combat-wounded (**Purple Heart recipients**) as meeting core-group veterans criteria without reference to percentages.

Legislation that would ignore the combat wounded as a recognized special group would trivialize the intent of the American people. The American populace recognize the sacrifices of men and women who served in combat. Any legislative initiative to deny a special eligibility status to the combat-wounded, would outrage the American public.

Mr. Chairman, the DVA is the nation's largest federal Health care provider. Studies available to Congress and DVA show VA Medical Centers provide more cost effective care than comparable private sector facilities. Take for example HMOs, they are profit driven. In other words, when subscribers get sick, HMOs lose money or pass on the cost to subscribers. On the other hand, the DVA provides acute and long-term care services that subsidize Medicare and Medicaid programs at great savings to the Medicare Trust

Fund and the state taxpayers. The DVA provides a wide range of specialized services not available in the private sector, tailored to the unique needs of combat wounded veterans.

Decentralizing DVA management operations can improve efficiency. Local directors understand the needs of the veteran community they serve and decentralizing can increase the responsiveness of local facilities. Deregulating of contracting, resource sharing and personnel management functions, could increase efficiency and would be more cost effective.

Funding for DVA is also in need of reform. Discretionary funding for DVA health care has failed to keep pace with medical inflation; and as a result, DVA has been forced to deny medical services to eligible combat-wounded veterans. Congress must make DVA health care accounts non-discretionary.

Congress must provide for alternative funding sources, such as third party reimbursements and Medicare payments for non-service-connected treatment and allow the DVA to retain those funds in the local facilities that provides these services.

On behalf of John C. Loberg, National Commander of the Military Order of the Purple Heart I want to thank you for your time and attention.

STATEMENT OF
JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO
ELIGIBILITY REFORM

WASHINGTON, D.C.

JULY 19, 1995

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.1 million members of the Veterans of Foreign Wars of the United States, I wish to express our appreciation for having been invited to participate in today's hearing with respect to reforming the Department of Veterans Affairs' eligibility standards for the delivery of health care to our nation's veterans. The VFW commends this committee for its continuing concern for the health care needs of this nation's veterans.

Mr. Chairman, reforming VA's eligibility standards has been a VFW priority goal for many years. Fundamental to the process is that every veteran has mandated access to a full continuum of VA health care. All service-connected veterans, to include World War I veterans, those exposed to ionizing radiation and herbicides, POW-MIAs, and those non-service-connected veterans who are financially indigent must be automatically entitled to care. We define "full continuum of care" to mean the range of care from preventive through outpatient and inpatient, to long-term care extending into that characterized as nursing home care. We recognize VA as "Case Manager" for the full range of ancillary services such as "meals on wheels," hospice care, hospital-base home care, etc. A combination of services administered by VA such as compensation and health care for some, and pension and health care for others would establish a wide-ranging socio-economic VA safety net.

At the outset, Mr. Chairman, many proposals have surfaced that would allow non-veterans to be treated in VA medical centers. It is the VFW's strongly held conviction that the opening of our VA health care system to the non-veteran population must not occur until all veterans have access and no veteran be denied health care.

Before discussing the various proposals before us today, I would like to take this opportunity to list several points the VFW considers essential in any eligibility reform bill which is presented to the full House for consideration. These are:

- All veterans should have a mandated entitlement in law to access to the full continuum of health care provided by the Department of Veterans Affairs.
- Eligibility for mandated entitlement is satisfied by all veterans who are service-connected from 0-100 percent.
- That veterans in receipt of VA pension has satisfied their eligibility requirement for mandated entitlement to the full range of VA health care. That medically indigent, non-service-connected veterans will satisfy their eligibility mandated entitlement to VA health care through some form of means testing.
- That the remaining universe of veterans mandated access to VA health care would establish their eligibility by some form of payment option, be it third-party insurance reimbursement, reimbursement from a state and/or federal programs such as Medicare or Medicaid, or for those without insurance by payment of a personal premium directly to the Department of Veterans Affairs.
- That any veteran who establishes eligibility for his/her mandated entitlement/access to VA health care is entitled to the full continuum of that care. The full continuum of care being defined as being preventive through outpatient and inpatient to long-term care.

Mr. Chairman, the first proposal under consideration is draft legislation submitted by you which would amend chapter 17 of Title 38 to provide for eligibility reform. While the VFW commends your efforts in addressing this very complex issue, VFW cannot support its provisions. We find the proposal restrictive and does not improve veterans access to VA. For example: your proposal would lower the means test threshold placing more of a burden on the medically indigent -- turning back the clock almost to the original means test level. With respect to outpatient care, we find your proposal limits and, in fact, complicates an eligibility process which is already too complex. Instead of expanding access we view a veteran having to clear more hurdles in order to be eligible for VA health care. Expanding outpatient care is crucial due to its critical role in making VA health care more cost effective in the long run.

Another area of concern with your proposal is the freezing of nursing home care. As veterans advance in age and become more frail and infirm, VA must expand this vital component of the full continuum of care. We also cannot support your second alternative, changing the eligibility for inpatient care for veterans with service-connected disabilities rated 10% through 20% from a mandatory eligibility to a space available discretionary eligibility. As stated previously, we not only believe VA should provide a full continuum of care to all veterans, but it must particularly provide care to all of those who sustained a service-connected injury. We view this particular provision a dangerous precedent which could ultimately lead to VA being relieved

of its primary mission of caring for those who have sustained injuries while in the service to their nation.

Mr. Chairman, your proposal's definition of core group is not what we define as the "core" group and the level of care is not what we define as a full continuum of care. We believe the draft proposal does not promote the practice of good medicine because it perpetuates a segmented health care system.

H.R. 1385, the *Veterans' Health Care Reform Act of 1995*, was introduced by Congressmen Chet Edwards and G. V. "Sonny" Montgomery. While we are more receptive to H.R. 1385 than we are with the draft proposal submitted by Congressman Stump, we suggest that the bill be amended to include service-connected disabled ratings of 0% through 100%. This would come much closer to satisfying the VFW's definition of "core" group.

Finally, Mr. Chairman, I would direct your attention to the recommendations contained in the *Independent Budget (IB)* with respect to eligibility reform. As you are aware, the recommendations have been drafted into bill form and are soon to be submitted to the Congressional Budget Office for cost estimates. The VFW along with the three other co-authors of the *Independent Budget* have worked long hours in drafting eligibility reform provisions in which we all basically agree. Not only will this proposal provide the full continuum of care for all veterans but it is estimated to save VA \$2 billion. We trust that once the IB proposal is introduced into Congress, it will receive your fullest consideration.

Inasmuch as the VFW has not been provided a copy of the Administration's eligibility reform proposal, we will not be able to comment on its provisions.

This concludes my statement. I will be happy to respond to any questions you may have.

STATEMENT OF
GORDON H. MANSFIELD, EXECUTIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
VARIOUS ELIGIBILITY REFORM PROPOSALS
JULY 19, 1995

Chairman Stump, Representative Montgomery and members of the House Committee on Veterans' Affairs, Paralyzed Veterans of America (PVA) is pleased to be invited to express our views regarding various proposals to provide long-needed eligibility reform for the Department of Veterans Affairs' health care system.

Under discussion today are: a proposal submitted by Chairman Stump; Legislation H.R. 1385, introduced by Rep. Chet Edwards (D-Tex) and Ranking Minority Member G.V. (Sonny) Montgomery (D-Ms); a proposal (so far un-reviewed) submitted by the Administration; and, an Independent Budget proposal submitted by the Independent Budget organizations, PVA, AMVETS, Disabled American Veterans and Veterans of Foreign Wars. Mr. Chairman, we are at a disadvantage today not having had an opportunity to review some of these proposals in a comprehensive manner. We have also not been able to review cost data on all but our own Independent Budget proposal. We would appreciate the opportunity to comment in detail on each of these proposals at a later date. We would like to have the opportunity to share those comments with the members of this Committee prior to any mark-up session the Committee might schedule.

We would like to comment on the general applicability of each of these concepts in meeting the standards of true VA eligibility reform. But first, I believe it is important to review how VA eligibility got into such a mess in the first place. We don't need to repeat the same mistakes twice.

VA health care eligibility rules are a shambles. The current system often denies veterans appropriate and convenient health services by frequently forcing health care professionals to provide what care they do in inappropriate and inefficient settings.

The consequence is gross inconvenience for many veterans seeking care and utter confusion trying to sort through the bureaucratic maze of eligibility criteria placed in their way. The VA is a strikingly inefficient system, forced by rules imposed upon it to provide care in wholly inappropriate settings at unnecessarily higher cost to the American taxpayer.

Ironically, the Congress devised this eligibility criteria in the attempt to curtail the rising cost of operating the system. But the over-regulation of medical services and fragmentation of the eligible veteran population achieved the exact opposite effect. The Congress chose to limit utilization and cut costs by chopping the veteran population up into health care "haves and have nots," with varying degrees of eligibility in between. The statute then dictated, not only who would get services, but how and under what circumstances veterans would care. A statute is not very flexible health practitioner. It does not respond to the medical need of the individual or the rapid pace of change in today's medical market place. The Congress built the inflexible, largely inpatient-based, health care system over the past fifty years. It then used those hospitals as the instruments to ration access with rules determining who got into them, when they got into them and what services they would get when they did. The statute unfortunately failed to notice when the medical marketplace long ago deemed that an inpatient-centered model of care was no longer economically viable. Health care in America marched on, but VA stayed right where the Congress put it. This Committee should not repeat these mistakes in trying to reform VA again. There is a better way.

THE INDEPENDENT BUDGET FOR FISCAL YEAR 1996 (IB):

This year, the Independent Budget, authored by PVA, AMVETS, Disabled American Veterans, and Veterans of Foreign Wars, proposed a clear blueprint for eligibility reform. Every member of the Committee has received a full copy of the IB plan. The proposal has been translated into legislative language and has been given to both House and Senate Committees on Veterans' Affairs. We are awaiting Congressional Budget Office analysis.

The IB plan shows exactly how VA can achieve dramatic savings by shifting the focus of its care from inpatient to outpatient venues and allowing practitioners, not the law, to determine the most effective means providing care to currently eligible veterans. The IB identified over \$2 billion in savings from projected funding levels if the system implemented eligibility reform and managed care service delivery reorganization. Of most importance, these savings proposed by the Independent Budget accrue even if the system maintains its current patient base under existing Category A criteria. The IB does not assume that eligibility for certain veterans will have to be curtailed in order to provide a comprehensive benefit for a few.

In theory, the Independent Budget judges that for every inappropriate inpatient day avoided, VA could provide three appropriate, cheaper outpatient visits. VA's own data shows that up to 40 percent of inpatient care days could be more appropriately shifted to more cost-effective venues. The IB assumes that eligibility reform will allow VA to dramatically reduce the number of inpatient days for acute care and unnecessary inpatient extended care days by shifting to outpatient and more appropriate institutional and non-institutional services. The savings accrue from a consolidation of services and shift to more appropriate venues of care. The plan assumes VA will be given the flexibility to create broad-based cost savings, extending its ambulatory capability through sharing agreements with other public and private

providers, and achieve substantial cost reductions through primary and preventive care efficiencies. The plan asks that VA be able to keep both Medicare and other third party reimbursements to cover the cost of care for veterans eligible or insured by other plans. The IB also assumes that VA will be able to increase its patient base and recover additional costs from sharing agreements with the Department of Defense and other providers. The private sector is doing this on its own every day. The Congress needs to give VA the statutory, regulatory and management flexibility to do the same.

Many VA health facilities are seeking to reform their own services while waiting for the Congress to enact true eligibility reform. The Veterans Health Administration (VHA) has undertaken a comprehensive system-wide reorganization plan designed to decentralize management and rearrange services to meet current and future veteran health care demand in the most efficient manner based on geographic need. The system needs to respond to changes in demographics and market pressures, including potential major shifts in utilization caused by changes in private sector, State and federal health program coverage. Changes in Medicare and Medicaid contemplated by the Congress could have an untold effect on VA utilization completely unrecognized by policy and budget analysts in the debate over VA eligibility reform. The VISN plan hopefully will allow local managers to shift resources, re-align services and points of access to provide the most cost-efficient health care product within their own service areas.

Individual VA hospital directors are experimenting with managed care products that increase the availability and quality of services while cutting costs. For instance, the North Chicago VA Medical Center instituted a team approach to care that increased enrollment five times over, but saved the station \$15 million in doing so.

Congressional Budget Office estimates on Medicare have projected savings up to 19.5 percent if every beneficiary enrolls in a closed panel Health Maintenance Organization (HMO). Routinely, according to reports (Richard Kogan, Senior Fellow at The Center on Budget and Policy Priorities, Washington D.C.) CBO generally finds 6 to 8 percent savings from managed care attributed to the reduction of the over-consumption of services. Total HMO enrollment would be an unrealistic achievement for Medicare. However, as a closed provider system with a global budget, VA could use managed care practices particularly well to its advantage and achieve substantial savings. A 20 percent cost reduction from existing VA budget levels would bring nearly \$3.5 billion in savings. The IB is projecting only \$2 billion in savings. These estimates are well within reality limits. Enactment of the Independent Budget proposal remains our primary recommendation.

CHAIRMAN STUMP'S PROPOSAL:

We have had an opportunity to review an outline of the eligibility reform proposed by Chairman Stump. We would like to respond with a more in-depth analysis after we have seen the actual legislative language and budget estimates.

Mr. Chairman, we greatly appreciate your willingness to respond to this issue in a definitive way. Too many people seem ready to solve VA's ills by shutting the system down rather than attempting to cure what ails it. The patient has problems, that's true. We just need to find the right cure that is in the best interest of the veteran and the American taxpayer.

The Chairman's legislative draft addresses the main problem with eligibility in the system at the present time: VA's inability to provide a full, cost-effective continuum of care. However, the proposed bill stops short of the expansion of eligibility and efficiencies called for by the Independent Budget. Instead of consolidating current diverse groups of VA eligibles, the bill

creates new subdivisions of veterans within the existing Category A hierarchy. The proposal increases access to the system for some, by denying, and actually reducing eligibility for others. In this regard, the plan keeps the worst of what we already have in the stratification of current Category A eligibility and adds additional layers of eligibility for a new core group on top of the regulatory jumble already in place. Current title 38 provisions divide veterans into 12 eligibility classifications based on service connection, income and veteran status. This new proposal adds three new super categories of veterans to that list: service-connected over 50 percent, nonservice-connected at twice the pension limit (\$16,074), and veterans eligible for a new pilot program of contract care.

The proposal sharply reduces current income limits through a new means test for nonservice-connected eligibility. This proposal takes away direct access to the system to veterans over that limit but below the current means test levels. One version of the proposal would reduce to "discretionary," inpatient and outpatient services for service-connected disabled veterans rated 0 to 40 for nonservice-connected disabilities. At the same time, under the proposed bill, nonservice-connected veterans with incomes below twice the pension level would be eligible for the full continuum of care.

We are concerned, Mr. Chairman, that many of the provisions of the draft bill were designed solely to find savings in shrinking the pool of veterans eligible for VA services, not to address the core problem within the system which is - what those services are and how they should be provided. Under the bill, some veterans would indeed receive the full continuum of care. But the balance of current VA eligibles would be in the same grey area of eligibility they find themselves in today. So also would VA be in the same quandary it is now, trying to provide appropriate and cost-

effective care for those who found themselves neither eligible nor ineligible for VA services.

SPECIALIZED SERVICES AND MANAGED CARE:

We would like to express another comment of caution regarding the erosion of VA specialized services capabilities under managed care scenarios. Earlier in this testimony we referred to the efficiencies and savings that accrue to contemporary health care systems through managed care. But, in doing so, there are "good managed care systems" and "bad managed care systems." Managed care programs produce savings by setting up closed enrollment systems and by controlling utilization of services through gate keepers. The savings accrue largely from controlling or limiting access to specialty care and specialized services. Health care barriers of this kind can have disastrous impact on people with disabilities who routinely seek and require direct access to specialty care.

PVA has testified repeatedly that specialized services are the core of VA's present and future mission. Of major importance to PVA's members are VA's network of SCI centers and care for spinal cord dysfunction. The members of this Committee have understood this fact by including very strong protections in VA reform legislation in the past to ensure the provision of specialized services within the system. We believe any bill approved by the Committee should include similar language.

Concern over access to specialized services takes on even greater importance when provisions in VA reform legislation require va to become a managed care system. Chairman Stump's draft proposal contains language making managed care the system of choice for VA. In doing so, the provision makes no allowance for the protection of specialized services within VA facilities or veterans access to receive them. This is especially troublesome when the new "core group" set aside for the full continuum of care provided by the system consists of seriously disabled veterans rated 50 percent or

more and medically indigent veterans with severe disabilities. Managed care as contained in the bill needs to be well defined to ensure these veterans get the appropriate services they need, without restriction, interruption or inconvenience.

EDWARDS/MONTGOMERY LEGISLATION, H.R. 1385

Of all the proposals we have reviewed so far, the legislation introduced by Representatives Edwards and Montgomery most closely follows the prescription for eligibility reform set forth in the Independent Budget. With the exception of veterans with noncompensable service-connected disabilities, the bill offers a full service plan to all present Category A eligibles. The bill allows VA to break down the barriers between inpatient and outpatient care placing treatment decisions in the hands of health care professionals, not eligibility criteria. As with the Stump bill, the proposal would allow VA to collect and retain third party reimbursements and shift the focus of service from inpatient to more cost effective outpatient care. The bill gives VA health professionals and providers the ability to design their health care systems to meet patient demand in the most cost-effective manner based on the resources available to them. Lastly, the bill addresses our concern that VA specialized services, such as care for veterans with spinal cord dysfunction, face a difficult future under any form of VA reorganization without strong legislative mandate from the Congress to protect their future operation.

We understand that the proposal to be submitted by the Administration is similar to the Edwards/Montgomery bill. We have not yet had an opportunity to review the draft of the legislation. We will submit a full analysis of the legislation to the Committee at a future date.

Mr. Chairman, this concludes our testimony. I will be happy to respond to any questions you may have.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
THE AMERICAN LEGION
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
BEFORE THE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JULY 19, 1995

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to testify on health care eligibility reform within the Department of Veterans Affairs. We hope this hearing will initiate action to change what must be changed, and to build on the solid foundation that already exists within the Veterans Health Administration.

Over the past several years, The American Legion has testified on its vision of what the VA hospital system represents and what conditions need improvement. Prior to the establishment of the *Commission on the Future Structure of Veterans Health Care*, improving veterans access to timely, quality health care has been and continues to be a major objective of The American Legion. On occasion this has seemed to be an elusive goal. We believe the VA hospital system must change its methods of providing health care and view eligibility reform as the primary mechanism to accomplish the necessary transformation to becoming a model health care delivery system.

The American Legion is encouraged to see VA working to implement the Veterans Integrated Service Networks (VISNs). This field reorganization will help increase veterans' access to care and enhance the efficiency, effectiveness and quality of care provided. Once comprehensive reform of the VA medical care system is complete, the VISNs will represent a vehicle for sensible medical care delivery.

We know that eligibility reform is essential. However, The American Legion believes much can be done to make VA fiscally viable through eligibility reform. Just changing the rules without changing VA's role in the expansion of veterans health care services--although good, is clearly not enough. The next logical step from eligibility reform is a plan to take fiscal advantage of these changes by expanding the population served and the way VA delivers health care.

Mr. Chairman, any changes in eligibility for VA medical care should bring a new universe of patients to VA. With those veterans would come an improved source of funding to the Medical Care Cost Recovery Fund (MCCR). Therefore, along with eligibility reform must come a revision of Title 38, Section 1729 (g)(4), which now requires the Secretary of Veterans Affairs to return to the U.S. Treasury the unobligated balance remaining in the MCCR Fund not later than January 1 of each year.

Mr. Chairman, changing eligibility for VA care would have a domino effect and cannot take place in a vacuum. If we can presume that changes in eligibility will increase third-party payments and co-payments and deductibles, then we can only presume that the population of veterans served must expand as well. If we persist in limiting the population of veterans served to Category A veterans as it is today, then we will not see an appreciable increase in dollars returned to VA. In these times of shrinking resources, increasing the funds coming into the MCCR Fund, as well as reducing the ever-expanding cost of operating the MCCR program, is imperative for the fiscal well-being of VA.

Mr. Chairman, we have reviewed the several other eligibility reform proposals and have concerns that some of these proposals do little to expand the population of eligible veterans or to provide additional income streams for the VA health care system. In some cases, the proposals actually take away from veterans by further limiting access to those allowed to use the system. Additionally, the bill could further restrict veterans' access to care as resources become more constrained in future years.

If VA is to survive, Mr. Chairman, expansion of funding streams for the care of nonservice-connected conditions must take place by broadening, not limiting, eligibility.

The bottom line in this scenario, Mr. Chairman, is that eligibility reform must do more than move Category A veterans to the most appropriate setting for quality care. Although this is a paramount reason for changing the law, it must also allow new veterans to come to VA and bring their third-party dollars to help defray the cost of caring for these nonservice-connected veterans.

With eligibility reform, The American Legion envisions VA evolving into a market-driven, customer-focused, managed care delivery system. The 22 Veterans Integrated Service Networks can develop an open enrollment health care plan for veterans and their dependents to receive comprehensive quality medical care. Through various enrollment plans, VA would offer basic, comprehensive and supplemental benefit packages to veterans (males as well as females) and their dependents, with no out-of-pocket costs for certain service-connected and low-income Category A veterans' health care. Other eligible veterans can purchase VA health care benefits packages during the open enrollment period.

The most viable approach for VA to develop a comprehensive health care delivery system is through the Veterans Integrated Service Networks. The full continua of health care services are available in VA from outpatient care to long-term nursing home care. A VA integrated health care business office would administer the VA health care plan in each VISN. The goal of a VA Health Care Plan, based on the VISN concept, is to better serve constituents, eliminate duplicative services, create economies of scale, and enhance the survivability of the VA medical care system.

Mr. Chairman, The American Legion is currently drafting legislation that will establish an expanded VA health care system. We hope to present the bill soon. Meanwhile, VA needs to prepare for the implementation of the Veterans Integrated Service Networks and ensure the best possible service to its customers.

Mr. Chairman, the VA eligibility reform legislative proposal was not available for examination prior to development of the Legion's testimony for today's hearing. In that regard, we can only comment on the VA initiative as expressed in its Reinventing Government Phase II proposal.

VA proposes legislative changes for prosthetics' eligibility, and to permit care in the most appropriate setting as clinically determined, and to manage that care across all settings. VA estimates that there will be a shift of approximately 20 percent of its inpatient workload to outpatient care over a two-year period. With this workload displacement and concomitant transfer of funds, VA expects this proposal to be budget neutral.

The VA Reinventing Government Phase II proposal also suggests development of several Medicare reimbursement demonstration projects. To ensure that Medicare eligible veterans have VA health care as a viable option, VA proposes to recover revenues from Medicare for designated categories of veterans. The pilots will serve to identify a range of detailed options with defined parameters and cost impacts for consideration.

Also, VA proposes to retain 25 percent of the funds collected from third-party insurers that exceed the budget baseline while continuing the current practice of covering all collection operating expenses from the funds collected.

VA would also simplify the current means-testing process to improve customer service and reduce the time and effort committed to this process. The veteran would be asked for permission to access his or her IRS information and would affirm that current income is below established limits and that no significant changes in income had occurred. This simplification would eliminate the current income and total asset means-test computation and rely strictly on an income-based determination.

In the area of health care reform, VA proposes that the Vice President task the Secretaries of Defense and Veterans Affairs to investigate and report on the feasibility of greatly increasing sharing and integration of the VA and DOD health care systems. Operational issues will be addressed and approaches developed to communicate the Secretaries' strong support for innovation and interagency cooperation to overcome traditional interests in maintaining separate systems. Potential savings and program improvements are projected from reductions in overhead, infrastructure, personnel need, common administrative systems, and uniform health benefits packages.

Mr. Chairman, the VA Reinventing Government Phase II proposal is a step in the right direction. Many of the systemic changes sought by The American Legion are included in the proposal. There are significant differences, however, in the VA proposal and the system changes to be recommended by The American Legion.

The VA proposal would only guarantee access for VA health care to entitled veterans. The American Legion proposal would guarantee access to all veterans, through a combination of federal funding and third-party insurance coverage. While the Legion's proposal is in the draft stage, once completed, it will reform the entire VA health care system. This restructuring includes eligibility reform for mandatory and discretionary veterans, granting access to care for all veterans and their eligible dependents, and strengthening the fiscal foundation of the system.

The American Legion is encouraged that there is a clear recognition within the Reinventing Government Phase II proposal that the VA health care system must be protected and improved. We are hopeful that by working together, Congress, VA, and the veterans service organizations can agree on what changes must be made and develop a realistic blueprint for achieving these changes within a reasonable period of time.

Mr. Chairman, thank you again for letting us testify before this Committee on improving and protecting the VA medical care system. The American Legion believes that by working together we can significantly restore the vitality of the VA medical care system for years to come.

Mr. Chairman, that concludes our statement.



NCOA

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STATEMENT OF

LARRY D. RHEA

DEPUTY DIRECTOR OF LEGISLATIVE AFFAIRS

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

ON

VA HEALTH CARE ELIGIBILITY REFORM

JULY 19, 1995

The Non Commissioned Officers Association of the USA (NCOA) welcomes this opportunity to comment on various proposals to reform the Department of Veterans Affairs (DVA) health care eligibility system. The Association salutes the distinguished Chairman of the House Committee on Veterans Affairs for holding this full-committee hearing and for his initiative and leadership on an issue that is critically important to the DVA and all veterans.

NCOA, along with other veteran service organizations, has been advocating change in the DVA health care eligibility system for many years. During the past two years in particular, NCOA, as one of the ten member organizations in the Partnership for Veterans Health Care Reform, has made a concerted effort to be a part of the dialogue to structure meaningful, long-term eligibility reform.

The fact that today's hearing is taking place can be credited, in part, to the efforts of the Partnership organizations these past two years. The lion's share of the credit though is reserved for and appropriately extended to Chairman Stump for his resolute effort to bring about needed reform. NCOA would be remiss if the Association did not also acknowledge the hard work and determination of the Committee's ranking member, Mr. Montgomery, Representative Edwards and the majority and minority staff during the past seven months. The Association extends a special word of thanks to the majority and minority staffs for their efforts, openness and candor in discussions with veterans groups preliminary to today's hearing.

THE GOAL IS CLEAR - THE PATH IS UNCLEAR

There is no question that everyone seems to agree on the goal of reforming VA's health care eligibility rules. Congress, DVA, and veterans clearly recognize that the current criteria which has been pieced together over many years is not only confusing and burdensome but is also inefficient and adds unnecessary cost to the delivery of required care. It makes no sense to continue the inappropriate practices which current rules require by emphasizing in-patient care when ambulatory or outpatient care is more appropriate, at less cost. By allowing the VA to shift care from an inpatient emphasis to an outpatient setting will benefit veterans and taxpaying Americans. In brief, the goal seems clear - simply allow the VA to practice

common-sense medicine.

Although the goal appears reasonably clear, the pathway to achieve it is not so readily apparent. On a subject as complex as eligibility rules, gaining consensus on questions that will have a long-term, major impact on the future of VA health care is a difficult undertaking. The difficulty of that task is compounded since it is NCOA's impression that any changes enacted will, of necessity, have to be budget-neutral. That fact alone adds to the urgency of the task.

Several proposals for eligibility reform have been put forward, including: the Chairman's draft discussion document; Mr. Edwards bill, H.R. 1385; and, the proposal contained in the Independent Budget. All three proposals have the common ground of allowing the VA to deliver care to veterans on the basis of clinical or treatment need by changing the VA from a bed-based system to one that encourages greater use of ambulatory care services. There are, however, areas of divergence between the proposals.

In NCOA's view, two immediate questions arise that must be answered even before differences in the current proposals are discussed. Those questions are: (1) How far do we go? and, (2) How fast do we undertake reform? Consensus on these two questions probably will be as difficult as gaining agreement on other critical questions in the proposals. Nonetheless, NCOA believes that the need for reform is sufficiently urgent that the Committee must undertake some crucial first steps.

COMMON GROUND FIRST STEPS

In view of that urgency, NCOA believes that the Committee's first steps should be to find those areas where there is agreement and pass legislation to make those changes. Even if this means that we must come back at a future point and deal with some of the more controversial and complex questions, then so be it. Future funds are simply not going to be available to allow the continuation of business as usual.

First, Mr. Chairman, NCOA believes we need to eliminate a restriction that makes absolutely no sense and forces VA to engage in costly medical care practice which the system can no longer afford. If today's hearing results only in the introduction and passage of legislation that would repeal the "...to obviate the need..." language, that alone would be a major first step in practicing common sense medicine. The reasons for this change so are so obvious that NCOA considers further comment unnecessary.

Second, the VA must be permitted to practice "common-sense medicine." To allow the VA to do so is a rather simple proposition in NCOA's view - give VA physicians the authority to provide needed care in the most appropriate clinical setting. The health care provided to an eligible veteran should and must be determined on the basis of the patient's medical need.

The legal hurdles that veterans and physicians must now deal with has added incalculable cost to the delivery of health care. The current irrational system of eligibility hurdles must be repealed. Once eligibility for health care has been established, VA physicians should be confronted with only the question of how best to deliver the needed care in a cost-effective manner. If suitable care can be provided on an ambulatory or out-patient basis, then we should do it. If, in the professional view of the VA physician, the medical care needed requires hospitalization, then the veteran should be hospitalized. By VA's own estimates, 40 percent of inpatient care is for "non-acute" reasons that could more efficiently and less-expensively managed in an outpatient environment. That fact alone should be argument enough to abandon the archaic rules that now govern VA health care.

The third major point that NCOA wishes to underscore, and on which there appears to be widespread agreement, deals with cost-recovery. Unlike every other health care provider in the Nation, VA is not permitted to retain medical care costs recovered from third parties. Although the VA is devoting considerable effort in the medical care cost recovery area, the fact that monies recovered are now required to be returned to the U.S. Treasury is a major impediment and dis-incentive. The full benefit to VA and veterans will never be realized unless a change is made.

VA must be certified as an authorized provider for MEDICARE and allowed to recover the cost for care provided to a MEDICARE eligible veteran. Similarly, the VA must be allowed to retain collections, above that required for budget reconciliation, from MEDICARE. How and where the VA is allowed to target monies collected through cost-recovery is subject to debate. There is little debate though, in NCOA's view, that the VA and veterans should be the beneficiary of monies collected that are above the reconciliation target.

MILITARY RETIREES ARE VETERANS TOO

Along the same lines, NCOA is compelled to comment on the recently signed Memorandum of Understanding between the Departments of Defense (DOD) and Veterans Affairs. The agreement that was signed on June 29, 1995, will enable DVA medical centers to become eligible for reimbursement for health care provided to Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) beneficiaries.

The agreement makes DVA medical centers eligible to apply through DOD's managed care support contractors to become TRICARE providers. Beneficiaries can continue to use military treatment facilities (MTF) and private-sector providers, or those who prefer care from a DVA medical center, can be referred to or choose a TRICARE-approved DVA provider. Under the agreement, the cost to beneficiaries will be the same as for a private-sector provider.

NCOA salutes this initiative to provide CHAMPUS eligible beneficiaries with an additional health care alternative. The Association is dismayed and deeply concerned that the best interests of eligible beneficiaries do not appear to have been served. NCOA is referring to the cost that beneficiaries will incur if care is provided in a DVA medical facility. Under the agreement, federal DVA facilities are viewed as private-sector providers and the cost to CHAMPUS eligible beneficiaries will be the same as if care actually had been provided by the private-sector.

Currently, CHAMPUS eligible beneficiaries can receive care in federal military treatment

facilities without cost. To impose any cost on those same eligible beneficiaries for treatment in another federal facility, even though that facility is managed by the DVA, is, in NCOA's opinion, an abrogation of a core obligation that the federal government has to those beneficiaries.

NCOA has and will continue to support sharing arrangements between DOD and DVA that are mutually beneficial to both department's beneficiaries. However, NCOA strongly believes that DVA, as a federal entity, should be viewed as an extension of the MTFs insofar as CHAMPUS eligible beneficiaries are concerned. In this regard, the Association believes that CHAMPUS co-payments should be waived for treatment of eligible beneficiaries in DVA medical facilities.

As a recognized and fully-accredited veterans service organization, NCOA understands the mission and obligation of the DVA to the Nation's veterans. Above all else and without question, DVA has an unalterable obligation to veterans with service-connected disabilities. It is also clear to NCOA that military retiree veterans served under a promise, believing it to be an unalterable federal obligation, that guaranteed them a lifetime of cost free medical care. Waiving the co-payment for CHAMPUS eligible beneficiaries who are treated in DVA medical facilities would further fulfill that promise.

CONCLUSION

NCOA believes that today's hearing represents a great opportunity to start the process of reforming VA's health care eligibility rules. If this hearing results in producing legislation that addresses only the three central points made in our testimony - repeal the "...to obviate the need..." language; permit the VA to practice "common sense" medicine based on clinical need; and, recognizing VA as an authorized MEDICARE provider - then, in NCOA's opinion, a gigantic step will have been taken. NCOA is also hopeful that Committee members will use their influence so that CHAMPUS co-payments can be waived for treatment of CHAMPUS eligible beneficiaries in DVA medical facilities.

Thank you.



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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

"VVA, At Work in Your Community"

Statement of

VIETNAM VETERANS OF AMERICA

Presented By

Kelli R. Willard West
Deputy Director, Government Relations

Before The

House Veterans' Affairs Committee

Regarding

VA Health Care Eligibility Reform

July 19, 1995

Introduction

Mr. Chairman and members of the Committee, Vietnam Veterans of America (VVA), appreciates the opportunity to present its views on one of the most complicated and critical issues facing American veterans today. Ongoing changes within the Veterans Health Administration (VHA), innovations in the private sector health-care delivery systems, and the federal budget crisis' effect on other public health programs make VA's current health care eligibility criteria more obsolete than ever. Eligibility reform is a very important component to the evolution of the VA health care system. VVA appreciates your sense of urgency, Mr. Chairman, in putting this issue before the 104th Congress.

The veterans service organizations (VSOs) have been called upon to examine several proposals for accomplishing this common goal: the draft legislation prepared by the Committee staff, Mr. Edwards' legislation (H.R. 1385), and the principles put forth in *The Independent Budget for Veterans Affairs Fiscal Year 1996*. It is our understanding that this hearing regarding the broad principles of eligibility reform is aimed to set the stage for further discussion when Congressional Budget Office (CBO) cost figures and the VA's own proposal become available. I will begin by providing a general overview of VVA's position on VA health care and eligibility reform, then discuss our comments/concerns with the proposals at hand.

We commend you, Mr. Chairman, for holding this hearing and look forward to working with you and the Committee on this issue, in order to achieve the best possible eligibility reform plan for our nation's veterans.

VVA's General Position on VA Health Care

As a single-generation organization representing Vietnam era veterans, VVA has a rather unique perspective on VA health care. This is the "sandwich generation," if you will, caught between the concerns of raising families and contemplating the problems of aging. Vietnam veterans currently represent the largest subgroup of the veterans population. The veteran population as a whole is getting smaller as the World War II generation passes on, but the Vietnam generation is only now approaching middle-age. Thus, the rate of reduction in the veterans population will slow somewhat for a period of years, but also grow older. As the Vietnam generation ages, these veterans will become more costly in terms of health care expenditures.

Vietnam veterans, by virtue of their economic status, are more likely to become dependent upon VA health care as they age than were World War II veterans. Vietnam veterans have disproportionate representation among dislocated workers, have lower earning rates, and represent a large percentage of the homeless in the U.S. It logically follows that Vietnam veterans are less likely to have health care insurance coverage upon retirement, other than Medicare and Medicaid.

As such, Vietnam veterans have unique concerns about health care options. Many Vietnam veterans have spouses and family members who need improved access to affordable health care. VVA 1993 Convention Resolution P-13-93 calls for organization support for "legislation ensuring that all veterans and their families have access to health care coverage meeting minimum requirements which is provided at a reasonable cost to both the veteran and his or her family." This position statement allows VVA to support the addition of veterans' dependents to a VHA enrollment-type system. Additionally, many Vietnam veterans have aging parents who face expensive nursing home care. The large majority of Vietnam veterans have not reached retirement age and remain in the workforce, thus they have serious concerns about their tax dollars being spent wisely.

Vietnam Veterans of America's membership favors eligibility and health reform plans to create greater VA and private sector health care efficiency, improve quality, enhance access, provide more choices, and improve responsiveness to the unique needs of veterans. These objectives are not mutually exclusive, and many can be achieved through VA eligibility reform.

To achieve these objectives, VVA is proud to collaborate with our VSO colleagues in the highly successful *Partnership for Veterans Health Care Reform*. This unprecedented unity among the VSOs is a testament to the commonalities in the health care needs of various sectors of the veteran population and to the necessity of change.

Core Group -- Mandatory Category Veterans

Service-connected disabled veterans and low-income veterans should always remain VA's highest priority. This principle must be maintained in Title 38. Federal funding must be sustained to meet the nation's obligation to this core group of VA eligibles. VVA firmly believes that services for this population can be improved and enhanced through eligibility reform -- allowing access to a continuum care and increasing quality -- by eliminating barriers to outpatient care.

VA's own estimates indicate that some forty percent of its inpatient episodes of care could be more cost-effectively provided in another setting. Thus, there are very significant cost savings to be achieved by shifting from the outdated acute care emphasis to primary care modalities in the outpatient setting. The efficiencies should logically allow VA to provide the outpatient services because these core group veterans would not necessarily get more care, but simply more efficient care. Even if one assumes a slight-to-moderate influx of core group veterans, the efficiencies should sustain the system.

Discretionary Category Veterans

Shifting to more efficient outpatient care, VA will likely have an increased capacity to provide care. Just as non-service connected, higher-income veterans can currently access the VA system when resources permit, with eligibility reform the same opportunity should exist for veterans who wish to pay for these services. As proposed in both bills under consideration today, in *The Independent Budget*, and by *The Partnership for Veterans Health Care Reform*, VHA should be allowed to retain a portion of the monies collected for services to discretionary veterans. These funds can then be reinvested to improve services for all veterans -- mandatory and discretionary. Facility enhancements, equipment purchases, addition of services and access points, and a host of innovations could be accomplished with these new funds.

This is the basic premise behind the VSOs' analysis detailing that eligibility reform can increase services and still reduce the VHA's reliance on federal tax dollars. By bringing in new sources of funding and increasing efficiency, VHA could make some of these improvements without tapping into the annual federal appropriation.

Basic Components of Eligibility Reform

VVA does not believe that the aforementioned goals are pie-in-the-sky. The veterans community, including VVA, continues to work toward improving VHA efficiency. Recognizing that federal budget constraints will continue to be debilitating to veterans health care, VVA and *The Partnership* continue to advocate less reliance on federal funding for the Veterans Health Administration. To accomplish this, the population of veterans who can receive VA care must be expanded, while at the same time allowing VA to retain 3rd-party payments including Medicare reimbursement, insurance payments, and individual copays.

Federally appropriated funds must continue to meet the nation's responsibility for "core" group veterans (service-connected disabled and low-income veterans). But, these additional funding streams will allow VA to reinvest to improve and enhance services for all veterans. To meet the demand for services of this larger eligible veteran population, VA must expand its points of access to care and shift emphasis toward more cost-effective and convenient outpatient modalities of care. Additionally VHA's specialized programs must be maintained and protected.

In essence, VA health care eligibility reform should not delineate who can and cannot receive services, but rather who should be required to pay for the care and how much.

Specialized Programs

VVA takes great pride in its role in identifying the need for special programs within the VA to meet the mental health needs of veterans suffering from Post Traumatic Stress Disorder (PTSD). It is now widely recognized that PTSD is not a problem unique to the Vietnam generation. Veterans from all eras can and do experience problems and concerns related to experiences within the military and in combat. Civilians experiencing unusual trauma can also be diagnosed with PTSD symptomology detailed in the American Psychiatric Association, *Diagnostic and Statistical Manual*. VVA strongly advocates that the unique, cost-effective PTSD services of the Vet Center program be expanded to all veterans and their families.

VVA is adamant about protecting the VA programs designed to meet the needs of the PTSD-afflicted. We are also very supportive of VHA's other specialized programs, such as spinal cord injury medicine, blind rehabilitation, advanced rehabilitation, prosthetics, mental health, long-term care, and homeless programs. We urge the Committee to acknowledge the PTSD programs -- including the Vet Centers -- as one of VHA's unique specialties which are virtually unmatched in quality or quantity among non-VA health care providers. Additionally, we urge you to vigorously protect all VHA specialized programs. Caring for uniquely-veteran health-care needs is the primary mission of the VHA, but these specialized programs are also a central part of VHA's other missions -- training medical professionals, health research, and national emergency back-up.

Committee Staff Draft Summary

While the Veterans Health Administration (VHA) is in the midst of internal reorganization efforts aimed at reducing bureaucracy, making VHA more responsive to patient needs, and allocating resources more efficiently, passage of eligibility reform legislation as detailed above would greatly enhance these efforts and improve VHA services to our nation's veterans. VVA and the veterans community have endorsed the VHA reorganization plan, "Vision for Change," put forward by VA Under Secretary for Health Dr. Kenneth Kizer. Kizer's plan would decentralize resource allocation, allowing local managers to take into consideration local health care resources and market, the demographics of the local veteran population, effects of state legislated health reforms, budget cuts to Medicare and Medicaid, and other factors. VVA has long advocated for improvements to VHA programs, which enhance efficiency and provide more benefit with the same federal tax dollars.

At this juncture, VVA notes that the private sector is also making radical changes in the way health care is delivered, various state legislatures are moving forward with local reform initiatives, and federal Medicare and Medicaid health-care programs are experiencing significant budget concerns, all of which will effect the way veterans receive health care services inside or outside the VA.

Recognizing budget limitations, it may be necessary to work incrementally toward the broader goal of a VHA system accessible to all veterans. In the context of the Conference Report on the FY 1996 Budget Resolution, it is even more critical that VHA be allowed to practice modern medicine with an emphasis on cost-effective care. Facing zero growth in discretionary medical care expenditures, VHA will be forced to cut programs and turn away veteran patients unless eligibility reform is implemented and efficiencies are realized.

It would be very difficult for VVA or any VSO to support proposals to reduce the population of veterans with VHA health care eligibility. We are very concerned about both alternatives put forth in the Committee staff draft. Reducing the pool of eligible veterans who can access VHA care would be detrimental to VHA efforts to collect 3rd party reimbursements and copayments, and would thus hamper any VHA reform initiatives that might be undertaken with these funds. At the same time the 104th Congress aims to simplify laws and federal regulations, this proposal would add further layers and complicated criteria to the existing VA health care eligibility morass. Additionally, VVA is very reluctant to draw a "cut-off" delineating which vets can use VA until cost figures are available.

Another corollary concern with further restricting eligibility is the impact this may have on Veterans Benefits Administration (VBA) claims processing. If eligibility reform is implemented to provide broad access to the system to all service-connected veterans, excluding 10-20 percent, VBA may experience an influx of upgrade claims. Veterans in this category represent the bulk of service-connected disabled veterans. Vietnam veterans fall into this category in significant numbers.

For this reason, it would be difficult for VVA to support the main components of the Committee staff draft proposal. There are elements of the bill which are very favorable, such as emphasis on ambulatory care, the Medical Advisory Commission, the focus on women's health, and the scenario for distribution of 3rd party reimbursements and copays.

