# BARRIERS AND RISKS: VA HEALTH CARE COMPETITIVENESS AND THE HEALTH SECURITY ACT

## HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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# CONTENTS

Page

OPENING STATEMENTS

Chairman Evans ..... 1
Hon. Luis V. Gutierrez ..... 8

WITNESSES

Baine, David P., Director, Federal Health Care Delivery Issues, Health, Education, and Human Services Division, U.S. General Accounting Office, accompanied by: James R. Linz, Assistant Director, Health, Education, and Human Services Division; and Terry Saiki, Senior Evaluator, Seattle Office 5
Prepared statement of Mr. Baine ..... 32
Perreault, Robert A., Director, Health Care Reform Office, Veterans Health Administration, Department of Veterans Affairs, accompanied by: Gary J. Krump, Acting Assistant Secretary for Acquisitions and Facilities; Nora Egan, Associate Deputy Assistant Secretary for Human Resources Management; Audley Hendricks, Assistant General Counsel; and William Thomas, Assistant General Counsel ..... 3
Prepared statement of Mr. Perreault ..... 25

MATERIAL SUBMITTED FOR THE RECORD

Statement:
Hon. Jesse Brown, Secretary of Veterans Affairs ..... 31
Written committee questions and their responses:
Chairman Evans to Department of Veterans Affairs ..... 47, 85
Chairman Evans to U.S. General Accounting Office ..... 104

# BARRIERS AND RISKS: VA HEALTH CARE COMPETITIVENESS AND THE HEALTH SECURITY ACT

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**WEDNESDAY, JUNE 29, 1994**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The subcommittee met, pursuant to call, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans and Gutierrez.

## OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning and welcome.

Today's hearing continues this subcommittee's active examination of important issues related to veterans' health care and national health care reform. The focus of today's hearing is VA health care competitiveness and the Health Security Act.

This subcommittee expects several fundamental issues to be addressed during today's hearing. They include: What are the challenges and barriers VA faces in becoming a competitive health provider? How does the Health Security Act address barriers to VA competitiveness? What will be the impact of eliminating barriers to VA health care competitiveness? Are VA's plans for becoming a competitive health care provider adequate and realistic? Is VA accomplishing the changes needed to become a competitive health care provider?

While it seems as though the topic of national health care reform has become almost inescapable, there are many important questions related to veterans' health care and the Administration's national health care reform proposal which are deserving of further attention and that is the purpose of today's hearing.

Under the Health Security Act as proposed by President Clinton, VA will become a competitive health care provider. To be viable and the preferred health care provider of veterans and their dependents, the Department of Veterans Affairs can't stand pat. VA must be ready to hit the ground running under national health care reform.

To meet this challenge, Secretary Jesse Brown established the VA Health Care Reform Board and the National Health Care Reform Program Office. VA has undertaken an extensive and intensive effort to identify the challenges which it faces and to develop

strategies intended to ensure VA's success in competitive health care reform.

Because of the importance of this issue, several months ago this subcommittee requested that the General Accounting Office examine barriers that the VA would face becoming a competitive health care provider. GAO has examined this issue and is prepared to share the results of this review with us. It is important for the VA to examine GAO's conclusions and make the adjustments VA believes are needed to remain a viable and cost-effective provider of health care to veterans.

We look forward to receiving the testimony to be presented by today's witnesses who represent the Deapartment of Veterans Affairs and the General Accounting Office. The prepared statements of each witness will be included in their entirety in the written record, without objection we will also use a unique format today for this proceeding and will explain this change in a moment.

Testifying on behalf of the Department of Veterans Affairs this morning is Robert Perreault, the newly appointed Director of VA's Health Care Reform Office. Bob is accompanied at the witness table by Gary J. Krump, Acting Assistant Secretary for Acquisitions and Facilities, and Nora Egan, Associate Deputy Assistant Secretary for Human Resources Management. He is also accompanied this morning by Audley Hendricks, Assistant General Counsel, and William Thomas, Assistant General Counsel, who are seated in the audience and are prepared to provide assistance if needed.

Testifying on behalf of the General Accounting Office today is Dave Baine, Director of Federal Health Care Delivery Issues, Health, Education, and Human Services Division. He is accompanied by Jim Linz and Terry Saiki.

Bob, before you begin, I want to comment briefly on the format for today's hearing as it is different than our customary procedure. As there are only two panelists—one panel, two witnesses, testifying this morning, the chair believes a slight departure from the standard question and answer format of most Veterans' Affairs Committee hearings is appropriate today and will be very helpful to us and assist this subcommittee better and more fully examine the issues before it today. I invite and encourage both witnesses to react to each other and to comment on the opinions and responses which each will offer during this hearing. While questions will still be directed to either or both witnesses, the discussion-oriented format is expected to help this subcommittee gather the facts and opinions it needs to make informed policy decisions.

At this point, Bob, we will start with you.

**STATEMENTS OF ROBERT A. PERREAULT, DIRECTOR, HEALTH CARE REFORM OFFICE, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: GARY J. KRUMP, ACTING ASSISTANT SECRETARY FOR ACQUISITIONS AND FACILITIES; NORA EGAN, ASSOCIATE DEPUTY ASSISTANT SECRETARY FOR HUMAN RESOURCES MANAGEMENT; AUDLEY HENDRICKS, ASSISTANT GENERAL COUNSEL; AND WILLIAM THOMAS, ASSISTANT GENERAL COUNSEL; AND DAVID P. BAINE, DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY: JAMES R. LINZ, ASSISTANT DIRECTOR, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION; AND TERRY SAIKI, SENIOR EVALUATOR, SEATTLE OFFICE**

## STATEMENT OF ROBERT A. PERREAULT

Mr. PERREAULT. Mr. Chairman and members of the committee, I appreciate the opportunity to introduce myself to the subcommittee and to provide the members with information that will be of benefit as health care reform and the VA's future in that arena are decided upon by the Congress.

With me today, as you mentioned, are Mr. Gary Krump, the Acting Assistant Secretary for Acquisition and Facilities; Ms. Nora Egan, the Associate Deputy Assistant Secretary for Human Resources Management; Mr. Audley Hendricks, Assistant General Counsel and VA ethics officer; and Mr. Bill Thomas, Assistant General Counsel.

Having served as director of two VA medical centers, most recently as the director of the Philadelphia VA Medical Center, I bring to my new role firsthand knowledge of the challenges that will confront the VA as well as the realities of running a VA hospital in the local health care market.

I believe that the President's proposed Health Security Act provides VA a unique opportunity to demonstrate that we can successfully compete in the marketplace and provide comprehensive health care services to our patients. The inclusion of the VA in the Health Security Act acknowledged the important role that the VA plays in the delivery of health care to our Nation's veterans and demonstrated the President's desire to assist the VA in the health care marketplace by addressing those barriers that need to be removed and by providing the necessary tools the VA needs in order for the VA to compete effectively with the private sector.

Major problems facing the VA health care system today include complicated and confusing eligibility rules that have the effect of excluding many veterans from VA care and providing only fragmented care to many other veterans, complete reliance on discretionary appropriations which are under great pressure, and limited authority to conduct marketing and promotion and infrastructure deficiencies.

The President's proposal would maintain an independent VA health care system and provide the means to improve access, quality, and efficiency in the new national health care arena. The Health Security Act would allow all veterans and their family

members to enroll in a VA health plan, permit VA to receive and retain monies associated with providing services, and provide for an investment fund that would enable VA to successfully establish health plans.

In implementing the Health Security Act, VA has identified several key initiatives that will be critical to our success in a competitive environment. First, VA must adopt a customer service orientation that will prevail at all levels of the organization. In the competitive marketplace, the long-term survival of VA health care system will depend on how well we serve our patients when they have alternate health care choices. In addition, VA realizes that we need to provide better geographic accessibility and we must reduce our waiting times to competitive levels if we are to attract and retain our customers.

We also recognize the necessity to adopt a business orientation similar to private health care organizations. New program initiatives will be reliant upon enrollee demographics and local market conditions. Local networks will require management flexibilities which the President's proposal provides to rapidly adjust local operations to meet demand for services. VA would have increased flexibility in contracting and in establishing salary and benefit structures for employees.

Although the Department must wait for final passage of the health care reform to realize major changes in our programs, we are developing plans for implementing that legislation. VA has developed and provided to Congress a summary of our planning efforts to date. The Health Care Reform Office is now planning the more detailed steps that will be required to transition to the reformed national health care environment. Our goal is to be the health plan of choice for veterans and their families.

Needless to say, the enactment of health care reform legislation is critical to our ability to compete in the marketplace. We welcome the challenge and look forward to the opportunity to fully and effectively compete.

Mr. Chairman, this concludes my formal testimony. If you would indulge me though, I would like to read the Secretary's comments.

Mr. EVANS. Without objection, we will include those comments in their entirety in the record.

(See p. 31.)

Mr. PERREAULT. "The VA will be prepared to compete under national health reform. We at VA have every confidence in our ability to compete with our health care providers under the provisions of the President's Health Security Act. We have a solid infrastructure upon which to build, proven competence, a remarkable history of achievement in health care delivery and scientific research, and the unrivaled dedication and compassion of our team of administrative and health care professionals to ensure our viability. GAO's preliminary concerns about risk from VA reform implementation efforts are premature. VA's detailed planning and development efforts are just beginning. As we implement health care reform, we will have many obstacles, some unforeseen, to overcome, including those referred to in GAO's analysis. Our planning will deal with issues of VA's capacity, accessibility of VA care, contracting and ethics rules, financial management, and management structure and

control. If Congress chooses to maintain an independent health care delivery system for veterans, and provides the tools and resources necessary for VA to be a competitive, then I feel certain that VA will be able to avoid the grim results about which the GAO conjectures. As you know, our efforts and plans will be subject to continuing oversight of many external groups including the House Veterans' Affairs Subcommittee on Oversight and Investigations. The public and those in Congress who support an improved VA system for veterans should not be alarmed by GAO's comments. When GAO completes its report, VA will provide its own detailed analysis and views regarding its contents. VA is prepared to effectively manage any potential risks or obstacles to improve veterans' health care. There is no denying that VA is entering an era of great challenge and risk brought on by the competitive environment of reform. Risk is inherent in change, but failure to change is the greatest risk of all. VA is up to the task. We can and will be ready." And that was signed, "Jesse Brown, Secretary of Veterans Affairs."

Mr. Chairman, I have one other comment. I would like to apologize. We have not responded yet to the questions you sent in your letter of June 20 related to education and training. We are preparing very comprehensive answers to those questions, and we expect to have them for you within a few days.

[The prepared statement of Mr. Perreault appears at p. 25.]

Mr. EVANS. Thank you very much. I appreciate that.

Dave.

## STATEMENT OF DAVID P. BAINE

Mr. BAINE. Thank you, Mr. Chairman, and good morning.

Thank you for asking us to testify today as the subcommittee continues to examine veterans' health care provisions of the administration's proposed Health Security Act.

Mr. Chairman, VA faces many challenges as it attempts to restructure its health care system to compete in a managed care environment. We identified more than 25 legal and structural barriers that could hinder VA's efforts to establish competitive health care plans. The Health Security Act would overcome many of the legal barriers by expanding entitlement to VA health care or by exempting VA from Federal and State requirements developed to prevent fraud and abuse and ensure quality of, and access to, health care services.

Many of the structural barriers, however, are likely to inhibit VA's efforts to establish competitive health plans. As a result, significant risks are associated with efforts to convert the VA delivery system into a series of managed care plans.