The pilot project to evaluate contract care for veterans residing at a 75 mile distance from the nearest VAMC is an interesting idea. However, VVA has a few concerns with its structure. VVA has long advocated giving veterans a choice of providers, but the pilot restricts participating veterans from using VHA services, except for those designated as specialized. Within the pilot program and the eligibility reform proposal as a whole, we urge the Committee to identify PTSD treatment as a VHA specialized program and not restrict Vet Center eligibility or access to any veteran. Additionally, health screening for veterans with effects of environmental exposures (such as Agent Orange, Gulf War Syndrome, radiation, etc.) must be accommodated in the pilot project.

The emphasis on managed care practices is a good method of pushing the VA health system into more modern practices of medicine. VVA cautions the Committee to be careful when defining "managed care" though. In the private sector, some managed care providers attempt to preclude patients from seeking costly specialized care. The veteran population is generally older and sicker than mainstream managed care patients, and has unique needs for specialized programs. Care must be taken to assure that access of service-connected disabled veterans to VHA specialized programs is not restricted.

H.R. 1385

While this legislation is certainly not the be-all-and-end-all of eligibility reform proposals sought by the veterans community, VVA believes it represents a pragmatic approach to an uncertain demand for VHA services and volatile budgets. Because of our opposition to reducing the pool of veterans accessing the VHA system, this legislation is more acceptable. The bill, similar to the Committee's draft summary, would ease access to more cost-effective outpatient services and provide incentives for collecting reimbursements and copays, but unlike the Committee staff draft, it would not reduce current benefits for low-income veterans or the majority of service-connected disabled veterans.

H.R. 1385 fits VVA's premise that opening access to outpatient care is not creating a new or enhanced benefit, but rather providing a more cost-effective benefit. Thus, this proposal would allow VHA to provide more appropriate and higher quality care to the current core group veterans. The bill also allows greater flexibility to VHA on how to achieve this enhanced outpatient capacity.

Again, VVA views this legislation as a pragmatic step toward broader reform of the veterans health care system. This incremental approach may prove favorable to the overall goals of system change than a comprehensive approach, as it would provide for evaluation of use and time to expand access.

Conclusion

In light of the uncertainties with CBO cost estimates on these proposals, and the forthcoming eligibility reform plan from the Administration, VVA ultimately reserves judgement on the legislative proposals before us today. This is the first year VVA has endorsed the *Independent Budget*. Its new approach detailing specific proposals for reforming the veterans health care system is very favorable and agrees with ideas of VVA and *The Partnership for Veterans Health Care Reform*. The cost analysis presents a very logical approach to alleviating

veterans' problems with the system, as well as Congress' financial burden.

As an endorsing organization, VVA is pleased that the Committee has presented the *Independent Budget* to CBO for further analysis, and continues to review these principles. It is our belief that the desired reforms will, in fact, save federal tax dollars while at the same time improving service and expanding access to care for veterans. At this point, VVA continues to support the eligibility reform proposal set forth in this document.

Again, VVA appreciates this opportunity to discuss priorities and general philosophy regarding eligibility reform. We look forward to working with you, Mr. Chairman, and the Committee to achieve a more efficient, accessible, and enhanced quality health care system for American veterans.

Mr. Chairman, this concludes our testimony.

STATEMENT OF ROBERT I. KEIMOWITZ, M.D.
DEAN FOR ACADEMIC AFFAIRS
THE GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE
AND HEALTH SCIENCES

REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 19, 1995

Good morning, Mr. Chairman and Members of the Committee. I am Robert Keimowitz, dean for academic affairs at the George Washington University School of Medicine and Health Sciences. I am pleased to appear today to share my views and those of the Association of American Medical Colleges (AAMC) on reform of the rules that determine a veteran's eligibility to receive health care services through the Department of Veterans Affairs (VA) health system.

The AAMC represents the 125 accredited United States medical schools; nearly 400 major teaching hospitals, including 74 VA medical centers; over 90 professional and academic societies; and the nation's medical students and residents. Together, the members of the AAMC work to improve the nation's health through the advancement of academic medicine. As we near the 50th anniversary of the first affiliation between a VA medical center and a medical school, academic medicine looks back with pride on its record of service to our nation's veterans. Likewise, we look forward to continuing this productive and beneficial relationship over the next 50 years and beyond.

Since the Hines VA Medical Center and Northwestern University entered into the first collaboration in January 1946, affiliations between medical schools, other health professions schools, and VA medical centers have contributed to attaining the goal set forth for VA in the policy memorandum that still guides the affiliations today, that is, "affording the veteran a much higher standard of medical care that could be given him with a wholly full-time medical service." Nearly 10,000 faculty from these academic affiliates direct or provide care for veteran patients and teach residents and students at VA medical facilities. Today, 130 of the 171 VA medical centers are singly or jointly affiliated with 105 of the nation's 125 medical schools.

The AAMC applauds this committee for embarking on a thorough review of VA's eligibility standards. Academic physicians are well aware that the current eligibility criteria hamper VA health professionals' efforts to provide appropriate medical care to veterans. These criteria have evolved around a model of health care delivery that emphasizes inpatient hospital care. Today, however, most health care providers and organizations are moving away from that model to a delivery style that focuses on primary and preventive care in outpatient settings. While most policy experts believe this new model of care is more efficient and cost-effective than the traditional hospital-based system, the current eligibility criteria preclude many veterans from receiving both outpatient and inpatient care.

Many of the veteran patients my colleagues see at the Washington VA Medical Center have conditions or diseases that could be treated more effectively if the patients had access to outpatient care. Current eligibility rules, however, require physicians to admit many veterans to the VA hospital even if their ailments could be treated less expensively and more compassionately on an outpatient basis. With different rules for hospital care, outpatient care, and long-term care -- rules that depend on each particular veteran's disability status, their special classification, and their income level -- the ability of most veteran patients to receive adequate health care in the VA health system is a testament to the tenacity and perseverance of both the veterans who seek VA care and the physicians and health professionals who provide that care.

Before I proceed further, let me say that, like many of today's witnesses, the AAMC is concerned with the seven-year freeze on funding for VA medical care assumed by the congressional budget resolution for fiscal year 1996. With level funding, inflation will continue to erode VA's power to provide veterans with appropriate health care services. The effects of this erosion will most likely be manifested in a gradual diminution of VA's notable, yet expensive, services in the areas of spinal cord dysfunction medicine, blind rehabilitation, prosthetics and orthotics, and post-traumatic stress disorder treatment.

Eligibility reform, however, provides this Congress with an opportunity to adopt health policy that makes sense both medically and fiscally. For instance, the fiscal year 1996

Independent Budget, prepared by AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States, estimates that VA could save \$2 billion by diverting inpatients to more appropriate outpatient or long-term care settings. The AAMC believes eligibility reform can enable Congress to allocate limited federal resources more effectively, yet maintain its commitment to those who have borne the battle on our nation's behalf.

The AAMC would prefer to withhold its comments on the specifics of the eligibility reform proposals being offered by Chairman Stump, Representative Edwards, and the Clinton administration until we have had an opportunity to review and compare all of the proposals thoroughly and carefully. However, I would like to elucidate three general principles on which the AAMC and its member institutions believe eligibility reform should be based.

First, the new eligibility criteria must not inhibit health professionals and administrators from making proper clinical decisions on how best to care for patients or on the most appropriate venue for such care. Congress should allow all eligible veterans to qualify for a full and comprehensive continuum of care, including outpatient care, hospital care, long-term care, and the outstanding specialized services that are the hallmark of the VA health system.

Second, the new eligibility criteria should identify and clearly define the population of patients to be served and should allow VA to concentrate its efforts on that population. In today's fiscal climate, this Congress may have to make difficult choices about what veterans to serve with VA's limited resources. However, determining a distinctly identified cohort of entitled patients will enhance VA's ability to balance its resources and capabilities with the needs of its constituents.

Third, and lastly, Congress's package of eligibility reforms should not distract VA from its efforts to create a more rational and effective system through which to deliver health care to its patient population. As set forth in our April testimony before the Subcommittee on Hospitals and Health Care, the AAMC supports the general principles underlying VA's

"Vision for Change," the VA reorganization plan submitted by Secretary Jesse Brown and Under Secretary for Health Kenneth Kizer. We believe that Dr. Kizer and his colleagues within the Veterans Health Administration should be given a full opportunity to implement their proposed reorganization, and we urge the Committee to allow VA to focus on reorganization without the additional burden of new missions or programs that might drain resources and talent away from the restructuring efforts.

As VA begins to put its reorganization plan into motion, the AAMC believes Congress should act on eligibility reform with all deliberate speed. Although it is not absolutely necessary to reform the eligibility criteria before the reorganization commences, a long delay in approving eligibility reform will hamper VA's efforts to deliver health care through its revamped delivery system. For instance, VA hopes to create incentives to provide cost-effective care by implementing a capitated health care system, under which VA would receive a fixed payment amount per person to cover all services, from outpatient care to specialized services, over a specific period of time. However, a capitated system requires that all enrollees receive the same basic benefit package in return for periodic payments that do not vary based on health status or income. Under the patchwork quilt of eligibility criteria that exists today, it would be difficult for the proposed Veterans Integrated Service Networks to settle on one fixed payment per person without one uniform benefits package.

Once again, the AAMC and its member institutions appreciate your willingness to tackle eligibility reform and look forward to working with you to disentangle the current eligibility criteria and create a system that encourages appropriate and efficacious medical care for our nation's veterans. However, eligibility reform is one of several strategies and changes in policy that are critical to the health of veterans and the future of VA. While it considers eligibility reform, the committee should also consider

- allowing VA to retain third-party collections, including Medicare payments, and thereby increase its funding base and reduce its reliance upon federal appropriations; and
- continuing to urge appropriators to provide adequate funding for VA medical care

and, in addition, VA health research, which supports the study of conditions that directly affect veterans and provides incentives for top physicians and scientists to choose VA careers; and

- allowing VA medical centers to treat non-veteran patients, as long as the high quality of care for eligible veterans is not compromised and VA is reimbursed properly for all care provided to non-veterans.

Thank you for allowing me to present the views of the Association of American Medical Colleges on reform of VA's eligibility standards. I would be pleased to answer your questions.



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Statement of

**Nurses Organization of Veterans Affairs
(NOVA)**

By

Lynna C. Smith, MN, RN, CS, ARNP

Before the

COMMITTEE ON VETERANS' AFFAIRS

On

Proposals to Reform the VA's Eligibility System

July 19, 1995

Mr. Chairman and Members of the House of Representative Veterans Affairs Committee, I am Lynna Smith, MN, RN, CS, ARNP, a Nurse Practitioner at the American Lake Division of the American Lake/Seattle Veterans Affairs Medical Center in Tacoma, Washington. As President of the Nurses Organization of Veterans Affairs (NOVA), I am testifying on behalf of NOVA, and I speak for the more than 40,000 VA professional nurses.

It is an honor and privilege for me to represent NOVA here today and testify on eligibility proposals for veterans health care. This testimony will focus on the effect eligibility regulation has on the health care of veterans and on the ability of VA nurses to provide quality health care. NOVA strongly supports the Veterans Health Administration (VHA) as an independent health care system providing a full range of services to all veterans. This care must be enhanced by education and research programs benefiting both veterans and the nation. The VHA functions in concert with major trends in the health care profession and reflects those changes in its care of veterans. NOVA believes that the VHA reorganization goals will transform the VA into a responsive, decentralized, customer-driven organization providing high quality, cost-effective, accessible service for ALL veterans. NOVA members are committed to providing quality health care for the veteran.

As the VA's veteran population is aging and represents a high percentage of complex, very ill patients, NOVA believes that the use of nurses as case managers to integrate, coordinate, and advocate for individuals requiring extensive services will decrease fragmentation of health care. It will also provide more holistic care for individuals with complex needs. NOVA supports research-based clinical practice that promotes standardized clinical practice and enhances the quality of care.

NOVA also believes that confusing eligibility regulations impede quality health care. Examples from VA nurses cite needless admissions to fit prosthetic appliances and difficulty getting prosthetic appliances following outpatient surgery, while readily available for inpatients. Another situation describes a veteran prepared for outpatient surgery when the staff received a call that the veteran was ineligible. The surgery was completed as planned, however, the

veteran received a bill. It is very frustrating for VA staff and for the veteran to understand the complex rules involving different levels of service connection, income levels and insurances, each with different eligibility rules for different health care settings. In a time of budgetary restraint, how can we justify the staff and providers time to sort out and document confusing eligibility regulations.

NOVA supports the Mission Commission statement that "...all veterans, once admitted to the VA health care system, should be accorded the full continuum of services, from preventive to long term care, including nursing home care." NOVA agrees with the authors of *Strategy 2000, Phase II: Meeting the Special Health Care Needs of America's Veterans* that, the "VA must be able to provide the same continuity of care, in the most appropriate setting, that an individual could receive in the private sector." We believe that empowering the VA Medical Centers to tailor programs to meet the needs of veterans in their catchment area is essential for effective health care.

PROPOSALS FOR ELIGIBILITY REFORM

The Independent Budget for Veterans Affairs Fiscal Year 1996 recommendations include:

- Core group or mandatory veterans must have access to the full continuum of care, from primary through long-term care.
- To succeed as more than a "safety-net" program within today's health care environment, VA must provide a continuum of medically necessary health care services for its clients.
- Those with catastrophic disability need to be included in the mandatory category for veterans' health care benefits.
- The VA needs to establish outpatient case-management programs for high-risk populations such as hypertensive, diabetic, chronically mentally ill or frail elderly patients.
- The VA needs increased capacity in its primary care, ambulatory surgical and long-term care programs, to ensure that VA can divert hospital inpatients into more cost-effective and appropriate venues of care.

NOVA agrees with the recommendations of *The Independent Budget* authors. VA nurses have shared examples of veterans with catastrophic disabilities, which may be helpful in understanding their health care needs. In the first situation, a 65 year old veteran retired from the Teamsters Union was admitted to a community hospital for bladder obstruction and prostate cancer. As the veteran was 65 years old, the Teamsters canceled his insurance and transferred him to Medicare. His therapy cost about \$ 30,000 of which he was responsible for \$6,000. On his retirement pay, this was not affordable, so he came to the VA for care and paid the co-pay of about \$ 1,200 and was able to receive treatment.

The second situation concerns a 70 year old veteran with a frontal sinus tumor, who was not treated by a community physician because he was "too old to do anything about the tumor." One year later he came to the VA because of pain; he required extreme surgical intervention resulting in the loss of an eye and his nose followed by radiation. A year later he is functioning well and is being fitted with an acceptable prosthetic device to make his appearance more "socially acceptable." The VA nurses comments are that the VA values all people and treats the person, not the age.

The third situation is an 81 year old veteran in good health, who had a successful prostate procedure in a community hospital. Following surgery, his blood pressure increased, and he was treated aggressively and subsequently suffered a severe stroke. Through Medicare, he was given two weeks of rehabilitation. Unfortunately, he suffered an aspiration pneumonia, and when he recovered was told the rehabilitation coverage was gone. He was placed in a nursing home at \$3,200 monthly, where he was fed through a tube and, there was no rehabilitation available. The family had to consider another placement because within two years his life's savings would be used up and his wife would have nothing to live on. He had also developed severe stasis ulcers (bed sores). His family was able to transfer him to a state/VA run Soldiers Home where the care was excellent, and he learned to swallow. The cost was his Social Security income of \$1,300 monthly and his wife was able to live independently. He subsequently passed away due to infection complications of the stasis ulcers. These three

situations show the VA "Putting the Veteran First." In each of these situations the veteran participated financially in his care, but there are veterans who are not able to do so.

H.R. 1385 The Veterans Health Care Reform Act of 1995

NOVA agrees with the direction of expanding the capacity of the Department of Veterans Affairs to provide outpatient care and to decrease duplication of services within service-delivery areas established by the Secretary.

NOVA applauds the inclusion of preventive health services, prosthetic appliances and home care to the health care included with outpatient services. NOVA also applauds the provision for specialized treatment and rehabilitative needs of disabled veterans.

NOVA believes that any veteran with a service connected disability should be included in the core group. We also believe that the percentage of the amount of the recoveries and collections to be made available to the medical centers, or networks of medical centers, at which such recoveries have been at above average levels should be increased to at least 50 percent. Consideration of Medicare reimbursement should again be discussed. Veterans in the Tri Care Program tell us that the Department of Defense (DOD) bills the HMO for services and medical visits, the HMO bills Medicare and then reimburses the DOD. One veteran suggests that the VA follow this same procedure. This process produces an extra administrative layer and needs careful consideration.

**Draft Legislation to Reform the Eligibility and Delivery of Health Care within the
Veterans Health Administration, as of July 11, 1995**

The delivery of care to veterans based on clinical or treatment need is crucial and commendable in defining delivery of health care. The eligibility change paragraph remains confusing and complex. The two times the pension amount cited is much less than the income currently used for the means test, and NOVA could not support this change. The change in prosthetics

services, devices, and appliances is commendable, however NOVA recommends removing the hospitalization requirement for all core veterans.

The Medical Advisory Commission is interesting. NOVA recommends nursing representation on the Commission. The Nursing Home Care recommendations are excellent. However with the veteran population aging, NOVA recommends letting the individual VA Medical Centers adjust to the needs of the veterans in their catchment area.

The Pilot Programs - Before instituting new programs, evaluation of the current rural clinics and mobile clinics is recommended. Veterans who live at a great distance from the VA may have community physicians but are unable to afford the cost of medications. Many veterans have multiple health care problems and medications may cost \$200 to \$300 or more monthly, and on an income of \$800 to \$900 monthly is prohibitive, so they travel to the VA. The **National Survey of Veterans** showed that cost and unique therapy were major reasons for choosing VA health care services.

Reimbursement - The current collections program is working very well with a steady growth in collections over time. Contracting out these services may precipitate a delay in the program. Following the pilot, should we wish to bring the program in house again, the personnel would be gone, requiring start up delays again. The other recommendations are commendable.

Women's Health Care - NOVA is very interested in these programs and would be pleased to discuss these services with the Committee.

Mr. Chairman, NOVA is pleased to have your leadership and skill in our mutual effort to ensure quality health care for Veterans. We would like to thank you for the opportunity to share with you VA nurses' concerns on VA eligibility reform. We thank you for the Committee's ongoing support of nursing and pledge to continue to work with your Committee and Congress in serving our Nation's veterans.

To quote Mr. Montgomery's Memorial Day 1995 letter, "We have asked much of our fighting men and women. Remembering what Memorial Day is for, and what gives it meaning is how each one of us remembers the great sacrifices which have made possible the blessings we share as Americans today." VA nurses are committed to the VA mission of providing quality, efficient and effective health care.

STATEMENT

BY

CHIEF MASTER SERGEANT JAMES D. STATON, USAF (RET.)

EXECUTIVE DIRECTOR

AIR FORCE SERGEANTS ASSOCIATION

Mr. Chairman and distinguished committee members, the 160,000 members of the Air Force Sergeants Association are grateful for the attention being placed on reforming the Department of Veterans Affairs' (VA) health care delivery system by both yourselves and the VA. We are hopeful that improved services for our nation's veterans will be the outcome of these efforts. AFSA represents the millions of active duty and retired enlisted Air Force, Air Force Reserve and Air National Guard members, and their families.

As we have noted in earlier testimony to this committee, we are hopeful that the proposed reforms will lead to an increase in the use of outpatient care as opposed to the current reliance on inpatient, hospital care. It appears that the reforms being proposed by this committee would codify this through law, helping to ensure that the Veterans Health Administration (VHA) follows through on its promise of reform. The definition of "core-group veterans" mostly satisfies the criteria for providing care to most of those who have earned it as a result of their service to this nation.

We recognize that the ever-increasing costs of health care mean that non-traditional forms of delivery are needed in order to have the resources to care for our nations' veterans. Managed care is being touted by many as a way to save important dollars. We support the pilot proposal to contract out care, in three separate regions, for eligible core-group veterans who live at least 75 miles away from a VA medical center. We are satisfied that, under the proposal, they would be offered some type of choice regarding their provider at no cost to themselves. This may satisfy the concerns of many that budget-cutting could result in the construction of fewer VA hospitals and a continued difficulty of access. This association also appreciates that this would be a very limited proposal, limiting a future Congress' ability to diminish government involvement in veterans' health care. Important, too, is that veterans' eligibility to receive specialized services from the VA for spinal cord injury, blind rehabilitation services, prosthetics, chronic hospital-based mental health services rehabilitation services and nursing home care would remain.

However, we continue to express concern that the VA's health facilities not be opened to non-eligibles until all eligible veterans are receiving treatment through the VA's facilities. There is language in your proposal that would allow the VA to participate in Medicaid-reform pilot programs in three states and be reimbursed for it. Even with language stating that while administering this program at test sites, " ... the Secretary shall ensure that veterans receive priority for health care at the medical center and that the relative priorities of veterans for health care is maintained," and that the only services that may be provided at each center are those that " ... the Secretary determines are underused at that medical center," we are leery of the apparent lack of controls regarding this proposal.

What is to be the basis for judging whether or not veterans are receiving priority treatment? The proposed decentralization of the VHA into separate Veterans Integrated Service Networks in order to give greater autonomy to those in the field could also lead to a lessened ability to provide effective oversight of medical centers and hospitals. While

(more)

we understand that this program is designed to study whether or not this could be a funding source that can put valuable dollars back into individual hospital budgets, we are concerned about the quality of the oversight contained in this particular proposal. This committee must ensure that the budget considerations of local administrators do not interfere with our obligations to our bravest patriots.

Finally, the proposal to change the eligibility for inpatient care for veterans with service-connected conditions rated 10 to 20 percent from mandatory to space available and discretionary is wrong. These individuals should never be denied care because they happen to be lucky enough to escape more serious injury for their service. If they received their injuries because of service to their country, then they are owed a guarantee of care for their injury.

Mr. Chairman, we do not doubt your commitment to our veterans. We support your efforts to restructure veterans health programs so that dollars are spent in the wisest possible way, in order to provide the most and best care possible. We endorse the plan to deliver increased care on an outpatient basis. We also support the pilot proposal to contract out for care in areas where veterans have difficulty in receiving service. We cannot, however, support the test proposal to open the VHA to non-veterans unless there is assured oversight to ensure that veterans will, in fact, receive priority care and that only those services that are truly underused will be opened up. However, we do believe that as a draft effort, this is a good step towards restructuring the VA so that more veterans are served in better ways. As always, Mr. Chairman, AFSA is ready to support you on matters of mutual concern.



Statement of Dr. Samuel V. Spagnolo, President, National Association of VA Physicians and Dentists

On behalf of the National Association of VA Physicians and Dentists (NAVAPD), I am pleased to submit this written testimony for the record with respect to reforming the Department of Veterans' Affairs eligibility standards for the delivery of health care to our nation's veterans.

NAVAPD represents approximately 15,000 doctors in the VA system. We commend the Committee for addressing the issue of eligibility reform, which we believe is one of the most important, albeit difficult, issues facing the VA today. The VA has struggled to function for many years under eligibility criteria that are outdated, highly complex, inequitable and outrageously inefficient.

For doctors, who must administer these complex regulations and provide quality medical care to veterans, the eligibility labyrinth has been a source of constant frustration that the system can be so irrational and, at times, unfair.

NAVAPD wholeheartedly agrees with Dr. Kenneth Kizer, VA Under Secretary for Health, when he stated in his testimony before this Committee that "the ability of most veteran patients to receive adequate healthcare through the VA is a testament to the tenacity and perseverance of both the veterans seeking care and the healthcare professionals who provide that care."

NAVAPD welcomes the opportunity to comment on the various eligibility proposals before this Committee. However, before addressing the specifics of each proposal, we would like to emphasize what eligibility reform must NOT do.

First, eligibility reform must not prevent doctors from making proper clinical decisions on how to treat patients. Doctors must be able to provide eligible veterans with a full continuum of care in the most appropriate treatment venue. This includes making clinical decisions on whether to treat a patient on an inpatient or outpatient basis or whether to provide nursing home care. Once Congress clearly determines the population of patients to be served by the VA, then it must allow doctors to provide the best quality care for that population, without onerous restrictions. NAVAPD recognizes that identifying a segment of the Veteran population is difficult, but simply and clearly stating eligibility criteria will greatly enhance the delivery of quality care to patients.

Second, eligibility reform must not jeopardize access to quality specialized programs. The VA has a unique role of providing specialized care in such areas as prosthetics and orthotics, spinal cord dysfunction, cardiac surgery, organ transplantations, cancer treatments, post traumatic stress disorder and Persian Gulf Syndrome. All eligible veterans should have access to quality specialized services as determined

necessary by their physicians. NAVAPD shares the concern of David Baine of the General Accounting Office, as he outlined in his testimony before this Committee:

Eligibility reform could significantly increase demand for VA health care services, putting pressure on the Congress to increase VA appropriations and on VA to develop rationing policies that would ensure that limited resources are directed toward those veterans with the highest priority for care and the greatest need....VA would need to ensure that funds needed to provide specialized services, such as treatment for spinal cord injuries, not available through other programs are not diverted to pay for outpatient services for veterans who could get those services through other programs.

To guard against erosion of VA specialized services through eligibility reform, NAVAPD joins the Paralyzed Veterans of America and the Vietnam Veterans of America in asking the Committee to include legislative language that would ensure eligible veterans get the appropriate specialized services they need, without restriction, interruption or inconvenience.

The Administration's Proposal

NAVAPD has not obtained a copy of the Administration's proposal on eligibility reform, but based upon Dr. Kizer's testimony on the proposal before this Committee, we offer the following comments.

NAVAPD generally supports the broad outline of the Administration's proposal as described by Dr. Kizer. The proposal would simplify eligibility criteria to some degree and would eliminate the current restrictions governing access to outpatient care and general preventative treatment.

However, the proposal stops short of providing a full continuum of care to eligible veterans. The VA proposal provides that a specified core group of veterans (referred to commonly as category A veterans) would receive "healthcare," including hospital care, outpatient care, disease prevention services, pharmaceuticals, medical equipment, and prosthetic equipment and devices. The VA would retain the authority to provide core group veterans with other types of healthcare, including nursing home care, as resources allow, but would not guarantee these veterans access to other types of healthcare.

NAVAPD is sensitive to the VA's concern to retain the flexibility needed to contain costs. However, we also believe that the quality of medical care provided to eligible veterans is impacted significantly by restricting access to the full spectrum of health care services. We ask the VA to

reconsider its decision and to provide all eligible veterans with a full continuum of care.

Committee Staff Draft Summary

The Committee's proposal contains several elements which NAVAPD can support. We applaud the establishment of a "new treatment priority," whereby VA physicians are allowed to treat eligible veterans on the basis of clinical need, removing any restrictions on access to outpatient care. We are pleased to see a provision giving eligible veterans needed prosthetic services, devices and appliances, without regard to service connection. We also support the provision authorizing core group women veterans to receive preventative and wellness services.

However, we are concerned that the Committee's draft does not simplify eligibility standards, but instead adds yet another layer of complexity. New eligibility criteria should clearly define the population to be served, and then provide that population with a full continuum of health services.

NAVAPD is also concerned with the draft provision which mandates that the VA administer the VHA through the use of "managed care." As we have testified previously before this committee's Subcommittee on Hospitals and Health Care (May 11, 1995 Hearing on VHA Reorganization), NAVAPD recommends that the VA proceed with caution as it moves towards a managed care system, taking care to consult with and directly involve doctors and other stakeholders in the restructuring.

We agree with the testimony of the Paralyzed Veterans of America that "there are 'good managed care systems' and 'bad managed care systems.'" Bad managed care will adversely affect the quality of care delivered to veterans, especially in specialized services. We believe that the VHA under its new reorganization plan has the authority under current law to proceed with the implementation of managed care in an orderly, cautious manner. We would recommend, therefore, that the committee eliminate from its draft the mandatory provision for managed care of the system.

Finally, we would like to briefly comment on the Committee's draft provision for the establishment of an Advisory Committee on Appropriate Medical Practices. This committee would review resource allocation methodologies of the VHA and make recommendations on matters that directly affect how health care is delivered to veterans. Although NAVAPD generally is opposed to more centralization of the system, we would support this committee as a way to ensure that doctors and other stakeholders are directly involved in the VHA's new reorganization. We recognize that the new VISN structure envisions regular input from all stakeholders within each VISN; however, the effectiveness of this input will vary among VISN directors. This committee would be one way of

providing a check on the system to make sure the views of stakeholders are taken into consideration when decisions are made. Another benefit of such a committee would be to eliminate any discrepancies that may exist in the development of practice perimeters and health care guidelines among the various VISNS.

H.R. 1385

The bill authored by Congressmen Edwards and Montgomery resembles many aspects of the Administration's proposal. As with the Administration's proposal, NAVAPD fully supports removing all obstacles that now exist for the delivery of outpatient care. NAVAPD also strongly supports the language included in the bill ensuring that the VA maintains its capacity to provide for specialized treatment and rehabilitative needs of disabled veterans.

However, the bill specifies that eligibility reform would expire in three years. We agree with the Administration that there is no need for making eligibility reform time limited.

The Independent Budget

NAVAPD has not yet reviewed the details of the Independent Budget, authored by PVA, AMVETS, Disabled American Veterans and the Veterans of Foreign Wars. However, it appears from a review of their testimony before this Committee that their proposal is similar to the Administration's proposal. We reserve judgment on the proposal until we have had time to review it.

Summary

We thank the Committee for the opportunity to comment on eligibility reform, and we encourage the Committee to move expeditiously on legislation this year. We believe eligibility reform is an essential ingredient in any VHA reorganization. A long delay in implementing eligibility reform will unnecessarily hamper the VA's attempt at reorganization.

Eligibility reform is a complex and daunting task. We again commend the Committee for taking on this issue. As always, NAVAPD stands ready to answer any questions about its position and to work with the VA and Congress at any time.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

QUESTIONS FOR THE RECORD
FROM CHAIRMAN STUMP
FOR
DR. KIZER
UNDER SECRETARY FOR HEALTHCommittee on Veterans' Affairs
Hearing on July 19, 1995

Question 1: Within the context of Eligibility Reform, should there be an effort to define a standard benefits package to control costs for nonservice-connected care? At the present time, a nonservice-connected veteran could be eligible for many more services than a service-connected veteran just by virtue of the fact that he or she is poor.

Answer: The Administration's Eligibility Reform proposal in effect defines the services for which veterans are eligible. Further, it would remove the distinctions presently in law that created the circumstance your question describes and under which certain poor nonservice-connected veterans can have broader eligibility for outpatient care than veterans with service-connected disabilities rated 20 percent or less disabling. Having said this, though, the concept of a standard benefits package is something which we may want to further explore.

Question 2: Understanding that the Independent Budget which is predicated upon the VA's ability to attract large numbers of higher income veterans and their insured dependents to the system, in your opinion, is it possible to enroll this group without substantial capital for facilities improvements?

Answer: Currently, and for the foreseeable future, our primary focus is on our currently served population. As evidenced by our Eligibility Reform proposal, we first want to ensure that we are providing quality, compassionate, and cost-effective care to our current users--the service-connected and lower-income veterans (and certain other "special groups" included in Category A). By constraining our service delivery reform efforts to these veterans, for now, we expect to be able to accomplish a substantive expansion of our ambulatory care services and improve access to primary and preventive care in a budget neutral fashion. It is our expectation that with Eligibility Reform VHA will reduce its costs by shifting some inpatient care to less costly settings. The resources that are made available by these shifts will be used to cover the costs of expanded outpatient care, including necessary infrastructure costs.

However, the Independent Budget contemplates the delivery of services to higher-income veterans and dependents if the Secretary determines that VA has the resources and space to treat them. It says that expanded access for this new population can be achieved by leasing, sharing, and contracting out. Under these circumstances, we don't envision enrolling this group if facility improvements (or other needs) are needed and the necessary capital is unavailable. Essential to this process would be gaining expanded sharing authority.

**Committee on Veterans' Affairs
Hearing on July 19, 1995
Followup Questions for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health
from Honorable G.V. (Sonny) Montgomery
Ranking Minority Member**

Question 1: In his testimony, Mr. David Baine of the General Accounting Office discussed a proposal "to increase cost sharing for nursing home care--a discretionary benefit for all veterans--either through increased copayments or state recoveries." In that connection, please respond to the following as related to the question of copayments:

a. It is our understanding that veterans who elect to apply for nursing home care in State homes are subject to cost-sharing requirements in most states. What information do you have regarding the pattern among States of charging veterans for part of the cost of their care?

Answer: Prior to your asking this question, I did not know that the VA does not routinely request information from State homes regarding their policies for charging veterans for part of the cost of their care since establishment of such policies is a State decision. VA has authority solely to verify that VA per diem payments made to each State home are at the rate established annually by the Secretary and approved by the Congress and the President and that the payments do not exceed one-half of the total cost of care for veterans. However, because of prior questions regarding how State homes charge veterans, we did informally ask for information from a small sample of State homes. Based on information from four State homes, the only trends noted were that charges varied for veterans dependent on his/her ability to pay, whether the veteran had dependents, other deductions such as third party offsets including VA per diem payments and those specified by the State. In addition, the veteran was provided a monthly personal needs allowance specified as \$90 by three of the four State homes. Your query prompts me to pursue the matter further, and I hope to conduct a more thorough survey in this regard in the months ahead.

b. Please provide any data you have on lengths of stay and level(s) of nursing home care provided in State homes.

Answer: The average length of stay in State veterans nursing homes in FY 1994 was 222.1 days. Days of care are limited to that fiscal year.

State veteran nursing homes provide a number of levels of care ranging from long-term management of residents with reduced physical functioning, to restorative rehabilitation. Some homes have established special care programs to care for persons with Alzheimer's disease or other types of dementia.

c. Please inform us regarding the level(s) of care, and average lengths of stay in VA nursing homes, and comparable data on VA-supported care in contract nursing homes.

Answer: Both the VA Nursing Home (VANH) and the Community Nursing Home (CNH) Programs provide all levels of nursing home care. These levels include: rehabilitation; special care needs, such as parental feeding; clinically complex care; behavioral management and reduced physical functioning.

The average length of stay in VANHs was 156.2 days in FY 1994 and 110.2 days in CNHs. Days of care are limited to that fiscal year in both programs.

d. What was VA's average per diem cost, and range of such per diem costs, of providing skilled nursing home care?

Answer: In FY 1994 the average per diem cost in VANHs was \$207.20 and \$106.29 for CNHs. The range of costs were \$128.90 to \$329.91 for VANHs and \$66.86 to \$299.31 in CNHs. In citing these numbers, though, one must understand that the average per diem cost for VANH beds is artificially inflated since the most VA nursing homes are physically a part of an acute care hospital and in computing the per diem cost various fixed overhead costs are included in the rate that would not apply for a freestanding nursing home. Likewise, the acuity of patients in VANHs tends to be considerably higher than in community nursing homes. Indeed, VA's low acuity patients are the ones that are generally sent to community facilities. VA hospitals and nursing homes often find it impossible to place patients in community nursing homes because of their higher acuity (i.e., more complicated/more difficult conditions). Finally, in comparing these rates one must remember that VA generally provides rehabilitative services to all of its patients and these charges are not typically included in the quoted community nursing home rates since these services are only provided for selected patients, and then there is an additional charge for it.

e. In your testimony you expressed opposition to a proposal to cap the number of VA-operated nursing home beds. According to an IG report of March 31, 1995, assessing the VHA's Nursing Home Care Program, "VHA plans to provide institutional home care each day to about 48,000 veterans by 2000, and about 63,000 by 2010, as compared to 32,400 veterans a day in 1993." Does that statement accurately reflect current VHA plans; under those plans, what number of veterans would receive care in VA, State home and community nursing home beds, respectively? To realize those plans for provision of VA nursing home care, approximately what is the total cost of major construction funding VA would need; what number of projects and costs are associated with planned new or replacement construction and what number of projects and cost with planned renovation and environmental improvement projects?

Answer: The statement regarding the number of veterans to be cared for in nursing homes noted above represents the projections of total nursing home need produced by VHA's nursing home planning model, and they include VA-owned and operated, as well as community and state home nursing home census. The planning model projects the number of nursing home census that VHA can expect to need based on current utilization rates applied to the projected veteran population. VHA has operated under the policy of supporting a 16 percent market share for nursing home beds, with a program mix of 30 percent VA, 40 percent community, and 30 percent state. The numbers noted above are the entire 16 percent market share, which must be further broken down into the program mix. The projected census need for 2005 is 57,644, of which 30 percent, or 17,293, would be VA-owned and operated. As of the end of FY 1994, VA had 14,892 average operating nursing home beds with an average daily census of 14,147. A need for an additional 3,100 VA census capacity is projected for 2005, the current planning horizon. Projects included in the last 5-year plan for the FY 1997 budget cycle identified plans for about 3,400 new and replacement nursing home beds at a cost of about \$326 million.

We are currently reviewing the model and assessing evidence regarding the extent of the need for long-term care, the availability of community nursing home beds, and the appropriate mix of institutional and non-institutional care. Before any projects proceed, the need will be revalidated.

f. Please provide data comparable to that requested in the preceding question regarding VHA's capacities, plans and costs for providing non-institutional long-term care and health-related services in 2000 and 2010.

Answer: VHA is in the process of developing and implementing an integrated planning model for institutional and home and community-based long-term care. Previous planning efforts have tended to overlook community-based long-term care services. Estimates of need for services have not been forecast. This planning process is expected to be completed in FY 1996.

QUESTIONS FOR THE RECORD
FROM HONORABLE TIM HUTCHINSON, CHAIRMAN,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
FOR
DR. KIZER
UNDER SECRETARY FOR HEALTH

Committee On Veterans' Affairs
Hearing On July 19, 1995

Question 1: Dr. Kizer, I would like to commend you, during your rather brief tenure as Under Secretary for Health, for your willingness to tackle some of the most difficult issues facing veterans health care. Although the proposal that you present is in draft form and presumably a working document, I have some specific questions concerning the ease of its implementation. Under the liberalized treatment definition to furnish care and treatment in the most appropriate setting, how can you ensure that the service-connected will receive priority care? As I mentioned in my opening statement, I have direct knowledge of service-connected veterans who have been subject to what can only be called rationing and a skewed priority system that appears to benefit nonservice-connected veterans. What guarantees can you offer these veterans?

Answer: Guarantees are difficult, but all veterans have my firm commitment that the intent of reforming eligibility criteria is to enable rational management of our health care delivery and our resources and to ensure that we consistently provide quality patient care services to our eligible population of veterans.

The "skewed priority system" to which you refer is precisely what we are trying to change through our Eligibility Reform proposal. For the most part, in our "reformed" VA, once a veteran is determined to be "eligible" for VA health care services, he/she will be treated based on a medical assessment of his/her condition. That is rational delivery of health care.

Further, our Eligibility Reform proposal provides that if necessitated by resource limitations, the Secretary will be authorized to prioritize service delivery among eligible veterans. The priorities we propose would give higher priority to service-connected veterans over any nonservice-connected veterans.

Question 2: Looking at the Independent Budget Proposal and its projected savings of \$2 billion, could you please comment on the validity of the proposed savings and the methodology used to develop the cost estimates?

Answer: Although we have not been informed about the specific methodology used in the Independent Budget (IB) (and I have asked), we understand that it is expected that the proposed savings would be generated principally by redirecting a percentage of our inpatient workload to other less costly settings. The IB references research findings that suggest significant percentages of VA's inpatients are "non-acute" and could be more appropriately treated in other settings. Further, the IB suggests that as many as 300,000 inpatients could be diverted to outpatient and long-term care settings over a two-year period.

We agree with the IB's basic premise; however, the shift from inpatient care anticipated by the IB is outdated and appears substantially inflated at this time. We believe

that Eligibility Reform will assist VA in achieving greater efficiencies through the effective management of the care of the patient population. As a result of the application of a variety of modern health care management practices, in combination with the removal of the current statutory barriers to providing national care, VA also expects that there will be a shift in workload from inpatient to outpatient (predominantly). In our analysis, we are prospectively estimating that approximately 5 percent of VA inpatient workload will be shifted to outpatient care in the first year after enacting eligibility reform and an additional 15 percent will be shifted in the second year. Taking a number of other factors into account, we conservatively estimate that VHA could have approximately \$228 million available for reinvestment as a result of the inpatient to outpatient shift.

Question 3: Eligibility Reform has been the concern of all those who are in any way connected to VA health care. Realizing that your proposal seeks to reach this goal by allowing VA to determine the appropriate venue for the delivery of health care, could you comment on an approach that would define eligibility by exposure to combat or hostile fire instead of by income?

Answer: The Secretary of Veterans Affairs has spoken quite clearly on this subject. He has noted that suggestions that infer some qualitative or value differences among veterans based on the venue in which they provided service to their nation inappropriately trivialize and demean the contributions made. He believes, as does this Administration and the vast majority of Americans, that the government created our veterans, asked them to give up everything--homes, families, jobs, school--to stand vigil over freedom and democracy. As they entered military service, these individuals were not asked to make their sacrifices based on a degree of danger or a preferred location. Having asked for these sacrifices and created these veterans, the government, in turn, created an obligation to repay veterans for their sacrifices. Therefore, we do not support any proposal that relates a veteran's eligibility for his/her earned benefits to the venue of service or whether they were lucky or unlucky enough, as the case may be, to have been wounded in combat.

Committee on Veterans' Affairs
Hearing on July 19, 1995
Followup Questions for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health
from Honorable Chet Edwards
Ranking Minority Member
Subcommittee on Hospitals and Health Care

Question 1: VA's draft bill would authorize provision of residential care for up to 90 days on a post-hospital care basis to those without resources to cover such care. Would you please explain the rationale for that provision? Why not authorize VA to provide such care through its own facilities rather than through contracts?

Answer: The authority to provide residential care, in lieu of more costly inpatient hospital care, ensures that veterans will be provided needed post-hospital care in the most cost-effective settings. Often veterans have traveled some distance for inpatient treatment at a tertiary care facility and their recuperation would be compromised by immediately undertaking return travel. Some veterans lack the family support system that might otherwise be able to provide the needed post-hospital care. Proper recuperation from acute medical/surgical interventions is important to the lasting effectiveness of the intervention and in the longer term to the prevention of repeat episodes of the acute need. In considering this you must remember that residential care would be provided as an option to inpatient acute care.

Question 2: Last year VA recovered more than \$500 million in medical care costs through aggressive collection efforts (up from \$105 mil. in '88 and from \$267 mil. in '91). Yet it's proposed that VA should contract out that activity in a number of geographic areas. Are there activities that would make sense for VA to contract out, and, if so, is this one of them? If not, why not?

Answer:

1) VA is currently conducting an analysis to determine if contracting out the Medical Care Cost Recovery (MCCR) program's billing and recovery functions at VA Medical Centers would be beneficial to the Department. We believe it is unlikely, however, that contracting out MCCR's activities will increase the revenues the program deposits in the U.S. Treasury, especially if done in random, geographic areas. Preliminary estimates show that contracting out these activities would result in additional costs, loss of MCCR's value-added benefits and loss of revenue.

A) Excessive Cost

- The General Services Administration (GSA) has awarded contracts for health care cost recovery services. The pricing structure awarded by GSA for services similar to MCCR activities requires payment in excess of current MCCR costs. While total MCCR costs amount to 18 cents for every dollar collected, the actual cost of collection that is equivalent to the activities that contractors perform is under 3 cents for each dollar collected. In the most successful VA facilities, it is estimated that the contractor costs would be more than double what MCCR

expends. The result would be a higher operating budget and *lower returns to the Treasury.*

- In the GSA contracts, the most comprehensive activity offered, the "turnkey" activity, encompasses the entire range of billing and collection functions provided by the private sector. However, the identification, billing and collection activities currently performed by MCCR are not included in these "turnkey" activities. Not only would VA be forced to pay additional compensation for the services received, MCCR would still be required to maintain FTE and resources in the medical centers to perform functions not covered by the contractor. The attached provides a comparison between the functions that are performed by a "turnkey" contractor and those functions remaining in MCCR.

B) Loss of MCCR's Value-Added Benefits

- Should contract costs exceed available operating budget boundaries, MCCR will have to reduce its value-added investments in VHA to cover these additional expenses. These investments include: data capture, equipment, financial systems development, and training for support personnel.
- Many highly specialized positions, such as Utilization Review nurses, are currently funded by MCCR. These positions may be shifted back to the medical care appropriation, requiring an increase in personnel costs.
- If first party collections are also contracted out, there is the risk that the veteran may be treated with less sensitivity. The contractor will want to maximize collections and may be less sensitive to issues such as hardship and waiver consideration.

C) Loss of Revenue

- Should the contractor fail to match MCCR's success, VA's returns to Treasury would be decreased.
- Should the contractor fail to completely satisfy VA's needs, there would be additional costs incurred in reimplementing the MCCR program at the facility or facilities where the activities were contracted out.
- During reimplementation there is the risk of reduced recoveries.
- There is a risk of incurring additional expenses to connect contractor computer systems with VA computer systems.

2) There are many unique aspects to VA's recovery of funds which would hinder a comprehensive contracting effort.

- Insurance identification poses a special problem to VA. There are no economic incentives for the veteran to disclose insurance information to VA. Eligibility for VA medical care is not affected by insurance coverage, and VA patients are not billed on the basis of their insurance coverage. Private sector hospitals bill the patients for uncovered charges making providing insurance information a high priority for the patient.
- The MCCR process is much more than just billing and collection activities. It includes a number of identification activities unique to VA. These activities include items such as determining service-connection, processing copayment exemptions, capturing clinical data and the extra activities associated with insurance identification.
- VA also performs **all** identification, billing and collection functions associated with a patient encounter. In the private sector, these costs are split between medical centers and the providers' (physicians') offices. For example, in the private sector, a physician's office would have already identified a patient's billable insurance coverage prior to admission to a medical center.
- VA is prohibited from billing Medicare. Based on FY 1993 and FY 1994 data, we have determined that about 60 percent of the individual billings are for patients over 65 years of age. These are Medicare eligible patients and, if they have insurance, it is almost always a Medicare supplemental policy which only covers those costs not covered by Medicare (20 percent). This severely reduces the ratio of amount collected versus amount charged.
- VA does not hold veterans responsible for insurance carrier copayments and deductibles, again eliminating a source of revenue which would increase our cost-to-collection ratio.

3) MCCR *has* initiated contracts for activities where the program has exhibited a need for outside services. GSA negotiated national vendor contracts for certain health care cost recovery services. The contracts provide users the option of contracting for selected services, or for the entire range of billing and collection functions provided by the private sector (this latter is called the "turnkey" function). In FY 1995, MCCR has chosen to use the GSA contracts in the following manner:

- MCCR began pilot testing an unfunded initiative to increase insurance identification. This GSA contract allows MCCR to pull names and other unique identifiers from VA data bases and have them matched with a contractor's data base containing insurance information. We are pursuing this avenue in an attempt to increase the number of identifiable cases of billable treatment.
- MCCR has obtained Advisory and Assistance services to: conduct an analysis of MCCR's costs incurred versus amounts collected; provide alternative organizational structures for MCCR field-based activities; develop performance measurements; and conduct a cost/benefit analysis of MCCR's scanning efforts.
- MCCR is analyzing the possibility of using the "turnkey" activity at certain facilities.

Question 3: It's been proposed that title 38 be amended to require VA to administer care through the practice of "managed care." [As proposed that term is not defined.] In your view, is such legislation either needed or desirable?

Answer: As a general rule, it is my view that legislating specific practices in health care delivery is not a good idea. Even presuming that agreement could be reached on a definition of the term, it is apparent from the Medicare debate that "the jury is still out" with respect to the desirability of such a requirement, particularly for an aging, chronically ill population (such as both the Medicare and veteran populations). Further, it is significant to note that VA traditionally provides services that are as yet not typically provided--to the extent provided by VA--by managed care entities, e.g., extended residential substance abuse care.

Question 4: Would the enactment of an Eligibility Reform measure such as you have proposed result in a decrease in costs of hospital care? Please explain.

Answer: To the extent that we are talking about our current population of users, the answer is, generally, yes. This presumes that we are comparing total inpatient costs today to total inpatient costs "tomorrow" for our current population of veteran users. However, since many of the inpatient episodes that we expect will be shifted to other patient care settings as a result of eligibility reform are the "less severe" and represent the shorter lengths of stay, the severity of the remaining inpatient workload and the intensity of care for those inpatients can be expected to be heightened on average. Therefore, this may result in an increase in the average cost per episode of inpatient care.

Question 5: Would you please describe the VA's estimate of the costs associated with providing care under your proposed

Eligibility Reform measure, and the basis of that estimate? In that regard would you share with us any studies which provide support for your estimate?

Answer: I have attached a table entitled "Estimating Eligibility Reform" which details the formula we applied to attempt to estimate the projected effect of Eligibility Reform. In applying this formula we made a number of estimates which are explained on the table. But, it is most important to note that the two most significant assumptions are the number of admissions that might be shifted to outpatient care and the relationship made between the shifted inpatient episode and the resulting increase in outpatient care. For purposes of this estimate, we assumed that a two year total shift of 20 percent of inpatient workload is reasonable. This estimate has some basis in research findings and reported private sector experiences. Although some VA-specific research has suggested the potential of substantially larger shifts, we believe that a conservative estimate is more reasonable. Further, we assumed that outpatient care will increase by 70 percent of the average cost of the shifted inpatient admissions. At present, we are not aware of a research-based correlation that can be made between the shifted admissions and the resulting outpatient visits.

We have included with these response copies of three studies which we found pertinent to our estimating efforts:

- Wickizer, T, Wheeler J, and Feldstein, P. *Does Utilization Review Reduce Unnecessary Hospital Care and Contain Costs?* Medical Care 1989; 27:6.
- Booth, B, Ludke, R, Wakefield, D, et al. *Nonacute Days of Care Within Department of Veterans Affairs Medical Centers.* Medical Care 1991; 29 (suppl.):8.
- Smith, C, Williamson, J, Goldman, R, et al. *Pilot Study of the ISD* Measurement of Appropriateness of Bed Utilization.* Final report submitted to HSR&D Service Department of Veterans Affairs. Washington, DC: June 1993.

Question 6: Your eligibility proposal would change the "means test" criteria for determining veterans' eligibility for care. Those changes would appear to simplify the process. Would they also enable you to reduce the number of Medical Administration Service staff, and, if so, by how many FTEE?

Answer: Our proposal to change the means test criteria is still under review within the Administration and we plan to submit a proposal for means test reform in the near future, but not as part of our REGO legislation.

Question 7: How would the means-testing process change under your proposal? What is the rationale for changing to a "taxable income" test?

Answer: As discussed in the previous question, our proposal to change the means test criteria is still under review within the Administration and we plan to submit a proposal for means test reform in the near future, but not as part of our REGO legislation.

Question 8: Could you describe the benefits you see from the proposal in your bill to broaden VA's sharing authority? What would it allow you to do you can't now do?

Answer: The broadening of VA's sharing authority to permit sharing with most health care entities is critical to VA's efforts to restructure how health care is delivered, to establish integrated systems of care, to improve access and to achieve the efficiencies of modern health care management techniques. This authority will permit VHA to establish appropriate contractual linkages and foster cooperation among the partners predicated on their shared values and vision. For example, the new authority will permit VA to share with health plans in addition to providers. Sharing arrangements such as these will allow improved service with low capital and fixed cost. Linkages based on information sharing will be used instead of "bricks & mortar."

Question 9: You consider your Eligibility Reform proposal to be budget neutral. Would you explain how you achieve that? Is it based on a shift of workload from inpatient to outpatient care?

Answer: The attached table referred to in the answer to question #5 depicts the basis for our position that we can achieve Eligibility Reform on a budget neutral basis. As indicated above, it is largely based on a shift of workload from inpatient to outpatient care.

Question 10: Does the VA health care system have the outpatient care capacity to make the "shift" from inpatient to outpatient care assumed in your draft bill? Does that "shift" mean large-scale closures of hospital wards?

Answer: With some adjustments, we believe that the VA system does have the outpatient care capacity to make the discussed shift. While we can anticipate that some hospital wards will no longer be needed for inpatient care, we would expect that they could readily be converted to accommodate outpatient services.

Comparison of Activities Included in MCCR Cost of Operations and A Third Party Collection Contractor Operation

MCCR is required to fund ALL activities involved in the identification, billing and collection of recoveries from copayments and third party payers. The list of activities below are *representative* of those items which MCCR is required to fund. Those activities typically performed by a contractor and upon which a contractor's estimate of cost is made are indicated by a (√) in the "Contractor Cost of Operation" column.

Activity	MCCR Cost of Operation	Contractor Cost of Operation
Admissions & Registration	√	
Insurance Identification	√	
Insurance Verification	√	√
Utilization Review & Continued Stay Reviews	√	
Ambulatory Care Documentation: Coders, Scanners, Software, etc.	√	
Inpatient Documentation	√	
Bill Statement Generation	√	√
Bill Processing and Handling	√	√
Establishment of Accounts Receivable	√	
Pharmacy staff copay processing	√	
Collection Contacts and Follow-up (includes answering inquiries, reviewing explanation of benefits, etc)	√	√
Agent Cashier Collection Transactions	√	
Accounts Posting & Reconciliation	√	
Software Development and Support	√	
ADP Equipment (PC, DHCP servers, etc.)	√	
Medical Center utilities, leasing, etc.	√	
Renovations	√	
Furniture, equipment, fax, photocopiers, etc.	√	
Medical Center management overhead	√	
District Counsel Staff	√	

ESTIMATING ELIGIBILITY REFORM

FORMULA: $P = (No \times Lo \times Ctp) - (No \times Ctp) + (F + B)^*$

	# Admissions	\$/Adm.	ALOS	# Days	# Visits*	% Inpt. Admits. Shift	15% Inpt. Admits. Shift	Days Shifted
Year 1	891,400	9,623	15.20	13,549,280	25,300,000	44,570		311,990
1996								
Year 2	846,830	9,667	15.26	12,922,626	27,528,708	0	127,025	889,172
1996								
2-Year	719,805	10,991	16.72	12,093,454	24,310,711		171,995	1,201,162
Total								

	Ctp	Cop	Cadm	inpt.* Ctd	Ctp* 7 Cdm	Cop* 7 Cdm	P@Ctp* 7 Cdm
Year 1	633.20	197,645,465	176.92	4,434.30	3,104.15	138,351,296	782,803
1996							
Year 2	633.50	563,290,145	176.92	4,434.30	3,104.15	394,303,102	2,228,708
1996							
2-Year		760,935,610				532,655,067	3,010,711
Total							

* $P = (No \times Lo \times Ctp) - (No \times Ctp) + (F + B)$, where
 P = amount available for reinvestment into VA, e.g., for construction costs, new VA workload, and new noninstitutional long-term care
 No = number of patients shifted from inpatient to outpatient care as a result of reforming the eligibility rules.
 Lo = average of hospital stay in days for No patients.
 Ctp = average per diem cost per inpatient day (FY 96).
 Cop = average cost of care per outpatient visit.
 Cadm = average cost of care for the shifted admission = inpatient days shifted x the inpatient per diem / # shifted admissions.
 Ctp* 7 = average cost of care provided on an outpatient basis for shifted patients = 7 Cadm.
 Cop* 7 = 10% of outpatient fee-basis cost (\$263,320,000).
 B = 10% of beneficiary travel cost (\$108,900,000).
 $P = (171,995 \times 7 \times \$633.50) - (171,995 \times \$3,104.15) + \$19,222,000 + \$19,222,000 = \$267,502,743$
 The \$39,222,000 represents 10% savings in outpatient fee-basis plus 10% savings in beneficiary travel (\$28,332,000 + \$10,890,000).

- Assumptions:
1. Eligibility reform will cause a 5% reduction in 1st year and a 15% reduction in the 2nd year for admissions who shift to outpatient care.
 2. The 1996 budget projections are used for all utilization measures.
 3. The ALOS for the admissions shifted to outpatient care is 7. (Lo)
 4. The ALOS for remaining inpatient is constrained to a 2-yr. 10% increase for activity since inpatient practice efficiencies are also assumed.
 5. The cost of outpatient shifts, Cop, is 0.7 of the shifted admission cost, Cadm.

Notes:
 The item (in) indicates either the second year cost for some variables, or the ending result after two years for other measures.
 The utilization does not include certain hospital equipment visits do not include fee-basis, beneficiary travel is not included.
 The outpatient visit increase equal to the Cadm increase (F) divided by the Cop (7).
 Calculated variables illustrated in table cells and formulas below are rounded, but actual calculations carry many more digits accuracy.

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Does Utilization Review Reduce Unnecessary Hospital Care and Contain Costs?

THOMAS M. WICKIZER, MPH, MA,* JOHN R.C. WHEELER, PhD,†
AND PAUL J. FELDSTEIN, PhD‡

Research indicates that approximately one in five hospital admissions is unnecessary or inappropriate, based on accepted clinical criteria. Various cost-containment approaches have been initiated to reduce unnecessary hospital care. Among these approaches, hospital utilization review (UR) has shown promise as a cost-containment strategy. Although third party payers are increasingly relying on UR and similar approaches to contain health care expenditures, little is known about the effects of these efforts. This study analyzes insurance claims data on 223 insured groups for 1984 through 1986 to determine the effects of a UR program instituted by a commercial insurance company. It was found that UR had a significant negative effect on both utilization and expenditures, even after controlling for a large number of factors. Specifically, UR reduced admissions by 13%, inpatient days by 11%, expenditures on routine hospital inpatient services by 7%, expenditures on hospital ancillary services by 9%, and total medical expenditures by 6%. Even though UR reduced the level of utilization and expenditures, it did not appear to influence the rate of change in these areas over time. These findings suggest that hospital UR programs can reduce utilization and expenditures and generate cost savings, thereby helping to improve the efficiency of medical care resources consumption. Key words: utilization review; cost containment; utilization management. (Med Care 1989; 27:632-647)

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There continues to be widespread concern that the health care cost problem reflects, in part, unnecessary or inappropriate use of hospital services. Although estimates vary, studies have found that 10 to 20% of hospital admissions and 20 to 30% of total patient days are inappropriate or unnecessary, based on accepted medical criteria.¹⁻⁴ It is unclear how much could actually be saved if unnecessary hospital care were eliminated, but indirect evidence suggests the savings may be substantial.⁵

In response to pressure from private employers and government to contain health care costs, third party payers have initiated various cost-containment programs. One

program that has received prominent attention as an approach to cost containment is hospital utilization review (UR). Although both private commercial insurers and Blue Cross plans are increasingly relying on UR to contain the rate of growth in hospital expenditures,⁷ little is known about the cost savings potential of UR. This study presents the results of an evaluation of a hospital inpatient UR program instituted by a private commercial insurance carrier, based on analysis of claims data for 223 insured employee groups covering the period 1984 through 1986.

Although UR has been touted as having the potential to achieve cost savings, its effects on behavior and costs are not well understood. UR studies have provided mixed results and have been criticized on methodological grounds. Few studies have provided reliable data on outcomes or developed conceptual models to explain how UR affects patient or provider behavior.

The best-known early form of hospital UR was the federal government's Professional Standards Review Organization (PSRO) program. Studies of PSROs found that they had little impact on the utilization of resources by Medicare patients.⁸⁻¹⁰ A study undertaken in 1978 by the Institute of Medicine concluded there was no evidence that PSRO-type utilization review activities were effective in reducing length of stay or number of hospital days.¹¹ On the other hand, two studies of the Certified Hospital Admission Program (CHAP), a program initiated by the California Medi-Cal program in 1970 to control hospital admissions and length of stay, found UR did reduce hospital use by as much as 10 to 15%.^{12,13} These studies, however, have been criticized for drawing conclusions regarding the effects of UR based on projected utilization rates, without controlling adequately for the influence of co-variate factors.¹⁴ Chassin concluded that, up until 1978, research had not produced conclusive data on the impact of UR programs.¹⁵

In contrast to the UR studies noted above, studies of mandatory second-surgical opinion programs, a type of UR activity, have generally yielded results showing more positive effects. The second-surgical opinion programs initiated by the Massachusetts Medicaid program and by a New York Taft-Hartley welfare fund were found to have generated approximately \$2 to \$4 in savings for every \$1 spent.^{16,17}

More recent studies of hospital inpatient UR programs initiated by Blue Cross plans¹⁸ and by private sector employers¹⁹ have reported results suggesting UR can reduce admissions and inpatient days from 10 to 20% and achieve substantial cost savings. However, these studies have many of the same limitations as other UR studies and fail to control for the effects of external factors and trends that influence hospital utilization and costs, causing the results to be suspect. Although the weight of evidence suggests UR may be effective in reducing hospital utilization and costs, the lack of replicated, methodologically sound studies leaves this open to question.

The present study was conducted as part of a project to evaluate the effects of private cost-containment programs. The purposes of the study were: (1) to determine the effects of UR on health care utilization and expenditures, (2) to examine the influence of UR on the growth in expenditures over time, and (3) to assess whether self-selection affects utilization and expenditures of insured groups that adopt UR. In a previous paper, we examined the effects of UR on hospital use and medical expenditures based on claims data for 1984 and 1985.²⁰ The analysis reported here incorporates a third year of claims data for 1986, includes groups not analyzed in our previous study, and presents more detailed information about methodological procedures and findings.

This report has a number of advantages over previous UR studies. First, it analyzes the experience of a large number of insured

groups located in different geographic regions. Many previous UR studies involved essentially case studies that relied on simple before-and-after comparisons and projected use rates to estimate UR effects. Second, unlike many previous studies, this study was able to control for the effects of a large set of factors, including employee demographic characteristics, health care market area factors, and benefit plan features. Third, by analyzing total medical expenditures, which include all inpatient and outpatient expenditures, this study was able to assess UR's impact based on a comprehensive measure that captures the effects of the substitution of outpatient for inpatient care arising from UR.

Conceptual Framework

UR programs are designed to provide incentives in a variety of forms that encourage the use of hospital services that are necessary and appropriate. The UR program we analyzed uses economic incentives to alter patient behavior. Patients who fail to abide by UR guidelines are subject to financial penalties, which result in reduced coverage of benefits. UR, in effect, raises the relative price of hospital care to patients who unnecessarily or inappropriately use hospital services, as defined by UR guidelines. Assuming these services are not totally price inelastic, this higher price should reduce the use of inappropriate care. Of course, factors other than price influence utilization and need to be taken into account.

Figure 1 presents a conceptual framework for analyzing UR program operation, showing the relationships among factors believed to influence utilization, expenditures, and insurance premiums. As shown, it is expected that UR program operation will influence patient behavior, which, in turn, will influence utilization and expenditure patterns. In addition, it is expected that the characteristics of employees and insurance benefit plan features will influence patient

behavior and the decision to consume care, and that, independent of this behavior, health care market factors will influence utilization and expenditure patterns.

Insurance premiums⁵ for the current year are based largely upon expenditures of the previous year, but may also be influenced by supply and demand factors in the health insurance market. To the extent UR reduces expenditures, it may also influence premium levels; hence, premiums can be viewed as an ultimate outcome measure. UR may also lead to restructuring of insurance benefit plans, but this outcome is not formally shown in the model. A firm's decision to adopt UR depends upon insurance premium costs, as well as on the firm's ability to pass these costs on in the form of higher product prices. As the model indicates, supply and demand factors in the product market are the principal constraints that affect a firm's ability to pass on premium costs. Further, labor market conditions, in particular the extent of unionization in industry, are likely to influence the ability of firms to adopt cost-containment programs such as UR.

The principal expectation of interest emerging from the model shown in Figure 1 is that insured groups operating under UR will have lower utilization and expenditure levels than groups not operating under UR, *ceteris paribus*.

Methods

UR Program Operation

The UR program analyzed in this study represents two discrete review activities: preadmission certification and concurrent review. Because of data limitations, it was not possible to examine the separate effects of preadmission certification and concurrent

⁵ Although premiums are not analyzed as part of the present study, they do represent an important outcome measure being analyzed as part of our larger study and hence, are included in the model shown in Figure 1.

FIGURE 1
SIMPLIFIED MODEL OF
UTILIZATION REVIEW PROGRAM OPERATION

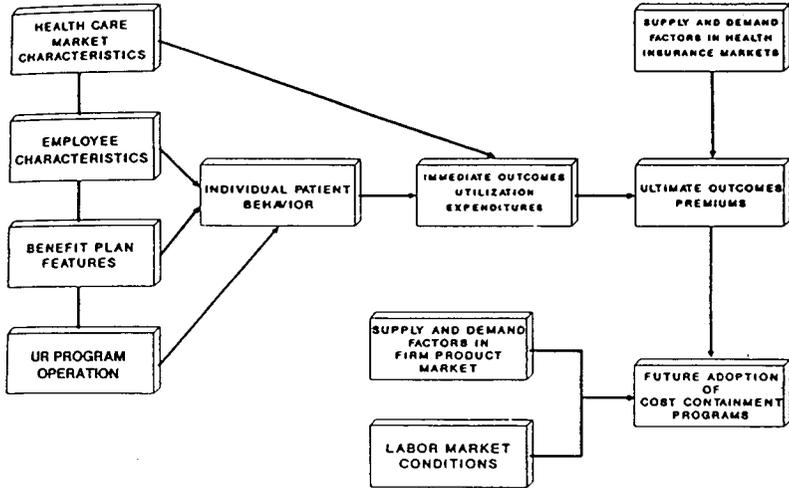


FIG. 1. Conceptual framework for analyzing utilization review program operation.

review. (Very few groups adopted concurrent review alone.) Thus, for purposes of analysis, the two activities are treated as one UR program.¹¹

¹¹ Some groups adopted cost-containment programs other than UR, e.g., weekend admission limitation or ambulatory surgery, raising a potential question of attribution. However, UR is comprehensive in that it affects all hospital admissions, while other cost-containment programs affect a relatively small percentage of admissions. Further, other cost-containment programs tend to be redundant once a group has adopted UR (UR would not authorize a Saturday admission for elective surgery scheduled for Monday regardless of whether a weekend limitation program was also in effect). To examine whether the adoption of multiple programs could pose potential problems for our analysis, we included variables in our statistical model representing each type of cost-containment program. Regression analysis indicated these programs had no statistically significant effect, either individually or as a group. Fur-

ther, their inclusion in the model did not lead to any meaningful change in our estimates of UR effects. Thus, we believe that the effects we estimate can confidently be attributed to UR activity.

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describing the patient's medical condition and planned course of treatment. The review panel notifies the physician, patient, and hospital of its decision regarding the appropriateness of admission and planned length of stay. If needed, the review procedure can be performed after the patient is admitted.

Concurrent review is designed primarily to control length of stay and use of ancillary services. The patient's treatment plan is reviewed by a registered nurse on-site, based on established medical criteria. If the treatment plan is judged appropriate, the stay is approved until the next review cycle, usually three days. Review is performed on this basis throughout the patient's stay in the hospital. If the review is disapproved, the nurse refers the case to a physician-advisor who either confirms the need for continued treatment or suggests alternate treatment.

UR is compulsory for all insureds (employees and dependents) covered by it. Patients who do not follow specified UR procedures are subject to financial penalties. For example, if an employee fails to get authorization for admission as required by preadmission certification, he may have his covered hospital room and board expenses reduced by some specified amount, usually 20%. Physicians and other providers are not subject to penalties. There is a charge by the insurance carrier of approximately \$1.25 to \$1.60 per employee per month for UR, depending upon the number of employees covered by UR and the specific UR activities selected.

Data

This report analyzes insurance claims data on 223 insured groups. Ninety-one (40%) groups operated under UR for some period of time during 1984 through 1986. The remaining 132 groups, which did not operate under any cost-containment program during this time, form the comparison

group for the analysis. Forty percent of the groups that adopted UR did so before January 1984, 38% of the groups adopted UR sometime during 1984, and the remaining 22% adopted UR during 1985. The groups are comprised mainly of employees of private companies, along with their insured dependents. A small percentage of the groups consist of employees of municipal and state government agencies and members of Taft Hartley Union Welfare Trusts. The size of the average group is 1,511 insureds, 663 employees and 848 dependents.

We selected groups for study based on several criteria, including: (1) A minimum of three quarters of account activity had to be available; (2) Population data on employees had to be available; (3) The group could not consist of retirees only; (4) Claims data had to include hospital and physician services and not just dental or vision services; and (5) The group had to have a minimum of approximately 100 insured individuals. Our intention was to select as many groups for study as possible meeting the above criteria.

As of the second quarter 1985, there were 558 insured groups with active policies potentially available for selection. Of these groups, 263 (47%) were selected for study, based on the above criteria. However, 40 of these groups have been excluded from this analysis because they operated under cost-containment programs other than UR and, therefore, could not be included in the comparison set of groups.

The unit of analysis for the study is the insured group. Claims data for the 223 groups selected for study were pooled over the 12-quarter study period, creating a time series/cross-section database of 1,848 usable and complete quarterly observations. Of these 1,848 observations, 766 represent groups that operated under UR during 1984 through 1986, and 1,082 observations represent groups that did not operate under any cost-containment program. Not all study groups had data covering all 12

quarters because some groups started their accounts after the beginning of the study period and other groups cancelled their accounts prior to the end of the study period.

We measured all dependent variables as a rate to adjust for differences in the size of groups, e.g., admissions per 1,000 insured persons. Population data were collected from the insurance carrier's billing system and updated quarterly. Admissions and inpatient days were measured per 1,000; expenditures were measured on a per insured person basis. Because complete information on dependents was unavailable for many groups, we developed a simple algorithm to estimate the number of dependents for groups with dependent coverage, based on county level census data pertaining to average household size.

Empirical Model

To test our expectations regarding the effects of UR, we compared utilization and expenditure rates of insured groups that operated under UR during the period 1984 through 1986 with those of groups that did not do so. More formally, we tested the following empirical linear model:

$$Y_{ij} = a + bB_{ij} + cE_{ij} + dM_{ij} + eQ_j + fT_j + gU_{ij} + u_{ij}$$

where

Y_{ij} specifies a vector of outcome variables representing some measure of utilization or expenditures for the i th insured group in the j th quarter.

a specifies a constant term.

B_{ij} specifies a vector of exogenous variables representing benefit plan design factors for the i th group in the j th quarter.

E_{ij} specifies a vector of exogenous variables representing employee characteristics for the i th group in the j th quarter.

M_{ij} specifies a vector of exogenous variables representing health care market area factors for the i th group in the j th quarter.

Q_j specifies a vector of quarter dummy variables representing the j th quarter.

T_j specifies a time trend variable (ranging in value from 1 to 12) representing the j th quarter.

U_{ij} specifies a binary variable coded 1 if the i th group had UR in operation during the j th quarter and 0 if not.

u_{ij} specifies an error term with mean zero and variance σ_i^2 .[†]

This model enabled us to determine the effects of UR on utilization and expenditures, while controlling for the effects of other factors. The purpose of including a time-trend variable was to control for five earlier trends in utilization and expenditure. Including quarter dummy variables allowed us to control for seasonal factors that influence utilization: the estimated coefficient of the UR term represents the aggregate effect of the two UR activities, preadmission certification and concurrent review. Rejection of the null hypothesis of no difference in use and expenditures between UR and non-UR groups implies that UR has a significant effect.

A listing of the variables used in the multivariate analysis, along with variable definitions, symbols, and descriptive statistical information, is provided in Table 1.[#] Included in the table are six dependent measures representing the equations to be estimated: admissions per 1,000 insured persons per quarter (ADMS), average length of stay (LOS), inpatient days per 1,000 insured persons per quarter (INPDAYS), hospital room and board expenditures per insured person per quarter (HOSR&B\$), hospital ancillary expenditures per insured person per quarter (HOSANC\$), and total medical expenditures per insured person per quarter (TOTMED\$).^{**}

[†] σ_i^2 implies the error terms have nonconstant variance (that is, the error terms are heteroscedastic). For a discussion of this problem, see page 15.

[#] The time-trend variable, quarter dummy variables, and UR binary variable are not included in Table 1.

^{**} Note the mean values shown in Table 1 are based on raw data unadjusted for factors believed to influence utilization and expenditures

TABLE 1. Descriptive Data and Definitions of Variables Used in Multivariate Analysis

Variable Definition	Symbol (Data Source) ^a	UR Groups ^a	Non-UR Groups
Dependent Measures			
Admissions per 1,000 insured persons per quarter	ADMS (a)	23.4 ^c (10.9) ^d	28.3 (14.8)
Average length of stay	LOS (a)	6.0 ^c (3.2)	6.4 (4.2)
Inpatient days per 1,000 insured persons per quarter	INPDAYS (a)	142.9 ^c (95.9)	182.2 (144.6)
Hospital room and board expenditures per insured person per quarter	HOSR&BS (a)	\$38.29 ^c (\$29.55)	\$46.87 ^c (\$42.23)
Hospital ancillary expenditures per insured person per quarter	HOSANC\$ (a)	\$54.62 ^c (\$41.53)	\$65.55 (\$62.47)
Total medical expenditures per insured person per quarter	TOTMED\$ (a)	\$212.43 ^c (\$102.98)	\$234.55 (\$136.94)
Exogenous control variables^a			
% male employees under 19	M%UN19 (b)	0.1% (0.2%)	0.1% (0.3%)
% female employees under 19	F%UN19 (b)	0.1% (0.2%)	0.1% (0.2%)
% males 20 to 50	M%20T50 (b)	26.9% (5.9%)	26.7% (8.0%)
% females 20 to 50	F%20T50 (b)	26.3% (12.7%)	27.0% (8.0%)
% males over 50	M%OV50 (b)	17.8% (8.4%)	19.2% ^a (10.9%)
% females over 50	F%OV50 (b)	6.7% (2.5%)	6.6% (4.2%)
% of covered expenditures for childbirth and pregnancy	CHILP% (a)	7.8% (7.3%)	7.9% (8.1%)
% of covered expenditures for ischemic heart disease	HDIS% (a)	3.9% (6.3%)	4.0% (7.9%)
% of covered expenditures for other heart disease	OHDIS% (a)	2.1% (4.3%)	2.5% (4.8%)
% of covered expenditures for diseases of the urinary tract system	DISURS% (a)	2.7% (3.9%)	2.6% (4.7%)
% of covered expenditures for female genital-related diseases	DISFC% (a)	5.2% ^c (5.0%)	4.3% (6.5%)
% coordination of benefit (COB) savings	COBSV% (a)	4.9% (6.1%)	4.4% (6.4%)
% COB Medicare savings	MEDSV% (a)	1.3% (5.2%)	1.2% (3.8%)
% COB Medicare subtraction savings	MEDSB% (a)	0.7% (1.8%)	2.1% (9.8%)
% COB Medicare carve out savings	MEDCA% (a)	0.2% (1.5%)	0.3% (2.0%)
HMO penetration rate	HMO% (e)	10.9% (13.2%)	11.4% (12.0%)
Hospital average occupancy	OCCUP (c)	65.6% (9.3%)	67.4% (8.5%)
Number of office-based MDs per 1,000 population in market area	MIDSCAP (d)	2.1 (0.8)	2.2 ^c (0.8)
Northeast region	NOREAST (f)	18.3%	18.2%

TABLE 1. Continued.

Variable Definition	Symbol (Data Source) ^a	UR Groups ^b	Non-UR Groups
North Central region	NORCENT (f)	27.8%	42.6% ^c
South	SOUTH (f)	29.5% ^d	23.9%
West	WEST (f)	24.4% ^e	15.4%
% of charges covered for semiprivate room before co- payment	SEMIPRV% (a)	93.4% (13.1%)	94.1% (15.5%)
% of charges covered for physician office visit before co-payment	MDOFFC% (a)	87.9% (16.2%)	88.8% (10.0%)
% of charges covered for hospital OPD visit before co-payment	HOSOPD% (a)	92.4% (11.8%)	94.2% (11.4%)
Deductible	DEDUC (b)	\$140.79 ^c (\$53.13)	122.97 (550.09)
Co-insurance rate	COINS (b)	80.0% (2.9%)	80.0% (3.7%)
Co-insurance rate for inpatient mental health services	MHCOINS (b)	84.0% ^e (18.8%)	80.6% (19.3%)
Base plan coverage for hospital room and board charges	BASERB (b)	63.7% ^e	51.3%

^a The data sources represent: (a) insurance claims information; (b) data obtained from the insurance company's account files; (c) American Hospital Association (AHA) annual survey data for years 1984 through 1986; (d) American Medical Association (AMA) annual survey data for years 1984 through 1986; (e) Interstudy HMO survey data for years 1984 through 1986; and (f) Area Resource File (ARF) data.

^b The descriptive statistical information shown in Table 1 is based on 1,848 pooled quarterly observations, 766 observations representing UR groups and 1,082 observations representing non-UR groups.

^c $P < 0.001$.

^d Standard deviations in parentheses.

^e $P < 0.05$.

^f Expenditure data are adjusted to reflect January 1985 prices.

^g $P < 0.01$.

^h Does not include time-trend variable, quarter dummy variables, or UR binary variable.

To control for differences in casemix and population characteristics, a set of proxy variables was included in the model. These included six variables representing the age/sex distribution of the employee population (e.g., percent male employees under 19, M%UN19; percent female employees under 19, F%UN19; percent male employees 20 to 50, M%20T50), five variables measuring expenditures on different disease categories as a percentage of total covered expenditures (e.g., percentage of covered expenditures for childbirth and pregnancy, CHILP%; percentage of covered expendi-

tures for ischemic heart disease, HDIS%), and four variables pertaining to coordination of benefit savings for dependents (COBSV%) and for Medicare eligible employees and retirees (MEDSV%, MEDSB%, and MEDCA%).^{††} In general, we expected insured groups with a higher percentage of older employees and with a higher percentage of Medicare coordination of benefit savings to have higher utilization and expenditure rates, *ceteris paribus*.

^{††} A small percentage of insureds in some groups were Medicare eligible employees or retirees.

To control for the effects of health care market factors, we included in our model three variables representing HMO penetration rate (HMO%), hospital occupancy (OCCUP), and number of office-based physicians per 1,000 population in the MSA (MDSCAP). For purposes of the study, the health care market was defined in terms of the Standard Metropolitan Statistical Area (SMSA). We expected HMO penetration rate to exert a negative influence on the utilization and expenditure rates of groups, and expected hospital occupancy and the physician-to-population ratio to have a positive influence on groups' hospital use and expenditure rates, *ceteris paribus*. Our model included a set of dummy variables pertaining to geographic region to control for unmeasured regional effects. We expected groups located in the West to have lower hospital utilization and expenditure rates compared to groups located in other geographic regions.

Finally, our model included a set of seven variables to control for the effects of differences in benefit plan design features. Three of these variables represent the percentage of charges covered by insurance for semi-private room (SEMIPRV%), physician office visit (MDOFFC%), and hospital OPD visit (HOSOPD%). Two variables represent the level of co-insurance (measured as the percentage of charges paid by insurance) for acute care services (COINS) and for inpatient mental health services (MHCOINS). The remaining two variables represent deductible level (DEDUC) and the presence of base plan (first dollar) coverage for hospital room and board charges (BASERB). We expected the utilization and expenditure rates of groups having more comprehensive insurance coverage to be higher than those of groups with less comprehensive coverage, *ceteris paribus*.

Because of the structure of the data used to test our empirical model, we were concerned about possible specification problems. In particular, we were concerned that

the error terms in our model might be heteroscedastic as well as serially correlated. (Although these problems do not lead to biased parameter estimates, they do lead to biased standard error estimates and therefore biased *t*-statistics). We felt heteroscedasticity was likely to arise because we were analyzing aggregate data on groups that varied widely in size (range 150 to 39,000 insureds). Our concern about serial correlation arose because we had multiple observations on groups over time.

Application of the Goldfield-Quandt test²¹ revealed the model's error terms were heteroscedastic ($F_{750,750} = 2.21$). To correct this problem, we carried out a standard weighting procedure on the data (multiplying each observation by the square root of the group's population), which gave more weight to larger groups, and then performed weighted least squares regression analysis on the transformed data.

Diagnosing serial correlation in models that use pooled (longitudinal) data presents special problems because conventional autocorrelation estimators are not consistent as *N* (the number of observations) goes to infinity but *T* (the number of time periods) remains small. However, as part of other analyses, we tested for autocorrelation using the method developed by Solon,²² which allows correction for the inconsistency of autocorrelation estimates. The results of these tests, along with other residual analysis performed on the data, strongly suggest that serial correlation does not pose a major problem for the present analysis.

Another concern was that our estimates of UR effects might be influenced by selection. Selectivity bias is always a potential problem when data are obtained from non-experimental procedures. Although we were able to control for a large number of factors, we could not be certain that our study groups were similar in all respects except for UR. The fact that some groups cancelled their insurance policies prior to the end of our study period also raised the pos-

sibility that our results might be influenced by sample attrition. To assess possible problems arising from selection and attrition, we performed several specification tests on the data. The results of these tests are reported below.

Results

Table 2 presents information summarizing the effects of UR on three measures of utilization—admissions, length of stay, and inpatient days—based on weighted least squares regression analysis. The table shows the estimated regression coefficients for the UR variable as well as for the exogenous control variables included in the model. The adjusted R^2 values for the three equations are in the range of 0.50 to 0.60, indicating that the model explains approximately 50 to 60% of the variance in utilization.

As Table 2 indicates, even after controlling for the effects of exogenous factors,†† UR has a significant negative effect on admissions. The estimated regression coefficient on the UR term is approximately -3.7 , implying that UR groups, on average, experienced almost four fewer admissions per 1,000 insured persons per quarter compared to non-UR groups. Although the sign on the UR variable in the length-of-stay equation is negative, it is not significantly different from zero. Thus, the observed effect of UR on inpatient days occurs mainly through its effect on admissions. It appears that UR reduces utilization overall by approximately 20 days per 1,000 insured persons per quarter.

A number of the exogenous variables exerted a significant effect on insured groups' utilization. Compared to groups located in the West, groups located in the other census regions experienced higher rates of utilization,

especially those groups in the North Central Region. Groups with a high proportion of older male employees had more admissions and longer average lengths of stay, but the opposite was true for groups with a high proportion of older female employees. As expected, groups that had relatively more Medicare eligible insured persons, as indicated by the level of Medicare coordination of benefit savings, experienced significantly higher utilization rates. Finally, groups located in markets having either high HMO penetration rates or low hospital occupancy rates experienced lower average admission rates.

Table 3 presents information showing the effects of UR on expenditures. The R^2 values for the expenditure equations are similar to those observed for the utilization equations, as is the pattern of effects of the exogenous variables. As Table 3 shows, UR has a significant negative effect on both hospital inpatient expenditures and total medical expenditures. Hospital routine expenditures (room and board charges) and expenditures on ancillary services were found to be reduced by \$3.15 and \$6.16 per insured person per quarter, respectively, or by about \$13 and \$25 per year. UR appeared to reduce total medical expenditures per insured person per quarter by almost \$14, or by about \$56 per year. Because this measure included expenditures on all outpatient as well as inpatient services, it captured whatever substitution effects may arise from UR.

As a means of summarizing the information presented in Tables 2 and 3, we calculate the percentage changes in utilization and expenditures due to UR, based on the estimated regression coefficients, and provide confidence intervals for these percentage change figures (see Table 4). It appears that UR reduced admissions and inpatient days by approximately 13% and 11%, respectively. UR reduced expenditures on hospital routine and ancillary services by approximately 7% and 9%, respectively, while reducing total medical expenditures

†† The variable COINS was dropped from the final regression analysis because it did not have sufficient variance to generate a reliable estimate (see descriptive information provided in Table 1).

TABLE 2. The Effects of UR on Hospital Utilization, Based on Weighted Least Squares Regression Analysis of 1,848 Pooled Quarterly Observations for 1984 through 1986

Measure	ADMS	LOS	INPDAYS	Measure	ADMS	LOS	INPDAYS
Constant	37.73 [*] (4.418) [†]	5.385 [*] (1.208)	198.240 [*] (39.496)	DISURS%	17.813 [‡] (7.377)	-2.982 (2.044)	118.910 (65.940)
Time	-0.122 (0.080)	0.083 (0.022)	-0.987 (0.712)	DISFC%	-1.452 (6.150)	-6.033 [‡] (1.683)	-168.630 [*] (54.970)
QRT2 [§]	1.465 [‡] (0.670)	0.347 [‡] (0.183)	17.711 [*] (5.994)	COBSV%	15.800 [*] (5.022)	3.289 [‡] (1.372)	182.040 [*] (44.891)
QRT3	0.103 (0.680)	0.374 [‡] (0.186)	8.061 (6.080)	MEDSV%	7.625 (5.758)	2.476 (1.571)	99.134 [‡] (51.475)
QRT4	-1.675 [‡] (0.696)	0.239 (0.190)	-6.496 (6.219)	MEDSB%	14.895 [*] (2.597)	3.967 [*] (0.708)	256.380 [*] (23.213)
NOREAST [¶]	0.067 (1.227)	1.706 [*] (0.337)	36.108 [*] (10.972)	MEDCA%	89.210 [*] (16.115)	1.947 (4.392)	590.020 [*] (144.060)
NORCENT	4.560 [*] (0.918)	1.091 [*] (0.252)	59.819 [*] (8.208)	HMO%	-0.092 [‡] (0.034)	0.008 (0.009)	-0.219 (0.306)
South	3.315 [‡] (1.095)	0.481 (0.300)	33.570 [*] (9.790)	MDSCAP	-1.081 [‡] (0.475)	0.202 (0.130)	-0.610 (4.245)
M%UN19 [¶]	-1.895 (1.152)	-0.684 [‡] (0.328)	-27.296 [*] (10.302)	OCCUP	-0.087 [‡] (0.036)	-0.001 (0.010)	-0.671 [‡] (0.325)
F%UN19	-2.279 (1.477)	-0.367 (0.406)	-19.447 (13.204)	SEMIPRV	-0.078 [‡] (0.019)	-0.007 (0.005)	-0.076 (0.178)
F%20T50	0.076 [‡] (0.029)	0.025 [‡] (0.008)	1.000 [‡] (0.255)	MDOFFC%	0.039 (0.027)	-0.009 (0.007)	-0.216 (0.239)
M%OV50	0.286 [‡] (0.040)	0.013 (0.011)	2.370 [‡] (0.360)	HOSOPD%	-0.020 (0.025)	0.002 (0.007)	0.032 (0.227)
F%OV50	-0.395 [‡] (0.094)	-0.025 (0.026)	-2.071 [*] (0.841)	DEDUC	0.005 (0.005)	0.001 (0.001)	0.050 (0.045)
CHILP%	7.408 (4.277)	-8.069 [*] (1.172)	-169.400 [*] (38.231)	MHCOINS	-0.037 [‡] (0.12)	-0.006 (0.003)	-0.409 [*] (0.104)
HDIS%	7.457 (4.492)	-1.418 (1.225)	18.191 (40.155)	BASERB	1.434 [‡] (0.569)	-0.103 (0.156)	3.612 (5.086)
OHDIS%	5.924 (6.611)	-2.104 (1.802)	21.429 (59.096)	UTILREV	-3.684 [*] (0.537)	-0.114 (0.147)	-19.427 [*] (4.804)
				R ²	0.60	0.49	0.51

* $P < 0.001$.