As we have previously testified before this and other committees, VA's complex eligibility and entitlement provisions prevent it from providing comprehensive health care services to most veterans. VA also lacks the authority to treat veterans' dependents. The Health Security Act would overcome these barriers by allowing VA to provide the same set of comprehensive benefits to veterans enrolling in VA plans as provided by competing managed care plans. VA would also be authorized to enroll veterans' dependents.

Under the provisions of the Health Security Act, about nine million veterans would be entitled to free comprehensive care benefits

if they enrolled in VA plans. While it is unlikely that all nine million would seek to enroll in such plans, if they did, this entitlement could require VA appropriations of about $16 billion to cover their premiums. Additional appropriations would also be needed to cover the costs of copayments, deductibles, and coinsurance for the core group veterans, and the employer's share of premiums for self-employed core group veterans. Most of the increase in VA's appropriation would result from cost shifting from Medicare and other programs.

If, on the other hand, VA's plans do not enroll enough veterans to make those plans financially viable, the Government might have to subsidize the plans to keep them operational or allow the plans to fail, leaving one or more regions of the country without such a plan. In the latter case, veterans from failed health plans would no longer have VA benefits. Such a result may not be politically feasible, resulting in legislation to permit the Government to pay the premiums and cost shares of veterans enrolling in private sector health plans.

Service-connected veterans could find it harder to access their veterans' benefits under the Health Security Act for several reasons. This is because enrollment in a VA plan would be on a first come, first served basis under the Act, shifting VA's priorities away from service-connected and low-income veterans. If a health plan does not have the capacity to provide services to all veterans seeking to enroll in the plan, some veterans in the core group could be denied enrollment in the plan and thus a significant portion of their health benefits.

Complex Federal procurement laws and regulations limit VA and other agencies' flexibility in procuring items and services. The Health Security Act would exempt VA from competitive bidding requirements in the procurement of services by a VA plan and expand VA's sharing authority.

Amendments to the Act approved by the Subcommittee on Hospitals and Health Care broadened the exemption from contracting requirements. Under these amendments, health plans would be exempt from virtually all contracting laws and regulations.

Reducing contracting requirements, however, heightens the potential for abuse. Mr. Chairman, VA has a long history of problems in administering contracts and sharing agreements. As a result, the expanded contracting envisioned under the Health Security Act with both medical schools and private institutions greatly increases the potential for fraud, abuse, and conflicts of interest.

In addition to exemptions from general contracting requirements, the Act would exempt VA plans from specific requirements related to risk contracting. Although risk contracting is a common practice among managed care plans, the practice requires that the contractor has sufficient enrollment to spread the risk.

VA plans to engage in risk contracting with private health plans and individual providers. If VA contracts with individual providers who have too narrow a patient base or assigns too much risk to the providers, the providers have a greater incentive to withhold services and the potential for their insolvency increases.

VA plans would not be accountable to Medicare and Federal HMO requirements developed in response to a history of abuses

under the Medicare program and Medicaid program. For example, some managed care plans were underfunded, disregarded complaints, or denied needed treatments. Several Medicare and Federal HMO requirements which are detailed in our prepared statement were established to prevent such abuses. As deemed Medicare HMO's, VA plans and their contractors and subcontractors would not have to meet any of these requirements.

Currently, VA is almost entirely dependent on appropriations to finance its health care programs. As a result, the availability of services and programs is dependent of VA's level of funding. The Health Security Act would create several new sources of funding to make VA plans less dependent on appropriations. These revenues and payments would flow in many directions and involve entities both inside and outside of VA. VA estimates that plans could have 30 different revenue streams.

VA's accounting systems were not designed to accommodate the many funding sources and accounts to which expenses must be charged. Failure to charge the cost of each patient's care to the proper account would violate statutory restrictions on the use of appropriated funds and could lead to shortages of appropriations.

Many VA facilities are outdated and lack the patient amenities of private sector hospitals. In addition, VA lacks a network of providers that would allow veterans to obtain health care services close to their homes. The Health Security Act would create a veterans' health care investment fund with an initial authorization of $3.3 billion which was increased to a little over $4 billion in the recent subcommittee markup.

The funds to be appropriated to the investment funds are not, however, based on an assessment of what changes need to be made to make VA plans competitive. As a result, VA does not now know where the funds should be spent or whether the funds to be appropriated are adequate. Without such an assessment of start-up costs, the Congress may be faced with having to appropriate billions of dollars more in the future to make the plans competitive. The start-up funds could essentially represent a foot in the door, making it hard for the Congress to limit future expenditures to make the plans competitive.

One of the most significant barriers to VA's successfully competing against private sector managed care plans is VA's inability to generate accurate cost data on items and services that it provides and estimate the potential use of VA health care services. Without such data, VA health plans cannot set accurate premiums, determine when to contract for services rather than provide them directly, or set prices for services sold to other health plans that are adequate to recover their costs. As a result, the financial risk of VA health plans incurring substantial losses is, in our opinion, pretty significant.

VA officials also view local autonomy as an essential ingredient in developing competitive health plans. VA plans need to be able to quickly adapt to local conditions. VA plans to give medical centers and health plans greater autonomy, however, would heighten the risks we have discussed here this morning.

Failure to monitor policy implementation under VA's currently decentralized management structure has been a recurring theme of

our work on VA health plans' programs for many years. Similarly, many of the problems addressed by this subcommittee have focused on the failure of VA's Central Office and regional offices to identify and correct problems.

In conclusion, Mr. Chairman, the proposed Health Security Act would alleviate most of the legal barriers to VA's ability to develop competitive, managed care plans. It would do so, however, by eliminating a series of internal controls developed over many years to protect both the interests of the Government and its citizens. VA health plans would be exempt from important fiscal and quality safeguards, greatly expanding VA's financial liabilities but potentially diminishing its quality of care and veterans' access to care and increasing the risk of fraud, waste, and abuse.

The challenge, we believe, facing the Congress is in deciding whether the benefits to VA's competitiveness that would be created through the provisions of the Health Security Act and its amendments outweigh the risks that would be created by the same provisions.

That concludes a summary of our statement. We would be glad to take your questions.

[The prepared statement of Mr. Baine appears at p. 32.]

Mr. EVANS. Thank you, Dave.

The Chair is now very pleased to recognize my fellow colleague from Illinois, Congressman Gutierrez.

## OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

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

No matter what people have to say about health care reform, I think that there is little doubt about this. No single domestic issue has so captured the Nation's attention in recent years than has the issue of national health care reform. People have lined up on various sides of the issue, and that is to be expected considering the scope and the depth of the health care reform debate.

But regardless of your personal thoughts, regardless of your politics, you have to admire the fact that so many members of the electorate, so many members of the general public, have taken the time to educate themselves on this great issue of the day, and the public is truly, I believe, engaged.

What is unfortunate is that so much of this issue is addressed behind closed doors. In other words, it is ironic that an issue that is so important to the public is not dealt with in public. In the last few days even we, as Members of Congress, have had to wait to find out what direction the debate was taking until a select group of Members, mostly in the other body, were done with their rump meetings and closed door sessions, meetings where key components of the Health Security Act were either salvaged or savaged. Mr. Chairman, that is why I am very glad that today we have the opportunity to discuss health care in an open setting.

The questions we will discuss this morning in the light of day are these: What does health care reform mean to the veterans of the United States? Will the VA be able to compete under health care reform? At this point I can't say yes or no, but I do know right off the bat that there are certain things that VA can do to heighten its ability to compete. The VA must undertake improvements de-

signed to close the gap between VA and its private sector counterparts, the VA must enhance the physical condition of its facilities, the VA must shorten the unbearable waiting times that delay the delivery of care, and the VA must make sure that it demonstrates respect to its patients.

If we take the correct steps and if we point out the risks involved, perhaps we could find a way for everyone to win—the VA, the veteran, and even the Nation as a whole—because Americans will know that we are fulfilling our obligations to the men and women who serve us.

Thank you very much, Mr. Chairman, for calling this hearing, and thank you very much for allowing me to read this opening statement.

Mr. EVANS. We appreciate the gentleman's participation in this hearing as well as all other hearings that we have held. I want to emphasize a particularly important comment made by the gentlemen from Illinois. It is not the intention of this Subcommittee to lessen in any way the ability of the Department of Veterans Affairs to compete. As VA prepares for the competitive environment of national health care, I hope the Department will remember an old Marine Corps saying: "The more you sweat in peace, the less you bleed in war." We need answers to the questions that GAO has raised not only for our benefit, but for our constituents as well. Throughout my district and throughout the country wherever I have been to hold a forum or hearing with other Members recently, this is the number one concern that veterans raise. They are concerned that, while they have had some problems with the Department of Veterans Affairs, that the health care system they have relied on, in the case of World War II veterans for decades at this point, may not be there unless we are very careful in our deliberations over national health care.

So it is in that spirit that we meet today, to seek answers, if not today through this discussion, through the question and answer format, then through the responses of our witnesses to questions submitted to them following this hearing. I hope to work closely with this Administration to fashion a health care bill that, in particular, helps the Department of Veterans Affairs improve, and particularly to address the funding problems it had during the 1980's.

This makes clear our intention and focus here today.

My first question is directed to GAO. What has the GAO learned from examining managed care programs under Medicare and Medicaid to this point?

Mr. BAINE. Mr. Chairman, we have been looking at managed care programs under Medicaid since the early to mid-eighties. Jim Linz specifically has looked at a lot of the Medicaid and Medicare managed care programs.

Basically what we have learned is that at the outset of the development of managed care under Medicaid, there were many organizations set up that ended up, in essence, siphoning health care funds into related organizations. This we see as a fairly significant risk as the country goes increasingly to managed care. Jim can relate some of his experiences if that would be helpful to the subcommittee.

Mr. EVANS. That would be helpful.

Mr. LINZ. We have done a whole series of jobs looking at various Medicaid managed care programs: Arizona; the initial demonstration projects in California; there were a series of Medicaid HMO's in Chicago that we have looked at; we have also looked at the Medicare HMO program in South Florida. In each case we identified a series of problems.

Dave focused on one of the problems, and that is the propensity of managed care programs to set up related parties and then contract, largely on a risk basis, with subcontractors that were outside of Federal regulation. That is part of why the Medicare and Medicaid regulations were adjusted to hold subcontractors to the same standards. That is one of the concerns we have with relieving VA of some of those oversight requirements.

In the Chicago area particularly, we found that the contractors were frequently subcontracting with small groups of providers or even with individual providers to transfer significant amounts of risk. They would hold a small provider accountable for hospital care for specialist services, all out of one capitation payment. In a situation like that, if you have one really sick patient, that provider is going to become insolvent.

So what the Medicare-Medicaid standards require is that you enroll a sufficient number of beneficiaries to spread the risk and reduce the likelihood of insolvency. That is why we think it is important that VA plans follow that kind of rule.

There also were marketing difficulties at a lot of the plans. Either the plans misrepresented what services they were providing or they would enroll individuals they knew were not eligible in order to get the payment. There was considerable concern about underservicing of beneficiaries. There has been a problem in every one of the managed care programs in getting good data on what services are actually being provided. That is a problem in managed care because providers lose the incentive to provide utilization data.

Under a traditional fee-for-service program a provider gets paid by providing information on the services provided. Under managed care, providers have already received payment so they don't have much of an incentive to provide data on the services provided. Requirements have evolved over time in Medicare and Medicaid to put strict financial penalties on plans that don't submit data, and that is the main problems we found.