† Standard errors in parentheses.

‡ Omitted variable QRT1.

§ $P < 0.05$.¶ $P < 0.01$.

‡ Omitted variable WEST.

¶ Omitted variable M%20T50.

by approximately 6%. As shown, the confidence interval for the total expenditure measure indicates that 95 times out of 100 the true percentage reduction in total medical expenditures would be somewhere between 2.0% and 9.7%.

UR may affect either the level of expenditures or the growth in expenditures over time. To examine this issue empirically, we included in the regression model a term rep-

resenting the interaction of the UR dummy variable and the quarter time trend variable. This procedure amounts to testing whether the slopes of UR and comparison groups differ. Observing a statistically significant negative sign on the interaction term would suggest that UR reduces the rate of growth in utilization or expenditures.

An interaction term was added to the regression equations shown in Tables 2 and 3

TABLE 3. The Effects of UR on Health Care Expenditures, Based on Weighted Least Squares Regression Analysis of 1,848 Pooled Quarterly Observations for 1984 through 1986

Measure	HOSB&B\$	HOSANC\$	TOTMEDS	Measure	HOSB&B\$	HOSANC\$	TOTMEDS
Constant	75.540* (11.307)*	99.114* (16.110)	272.860* (37.828)	DISURS%	-4.881 (18.878)	37.208 (18.311)	96.442 (63.157)
Time	0.400* (0.204)	1.252* (0.291)	6.810* (0.683)	DISFC%	-78.318* (15.738)	-88.480* (22.422)	-221.330* (52.650)
QRT2 ^d	5.790* (1.716)	6.023* (2.445)	9.776 (5.741)	COBSV%	64.121* (12.852)	37.065* (18.311)	83.623* (42.996)
QRT3	3.731* (1.741)	2.854 (2.480)	1.717 (5.824)	MEDSV%	72.507* (14.737)	87.987* (20.996)	226.250* (49.302)
QRT4	-0.683 (1.741)	-1.753 (2.537)	-13.825* (5.957)	MEDSB%	61.691* (6.646)	111.740* (9.469)	256.170* (22.233)
NOREAST ^e	3.622 (3.141)	-8.009 (4.476)	-3.527 (10.509)	MEDCA%	22.282 (41.242)	113.140* (58.760)	357.170* (137.970)
NORCENT	13.182* (2.350)	12.674* (3.348)	30.149* (7.862)	HMO%	-0.039 (0.087)	0.023 (0.125)	0.865* (0.293)
South	-1.310 (2.803)	9.768* (3.993)	-0.406 (9.372)	MDSCAP	4.138* (1.215)	2.477 (1.732)	9.203* (4.066)
M%UN19 ^f	-8.558* (2.949)	-1.094 (4.202)	-9.630 (9.867)	OCCUP	-0.172 (0.093)	-0.355* (0.133)	-0.566 (0.312)
F%UN19	-8.200* (3.780)	-11.550* (5.386)	-45.079* (12.646)	SEMIPRV	-0.134* (0.051)	-0.225* (0.073)	-0.679* (0.171)
F%20T50	0.355* (0.073)	0.511* (0.104)	1.483* (0.245)	MDOFFC%	-0.221* (0.068)	-0.084 (0.094)	-0.196 (0.229)
M%OV50	0.573* (0.103)	0.967* (0.147)	2.463* (0.345)	HOSOPD%	-0.110 (0.065)	-0.192* (0.093)	-0.639* (0.217)
F%OV50	-0.702* (0.241)	-0.840* (0.343)	-0.646 (0.805)	DEDUC	0.044* (0.013)	0.039* (0.018)	0.168* (0.043)
CHILP%	-33.003* (10.945)	-68.288* (15.594)	-169.550* (36.617)	MHCOINS	-0.144* (0.030)	-0.101* (0.042)	-0.367* (0.099)
HDIS%	4.009 (11.500)	80.612* (16.389)	94.510* (38.460)	BASERB	0.244 (1.456)	-3.237 (2.074)	-1.337 (4.871)
OHDIS%	26.228 (16.919)	63.970* (24.105)	151.960* (56.602)	UTILREV	-3.147* (1.375)	-6.163* (1.960)	-13.753* (4.600)
				R ²	0.48	0.49	0.62

* $P < 0.001$.

^b Standard errors in parentheses.

^c $P < 0.05$.

^d Omitted variable QRT1.

^e Omitted variable WEST.

^f Omitted variable M%20T50.

^g $P < 0.01$.

and groups that had had UR in effect for at least 10 of the 12 quarters during 1984 through 1986 were compared with groups that operated without UR during this period. We were unable to reject the null hypothesis of no difference in slopes in every case. Therefore, it appears that UR leads to a one-time reduction in utilization and expenditures, with little effect on the growth of utilization or expenditures over time.

Selection Bias Analysis

Because our data were obtained from nonexperimental procedures, we were concerned that the results of our study might be influenced by selection bias. To examine this possibility, we performed the two-step Mill's ratio selection bias procedure developed by Heckman.^{23,24} The first step of this procedure involves estimating a probit equation to construct a regressor that repre-

TABLE 4. Summary of UR Effects Based on Pooled Quarterly Observations, 1984 through 1986 (N = 1,848)

Measure	Regression Coefficient	Percent Change (95% Confidence Interval)
ADMS	-3.684* (0.537)	-13.1% ^b (-9.3% to -16.8%)
LOS	-0.114 (0.147)	—
INPDAYS	-19.427* (4.84)	-10.7 (-5.5% to -15.9%)
HOSR&BS	-3.147* (1.375)	-6.7 (-0.9% to -12.5%)
HOSANCS	-6.163* (1.960)	-9.4 (-3.5% to -15.3%)
TOTMEDS	-13.753* (4.600)	-5.9 (-2.0% to -9.7%)

* $P < 0.001$.

^b The percentage change estimates are based on the following (quarterly) average utilization and expenditure rates for non-UR groups: 28.2 admissions per 1,000 insured persons; 182.2 inpatient days per 1,000 insured persons; \$46.87 per insured person for hospital room and board charges; \$65.55 per insured person for hospital ancillary charges; and \$234.55 per insured person for total medical expenditures.

^c Standard errors in parenthesis

^d $P < 0.05$.

^e $P < 0.01$.

sents the UR selection decision. In the second step, this additional regressor is included in the original model, which is then estimated by ordinary least squares. This procedure provides information that indicates whether selection exists and then "corrects" for it.

We performed the Heckman procedure, first estimating the probability of selecting UR, based on a set of variables (several of which were excluded from the original equation) pertaining to market area characteristics, benefit design features, size of group, and other factors. The inverse Mill's ratio was then constructed from the probit analysis and included this as an additional regressor in our empirical model. Of the six utilization and expenditure equations, the "selectivity regressor" was statistically sig-

nificant ($P < 0.05$) in only two equations; however, in neither case was the overall explanatory power of the model changed, nor was there any meaningful change in the UR coefficient.

The Heckman procedure imposes a certain functional form on the structure of the disturbance terms because it assumes the disturbance structure has a bivariate normal density. An alternative procedure developed by Olsen uses linear probability analysis to test for selection.^{25,26} (One disadvantage of this procedure is that it can lead to probability estimates that fall outside the range of 0 and 1.)

In addition, we used Olsen's procedure as a second test for possible selection bias. The selectivity regressor was not statistically significant in any of the six utilization or expenditure equations.

Unfortunately, both of the above procedures often have practical limitations that hinder their usefulness, such as difficulty in identifying the probit or linear probability equations because excluded variables are often unavailable. Even if the equations are identified, multicollinearity is often introduced when the selectivity regressor is added to the original model, making it difficult to estimate parameters reliably.

For this reason, we undertook a third procedure, which essentially involved analyzing the utilization and expenditure patterns of a subset of 36 groups that crossed over from non-UR to UR during the study period. This analysis allowed us to compare utilization and expenditures of groups before versus after UR adoption, a comparison that should be free of selectivity problems, since groups are essentially compared to themselves over brief time intervals.

To compare the groups, we used analysis of co-variance, entering a time-trend variable as a co-variate in the analysis. This enabled us to compare the pre- and post-UR experience of the groups, while adjusting for the effects of exogenous trends in-

fluencing groups' hospital utilization and medical expenditure rates over the period of analysis.

The analysis indicated that groups experienced significant reductions in their utilization and expenditures after adopting UR. Admissions declined from 26.9 to 23.2 per 1,000 insured persons per quarter ($P < 0.05$); hospital inpatient routine (room and board) expenditures per insured person per quarter declined from \$42.98 to \$35.63 ($P < 0.10$); and total medical expenditures per insured person per quarter declined from \$240.15 to \$200.48 ($P < 0.01$). We found no evidence that the results of this before-and-after analysis were influenced by regression toward the mean. Taken together, the results of these analyses provide firm evidence for the conclusion that our findings regarding UR represent a real effect and not an artifact of selection.

In addition to selectivity bias, we were concerned that the estimates might be influenced by sample attrition. Of the 223 study groups, 75 canceled their accounts sometime during 1985 or 1986 prior to the end of the study period, accounting for 24% of the total observations analyzed. Non-UR groups were almost three times as likely to cancel their accounts as were UR groups, with 15% of UR groups canceling their accounts as opposed to 46% of non-UR groups.

If UR and non-UR groups that canceled their accounts had different utilization and expenditure patterns, the results of our analysis could be subject to bias. For example, if UR canceled groups had higher use and expenditure rates relative to other UR groups, while non-UR canceled groups had lower rates relative to other non-UR groups, our results could overestimate the true effect of UR. To assess this possibility, we compared the utilization and expenditures of UR and non-UR groups that canceled their accounts with UR and non-UR groups that did not. We found no statistically significant

differences in utilization or expenditures between the groups, based on two-tailed *t*-tests with an alpha level of 0.05. As a further check, regression analysis was performed a second time with the observations representing canceled groups excluded. In almost every case, the magnitude of our estimates of UR effects actually increased when the canceled groups were excluded from the analysis. Thus, we do not believe that sample attrition has influenced our estimates of UR effects to any significant degree.

Discussion

The results presented here suggest UR can decrease hospital utilization and reduce health care expenditures. After controlling for a large number of factors believed to influence utilization and expenditures, we estimated UR reduced inpatient days and total medical expenditures by approximately 11% and 6%, respectively. These results appear to represent a real effect rather than the influence of selection or attrition bias. UR does not appear to affect the rate of change over time in hospital utilization or expenditures; hence, the effects reported here should be viewed as one-time reductions in the level of hospital use and expenditures.

Our estimate of the effect of UR on inpatient hospital utilization is generally consistent with estimates that have been reported previously.^{12,13,18,19} However, our estimates of UR's expenditure effects suggest that the cost savings potential of UR is smaller than what has been inferred from previous studies, which have performed more limited analysis focused on inpatient utilization.

In an earlier report,²⁰ we estimated that UR reduced total medical expenditures by approximately 8% in 1984 and 1985. Although this figure is somewhat higher than the 6% estimate derived from this analysis,

the difference is not statistically significant. We estimated that UR yielded net savings of approximately \$145 per employee per year, based on an 8% reduction in medical expenditures. The 6% figure obtained from this analysis suggests the net savings per employee would be approximately \$115. Since the lower figure is based on analysis incorporating an additional year of data, it may be a better estimate of the savings an average employer might expect to realize from UR. However, employers with relatively high utilization rates (more than 125 admissions per 1,000 insureds per year) are likely to realize greater cost savings from UR.²⁰

The analysis presented here suggests that UR represents a viable approach to cost containment that can help improve the efficiency with which medical care resources are consumed. However, it should be emphasized that these results are based on analysis of one insurance carrier's UR program. The stringency with which UR guidelines are applied and the level of penalties invoked for noncompliance, as well as other factors specific to the UR program, are likely to influence outcomes. Therefore, caution should be used in attempting to generalize the findings reported here.

There remains the challenge of determining how UR affects the quality of care and the health status of patients. Because our data were limited to claims information, we were unable to explore the important question of the effects of UR on quality. In addition to examining UR's impact on quality, subsequent work should also examine the extent to which UR programs affect premiums of employers, the conditions under which UR is most effective in achieving cost savings, and the factors associated with adoption of UR by employers.

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Nonacute Days of Care Within Department of Veterans Affairs Medical Centers

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The Iowa Health Services Research and Development (HSR&D) Field Program conducted a nationwide study to estimate rates of nonacute inpatient days of hospitalization for a stratified random sample of 50 Department of Veterans Affairs Medical Centers (VAMCs) and identify possible reasons for their occurrence. The 50 VAMCs were randomly selected from the 136 VAMCs providing both medical and surgical inpatient care. Trained registered nurses reviewed every day of stay for approximately 125 randomly selected medical/surgical hospitalizations from each VAMC using the Appropriateness Evaluation Protocol. Overall rate of nonacute medical/surgical days within the 136 VAMCs was estimated to be $48 \pm 2\%$ with VAMC-specific rates ranging from 38-72%. The entire stay was completely acute for 25% of the hospitalizations; the entire stay was completely nonacute for 31%. For mixed acute-nonacute stay cases, the last one third of the stay had a greater proportion of nonacute days than the first or middle one third. For 87% of all the nonacute days of care, the patient did not need continued hospitalization beyond the day reviewed. The most frequently occurring reason for these nonacute days when continued hospitalization was not needed was conservative patient management. For days when the patient did need continued hospitalization, the most frequent reasons for the nonacute days were related to operational inefficiencies. Key words: nonacute; days of care; Department of Veterans Affairs Medical Center. (Med Care 1991; 29(suppl):A551-63)

The Iowa Health Services Research and Development (HSR&D) Field Program con-

ducted a nationwide study with the following goals: 1) to estimate the magnitude of

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nonacute inpatient care within each of 50 Department of Veterans Affairs (VA) Medical Centers (VAMCs) and for the 136 VAMCs that provide both medical and surgical inpatient care; and 2) to identify possible reasons for the nonacute care.¹ A two-stage cluster sampling scheme utilizing stratification at both stages was developed to randomly select 1) 50 VAMCs from the 136 VAMCs within 21 strata defined by the seven VA geographic regions and three average length of stay categories and 2) approximately 125 fiscal year 1986 (FY86) medical/surgical hospitalizations from each sampled VAMC within 10 strata defined by medical/surgical bed section and five length of stay categories. The Appropriateness Evaluation Protocol (AEP) was used on a retrospective medical record review basis to assess the need for acute inpatient services on every day of care. A day of inpatient care was determined to be nonacute if none of the AEP clinically based criteria indicating a need for inpatient hospital level care were documented in the medical record. The medical record reviews were conducted by 26 registered nurse abstracters trained by the developers of the AEP.

The study was conducted under the assumptions that the care provided is medically necessary irrespective of the level at which it is provided; all levels of care are potentially available at each VAMC; only clinical considerations, and social factors that in the professional opinion of the treating physician would affect clinical decision-making, justify care at the acute inpatient level; all essential data for determining clinically-based need for acute care are documented in the medical record; and private sector clinical medical practice regarding the location and timing of care, as reflected in the AEP, is equally applicable for the VA. A previous report presented the estimated rates of nonacute admissions for the 50 individual VAMCs and for the population of 136 medical/surgical VAMCs.² This article discusses the methodology for estimating

the rates of nonacute days of care for each of the 50 VAMCs and the population of 136 medical/surgical VAMCs and presents the estimated rates. In addition, this study examines the distribution of the nonacute days of care across the entire stay, the need for continued hospitalization, and the reasons for the nonacute days of care.

Estimation Procedures

The rate of nonacute days was estimated for each of the 50 VAMCs in the sample and for the 136 medical/surgical VAMCs as a group. This rate is the ratio of two random variables: number of nonacute days to total days of medical/surgical care. As discussed previously,¹ days of discharge and those days of care when a patient was transferred from a medical/surgical bed section to psychiatry, rehabilitation, alcoholism treatment, or intermediate medicine were excluded and, thus, total days reflect only length of stay in a medical/surgical bed section. Total days of medical/surgical care is a random variable because only the number of hospitalizations was fixed by the sampling design. The ratio estimator of the rate of nonacute days within a VAMC was computed as a weighted sum of ratio estimates within the 10 sampling strata defined by the admission bed section and length of stay categories.^{3,4} As a general rule, the ratio estimator is biased in the order of $1/n$, where n is the appropriate sample size. However, in large samples, the bias is negligible and the ratio is approximately normally distributed. As a result, the usual confidence intervals can be calculated. The VAMC-specific estimated variance for the ratio estimator is a complex function of stratum weights, standard deviations of total nonacute days and lengths of stay within strata, and the correlations between nonacute days and length of stay.

The VAMC-specific estimates for rates of nonacute days were aggregated to compute an estimate of the overall rate of nonacute

days of care within the 136 medical/surgical VAMCs as a group. This estimate reflected the ratio of two weighted averages, non-acute days of care and total days of care, in the 50 VAMCs.⁴ The weighting was composed of the inverses of the sampling fractions from each stage in the two-stage sample design. The variance estimate was calculated by a similar extension of the within-VAMC variance to the two-stage sample design.

Ninety-five percent confidence intervals were placed around each estimate of non-acute days of stay. All formulas used to calculate the rates and standard errors are available from the authors on request.

Analyses

The VAMC-specific estimates of the rates of nonacute days of care were rank ordered, and descriptive statistics were computed for the distribution. For each hospital stay longer than 1 day, the proportion of non-acute days was calculated as the number of nonacute days divided by the number of days in a medical or surgical unit. Hospitalizations in which the patient was admitted and discharged on the same day and those with discharges on the day after admission were excluded because these hospitalizations were not reviewed using the AEP day of care criteria, only the AEP day of admission criteria.

The AEP abstracters were required to list up to three reasons for each nonacute day, with no hierarchical ordering of reasons when more than one reason was documented. The frequencies of reasons for non-acute days of care were tabulated for each sampled VAMC and the 50 VAMCs as a group by summing over the three possible reasons. In addition, the reasons for non-acute days of care were categorized according to whether the patient needed continued hospitalization beyond the day of stay under review and whether the admission was medical or surgical. Reviewers determined the

need for continued stay at the acute inpatient level of care in the particular VAMC beyond the day of care being reviewed by looking ahead in the medical record to identify any scheduled procedures, such as a surgical procedure, that required an inpatient stay. However, unpredictable events such as a stroke or a nosocomial infection would not be considered to indicate the need for continued hospitalization. Because of the nonhierarchical ordering of reasons and the small expected frequencies, variation in the relative frequencies of the reasons across the 50 VAMCs was not examined statistically but was simply compared descriptively.

Each hospital stay longer than 3 days (i.e., with at least 3 days of care reviewed after the day of admission) was divided into thirds and categorized by length of stay stratum (4-7, 8-14, 15-28, and 29+ days). The distributions of nonacute days by the respective thirds of the stay were then calculated to identify whether more nonacute days occurred in specific thirds of the stay and whether location of nonacute days within the stay varied by length of stay. Conceptually, nonacute days in the first one third may be indicative of premature admissions, nonacute days in the second one third may be indicative of problems in effectively coordinating services, and nonacute days in the last one third may be related to difficulties in achieving timely discharges. Previous research has shown that nonacute days are more likely to be found in the last one third of the hospital stay, indicating potential discharge problems.⁵⁻⁸

For these analyses, days of hospitalization were classified as following either a medical or surgical admission, depending on whether the admission was reviewed by the AEP medical or surgical admission criteria and not on the actual bed section in which the patient was hospitalized on that day of care. The VA bed section for each day of care was not obtained during the review process. Therefore, the designation of medical and surgical refers to the type of AEP admission

review, not VA bed section for the day of care.

Results

Estimated Rates of Nonacute Days of Care

The study estimated that $48 \pm 2\%$ of the medical/surgical inpatient days of care were nonacute in the 136 medical/surgical VAMCs during FY86. Therefore, there is a 95% probability that the true rate of nonacute medical/surgical days in the 136 VAMCs was between 46 and 50% in FY86.

The VAMC-specific estimates, together with their respective confidence intervals, are displayed in rank order in Figure 1. The distribution of nonacute days ranged from 38–72% with a median of 49%. The margins of error for the estimates were relatively large, such that several confidence intervals contained values greater than 100% or less than zero, which are not allowable values for a rate. Therefore, the upper or lower bounds of those intervals were truncated to 100% or 0%, respectively. Also, all the con-

fidence intervals overlapped. The magnitude of the variance estimates for nonacute days in each VAMC was due, in part, to the considerable variability in the number of nonacute days within the longest length of stay stratum (>28 days). The large frequency of both very long nonacute and very long acute stays in most VAMCs resulted in extremely wide variation around the stratum mean. In addition, variation in length of stay, another contribution toward the variance of the ratio estimator, was obviously large for the longest length of stay stratum. However, even when the longest length of stay stratum was deleted from the estimates, the confidence intervals were still extremely wide.

Proportion of Nonacute Medical and Surgical Days of Stay

Of the 56,254 medical/surgical days of care reviewed (excluding the day of admission and discharge), 27,985 (49.7%) were nonacute (Table 1). Descriptively, 50%

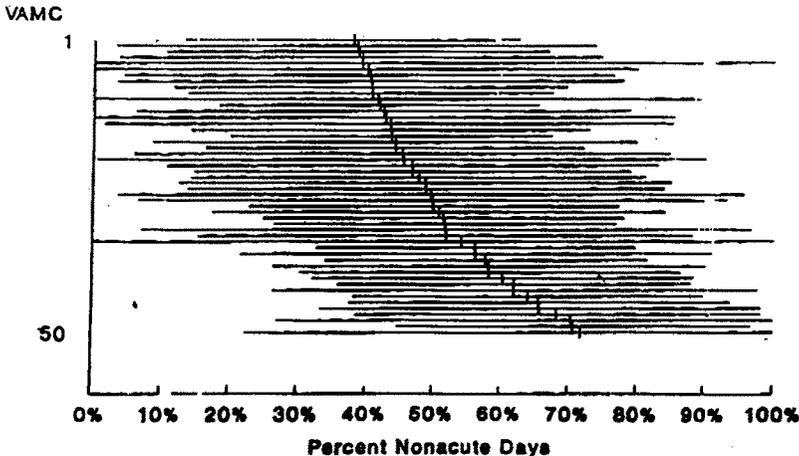


FIG. 1. Estimated rates of nonacute days for each VAMC with associated 95% confidence intervals. Excluding admission and discharge days. Displayed in rank order of estimates.

TABLE 1. Numbers and % of Nonacute and Acute Days of Care Following a Medical and a Surgical Admission

Admission	Day of Care Decision		Total
	Nonacute	Acute	
Medical			
N	23,337	23,048	46,385
%	50.3	49.7	82.5
Surgical			
N	4,648	5,221	9,869
%	47.1	52.9	17.5
Total			
N	27,985	28,269	56,254
%	49.7	50.3	100.0

(23,337/46,385) of the days of stay associated with a medical admission and 47% (4,648/9,869) of the days associated with a surgical admission were nonacute. Due to the extremely large numbers of days, these proportions are statistically significantly different at the $P = 0.0001$ level according to a chi-squared test of independence. Whereas a significant positive linear relationship

(Pearson's product moment correlation coefficient = 0.63, $P < 0.0001$) was found between the proportions of nonacute medical and surgical admissions across VAMCs,² the relationship between the proportions of nonacute days of care following medical versus surgical admissions across VAMCs was not significant (Pearson's product moment correlation coefficient = 0.19, $P = 0.18$).

Distribution of Nonacute Days Within Hospital Stays

As illustrated in Figure 2, the distribution of the proportion of nonacute days within a stay was not at all similar to that of a normal distribution in which the probability or relative frequency is concentrated at the distribution's mean. In fact, the reverse was true. Instead of the bell-shaped curve of a normal distribution, the shape of the distribution approximated a "negative" or an inverted bell with the relative frequencies concentrated at the tails and few observations at the

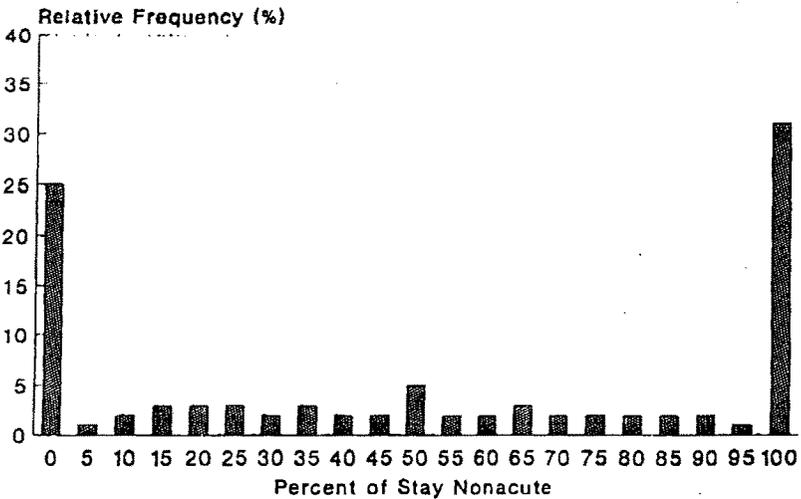


FIG. 2. Percent of stay nonacute for hospitalizations longer than 1 Day (N = 5,411). 0-1 day stays excluded from sample.

mean. Over one half the stays (56%) were determined to be either completely acute (25%) or completely nonacute (31%). The stays with a mix of acute and nonacute days were relatively evenly distributed between 1 and 99%.

This U-shaped distribution was essentially the same, with only minor variation, for each individual VAMC, each length of stay stratum, and each admission bed section stratum (medical or surgical). The longest length of stay stratum (> 28 days) had more mixed stays, but the inverted distribution was still dominant. It is these distributions that partially account for the very large VAMC-specific variances described earlier. Given the variance is the squared differences between observed values and the sample mean, the distributions presented in Figure 2 could not have resulted in precise estimates of the rates of nonacute days for individual VAMCs.

When the hospital stays for cases with a mix of acute and nonacute days and lengths of stay greater than 3 days (at least 3 days beyond the day of admission) were divided into thirds within the length of stay strata, the last one third of the stay was found to have considerably more nonacute days than either the first or second one third (Table 2). Overall, the first one third of the stay had the lowest proportion of nonacute days (40%), followed by the second one third (43%). The greatest proportion of nonacute days was in the last one third of the stay (61%), suggesting possible difficulties in achieving timely discharges. When the stays

were stratified by length-of-stay category, the proportions of nonacute days in the second one third tended to be slightly greater than those in the first one third for all length-of-stay categories except the shortest (4-7 days). In this category, the proportion in the first one third was similar to that in the second one third of the stay. In the longest length-of-stay category (> 28 days), however, the last one third had proportionately fewer nonacute days, which was primarily due to a few very long hospitalizations for which almost all days of stay were determined to be acute.

Need for Continued Hospitalization

For 87% of all nonacute days of care, the patient did not require continued hospitalization beyond that day (Table 3). When the patient's entire stay was completely nonacute, which accounted for approximately 37% of all the nonacute days of care, the patient did not need continued hospitalization beyond the day reviewed for almost all (98%) of the days. The small percentage of cases where the patient did need continued hospitalization was due to circumstances such as a patient being scheduled for a test or procedure (i.e., a need for continued hospitalization) but never having the test or procedure performed and not meeting other criteria that would justify an acute level of care (i.e., nonacute day of care). However, 80% of the nonacute days in the mixed stays were associated with the lack of need for continued hospitalization.

Need for continued hospital care was greater for nonacute days after a surgical admission (34%) than for nonacute days after a medical admission (9%). This was particularly the case for mixed stay hospitalizations (41 vs. 15%, respectively). The larger percentages for the surgical admissions may be because a scheduled surgical procedure, regardless of whether the procedure is actually performed, is justification of a need for continued hospitalization.

TABLE 2. Proportion of Nonacute Days by Location Within Stay and Length of Stay for Mixed Stays Only (36,479 days of care)

Location (Thirds)	Length of Stay (days)				Total
	4-7	8-14	15-28	>28	
First	32.6	35.9	39.7	42.5	39.6
Second	32.8	40.5	45.2	44.8	43.1
Third	65.9	63.2	63.4	55.7	60.7

TABLE 3. Need for Continued Hospitalization Beyond the Day of Care Reviewed Associated With Nonacute Days of Care for All Hospitalizations, Completely Nonacute Hospitalizations, and Mixed Stay Hospitalizations by Type of Admission

	Continued Hospitalization				Total N
	Needed		Not Needed		
	N	%	N	%	
All Hospitalizations					
Medical admissions	2,195	9.4	21,142	90.6	23,337
Surgical admissions	1,579	34.0	3,069	66.0	4,648
Total admissions	3,774	13.5	24,211	86.5	27,985
Completely Nonacute Hospitalizations					
Medical admissions	95	1.0	9,051	99.0	9,146
Surgical admissions	168	13.6	1,066	86.4	1,234
Total admissions	263	2.5	10,117	97.5	10,380
Mixed Stay Hospitalizations					
Medical admissions	2,100	14.8	12,091	85.2	14,191
Surgical admissions	1,411	41.3	2,003	58.7	3,414
Total admissions	3,511	19.9	14,095	80.1	17,605

As illustrated in Table 4, approximately 95% of the nonacute days of care in the last one third of the hospital stay did not require continued hospitalization beyond the day of care reviewed. This again suggests possible difficulties in achieving timely discharges. For medical admissions, 85% of the nonacute days during the first one third of the stay and 88% during the second one third were associated with patients who did not require continued inpatient level of care. For surgical admissions, however, only 30% of the nonacute days during the first one third and 64% during the second one third were days where continued hospitalization was not needed.

Reasons for Nonacute Days of Care

When the reviewers determined that the patient needed continued hospitalization beyond the day of care reviewed, the most frequent reasons for the nonacute day were related to operational inefficiencies, such as premature admission and delay in receiving results of diagnostic tests or consultation (Table 5). Each of these reasons accounted for approximately 24% of the nonacute days. Premature admission was the reason for 42% of the nonacute days after a surgical admission but only 10% of the nonacute days after a medical admission. On the other hand, 32% of the nonacute days after a med-

TABLE 4. Number and % of Nonacute Days of Care Where Continued Hospitalization Beyond the Day of Care Reviewed Was Not Needed By Type of Admission and Third of Stay (Stays of 3 Days or Less Not Included)

Admission	First	Third of Stay		Total
		Second	Third	
Medical	5,426 (85.4%)	6,284 (88.4%)	8,907 (95.6%)	20,619
Surgical	444 (30.5%)	718 (64.0%)	1,569 (93.6%)	2,731
Total	5,870 (75.1%)	7,004 (85.0%)	10,476 (95.3%)	23,350

TABLE 5. Reasons for the 3,774 Nonacute Days of Care for Medical and Surgical Admissions When Continued Hospitalization is Needed*

Reason	Admission					
	Medical		Surgical		Total	
	N	%	N	%	N	%
Premature admission	240	10.1	794	42.3	1,034	24.2
Delay in receiving results of diagnostic test or consultation	768	32.2	258	13.7	1,026	24.1
Patient out on pass	343	14.4	370	19.7	713	16.7
Problem in hospital scheduling of operative procedure	386	16.2	198	10.5	584	13.7
Problem in hospital scheduling of tests or nonoperative procedure	260	10.9	53	2.8	313	7.3
No reason identified	235	9.8	59	3.1	294	6.9
Delay due to procedures not done on weekend—40 hour week problem	125	5.2	109	5.8	234	5.5
Patient bumped because of operating room problem	17	0.7	22	1.2	39	0.9
Other	12	0.5	16	0.9	28	0.7
Total	2,386	100.0	1,879	100.0	4,265	100.0

* Medical record abstracters could list up to three reasons for nonacute days of care with no hierarchical order assumed. Thus, N represents the number of times the reason was listed and % represents the percentage of total reasons in which the reason was listed.

ical admission were due to a delay in receiving test or consultation results as compared with 14% of the days for a surgical admission. In addition, 21% of the nonacute days where continued hospitalization was needed were attributed to delays in scheduling operative or nonoperative procedures. For medical admissions, problems in scheduling an operative procedure accounted for 16% of nonacute days and problems in scheduling tests or nonoperative procedures for 10% of the days. For surgical admissions, these two reasons accounted for 11 and 3% of the nonacute days, respectively. The nonacute days following medical admissions were for procedures scheduled after the patient was admitted and therefore were not reviewed by the AEP surgical admission criteria. This rationale also applies to the small number of days after medical admissions in which patients were "bumped" because of an operating room problem.

For 17% of the nonacute days when the patient needed continued hospitalization

(14% for medical admissions and 20% for surgical admissions), the patient was out on pass. These were days when the patient was allowed to leave the medical center for at least a day, e.g., over the weekend, but was expected to return to the medical center to resume hospitalization. Even though the patient was not in the hospital, the day of care was classified as nonacute because the patient did not meet medical criteria for an inpatient level of care and had not been formally discharged. For those patients who needed continued hospitalization beyond the day reviewed, this may actually have been an appropriate use of hospital resources, potentially equivalent in terms of quality of care and cost to a formal discharge and readmission.

When the reviewers determined that the patient did not need continued hospitalization beyond the day reviewed, conservative patient management was the primary reason for the nonacute days of care, accounting for approximately 43% of these non-

TABLE 6. Reasons for the 24,211 Nonacute Days of Care for Medical and Surgical Admissions When Continued Hospitalization is Not Needed*

Reason	Admission					
	Medical		Surgical		Total	
	N	%	N	%	N	%
Conservative patient management	11,610	41.8	1,963	48.2	13,573	42.6
Patient needs lower level of care	8,465	30.4	834	20.5	9,299	29.2
Awaiting placement in nursing facility	1,592	5.7	113	2.8	1,705	5.3
Patient out on pass	1,309	4.7	195	4.8	1,504	4.7
Failure to initiate timely discharge planning	990	3.6	89	2.2	1,079	3.4*
Outpatient procedure (override)	131	0.5	526	12.9	657	2.1
No documented plan for active treatment or evaluation of patient	625	2.2	30	0.7	655	2.1
Stay on detoxification unit	546	2.0	0	0.0	546	1.7
Medical stay for physical rehabilitation service	321	1.2	154	3.8	475	1.5
Lower level of care (override)	409	1.5	30	0.7	439	1.4
Patient/family requires additional health education	137	0.5	42	1.0	179	0.6
Other	1,665	6.0	100	2.5	1,765	5.5
Total	27,800	100.0	4,076	100.0	31,876	100.0

* Medical record abstractors could list up to three reasons for nonacute days of care with no hierarchical order assumed. Thus, N represents the number of times the reason was listed and % represents the percentage of total reasons in which the reason was listed.

acute days (Table 6). Surgical admissions had a slightly higher percentage of days attributed to this reason (48%) than medical admissions (42%). The second most frequent reason for the nonacute days was that the patient needed a lower level of care, such as nursing home care (29%); 30% of these nonacute days were associated with medical admissions and 20% were associated with surgical admissions.

Thirteen percent of the nonacute days of care associated with surgical admissions were due to an outpatient procedure override. If an approved outpatient procedure was performed on an inpatient basis and no patient risk factors were present, the surgical admission was deemed to be nonacute. However, the patient's day of care on which the procedure was performed would normally meet AEP criteria for an acute day of care. To deal with this conflicting situa-

tion, the day of care on which the procedure was performed was overridden from acute to nonacute.

A number of nonacute days were due to the VA providing nonmedical/surgical care in the acute care setting. Examples of such days were for physical rehabilitation (1.5%), psychiatry services (0.5%), and stays in detoxification units (1.7%). These days may have been a consequence of unavoidable constraints within the specific facility, such as a patient needing psychiatric care when the VAMC had no inpatient psychiatric service and, therefore, having to be cared for in an acute medical/surgical bed. Other nonacute days may have been a consequence of poor documentation, such as absence of notes regarding patient transfer to an intermediate care bed. Not frequently cited were reasons associated with the VA's social mission, such as VA eligibility or social/eco-

conomic considerations delaying discharge. However, the extent to which such reasons are documented in the medical record is unknown.

Discussion

The study estimated that almost one half ($48 \pm 2\%$) of the days of care provided in acute medical and surgical units in the 136 medical/surgical VAMCs during FY86 may not have required an acute inpatient level of care based on the AEP clinical criteria. This result does not imply that no medical care was needed but does suggest that the needed care could have been provided at a less service-intensive and possibly less expensive level if the resources and incentives to do so existed. Some of the days determined to be nonacute may have been a consequence of poor medical record documentation. However, without evidence in the medical record justifying the need for an acute inpatient level of care, the care was assumed to have been nonacute.

The overall estimate of nonacute days of care is somewhat higher than the percentage cited in the General Accounting Office (GAO) report.⁹ That study indicated that 43% of medical/surgical days in the VA during FY82 and 31% in FY84 could have been avoided. The GAO study of FY82 patients comprised a random sample of only 50 records from each of seven VAMCs and used the Intensity of Service, Severity of Illness, and Discharge Screening (ISD) criteria rather than the AEP. These seven VAMCs were among a group of 15 VAMCs selected to be representative of VAMCs as defined by geographic location, length of stay, size (number of beds), and university affiliation. However, these seven did not include any of the five smallest hospitals of the 15 and all had some degree of university affiliation. Critically, it appears that neither the 15 nor the seven within the 15 were selected at random, thus raising issues of bias and generalizability. Patients whose length of stay ex-

ceeded 99 days or who were discharged from psychiatric, intermediate medicine, rehabilitation, and spinal cord injury wards were likewise excluded.

The GAO also reviewed a sample of patients hospitalized in six of the seven VAMCs in FY84. This sample was reviewed concurrently by a team of physicians using clinical judgment rather than explicit criteria and a screening instrument. Patients were evaluated if they occupied wards specifically identified as "representative," although this criterion was not defined or measured. The proportion of unnecessary days identified by this second method was lower than that based on the ISD criteria. As found in the current study and reported elsewhere,¹⁰ physicians may be more likely to rate care as acute than nonacute, particularly if they have not been trained to focus strictly on utilization review. Given the lack of consistency in the methodology, it is impossible to disentangle whether the difference between the two rates of nonacute care reported by the GAO is due to review approach, sampling bias, or effect of time.

It is also not clear from the GAO report how the estimates of nonacute care were calculated. The rates of unnecessary days of care (43% in FY82 and 31% in FY84) appear to be descriptive only, given that no estimate of sampling variability was presented. The confidence interval for the estimated total number of nonacute days within the seven VAMCs was $255,316 \pm 39,263$ days. However, without knowledge of the exact estimation methodology used, it is not clear whether a more precise estimate could have been obtained. In any case, the confidence interval presented is, indeed, imprecise. The margin of error is 15% of the estimate, a size that may have been due to the small number of patients ($7 \times 50 = 350$) and relatively small number of days reviewed (total not presented in the report, but could not have been much greater than 5,000). In contrast, the sample of 6,063 hospitalizations and

56,254 days of care reviewed in the current study permitted the estimation of the rate of nonacute days of care for the entire population of 136 medical/surgical VAMCs with a 2% margin of error. In addition, the sample design for the current study allowed estimation of VAMC-specific rates of nonacute days of care and identification of VAMCs with low and high rates, which ranged from 38-72%. This range is somewhat comparable to the descriptive values presented in the GAO report, where the percentage of "avoidable days" ranged from 32-51%, and to the results of the GAO's concurrent review of six of seven hospitals (22-40%).

The two reviews conducted by the GAO are neither strictly comparable to each other nor to the study reported here. In the current study, all patients admitted to medical or surgical services with lengths of stay less than 1 year in FY86 were sampled, and all days in acute medicine or surgery bed sections were reviewed. This scheme thus provides a better sampling of care provided by the VA in acute care settings. In addition, the randomly sampled hospitalizations were representative of VAMC workloads within the randomly sampled VAMCs, thus avoiding bias in selection of VAMCs or hospitalizations.

The estimated rate of nonacute medical/surgical days of care (48%) tended to be higher than those previously reported in studies of private sector hospitals since 1983, although direct comparisons are difficult to make for reasons discussed previously.² Restuccia et al.⁴ found nonacute patient day rates ranging from 18-46% for three Massachusetts hospitals in 1984-1985 using the AEP. It must be noted, however, that Massachusetts is a highly regulated state; thus, the rates would be expected to be lower than in other less regulated states. Strumwasser and Paranjpe¹¹ reported that 39.6% of the medical/surgical patient days for a random sample of 1,266 admissions to 21 randomly selected southeastern Michi-

gan hospitals in 1983 were nonacute based on an AEP review. Although their overall rate was lower than the current study's estimate (48%), they also found wide variation in the rates among hospitals. For medical days of care, the rates ranged from 15-74%, with an average rate of 42%. For surgical days of care, the rates ranged from 0-65%, with an average rate of 28%. These compare with the current study's estimates of nonacute days, which ranged from 38-72%. Although the upper levels of the ranges tended to be fairly comparable across the two studies, the current study did not find lower rates of nonacute days approaching the levels of some hospitals reported by Strumwasser and Paranjpe.

In the current study, the VAMC-specific estimates for nonacute days of care were relatively imprecise as all the confidence intervals overlapped each other even though there was a wide range of estimates. Therefore, even with the most lenient of decision rules, no VAMC-specific rate would appear to be significantly different from another. The large margins of error for the VAMC-specific rates (approximately 50% of the estimates) were calculated from sample sizes between 113 and 125 per VAMC. These margins of error, compared with a 15% margin of error in the GAO report from a sample size of 350 and a 2% margin of error for the overall estimate for the 136 VAMCs, indicate the strong effects of smaller sample sizes on precision. Given that the ratio estimators were the minimum variance estimators among all linear, unbiased estimators,³ and given the U-shaped distributions of nonacute days of care, it is not clear how more precise estimates could have been obtained with the given VAMC sample sizes. These were sample sizes specifically calculated to achieve good precision for the estimates of nonacute admissions, not of nonacute days of care.

The findings, that 1) 95% of the nonacute days of care in the last one third of the hospi-

tal stay did not require continued hospitalization beyond the day of care reviewed, 2) 43% of the nonacute days where continued hospitalization was not required were related to conservative patient management and 29% were associated with the patient needing a lower level of care, and 3) 61% of all days in the last one third of the stay were nonacute, point to the need to improve the effectiveness and efficiency of the discharging process. Given that "failure to initiate timely discharge planning" and "nondocumented plan for active treatment or evaluation of patient" accounted for only 3% and 2%, respectively, of the reasons for nonacute days of care when continued hospitalization was not needed, the critical issue may not be whether discharge planning is being done. Rather, the stringency of the discharge criteria being used and/or the effectiveness of the discharge planning and actual discharging process may be the central problem.

Overwhelmingly, the study's abstracters ascribed the nonacute care to reasons that could be considered the responsibility of the hospital and/or physician rather than the patient/family or the environment. The absence of social factors documented in the medical record may represent a crucial factor in understanding the high rates of nonacute days of care. Rather than attributing the vast majority of these nonacute days to hospital and physician actions, and thus suggesting large inefficiencies, it may be that the patient's social situation was being addressed with resources from the acute inpatient care environment without being documented in the medical record. Study and documentation of these social needs are required for VA policy makers to determine how to meet both its medical care and social support missions most effectively and efficiently.

Although the proportion of nonacute days of care were found to be similar for medical and surgical admissions, there ap-

pear to be differences in the nature of the reasons for the nonacute days, particularly when continued hospitalization is needed. The major reason for nonacute days of care associated with the surgical admissions where continued hospitalization was needed was premature admission, i.e., patients admitted several days before scheduled surgery. In fact, 53% of the 1,518 patients scheduled for an elective procedure did not have surgery performed within 24 hours of admission.² On the other hand, the primary reasons for the nonacute days associated with a medical admission where continued hospitalization was needed related to operational inefficiencies in scheduling and receiving the results of tests, consultations, and nonoperative procedures. Also, substantially greater percentages of nonacute days of care during the first two thirds of the stay that did not require continued hospitalization beyond the day reviewed were associated with medical admissions versus surgical admissions. Thus, for medical admissions, there appears to be the need to focus on the efficiency of the production process once the patient has been admitted. For surgical admissions, questions need to be raised about the policies related to preadmission testing, appropriate duration of time before surgery for anesthesia workup, and preoperative lengths of stay.

The results of this study suggest that changes in admitting and continued stay practices may be needed to reduce the level of nonacute hospital level care. In particular, the finding that 31% of the hospitalizations were completely nonacute suggests that stringent reviews of the need for hospitalization should be undertaken either before admission through mechanisms such as preadmission review and certification or soon after admission through explicit concurrent review practices. In 1985, the GAO recommended that the "VA develop expectations regarding patient management practices, generate better information to assess hospi-

tal performance, and improve hospital monitoring systems."¹⁰ It is noteworthy that this report was issued immediately before the study period in question here. These recommendations are supported by the results of the current study.

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ABSTRACT

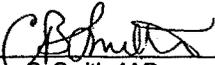
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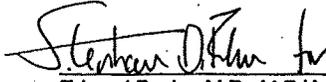
"Pilot Study of the ISD* Measure of Appropriateness of Bed Utilization"

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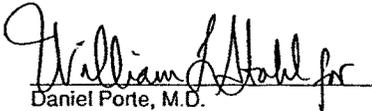
The objective of this pilot study was to evaluate the validity and reliability of the InterQual ISD* system for assessing the appropriateness of admissions and days of care on acute medical, surgical, and psychiatric services in VA hospitals. Twenty-four hospitals were randomly selected from stratified groups to represent the variety of VA hospitals, and utilization reviewers from these hospitals were trained in use of the ISD* criteria. Over a nine-month period, hospital reviewers submitted copies of one chart and its concurrent review each week from each of the three clinical services to InterQual for master review. Reliability of hospital reviewers, as measured by agreement with the master reviewers, was excellent for all three service criteria with 85% overall agreement and a kappa statistic of 0.7 (kappa adjusts for chance agreements and a value of >0.4 is satisfactory). Validity of the ISD* criteria was tested by comparing the ratings of the InterQual master reviewers on 70 charts from each clinical service with the ratings of panels of nine physicians representing each of the clinical services. The medical criteria were validated (74% agreement, kappa 0.5) as were the surgical criteria (74% agreement, kappa 0.45), while the psychiatric criteria were not validated by the physician panel (66% agreement, kappa 0.294). Nonacute admissions and days of care as determined by the master reviewers using the ISD* criteria were found to be 47% for medical service admissions and 45% for days of care. On surgical service, 64% of admissions and 34% of days of care were nonacute. High rates of nonacute admissions and care were found in all hospitals studied. Reasons for nonacute admissions and days of care included nonavailability of an ambulatory care alternative; conservative physician practices and delays in physician discharge planning; social factors such as homelessness; and long travel distances from home to the hospital.



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EXECUTIVE SUMMARY

HSR&D Project SDR #91-010

Pilot Study of the ISD* Measure of Appropriateness of Bed Utilization.

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I. Abstract. The objective of this pilot study was to evaluate the validity and reliability of the InterQual ISD* system for assessing the appropriateness of admissions and days of care on acute medical, surgical, and psychiatric services in VA hospitals. Twenty-four hospitals were randomly selected from stratified groups to represent the variety of VA hospitals, and utilization reviewers from these hospitals were trained in use of the ISD* criteria. Over a nine-month period, hospital reviewers submitted copies of one chart and its concurrent review each week from each of the three clinical services to InterQual for master review. Reliability of hospital reviewers, as measured by agreement with the master reviewers, was excellent for all three service criteria with 85% overall agreement and a kappa statistic of 0.7 (kappa adjusts for chance agreements and a value of >0.4 is satisfactory). Validity of the ISD* criteria was tested by comparing the ratings of the InterQual master reviewers on 70 charts from each clinical service with the ratings of panels of nine physicians representing each of the clinical services. The medical criteria were validated (74% agreement, kappa 0.5) as were the surgical criteria (74% agreement, kappa 0.45), while the psychiatric criteria were not validated by the physician panel (66% agreement, kappa 0.294). Nonacute admissions and days of care as determined by the master reviewers using the ISD* criteria were found to be 47% for medical service admissions and 45% for days of care. On surgical service, 64% of admissions and 34% of days of care were nonacute. High rates of nonacute admissions and care were found in all hospitals studied. Reasons for nonacute admissions and days of care included nonavailability of an ambulatory care alternative; conservative physician practices and delays in physician discharge planning; social factors such as homelessness and long travel distances from home to the hospital.

II. Introduction and Background. In 1986 and in 1989 two VA-HSR&D initiated studies showed that more than 30% of admissions to acute care medical and surgical services were "nonacute," meaning that the admission was unjustified or inappropriate based on lack of documented need for the acute level of care^{1,2}.

Additionally, one of these studies³ concluded that an even larger percentage of hospital days spent on acute medical and surgical services were nonacute, that is, the patients could have been cared for at a lower and less expensive level of care. In 1990 the Office of Quality Management charged a Utilization Management Task Force to help them develop a VA system-wide program which would assist managers at the national, regional and hospital levels assess the appropriateness and efficiency of utilization of acute medical surgical and psychiatric beds in VA. A major goal of this program would be to identify reasons for inappropriate bed utilization and to recommend corrective changes in VA policies and practices.

The Task Force recommended this study to evaluate a new review instrument under field conditions. The AEP (Appropriateness Evaluation Protocol) instrument used in the two previous studies did not include criteria for assessing psychiatric admissions, and the experienced UR members of the Task Force felt that the AEP was difficult to use for nonmedical reviewers. The Task Force members chose the InterQual ISD* (Intensity, Severity, Discharge)⁴ instrument for evaluation in the pilot because it provided criteria for psychiatry as well as medicine and surgery, and because it was already in use in many VA hospitals.

III. Objective. The objective was to evaluate the validity and reliability of the InterQual ISD* utilization review criteria for assessing the appropriateness of admissions and days of care on acute medical, surgical and psychiatric services in VA hospitals. Additional goals were to compare the efficacy of two methods for training and monitoring hospital based reviewers:

- A. The use of master reviewers with immediate feedback and negotiation to agreement.
- B. Standard teaching charts with written feedback.

Although not a primary goal of this pilot project, it was expected that the review of over 2000 patient charts should give an indication of the current (1992) extent of the problem of nonacute admissions and days of care in VA hospitals and provide some insights into the reasons for the nonacute care.

IV. Methods. The InterQual ISD* criteria used in this study were the 1991 criteria for medical and surgical admissions and the 1992 criteria for psychiatry. The criteria were only slightly modified to facilitate the study. They were based on evaluations of three components of medical care as documented in the clinical record:

- A. **Severity of Illness** criteria included objective clinical parameters, such as high fever or hypotension, that reflect the need for hospitalization.
- B. **Intensity of Service** criteria included diagnostic and therapeutic services, such as hourly vital signs or intravenous medications, that generally require hospitalization on an acute service.
- C. **Discharge Screens** included measures of patient instability, such as continued fever or confusion, that reflect the need for continued hospitalization.

To allow for generalization of our findings to the entire VA hospital system, the 24 study hospitals were randomly selected from a matrix of hospital types that was stratified to include each of the six hospital complexity groups and the four VA geographic regions. Hospital reviewers were the current utilization reviewers at each hospital. They all attended a two-day training course on the use of the InterQual ISD*

criteria and the reviewers from each hospital were then randomized into two groups for comparisons of two training methods.

The study was conducted over a nine-month period during which reviewers from each of the three clinical services submitted one randomly selected chart and review each week to InterQual Inc. for review by a small group of professional master reviewers. The reliability of the hospital reviewers was evaluated by measuring the degree of agreement between the hospital reviewers and the master reviewers. The two training methods were evaluated using this same reliability data base to assess the magnitude of changes in reliability over time. For all admissions or days of care that were determined to be nonacute, the reviewers selected, in order of importance, up to three reasons for failing to meet criteria.

The validity of the ISD* instrument was evaluated by comparing the degree of agreement between master reviewers with the judgements of separate panels of nine internists, surgeons and psychiatrists who reviewed 70 charts from each service using clinical judgment rather than the ISD* instrument.

V. Results.

Validity. The three physician panels were first evaluated for internal consistency regarding their judgements after the consensus conferences. The mean square error measure of the degree that individual panelists differed from the group mean was quite low for the medical panel (0.69), and higher for the surgery (1.70), and highest for the psychiatry panel (2.25); indicating that the psychiatry panel had the greatest difficulty reaching consensus. The major test of validity of the InterQual ISD* criteria was comparison of the ratings of InterQual master reviewers with the "gold standard" determinations of the panels regarding appropriateness of admissions. The medicine and surgery ISD* criteria were both validated by their panels which agreed with the ISD* determinations on 74% of the charts. The kappa statistic which adjusts for chance agreements in measuring agreement was 0.502 for the medical criteria and was 0.46 for the surgical criteria. Values that are greater than 0.4 are usually judged to indicate satisfactory agreement. The ISD* psychiatry criteria, in contrast, were not validated by the panel of psychiatrists. There was agreement on only 66% of the charts and the kappa value was unsatisfactory at 0.294. Because the criteria for all of the three services allowed a false negative rate of greater than 25%, the steering committee recommended that the InterQual ISD* criteria not be used to exclude any individual patients from admission to the hospital. They did feel that the medicine and surgery criteria were sufficiently valid to be useful in assessing the rates and causes of nonacute admissions and days of care in evaluating policies and programs at the hospital and larger system levels.

Reliability. There was a high degree of agreement between the hospital reviewers and the InterQual master reviewers using admission criteria for medicine (88%, kappa 0.75), surgery (86%, kappa 0.71) and psychiatry (83%, kappa 0.63). Similar agreement was found for the appropriateness of the days of stay criteria.

Evaluation of two training methods. Both groups of hospital reviewers showed a slight decrease in reliability over the nine-month study period and there was no significant difference between the two interventions.

Nonacute admissions and days of care. Concurrent review of 2432 admissions to acute medical, surgical and psychiatric services in the 24 pilot hospitals indicated that more than 30% of admissions and days of care were determined to be nonacute by both the master reviewers and the hospital reviewers. The physician panels also found similar high rates of nonacute admissions on review of the 70 charts used in the validity study.

Percent Nonacute Admissions And Days of Care

<u>Service</u>	<u>Master Reviewer</u>	<u>Hospital Reviewer</u>	<u>Physician Panels</u>
Medical			
Admit	47%	38	36
Days	45	36	-
Surgical			
Admit	64	57	64
Days	34	32	-
Psychiatry			
Admit	42	32	41
Days	38	32	-
Total			
Admit	50	42	47
Days	37	33	-

These high rates of nonacute admissions and days of care were found in all 24 hospitals studied and the spread between the hospitals with the highest and those with the lowest rates (41-68%) was small indicating the problem of nonacute care was system-wide.

Reasons. Practitioner reasons such as conservative practice for admissions and delays in discharge planning for nonacute days of care accounted for 32% of nonacute admissions and 43% of nonacute days of care for medical service. Lack of availability of an ambulatory program for surgery and invasive medical procedures explained 36% of nonacute admissions to surgery and 18% to medicine. Other important reasons for nonacute admissions included social and environmental reasons such as homelessness and long travel distances to the hospital. Administrative reasons included admissions to permit placement in nursing homes, payment for travel or for disability evaluations.

Conclusions. The ISD* utilization review criteria were validated for the medical and surgical criteria but not for the psychiatric criteria. Under the conditions of this pilot study, hospital reviewers were found to be able to use the ISD* criteria in a reliable manner and intensive methods for continuing training were not necessary to maintain reliability. Using these criteria in a concurrent review of 2432 admissions to 24 VA hospitals, more than 30% of acute admissions and days of care were determined to be nonacute. Conservative practices by physicians and the lack of availability of ambulatory care alternatives were the most common reasons for nonacute admissions and days of care.

VI. Recommendations

A. VA should establish a system-wide program for using the ISD* criteria for utilization review with emphasis on identifying the local and systemic reasons for nonacute admissions and days of care and for monitoring the effectiveness of changes in policy.

B. VA physicians need to be encouraged to make greater use of ambulatory care alternatives and to be more effective and timely in planning for patient discharges.

C. VA needs to facilitate the shift of care from the inpatient to the outpatient setting. This should include incentives in the reimbursement methodology for providing ambulatory care, changes in eligibility regulations that promote rather than prohibit ambulatory care, prioritization of construction funds and seed funds for new programs to support the shift to ambulatory care.

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FINAL REPORT

**Pilot Study of the ISD* Measurement of
Appropriateness of Bed Utilization**

SDR #91-010

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June 16, 1993

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I. OBJECTIVES

The immediate objective of this study was to develop a reliable and valid system for assessing the appropriateness of admissions and days of care on acute medical, surgical and psychiatric services in VA hospitals. Such a system should be able to estimate the extent and distribution of the practice of admitting nonacute patients to acute services in VA hospitals, and identify specific causes of this practice that can be changed. The ultimate objective was to have this evaluation system accepted by hospital, regional and VA central office managers as useful for identifying opportunities for improving policies and practices in ways that will lead to patients being cared for at a more appropriate level of care. There were two goals involved in achieving these objectives:

A. Goal #1

To evaluate the reliability and validity of the InterQual ISD* (Intensity, Severity, Discharge) instrument for assessing the appropriateness of bed utilization in VA hospitals. This was done under field conditions over a nine-month period using hospital based reviewers. Our hypothesis was that one or both of our selected methods for training and monitoring reviewers in the use of the ISD* instrument will result in a measurement system that is both reliable and clinically valid. We tested reliability by comparing assessments done by hospital-based reviewers with assessments made by master reviewers. Validity of the ISD* instrument was tested by comparing the assessments of master reviewers with the clinical assessments of panels of VA physicians who are expert in the fields of medicine, surgery and psychiatry.

B. Goal #2

To compare the efficacy of two methods for training and monitoring hospital-based reviewers: 1) The use of master reviewers with immediate feedback and negotiation to agreement, and 2) Standard patient charts. Our hypothesis was that the master reviewer method would be more effective over a shorter period of time in training hospital-based reviewers and more effective in maintaining the reliability of their reviews.

II. INTRODUCTION AND BACKGROUND

The VACO Office of Quality Management established a Utilization Management Task Force in 1990 to advise them on the development of a national policy and data base which would assist managers at the national, regional and hospital levels assess the appropriateness and efficiency of bed utilization. In the past, VA medical centers were allowed the freedom to develop their own standards, criteria and measurement instruments for utilization review, and as a result there was no national data base to

assist managers in identifying VA system-wide problems and in developing corrective policies.

Two recent VA-HSR&D initiated studies of multiple medical centers suggested that more than 30% of admissions to acute care medical and surgical services were "nonacute," meaning that the admission was unjustified or inappropriate based on lack of documented need for the acute level of care^{1,2}. Additionally, one of these studies³ concluded that an even larger number of hospital days (48%) spent on acute medical and surgical services were nonacute, that is, the patients could have been cared for at a lower and less expensive level of care.

Assessments of the reasons for nonacute admissions indicated that major causes were lack of availability or utilization of ambulatory care facilities for minor surgeries, invasive testing, and short-term therapies such as blood transfusions and chemotherapy. Other reasons that might be correctable included premature admissions, and the need for a lower level of institutional care such as a nursing home. Reasons which are not as easily altered included long travel distances between home and hospital and social factors such as lack of resources to care for minor illness at home.

Understandably, VA managers (and the Office of the Inspector General and the General Accounting Office) were concerned about these reports of high rates of inappropriate or nonacute admissions and days of care. This concern led the Office of Quality Management to ask the Utilization Management Task Force to help determine the reliability and validity of the appropriateness measures used, and to develop a system-wide utilization review program that would help us understand the extent and causes of these allegedly nonacute admissions and days of care. The demonstration at one VA facility that the proportion of nonacute admissions and days of care decreased by 33% and 39% respectively from 1986 to 1988, presumably as a result of corrective actions, indicates VA needs to be collecting utilization review data over the next 5-10 years to assess the effectiveness of managerial and policy changes⁴.

Data collected in studies of the appropriateness of bed utilization will be used by VA managers to identify problem areas and suggest corrective solutions that will likely involve the shifting of significant resources within the services of individual hospitals, and between hospitals. Thus, it is critical that the reliability and validity of the data be acceptable to everybody involved. Because the previous studies were of fewer than 1/3 of VA medical centers, and because they were conducted under highly controlled research conditions, the next step in implementing a program for VA system-wide surveillance is to evaluate the reliability of the measurement instrument under field conditions. In addition, there is the need to test further the validity and clinical significance of appropriateness measures. Although both studies included physician panels to assess the validity of their measurements, the results were variable and the validity of the test instrument and their findings can be questioned. Particular attention needs to be given to selecting panelists who are recognized by their peers as experts in their professional disciplines and who understand VA practice conditions.

The science of utilization review is rapidly improving. However, it is far from exact and there is no general agreement regarding the best measurement instruments or the

most reliable methods for training and monitoring reviewers^{5,6}. The recently published studies of bed utilization in VA hospitals have been helpful for suggesting where significant problems and solutions might be found, but they are not easily generalizable to the whole VA system. The AEP (Appropriateness Evaluation Protocol) measurement instrument used in these studies⁷ was felt by the experienced UR members of the task force to be difficult for nonmedical people to use and to be inadequate for assessing appropriateness of alcohol/drug rehabilitation and psychiatric admissions. The ISD* (Intensity, Severity, Discharge)⁸ measurement instrument developed by InterQual was felt by the task force to be easier to use by nonmedical reviewers and it allowed for evaluation of psychiatric admissions. It has had some evaluation in the VA system⁹, with excellent Interrater reliability (Kappa 0.8); however, its utility in VA has not been widely tested. In particular, all reported evaluations of AEP and ISD* instruments have been in research settings where selection and monitoring of the reviewers have been under good control. In the Iowa studies^{1,7} all reviewers were trained and supervised at the study center, while in the Region I study², highly experienced professional reviewers were used. There was, therefore, a need to test the ISD* instrument in a larger population, using hospital-based reviewers under "field conditions" so that the results can be more generalizable to the entire VA hospital system.

The methods for training and monitoring hospital-based reviewers are also not highly developed nor generally agreed upon. In this study we evaluated two methods for training and monitoring reviewers: a) the use of standard charts, and b) the use of master reviewers with immediate feedback. In addition to its usefulness for utilization management, the outcome of this comparison should be of value in deciding how to train and monitor reviewers in a wide variety of other VA quality assessments.

We also evaluated the clinical relevance and validity of the ISD* instrument using structured group process methods with expert physician panels. In one of the few comparisons of AEP with ISD* in a non-VA setting, Strumwasser et al¹⁰ found better validity as determined by physician panels with ISD* than with AEP. In this study we had access to the test charts used for validation of AEP in the Iowa study, and thus had the opportunity to compare the validity of these two instruments in the VA setting.

III. SIGNIFICANCE TO VA

This study has already provided information to VA managers which helped them decide it was feasible to establish a national system for utilization review (see Implementation and Progress Report). Since both of the methods for training and monitoring of reviewers were associated with satisfactory reliability of reviewers and with concurrence of clinician reviewers about the validity of the instrument for medicine and surgery, it has been decided to proceed with the VA system-wide assessment of bed utilization for these services. Because the ISD* criteria for psychiatry were not validated, a task force has been charged with developing and testing revised criteria and these will be incorporated into the system-wide UR review. We expect that a

reliable and valid UR system will remain in place for several years to allow for assessment of the effects of policy and managerial changes on bed utilization in VA.

Although the focus in this study was on the question of the appropriate level care on inpatient services in VA, it is important to emphasize that the training techniques and the measurement and evaluation instruments that were developed and refined in this project are applicable to other health care quality problems such as accessibility and timeliness of medical services.

IV. RESEARCH DESIGN AND METHODS

A. Overview and Research Design

Both major goals were simultaneously tested in a pilot study of the ISD* Instrument in 24 VA hospitals. Hospital-based review teams attended a two-day training course on the use of the InterQual ISD* Instrument and on the mechanics of this pilot study. Over the next nine months, hospital reviewers conducted concurrent reviews of 10% of acute hospital admissions to medicine, surgery and psychiatry services for inappropriateness, (hereafter called "nonacute"), of the admissions and days of care. For all admissions or days of care that were determined to be nonacute, the reviewers selected in order of importance, up to three reasons for failing to meet the ISD* criteria.

1. Goal #1 - Reliability and Validity

To evaluate the reliability of hospital reviewers, each hospital submitted a complete copy of the records from 108 randomly selected admissions [36 medical, 36 surgical and 36 psychiatric] to master reviewers for their evaluation. The degree of agreement [reliability] between master reviewer's and hospital reviewer's assessments of acuteness of admissions and days of care was then assessed. The validity of the ISD* instrument was evaluated by comparing the degree of agreement between master reviewers with the judgements of panels of nine internists, surgeons and psychiatrists that reviewed charts using implicit clinical judgment rather than the ISD* instrument.

2. Goal #2 - Comparisons of Two Training Methods

The 24 hospitals were randomly assigned to one of two groups to assess the two methods for training and monitoring field reviewers. Method A used immediate master reviewer feed back with negotiation to agreement, while Method B monitored and trained the field reviewers using 30 standard charts for each clinical service with written feedback each week during the nine-month period of the study.

B. Sampling: Selection of Hospitals and Patients

1. Selection of Hospitals

In this pilot study we were concerned with the generalization of our findings for the entire VA hospital system. For this reason, we selected a broad range of hospital types that represented the diversities characteristic of the VA system. Randomization was done within a stratified matrix of hospital types which included all six of the VA Resource Allocation Model (RAM)¹¹ hospital groupings according to size and complexity, and each of the four geographic regions within each RAM group. We did not attempt to stratify the hospitals according to length of stay scores as done in the Iowa study because the goal of this pilot was to evaluate a measurement instrument, not to assess relative numbers of inappropriate days of care. One hospital was selected using a randomized numbers table to represent each of the 24 possible combinations of RAM group and region. In seven of the 24 selections, the initial hospital selected did not choose to participate; in five of these, the second hospital randomly selected agreed to participate; for the remaining two, the third hospital chosen agreed to participate. In most instances, the refusal to participate was due to impending reviews by the JCAHO and the need to have all UR staff assigned to this task.

All but one hospital had acute medical services in FY 1989, all but two had acute psychiatric services, and 20 of the 24 had acute surgical services.

In order to reduce the potential confounding effects of hospital type, region and number of reviewers per hospital team, the 24 hospitals were stratified into two groups for comparison of the two methods for training and monitoring. For each of the six RAM groups of hospital types two of the four hospitals were randomized to Method A and two to Method B. For each of the four regions, three hospitals were randomized to Method A and three to Method B. Serendipitously, the number of reviewers per hospital team were also equally distributed between the two treatment groups (7 hospitals in each group had three reviewers/team, and five hospitals in each group had two reviewers).

2. Selection of Patients

Patients were selected for utilization review on a randomized basis with proportional representation (approximately 10%) from each of the three acute clinical services: medicine (including neurology), surgery and psychiatry. Patients admitted to chronic care services (rehabilitation, nursing home), or to special program services such as alcohol and drug rehabilitation, were excluded from this study. For smaller hospitals a minimum of 10 patients for review per service per week was required so that all reviewers would be sufficiently busy to maintain their skills.

Selection of charts to be submitted for the master review was also done using a random numbers method. The random selections were computed at a central site and sent to the hospitals on a weekly basis. One completed chart was selected from each

of the three clinical services each week to be copied and submitted for master review. Compliance was 100% with the required submission of one chart/wk for master review for the 36-week duration of the study.

To assess **Interrater reliability** of the hospital reviewers for the 20 hospitals with both medical and surgical services, the two hospital reviewers were randomly assigned one chart each week for duplicate review.

C. Hospital Reviewers

Because this pilot study was designed to test the effectiveness of a utilization review program under field conditions, the hospitals were instructed to use their own judgement in selecting hospital reviewers. The only guidance given to the hospitals was that the reviewers should be familiar with hospital records and they should have had enough experience in record review to be able to discuss appropriateness of admissions with clinicians. The majority of the reviewers were RN's (40) or medical record technicians (12), while eight were experienced coders, LPN's or health systems specialists.

Hospitals were limited to a maximum of three reviewers so that they would maintain their skills, and the majority of hospitals selected individual reviewers for each of the three clinical services; medicine, surgery and psychiatry. Since a major goal of this study was to evaluate the performance of hospitals over time in response to our educational interventions, turnover of reviewers during the nine-month study period was discouraged. There were 60 reviewers at the beginning of the study and five of these were replaced during the subsequent nine months.

D. Master Reviewers

Master reviewers were provided through contract with InterQual, the organization that developed the ISD* criteria. Six reviewers were used with the majority of the reviews conducted by two individuals. Agreement between the master reviewers exceeded 94% which was greater than that observed between the master reviewers and the hospital reviewers.

The master reviewers had two tasks. First, they reviewed the charts submitted each week by the hospital reviewers. The degree of agreement was the basis for our evaluation of reliability of hospital reviewers and the effects of the educational interventions. Second, they participated in the educational intervention by calling the 12 hospital reviewers in the A group to give them immediate feedback and to negotiate to agreement when there were disagreements.

E. Educational Interventions for Hospital Reviewers

1. General

Initial education of all hospital reviewers about the format and operation of the

study and about using the InterQual ISD* criteria was done during a two-day seminar in the fall of 1991. The study coordinators and staff from InterQual conducted didactic sessions on the first day and devoted the second day to actual chart reviews with individual and group discussions. When hospital reviewers left the study, their replacements were trained by a combination of extended telephone conferences with the same study staff and InterQual educators who conducted the initial conference, and by mentoring from established reviewers at their hospital.

At the end of the training sessions, each reviewer was given a pretest consisting of 10 charts in their area of concentration (medical, surgical, psychiatric). At the end of the study, the same charts were reviewed again as a post-test to evaluate learning and maintenance of skills.

A variety of techniques were used to facilitate the participation of hospital reviewers in the study. During the first two months of the study, weekly telephone conferences were held to answer questions and clarify policies and procedures. When common areas of confusion were identified, or when the study coordinators identified a need to add more detail to operational policies, mailings were sent to all study participants. A telephone "help line" was maintained by one of the study staff throughout the study to provide immediate answers to questions about operational policies. These conferences did not consider decisions regarding individual patients.

Midway through the study, the reviewers at each hospital were jointly interviewed using a structured questionnaire to evaluate degree of understanding about the study protocol and compliance. On a few occasions it was necessary for several study staff to visit one of the participating centers to help resolve confusion about the study policies or to address compliance issues. Overall, compliance with the study protocol was remarkably good, with all 24 hospitals completing the study and submitting 100% of the required patient charts to master reviewers.

2. Specific Interventions

Continuing education of the reviewers in the 12 hospitals in Group A was achieved by providing telephone feedback from master reviewers when they did not agree with the determinations of the hospital reviewers. The feedback was in the form of a discussion, and the goal was to "negotiate to agreement," that is, at the end of the discussion the master reviewer and the hospital reviewer were to agree about the final chart evaluation. In 93 instances, the opinion of the master reviewer prevailed. In 65 instances, the new information provided by the hospital reviewer caused the master reviewer to change their evaluation. In the four instances when the master reviewer and the field reviewer could not agree, a second master reviewer was asked to review the chart and make the final determination. In all analyses where comparisons were made between determinations by master and hospital reviewers, the data used were gathered before the negotiation to agreement began.

Reviewers in the 12 Group B hospitals were mailed a test patient chart (standard charts) each week for review. Their results were compared with the review of the master reviewers, and a summary letter describing the master reviewers

determinations and a discussion of common errors was sent back to the Group B reviewers. This written feedback and instruction was generally provided within six weeks of the initial mailing.

The effectiveness of the two educational interventions was evaluated by comparing the degree of agreement (reliability) between the hospital and master reviewers over time. In addition, the two groups were compared for performance on the pre- and post-tests.

F. Use of ISD* Review System with Adult ISD* Criteria

The intent of the UM Task Force was for reviewers to use the ISD* review system as it is described in the InterQual guidebook, January 1991 edition. The ISD* criteria for determining the necessity or appropriateness of admissions and continued stay to acute hospital services are based on three components:

- a) Severity of Illness. These criteria included objective clinical parameters, such as high fever or hypotension, that reflect the need for hospitalization.
- b) Intensity of Service. These criteria included diagnostic and therapeutic services, such as hourly vital signs or intravenous medications, that generally require hospitalization on an acute service.
- c) Discharge Screens. These included measures of patient instability, such as continued fever or confusion, that reflect the need for continued hospitalization.

In December 1991, InterQual released revised criteria for psychiatric admissions and these were used in the study. Since these new psychiatric criteria were released after the initial training period, we conducted a two hour telephone conference for all hospital reviewers to educate them about the changes in the psychiatric criteria. Written clarification of the new criteria were also sent to each hospital. The psychiatric reviewers then re-reviewed the 10 psychiatric charts on the pretest before beginning the study.

1. General Guidelines and Assumptions

The mind-set or attitude of reviewers as they reviewed charts was of particular concern to the study investigators. During initial training sessions, several hospital reviewers expressed concern that the results of this study might embarrass them or their hospitals. Initial questions often reflected the desire to find some way to approve each admission, and there was a common concern that rating an admission as nonacute would lead to denial of care for the veteran. Considerable emphasis was

therefore given during the initial educational sessions and subsequent telephone conferences to the general assumptions and attitudes that guided the study. The following "Attitude" guideline was given to all hospital reviewers:

The mind-set or attitude of reviewers can have a significant effect on the outcome of this study. The goal of the study is to test the ISD* measurement instrument and the reliability of hospital reviewers under field conditions. The reviewers' primary commitment should be to impartial use of the ISD* guidelines and criteria. You will not be personally evaluated according to percent of admissions that you rate nonacute, nor will your hospital be made to look bad if you are too strict in your interpretation of the guidelines. Hospital specific data will not be released as a part of this study, nor will your "toughness" or "easiness" as a reviewer be monitored.

Another major assumption that needed constant articulation was that the reviewers should assume that alternative levels of care would be available. For example, if an otherwise healthy patient was admitted for a simple hernia operation that the ISD criteria indicated could have been done as an ambulatory procedure, the fact that a VA hospital did not provide ambulatory surgery should not lead the reviewer to rate the admission as appropriate or "acute." Reviewers were told that a major objective of the study was to identify the deficiencies in the VA system that made it difficult to provide needed care at an appropriate level. Similarly, constant reminders were given to the reviewers that they were to assume that all patients needed some form of care. The question to be evaluated was not the accuracy of the diagnosis or the need for the procedure, rather it was to determine if the care was given at the most appropriate and cost effective level.

2. Modifications to InterQual ISD* Instructions

The UR Task Force determined that the ISD* criteria should be used in an unmodified form as possible so that the findings in the VA system could be compared to a "community" standard. Only minor changes were made in the ISD* criteria. Nevertheless, to facilitate the pilot project and fit the criteria to the VA environment, it was necessary to make the following changes in the instructions given in the InterQual ISD* guidebook:

a. Referral of all nonacute admission determinations for physician peer review was not required. Reviewers were encouraged to discuss each of these cases with the responsible caregivers and to record the substance of the discussion. However, such contacts were not required, nor were supplemental written notes by admitting physicians required to document these discussions.

b. Because VA hospitals generally do not maintain classic emergency rooms, we chose not to use the InterQual requirement for meeting both seriousness of illness (SI) and intensity of service (IS) in the first 24 hours for emergency room admissions. Thus the same criteria were used for admissions from the admitting office and the clinic.

c. The InterQual method for assessment of "variance days" for patients not meeting the ISD* criteria was not used; instead, we implemented a "Reasons List" to identify the causes of nonacute admissions and days of stay.

d. The InterQual "A-Appropriateness" criteria for use of special care and ancillary care units such as intensive care units, telemetry, rehabilitation, and alcohol and drug admissions were not applied to patients admitted to these units. For patients admitted to intensive care and telemetry units, we only applied the regular ISD* criteria for admission to acute medicine or surgery units. For the rest, we confined our review to admissions to acute medical, surgical, and psychiatric units. Thus we did not review admissions to chronic care, rehabilitation, or special alcohol and drug treatment units.

e. We did not review each day of hospital care as advised by InterQual, and instead limited our reviews to admissions and days 3, 6, 9, 14, 21 and 28 at which time the review terminated even if the patient was still in the hospital. This "sampling" method was used to reduce the daily workload of the hospital reviewers.

G. Reasons List

Reviewers were instructed to identify and record up to three reasons, in priority order, each time an admission or day of care was determined to be nonacute (see Appendix I for the Reasons List). They were encouraged to discuss the possible reasons with the primary caregiver if the chart was not adequate for this determination.

H. Other Instructions to Reviewers

1. Confidentiality of information in patient charts was emphasized, and before copies of charts were sent to the master reviewers, all patient identification information, including names of relatives and referring physicians, was blacked out.

2. Concurrent review was a goal, and reviewers were instructed to see their patients within 24 hours of admission to begin the review process. Patients admitted on weekends were to be seen at the first working day. When review began later than 24 hrs after admission, the importance was emphasized of only utilizing information that was available in the chart for the day reviewed.

3. Assignment of patients to services was guided by the arbitrary rules that "boarders" or patients admitted to clinical service "A" but housed on the wards of service "B" were assigned to the admitting service. Transfers of patients to another acute service were submitted under the category of the admitting service, however, criteria applicable to the new service could be used to justify a day of care. For

example, a patient admitted to medical service for GI bleeding and transferred to surgery for operative intervention was reported as a medical patient, but assessment of appropriateness of days of care included the surgical criteria. Transfers of patients from an acute service to a chronic care bed, such as the hospital nursing home or rehabilitation service, were considered as discharged at the time of transfer.

I. Validity Assessment by Physician Panels

1. Overview

The validity of the ISD* was assessed by comparing the judgments of appropriateness of admissions and length of stay given by master reviewers using the ISD* Instrument against the consensus judgment of three panels of expert physician reviewers. The panels covered the three broad specialty areas of general internal medicine, surgery, and psychiatry.

Three goals guided the process of panel selection and chart review. The first was to represent the body of knowledge in each general specialty area. To meet this goal, we attempted to have a diversity of subspecialists on each panel. The second goal was to ensure the members of the panels reflected the population of VA clinicians. To meet this goal, a complex process was used to elicit nominations of experts from VA clinicians. The third goal was to ensure patient charts being reviewed adequately reflected the general distribution of the VA patient population to which the results would apply. Selecting the charts at random, and reviewing a sufficiently large enough number supported this goal.

2. Selection of Panels

A three-staged nomination process was used to select experts from the VA clinician population¹². First, 30 hospitals were selected at random within RAM group and region, excluding those hospitals in the study. For the second stage, physicians were selected randomly within hospitals and again within the general specialty areas of medicine, psychiatry, and surgery. The number selected was proportional to the size of the institution. This initial group of physicians constituted the *nominators of nominators* and consisted of 195 internal medicine physicians, 186 psychiatrists, and 202 surgeons. Each physician was asked to provide five names of physicians in their professional area *"whom you respect and judge as well informed to nominate panel experts within VA."*

Sixty-three percent of the sample returned nominations providing a total of 1220 separate physician's names with 415 receiving two or more nominations. In general, nominators of experts were chosen randomly from the group that received two or more nominations. The final stage of the nomination process began when final nominators were selected from this group. To maintain balance between the different-sized hospitals, the number of nominators was based on size. One nominator from each hospital and within each specialty area was chosen randomly in the small (< 400 bed)

hospitals, two nominators for each specialty area in the medium-sized hospitals (401 to 825 bed), and three nominators for each specialty area for the large hospitals (> 825 beds). The resulting list of final nominators was 65 in medicine, 59 in surgery, and 62 in psychiatry.

This nominator group were asked to nominate three experts within VA and two outside VA "whom you respect and feel are well informed enough to perform as experts on the issue of appropriateness of admissions within your general specialty area (medicine, surgery, or psychiatry). Three of these nominations should come from within the region in which you practice, two within VA nationally, and two need to be highly qualified physicians outside VA. Experts need to be chosen on the basis of their clinical knowledge, their knowledge of general issues in health care delivery, and your estimation of their humanitarianism and integrity. For those chosen from within VA, experts should be familiar with the institution's policy and procedures and have QA or UR experience. Finally, since we will be using consensus techniques, it is essential that your nominees be flexible and work well in groups."

Sixty-three percent of this group responded producing a total of 429 experts nominated across all services. Selecting those nominated at least two or more times resulted in 14 nominated experts in surgery, 20 in medicine, 23 in psychiatry, and seven outside of VA.

Three criteria were used to select experts from this final nominated list. First, every effort was made to include a wide-range of subspecialists on the panel. In addition, the psychiatric and surgery panels were also required to have a general internal medicine specialist. The second criterion was that the panel members should reflect the differences in size, geographical location, and complexity of the hospitals in the VA system. The third and final criterion was that all physicians were required to have had some experience in QA.

The final composition of panels was diverse. There were nine members to each panel, eight from within VA, and one outside VA. On the medicine panel, there was a pulmonologist, oncologist, neurologist, cardiologist, endocrinologist, and three general internists. The non-VA physician was a general internist. The surgery panel consisted of a urologist, ophthalmologist, cardiac thoracic surgeon, vascular surgeon, abdominal surgeon, and three general surgeons. The surgery panel and the psychiatric panel also had one internal medicine practitioner as a member. In general, the nominated physicians responded very favorably to the request to be on the panel and appeared pleased to have the opportunity.

3. Chart Selection

Seventy charts were chosen to be reviewed within each specialty group. Forty-four of these were selected at random from charts under review by hospitals in the reliability portion of the study. The other twenty-six were charts used in the Iowa study¹. Every effort was made to ensure the charts were readable and all identifying information regarding the identity of the physician and the patient were removed.

4. Review Process

The actual review was conducted in two stages. For the first stage, charts were read individually by physicians at their home station over a period of six weeks. The second review consisted of a consensus conference where the full panel met together. For both reviews, physicians were given similar instructions. They were told to assume all levels of care are available at each VAMC, that private sector clinical medical practice applies to VA, to not consider social factors, and to not judge the quality of care or the accuracy of the diagnosis. They were to assume that the diagnosis was correct, that the patient was in need of care, and that the question to be answered was the appropriate level of care.

For the first review, each physician received an instruction packet, 35 charts, and a response form for each chart. The response form asked participants to judge whether the admission was appropriate on a 1 to 6 scale, with a 1 being "strongly agree" and a 6 being "strongly disagree." This format allows for both the dichotomous decision of acute and nonacute and an assessment of certainty. Participants were also asked to answer whether they believed the patient's illness was "severe enough to justify hospitalization" and whether "hospitalization was the required level of care" on the same 1 to 6 agreement scale. In addition, they were asked to indicate if there was sufficient information to make a decision and the care setting they believed to be appropriate. Finally, the appropriateness of the days of stay were assessed for days 3, 6, 9, 14, 21, and 28, if indicated.

A teleconference was conducted with each panel to clarify instructions and to provide a question and answer period. Each chart was reviewed by four physicians on the panel. To minimize the idiosyncratic effects of any single combination of physicians, charts were first assigned to the appropriate subspecialist and then randomly across physicians. As a result, no two charts were reviewed by the same group of physicians. The three physicians who worked outside VA were not given charts for the initial review.

After the response forms were returned, each chart was assigned a primary and secondary reviewer. The primary reviewer was charged with presenting the case to the full panel and the secondary reviewer was instructed to be a backup. Both were instructed to carefully re-review the charts and prepare to present to the entire group.

5. Second Review

The second formal review of the chart occurred during the full consensus conference. All panel members were present together for at least one full day, and most were present for the entire day and a half. To maximize the time, chart review was prioritized in terms of the degree of disagreement found on the appropriateness of admission question during the first review. Those charts where there was a 2-2 split on the initial review, were discussed first, followed by those charts where there was a 3/1 split on the admission question, and at least one day of stay where there was a 2-2 split. These charts were presented by the primary reviewer and received full review

and discussion by the group. Judgments of appropriateness of admission, as well as each day of stay, were made independently. All judgments were collected just after the time they were made and recorded. Every attempt was made to ensure that none were missing. There were several extra copies of the chart available for those who had questions.

Those charts where there was full agreement on the initial review were also presented by the primary reviewer, but in this case, were simply described and the panel made a decision regarding the need for a full discussion and review. If they judged the case to be clear, then the judgments of the four initial reviewers were accepted. For example, if a patient had been admitted for a rule/out MI (myocardial infarction), and the initial four reviewers had all agreed on the appropriateness of the admission on that day, discussion was waived if all agreed to accept the judgement of the original four reviewers. As a consequence, the appropriateness of the days of care for some charts was not reviewed by the whole group, and there was a simple global dichotomous judgment by all members to admit or to not admit. Charts where there was this verbal agreement were coded differently for purposes of establishing interrater reliability and for future analysis. By using this method, all charts were at least given a thorough review once by four physicians, and had the opportunity to be reviewed twice by the full group, if needed.

6. Group Process

A modified Nominal Group Process was used during the conference. Every effort was made to ensure all opinions could be heard. Participants were encouraged to focus on a specific case, to limit their contributions to factual material, and to avoid making judgments about the accuracy of the diagnosis or the quality of care. Discussion was closed when no new information could be offered. Unanimity was not required. After the discussion had ended, anonymous written judgements regarding the appropriateness of the admission and days of care were independently made by the members. For the purpose of comparing our study with the Iowa study in the data analysis, consensus was defined as either the majority vote (>50%) or 75% of the group members present agreeing on the dichotomous decision of acute/nonacute.

Prior to beginning each consensus conference, every physician received a summary of the overall judgments of the previous reviewers, a written review of each chart, and a listing of their own ratings on the charts they personally reviewed in the initial review. In addition, additional charts were available for any panel members who wanted to review them. As in the first review, panel members were asked to assume all services were available for each VAMC, to not consider social factors, to assume the standards of care was similar to the private sector, and to not judge the quality of care.

Responses were collected on the identical form used in the first review. Physicians were asked to report any missing information and if they judged the admission as not appropriate, to report what level of care they did judge as appropriate.