Mr. EVANS. GAO is concerned here in terms of the Health Security Act's impact on the Department of Veterans Affairs health care system that it will be exempt from those kind of Medicare HMO restrictions. Is that correct?

Mr. LINZ. Yes.

Mr. BAINE. Yes.

Mr. LINZ. And they also would not be required to comply with the regional alliance requirements. VA plans would be expected, to the extent that the Secretary determines it is practical, to comply with regional alliance standards, but a regional alliance could not deny participation to a VA plan for any reason.

Mr. EVANS. Let me ask the VA if they can respond to this or describe their plans for safeguards if the VA is exempt from these kinds of regulations and restrictions. What does VA have in mind

and will this be something that the Central Office mandates, because I am concerned about the autonomy provided by the legislation. Can you comment on that?

Mr. PERREAULT. Yes. There are two issues here. The proposed Health Security Act would give the VA Medicare provider status as well as deemed HMO status. With respect to Medicare provider status, Medicare accepts joint commission accreditation as meeting their requirements.

In prior discussions with HHS, there has been a reluctance on their part to accept VA's performance in joint commission as meeting their standard, yet in the last four years we have been five to 10 points on average higher than community facilities in joint commission performance. So I would suggest that that indicates we are at least meeting quality performance requirements for provider status equal to and above the community.

With respect specifically to Medicare HMO requirements, we believe we need flexibility in a number of ways to operate in the community that, as a Government agency, puts us and sets us apart from many of what our competitors are. This doesn't remove the already in place and well established requirements that cover a broad range of areas including ethics violations and conflict of interest regulations or contracting regulations. Mr. Krump can expand on that in specific detail.

A particular point, too, I would like to make about the risk contracting as we look to establishing contracts with provider organizations, there is no question that we will establish contracts with group practices, IPA's, or managed care organizations, expand sharing agreements with our affiliates, look to expand sharing agreements or relationships with city, county, and State health agencies, to expand access points to provide veterans care at the same level of ability that many of our competitors will provide, but how we do that will differ depending on who the source of the provider services are.

In fact, the practice in the community in individual provider contracts is not to do risk contracting, it is to do fee-for-service contracting. So we will evaluate those risks as we address each of those issues in the marketplace.

Mr. EVANS. The gentleman from Illinois is recognized.

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

Mr. Baine, you have expressed some concern about the decentralization that will occur under managed care should that come about, that the increased autonomy of the local VA facilities may raise the risk that problems will not be resolved in a quick and effective manner. You use an example of an area that I have dealt with quite a bit, the problems faced by women veterans.

Many of the problems that the GAO pointed out in 1982 still exist in 1994. Even though VA medical centers have submitted actions plans years earlier, the VA's Central Office has not reviewed those plans. Doesn't that example seem to suggest that we should be concerned about the Central Office as it stands now?

In other words, it seems to me that we should not only worry about the relative power of the Central Office but also the work with which it has authority.

Mr. BAINE. Congressman, you are correct in your statement that the amount of decentralization that may occur as VA goes to managed care is a concern. As you know, we have been up here many times testifying on various issues, and invariably what we find as it relates to any particular issue, whether it is the control over controlled substances or women veterans or whatever, is that the performance of the medical centers varies all over the place. Some are very good, some do not emphasize that particular area.

Our concern with regard to decentralization is how are the medical centers going to be held accountable to whatever kind of a managed care plan VA wants to go to.

We understand and don't argue with the fact that implementation of a nationwide managed care plan has to be based on local conditions because every medical center operates in a community where there are particular local conditions. Our concern is based primarily on our past work on the extent to which medical centers are held accountable for their actions as they relate to particular issues.

Mr. GUTIERREZ. Thank you, Mr. Baine.

I have a question for Mr. Perreault.

I believe that it has been the position of Secretary Brown that veterans and other enrollees in the VA health care plan should have access to the same standard benefits package as any other American, and I agree with the Secretary. I believe that it is wrong to tell veterans that there will be special restrictions on what elements of the benefits package are available to them. If anything, we should add on to the package so that they will have special access to things like spinal cord rehabilitation.

For me it is primarily a matter of fairness, and I don't think it is right to tell veterans that all other Americans will have access to a standard benefits package but if you are a veteran you get the benefits package minus A, B, or C.

In addition to it being a matter of fairness, it is also an economic concern, a matter of competitiveness, I think. In other words, is the Secretary's position also based on making the VA an attractive option for potential users?

Mr. PERREAULT. I would say that it certainly is the Secretary's position that the VA will be an attractive plan for potential users. Essentially the Health Security Act proposal would provide the comprehensive benefits package to all veterans and, in addition to that, continue eligibility for medical care as currently codified in Title 38, Chapter 17. So there would be additional benefits above and beyond the comprehensive benefits package available to veterans. I think that is a large incentive for veterans to be attracted to the VA plan.

Mr. GUTIERREZ. So following that logic then, I want to know if you think that limiting the ability of women to receive certain services at the VA could—and I say "could"—have a negative impact on the VA's ability to compete with other providers that do comprehensive services.

Mr. PERREAULT. I don't expect we have any intention of limiting our ability to provide services to women. I think we have historically principally provided services to men and it has taken some time to evolve in a transition to meet a lot of the requirements nec-

essary for privacy and convenience. It has been and there have been difficulties in recruiting gynecological services, for example, but we are making, I think, very good progress in that regard.

In Philadelphia, when I left, our network as a network of four hospitals was funded specifically for a women's comprehensive health program. It was the only network funded under this program last year, and through that we have put in place a mammography unit, we have hired gynecology services both directly and through consultation at the other four hospitals in the network, and that kind of practice has gone on throughout the country. So I think we are responding well to a number of the issues and the problems that have been raised in that regard and will continue to do so.

We will have much expanded authority under the Health Security Act as well to contract for those needed services that we don't have available through VA facilities now.

Mr. GUTIERREZ. And so you would be in agreement that not being able to provide some kind of services, and particularly to women, would have a negative impact on the VA's ability to compete with other providers?

Mr. PERREAULT. No, I don't agree. I would say that we will be able to provide those services so it will not have a negative effect.

Mr. GUTIERREZ. I understand, and so the converse is correct. And just so you know, Mr. Perreault I am not suggesting that the VA would want to limit the package. I would suggest that the Members of this committee have already in past actions limited the package of benefits when we look at women's services particularly, and that is just the record of the committee here in Congress, and indeed we have already passed the Security Act in which we have already taken up the issue of women and whether they have the same rights as under the health care package, and so I just wanted to raise that issue so that we could have it on the record.

Thank you very much, Mr. Chairman.

Mr. EVANS. Minority counsel.

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. Baine, you estimate that it will require approximately $16 billion in appropriated funds just to cover the cost of premiums of core entitled veterans. Please explain why this is an extreme example.

Mr. BAINE. What we tried to do was make an estimate of what the premium costs would be if all nine million core group veterans—that is to say, service-connected, low-income, World War II, and Mexican War veterans were to sign up for a VA health plan. We recognize that not all nine million will enroll in a VA plan. How many of those nine million might enroll depends greatly on what the relative benefit level is between the VA—what the VA benefit is as compared to the comprehensive plan that ultimately comes out of a national health reform proposal.

Jim and Terry can elaborate on how we came up with the estimate. The reason we developed the estimate is to show the relative magnitude of the appropriations that would be required just to cover the premiums. This does not cover appropriations for copayments, deductibles, and that sort of thing.

Jim, do you want to explain the $16 billion number?

Mr. LINZ. We started with VA's 1987 Survey of Veterans and identified the core group veterans. For the Medicare eligible veterans in the core group we used national averages of Medicare HMO payments and just calculated out what the payment would be. We did this because for a Medicare eligible veteran that enrolls in a VA health plan, VA would be responsible for the entire cost of their premium. So it basically would be a cost shift from the Medicare trust fund to VA appropriated funds to pay for their care.

It is not an increase in Government cost necessarily, but it is an increase in VA appropriations. For the non-Medicare eligibles in that nine million, we took 20 percent of CBO's estimate of the self-enrollment cost and used that as a conservative estimate of what VA's share would be. For those that are self-employed, VA would pay 100 percent. So we think it is a conservative estimate.

What we are really saying is, the closer VA health plans get to looking like a Kaiser or a private HMO in terms of the provider network and so forth, the more likely it is that the cost incentives are going to draw veterans in.

If you leave VA with its current network of hospitals and clinics, cost probably won't be a deciding factor, but if veterans can use private hospitals close to their homes or their current physician, then cost becomes a much more important factor in determining who is likely to enroll, and at that point it is not inconceivable that up to nine million might enroll.

Ms. DONOHUE. Mr. Perreault, do you agree with GAO's estimate that it will cost approximately $16 billion just to cover the cost for core entitled veterans under the Health Security Act, and why or why not?

Mr. PERREAULT. We don't agree.

Let me suggest that there are estimates about the VA population that would be attracted that are all over the map in this area. The VA has not yet put an estimate on the table in the hope that we will be able to derive that through a comprehensive business planning effort.

This same group of GAO auditors has estimated that the VA would lose 40 percent of its current population. So we have a range of estimate that is over 400 percent in the difference of what the VA enrolled population might be. CBO has estimated the VA would lose 27 percent of its population.

I think the answer to the question about what the VA enrolled population is right now nobody knows. I think we will develop that through a business planning effort as we develop expanded access capability that will have an impact on our ability to attract additional people.

That is not to say that there are not some risks and some shifts in the appropriation that the GAO has pointed out, I think quite appropriately. Those kinds of shifts would occur, and we expect that some of those shifts will be likely.

Mr. BAINE. Could I make a comment on the estimate at the other extreme?

Ms. DONOHUE. Please do.

Mr. BAINE. The estimate that we made two years ago, I believe, in terms of the reduced demand for VA services, was based on the assumption that VA was going to be set apart from any kind of a

universal access system. We did believe and we still do that if VA were set apart and not made a part of the national health reform proposal, that the demand for VA services would go down significantly.

Under the Health Security Act, both the benefit structure and particularly the cost sharing provisions have been addressed by the Act itself, and therefore VA is a fully competing provider but with a benefit structure that is fairly rich in comparison to what is anticipated, based on two very, very different assumptions.

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

GAO has reported that, "Medicare is a primary source of Federal support for veterans' health care needs and that the VA provides treatment for service-connected disabilities and serves as a safety net for low-income and uninsured veterans." Can each of you compare the cost-effectiveness of veterans' health care provided by the VA and veterans' health care provided by Medicare?

Mr. PERREAULT. I would like to respond for the record to that question. Mr. Chairman, as you know there have been numerous studies to compare the VA and the VA's costs with Medicare, and there is seldom a consensus on the accuracy of those estimates, so I would like to respond for the record.

Mr. EVANS. All right.

Mr. BAINE. I would agree with Bob on that issue. There are many, many reports and studies that have been done comparing the relative costs of VA vis-a-vis private sector providers. We are in the process, Mr. Chairman, of taking a look at three or four, perhaps five, of the studies that have been done by VA on this very issue.

Our preliminary finding is that the conclusions that these studies come to are not based on solid methodologies or solid data. We are in the process of trying to further analyze those studies and talk them over with the VA staff who did the work. I believe the answer to your question is that there are no real good comparisons between what it costs VA vis-a-vis Medicare for a variety of reasons.

Mr. EVANS. When might the assessment by GAO of those studies be done?

Mr. BAINE. I'm sorry, I didn't hear you, sir.

Mr. EVANS. When might the assessment by GAO of those studies be completed?

Mr. LINZ. We are in the process of drafting our report now. We have done the preliminary assessments of the studies, and we are just trying to organize our thoughts on where the deficiencies are and trying to put it together into a report.

Basically, as David said, we have not found any studies that would convince us that VA care is less expensive or even comparable to private sector care. Nor do the studies suggest that they are less cost effective; we just don't know; there are no valid studies out there.

Mr. EVANS. All right.

Mr. BAINE. Mr. Chairman, the area of relative cost effectiveness is a very, very tough issue to get your hands around, and I think VA would agree with that. Part of the reason for that is, you have

got two very different systems. In VA you have the providers as part of the system; in Medicare you do not. There are always questions about the extent to which capital costs should be included in the comparisons, and you can argue for days, and I suppose we have, about whether to include those kinds of things in cost comparison studies. So this is a very, very tough issue to get your hands around.

Mr. EVANS. Will veterans' health care needs be adequately served if an independent and viable VA health care system is not maintained?

Mr. PERREAULT. I don't believe they will be, especially those services associated with the Title 38 benefits. VA has special expertise in a number of areas, as has been discussed in many of the Veterans' Affairs Committee hearings over the years, and we believe that we need to carry that special expertise forward to provide the level of service necessary.

We also, in development of the challenge to meet the health care reform initiative, have included the veterans' service organizations' representatives in that effort, and there is a consensus among the VSO groups that the VA needs to be retained as an independent health system to meet the unique needs of veterans. So for that and a number of reasons we believe that it is necessary to maintain an independent VA health care system.

Mr. EVANS. Dave, do you have a comment?

Mr. BAINE. Yes, I believe, Mr. Chairman, we have testified before that we think it is possible to preserve the veteran benefit without necessarily preserving the health care system—the VA health care system as it is constructed today or developed today.

That is not to say that preserving the system is not one way to go about preserving the benefit. We have done some work, with regard to the health care systems in other countries, the veterans' systems in other countries. In those particular instances, the veterans' benefits were preserved and enhanced but the direct delivery systems were made part of the national health systems of those countries.

Mr. EVANS. What is the future of VA health care if the Department of Veterans Affairs is not part of national health care reform?

Mr. PERREAULT. What is the future? I'm sorry?

Mr. EVANS. What would be the future of VA health care if the VA was not made part of a national health care reform system?

Mr. PERREAULT. We could make a number of assumptions about what that VA future would be. If the VA were retained, given the current range of eligibility and benefits within Title 38, Chapter 17, we see that we would be at a great competitive disadvantage when standing next to that, were the comprehensive benefits of health reform available to all Americans.

So I believe and I think the VA position would be that we would be at great risk in attracting and maintaining the VA system if we stood apart from the national health reform effort and I think that this is essentially why the VA was included in the task force efforts of the White House.

Mr. EVANS. Before recognizing minority counsel, which veterans should be entitled to free comprehensive health care services under national health care reform?

Mr. PERREAULT. Which veterans should be?

Mr. EVANS. Yes.

Mr. PERREAULT. Well, the Health Security Act would continue to include those veterans entitled to comprehensive—well, all veterans would be entitled to the comprehensive benefits package. Those veterans who have specific enhanced eligibility under Title 38 would continue to have that enhanced eligibility as a part of their enrollment in a VA plan. We don't disagree with that.

Mr. EVANS. I yield to minority counsel.

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. Perreault, let me ask you the flip side of the chairman's question. What will happen if Congress does not enact the Health Security Act this year? Will VA endorse an eligibility reform plan that will enable VA to move forward regardless of what happens with national health care reform?

Mr. PERREAULT. The VA sees that the eligibility complexity in current authority has been a problem in delivering care. It is the VA position, however, that eligibility reform is inherent in the National Security Act proposal, so it is our position that health reform occur through the Health Security Act.

Ms. DONOHUE. Mr. Baine, your report states that the Health Security Act would shift VA priority away from service-connected and low-income veterans. Please explain.

Mr. BAINE. Our point when we made that statement, is that under the Health Security Act, if VA were to establish managed care plans under which people could enroll, the enrollment, as we understand it now, would be on a first come, first served basis, and therefore higher-income veterans have every bit as much opportunity to enroll as the service-connected, low-income veterans. To the extent that happens, VA would be then obligated to serve higher-income veterans rather than the lower-income and service-connected veterans.

Mr. LINZ. Could I expand on that just a minute? When it becomes an issue is when the demand for enrollment would exceed the capacity of the health plan. If four million veterans sought to enroll in the VA and the VA health plan only has the capacity to enroll two million and you have enrollment on a first come, first served basis, then service-connected veterans or other core group veterans might be denied enrollment at the same time VA plans were enrolling higher-income veterans and dependents of veterans.

Mr. PERREAULT. I would like to make a comment about that, if I might. That is a possible outcome. It is speculation in the extreme. The other extreme is to say that under the provisions and the authority that the VA would have with the Health Security Act, we will be able to meet the demand for all of those who seek to enroll in the VA system.

I would also suggest that we don't expect to meet the requirements of Title 38 that currently mandate the VA to provide care to service-connected and low-income veterans. We fully expect to be able to meet that requirement.

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. EVANS. That wouldn't be done, Bob, on a first come, first served basis?

Mr. PERREAULT. Well, the point is, I think, looked at from a different perspective. The point is that with contracting authority, if demand exceeds what we have in current provider organizations, VA facilities with an increased demand will have the authority, the flexibility, and the revenue to contract with additional providers to meet that demand.

Mr. EVANS. But a veteran that has relied perhaps on the VA in the past because of the unique services that the VA health care system has rendered that veteran, could he be excluded basically?

Mr. PERREAULT. I don't think so.

Mr. EVANS. But you don't know?

Mr. PERREAULT. I would say now we will not—they are not going to be iced out. I mean we are going to have the capabilities, given the authority we would have, to provide care to all veterans that demand that care.

Mr. EVANS. All right.

Mr. BAINE. Mr. Chairman, I think the VA's assumption is that the capacity of the system will be great enough—I mean it is based on sort of a relatively unlimited capacity of the system, and therefore the service-connected, low-income veterans would always be taken care of.

Generally, managed care plans determine what the capacity is and then start an enrollment process. In this particular case—as I understand it anyway, and I could be wrong—in this particular case, the assumption is that the capacity of the system because of the contracting authority and—primarily because of the contracting authority—is unlimited.

Mr. EVANS. The VA plans to be prepared to compete in the health care marketplace competition no later than January 1, 1997. How much will this cost? How will these resources be used? And how will this be determined?

Mr. PERREAULT. We have embarked on a plan now to begin marketing research and business planning which will give us the ability to answer those questions more definitively.

The goal behind the design of these initial studies—and we used outside consultants to do that who have specific expertise in these areas—is to define a population that might be attracted given a change in the structure of the VA's ability to provide services, and that structure would be one that makes assumptions about our having greater access points, our having some improved conveniences and amenities within existing VA facilities, and our having reduced waiting times and the level of service that is now found in many of the existing managed care environments. It is also one that will take into consideration what the competitors are doing. And through that analysis we will build business plans on the basis of an organizational entity that will be larger than what the current VA facilities are but on a health plan basis or a VSA basis, some geographic area where we would expect to analyze the impact of a veteran population in that area and our ability to respond to it through a contractor and provider network as well as the existing VA facilities.

Mr. EVANS. Can you describe VA's authority under the Health Security Act to change the mission of a facility or to close a facility?

Mr. PERREAULT. I think the VA authority would be broad under the Health Security Act to react to marketplace demand. There is no question in my mind that there will be a necessity for some mission changes to react to the marketplace demand, especially as we plan on a different level. I mean we have planned grassroots, bottom-up, facility specific, and this planning perspective will change dramatically to respond to the needs of a health plan however they are established over a given geographic area. That will result in some shift in services.

Mr. EVANS. What authority does the VA have under the Health Security Act to make those changes in the mission of a facility or to close a facility? What specifically in the Act would empower the VA to make those kinds of changes?

Mr. PERREAULT. I will have to answer that for the record, and I would say at this point that there is no intention to close any facilities.

Mr. EVANS. According to GAO's written testimony, VA officials believe VA must be exempted from a series of existing laws and regulations to compete with the private sector health plans. Can both of you comment on and identify the Federal and State regulation exemptions granted to VA by the Health Security Act?

Mr. BAINE. Mr. Chairman, our analysis of the Health Security Act and the recent amendments indicates that the VA would be exempt from most Federal procurement laws and regulations, that it would be exempt from most Federal personnel rules and it would be exempt from most Federal HMO and Medicare requirements, that VA could not be rejected by a regional health alliance under the Act, that the requirement to notify Congress of administrative reorganizations that is currently in Title 38 has been removed, that VA would be exempt from State regulations with regard to HMO's, the construction and establishment of HMO's, and that many of the restrictions on marketing would be removed.

That is at least a partial list of the exemptions that have been made through the Health Security Act.

Mr. EVANS. Possibly an exemption from minimum wage laws?

Mr. LINZ. Yes, sir, as part of the exemptions from procurement requirements, our view is that that might extend as far as an exemption from minimum wage laws.

Mr. EVANS. Are other plans given this kind of broad exemption from Federal or State regulations?

Mr. LINZ. No. Some of these requirements, like Federal procurement requirements, would not apply to private sector plans in any event, but the DOD and IHS plans generally would not get these same types of exemptions. They would be subject to Federal Medicare regulations, to the procurement regulations and so forth.

One thing I might add on the State exemptions: VA facilities, as are essentially all Federal health care facilities, are currently exempt from State laws, so that is not a new exemption.

Mr. EVANS. Bob, do you have any response?

Mr. PERREAULT. I would agree that the exemptions with respect to the States for the most part are nothing really new to the VA. We are not required to comply with State requirements.

There would be an additional impact of that exemption as it relates to the varied State laws associated with HMO organization

and regulation and risk contracting that also have aggregated into Federal HMO laws.

I would like Ms. Egan and Mr. Krump to respond to some of the issues related to the exemptions related to human resources policy and regulation and to contracting authority.

Mr. KRUMP. Yes, sir.

Mr. Chairman, with regard to the exemptions from the procurement laws and regulations, currently our belief is that the effect of that exemption would be basically de minimis. The requirements in terms of conflict of interest and those other requirements currently exist in other sections of the United States Code. A Federal employee who had entered into a so-called "sweetheart deal," for example, would still be subject to criminal penalties under Title 18 of the Code.

In terms of other more flexible acquisition potentials, we have some experience in dealing with those at the present time, and all other aspects of Federal law, whether procurement or criminal law, would still apply except with regard to acquisition of health care services. So the net effect of removing us from the procurement regulations, quote, unquote, for health services would not specifically affect overall agency operations.

I believe, in addition, that with regard to certain other socioeconomic programs in the procurement field, we have an institutionalized bias towards supporting those programs, and without regard to who the incumbent Secretary is, the system itself would support socioeconomic programs, minority-owned businesses, veteran-owned business programs, women-owned business programs, so we don't believe that the net effect of the that exemption would have a substantial impact on our procurement program.

Ms. EGAN. Mr. Chairman, with regard to the H.R., the human resources program, the Health Security Act provides very broad language which gives the Secretary discretion to establish a personnel program that would meet the needs of the health care system with one proviso, the retention of veterans' preference.