V. RESULTS

A. Reliability of Hospital Reviewers

A major goal of this pilot project was to evaluate the reliability of hospital reviewers' ability to use the InterQual ISD* criteria under "field" conditions. Reliability was primarily evaluated by comparing the hospital reviewer against the InterQual master reviewers. The analyses compared the percent agreement between reviewers and tested the level of agreement with the kappa statistics. As shown in the following tables, the percent agreement and the kappa coefficients indicate that there was a high level of agreement.

Table 1. Comparison of All Hospital Reviewers to InterQual Master Reviewers

a. The agreement on acute admission is:

Hospital	InterQual		Total
	Acute	No	
Acute	1136	277	1413
No	72	947	1019
Total	1208	1224	2432

Kappa = 0.713
Percent agreement = 0.856

b. The agreement on all days of care (excluding admit) is:

Hospital	InterQual		Total
	Acute	No	
Acute	2752	417	3169
No	227	1358	1585
Total	2979	1775	4754

Kappa = 0.704
Percent agreement = 0.865

The above kappa and percent agreement for days of care should be treated as descriptive statistics only. Since there were several days of care for most patients, the entries in the above table are not independent and there is no strong evidence that the tables for different days are homogeneous.

Reliability testing of the use of InterQual admission criteria by the individual clinical services indicated that reviewers were most reliable using the medicine criteria (kappa 0.754), somewhat less reliable using surgery criteria (kappa 0.713), and least reliable using psychiatric criteria (kappa 0.634). These differences were not large, and all of the kappa values were greater than 0.6 indicating excellent agreement.

Table 2. Comparison of Clinical Service Hospital Reviewers to InterQual Master Reviewers - Admission

a. Medicine

Hospital	InterQual Admit		Total
	Acute	No	
Acute	444	90	534
No	15	317	332
Total	459	407	866

Kappa = 0.754
Percent agreement = 0.879

b. Surgery

Hospital	InterQual Admit		Total
	Acute	No	
Acute	242	75	317
No	27	397	424
Total	269	472	741

Kappa = 0.713
Percent agreement = 0.862

c. Psychiatry

Hospital	InterQual Admit		Total
	Acute	No	
Acute	450	112	562
No	30	233	263
Total	480	345	825

Kappa = 0.634
Percent agreement = 0.828

Reliability testing of the assessments of days of care for each of the clinical services are shown in Table 3. Again, a high level of agreement is seen for all three services and in the same order as seen for admissions.

Table 3. Comparison of Clinical Service Hospital Reviewers to InterQual Master Reviewers - Days of Care

a. Medicine

Hospital	InterQual Days of Care		Total
	Acute	No	
Acute	866	117	983
No	75	466	541
Total	941	583	1524

Kappa = 0.730
Percent agreement = 0.874

b. Surgery

Hospital	InterQual Days of Care		Total
	Acute	No	
Acute	521	61	582
No	46	227	273
Total	567	288	855

Kappa = 0.716
Percent agreement = 0.875

c. Psychiatry

Hospital	InterQual Days of Care		Total
	Acute	No	
Acute	1365	239	1604
No	106	665	771
Total	1471	904	2375

Kappa = 0.683
Percent agreement = 0.855

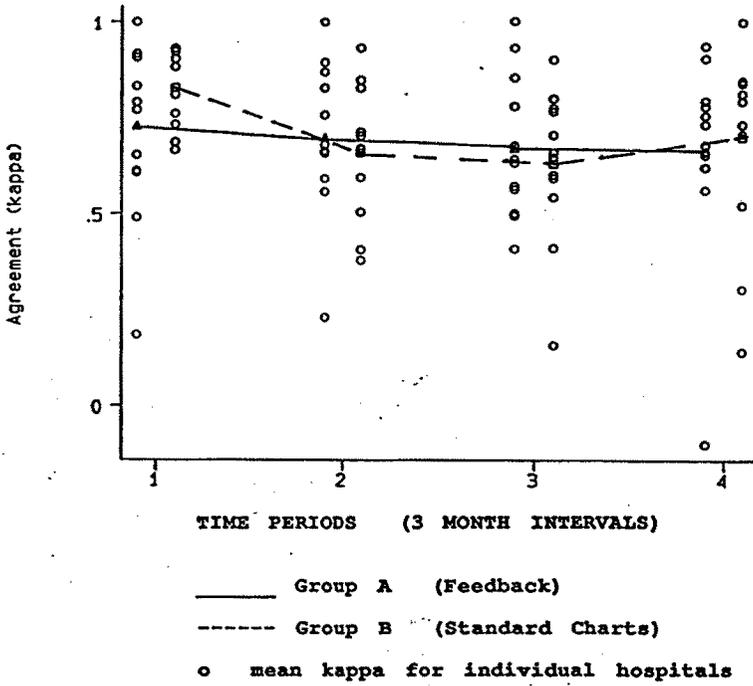
The high level of agreement between hospital and master reviewers was seen both for the admission criteria and for the review of days of care. The kappa values and percent agreements for admissions and days of care were very similar within each service. The disagreements between the hospital reviewers and the master reviewers were consistently in the direction of false positive determinations by the hospital reviewers. That is, hospital reviewers from all three services were more likely to rate an admission or day of care as acute with the master reviewers rating it as nonacute than the converse.

Interrater reliability was also tested in 20 hospitals that had both medical and surgical services. Charts were selected randomly each week alternatively from the medical and the surgical admissions, and both reviewers were asked to simultaneously review the charts concurrently without discussing their findings with each other. Within hospital interrater reliability was excellent for medical charts (89.1% agreement and kappa 0.758) and for surgical charts (91.7% agreement and kappa 0.835).

B. Comparison of the Two Educational Interventions

Our hypothesis was that master reviewer feedback (intervention A) would be more effective in achieving a high degree of agreement between hospital reviewers and the master reviewers than would use of standard charts with written feedback (intervention B). The hypothesis was primarily tested by separately comparing percent agreement and the kappa statistic for the two groups over the time period of the study. As shown in Figure 1, where changes were analyzed over four time periods, and in Table 4 where changes were analyzed over two time periods, both groups of hospital reviewers showed a slight decline in reliability over time. As hypothesized, the master reviewer feedback group A, showed a slightly smaller decline in reliability than did group B. Statistical analysis of the changes in kappa using nonparametric tests (Wilcoxon and Martin-divergent trend test) and the t test failed to detect a significant difference. The same methods were used to test the percent or proportion of agreement between the hospital reviewers and the master reviewers. The nonparametric tests did not detect a significant difference. The t test on changes between the two groups over four time periods gave a one-tailed $p = 0.047$. Because some of the assumptions required for a t test were not met, the t test result is less reliable. Thus, we concluded that the null hypothesis that there were no significant differences between the two interventions cannot be rejected.

Figure 1. Changes in Agreement (Kappa) Between Hospital and Master Reviewers from Group A vs Group B Over Four Time Periods



Four period Wilcoxon rank sum test, one tail $p = 0.078$
 t test for changes between the groups one tail $p = 0.047$
 Four period Martin divergent trend test $p = 0.104$

Table 4. Changes in Kappa for Agreement Between Hospital and Master Reviewers from Group A vs Group B Between First and Second Half of the Study

	Group A Feedback kappa (s.d)	Group B Standard kappa (s.d.)	Both kappa (s.d.)
period 1	0.711 (0.191)	0.751 (0.093)	0.731 (0.148)
period 2	0.669 (0.136)	0.662 (0.136)	0.665 (0.133)
difference	-0.042 (0.219)	-0.090 (0.097)	-0.066 (0.167)

Two period Wilcoxon rank sum test, one tail $p = 0.163$

Two period t test one tail $p = 0.250$

Four period Martin divergent trend test, one tail $p = 0.155$

Comparisons were also done between intervention groups A vs B on performance on the pretest vs post-test (Table 5). The test consisted of 10 patient charts for each of the three clinical services, and reviewers were scored for agreement with master reviewers ratings of the charts for acuity of admission and days of care. The medical and psychiatric reviewers did very well on the pretest (correct scores for admission of 94% and 87%), and as expected, there was little room for improvement over time. The pretest score for the surgical reviewers was lower (76%) and they did improve their scores on the post-test (86%). In general, the changes in test scores were similar for groups A and B, and the small differences that were seen were not statistically significant by analysis of variance.

Table 5. Comparison of Pretest and Post-Test Scores (% Correct) on Admission Criteria for Groups A vs B

Group	Pretest	Post-Test	Difference	Std.Dev.
Medicine				
A	96%	95	-.0182	.0982
B	92	93	+.0125	.1208
ALL	94	94	-.0022	.1092
Surgery				
A	76	85	+.09	.1197
B	76	87	+.1122	.0969
ALL	76	86	+.1011	.1066
Psychiatry				
A	85	84	-.0091	.0831
B	91	90	-.0061	.0831
All	87	87	-.007	.0810

C. Validity

Between-Rater Reliability Among Members of Expert Panels. The aim of the first part of the validity analysis was to see if the rating panels were reasonably internally consistent since this determination would affect our confidence in the use of their judgements as a gold standard. Our approach in this descriptive analysis was to compare each reviewers determination regarding the acuity of admission with the mean of the other reviewers (sometimes called a jackknife method). A Pearson product moment correlation was computed between each raters score and the jackknifed mean score. The resulting correlation coefficient ignores the degree of bias, i.e., whether some reviewers consistently gave higher or lower ratings than others. Therefore, the regression line of the raters score as predicted by the mean of the other raters and the line of perfect agreement were also plotted. The bias and mean square error (MSE) were then estimated by a jackknife method. The bias was the mean of the reviewers rating minus the mean of all other reviewers. The MSE was the mean of the squared difference between the reviewer and the mean of all other reviewers. The MSE can be viewed as the variability of the individual rater from the rest of the panel, and because it does include an effect of bias, we believe that it is the best measure of the consistency of each rater with the rest of the panel.

Table 6. Comparison of Interrater Reliability on First and Second Reviews of Admission Acuity for the Medicine, Surgery and Psychiatry Panels

reviewer	n		bias		correlation		MSE	
	1st	2nd	1st	2nd	1st	2nd	1st	2nd
med. 1	34	49	.84	.41	0.56	0.93	3.37	.93
med. 2	35	40	-.50	-.16	0.63	0.88	1.19	.51
med. 3	34	46	-.48	-.37	0.66	0.78	1.54	1.10
med. 4	35	49	.12	-.21	0.74	0.92	1.23	.45
med. 5	34	49	-.09	-.03	0.65	0.91	1.70	.83
med. 6	35	49	.70	.36	0.88	0.94	1.46	.48
med. 7	35	49	.39	.18	0.55	0.96	2.15	.28
med. 8	35	49	-.99	-.69	0.67	0.90	2.25	.97
med. 9		49	.46			0.91		.67
			MEAN		0.67	0.90	1.86	0.69

reviewer	n		bias		correlation		MSE	
	1st	2nd	1st	2nd	1st	2nd	1st	2nd
surg. 8		34	.59			0.89		.95
surg. 9	35	36	-2.17	-.96	0.27	0.67	8.15	3.02
surg. 10	35	36	1.49	1.36	0.62	0.75	4.29	3.04
surg. 11	34	36	.68	.16	0.75	0.88	1.91	.67
surg. 12	35	36	.89	.20	0.34	0.93	5.33	.99
surg. 13	35	36	1.23	.48	0.62	0.95	4.01	.71
surg. 14	35	36	-.89	-.46	0.60	0.86	2.82	.97
surg. 15	35	36	-1.39	.18	0.35	0.54	5.14	4.24
surg. 16	35	29	.18	-.05	0.73	0.90	2.47	.77
			MEAN		0.54	0.87	4.27	1.70
psy. 07		39	.13			0.79		1.32
psy. 17	35	38	.40	.30	0.41	0.45	2.64	2.22
psy. 18	35	39	.12	-.74	0.71	0.68	.86	1.33
psy. 19	35	39	-.16	1.31	0.69	0.68	1.03	3.29
psy. 20	35	39	.28	.59	0.01	0.68	3.15	1.55
psy. 21	35	39	.34	.65	0.78	0.85	2.33	2.22
psy. 22	35	39	-.70	1.46	0.55	0.48	1.43	3.51
psy. 23	34	39	.29	.53	0.56	0.74	1.58	1.29
psy. 24	33	39	-.60	1.31	0.50	0.46	1.79	3.56
			MEAN		0.53	0.65	1.85	2.25

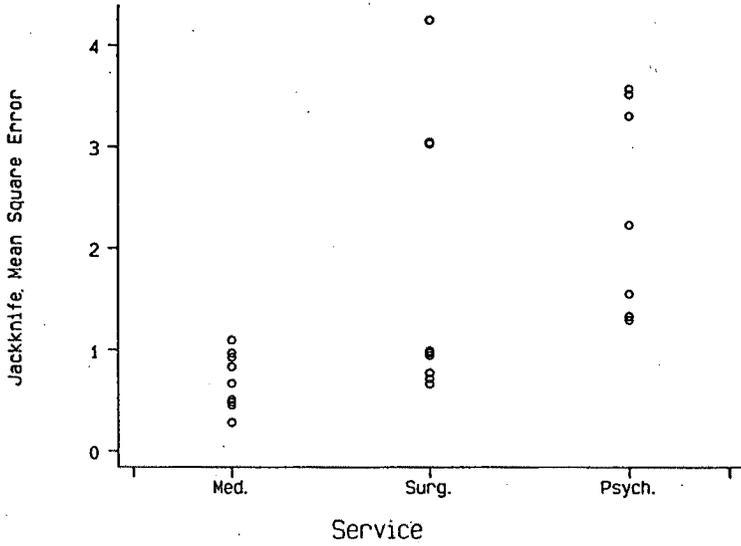
It should be noted that the internal reliability estimates in Table 6 for the second review were made only on cases where there was some disagreement, since six-point scale ratings were not collected on the cases where the four initial reviewers agreed. The selection of only the more difficult cases for internal reliability estimates is expected to reduce the internal consistency of the panel for the second review.

The internal consistency of the reviewers as measured by the jackknife correlations clearly improved on the second review in medicine and surgery as compared to the independent first review. In contrast, only slight improvement was seen between the first and second reviews by the psychiatrists. The internal reliability of the second medicine and surgery reviews was very good with most of the jackknife correlations around 0.90. The psychiatry panel was the worst of the three panels with a mean of 0.65 and three raters showing correlations of less than 0.5 on the second review.

The jackknife mean squared error measure of internal consistency of the three panels also showed good improvement between the first and second reviews by the medicine and surgery panels, while the mean MSE for the psychiatry panel actually worsened on the second review. Although both the surgery and psychiatry panels had some obvious outliers on the MSE measure of agreement, all of the members of the psychiatry panel had MSE values that were greater than the worst reviewer on the medicine panel (Figure 2). While the three physicians on the psychiatry panel with the highest MSE values pulled down the maximum MSE value attainable by the other panel members, the three outliers on the surgery panel were of similar magnitude, and the remaining members of the surgery panel agreed quite well among themselves.

These descriptive statistics indicate that the internal consistency of the medicine and surgery panels was quite good, while the psychiatry panel was noticeably worse by all measures. It is difficult to determine if the poorer performance of the psychiatry panel was a function of the particular members chosen, or it was a reflection of a general lack of consensus among practitioners regarding the practice of psychiatry.

Figure 2. Mean Squared Error for Members of Medicine, Surgery and Psychiatry Panels (o = MSE for Individual Panelists)



1. Agreement Between the Panels and InterQual

Our primary test of validity was to assess the agreement regarding acuity of the admission between the majority panel opinion after the second review group discussion with the ratings by the InterQual master reviewers. Majority was defined as a 4/0 vote for those charts where there was unanimity on the first review and consequently there was not an indepth second review discussion. For those charts where a second review was done, a majority was five or more of the usual nine panel members. In the few instances where only eight panel members voted and there was a tie, the mean value of the 6 point score was used to break the tie. Statistical analyses involved the percentage agreement, kappa, the biserial correlation between the fraction of the reviewers favoring admission and the InterQual ISD* decision, sensitivity, specificity and the positive predictive value of the ISD* reviewers as compared to the gold standard of the second review of the physician panels. For each of the three panels, there was greater agreement between the panels and InterQual on the second review than on the first review which was done before group discussion, thus only the results of the second review are presented. Because the second reviews occurred in a conference setting, independence of individual raters could not be assumed and therefore we did not calculate confidence intervals.

Table 7. Agreement Between Medicine Panel and InterQual ISD* Master Reviewers Regarding Acuity of Admission

Panel	InterQual ISD*		Total
	Acute	No	
Acute	29	16	45
No	2	23	25
Total	31	39	70

Kappa	0.502
Biserial correlation	0.56
Percent agreement	74
Sensitivity: 29/45	0.64
Specificity: 23/25	0.92
Pos Pred Value: 29/31	0.94
False Positive Rate: 2/25	0.08
False Negative Rate: 16/45	0.35

Table 8. Agreement Between the Surgical Panel and InterQual ISD* Master Reviewers Regarding Acuity of Admission

Panel	InterQual ISD*		Total
	Acute	No	
Acute	17	7	24
No	11	35	46
Total	28	42	70

Kappa	0.451
Biserial correlation	0.49
Percent agreement	74
Sensitivity: 17/24	0.70
Specificity: 35/46	0.76
Pos Pred Value: 17/28	0.61
False Positive Rate: 11/46	0.24
False Negative Rate: 7/24	0.29

Table 9. Agreement Between the Psychiatry Panel and InterQual ISD* Master Reviewers Regarding Acuity of Admission

Panel	InterQual ISD*		Total
	Acute	No	
Acute	29	12	41
No	12	17	29
Total	41	29	70

Kappa	0.294
Biserial correlation	0.33
Percent agreement	66
Sensitivity: 29/41	0.71
Specificity: 17/29	0.59
Pos Pred Value: 29/41	0.71
False Positive Rate: 12/29	0.41
False Negative Rate: 12/41	0.29

Hospital reviewers for Psychiatry
 Frequencies for all three reasons ignoring order
 Reasons in numeric order
 cases 2342 Nonacute 985
 cases with a reason 976 total for service 252

	admit	days						total
		3	6	9	14	21	28	
0 no reason code	1994	2151	2125	2113	2152	2207	2266	13014
1 Soc. no support	30	0	0	0	0	0	0	0
2 Soc. no family	8	0	1	0	0	0	0	1
3 Soc. homeless	31	1	0	0	0	0	0	1
4 Soc. respite care	6	0	0	0	0	0	0	0
5 Soc. other	16	1	1	1	1	0	0	4
6 Env. distance	7	0	0	0	1	1	1	3
7 Env. no communication	1	1	1	2	2	1	0	7
8 Env. other	0	10	9	4	3	4	3	33
9 Sch. delay appointment	0	1	0	1	0	0	0	2
11 Sch. premature admit	1	0	1	1	1	1	1	5
13 Bed no alternative	8	0	0	0	0	0	0	0
15 Bed no outpat. care	3	0	0	0	0	0	0	0
20 Adm. other care	3	0	0	0	0	0	0	0
21 Adm. from transfer	17	0	0	0	0	0	0	0
22 Adm. psychosocial	7	0	0	0	0	0	0	0
27 Adm. other	11	0	0	1	0	0	0	1
28 Com. misinfo.	2	0	0	0	0	0	0	0
29 Com. other	4	1	0	0	0	0	0	1
30 Prt. conservative	162	0	0	2	0	0	0	2
31 Prt. other	21	0	0	0	0	0	0	0
52 Soc. bad environ.	1	2	1	1	0	0	0	4
53 Soc. no family	0	5	3	3	4	1	1	17
54 Soc. education	0	2	3	2	0	1	1	9
55 Soc. fam. refused	0	0	0	0	1	1	1	3
56 Soc. reject plan	0	5	4	6	2	2	0	19
57 Soc. reject transfer	0	1	1	0	0	0	0	2
59 Soc. homeless	0	5	9	11	13	8	5	51
60 Soc. respite	0	1	1	0	0	0	0	2
61 Soc. other	0	4	7	5	4	2	0	22
63 Env. distance	0	2	2	3	4	3	1	15
65 Env. other	0	0	0	1	0	0	0	1
66 Sch. 40 hr. week	0	2	0	0	0	0	0	2
67 Sch. procedure	0	0	1	1	0	0	0	2
71 Sch. other	0	0	0	0	1	0	0	1
72 Bed no alternative	0	15	11	12	14	14	9	75
73 Bed wait for place	0	2	1	2	3	1	0	9
74 Bed transfer	0	1	1	1	1	2	0	6
77 Bed other	0	2	4	7	4	7	5	29
78 Adm. service related	0	0	0	0	0	1	0	1
79 Adm. research	0	2	1	0	0	0	0	3
80 Adm. pass	0	3	8	8	3	3	3	28
81 Adm. other	0	12	12	8	6	3	3	44
83 Com. Delay	0	0	0	0	1	2	0	3
84 Com. other	0	4	2	4	5	2	0	17
85 Prt. no discharge	0	5	3	5	3	5	4	25
86 Prt. no plan	0	15	16	16	25	22	17	111
87 Prt. conservative	2	61	80	88	70	49	31	379
88 Prt. no evaluation	1	29	31	32	22	9	6	129
89 Prt. overlooked	0	1	0	0	0	0	0	1
90 Prt. other	0	2	10	7	3	4	2	28
99 No reason found	25	12	11	13	12	5	1	54
totals	367	210	236	248	209	154	95	1152

These analyses indicate good agreement between the medicine and surgery panels and the InterQual ISD* criteria as determined by the master reviewers. In the second reviews, percent agreement was 74 percent, while the kappa values were both greater than 0.45, and biserial correlations greater than 0.45. In contrast, the psychiatry panel showed only 66% agreement with InterQual, the kappa value was unsatisfactory at 0.294, and the biserial correlation was low at 0.33.

The InterQual ISD* criteria did not differ very much in terms of sensitivity (percent of admissions determined to be acute by the panels that were judged as acute by InterQual). In contrast, there was wider variability in the assessment of specificity: the medicine and surgery InterQual criteria were more in agreement with the panels in judging an admission as nonacute (0.92 and 0.76) than were the psychiatry criteria (0.59). Similarly, the false positive rates were lower for the InterQual medicine and surgery criteria than they were for the psychiatry criteria. All three InterQual criteria had relatively high false negative rates of greater than 25% indicating that a decision to rate an admission as nonacute by InterQual was in conflict with the panels decision to declare the admission as acute.

An alternative way to evaluate the agreement between the physician panels and the InterQual master reviewers is to exclude those charts about which there was no clear consensus of opinion by the panel members. To allow for comparison between this study and the Iowa study in which physician panels were compared to professional reviewers using the AEP instrument, we defined consensus as 75% agreement or better. As shown in the table below, removing charts from the analysis that had less than 75% agreement among the panels during the second reviews notably increased the percent of agreement, but only slightly increased the kappa values for all three services. However, the relative rankings of the services remained the same for the kappa statistic, and the agreement over the psychiatric criteria continued to be unsatisfactory with a Kappa of 0.33.

Table 10. Agreement Between Physician Panels and InterQual Master Reviewers After Removal of Nonconsensus Charts

PANEL	Percent Agreement	Kappa
Medicine	90%	0.536
Surgery	96%	0.465
Psychiatry	79%	0.331

2. Sensitivity of the Agreement Results to Potentially Unreliable Reviewers

The previous analyses included all reviewers. While there was a tight clustering of internal reliability MSE values for the medicine panel members, there were three outliers in each of the the surgery and psychiatry panels. The analyses of percent agreement, kappa and biserial correlations were repeated after excluding the three reviewers in the surgical panel and the three in the psychiatry panels who had MSE values of greater than 3. This change had a surprisingly small effect: the percent agreement did not change for the surgical panel or for the psychiatry panel. The kappa value decreased slightly for the surgery panel from .479 to .454, and for the psychiatry panel from .294 to .291. This conclusion was consistent with our observation that the deviant reviewers did not agree with each other any more than they agreed with the rest of the panel.

3. Agreement Between Physician Panels and Field Reviewers

Our primary goal was to test the validity of the ISD* instrument and we therefore compared the panel ratings with those of the masters reviewers who we felt would be the most expert interpreters of the criteria. While clearly not as useful for examining the validity of the criteria, it is of interest to compare the ratings of the field reviewers with the judgements of the physician panels. Because many of the charts evaluated by the medicine and surgery panels were from the Iowa study, and consequently not rated by field reviewers, the analysis was limited to the psychiatry criteria where field reviewer ratings were available for 63 charts. The percent agreement between the psychiatry panel and the field reviewers was 71% (kappa 0.42). These values are somewhat higher than the agreement between the panels and the master reviewers (66%, kappa 0.29). To the degree that these differences may be more than chance variations, they suggest that the errors made by the psychiatry field reviewers in using the ISD* criteria may have made them more consistent with the judgements of the physician panel. Discussion with the psychiatry field reviewers indicated that they were sometimes tempted to let their clinical intuitions override a strict interpretation of the criteria. If this was the case, then it is not surprising that the field reviewers subjective judgements would tend to agree with the implicit judgements of the physician panels.

4. Comparison of ISD* Criteria with AEP Criteria

The charts selected for review by the physician panels included 48 charts used in the physician validation part of the Iowa study¹⁵. This allowed us to compare the ISD* criteria for medicine and surgery as used by the InterQual master reviewers with the AEP criteria as used by professional reviewers.

Table 11. Comparison of ISD* Criteria with AEP Criteria

Iowa AEP	InterQual Acute	ISD* No	Total
Acute	15	16	31
No	0	17	17
Total	15	33	48
Percent agreement	0.667		
Kappa	0.399		

Based on this small number of charts, there was marginal agreement between the two utilization review criteria with kappa just at the edge of acceptability. The disagreements were all in the direction of ISD* determining admissions as nonacute that were determined as acute or appropriate by the AEP criteria. Overall, the ISD* criteria were more stringent, approving 31% of admissions compared to a 65% approval rate for AEP.

D. Nonacute Admissions and Days of Care

Our concurrent review of a random sample of 2432 admissions to acute medical, surgical, and psychiatric beds in 24 randomly selected VA hospitals allows us to assess the extent and characteristics of nonacute admissions and days of care. Table 12 below summarizes the percent nonacute admissions and days of care on all three services as determined by master reviewers, hospital reviewers and the physician panels.

Table 12. % Nonacute Admissions and Days of Care on Three Clinical Services as Determined by Master and Hospital Reviewers and by Physician Panels

Service	Master Reviewer	Hospital Reviewer	Physician Panels
Medical			
Admit	47%	38	36
Days	45	36	-
Surgical			
Admit	64	57	64
Days	34	32	-
Psychiatry			
Admit	42	32	41
Days	38	32	-
Total			
Admit	50	42	47
Days	37	33	-

The InterQual master reviewers were the most likely of the three groups of reviewers to determine that an admission or day of care was nonacute, with an overall rate of 50% for admissions. The hospital reviewers consistently rated fewer admissions as nonacute than did the master reviewers, with an overall difference of 8%. The physician panels reviewed a much smaller number of charts (70 for each service), and did not have access to the InterQual or any other measurement instrument. Nevertheless, the physician panels came remarkably close to the master reviewers' overall assessment of the extent of nonacute admissions at 47%.

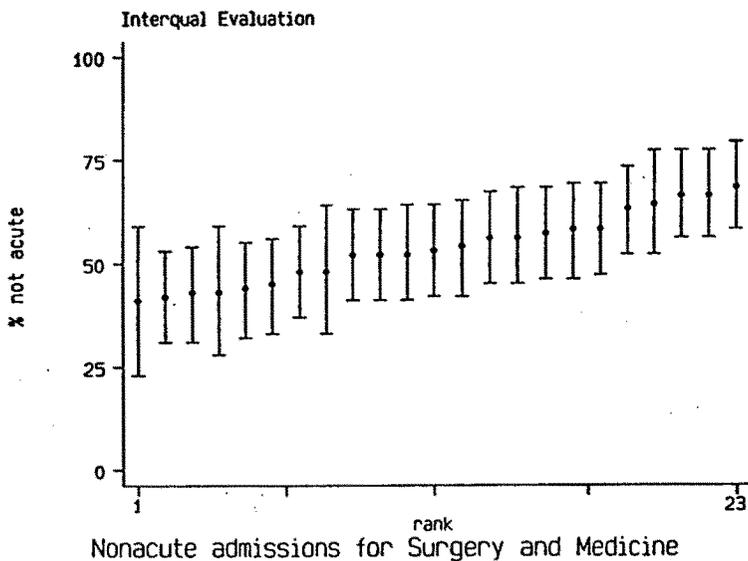
There were noticeable differences between the nonacute admission rates between the three services. All three reviewer groups gave surgical admissions the highest nonacute rates (57-64%). The hospital and master reviewers agreed that medical admissions were somewhat more likely to be nonacute than psychiatric admissions, however, the physician panels ranked them in opposite order.

Overall rates of nonacute admissions were higher than the nonacute rates for days of care according to the master reviewers (50% vs 37%), and the hospital reviewers (42% vs 33%). This discrepancy was associated with two phenomena. First, there was a strong tendency for patients initially rated as nonacute admissions to be discharged before the first day of care review on day three. This was true for 36% of nonacute admissions to medical service, and for 59% of nonacute admissions to surgical service. These were most often patients who had "short stays" for procedures that should have been done on an ambulatory care basis. Second, overall 30% of patients initially declared as a nonacute admission were found to be acute by day three. Some of these, as expected, were patients who had excessive (>24 hrs) wait before an approved hospital procedure such as major surgery. However, the largest proportion of nonacute admissions which were assessed as acute on day three were from psychiatry services. This may be an artefact related to the InterQual criteria that acute admissions require both a documented seriousness of illness determination as well as an intensity of service criterion, while approval of days of care on day three and thereafter only required a documented intensity of service. Routine use of locked wards in some facilities met an intensity of service criterion and led to all days of care being acute.

The distribution of nonacute admission rates for the combined medical and surgical services of the 23 hospitals as determined by the InterQual master reviewers is shown in Figure 3. The data from psychiatric services were excluded from this analysis because of the questionable validity of the psychiatric criteria. There is a noticeable similarity between the nonacute admission rates for all of the hospitals with a range of 41-68%. The confidence intervals for the hospitals with the lowest nonacute admission rates clearly overlap the intervals for those with the highest rates, and the narrow spread indicates that the extent of nonacute admissions is a characteristic of all the hospitals in our random sample and not a problem caused by a few outlier hospitals.

Figure 3. Percent Nonacute Admissions to 23 Hospitals According to InterQual Master Reviewers

(The mean percent nonacute admissions and the 95% confidence intervals are shown for each hospital and graphed in order of rank.)



E. Effect of Hospital Complexity and Regions

The distribution of nonacute admission rates for all three clinical services was analyzed for an effect of hospital complexity (6 groups) and of the VA's four geographic regions. As shown in the following two-way analysis of variance, there were no statistically significant effects of region or complexity group. One-way analysis of variance and nonparametric analyses also failed to demonstrate a significant effect of complexity or region.

Table 13. Two-Way ANOVA on InterQual Estimate of Nonacute Admissions by Complexity and Region

		Number of obs = 24		R-square = 0.5055	
		Root MSE = 9.37103		Adj R-square = 0.2417	
Source	Partial SS	df	MS	F	Prob > F
Model	1346.39499	8	168.299374	1.92	0.1321
Complexity	834.547513	5	166.909503	1.90	0.1540
Region	511.847476	3	170.615825	1.94	0.1661
Residual	1317.24286	15	87.8161905		
Total	2663.63785	23	115.810341		

F. Reasons For Nonacute Admissions and Days of Care

Hospital reviewers were asked to prioritize up to three reasons for each nonacute admission and day of care. The reasons were selected from a list organized into general categories and more specific examples (see Appendix I). Compliance with filling out the reasons data form was excellent (>99%), and the category "no reason found" was used infrequently (<7%). Analysis of the primary or first choice reasons was compared to analysis of unranked relative frequency of all reasons given and the differences were small. Because the latter method provides a richer database, in the following analysis we present the unranked relative frequency of reasons for nonacute admissions and days of care.

Table 14. Reasons for Nonacute Admissions and Days of Care - Medicine.

	PERCENT ADMISSION (n=440)	DAYS OF CARE (n=770)
Practitioner	32.2%	42.6
Administrative	17.9	3.1
Service availability	17.7	12.9
Social	11.3	11.9
Environmental	8.4	9.2
Scheduling	8.2	10.2
Communication	2.0	3.3
No reason given	2.5	6.4

Table 15. Reasons for Nonacute Admissions and Days of Care - Surgery

	PERCENT ADMISSION (n=660)	DAYS OF CARE (n=359)
Practitioner	21.1%	41.4
Administrative	6.8	11.9
Service availability	36.1	4.7
Social	4.8	12.8
Environmental	7.8	10.2
Scheduling	16.5	13.9
Communication	2.0	1.7
No reason given	3.0	1.8

Table 16. Reasons for Nonacute Admissions and Days of Care - Psychiatry

	PERCENT ADMISSION (n=367)	DAYS OF CARE (n=1152)
Practitioner	50.7%	58.4
Administrative	9.5	6.6
Service availability	3.3	10.4
Social	24.8	11.7
Environmental	2.2	5.1
Scheduling	.0	1.0
Communication	1.6	1.8
No reason given	6.8	4.6

Practitioner related reasons were most frequently identified for nonacute admissions to psychiatric and medical services (50.7% and 32.2%), and were the second most common reason for nonacute admissions to surgical services (21.1%). The specific reason "conservative practice" was almost always chosen (99%). This was generally interpreted by reviewers to mean both that no other social, VA system, or regulation reason was identifiable, and the decision of the practitioner to admit the patient to the acute hospital service was an example of conservative medical practice. Some hospital reviewers preferred to select this reason instead of "no reason found," and in these instances, it was more a default choice than a specific reason.

Administrative reasons were the second most common category for nonacute admissions to medical service (17.9%) and occurred with some regularity in surgery and psychiatry services (6.8% and 9.5%). In medical services, the most common specific administrative reason was "admitted as transfer from another VA" (5.5%). The next most common administrative reason in medical service was "admitted for transfer to a nursing home" (2.5%). This reflects the VA regulation that VA cannot pay for nursing home care for veterans unless they are currently hospitalized. A variety of other administrative reasons that were each identified in fewer than 1% of admissions included "disability evaluation," "by directive," "for testing," "admitted for transfer to another hospital," "research," "psychosocial," and "for sleep apnea studies."

Service availability was the most common category for nonacute admissions to surgical service (36.1%). Most often (30% of nonacute surgical admissions), the reason was lack of availability of an ambulatory surgery alternative. The lack of an alternative lower level of service was also an important reason for nonacute admissions to medical services (17.7%), and this was most commonly due to nonavailability of an ambulatory alternative (14% of nonacute admissions). Lack of an alternative lower level of care was an unusual reason for nonacute admissions to psychiatric services (3.3%).

Social reasons were the second most common cause for nonacute admissions to psychiatry services (24.8%), fourth most common for medical services (11.3%), and an unusual cause for admission to surgical services (4.8%). The specific social reasons were evenly distributed between "no support," "no family," and "homeless," with a small number of admissions to each service for "respite care."

Environmental reasons almost always meant the patient lived more than 75 miles from the hospital, and in the absence of a boarding or hoteling alternative, the patient needed to be admitted for care. This reason was listed for 8.4% of nonacute admissions to medical services, for 7.8% of admissions to surgical services, and for 2.2% of admissions to psychiatric services.

Scheduling reasons meant that the admission was premature because the necessary procedure, surgery, or test was not performed by the day after admission. In some instances, a long delay in scheduling a test or procedure in the clinics led to an admission to facilitate the care. Scheduling reasons were listed for 8.2% of nonacute admissions to medical services and for 16.5% of nonacute admissions to surgical services.

Communication reasons either meant the hospital received the wrong information about the patients need for care, or the inability to communicate with family resulted in the nonacute admission. This category was listed for approximately 2% of nonacute admissions to each of the three services.

No reason given was the selected category for a small percent of nonacute admissions to medical and surgical services and for 6.8% of nonacute admissions to psychiatry services.

The same general categories were used to describe reasons for nonacute days of care, however, the specific reasons were sometimes different than those listed for nonacute admissions.

Practitioner reasons were more commonly selected for nonacute days of care than for nonacute admissions in each of the three services. The specific category of "conservative practice" remained the most common specific reason for each of the three services. The new specific categories of "no discharge plan" or "no evaluation" were particularly common in psychiatry explaining 23% of nonacute days of care in this service, and less common in medical (8%) and surgical (6%) services.

Administrative reasons were less commonly selected for nonacute days of care than for nonacute admissions to the medical and psychiatric services, while the reverse was found for surgery. The specific reason, "patient on pass" was often selected for all three services, while unfortunately the nonspecific reason "administrative-other" was most commonly chosen in psychiatry and surgery, leaving us with little insight into what was the real reason.

Service availability as a reason for nonacute days of care generally meant that no alternative lower level of care, such as intermediate or nursing home beds, was available. This category explained 10.4% of nonacute days of care on psychiatry services, 12.9% on medical services, and 4.7% on surgical services.

Social reasons explained 11-12% of nonacute days of care on each of the three services, and the list of specific reasons was similar to that described for the nonacute admissions. Similarly, **environmental, scheduling, and communication** reasons were reported at about the same frequency for nonacute days of care and for nonacute admissions.

VI. DISCUSSION

The most critical goal of this pilot study was to assess the validity of the InterQual ISD* instrument for measuring the appropriate level of care. The validity test asks the question "Are we measuring what we want to measure?," and an affirmative answer to the question is required if the results of the study and data collected from a national UM program are to be used to influence health care policy. We elected to measure predictive validity by comparing the ratings of patient charts by master reviewers, who we felt would be most expert in interpreting the ISD* criteria, against the consensus judgements of panels of VA physicians who were selected to be experts in their specialties. The physician panels therefore served as the "gold standard" in this validity test.

The reliability of peer assessments as gold standards in validity tests has been questioned¹³ and we need to discuss our assumption that the panels constituted the best possible gold standard. The multi-nomination process for selection of panel members was designed to maximize the pool of potential nominees, and the final panel members represented a wide distribution of regions of the country and hospital complexities. In an attempt to gain the maximum amount of expert knowledge we selected individuals from the pool of nominees who had different specialty practice

backgrounds, and we were moderately successful in achieving this goal. In the medical panel we had experts representing most of the major subspecialties, however, some subspecialties such as infectious diseases, rheumatology, and dermatology were not represented. Similarly, the surgical panel had representation for the major surgical subspecialties, except for neurosurgery; and ear, nose, and throat surgery. In both panels, the several generalists appeared to be comfortable in guiding discussion in the unrepresented areas and we did not observe any instances of calls for outside consultants.

Our decision to primarily select panelists from VA hospitals was driven by our desire to have the final results accepted by VA physicians and managers. However, it could be argued that VA physicians might be biased in the direction of approving nonacute admissions because of the long tradition in VA of reimbursing hospitals according to bed days. The high false negative rates for InterQual (percent of charts determined by the panel to be acute or appropriate for admission that were judged by InterQual to be nonacute) for all three services, suggest a bias of the VA panel members to approve admissions, particularly for medical service. However, the false positive rates for InterQual in surgery and psychiatry were just as high or higher than the false negative rates, arguing against such a bias for these panels. Similarly, analysis of agreement within the panels did not support the presence of a one-way bias; the panelists who were significant outliers held biases in both directions and tended to cancel each other out to the degree that the consensus opinions of the panels did not change very much after the outliers were excluded from the analysis. A single non-VA expert was added to each panel to provide input from the private community. Interestingly, these non-VA panelists were not outliers in their opinions.

The analysis of the internal consistency of the panelists did show wide variability between the different panels. The medicine panel showed an excellent degree of consensus with no obvious outliers, while the surgical panel had a moderate degree of internal disagreement. The greatest degree of internal disagreement was observed among the members of the psychiatry panel, and this was of such a degree that it raises questions about the internal consistency and therefore the appropriateness of using the psychiatry panel as a gold standard. We have anecdotal information from private insurers that they too have experienced difficulty in bringing panels of psychiatrists to consensus regarding guidelines for the use of hospital care for psychiatric patients, and it is possible that this internal disagreement is a measure of the relative uncertainty about practices in the field of psychiatry as compared to medicine and surgery. For example, the ability of psychiatrists to predict subsequent violent behavior from patients seen in emergency rooms for complaints of violent behavior appears to be very limited¹⁴, and the ability to predict such behavior from reviewing a patient's chart is an important part of the assessment of appropriateness of admissions to acute psychiatric services.

There is an intrinsic conflict between the goal of having panels composed of physicians who represent the broad diversity of opinions and backgrounds characteristic of the entire VA, and the goal of having panels that exhibit a great degree of internal consistency. Our evaluation of internal consistency suggests that

we achieved a satisfactory balance for the medicine and surgery panels. Comparisons of the internal consistency of our medical and surgical panels, with those assembled in the Iowa study¹⁵, indicate a similar degree of internal agreement.

At the time we designed the validity evaluation we selected the kappa statistic as our major test of the degree of agreement between the panelists and the master reviewers. A kappa value of 0.4 or greater is typically selected as the threshold associated with meaningful agreement, and this value was exceeded for both the medicine (kappa 0.5) and surgery (kappa 0.45) panels. The kappa values for the ISD* medical and surgical validity test reported here are slightly higher than those reported by Strumwasser et al¹⁰ (0.36 -0.50) for comparisons of ISD* with the judgements of fee for service and HMO physician panels. In contrast, agreement between the psychiatry panel and the master reviewers was not acceptable (kappa 0.294). Other measures of agreement including biserial correlation and percent agreement also indicated better agreement between the medical and surgical panels and the InterQual master reviewers than was seen with psychiatry. We have not been able to find published studies evaluating the validity of psychiatric criteria for either the ISD* or AEP test instruments and thus have no benchmark for comparison of our findings in the psychiatry validation study. At this point, we cannot judge whether the lack of consistency in the psychiatry panel was a result of the selection process or a characteristic of the field of psychiatry.

The sensitivity of the ISD* criteria as compared to the physician panels was similar among the three services, ranging from 0.64 for medicine to 0.71 for psychiatry. However, there were large differences in specificity with the values ranging from 0.59 in psychiatry, to 0.76 for surgery, and 0.92 for medicine. The sensitivity and specificity values found in this study were somewhat lower than those found in the Iowa validation study of the AEP Instrument (0.72 to 0.96), however, direct comparisons of the two studies are difficult because of differences in the size of the panels and in the methods used to define consensus.

We were able to compare the ISD* criteria with the AEP criteria when applied by professional reviewers in a small sample of 48 charts that were used in the Iowa validity study and again in our validity study. The agreement between the two criteria sets was marginal with a kappa value of 0.399, a statistic that may have been influenced by the small number of charts analysed. Our comparison indicated that the ISD* criteria were more likely to rate admissions as nonacute than were the AEP criteria. Our findings are in conflict with those reported by Strumwasser et al¹⁰ who concluded that the AEP was more likely to overestimate the rate of nonacute care than ISD*. Because our comparison was based on a small number of charts, we do not feel comfortable in using our comparison as a significant factor in selecting utilization review criteria.

The steering committee for this study reviewed the data regarding internal consistency of the panels, and the degree of agreement between the panels and master reviewers. They concluded that the InterQual ISD* criteria for medicine and surgery as applied in this study had been validated, but the criteria for psychiatry were of questionable validity and further development and testing was needed before the

psychiatry criteria should be used by the VA. They also considered the various settings in which these criteria could be appropriately applied. Because the criteria for all of the three services allowed a false negative rate of greater than 25%, they recommended that the InterQual ISD* criteria not be used to exclude any individual patients from admission to the hospital. The steering committee did feel that the medicine and surgery criteria were sufficiently valid to be useful in assessing the rates and causes of nonacute admissions and days of care in evaluating policies and programs at the hospital and larger system levels.