At this point, what we envision is developing a plan which would (perhaps) retain those parts of Title 5 and Title 38 that are able to meet our needs; but, to the extent that VA strives to be an employer of choice in any geographic area, we would adapt our system to enable us to be competitive with our primary competitors for health care occupations.

Therefore, I do not anticipate that what the VA would offer would be any less than we offer now and, in fact, we would hope that we would be able to expand our ability to offer a variety of benefits to make our employment offers more competitive and provide greater flexibility for training and education for our employees to serve as incentives for joining the VA system.

Mr. EVANS. So VA in your opinion needs a specific exemption from bid protests?

Ms. EGAN. I'm sorry?

Mr. EVANS. Mr. Krump.

Mr. KRUMP. Well, sir, as a practical fact of the matter, we haven't had a sustained bid protest against us in two years. I don't believe that from the standpoint of a bid protest, per se, it is going to have a substantial impact on the operation of the VA procure-

ment system. We will still have warranted contracting officers who will be warranted in accordance with the requirements of the Federal Acquisition Regulations; they will still maintain a fiduciary responsibility to the United States; they will still be able to resolve those disputes as they could now under the agency protest procedure without regard to whether or not they had to go to GAO. If a blanket exemption were granted to protest, that would still not relieve the agency of being able to respond under standard commercial practice.

So to the extent that a disappointed offeror was not able to file a bid protest, that would not, in and of itself, cut off all legal remedies.

Mr. EVANS. Would there be an exemption from minimum wage for the VA?

Mr. KRUMP. Well, sir, I have read the testimony from the GAO, and I have a hard time making that connection myself because of the fact that the Act—as it is worded—would not grant an automatic immunity from any of the other socioeconomic programs or minimum wage requirements that I am aware of.

Mr. EVANS. And no exemption from minority contracting?

Mr. KRUMP. Not specifically.

Mr. EVANS. Let me yield to minority counsel.

Ms. DONOHUE. Mr. Perreault, it is well known that VA contributions in the areas of medical research and education have been instrumental in making overall American health care and science the best in the world. What effect would enactment of the provisions of the Health Security Act have upon VA's research program?

Mr. PERREAULT. We expect that the enactment of the Health Security Act will not negatively affect the VA's mission in medical education and research. It is intended that we will continue to have that as a principal mission requirement of the VA and that we will operate an active relationship and affiliation with medical schools both for medical education and research in a manner like we have in the past.

Ms. DONOHUE. Veterans have often stated that their special disabilities make it essential that VA provide specialized services such as spinal cord and blind rehabilitation, mental health services such as post traumatic stress disorder care, and long-term care. If the provision of these services vary geographically, how will VA meet the needs in areas where such care is inaccessible or not available?

Mr. PERREAULT. Again, we think that where care is inaccessible or inconveniently available now, we will be able to provide those services through the expanded contracting authority we have. But I also believe that the dynamic of how we operate in this kind of environment may result in the creation of some of those services in other locations. I mean the analysis will be based on the demand of a population to support whether the service is provided by VA employed staff and VA facilities or purchased on a contract arrangement.

Ms. DONOHUE. Who will be the case manager for the veteran who receives one or multiple services that are contracted out?

Mr. PERREAULT. There are a number of policies that will be developed for how managed care will be developed and implemented both with VA providers and with contractor providers. Regardless

though of who the provider is, there will be a requirement to submit to quality performance plans that we expect to develop through the establishment of medical record systems.

A point made earlier by Mr. Baine that there is little incentive to collect data related to specifically provided procedures I don't agree with at all. As a matter of fact, it is the lifeblood of—success of managed care organizations to monitor utilization, and we understand that. We are prepared to develop the systems to put in place to do that both from VA facilities as well as to require that from our contractors in a way that the care can be monitored.

We have already under way in the VA the development of event-driven reporting which will result in reporting specifically in a manner consistent with what is now done in the managed care industry for ambulatory care procedures using CPT coding. We have had for a long-standing period of time, coding in discharge diagnosis using ICD9 coding. So we expect that we will use that data to develop quality performance requirements and standards that will apply equally to our contractors as it will to VA providers.

Ms. DONOHUE. Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Will VA managed care plans comply with regional alliance standards under the Health Security Act?

Mr. PERREAULT. We have an exemption within the proposal of the bill, so a number of those standards we will meet or exceed anyway, and for those that we don't, it would probably be for some reason in the difference of our legal status.

Mr. EVANS. How will VA select providers with whom it will risk contract? Will all VA plans use the same selection process?

Mr. PERREAULT. Definitively the answer to that question is not determined yet. I expect there will be great variability in how some of those contracts are established depending on a given market situation in a region while at the same time having some essential standards in how those risk contracts are established.

But a point I want to make again is that we will likely have risk contracting associated with most of our large group contracts and our IPA contracts, contracts with other managed care organizations for example, and not as likely to have risk contracts if we contract with individual providers. I think there is an underlying principle there that does result in avoiding some of the risk that the GAO has alluded to in that regard as you get to a small provider, because you do need a population base associated with a provider organization to spread risk for that financial liability and we wouldn't expect a capitated payment performance from a very small provider, individual provider.

Mr. EVANS. Will VA risk contractors be allowed to subcontract to other providers?

Mr. PERREAULT. We expect so.

Mr. EVANS. Does minority counsel have any questions?

Ms. DONOHUE. No, thank you.

Mr. EVANS. I think at this time we will call on the witnesses to offer any final remarks you might want to make. We will, of course, be submitting numerous additional written questions and look forward to your prompt response given the timeliness of these issues. Those answers will be made part of the record. At this time I would

like to yield to either one of you for any final comments that you might want to make.

Mr. PERREAULT. Mr. Chairman, we appreciate the opportunity to respond to your questions today and your concerns. I am confident, as is the Secretary, that the VA can respond to this challenge in developing a position where we will be competitive in a health reform environment, and I appreciate the opportunity to present our comments today.

Mr. EVANS. Thank you, Bob.

Dave.

Mr. BAINE. Mr. Chairman, we also appreciate the opportunity to be able to come up and testify on these issue which we believe are important as the Congress deliberates the VA's role in a reformed health care system. I saw for the first time this morning, Mr. Brown's statement, and I wanted to assure you that we are in no way trying to be alarmist in this regard. We have talked to the VA about the issues that are included in our testimony. We have talked to them extensively, and we hope to continue to work with the VA as health reform is further debated, and we will certainly be glad to continue to respond to your questions and issues as they come up as the debate continues.

Thank you.

Mr. EVANS. I want to thank you both, and your associates, for appearing today. It has been very helpful to us, as will the answers to the written questions. Thank you very much.

This hearing is now adjourned.

[Whereupon, at 9:47 a.m., the subcommittee was adjourned.]

# APPENDIX

TESTIMONY OF
ROBERT A. PERREAULT, DIRECTOR
HEALTH CARE REFORM OFFICE
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
JUNE 29, 1994

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM BOB PERREAULT, NEWLY APPOINTED DIRECTOR OF THE VA'S HEALTH CARE REFORM OFFICE. I APPRECIATE THIS OPPORTUNITY TO INTRODUCE MYSELF TO THE SUBCOMMITTEE AND TO PROVIDE THE MEMBERS WITH INFORMATION THAT WILL BE OF BENEFIT AS HEALTH CARE REFORM AND VA'S FUTURE IN THAT ARENA ARE DECIDED UPON BY CONGRESS.

HAVING SERVED AS DIRECTOR OF TWO VA MEDICAL CENTERS, MOST RECENTLY AS THE DIRECTOR OF THE PHILADELPHIA VA MEDICAL CENTER, I BRING TO MY NEW ROLE FIRSTHAND KNOWLEDGE OF CHALLENGES THAT WILL CONFRONT VA AS WELL AS THE REALITIES OF RUNNING A VA HOSPITAL IN A LOCAL HEALTH CARE MARKET. IN ADDITION, I HOLD THE BELIEF THAT VA SHOULD GRASP THE OPPORTUNITY THE PRESIDENT SEEKS TO GIVE US TO DEMONSTRATE THAT WE CAN SUCCESSFULLY COMPETE IN THE MARKETPLACE AND PROVIDE COMPREHENSIVE HEALTH CARE SERVICES TO OUR PATIENTS.

FROM THE BEGINNING OF THE PRESIDENT'S DEVELOPMENT EFFORT TO CRAFT A COMPREHENSIVE HEALTH CARE REFORM BILL, VA AND VETERANS' SERVICE ORGANIZATIONS (VSO's) WERE INCLUDED IN THE PROCESS. THE INCLUSION OF VA REPRESENTATION ACKNOWLEDGED THE IMPORTANT ROLE THAT VA PLAYS IN THE DELIVERY OF HEALTH CARE TO OUR NATION'S VETERANS. IN ADDITION, IT ALSO INDICATED THE PRESIDENT'S DESIRE TO ASSIST VA IN THE HEALTH CARE MARKETPLACE BY ADDRESSING THOSE BARRIERS THAT NEED TO BE REMOVED AND BY PROVIDING NECESSARY TOOLS THAT NEED TO BE PROVIDED IN ORDER FOR VA TO COMPETE EFFECTIVELY WITH THE PRIVATE SECTOR.

IN THAT REGARD, MY TESTIMONY FOCUSES ON THE CURRENT BARRIERS, BARRIERS THAT HAVE BEEN ADDRESSED IN THE HEALTH SECURITY ACT, AND THE CHALLENGES THAT VA HAS IDENTIFIED AS WE TRANSITION INTO THE REFORMED HEALTH CARE ENVIRONMENT.

**CURRENT LEGAL AND STRUCTURAL BARRIERS**

MAJOR PROBLEMS FACING THE VA HEALTH CARE SYSTEM TODAY INCLUDE: (1) COMPLICATED AND CONFUSING ELIGIBILITY RULES THAT HAVE THE EFFECT OF EXCLUDING MANY VETERANS FROM VA CARE AND PROVIDING ONLY FRAGMENTED CARE TO

MANY OTHER VETERANS; (2) COMPLETE RELIANCE ON DISCRETIONARY APPROPRIATIONS, WHICH ARE UNDER GREAT PRESSURE; (3) LIMITED AUTHORITY TO CONDUCT MARKETING AND PROMOTION; AND (4) INFRASTRUCTURE DEFICIENCIES.

**THE HEALTH SECURITY ACT AND VA**

THE PRESIDENT'S HEALTH CARE REFORM PROPOSAL WILL RESULT IN MAJOR IMPROVEMENTS TO VA'S HEALTH CARE SYSTEM. THE PRESIDENT'S PLAN WOULD MAINTAIN AN INDEPENDENT VA HEALTH CARE SYSTEM AND PROVIDE THE MEANS TO IMPROVE ACCESS, QUALITY, AND EFFICIENCY IN THE NEW NATIONAL HEALTH CARE ARENA. THE PRESIDENT'S BILL HAS PROVIDED VA WITH THE NECESSARY FRAMEWORK THAT IS ESSENTIAL FOR COMPETING IN THE MARKETPLACE. THE HEALTH SECURITY ACT WOULD: (1) ALLOW ALL VETERANS AND THEIR FAMILY MEMBERS TO ENROLL IN A VA HEALTH PLAN; (2) PERMIT VA TO RECEIVE AND RETAIN MONIES ASSOCIATED WITH PROVIDING SERVICES; AND (3) PROVIDE FOR AN INVESTMENT FUND THAT WOULD ENABLE VA TO SUCCESSFULLY ESTABLISH HEALTH PLANS.

**CHALLENGES FOR VA**

IN IMPLEMENTING THE HEALTH SECURITY ACT, VA HAS IDENTIFIED SEVERAL KEY INITIATIVES THAT WILL BE CRITICAL TO OUR SUCCESS IN A COMPETITIVE ENVIRONMENT. FIRST, VA MUST ADOPT A CUSTOMER SERVICE ORIENTATION THAT WILL PREVAIL AT ALL LEVELS OF THE ORGANIZATION. IN THE COMPETITIVE MARKETPLACE, THE LONG-TERM SURVIVAL OF THE VA HEALTH CARE SYSTEM WILL DEPEND ON HOW WELL WE SERVE OUR PATIENTS WHEN THEY HAVE ALTERNATE HEALTH CARE CHOICES.

IN ADDITION, VA REALIZES THAT WE NEED TO PROVIDE BETTER GEOGRAPHIC ACCESSIBILITY AND WE MUST REDUCE OUR WAITING TIMES TO COMPETITIVE LEVELS IF WE ARE TO ATTRACT AND RETAIN OUR CUSTOMERS.

VA ALSO RECOGNIZES THE NECESSITY TO ADOPT A BUSINESS ORIENTATION SIMILAR TO PRIVATE HEALTH CARE ORGANIZATIONS. NEW PROGRAM INITIATIVES WILL BE BASED ON ENROLLEE DEMOGRAPHICS AND LOCAL MARKET CONDITIONS.

LOCAL NETWORKS WILL REQUIRE MANAGEMENT FLEXIBILITY, WHICH THE PRESIDENT'S PROPOSAL PROVIDES, TO RAPIDLY ADJUST LOCAL OPERATIONS TO MEET DEMAND FOR SERVICES. VA WOULD HAVE INCREASED FLEXIBILITY IN

CONTRACTING AND IN ESTABLISHING SALARY AND BENEFITS STRUCTURES FOR EMPLOYEES.

**CONCLUSION**

THE PRESIDENT'S BILL OFFERS THE DEPARTMENT A UNIQUE OPPORTUNITY TO ENSURE THE VIABILITY OF THE HEALTH CARE SYSTEM FOR THE NATION'S VETERANS. ALTHOUGH THE DEPARTMENT MUST WAIT FOR FINAL PASSAGE OF HEALTH CARE REFORM TO REALIZE MAJOR CHANGES IN OUR PROGRAMS, WE ARE DEVELOPING PLANS FOR IMPLEMENTING THAT LEGISLATION.

VA HAS DEVELOPED AND PROVIDED TO CONGRESS A SUMMARY OF OUR PLANNING EFFORTS TO DATE. THE HEALTH CARE REFORM OFFICE IS NOW PLANNING THE MORE DETAILED STEPS THAT WILL BE REQUIRED TO TRANSITION TO THE REFORMED NATIONAL HEALTH CARE ENVIRONMENT. OUR GOAL IS TO BE THE PLAN OF CHOICE FOR VETERANS AND THEIR FAMILY MEMBERS. NEEDLESS TO SAY, THE ENACTMENT OF HEALTH CARE REFORM LEGISLATION IS CRITICAL TO OUR ABILITY TO COMPETE IN THE MARKETPLACE. VA WELCOMES THE CHALLENGE AND LOOKS FORWARD TO THE OPPORTUNITY TO FULLY AND EFFECTIVELY COMPETE.

MR. CHAIRMAN, THIS CONCLUDES MY FORMAL TESTIMONY, AND I WOULD BE PLEASED TO RESPOND TO QUESTIONS FROM THE MEMBERS.

## VA WILL BE PREPARED TO COMPETE UNDER HEALTH CARE REFORM

We at VA have every confidence in our ability to compete with other health care providers under the provisions of the President's Health Security Act. We have a solid infrastructure upon which to build, proven competence, a remarkable history of achievement in health care delivery and scientific research, and the unrivaled dedication and compassion of our team of administrative and health care professionals to ensure our viability. GAO's preliminary concerns about risks from VA's reform implementation efforts are premature.

VA's detailed planning and development efforts are just beginning. As we implement health reform, we will have many obstacles -- some unforeseen -- to overcome, including those referred to in GAO's analysis. Our planning will deal with issues of VA's capacity, accessibility of VA care, contracting and ethics rules, financial management, and management structure and control.

If Congress chooses to maintain an independent health care delivery system for veterans and provide the tools and resources necessary for VA to be a competitive, high quality provider of services under health care reform, then I feel certain that VA will be able to avoid the grim results about which GAO conjectured. As you know, our efforts and plans will be subject to continuing oversight of many external groups, including the House Veterans' Affairs Subcommittee on Oversight and Investigations.

The public and those in Congress who support an improved VA system for veterans should not be alarmed by GAO's comments. When GAO completes its report, VA will provide its own detailed analysis and views regarding its contents. VA is prepared to effectively manage any potential risks or obstacles to improve veterans' health care. There is no denying that VA is entering an era of great challenge and risk brought on by the competitive environment of reform. Risk is inherent in change, but failure to change is the greatest risk of all. VA is up to the task. We can and will be ready.

Jesse Brown
Secretary of Veterans Affairs

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

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# VETERANS' HEALTH CARE

## Efforts to Make VA Competitive May Create Significant Risks

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

GAO/T-HEHS-94-197

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as the Subcommittee continues to examine the veterans' health care provisions of the administration's proposed Health Security Act. We are conducting a series of studies--several of which were requested by Chairman Evans--on the potential effects of health reforms on the Department of Veterans Affairs (VA) health care system and options for restructuring veterans' health benefits. My comments this morning will focus on the preliminary results of work on one of those requests. Specifically, we will discuss

-- legal and structural barriers that could limit VA's ability to restructure its health care facilities into managed care plans and compete with private-sector health plans,

-- the extent to which the Health Security Act would overcome those barriers, and

-- the potential risks associated with efforts to make VA competitive with private-sector managed care plans.

Our work is based on meetings with VA central office and medical center officials and representatives from health maintenance organizations (HMO) and managed care associations, our reports over the last 10 to 15 years looking at managed care programs under Medicare and Medicaid, and our reports and ongoing work relating to veterans' health issues. We are currently drafting a report that will expand on the information we are presenting this morning.

RESULTS IN BRIEF

VA faces many challenges as it attempts to restructure its health care system to compete in a managed care environment. We identified more than 25 barriers that could hinder VA's efforts to establish competitive health plans. These barriers relate generally to (1) eligibility for VA health care services, (2) management flexibility to react to local conditions, (3) uncertainties about funding of VA health care services, (4) restrictions on marketing, and (5) VA's health care infrastructure. VA officials believe that for barriers other than those relating to VA's infrastructure, legislative action to exempt VA from a series of existing laws and regulations is essential if VA is to compete with private-sector health plans.

Most legal barriers that might limit VA's ability to compete with private-sector managed care plans would be addressed through the Health Security Act. For example, VA would be exempt from most federal contracting and personnel laws and regulations. In addition, VA eligibility would be reformed and new sources of funding established.

The act, however, would overcome many barriers by expanding entitlement to VA health care or by exempting VA from federal and state requirements developed to prevent fraud and abuse and ensure quality of and access to health care services. In addition, many of the structural barriers, such as VA's lack of adequate cost and utilization data, will likely inhibit its efforts to establish competitive health plans.

As a result, significant risks are associated with efforts to transform the VA direct delivery system into a series of managed care plans:

-- The expanded entitlement to free comprehensive care could add billions of dollars to VA appropriations if all veterans entitled to free care seek to enroll in VA health plans.

-- If capacity in VA health plans is limited, veterans with service-connected disabilities could be denied veterans health care benefits while high-income veterans with no service-connected disabilities are enrolled in VA health plans.

-- The potential for conflict-of-interest violations, kickback schemes, and diversion of patient care funds through related party transactions would be heightened because of exemptions from contracting, HMO, and Medicare requirements.

-- Complex revenue streams would make it increasingly difficult to keep appropriated and nonappropriated funds separate, creating the risk of violating a federal statute that requires that funds only be spent for the purpose for which they are appropriated.

-- Billions of additional dollars in start-up funds could be required to make VA health plans competitive because VA has not completely assessed what it must do to become a competing provider.

-- Setting accurate premiums, determining when it is best to contract for services rather than provide them directly, and recovering the costs of services provided to other health plans through contracts and sharing agreements will be difficult because VA lacks adequate systems to track costs and utilization.

-- Abuse of VA's enrollment process could increase because VA lacks adequate methods for verifying veterans' eligibility status.

-- Further decentralization of VA management could heighten risks created through exemptions from federal laws and regulations.

Obviously, the risks would be decreased to the extent that VA reinstitutes the internal controls that would be eliminated through the exemptions.

BACKGROUND

When the VA health care system was established in 1930, public and private health insurance were virtually nonexistent. VA developed its system as a direct delivery system with the government owning and operating its own health care facilities. It became the nation's largest direct delivery system with 171 hospitals and more than 200 outpatient clinics.

With the subsequent growth of public and private health insurance programs, most veterans now have one or more alternatives to VA health care. In 1990, 9 out of 10 veterans had other health care coverage in addition to access to services provided by VA. For example, about 27 percent of veterans were eligible for Medicare.

Still, about 2.2 million veterans made more than 20 million outpatient visits to VA health care facilities and had more than 970,000 hospital stays in 1991. Of these veterans, about 1 million had disabilities incurred in or aggravated by military service (service-connected), and 1.2 million had no disabling conditions relating to military service (nonservice-connected).

Veterans who use VA health care services tend to have lower incomes and less private insurance coverage than veterans using other providers. In other words, in addition to providing treatment for service-connected disabilities, VA serves as a safety

net for veterans lacking the resources to pay for private-sector health care.

Reforms of the nation's health financing system, such as those under consideration, would reduce the number of uninsured veterans. As a result, many veterans who currently rely on VA because they do not have health insurance or cannot afford the copayments and deductibles that would be required by private-sector hospitals and physicians, might seek care closer to their homes.

Of the many health reform proposals being considered, only one--the administration's proposed Health Security Act--would change the VA health care delivery system or VA eligibility to try to limit VA's potential loss of workload.

The Health Security Act would fundamentally change both how VA operates and the benefits to which veterans using VA are entitled. In this regard, the act would transform VA facilities into a series of managed care plans to compete with private-sector plans. This type of restructuring is already taking place in the private sector as hospitals and individual providers increasingly create or join managed care plans.

## BARRIERS COULD LIMIT VA'S ABILITY TO COMPETE WITH PRIVATE-SECTOR MANAGED CARE PLANS

We identified more than 25 barriers that could limit VA's ability to effectively compete with private-sector health plans. VA officials believe legislative relief is needed to overcome many of the barriers, some of which follow:

- -- Under the complex eligibility and entitlement provisions of chapter 17 of title 38 of the U.S. Code, most veterans are not eligible for the full range of comprehensive health care services required in a managed care environment.
- -- Veterans' dependents are not currently eligible for care in VA facilities, placing VA at a competitive disadvantage in trying to enroll veterans.
- -- Complex federal procurement laws and regulations limit VA's flexibility in procuring items and services.
- -- Requirements under section 510 of title 38 U.S.C. that VA notify the Congress before closing or relocating VA facilities would make it difficult to quickly react to market conditions by closing underused or inefficient facilities.
- -- Federal personnel requirements under titles 5 and 38 of the U.S. Code make it difficult to hire and fire employees and set pay levels to respond to local conditions.
- -- VA has to rely almost entirely on federal appropriations to pay for health care services and modernize its equipment and facilities.
- -- VA is restricted in conducting market research by the Paperwork Reduction Act.