The second most important goal of this study was to evaluate the reliability of hospital-based reviewers in applying the ISD* instrument under field conditions. A small group of professional master reviewers supervised by InterQual constituted the "gold standard" in this comparison. Internal agreement between master reviewers was excellent at 94%. The hospital reviewers proved to be reliable in applying all three service criteria with greater than 85% agreement and kappa values of greater than 0.7 for the medical and surgical criteria, and 82% agreement and kappa of greater than 0.6 for the psychiatry criteria. These kappa values for reliability are considerably larger than those reported by Strumwasser et al¹⁰ for the AEP and ISD* instruments, and compare with the kappa value of 0.7 for internal reliability reported by Ludke et al¹⁵ for highly trained and monitored reviewers in the Iowa study. The design of our study probably contributed to some disagreement between the hospital based reviewers and the master reviewers because the hospital based reviewers performed their reviews concurrently while the patient was in the hospital, and there was opportunity for discussions with patients and caregivers, while the master reviewers had to make their judgements retrospectively based only on information available in the chart and on notes from the hospital reviewers about additional information they may have collected. The fact that in the "feedback" group of hospitals, the master reviewer sometimes changed their initial opinion, and agreed with the field reviewer, illustrating that our process for providing additional information to the master reviewers was not always successful. Because a high degree of reliability was observed despite these design characteristics that tended to decrease agreement, the steering committee strongly agreed that the hospital reviewers were able to use the ISD* medicine, surgery, and psychiatry criteria in a reliable manner.

A third goal of this study was to compare two methods for training and monitoring the hospital-based reviewers. The data do not support our hypothesis that the method of providing feedback and negotiation to agreement from the master reviewers would prove superior to a less intensive use of standard training charts with written feedback in improving and maintaining the reliability of hospital reviewers. This conclusion was supported by data comparing the hospital reviewers with the master reviewers over time and by use of a pre- and post-test. We conclude that the initial training process was satisfactory, and that only a low level of monitoring and training similar to that employed in the standard chart arm of the study will be necessary to establish and maintain reliability if this utilization review instrument is applied throughout the VA system.

Although not a primary objective of this pilot study, the concurrent review of a random sample of 2432 patient charts by hospital and master reviewers, and of 210 charts by physician panels, provides a database that is sufficient to make estimates of the extent and characteristics of nonacute admissions and days of care in VA hospitals. Because the hospitals were randomly selected from strata that included representatives of all six hospital complexity groups and each of the four regions, it should be possible to generalize the results obtained from the 24 pilot hospitals to the entire VA system. Our expectation that rates of nonacute admissions would vary according to hospital complexity and to region of the country, was not confirmed and the relatively small variance attributable to these factors supports our contention that our results can be extrapolated to the universe of VA hospitals.

Rates of nonacute admissions and days of care were consistently greater than 30% for each of the three clinical services as evaluated by the master reviewers, hospital reviewers, and the physician panels. The steering committee was not able to agree about which of the three evaluators was most credible. Some felt that the physician panelists should be the ultimate gold standard, others felt that the hospital reviewers were most credible because they were the only reviewers who had access to concurrent information that might not have appeared in the chart, while others voted for the master reviewers who were most expert in applying a "community standard" measurement instrument. In the following discussion we have chosen to emphasize the data from the master reviewers because they had the greatest internal reliability and expertise in applying the ISD* instrument, and selecting them allows for comparisons of our results with other studies where expert reviewers were used. However, the most important conclusion that needs to be kept in mind is that all three types of reviewers concluded that a large percent of admissions and days of care in VA hospitals during the nine-month period of study were nonacute, that is, they could have been cared for at a lower level of care.

There are striking similarities in the nonacute rates for admissions and days of care in this study, and those described by Booth et al.³ in their study of 6000 admissions to 50 VA hospitals in 1986. They estimated that the overall rate of nonacute medical/surgical admissions for 136 VA hospitals was 43%, while our master reviewers found rates of 47% for medical admissions and 64% for surgical admissions. Winickoff et al in 1989 found similar nonacute admission rates in a smaller concurrent study of 253 admissions to five New England hospitals. The fact that these similar rates were identified using two different measurement instruments, AEP and ISD*, adds validity to our findings. The validity is further established by the finding that our physician panels using unstructured clinical judgement also found nonacute admission rates of 36% and 64% respectively for medicine and surgery. The steering committee noted that the repeated documentation of these rates in VA hospitals over a period of several years by investigators using different measurement tools indicates that the findings are "real."

The most important step in utilization management is to use the information collected in the utilization review process to identify opportunities for improving health care system policies and practices in ways that will lead to patients being cared for at a

more appropriate and presumably less expensive level of care. In this study, we pilot-tested a "reasons list" to capture explanations for nonacute admissions and days of care. At least one reason was found for more than 95% of nonacute admissions, and in many instances up to three reasons were identified. Some of the reasons, such as "conservative physician practice" are difficult to interpret, and this one in particular may have functioned as a default reason when no other reason was apparent. Nevertheless, this reason was the most common one over all services for inappropriate admissions and days of care, indicating the possibility that education directed at changing physician practice patterns may be effective in reducing nonacute hospitalizations. In initial discussions with members of the physician panels, several physicians expressed the opinion that VA hospitals "did best financially" when all the beds were full, an opinion that may be a holdover from earlier times when VA hospitals were reimbursed according to bed days. It is more certain that many nonacute days of care could be attributed to failures of physicians to perform timely discharge plans or evaluations, and these are areas where education is needed to change practice patterns.

Lack of an ambulatory care alternative was the most important reason for nonacute admissions to surgery (30% of nonacute admissions), and the second most important reason for nonacute admissions to medical service (14%). Assuming the accuracy of our observed rate of 64% nonacute admissions to acute surgical services and our observation that 30% of these were due to lack of ambulatory surgical alternatives, it is possible to estimate that 46,566 of the 242,372 acute surgical admissions to VA hospitals in 1992 could have been cared for at the less acute level if proper facilities had been available. This is a large number and its magnitude should encourage hospital and VA planners to direct more construction funds and FTE to ambulatory care. The common lack of adequate resources for providing timely evaluations and laboratory testing in the ambulatory care setting was reflected in the 16.5% of nonacute surgical admissions and 8.2% of nonacute medical admissions attributed to scheduling problems. Our steering committee was in agreement that further changes in the VA reimbursement methodology with the goal of rewarding ambulatory care would be a powerful and effective force in shifting the site of care from the hospital to the clinics. Ludke reported in the Iowa study¹⁵ that higher rates of nonacute admissions for a hospital in 1986 were associated with better financial performance under VA's reimbursement model suggesting that nonacute admissions were being financially rewarded. While VA's reimbursement model has changed since those data were collected, anecdotal reports indicate that the incentives in the current system still favor the use of inpatient care.

In contrast, the lack of an alternative lower level of care, such as nursing home beds, was less important as a reason for nonacute days of care, accounting for 12.9% of nonacute medical service days of care and for only 4.7% of surgical nonacute days.

Some current VA regulations and laws governing eligibility were found to contribute to inappropriate admissions and days of care. The requirement that nonservice connected veterans need to be admitted to a VA hospital before they are eligible for nursing home care accounted for over 5000 admissions to medical

services in 1992. Similar regulations that prevent veterans from receiving travel reimbursements when visiting clinics, but provide them when transferring between hospital inpatient services, also lead to nonacute admissions as do requirements that certain services such as a provision of prosthetic devices be provided only to inpatients.

The unique role VA plays in serving as a safety net for the poor and homeless was reflected in our observations that social reasons were important causes of nonacute admissions and days of care, particularly on psychiatry services (24.8%). The steering committee felt that allowing hospitals greater freedom to establish lodging or hoteling facilities would allow VA to meet these social needs at a less costly level. Adequate lodging facilities would also allow for more ambulatory care for those veterans who travel long distances to the VA hospital. The 8.4% of medical service admissions that were attributed to this environmental factor accounted for over 17,000 admissions to this service in 1992.

Not surprisingly, the reasons we identified as causes of nonacute admissions and days of care to acute medical and surgical services were very similar to the findings of the previously reported studies using the AEP Instrument. In the final report of the Iowa study, Ludke et al¹⁵ concluded that the major reason identified for nonacute admissions was location of the care in the acute bed service rather than the ambulatory care site, while conservative patient management was the most common reason for nonacute days of care. Winickoff et al² in their 1989 study reported that 82% of inappropriate admissions were because outpatient services should have been used either instead of or to shorten hospitalization.

VII. CONCLUSIONS AND RECOMMENDATIONS

1. The InterQual ISD* measurement instrument for utilization review, with only minor modifications, was found to be valid when applied under the conditions of this study for patients admitted to acute medical and surgical services in VA hospitals.

2. The InterQual ISD* criteria for psychiatry were not validated by a panel of nine psychiatrists, and further development and validity testing is needed before these criteria can be used in VA.

3. The InterQual ISD* criteria for medicine, surgery, and psychiatry could be applied in a reliable manner by hospital-based reviewers under the conditions similar to those used in this pilot study.

4. Hospital based reviewers can be trained in the reliable use of the InterQual ISD* criteria with an initial two-day training seminar, periodic updates during the year, and periodic monitoring of performance with written feedback to maintain reliability.

5. The ISD* criteria are as valid, reliable, and easy to use as the AEP criteria. Because 24 hospitals already have extensive experience with the ISD* criteria by participating in this pilot study, and the reviewers in these hospitals represent a valuable source of trainers, these criteria should form the basis for a system-wide utilization management program.

6. This pilot study identified a large percentage of nonacute admissions to acute medical (47%) and surgical (64%) services in 24 VA hospitals which were stratified and randomly selected to allow generalization of the findings to the VA hospital system. Rates of nonacute days of care were of similar magnitude for medical (45%) and surgical (34%) services.

7. The finding of similar rates of nonacute admissions and days of care in VA hospitals by VA-HSR&D studies conducted in 1986 and 1989 using different utilization review criteria adds validity to the conclusion that the high rates are real and should be addressed as a priority for cost-effective change by VA hospital and system managers.

8. High rates of nonacute admissions and days of care were found in all 24 hospitals studied, and the lack of variability in the rates between hospitals suggests that the causes are primarily system-wide rather than unique to individual medical centers.

9. The most important reason for nonacute admissions to surgical services in previous VA studies and in this study was the lack of an available ambulatory care alternative. This was also an important reason for nonacute admissions to medical services. These findings support the need to facilitate the shift of care from an inpatient to an outpatient setting. Specific recommendations to address this need are:

a. The reimbursement methodology for VA hospitals should be modified to encourage the movement of the site of care from inpatient to outpatient.

b. The eligibility regulations need to be adjusted to encourage outpatient rather than inpatient care. Legislation will be needed to allow contract nursing homes to be reimbursed by VA for patients admitted directly from outpatient status to nursing home care. Limitations need to be removed on eligibility for outpatient as compared to inpatient services such as dental services and provision of needed prosthetic devices.

c. Construction funds and seed money for additional FTEE to build and staff the outpatient facilities are needed to handle a significant shift of inpatient care to the clinics. During the initial phases of the transition from inpatient to outpatient care, the total cost of care may increase because of the need to provide the space and trained staff to accommodate new ambulatory activities before patients are moved out of the inpatient setting. However, we expect that over time the ambulatory site will be more cost effective than inpatient care.

d. Additional transition funds and regulatory freedoms are needed to allow hospitals to build and staff lodging facilities to accommodate veterans who live far away from the hospital or who lack the family support needed after ambulatory surgical and invasive medical procedures.

10. VA physicians need to be educated to make greater use of ambulatory care alternatives and to be more effective and timely in planning for patient discharges.

11. The VA should establish a system-wide program for using the ISD* criteria for utilization review with emphasis on identifying the local and systemic reasons for nonacute admissions and days of care. A stable utilization review system should allow VA managers to evaluate the effectiveness of changes in policy that are intended to reduce the rate of nonacute use of VA facilities.

VIII. IMPLEMENTATION PROGRESS REPORT

The value of this pilot study may be judged by the effect the study has on VA policies and practices and ultimately by documenting improvements in the quality of care. Implementation of the results of the pilot study began shortly after the study was completed in November 1992, and many months before this final report was submitted. The possibly premature beginning of the implementation process was in response to strong pressures on VA managers to address the problem of inappropriate use of acute bed facilities. The fact that after early review of this pilot study the data appeared to reconfirm the results of the two prior VA-HSR&D studies of bed utilization, added to the general desire to immediately begin implementation. The steps that have been taken to begin implementation of the findings of this pilot study as of May 1, 1993 are:

November 16, 1992 Steering Committee meeting in Seattle to review the completed results of the validity test and the 80% of the remaining data that were available by this time. The report of the Steering Committee based on this preliminary analysis is included in Appendix II. When the final data analysis was completed in March of 1993, there were insignificant changes in the results, and there was no need to alter the initial judgements of the Steering Committee.

December 1, 1992 The preliminary results and conclusions of the Steering Committee were presented to the staff meeting of the Chief Medical Director in VACO, and later in the day to the Quality Management Office Staff.

December 2, 1992 Data presented to the Utilization Management Task Force and used in the process of planning a VA system-wide UM program based on the InterQual ISD* medical and surgical criteria.

December 3, 1992 Data presented in a VA system-wide satellite presentation to the management and UM staff at all VA hospitals to lay the ground work for implementation of the VA UM program.

January 1993 Separate task force formed to revise the InterQual psychiatry criteria. This group has met by teleconference biweekly through May 1993, and revised criteria will be pilot tested by five of the original pilot facilities beginning in June. Repeat of the validity test by a panel of psychiatrists is planned for this fiscal year with the goal of implementing the new psychiatry criteria by early 1994.

June 1993 Training of reviewers from Region I hospitals to begin, and all hospital reviewers to be trained by October 1993 for implementation of the medical and surgical reviews in all hospitals by this date.

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REASONS LISTCLASSIFICATION OF CASES NOT MEETING
CRITERIA FOR ADMISSION AND LENGTH OF STAYNON ACUTE ADMISSIONS:Social Factors:

- 01. Lack of social support/unable to care for self.
- 02. Family unable to handle/care for patient.
- 03. Homeless
- 04. Respite Care
- 05. Other (specify in comments section)

Environmental Factors:

- 06. Distance to travel to hospital (over 75 miles).
- 07. No means of direct communication with veteran/family.
- 08. Other (specify in comments section)

Scheduling:

- 09. Delay in scheduling outpatient clinic appointment.
- 10. Delay in scheduling outpatient procedure.
- 11. Premature admission.
- 12. Other (specify in comments section)

Bed/Service Availability:

- 13. Alternative beds unavailable, eg., Intermediate Care, NHCU, hospice.
- 14. Outpatient procedure unavailable.
- 15. Other outpatient care unavailable.
- 16. Other (specify in comments section)

Administrative:

- 17. Admitted for NH placement.
- 18. Admitted for transfer to another acute care hospital.
- 19. Admitted for testing/procedure at a non-VA facility.
- 20. Admitted to be eligible for other VA care, ie., dental.
- 21. Admitted as a transfer from another hospital.
- 22. Admitted from a boarding home/contract NH for psychosocial reasons.
- 23. Admitted for disability evaluation.
- 24. Admitted to participate in a research program.
- 25. Administrative directive.
- 26. Admitted for sleep apnea study.
- 27. Other (specify in comments section)

Communication Problems:

- 28. Misinformation on status of patient.
- 29. Other (specify in comments section)

PRACTITIONER ISSUES

- 30. Medical management of patient is conservative, eg., criteria indicate treatment as outpatient or in long term care is appropriate, but physician evaluation led to placement in acute care.
- 31. Other (specify in comments section)

If you have been unable to identify any reasons from the above list, please

CLASSIFICATION OF CASES NOT MEETING
CRITERIA FOR ADMISSION AND LENGTH OF STAY

NON ACUTE DAY(S) OF CARE:

Social Factors:

51. Patient is convalescing from an illness, and it is anticipated that his/her stay in an alternative facility would be less than 72 hours.
52. Patient from unhealthy environment--patient kept until environment becomes acceptable or alternative facility found.
53. Lack of family for home care (or lack of supportive family).
54. Patient or family require additional health education for successful post-hospitalization.
55. Family refuses to take patient out of hospital.
56. Patient/family rejection of care plan.
57. Patient/family rejection of transfer to appropriate alternate facility.
58. Patient/family rejection of discharge plan because of finances.
59. Homeless
60. Respite Care
61. Other (specify in comments section)

Environmental Factors:

62. Weather
63. Distance to travel between hospital and home.
64. No means of direct communication with veteran/family.
65. Other (specify in comments section)

Scheduling:

66. Delay due to "40 hour week" problem (ie., procedures not done on weekend).
67. Problem in scheduling of procedure.
68. Patient "bumped" from schedule for procedure.
69. Waiting for appropriate procedure to be done at non-VA facility.
70. Procedure canceled, patient not properly prepared
71. Other (specify in comments section)

Bed Availability:

72. Alternative beds unavailable within the facility, eg., Intermediate Care, NHCU, hospice.
73. Awaiting placement in a community nursing home (NH placement).
74. Awaiting transfer to another acute care institution.
75. Non-facility based treatment not available (eg., home health care).
76. Patient comes from a federal facility (domiciliary, nursing home, etc.) which is unable to take him back at this time.
77. Other (specify in comments section)

Administrative:

78. Service-connected considerations delay discharge.
79. Patient remaining in hospital due to research project.
80. Patient granted pass.
81. Other (specify in comments section)

Communication Problems:

- 82. Misinformation on status of patient.
- 83. Delay in receiving results of diagnostic test or consultation needed to direct further treatment.
- 84. Other (specify in comments section)

Practitioner Issues

- 85. Failure to write discharge orders.
- 86. Failure to initiate timely discharge planning, eg., developing plan for transfer to non-acute level of care.
- 87. Physician's medical management of patient is conservative eg., criteria indicate discharge or transfer is appropriate, but physician evaluation led to continued acute care treatment.
- 88. No documented plan for active treatment or evaluation of patient.
- 89. Some aspect of care inadvertently overlooked causing delays.
- 90. Other (specify in comments section)

If you have been unable to identify any reasons from the above list, please use: 99. No reason identified.



DEPARTMENT OF VETERANS AFFAIRS
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APPENDIX II

February 9, 1992

In Reply Refer To:
663-11

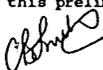
Ruth E. Parry, J.D.
 Director, HSR & D Service (12B)
 Va Central Office
 810 Vermont Avenue
 Washington, DC 20420

Subject: Steering Committee Report for HSR & D Service Directed Research
 Project #SDR 91-010, "Pilot Study of the ISD-A Measure of the Appropriateness
 of Bed Utilization" (Charles B. Smith, M.D. et. al)

The Steering Committee met in Seattle, WA on November 16, 1992 to review the status of this project. The data presented included the complete set of data from the validation study conducted by Dr. Williamson during July and August 1992. The data regarding reliability, comparisons of educational intervention groups, degree of nonacute admissions and reasons for nonacute admissions represented approximately 80% of the final data expected to be available for the study. The three month delay in concluding the study was caused by the delay in obtaining permission to contract InterQual as the master reviewer. This review of the Pilot Study was held before the final data were analyzed because the Office of Quality Management needed to have the opinions of the Steering Committee by December 1992, in time to have input to the National Satellite Conference, and in time for the drafting of a system-wide policy for Utilization Management.

The investigators and the Steering Committee felt that this premature meeting was acceptable because the most controversial part, the validity study, was complete and the results for the remaining part of the study were so definitive that it was unlikely that they would change after the remaining 20% of the data became available and were analyzed. Never the less, this Steering Committee report should be considered preliminary. The final data will be provided to the Steering Committee members in March, 1993, and possible changes in conclusions will be considered.

Dr. Perrin, the ad hoc Chair of the Committee and all members have seen and approved this preliminary report.


 Charles B. Smith, M.D.
 Chief of Staff (11)
 Seattle VAMC

cc: Galen Barbour, M.D.
 Debby Walder, R.N.
 Brenda Booth, Ph.D.
 Ira Strumwasser, Ph.D.
 Richard Winickoff, M.D.
 Barry L. Bell
 Larry Seidl, M.D.

PRELIMINARY STEERING COMMITTEE REPORT

PILOT STUDY OF THE ISD-A MEASURE OF APPROPRIATENESS OF BED UTILIZATION

November 16, 1992

Panel Members:

Brenda Booth, Ph.D.

Ira Strumwasser, Ph.D.

Richard Winickoff, M.D.

Barry L. Bell

Larry Seidl, M.D.

Edward Perrin, Ph.D., Ad Hoc Chair of the Committee

There were seven major decisions to be made by the Steering committee after listening to the presentation of the results of the study. These decisions concerned: 1) The internal validity (consistency) of the expert panels, evaluation of the InterQual criteria; 2) The external validity of the InterQual criteria as measured by the panels' agreement with the InterQual master reviewers assessment of the acuity of each case's admission to hospital; 3) The sensitivity and specificity of the InterQual criteria set and the "allowable" limits of these attributes; 4) The reliability of the hospital reviewers in using the InterQual criteria to evaluate the acuity of each admission; 5) The most effective training method for hospital reviewers; 6) The credibility of the estimate of nonacute admissions; and 7) The potential use of the InterQual criteria in the VA system.

1. **Internal validity:** This attribute was defined as the level of agreement of each expert panel member with the other members of his/her panel. It is important to consider this attribute in the context of the credibility of the panel as a whole; if there is little agreement among the panel members

about the acuity of the cases the panel considered, the credibility of the panels' judgment is diminished. On the other hand, if the panel is internally consistent, the credibility of its judgment is enhanced. However, it is acknowledged that since the considered cases represent multiple clinical domains, there is a need to have panels with members from diverse clinical backgrounds and a wide variety of expertise. This variety increases the credibility of the panels, findings. Accordingly, a diverse panel is expected to have some disagreements.

After considering the results from the analyses of internal consistency for the medicine, surgery, and psychiatry panels, the Steering Committee strongly agreed that the medicine panel had internal consistency. The Committee agreed only moderately that the surgery panel was internally consistent. There was moderate disagreement over the internal validity of the psychiatry panel with two Steering Committee members moderately disagreeing that the panel had internal validity and three members moderately agreeing that the panel exhibited this attribute. While these results are clearly not definitive, there is the most concern about the credibility of the psychiatry panel.

2. **External validity:** In estimating this attribute, the Steering Committee considered the results of the comparisons between InterQual's and the three panels' evaluation of the acuity of the same cases. For purposes of this analysis, external validity is defined as the degree to which the measuring instrument (i.e. InterQual criteria) actually measure the acuity of patients' clinical condition, assuming that the physician panels' evaluation represents the "gold standard."

The Steering Committee members moderately to strongly agreed with the external validity of the InterQual medicine and surgery criteria. However, the Committee split between moderately agreeing and moderately disagreeing over the psychiatry criteria. While there was no strong rejection of the validity of the psychiatry criteria, the uncertainty of the Steering Committee's evaluation must be considered.

3. **Sensitivity and specificity:** For each of these attributes, the Steering Committee was asked to estimate a level of acceptance that could be tolerated in evaluating patients' admission to hospital. In other words, what percent of false positives could be accepted for InterQual's evaluation of patients as acute and needing hospitalization when, in fact, the physician panels judged patient's condition as not acute? Conversely, what was the acceptable percent of InterQual's judgments that patients should not be admitted to the hospital where the panel rated them as acute and requiring hospitalization (false negatives)? The Committee's range of tolerance for false positives was quite broad, from 10 to 80 percent, with the median level at 20 percent. The range of tolerance for false negatives was also quite broad, from 5 to 60 percent, with 10 percent as the Steering Committee's median level of tolerance.

The false positive rates for the InterQual criteria were excellent for medicine (8 percent) and marginally acceptable for surgery (24 percent) using the Steering Committee's median level of tolerance as the "standard." The psychiatry rates were associated with a very large percentage of false positives (41 percent).

The InterQual false negative rates for all three services exceeded the Committee's standard by three-fold. This influenced the Committee's decision to not support the application of InterQual criteria for an individual's hospital admission decision.

4. **Reliability:** The Steering Committee was asked to consider the results of the analyses that compared the hospital reviewers' assessment of patients' acuity against the assessment of InterQual for the same medical records. In these analyses, InterQual was used as the "gold standard." The analysis of reliability is intended to reveal whether hospital reviewers can independently use the InterQual criteria with similar results to those of master reviewers.

The Steering Committee strongly agreed that the hospital reviewers were able to use the InterQual medicine, surgery, and psychiatry criteria in a reliable manner.

5. **Training method:** Two methods of training hospital reviewers were tested: One that employed concurrent review of a randomly selected set of records, review of the same records by InterQual, and feedback from the InterQual master reviewers to the hospital reviewers with discussion about each case until consensus was reached. The other method relied on standard records reviewed by both InterQual and hospital reviewers who were provided an acknowledgment of the summary level of agreement between the hospital reviews and InterQual's. It had been hypothesized that the first method of training would produce higher levels of agreement.

Although the feedback method resulted in a statistically significant greater level of agreement between InterQual and the field reviewers, the Steering Committee moderately disagreed that the "feedback" method produced practically better results. That is, the Committee did not find the difference was worth the greater costs associated with the feedback method.

6. **Credibility of Estimates of Nonacute Admissions:** The data produced by the study hospitals were aggregated and categorized into acute admissions and nonacute admissions. The records had been reviewed by field reviewers, InterQual master reviewers, and by the expert physician panels. The Steering Committee was asked to consider the results of these three types of reviews and to rank the results in terms of the credibility of each.

The results indicated that there was little agreement of which type of reviewer produced the most credible results. Each type of reviewer was ranked as the most credible by at least one member of the Steering Committee; InterQual and the physician panel was ranked as the most credible by two members of the Committee. Likewise, each reviewer type was ranked as the least credible by at least one Steering Committee member; field reviewers and physician panel were each ranked as least credible by two members. The observation that all three types of reviews yielded remarkably similar results (30 to 40 percent nonacute admissions) was emphasized by the Committee as a strong indication that the observation was "real."

7. **Use of InterQual Criteria in the VA:** After considering all of the study results, the Committee was asked to provide opinions about the potential usefulness of the criteria in the VA. There were three levels of

usefulness that were to be considered: At the patient level in which admissions would be screened and potentially denied if the criteria were not met; at the hospital level for developing admission policies and for allocation of resources; and at the system level to change eligibility criteria, reimbursement policies, and as a basis for program planning.

The Steering Committee did not agree over the use of the criteria at the patient level: Two members strongly agreed that such a use would be appropriate but one member strongly disagreed; two members had a moderate disagreement with such use. All Steering Committee members agreed that the use of the InterQual criteria at the hospital level would be appropriate, although that agreement was only moderate. The agreement was stronger over the use of the InterQual criteria at the system level. All members agreed that this type of use would be appropriate.

Summary: In summary, the Steering Committee recommended that the use of the InterQual criteria for medicine and surgery would be acceptable at either or both the hospital and the system level, but that their use at the patient level would be problematic. The criteria were found to be reliably used by hospital reviewers without ongoing training by InterQual. However, there was sufficient disagreement over the validity of the psychiatric criteria to suggest that the implementation of these criteria be delayed until further studies or modification are undertaken.

The results of this pilot study were reviewed by the Committee in relation to the recently published results from the Iowa and the Region I studies that used a different measuring instrument (Admission Evaluation

Protocol - - AEP). The great similarity between rates of nonacute admission detected by the InterQual instrument (this present pilot study) and the prior studies was noted. The Committee further concluded that the existence of a high rate of nonacute admissions to medical and surgical services had been confirmed.

The final discussion of the steering Committee was devoted to suggestions for lowering the high rate of nonacute admissions. The most consistent reason for the nonacute admissions in all studies was the nonavailability of alternatives to hospital care, particularly ambulatory care alternatives, and the veterans' inability to gain access to such services when they exist. Two factors were determined to be major contributors to this situation: Eligibility regulations, and the lack of financial incentives for hospital managers to encourage moving inpatient care to the ambulatory care mode.

CB Smith
2/1/93

Revised 2/8/93

DRAFT 10/27/92

FINAL VOTE TALLY 11/16/93

Questionnaire for UM Pilot Study Steering Committee

This preliminary questionnaire is designed to determine the areas of consensus and disagreement regarding interpretation of the results of the UM Pilot Study. It will help us allocate time during the meeting to those areas in most need of discussion.

The results of this preliminary questionnaire will be used to initiate the discussions, but they will not be recorded in the final report.

VALIDITY (are we measuring what we want to measure?) The question of validity of the InterQual ISD-A measurement instrument is important if the results of this pilot project are to be accepted by N/A physicians and managers. We chose to measure validity by comparing the ratings of InterQual Master reviewers using the ISDA instrument with ratings of expert panels of VA physicians. The science of statistically evaluating validity is not very mature, and we therefore have included several measures of the degree of agreement including % agreement, kappa, biserial correlation, sensitivity, specificity and r^2 . The assessment needs to consider how well the 9 panel members agreed with each other (inter-rater reliability), as well as the degree of the panels agreement with ISDA. Don Martin, our statistician will discuss these issues in more detail during the meeting. Based on the information you have received, please give us your current impressions in answering the following questions:

--check the appropriate box--

1/ The MEDICINE panel agreed with each other:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	1	4

2/ The MEDICINE panel agreed with the ISDA criteria:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	3	2

3/ The SURGERY panel agreed with each other:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	4	1

4/ The SURGERY panel agreed with the ISDA criteria:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	4	1

5/ The PSYCHIATRY panel agreed with each other:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	2	3	0

6/ The PSYCHIATRY panel agreed with the ISDA criteria:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	1	3	0

7/ In evaluating a test instrument, the sensitivity and specificity are important considerations. For the ISD-A measure of appropriateness of admissions, what would be your level of tolerance (in percent) for:

a/ False positives – rating patient admissions as appropriate when then in fact they were inappropriate?

b/ False negatives. – rating patient admissions; as inappropriate when in fact they were appropriate?

What other information would you like to have to help you make judgements regarding validity?

RELIABILITY

The major analysis of reliability of field reviewers compares their concurrent evaluations using ISDA criteria with a retrospective review of the same charts by

the InterQual master reviewers (the "Gold Standard"). Each of the three clinical services are analyzed separately, and for most of the analyses the data are pooled for two educational intervention groups (A and B). A separate analysis compares the two interventional groups over time. We also evaluated inter-rater reliability by asking two reviewers in each medical center to independently evaluate randomly chosen medical and surgical charts.

We would like you to compare the reliability data from this pilot study with reliability data from the Iowa study and the Region I study (see the J. Med. Care Aug 1991 Issue we sent to you). In making this comparison it is important to remember that those two published studies utilized highly trained and monitored reviewers, while the pilot study utilized reviewers who were already on staff at each hospital and who performed this function as part of other QA duties. Based on the information we have provided to you, please answer the following questions:

8/ The hospital-based reviewers were reliable in utilizing the MEDICINE ISDA criteria when compared to the InterQual master reviewers:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	1	4

9/ The hospital-based reviewers were reliable in utilizing the SURGERY ISDA criteria when compared to the InterQual master reviewers:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	0	5

10/ The hospital-based reviewers were reliable in utilizing the PSYCHIATRY ISDA criteria when compared to the InterQual master reviewers:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	1	4

11/ The educational intervention A (master reviewer immediate feedback with negotiation to agreement) which is more expensive, was sufficiently more effective

than intervention B (standard charts) that it should be used if the VA implements an ISDA-based utilization evaluation system in all VA hospitals:

strongly disagree moderately disagree moderately agree strongly agree

12/ What additional information would you like to have to help you in making judgements regarding reliability?

NON-ACUTE ADMISSIONS TO VA HOSPITALS

With the background of your current understanding of the strength of the validity and reliability evaluations, please evaluate the estimates of the percent admissions to acute services that were "non-acute" as given by the three groups of reviewers-

13/ Please rank the three groups of reviewers according to "credibility" -- i.e. to whose evaluations would you give the most weight? Rank the most credible #1 etc.

InterQual Master Reviewers	<input type="radio"/>	1-2 2-2 3-1
Field Reviewers	<input type="radio"/>	1-1 2-2 3-2
Physician Panels	<input type="radio"/>	1-2 2-1 3-2

ULTIMATE USE OF ISDA CRITERIA FOR UTILIZATION REVIEW IN THE VA

Your advice regarding the potential usefulness of the ISDA criteria for utilization management in the VA will be an important outcome from the steering committee meeting. Please indicate your degree of agreement with the following statements:

14/ Hospital reviewers should use the ISDA criteria to screen admissions of individual patients to VA hospitals?

strongly disagree moderately disagree moderately agree strongly agree

15/ Hospitals should use ISDA-based utilization review data to develop admission policies and to reallocate resources:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	3	2

16/ The VA system should use ISDA-based utilization review data to change eligibility criteria, reimbursement policies and as a basis for program planning:

strongly disagree	moderately disagree	moderately agree	strongly agree
0	0	2	3

17/ Are you familiar with other utilization review criteria that you believe would be more effective in the VA? Comment--

Hospital reviewers for Medicine
 Frequencies for all three reasons ignoring order
 Reasons in numeric order
 cases 2342 Nonacute 985
 cases with a reason 976 total for service 313

	admit	days						total
		3	6	9	14	21	28	
0 no reason code	2059	2258	2280	2345	2415	2450	2476	14224
1 Soc. no support	14	1	0	0	0	0	0	1
2 Soc. no family	13	0	0	0	0	0	0	0
3 Soc. homeless	8	1	0	0	0	0	0	1
4 Soc. respite care	4	0	0	0	0	0	0	0
5 Soc. other	11	1	1	0	0	0	0	2
6 Env. distance	36	2	1	1	0	0	0	4
7 Env. no communication	1	2	1	1	0	0	0	4
8 Env. other	0	6	3	5	3	2	0	19
9 Sch. delay appointment	4	0	0	0	0	0	0	0
10 Sch. delay procedure	11	0	0	0	0	0	0	0
11 Sch. premature admit	14	0	0	0	0	0	0	0
12 Sch. other	7	0	0	0	0	0	0	0
13 Bed no alternative	15	0	0	0	0	0	0	0
14 Bed no outpat. proc.	42	0	0	0	0	0	0	0
15 Bed no outpat. care	19	1	0	0	0	0	0	1
16 Bed other	2	0	0	0	0	0	0	0
17 Adm. NH placement	11	1	0	0	0	0	0	1
18 Adm. for transfer	1	0	0	0	0	0	0	0
19 Adm. testing	3	0	0	0	0	0	0	0
20 Adm. other care	8	0	0	0	0	0	0	0
21 Adm. from transfer	23	0	0	0	0	0	0	0
22 Adm. psychosocial	5	0	0	0	0	0	0	0
23 Adm. disability eval.	1	0	0	0	0	0	0	0
24 Adm. research	3	0	0	0	0	0	0	0
25 Adm. directive	4	0	0	0	0	0	0	0
26 Adm. apnea	9	0	0	0	0	0	0	0
27 Adm. other	11	0	0	0	0	0	0	0
28 Com. misinfo.	1	1	0	0	0	0	0	1
29 Com. other	4	0	0	0	0	0	0	0
30 Prt. conservative	132	1	1	1	0	0	0	3
31 Prt. other	8	0	0	0	0	0	0	0
51 Soc. convalescing	0	0	3	5	0	0	0	8
52 Soc. bad environ.	1	2	3	2	0	0	0	7
53 Soc. no family	0	3	3	3	4	2	1	16
54 Soc. education	0	3	1	2	0	0	0	6
55 Soc. fam. refused	0	1	2	0	0	1	0	4
56 Soc. reject plan	0	2	2	1	0	0	0	5
57 Soc. reject transfer	0	1	2	0	0	0	0	3
58 Soc. financial	0	0	1	0	0	0	1	2
59 Soc. homeless	0	4	3	3	1	0	0	11
60 Soc. respite	0	3	3	1	0	0	0	7
61 Soc. other	0	3	3	4	4	3	2	19
63 Env. distance	1	17	17	8	2	0	0	44
66 Sch. 40 hr. week	0	14	11	4	2	0	0	31
67 Sch. procedure	0	8	7	2	1	0	0	18
69 Sch. wait, non VA	0	1	1	3	1	1	1	8
70 Sch. canceled	0	0	0	2	3	1	0	6
71 Sch. other	0	5	4	4	1	1	1	16
72 Bed no alternative	0	9	10	7	8	10	4	48
73 Bed wait for place	0	5	4	6	5	5	2	27
74 Bed transfer	0	0	0	1	1	0	1	3

APPENDIX III - Page 2

75	Bed trt. not avail.	0	2	1	0	0	1	0	4
76	Bed Fed. facility	0	0	1	1	2	2	1	7
77	Bed other	0	2	3	4	1	0	0	10
78	Adm. service related	0	2	0	0	0	0	0	2
80	Adm. pass	0	5	5	0	2	1	2	15
81	Adm. other	0	1	3	1	1	0	0	6
82	Com. misinfo	0	0	0	0	1	0	0	1
83	Com. Delay	0	7	7	5	2	0	0	21
84	Com. other	0	2	0	1	0	0	0	3
85	Prt. no discharge	0	1	1	0	0	0	0	2
86	Prt. no plan	0	6	8	8	5	5	2	34
87	Prt. conservative	2	82	75	50	28	12	4	251
88	Prt. no evaluation	0	11	12	4	1	1	0	29
89	Prt. overlooked	0	1	0	0	0	0	0	1
90	Prt. other	0	2	0	2	0	1	1	8
99	No reason found	11	19	16	10	5	0	0	50
		-----	---	---	---	---	---	---	-----
	totals	440	241	219	154	84	49	23	770

Hospital reviewers for Surgery
 Frequencies for all three reasons ignoring order
 Reasons in numeric order
 cases 2342 Nonacute 985
 cases with a reason 976 total for service 404

	admit	days						total
		3	6	9	14	21	28	
0 no reason code	1539	1990	2049	2088	2115	2134	2135	12511
1 Soc. no support	7	1	2	2	1	0	0	6
2 Soc. no family	7	0	0	0	0	0	0	0
3 Soc. homeless	2	0	0	0	1	1	1	3
4 Soc. respite care	3	0	0	0	0	0	0	0
5 Soc. other	10	0	0	0	1	0	0	1
6 Env. distance	47	3	1	0	0	0	0	4
7 Env. no communication	0	1	1	0	0	0	0	2
8 Env. other	0	3	2	1	1	2	1	10
9 Sch. delay appointment	4	2	1	1	1	0	0	5
10 Sch. delay procedure	17	0	1	0	0	0	0	1
11 Sch. premature admit	65	2	0	0	0	0	0	2
12 Sch. other	14	1	0	0	0	0	0	1
13 Bed no alternative	1	1	1	1	0	0	0	3
14 Bed no outpat. proc.	195	1	0	0	0	0	0	1
15 Bed no outpat. care	4	0	0	0	0	0	0	0
16 Bed other	20	0	0	0	0	0	0	0
17 Adm. NH placement	2	0	0	0	0	0	0	0
18 Adm. for transfer	6	1	1	1	0	0	0	3
19 Adm. testing	3	0	0	0	0	0	0	0
20 Adm. other care	1	0	0	0	0	0	0	0
21 Adm. from transfer	6	0	0	0	0	0	0	0
23 Adm. disability eval.	1	0	0	0	0	0	0	0
24 Adm. research	6	0	0	0	0	0	0	0
26 Adm. apnea	2	0	0	0	0	0	0	0
27 Adm. other	14	0	0	0	0	0	0	0
28 Com. misinfo.	3	0	0	0	0	0	0	0
29 Com. other	9	0	0	0	0	0	0	0
30 Prt. conservative	109	1	1	1	0	0	0	3
31 Prt. other	19	0	0	0	0	0	0	0
51 Soc. convalescing	0	3	3	2	1	1	1	11
52 Soc. bad environ.	0	0	0	0	0	0	1	1
53 Soc. no family	0	7	3	2	0	0	0	12
54 Soc. education	0	0	0	1	1	0	1	3
56 Soc. reject plan	2	0	1	0	0	1	1	3
59 Soc. homeless	0	1	2	2	0	0	0	5
60 Soc. respite	1	0	0	0	0	0	0	0
61 Soc. other	0	2	0	2	1	1	0	6
63 Env. distance	0	8	4	4	0	0	0	16
64 Env. communication	0	2	0	0	0	0	0	2
65 Env. other	0	1	0	1	0	0	0	2
66 Sch. 40 hr. week	2	3	2	0	1	0	0	6
67 Sch. procedure	0	5	2	2	0	0	0	9
68 Sch. bumped	0	5	0	0	0	0	0	5
70 Sch. canceled	0	1	1	0	0	0	0	2
71 Sch. other	0	11	5	1	0	0	1	18
72 Bed no alternative	0	1	1	1	0	0	0	3
73 Bed wait for place	0	0	0	0	1	0	0	1
75 Bed trt. not avail.	0	0	1	1	0	0	0	2
76 Bed Fed. facility	0	1	0	0	1	0	0	2
77 Bed other	0	2	1	1	1	0	0	5
78 Adm. service related	0	0	1	0	0	0	0	1

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80	Adm. pass	2	7	4	2	2	0	1	16
81	Adm. other	0	14	6	2	1	0	0	23
83	Com. Delay	0	3	0	0	0	0	0	3
84	Com. other	1	2	1	0	0	0	0	3
85	Prt. no discharge	0	2	1	1	0	0	0	4
86	Prt. no plan	0	4	7	2	3	0	0	16
87	Prt. conservative	3	43	34	19	11	5	2	114
88	Prt. no evaluation	0	2	0	1	0	0	0	3
89	Prt. overlooked	0	1	0	1	0	0	0	2
90	Prt. other	0	2	3	1	1	0	0	7
92		0	0	1	0	0	0	0	1
99	No reason found	18	5	1	1	0	0	0	7
	totals	606	155	96	57	30	11	10	359

Hospital reviewers for Psychiatry
 Frequencies for all three reasons ignoring order
 Reasons in numeric order
 cases 2342 Nonacute 985
 cases with a reason 976 total for service 252

	admit	days						total
		3	6	9	14	21	28	
0 no reason code	1994	2151	2125	2113	2152	2207	2266	13014
1 Soc. no support	30	0	0	0	0	0	0	0
2 Soc. no family	8	0	1	0	0	0	0	1
3 Soc. homeless	31	1	0	0	0	0	0	1
4 Soc. respite care	6	0	0	0	0	0	0	0
5 Soc. other	16	1	1	1	1	0	0	4
6 Env. distance	7	0	0	0	1	1	1	3
7 Env. no communication	1	1	1	2	2	1	0	7
8 Env. other	0	10	9	4	3	4	3	33
9 Sch. delay appointment	0	1	0	1	0	0	0	2
11 Sch. premature admit	1	0	1	1	1	1	1	5
13 Bed no alternative	8	0	0	0	0	0	0	0
15 Bed no outpat. care	3	0	0	0	0	0	0	0
20 Adm. other care	3	0	0	0	0	0	0	0
21 Adm. from transfer	17	0	0	0	0	0	0	0
22 Adm. psychosocial	7	0	0	0	0	0	0	0
27 Adm. other	11	0	0	1	0	0	0	1
28 Com. misinfo.	2	0	0	0	0	0	0	0
29 Com. other	4	1	0	0	0	0	0	1
30 Prt. conservative	162	0	0	2	0	0	0	2
31 Prt. other	21	0	0	0	0	0	0	0
52 Soc. bad environ.	1	2	1	1	0	0	0	4
53 Soc. no family	0	5	3	3	4	1	1	17
54 Soc. education	0	2	3	2	0	1	1	9
55 Soc. fam. refused	0	0	0	0	1	1	1	3
56 Soc. reject plan	0	5	4	6	2	2	0	19
57 Soc. reject transfer	0	1	1	0	0	0	0	2
59 Soc. homeless	0	5	9	11	13	8	5	51
60 Soc. respite	0	1	1	0	0	0	0	2
61 Soc. other	0	4	7	5	4	2	0	22
63 Env. distance	0	2	2	3	4	3	1	15
65 Env. other	0	0	0	1	0	0	0	1
66 Sch. 40 hr. week	0	2	0	0	0	0	0	2
67 Sch. procedure	0	0	1	1	0	0	0	2
71 Sch. other	0	0	0	0	1	0	0	1
72 Bed no alternative	0	15	11	12	14	14	9	75
73 Bed wait for place	0	2	1	2	3	1	0	9
74 Bed transfer	0	1	1	1	1	2	0	6
77 Bed other	0	2	4	7	4	7	5	29
78 Adm. service related	0	0	0	0	0	1	0	1
79 Adm. research	0	2	1	0	0	0	0	3
80 Adm. pass	0	3	8	8	3	3	3	28
81 Adm. other	0	12	12	8	6	3	3	44
83 Com. Delay	0	0	0	0	1	2	0	3
84 Com. other	0	4	2	4	5	2	0	17
85 Prt. no discharge	0	5	3	5	3	5	4	25
86 Prt. no plan	0	15	16	16	25	22	17	111
87 Prt. conservative	2	61	80	88	70	49	31	379
88 Prt. no evaluation	1	29	31	32	22	9	6	129
89 Prt. overlooked	0	1	0	0	0	0	0	1
90 Prt. other	0	2	10	7	3	4	2	28
99 No reason found	25	12	11	13	12	5	1	54
totals	367	210	236	248	209	154	95	1152

Chairman Stump to General Accounting Office

Response to Questions for the Record
From Chairman Stump
Committee on Veterans' Affairs
Hearing on July 19, 1995

- 1) Has it been your experience that nonservice-connected veterans receive priority over service-connected veterans? Could you comment on a system that would give priority to nonservice-connected veterans based on exposure to combat or hostile fire. In your opinion, would this make the system fairer and less complicated? Looking at the North Chicago example - how is it possible for this facility to incorporate these changes? Is it a function of the RPM methodology and a lack of patients? Please provide an analysis.