Following are some barriers relating to VA's existing health care infrastructure, however, that could be addressed without legislation, although additional resources would be needed:

- -- VA's inadequate cost and utilization data do not support its move to a managed care system.
- -- Many VA facilities are outdated and lack the patient amenities of private-sector hospitals.

-- VA lacks a facilities network that would allow veterans to obtain health care services close to their homes.

-- Many veterans' negatively view the quality of care and customer service at VA facilities.

-- Centralized management limits the ability of VA health plans to react to local conditions.

-- A shortage of primary care physicians needed to quickly adopt managed care. About 20 percent of VA physicians are primary care physicians or generalists; about 60 percent of a managed care plan's physicians are typically primary care physicians.

-- VA lacks expertise in establishing and operating managed care plans.

-- Veterans used to "showing up" for treatment at VA hospitals and clinics without appointments will have to be educated on accessing care through a managed care system.

-- Private-sector health plans may be unwilling to contract with VA unless it grants their physicians admitting rights and meets other requirements established by the health plans.

## THE HEALTH SECURITY ACT WOULD ADDRESS MOST LEGAL BARRIERS

The Health Security Act would address most of the legal barriers mentioned, largely through expansions in VA entitlement and exemptions from federal and state requirements. For example, the act would authorize

-- VA to provide the same set of comprehensive health care benefits to veterans enrolling in VA health plans as provided by competing managed care plans;

-- VA to enroll veterans' dependents in VA health plans and to have broad authority to contract for health care services, enabling it to provide care to dependents either in VA facilities or through contract care;

-- VA to contract for services to a VA health plan without regard to laws requiring competitive procedures;[1]

-- VA health plans to be exempt from requirements that the VA notify the Congress before administrative reorganizations;

-- VA to be exempt from most federal personnel requirements and to establish its own personnel system tailored to individual health plan needs;

-- VA health plans to be deemed Medicare providers and Medicare HMOs, exempting VA from Medicare requirements; and

-- VA to market its health plans.

The act also contains several new financing mechanisms to help offset the costs of VA health plans. For example, VA would be authorized to recover and retain from Medicare the costs of health care services provided to higher income nonservice-connected, Medicare-eligible veterans. VA would also be authorized to retain

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[1]Under amendments approved by the Subcommittee on Hospitals and Health Care, VA could contract for any health care resource without regard to most procurement laws and regulations.

any premiums (both the employer and employee shares), copayments, and deductibles for veterans enrolling in VA health plans. In addition, VA would be authorized to sell its health care services to other health plans to provide services to veterans.

To give VA additional flexibility in financing health plan operations and construction projects, VA health plan revenues, including premiums, copayments and coinsurance, deductibles, and amounts received as reimbursements from other health plans for services provided to its enrollees, would be deposited in a revolving fund. The funds would be available without fiscal year limitations and could be distributed among VA health plans. VA would not be allowed to retain funds for items and services paid for through appropriations.

Unlike private-sector health plans, VA health plans would not be allowed to put funds from the revolving fund into investments. In addition, the Health Security Act would not establish specific reserves for VA health plans.

Finally, $3.3 billion would be appropriated over a 3-year period to cover construction of additional outpatient clinics, renovation of existing facilities, and other start-up costs for the health plans.[2]

Although these changes would help VA market competitive managed care plans, they would also create significant risks--risks to the government in higher costs and increased exposure to fraud and abuse and risks to veterans in decreased access to and quality of care. I would now like to discuss some of those risks.

## EXPANDED ENTITLEMENT COULD ADD BILLIONS TO VA APPROPRIATIONS

Under the provisions of the Health Security Act, about 9 million veterans would be entitled to free comprehensive health care benefits if they enroll in VA health plans (core group veterans). This entitlement could require VA appropriations of about $16 billion just to cover the premiums of core group enrollees. Although the entitlement expansion would increase overall government health care spending, most of the increase in VA appropriations would result from cost shifting from Medicare and other programs.

### About 9 Million Veterans Would Be Entitled to Free Comprehensive Care

The Health Security Act would greatly expand the number of veterans entitled to free comprehensive health care services. Currently, about 450,000 veterans with service-connected disabilities rated at 50 percent or higher are entitled to free comprehensive health care services from VA.[3] While millions of other veterans are eligible for free care from VA, they are entitled only to certain services, such as inpatient hospital care or outpatient treatment for their service-connected disabilities. Provision of other services is limited to services that can be provided within available resources. Under the Health Security Act, about 9 million core group veterans, including service-

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[2]Increased to $4.05 billion by the Subcommittee on Hospitals and Health Care.

[3]Nursing home care is currently an optional benefit for all veterans. Under amendments to the Health Security Act approved by the Subcommittee on Hospitals and Health Care, nursing home care would become a mandatory benefit for veterans with service-connected disabilities rated at 50 percent or higher and any veteran whose need for nursing home care results from a service-connected disability.

connected veterans, low-income veterans, former prisoners of war, and veterans of World War I or the Mexican Border period, would be entitled to free comprehensive inpatient and outpatient care if they enrolled in a VA health plan. Many of these veterans--those with incomes below 150 percent of the poverty level--would also be entitled to subsidized care if they enrolled in a private-sector health plan.

These provisions have two implications. First, if VA health plans succeed in attracting all veterans entitled to free care, VA could end up paying the veterans' cost share of premiums and other cost sharing for 9 million or more veterans. For the estimated 3.3 million Medicare-eligible veterans in the core group, VA would pay, through appropriations, the entire cost of their comprehensive benefit package. On the basis of nationwide average Medicare HMO payment rates, this could require about $13.5 billion in appropriations just to cover the costs of premiums. An additional $2.4 billion in VA appropriations could be required to cover the enrollee share of premiums for the core group veterans who are not Medicare eligible. Additional appropriations would also be needed to cover (1) the costs of copayments, deductibles, and coinsurance for the core group veterans and (2) the employer share of premiums for self-employed core group veterans.

Because the veteran population is aging rapidly, the potential cost implications of expanding entitlement to free comprehensive VA services for Medicare-eligible veterans are even more significant. In 1990, about 27 percent of the veteran population was Medicare eligible, but by the year 2000, 37 percent of the veteran population will be over age 65. And, by 2020, 45 percent of the veteran population is expected to be over 65.

On the other hand, if VA health plans do not enroll enough veterans to make those plans financially viable, the government might have to subsidize the plans to keep them operational or allow the plans to fail, leaving one or more regions of the country without a VA health plan. In the latter case, veterans living in the regions without a VA health plan would have to join another health plan and pay the employee portion of the premium. Essentially, veterans from failed VA health plans would no longer have VA benefits. Such a result may not be politically feasible, resulting in legislation to permit the government to pay the premiums and cost sharing of veterans enrolling in private-sector health plans.

## SERVICE-CONNECTED VETERANS MAY HAVE MORE DIFFICULTY ACCESSING VA HEALTH CARE

Service-connected veterans could find it harder to access their veterans benefits under the Health Security Act for several reasons.

First, enrollment in a VA health plan would be on a first-come, first-served basis under the Health Security Act, shifting VA priorities away from service-connected and low-income veterans.[4] Nonservice-connected veterans with high incomes and dependents of veterans would have the same priority for enrollment as core group veterans. As long as VA health plans have the capacity to enroll all veterans and dependents seeking to enroll, this shift in priorities will not affect service-connected veterans.

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[4]Chapter 17 of title 38 U.S.C. establishes priorities for care in VA treatment facilities. Generally, veterans with service-connected disabilities, former prisoners of war, and veterans with low incomes have the highest priorities for care when space or resources are not adequate to meet all veterans' needs.

If a VA health plan does not have the capacity to provide services to all veterans seeking to enroll in the plan, some veterans in the core group could be denied enrollment in the VA health plan and thus a significant portion of their veterans health benefits. At the same time, higher income nonservice-connected veterans and their dependents who enrolled in the VA health plan before it reached capacity would be guaranteed the comprehensive benefit package from the VA health plan. VA has stated its intent to market its plans to high-income nonservice-connected veterans, which would enable it to obtain Medicare and employer reimbursements.

Second, service-connected veterans enrolling in non-VA health plans may find it difficult to obtain care for their service-connected disabilities from VA. As I testified before this Subcommittee in April, service-connected veterans participating in our focus groups frequently indicated that they used VA only for treatment of their service-connected disabilities. These veterans choosing to enroll in non-VA plans could no longer use VA for treatment of their service-connected disability if the treatment is a covered service under the comprehensive benefit package unless their health plan agreed to pay VA for the care.

Originally, the Health Security Act would have required the veteran's private-sector health plan to pay the full and actual cost of care provided by a VA health plan. This could have made service-connected veterans liable for any copayments and deductibles imposed by their private-sector health plan. The Subcommittee on Hospitals and Health Care approved an amendment to the act to provide that VA health plans could not impose cost-sharing requirements for specialized services provided to service-connected veterans enrolled in non-VA health plans.

Because the VA health plans would now be liable for such costs without full reimbursement, they would have little financial incentive to provide treatment to service-connected veterans enrolled in other health plans. They would, however, obtain full reimbursement for services provided to nonservice-connected veterans enrolled in non-VA health plans.

## EXEMPTIONS FROM CONTRACTING REQUIREMENTS HEIGHTEN POTENTIAL FOR FRAUD AND ABUSE

Reducing contracting requirements heightens the potential for fraud and abuse. The Health Security Act would exempt VA from competitive bidding requirements in the procurement of services by a VA health plan and expand VA's sharing authority. Amendments to the act approved by the Subcommittee on Hospitals and Health Care broadened VA's exemption from contracting requirements. Under these amendments, health plans would be exempt from virtually all federal contracting laws and regulations in obtaining a health care resource, including the Procurement Integrity Act and perhaps even minimum wage statutes such as the Walsh Healy Act. In addition, losing bidders would no longer be allowed to file bid protests, and VA would no longer be subject to any laws or regulations mandating or giving priority to any source of supply, such as small businesses or minority contractors.

VA has a long history of problems in administering contracts and sharing agreements. For example, in a 1987 audit of scarce medical specialist contracts, VA's Inspector General reported that VA medical centers had awarded contracts for more services than were needed, paid for services they had not received, and had not established controls to ensure that contractor performance and billing complied with contract terms.[5] Our July 1992 follow-up to the Inspector General's report found that VA still lacked

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[5]Audits of Selected Aspects of VA's Program for Sharing Scarce Medical Resources, Report No: 7AM-A99-089, July 15, 1987.

sufficient data and evaluation criteria to ensure that problems were identified and corrected.[6]

Because VA medical centers' senior managers often receive part-time employment incomes from medical schools that receive millions of dollars through VA contracts, conflicts of interest could arise. In April 1993, we reported to this Subcommittee that these managers nevertheless participated in award or administration of contracts with medical schools. The expanded contracting envisioned under the Health Security Act both with medical schools and private organizations greatly increases the potential for conflicts to arise.

Although some bid protests may result in delays in individual procurements, we believe the government benefits overall from a system that permits review of procurement decisions and helps to ensure fairness in the procurement process. Revisions to federal procurement procedures are being considered as part of efforts to implement the recommendations made through the National Performance Review. As a general rule, GAO favors a consistent procurement process governmentwide.