Response: VA medical centers generally do not use service-connection in setting care priorities. Typically, medical centers have some form of triage to identify those veterans with the most urgent medical needs and such veterans are seen first. The remaining veterans, however, are generally provided care in the order in which they arrive for unscheduled appointments.

Establishing care priorities for nonservice-connected veterans based on their exposure to hostile fire would, in our opinion, place a greater emphasis on VA's initial mission of serving combat veterans. It would not be less complicated than the current priority system, however, because it would require an additional determination of exposure to hostile fire before VA facilities could set their priorities. One way to make such a determination less complicated would be to issue veteran identification cards that clearly indicate the veteran's priority for care.

We have not reviewed the recent changes at the North Chicago VA medical center that transformed the center into an HMO based model of health care delivery. The description of the North Chicago program attached to Mr. Gorman's testimony statement, however, makes the program sound quite promising in terms of cost savings and improved patient care. We would be happy to assist the Committee in an evaluation of this program and its possible applicability to other medical centers. Of particular interest in such an evaluation is the claimed 85 percent reduction in hospital days through implementation of primary care teams. As we noted in our prepared statement, such reductions in inpatient stays are dependent more on management improvements than on eligibility reform.

- 2) In your opinion, do you believe that VA can effectively implement eligibility reform that mandates treatment only in the most appropriate setting? What would, in your view, be the impact on service-connected veterans?

Response: We believe such a mandate would have limited effect

on the VA health care system. In our opinion, VA provides care in inappropriate settings primarily because of management inefficiencies not legal barriers. It should be the goal of any health care system to provide care in the most cost-effective setting.

To the extent that VA is able to shift care to more appropriate settings, resources should be freed up to better meet the health care needs of service-connected veterans. We would see no adverse effect from requiring VA to provide care in only the most appropriate care setting.

- 3) Could you comment on the work by GAO in which it has looked at contract care in the community. In your experience, are veterans more satisfied with services provided by community providers and paid for by the VA?

Response: We have not done any work focusing specifically on veterans satisfaction with VA versus contract care. We did, however, conduct a series of focus group meetings with veterans in various parts of the country last year.¹ In those meetings, veterans expressed a wide range of views about VA care. Some veterans credited VA with saving their lives and were highly complimentary of the care they received at VA. Others however, criticized the attitudes of VA staff, the excessive waiting times, and the inconvenience of getting to a VA facility.

Many veterans indicated that they use VA only for treatment of their service-connected disability or as a last resort if they are unemployed and do not have health insurance. This, in our opinion, suggests that these veterans would generally prefer to use private sector providers closer to their homes.

¹Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Reform (GAO/HEHS-95-14, Dec. 23, 1994).

Chairman Stump to Non Commissioned Officers Association

Question from the Honorable Bob Stump
Chairman, House Committee on Veterans Affairs

QUESTION: Do you believe that the VA's policy to charge CHAMPUS eligible beneficiaries will deter or negatively impact a beneficiary's decision to use VA health facilities?

Mr. Rhea: Imposing co-payments on CHAMPUS beneficiaries for treatment in a federal VA health facility provides no incentive whatsoever for those beneficiaries to choose VA.

Why should they choose the VA when their treatment priority is classified as discretionary? Why should a military retiree, for example, endure the long waiting lines and then incur the same cost as though treatment were provided in the private sector? Why would military retirees subject themselves to the insult of being looked upon as the deep pockets to finance health care for categories of non-service connected veterans whose treatment is mandated in law yet have one-fifteenth, one-twentieth, or one-thirtieth of the years of military service?

Given the alternative of VA or the private sector where out of pocket costs will be the same, CHAMPUS beneficiaries will opt for the latter for obvious reasons.

CHAMPUS beneficiaries perhaps would be more inclined to choose VA if the deductibles and co-payments were not a part of the equation in that decision. By waiving these out of pocket expenses for individuals, who after all were promised cost-free medical care, would produce a win-win situation for CHAMPUS beneficiaries and the VA. VA would still be able to claim the balance of the CHAMPUS payment.

Mr. Chairman, there are at least two other strange twists in this maze of eligibility regarding the level and extent of care provided to different categories of veterans that needs to be put on the table and openly discussed.

These same CHAMPUS beneficiaries lose virtually all of their health care options at age 65. They are denied health care in military treatment facilities and, since they lose CHAMPUS eligibility at that age, the VA option is even taken away.

The federal government has told the category of longest serving veterans, the military retiree, that MEDICARE, with its attendant costs and limitations, is fulfillment of the obligation at age 65. Yet, the federal government mandates, a lifetime of cost-free health care in the VA system, to include nursing home and domiciliary care, for some veterans who may have served as little as 181 days. At age 65, we shut out completely the military retired veteran and reward someone with AIDS or a drug or alcohol problem even though those conditions in the vast majority of cases are not even remotely related to military service that may have been performed twenty, thirty or forty year prior. At age 65, MEDICARE is OK for the military retired veteran to whom a very clear promise was made. For other categories of non-service connected veterans, MEDICARE is somehow an unspeakable term. Something is dramatically and drastically wrong with a federal VA system that tends to reward irresponsibility while punishing responsible, long-term, faithful military service.

Several comments have been made at this hearing concerning the joint-use facility at Travis Air Force Base. NCOA has and will continue to support this initiative but the Association is also compelled to comment on this in the context of current eligibility rules and the DOD/DVA Memorandum of Understanding. Bear in mind that CHAMPUS beneficiaries are treated on a space-available basis in military treatment facilities and, under the DOD/DVA agreement, they will be in the VA discretionary category.

Using the military retired veteran as an example again, they can be denied care from the military side at Travis and, if they can gain access to the VA side, they will incur deductibles and co-payments. Yet, some categories of non-service connected veterans, who may have only a small fraction of the years of military service, will have complete access to health care at no cost to them and regardless of whether the treatment was provided by DOD or DVA. NCOA respectfully suggests that something is terribly wrong in such an arrangement.

QUESTION: In your opinion, can the VA afford to cover the cost of spouse and dependent care if charges were waived?

Mr. Rhea: NCOA is only asking that CHAMPUS deductibles and co-payments not be applied to treatment received from a federal VA facility for these beneficiaries who had a very clear, distinct promise made to them. As stated earlier, VA could still collect the balance of the cost from CHAMPUS whose payment schedules are based, in part, on prevailing treatment costs in the private sector within an area and which amount to 75% to 80%. Given VA's repeated assertions that care in the VA system is less costly than comparable private sector care, it seems likely that VA might very well be able to cover the treatment with the CHAMPUS payment.

QUESTION: How is this policy different from the one proposed by the Independent Budget which seeks reimbursements from higher income veterans and their dependents?

Mr. Rhea: In actuality and on principle Mr. Chairman, there is enormous difference in what NCOA is advocating and that of the Independent Budget proposal.

The vast majority of CHAMPUS beneficiaries are not high-rollers leading a life-style comparable to the rich and famous. Eighty percent of the military force on active duty today is enlisted personnel. Of that, 88% are of the rank of E-6 and below. The typical E-6 has eight years of service with a monthly basic pay of approximately \$1,600. By any measure, that's not exactly high income.

Similarly, 72% of military retirees are enlisted. The typical enlisted retiree is an E-7 with 22 years of service earning in the neighborhood of \$1,200 per month in retired pay. After taxes and survivor benefit premiums are subtracted, the typical enlisted retiree receives less than \$1,000 dollars per month - again, not exactly high income.

Granted, most military retirees pursue other employment but as a necessity. However, the income level of military retirees should not be a part of this equation; hence, the principle. These people served under a promise and to have them incur out-of-pocket expenses for care in a federal facility is not honoring the promise and ignores the principle.

NCOA endorsed the Independent Budget and the issue of CHAMPUS beneficiaries is not specifically addressed. NCOA would be very disheartened with the authors of the Independent Budget if they had in mind that CHAMPUS beneficiaries should be charged deductibles and co-payments.

NCOA has no quarrel with collecting third-party payments from MEDICARE, CHAMPUS or other third parties. NCOA does have a quarrel with requiring co-payments from the veteran beneficiary who served the longest and under a very clear, distinct promise.

It seems to NCOA that VA only wants the non-service connected military retiree under two conditions: (1) as a source of revenue; and, (2) when the military retired veteran is impoverished, he or she is then welcomed. NCOA cannot help but conclude that under the DOD and DVA Memorandum of Understanding that military retirees have only earned the privilege of paying deductibles and co-payments for health care while other categories of veterans, even though no promise was made, are extended the privilege of medical-care for life, cost free.

Perhaps it is time to overhaul the DVA medical care system. And, perhaps, it is time for DOD and DVA to work together to fulfill promises that were indeed made.

Questions from the Honorable Chet Edwards
Ranking Member, Subcommittee on Hospitals and Health Care
House Committee on Veterans Affairs

QUESTION: The GAO's testimony dwells heavily on the possibility that eligibility reform could significantly increase demand for VA health care services and require VA to ration care. Is that risk sufficient in your view to suggest the desirability of (1) imposing co-payments on VA hospital and outpatient care, (2) cutting back on who is eligible for VA care, or (3) doing nothing?

Mr. Rhea: First, let's recognize that health care is being rationed by the VA right now. It is being rationed among service-connected veterans depending on percentage of disability rating. It is being rationed among and between some categories of service-connected versus non-service connected veterans. As mentioned earlier at this hearing, it is a common practice to provide comprehensive, cost free health care to some non-service connected veterans while limiting the care provided to some service-connected veterans. Rationing is being done and it is sanctioned in the current eligibility rules.

NCOA's considers your third option, do nothing, an untenable alternative. If do nothing is the decision, let's proceed now to close VA's doors because they cannot continue indefinitely in the current fashion which is undeniably inequitable. It is NCOA's impression that available resources won't support the current system forever.

NCOA believes that GAO's assessment is accurate regarding increased demand for VA health care, if eligibility reform along the lines being discussed thus far is implemented. There is a strong likelihood that shifting emphasis to outpatient care will increase demand even under the current eligibility system. When the military health care system established its network of outpatient, primary care clinics to reduce the demand on military treatment facilities and hospitals, the demand increased substantially. There is every reason to believe that a similar result would occur with the VA and, as with the military system, costs will increase.

In NCOA's estimation, the talk so far has only been around the margins of eligibility reform. In NCOA's view, we are going to have to face the tough questions surrounding the composition of the "core group." The dialogue must be returned to and focused around treatment of veterans with service-connected disabilities. That has to be first, foremost and always. That's not what it is today. After that, quite possibly, everything else might have to be discretionary care. Even then, discretionary care should favor the service-connected veteran and veterans who earned their health care entitlement, the military retiree.

The question of co-payments inevitably elicits cries of outrage and high emotion. But the reality is that deductibles and co-payments are not something new to some veterans. The military retired veteran has been subjected to that arrangement for many years and even during the time of their active military service. On June 29, 1995, the VA said it was the good and right thing to do to require co-payments from non-service connected military retired veterans who receive VA treatment. If the federal government considers it proper to require co-payments from its category of longest serving veterans, it seems reasonable that the question should be open for discussion among other categories of non-service connected veterans as well.

NCOA wants to be clear on the question of co-payments. No co-payments should even be contemplated for treatment of service-connected afflictions. That is a federal obligation incurred through federal military service. Similarly, NCOA believes it is wrong to impose co-payments on military retiree beneficiaries for treatment received in a federal VA facility. That too is a federal obligation that was promised and earned through long years of faithful, honorable federal military service. After that, as far as NCOA is concerned, the question is open to discussion.

QUESTION: If it is not possible to enact a comprehensive "eligibility reform", what is an acceptable "first step?"

Mr. Rhea: The Association's prepared testimony identified what we believe to be acceptable first steps on common ground among interested parties - repeal the "...to obviate the need..." language; permit the VA to practice "common sense" medicine based on clinical need; and, recognize VA as an authorized MEDICARE provider. These three first steps do not solve the more difficult, underlying problems of the eligibility rules but they would be steps in a positive direction. And, they are needed now.

QUESTION: The Association of American Medical Colleges in today's testimony expressed concern about the future of VA medical care funding. Assuming VA were to face a seven-year freeze, is the AAMC right in projecting that a likely result is a gradual reduction in such expensive services as blind rehabilitation, SCI care, prosthetics and PTSD care?

Mr. Rhea: The AAMC is more than justified in expressing their concern given the current eligibility structure. Right now and as a consequence of that structure, precious dollars are being siphoned from those medical disciplines to treat veterans with no service-connected disability whose care is mandated in law. As long as this situation exists, the AAMC has a very legitimate reason to be concerned, with or without a funding freeze.

This question goes back to the fundamental principle that NCOA addressed earlier. The focus of VA must be returned to the service-connected veteran. AAMC's concern will become an eventuality only if we allow it to.

COMMITTEE ON VETERANS' AFFAIRS
HEARING -- JULY 19, 1995
QUESTIONS SUBMITTED FOR THE RECORD BY
CHAIRMAN BOB STUMP
TO
KELLI R. WILLARD WEST
VIETNAM VETERANS OF AMERICA

1. VVA's past support for giving veterans a choice of providers is commendable and one that is supported by veterans in my district. Could you explain VVA's view on veterans enrolled or utilizing the choice option and their access to specialized services.

VVA has, as noted, favored extended use of the fee-for-service program, to allow veterans to utilize whatever providers they choose. VVA remains committed to providing health care choices to veterans to use providers inside or outside the VA. Various innovations contemplated in the VISN plan may allow greater choices for veterans, as the VA develops localized sharing and contract arrangements with DoD, community providers, etc. to provide care in the most cost-effective manner.

The pilot project contemplated in the committee staff draft bill would admirably provide a choice of providers option for veteran enrollees residing 75 miles from the nearest VAMC. VVA would advocate that veterans should be able to access VA for other than specialized services, if the VA represents his/her choice in a certain area. We are concerned that veterans enrolled in this pilot project would be precluded from using all but VHA specialized services. How specialized services is defined may have a tremendous impact on whether or not this enrollment pilot project is truly a viable choice for some veterans. Would the Vet Centers be defined as part of VA's specialized care, for instance?

Additionally, we are concerned that restricting the use of VA facilities for pilot project enrollees may adversely effect their choice of providers. For example, veterans in rural areas which are underserved by tertiary care facilities may wish to use the choice option for outpatient care, but access VA for inpatient care. The pilot, as we understand this provision, would preclude this unless the veteran enrollee were utilizing specialized services.

COMMITTEE ON VETERANS' AFFAIRS
HEARING -- JULY 19, 1995
QUESTIONS SUBMITTED FOR THE RECORD BY
THE HONORABLE CHET EDWARDS
RANKING MEMBER, SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
TO
KELLI R. WILLARD WEST
VIETNAM VETERANS OF AMERICA

1. *The GAO's testimony dwells heavily on the possibility that eligibility reform could significantly increase demand for VA health care services and require VA to ration care. Is that risk sufficient in your view to suggest the desirability of (1) imposing copayments on VA hospital and outpatient care, (2) cutting back on who is eligible for VA care, or (3) doing nothing?*

While VVA understands the concern that eligibility reform may open the system to a new group of eligible veterans, we do not agree that a significant demand for services is automatically imminent. It is our belief that veterans who need VA care (service-connected disabled or low-income veterans without other health care options) are already receiving these services -- in an extremely inefficient and inconvenient manner. Veterans and physicians discover ways to navigate the current eligibility web, and do receive/provide care. Eligibility reform should eliminate barriers to cost-effective modalities of care. There may be some minor influx of patients, but greater efficiencies and incentives for collection of third-party and copayment funds should cover the costs associated with any additional demand for services.

VVA is not opposed to imposing copayments on hospital and outpatient care for non-service connected, high income veterans. Our position has always supported the notion that VA health care should be first and foremost provided to service-connected disabled veterans, as well as indigent veterans. Those who do not fall into this "core" group of veterans should be allowed access to VA care, either at their own expense or through third party payments. Funds collected from high-income, non-service connected veterans should be reinvested to supplement care for core group veterans.

VVA is opposed to further constriction of the pool of veterans eligible for care in the VA. Doing so is a dangerous precedent; it is unfair to those currently eligible veterans who are service-connected disabled or indigent. The system was formed to meet their needs. In addition, cutting back on who is eligible for VA care is bad health care policy, particularly at a time when access to other federal health care programs may become more limited. Veterans who would lose access to VA in such proposals -- service-connected disabled under 50 percent or low-income veterans -- are perhaps the most vulnerable to the private-sector insurance market, due to pre-existing conditions exclusions and basic risk-adjustment. High maintenance health care consumers are expensive to insure, therefore many of these veterans may have no health care coverage.

2. *If it is not possible to enact a comprehensive "eligibility reform", what is an acceptable "first step"?*

VVA's definition of the ideal "comprehensive eligibility reform" would provide federally funded VA access to a continuum of care for service-connected disabled veterans and low-income veterans. Non-service connected, high-income veterans who wish to, should be able to access VA by paying for their care through a third-party or copayments. Recognizing that this may not be feasible in this budget climate, an acceptable first step would very simply eliminate barriers between inpatient and outpatient care and thus allow VA to provide comprehensive care to the current pool of eligible veterans in the most cost-effective manner.

3. *The Association of American Medical Colleges in today's testimony expressed concern about the future of VA medical care funding. Assuming VA were to face a seven-year freeze, is the AAMC right in projecting that a likely result is a gradual reduction in such expensive services as blind rehabilitation, SCI care, prosthetics and PTSD care?*

VVA is very fearful of the same problem. Private sector managed care insurers and providers aim to reduce costs by restricting access to expensive specialized services. The veteran population is very unique, however, with a high prevalence of disabilities needing these specialized services. VA's specialized, uniquely veteran programs must be protected, as in most cases, private sector substitutions simply do not exist or the quality is inferior. The prospect of a seven-year freeze on VA medical care spending presents a veritable reduction in services, as inflation will eat away ever larger portions of each year's budget. This will undoubtedly put pressures on specialized programs.



DEPARTMENT OF VETERANS AFFAIRS
Office of the General Counsel
Washington DC 20420

AUG 8 1995

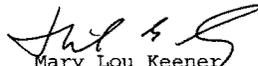
In Reply Refer To:

The Honorable Bob Stump
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

On July 19, 1995, the House Veterans Affairs Committee held a hearing on the subject of eligibility for VA health care benefits. Subsequently, on July 28, 1995, you asked that I respond to a post-hearing question regarding the meaning of the phrase "obviate the need for inpatient care." Enclosed is our response to the question.

Sincerely yours,


Mary Lou Keener
General Counsel

Enclosure

QUESTION: Do you agree with the view expressed by GAO [suggesting that existing law is relatively flexible] to the effect that current law would allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care?

ANSWER: We disagree with the view expressed by GAO. Congress first authorized VA to furnish outpatient care to "obviate" the need for hospital care with enactment of Public law 93-82 in 1973. Approximately two months after enactment, the Department promulgated implementing guidance for the new authority in Veterans Health Administration Interim Issue 10-73-42. That guidance, reflecting the Department's understanding of the term "obviate," provided that outpatient medical services could be furnished under the new authority when "necessary to treat a condition which would normally require bed care, or which, if untreated, could reasonably be expected to require such care in the immediate future." *Emphasis added.* That interpretation of the term "obviate" has continued almost unchanged to the present. It is now set forth in VHA Manual M-1, Part I, Chapter 17, section 17.30. In our view, cataracts generally do not constitute a disability which, if untreated, would necessitate hospitalization in the immediate future. Accordingly, we do not believe VA has authority to routinely treat cataracts on the basis that the treatment would obviate the need for hospital care.

Moreover, the GAO interpretation suggests that any condition or disability can be treated on an outpatient basis because the alternative is to hospitalize the veteran to provide such care. This interpretation ignores the issue of whether the condition to be treated requires hospitalization and focuses only on where VA may provide the care. It renders the statutory limitation meaningless.

Chairman Stump to Veterans of Foreign Wars

HEARING QUESTIONS

Imposed by

The Honorable Bob Stump
Chairman, Committee on Veterans' Affairs
U.S. House of Representatives
July 19, 1995

QUESTION: Please explain the apparent contradiction between your testimony and support of the *Independent Budget* proposal. The *IB* specifically includes opening or including dependents (non-veterans) into the system. I welcome your thoughts.

RESPONSE TO QUESTION: The VFW has long maintained that veterans be the #1 priority in receiving treatment at VA medical centers, and that until all veterans have access to VA health care and none are denied or delayed health care, we could not consider treating dependents or non-veterans in those centers.

The *Independent Budget* states on page xvi: "**Veterans must always have the highest priority for VA medical care.** The IBVSOs support the treatment of non-veterans within the VA medical care system when it is in the best interest of the veteran patient and the community to allow it. In exchange, all honorably discharged veterans should have access to the system -- VA must open its services to all non-mandatory veterans and their dependents as long as those individuals bring resources with them to cover the cost of their care. The IBVSOs also endorse and favor the enhancement of VA's structured sharing programs with the Department of Defense, academic affiliates and community medical facilities. In all instances, mandatory veterans must be assured an inviolable priority to access their health care system". This is essentially the VFW's position.

The
American
Legion



For God and Country

★ WASHINGTON OFFICE ★ 1808 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006-2847 ★
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August 15, 1995

Honorable Bob Stump, Chairman
U.S. House of Representatives
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Stump:

The American Legion is pleased to respond to follow-up questions from the Full Committee hearing of July 19, 1995.

Question submitted by Chairman Stump.

1. Your view of eligibility reform is predicated on bringing in a new universe of patients. If this is not possible, what do you think will happen to VA?

Answer

Without enabling a new universe of patients to access VA health care services, VA will slowly but surely lose much of its existing client base. Simultaneously, these phenomena will adversely affect VA's ability to recruit quality medical personnel, destabilize the education and medical research missions, and erode VA's ability to adequately provide back-up contingency assistance to the Department of Defense and the National Disaster Medical System.

Eligibility reform must not only provide a greater latitude between inpatient and outpatient services for current Category A patients, but also provide new funding streams for VA. By providing access to a VA health care plan for all veterans and their dependents, and others, VA can establish its presence in many new locations through enhanced sharing agreements, and in established locations.

The American Legion is cognizant of several eligibility reform proposals regarding VA health care. We believe any new proposal must provide access to more veterans than can now assuredly receive VA health care. The Legion looks forward to continued dialogue with the Full Committee on this subject.

Questions submitted by Honorable Chet Edwards.

1. The GAO's testimony dwells heavily on the possibility that eligibility reform could significantly increase demand for VA health care services and require VA to ration care. Is that risk sufficient in your view to suggest the desirability of (1) imposing copayments on VA hospital and outpatient care, (2) cutting back on who is eligible for VA care, or (3) doing nothing?

Answer

Does GAO believe VA does not now ration care?

Eligibility reform that does not offer VA health care to new users would not increase overall demand. If health care reform provided access to an increased pool of users, obviously these additional services will increase costs.

The American Legion recommends that new funding sources accompany any new group of VA health care beneficiaries. In previous testimony, the Legion has recommended that Medicare subvention and third party insurance reimbursements be deposited in a special VA Fund in the U.S. Treasury. This is a source of new funding streams. Another option is having the Secretary establish a system of an individual and family schedule of premiums, deductibles, copayments, and coinsurance charges for different health care benefit packages for non-entitled veterans.

Unfortunately, the GAO concern is premised on many "what if's" and does not attempt to define concrete solutions to its loosely structured opinions.

2. If it is not possible to enact a comprehensive "eligibility reform," what is an acceptable "first step"?

Answer

The American Legion believes it is possible to enact comprehensive VA health care reform.

The only acceptable "first step" would be an extensive pilot testing of The American Legion's Veterans Health Care Reform Plan. This plan will hopefully be introduced in the Congress in the fall of 1995.

3. The Association of American Medical Colleges in today's testimony expressed concern about the future of VA medical care funding. Assuming VA were to face a seven-year freeze, is the AAMC right in projecting that a likely result is a gradual reduction in such extensive services as blind rehabilitation, SCI care, prosthetics and PTSD care?

Answer

Assuming that fewer veterans would receive less VA health care under a seven-year budget freeze, the AAMC is not incorrect in their assessment.

This issue reinforces the need for enactment of comprehensive health care reform within VA. The patient base and resource base of VA must grow so that new funding streams are added to congressional appropriations, thus strengthening the system for years to come.

Mr. Chairman, thank you for the opportunity to comment on these important questions.

Sincerely,



Frank C. Buxton
Deputy Director
National Veterans Affairs and
Rehabilitation Commission

**RESPONSE FROM PARALYZED VETERANS OF AMERICA
TO FOLLOW-UP QUESTIONS FROM HEARING ON JULY 19, 1995
SUBMITTED BY THE HONORABLE BOB STUMP
CHAIRMAN OF THE HOUSE COMMITTEE ON VETERANS AFFAIRS**

1. Looking at the *Independent Budget* proposal for nursing home care, which turns a limited eligibility into a mandatory program, and understanding that VA nursing home care costs are above the national average, running well over \$40,000 per year, and also realizing that those veterans who currently use the VA for the most part don't have standard medical insurance—how can you assume that a new group of users could pay even nominal charges for probably the highest ticket item in the package?

The *Independent Budget* co-authors' proposal does not assume that Category A veterans will be required to pay any more for access to nursing home care than they are required to pay today. The "savings" projected in our proposal is for use of more appropriate care venues. Eligibility criteria often restricts care providers from placing chronically ill Category A veterans in long-term care settings that could more cost-effectively meet their needs. Instead, because of eligibility criteria, the providers must place some of these veterans in hospital beds. According to VA's FY 1996 budget submission, in FY 1996 a patient day in a medical bed section will cost VA an average of \$799 as opposed to \$229 in a VA nursing home (and even less in community or state nursing home beds). Based on a VA study of nonacute inpatient admissions¹, the *Independent Budget* model transferred approximately 10% of VA medical section hospital days to more cost-effective nursing home settings creating some of the savings projected in our budget (see response to question 2 below for more details).

Our proposal does suggest that where demand and capacity exist, non-Category A veterans and dependents could pay for their care in a VA nursing home or other VA facility. In fact, under our proposal, cost-reimbursement would be a requirement for these new users' entry into any care facility within the VA system.

2. I applaud the efforts of the *Independent Budget* to develop a rational process to address needed eligibility reform. I would like an understanding of the underlying numbers and methods which result in a \$2 billion savings.

Attachment 1 includes ranges from 4 different spreadsheets the *Independent Budget* co-authors used to develop our budget authority initiatives. Attachment 1A shows the number of current users (based on applications from veterans who received system care in FY 1994) the *Independent Budget* projects will continue to use the system. Some loss of veterans served (19%) is projected in states with active reform agendas. This projection is based on veterans' response in the *Survey of Medical System Users* (SMSU) to why they used VA medical facilities. Those in states with active reform agendas who did not rely upon specialized services and who responded "because of cost" were eliminated from the current user base. The *Independent Budget* also projected non-mandatory veterans who would use VA if access was less limited based on responses in the *Survey of Veterans* (SOV III) to why veterans used a non-VA facility for their last episode of care. About four-percent of veterans responded because they were ineligible for VA care. We assumed that these non-Category A veterans not now using the system for care would enter the system if access was improved for them. We also projected dependents who would be able to afford care at VA and who would choose VA as a provider. We applied veterans' income information and dependent information to extrapolate this number from both SMSU (current users) and SOV III (higher income non-users). The results are shown on Attachment 1B. We did not project utilization of veteran non-users and dependents who would enter the system, but rather applied an average private insurance expenditure per insured individual (1989, inflated) to determine how much VA could collect and capture from these new users (Attachment 1C). Medicare reimbursement for

¹ Booth, Brenda, et al. "Nonacute Inpatient Admissions to Department of Veterans Affairs Medical Centers", *Medical Care*, Volume 29, No. 8, Supplement, August 1991, pp. AS40-AS50.

higher income veterans was calculated based on information from a recent GAO report (GAO/HEHS-95-13) which indicated that half of VA's users are Medicare eligible. VA's *Summary of Medical Programs* indicates that only about 3% of the system's users are Category C or Non-Mandatory (higher income) veterans. From this information, we estimated that VA could collect reimbursements from only 1.5% of its current users. We applied Medicare's average total program payment per person served to this number to estimate the amount VA could collect under the Medicare reimbursement proposal. To estimate how much VA could collect from third parties, we subtracted its current collections (to allow VA to meet its deficit reduction requirements) from its total estimated receivables.

Eligibility reform estimates were founded on current utilization and studies of inappropriate non-acute inpatient care in medical, surgical, and psychiatric hospital settings. Attachment 1D shows how patient days in these settings were converted into outpatient visits or nursing home days. The inappropriate care rates were derived from a VA study whose principle investigator was Brenda Booth, Ph.D. published in *Medical Care* in 1991. Another study performed by Strumwasser (non-VA) was used to derive the psychiatric rate. A small portion of hospital medical days were converted to nursing home days (one day of nursing home care for one day of hospital care); the remainder of the "inappropriate" days were converted to outpatient visits (3 visits for each day of care).

3. Understanding the need for rationality in the eligibility reform process, please explain how expansion of eligibility will ensure that those most seriously injured—those with high degrees of service connection—will be insured priority within the VA system.

The *Independent Budget* proposal assumes no changes in the priority system for veterans' access to care. The co-authors believe strongly that the system was created to meet the special needs of veterans injured in combat and have repeatedly stated that these "specialized programs" designed to meet service-connected veterans' needs be the focus of the VA's medical care system. The co-authors assume that the same checks that exist today in the system for ensuring access to veterans with high degrees of service-connection would remain in place. The proposal the co-authors have submitted would allow VA to use its existing capacity more efficiently to meet all veterans' care needs.

4. Please explain within the *Independent Budget* proposal how the priority system for service-connected veterans is maintained. First, do you believe it should be? How will you ensure it?

Please see response to question 4 above.

Attachment 1A

Number of Individuals Who Would Enroll in a VA Health Plan

Current Users

Number Receiving Care in States with Options

2904748

MIN
TN
FL
OR
WA
UT

41134
94012
188257
36624
61688
26233
86902
2817846
1150401
860919

Veteran State Residents Who Will Leave

Current Users (Less State Residents with Options)

Number of Veterans w/ Dependents Who Enroll

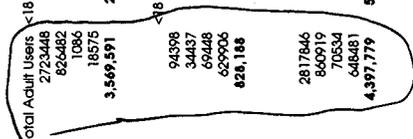
Number of Non-Mandatory Vet Users to Enroll (Not Now Using System)

19% Those eligible in states who are using VA because of cost (less 35% using special services)

SCV #1 identified used non-VA facility because ineligible for VA care (excluded for dualization)

Attachment B

	Total	<18	18-34	35-44	45-54	55-64	65-74	75-84	85+
Males									
Current Users (SMSU) Remaining	2723448	2723448	0	181469	409997	355330	690372	757437	245998
New Veteran Users (SOV)	826482	826482	0	71914	171487	152521	217322	148559	21337
Male Dependents of Current Users	13027	11941	0	76	163	141	271	304	98
Male Dependents of New Users	273719	18575	3967	3522	1279	4801	4264	556	185
TOTAL MALE USERS	3,836,676	3,569,591	257,085	565,169	509,271	912,767	910,574	267,989	90,175
Females									
Current Users (SMSU) Remaining	94398	94398	0	15780	12680	10990	14089	31560	7608
New Veteran Users (SOV)	34437	34437	0	7047	6256	2272	8528	7573	988
Female Dependents of Current Users	81389	11941	0	4861	10417	9028	17362	19445	6250
Female Dependents of New Users	855049	255144	43148	130789	124762	186897	120935	14531	4844
TOTAL FEMALE USERS	1,095,273	828,188	267085	70,836	164,142	147,052	226,877	179,514	29,377
All									
Current Users (SMSU) Remaining	2817846	2817846	0	197249	422677	364320	704462	788997	253606
New Veteran Users (SOV)	860919	860919	0	78980	177743	154793	225850	156143	22305
Dependents of Current Users	94416	70534	0	10580	17653	9169	19749	6386	2116
Dependents of New Users	1158768	648481	510287	47116	138311	126041	191696	125199	19387
TOTAL POTENTIAL USERS	4,931,949	4,397,779	534,170	328,282	749,311	656,323	1,197,644	1,090,088	297,366



Attachment C

FY 1995 Independent Budget Recommended Budget Authority			
FY 1994 Appropriation			
Reform of Access Criteria			
Shift Inpatient to More Appropriate Outpatient or Nursing Home Care			
Additional Workload Shifted from Inpatient Venues to Nursing Home			
	\$16,771,297,000		
		Change in workload	Cost per Unit
	(2,856,492,265)	(172,346)	1674
	66,541,525	421	54
		429	228
		3,503,324	192
Facility Activations for One Additional 120-Bed Leased NH	2,925,000		
Additional Workload Shifted from Inpatient Venues to Outpatient Care	637,604,966		
Subtotal (*) initiative	(\$2,147,721,000)		
Subtotal of Funding from Discretionary Spending Required	\$16,623,576,000		
Authorization for Medicare Reimbursement for Higher Income Veterans	\$133,677,000	35,571	3,758
Retention of Full Collection of Third Party Reimbursements	\$500,000,000		
Authorization to Retain Payments from Dependents and New Veteran Users	\$2,006,828,000	1,543,714	1,300
TOTAL BA RECOMMENDED	\$19,564,081,000 *		

(2,856,492,265) from VA hospital inpatient beds based on FY 1994 data
 66,541,525 from VA Home Care program
 8,455,590 general State Home AOC
 35,701,380 general VA NH AOC
 66,541,525 subtotal general NH AOC

133,677,000 higher-income veterans from whom VA could collect Medicare
 2,006,828,000 reimbursement for all new veterans and dependents entering the system

Amounts include program payments for patient interest, 1994

Amounts include Medicare Priority Reimbursement for medical services, 1994 values

Note: If VA received these authorities for FY 1995 the amount of appropriated dollars for VA would be \$16 billion as contrasted with the \$16.2 billion Congress appropriated to VA in FY 1995. This amount would include funding for all 18 proposed initiatives and full funding of all uncommitted costs. This amounts to a \$2.8 billion savings.

Responses of the *Independent Budget* to Questions by Congressman Edwards

1. The GAO's testimony dwells heavily on the possibility that eligibility reform could significantly increase demand for VA health care services and require VA to ration care. Is that risk sufficient in your view to suggest the desirability of (1) imposing copayments on VA hospital and outpatient care, (2) cutting back on who is eligible for VA care, or (3) doing nothing?

PVA does not concur with this part of the GAO's testimony. In 1993, PVA conducted a series of 14 focus groups with veterans who are eligible for VA health care in diverse localities across the country. PVA found that the veterans that have the most favorable perception of VA and who are most likely to use it in the future, under a variety of scenarios, are veterans who use it now or veterans who lack access to health care. Veterans who described themselves as past VA users or non-users most commonly cited a previously established relationship with a physician and their ability to choose physicians in their care plans as the reasons for lack of interest in switching providers, even when incentives for VA use, such as no out-of-pocket cost, free pharmaceuticals, and access to long-term care were mentioned. We are aware that VA's interviews yielded somewhat different information; however, the scenario offered in their survey which offered veterans a choice of receiving care from a VA network of community providers that could include their own physician is not the situation that currently exists in VA and is not likely to come about in the near future. The *Independent Budget's* projection of "new users" is based on individuals in the 1987 *Survey of Veterans* who identified their reason for not using VA medical care as "not eligible"—an increase of approximately five percent of the veterans who are not Category A. We feel that without significant changes in infrastructure (specifically, the creation of community-based primary care clinics) VA's ability to attract further participation from the Category A population is severely curtailed.

2. If it is not possible to enact a comprehensive "eligibility reform", what is an acceptable "first step"?

The *Independent Budget* offers a plan for innovative financing and management initiatives that would allow VA to provide the spectrum of services to Category A veterans that the *Independent Budget* co-authors feel is appropriate at a lower expense than the government experiences for VA care today. We strongly believe that this package of legislative and management initiatives is the appropriate first step to enacting eligibility reform.

3. The Association of American Medical Colleges in today's testimony expressed concern about the future of VA medical care funding. Assuming VA were to face a seven-year freeze, is the AAMC right in projecting that a likely result is a gradual reduction in such expensive services as blind rehabilitation, SCI care, prosthetics and PTSD care?

While PVA has not completely assessed the impact of a seven year freeze, we certainly believe that such a freeze would have adverse consequences for the entire VA health care system, including its specialized services. Assuming a relatively low inflation rate of 3% each year (medical care inflation is likely to be up to three times as high) the value of VA's health care dollar drops as follows:

Baseline 1995-\$16.23 billion
 Year 1 (FY 1996)-\$15.74 billion
 Year 2 (FY 1997)-\$15.27 billion

Year 3 (FY 1998)-\$14.81 billion
Year 4 (FY 1999)-\$14.36 billion
Year 5 (FY 2000)-\$13.94 billion
Year 6 (FY 2001)-\$13.52 billion
Year 7 (FY 2002)-\$13.11 billion

This "freeze" will amount to a *de facto* "cut" of over \$3 billion (or about 19%) of their current budget. If inflation is higher than 3%, the buying power of the VA health care dollar will be even more significantly eroded. VA officials will certainly have to find places to cut services to veterans to keep their facilities and programs operational.



Military Order of the Purple Heart

QUESTIONS FOR THE RECORD
FROM CHAIRMAN STUMP
FOR
GREGORY A. BRESSER
NATIONAL SERVICE DIRECTOR

Chairman Stump:

I appreciate your willingness to testify on behalf of the most deserving group of veterans served by the VA, the combat injured. Understanding that nonservice-connected veterans often receive priority care in the VA, could you comment on an eligibility system that would include priority for those veterans who have no service-connected injuries but instead is based on exposure to combat or hostile fire. It is my understanding that this designation can be tracked through military pay records. In your opinion, would this make the system fairer and less complicated?

Gregory A. Bresser:

One of the problems today is the VA system is stymied by an unclear and inflexible bureaucracy. Creating a new and separate eligibility, would only add to the confusion of eligibility which already exist today. The system needs to be clear in determining who is eligible for what services.

In our opinion a nonservice-connected veteran who needs medical care or treatment resulting from exposure to combat or hostile fire is most likely suffering from a functional loss of use or dysfunction as a result of military service, and should be service-connected for that disability. Therefore, it would be the VA's responsibility and duty to assist the veteran in obtaining service-connection.



Military Order of the Purple Heart

Chartered By Congress

Gregory A. Bresser, National Service Director
 Response to follow-up questions from
 the Honorable Chet Edwards
 Ranking Member
 Subcommittee on Hospitals and Health Care

Honorable Chet Edwards:

The GAO's testimony dwells heavily on the possibility that eligibility reform could significantly increase demand for VA health care services and require VA to ration care. Is that risk sufficient in your view to suggest the desirability of (1) imposing copayments on VA hospital and outpatient care, (2) cutting back on who is eligible for VA care, or (3) doing nothing?

Gregory A. Bresser:

Those three alternatives are unnecessary. The GAO's concept of increased demand for VA health care services fails to take into consideration several necessary parts to achieve real reform.

Allow the VA to retain third party collections, copayments and Medicare payments for non-service-connected care, without a reduction of appropriated funds for service-connected treatment. Studies show that VA medical centers provide more cost-effective care than private sector health care facilities.

This would allow veterans a choice, improve the quality of VA provided health care, insure adequate funding for services provided, and be a major saving to the Medicare Trust Fund.

Honorable Chet Edwards:

If it is not possible to enact a comprehensive "eligibility reform", what is an acceptable "first step"?

Gregory A. Bresser:

Congress must allow veterans the opportunity to bring their Medicare dollars to the VA for non-service-connected medical treatment. Allow the VA to retain those Medicare dollars at the VA facility providing the treatments. Simplify the convoluted eligibility criteria for VA health care. Provide legislation that would clearly allow all combat wounded veterans with eligibility based on being a Purple Heart recipient.

Honorable Chet Edwards:

The Association of American Medical Colleges in today's testimony expressed concern about the future of VA medical care funding. Assuming VA were to face a seven-year freeze, is the AAMC right in projecting that a likely result is a gradual reduction in such expensive services as blind rehabilitation, SCI care, prosthetics and PTSD care?

Gregory A. Bresser:

No. Provided the funding for those specialized programs are maintained as centralized funds and not grouped into the general operating budget and used as discretionary funds.

The number of veterans requiring these service will decline over the next seven years with respect to the average age of veterans today. Therefore, in the case of a budget freeze current funding levels and Medicare dollars should carry these programs for seven years.

Studies have shown VA Medical Centers provide more cost-effective care than comparable private sector health care facilities. The private sector would not want to enroll the typical VA patient who is often older, indigent, disabled or chronically ill. The VA provides specialized medical services largely unavailable in the private sector.