## EXEMPTING VA FROM RISK CONTRACTING REQUIREMENTS COULD PLACE BOTH THE GOVERNMENT AND VETERANS AT RISK

In addition to exemptions from general contracting requirements, VA health plans would be exempt from specific requirements relating to risk contracting, such as those that apply to Medicare HMOs. Because VA has no prior experience in risk contracting, such exemptions heighten the potential for fraud and abuse and could affect veterans' access to needed medical services. Although VA managed care plans would be expected, to the extent VA decides practicable, to comply with regional alliance standards, the regional alliances could not reject a VA health plan for any reason.

Under risk contracting, individual physicians or groups of physicians are paid a fixed monthly amount per enrolled recipient (capitation) to provide a defined set of items and services to all enrollees. This gives the contractor a financial incentive to control the use of services and ensure that only necessary care is provided. Although capitation has significant potential for containing health care costs, it also poses the danger of diminished quality of care should a contractor try to cut costs by inappropriately reducing services to enrollees.

Generally, the closer financial incentives are to individual treatment decisions and the more risk transferred to individual physicians or small groups of physicians, the higher the potential for adverse effects on quality of care. The amount of financial risk is lowest when the capitation covers only primary care services and increases as the physician or group of physicians is made responsible for a wider range of services, such as care by specialists and hospital care.

Although risk contracting is a common practice among managed care plans, the practice requires that the contractor has sufficient enrollment to spread the risk. VA plans to engage in risk contracting with private health plans and individual providers. If VA contracts with individual providers who have too narrow a patient base, the providers have greater incentive to withhold services, and the potential for their insolvency increases.

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[6] VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

VA health plans would also not be accountable to Medicare safeguards. Because of their deemed Medicare status under the Health Security Act, the Health Care Financing Administration would have little recourse against VA health plans if they fail to enforce Medicare safeguards. These safeguards were instituted over many years in response to a history of Medicare abuses by managed care plans. Practices found in some managed care plans include underfinancing plan operations, disregarding complaints, and denying needed treatments. With limited experience in preventing or detecting such activities, VA health plans would be increasingly vulnerable to fraud and abuse.

Before a managed care plan can enter a risk contract with Medicare, it must meet both Medicare-specific and federal HMO requirements. These requirements essentially establish minimum standards for HMOs. For example, managed care plans must meet certain financial solvency requirements to protect enrollees against the risks of an HMO's bankruptcy.

Medicare and federal HMO requirements

-- establish standards for risk contracting,

-- require disclosure of ownership and control arrangements and related party transactions to prevent diversion of patient care funds,

-- require that health plans have prior operating experience,

-- define minimum quality assurance mechanisms,

-- establish reserve requirements to ensure that health plans maintain adequate funds to pay for health care services, and

-- regulate marketing activities.

As deemed Medicare HMOs, VA health plans would not have to comply with these requirements.

## COMPLEX REVENUE STREAMS WOULD INCREASE VA's RISK OF VIOLATING STATUTORY RESTRICTIONS ON USE OF APPROPRIATED FUNDS

Although VA is improving its financial management systems, the systems will face additional challenges under managed care because of the complexities of multiple revenue sources and accounts to which expenses must be charged. Without effective and reliable systems, VA health plans could violate statutory restrictions on use of appropriated funds. VA's financial records would not reflect the costs of the various programs, making informed decision-making difficult.

VA accounting systems were not designed to accommodate the many funding sources and accounts to which expenses must be charged. Under the Health Security Act, expenses of providing medical care to veterans would be charged to two major funds, the medical care appropriation and the Health Plan Fund. Each would receive revenue from various sources. Revenues and payments would flow in many directions and involve many entities both inside and outside of VA. VA estimates that health plans could have 30 different revenue streams. For example, anticipated revenue sources include appropriations, Medicare payments, Department of Defense (DOD) and Indian Health Service reimbursements, enrollee premium payments from health alliances, enrollee copayments and deductibles, fee-for-service payments from private health plans, and intra-VA payments. These revenues would be deposited in one of the two funds depending on whether the patient is in the core group entitled to free care or not. Costs of providing care must also be debited to the correct fund. Failure to charge the cost of each

patient's care to the proper account would violate statutory restrictions on the use of appropriated funds and could lead to shortages in appropriations. Also, the financial records would not reflect the costs of providing care to each type of beneficiary. Thus, no informed decision-making would be possible.

These problems would be partially addressed through an amendment to the Health Security Act approved by the Subcommittee on Hospitals and Health Care by combining appropriated and nonappropriated funds for the comprehensive benefit package in the Health Plan Fund. The issue would still remain, however, for those health care benefits provided under chapter 17 of 38 U.S.C. that are not covered under the comprehensive benefits package.

## ADDITIONAL FUNDS MAY BE NEEDED TO MAKE VA PLANS COMPETITIVE

The Health Security Act would create a Veterans Health Care Investment Fund with an initial authorization of $3.3 billion over 3 years.[7] The amendments to the Health Security Act approved by the Subcommittee on Hospitals and Health Care specify that the funds could be used for start-up costs for VA health plans, including consulting services, equipment, improving management information and accounting systems, marketing, minor construction, and, with some restrictions, major construction. The fund could, for example, be used to address the shortage of primary care facilities and the lack of patient amenities in outdated VA hospitals.

The funds to be appropriated to the Investment Fund are not, however, based on an assessment of what changes need to be made to make VA health plans competitive. VA is making such an assessment but has not yet developed an estimate of start-up costs or identified the cost of construction projects needed to bring VA facilities up to private-sector standards. In addition, our ongoing work on planned VA construction projects indicates that VA does not have an effective method for identifying and prioritizing construction needs within its recently established health care networks. As a result, VA does not know where the funds should be spent or whether the funds to be appropriated are adequate.

Without an assessment of start-up costs, the Congress may be faced with having to appropriate billions of dollars more in the future to make VA health plans competitive. In our opinion, the Congress should know in advance what VA believes it will take to improve its facilities and expand its provider network. The Congress could then decide whether to appropriate the funds to establish VA health plans.

Currently, however, the start-up funds could essentially represent a "foot in the door," making it hard for the Congress to limit future expenditures to make VA health plans competitive.

## INADEQUATE COST AND UTILIZATION DATA INCREASE RISKS IN PRICING AND CONTRACTING DECISIONS

One of the most significant barriers to VA successfully competing against private-sector managed care plans is VA's inability to generate accurate cost data on items and services that it provides and estimate potential use of health care services. Without such data, VA health plans cannot set accurate premiums, determine when to contract for services rather than provide them directly, or set prices for services sold to other health plans that are adequate to recover costs. As a result, the financial

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[7]Increased to $4.05 million by amendments approved by the Subcommittee on Hospitals and Health Care.

risk of VA health plans incurring substantial losses is significant.

If VA sets premiums too low, additional funds may need to be appropriated to cover any shortages. Without such an appropriation, VA health plans may be unable to provide needed health care services with available funds. This would create an incentive to deny VA enrollees needed health care services or inappropriately divert funds appropriated for VA health care benefits not covered under the comprehensive benefits plan to pay for health care provided to veterans and their dependents under the VA health plan.

Premiums set too high, on the other hand, would decrease the need for appropriated funds by shifting more of the costs of veterans' health care to veterans' employers. It would also benefit enrollees in non-VA health plans--both veterans and nonveterans--by increasing the employers' share of premiums. This is because the employer contribution toward a health plan's premium would be set at 80 percent of the weighted average of the premiums for all participating health plans; the enrollee would pay the difference between the premium and the employer contribution. Under the Health Security Act, the regional alliances could reject non-VA plans but they would be required to accept whatever premiums VA health plans propose. In fact, regional alliances would not be allowed to reject VA health plans for any reason.

VA premiums may be higher than premiums of competing health plans if their costs are higher or their enrollees are more disabled or older.[8] Because veterans are older than the general population, their health care utilization and the costs of providing services can be expected to be higher than those of the overall population.

Just as cost and utilization data are critical in setting VA health plan premiums, they would be critical in setting capitation payments to risk contractors. Rates set too high could affect the financial solvency of VA health plans; rates set too low could affect the solvency of the risk contractors and lead to underservicing of health plan enrollees.

Accurate cost data are also important in determining when to purchase health care services from non-VA providers. We noted in our December 1992 Transition Series report on the VA that it has not provided clear guidance on how cost comparisons should be made to determine if care could be purchased more economically than VA could provide it.[9] Our ongoing work shows, however, that VA medical centers still do not know how to make such cost comparisons.

Finally, VA needs accurate cost data to determine appropriate prices to charge for items and services sold to other health plans. If prices are set too low, funds from other sources would be needed to subsidize losses, and less money will be available to provide services to veterans.

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[8]The effects of inaccurate premiums would depend on the risk adjustments made by regional alliances. For example, if VA premiums are set too low but VA receives a favorable risk adjustment for enrolling an older and more disabled population, then the effects of the low premiums would, at least to some extent, be offset. If, on the other hand, the risk adjustment is not favorable to VA, then premiums set too low would heighten VA's problems in trying to provide care with available resources.

[9]Veterans' Affairs Issues (GAO/OCG-93-21TR, Dec. 1992).

ELIGIBILITY VERIFICATION WOULD BE MORE DIFFICULT FOR VA THAN FOR PRIVATE-SECTOR PLANS

Unlike private-sector managed care plans that can enroll any individual who applies, specific eligibility criteria exists for enrollment in VA health plans. This creates an additional burden on VA health plans to establish mechanisms to quickly (1) verify an applicant's eligibility to enroll in a VA health and (2) determine whether they are entitled to free care. Without an adequate eligibility verification system, VA runs the risk of enrolling ineligible individuals and providing them free care.

Under the Health Security Act, VA health plans could enroll only veterans, their dependents, and Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) beneficiaries. As I discussed earlier, veterans in the core group--service-connected veterans, low-income veterans, former prisoners of war, and veterans of World War I or the Mexican Border Period--would be entitled to free comprehensive health care services if they enroll in VA health plans.

VA does not have a central database on veterans' health care eligibility to enable it to quickly determine whether an individual meets the basic eligibility requirement--that he or she is a veteran or CHAMPVA beneficiary. The Beneficiary Identification and Records Locator System (BIRLS), VA's most complete database of information on veterans, contains Social Security numbers on only about 18 million of the approximately 27 million veterans. In addition, BIRLS contains no data on veterans' incomes and incomplete data on service-connected disabilities. As a result, it would be of limited use in determining an individual's eligibility to enroll in a VA health plan.

In addition, VA currently lacks an adequate system for determining whether a veteran is in one of the core group categories and thus eligible for free care. VA can quickly tell whether a veteran has a compensable service-connected disability through a check against its computerized Compensation and Pension File but has no way of quickly verifying core group status of most other veterans. For example, the Compensation and Pension file does not contain records of most veterans with "0" percent service-connected disabilities because they do not receive cash payments. VA estimates, however, that about 2 million veterans have "0" percent disabilities.

Similarly, VA cannot quickly verify the incomes of nonservice-connected veterans to determine in which eligibility category to place them. Preliminary results from VA's first income verification match against tax records, in December 1993, showed that about 18 percent of nonservice-connected veterans underreported their incomes when applying for VA health care. Without a system that gives VA prompt access to income data, VA may incorrectly place veterans or nonveterans in the core group and provide free enrollment in the VA health plan. The income verification system is still being tested, and VA does not plan to conduct another match against tax records until November 1994.

FURTHER DECENTRALIZATION COULD INCREASE RISKS

The final risk I would like to discuss is VA's plan to further decentralize management.

Failure to monitor policy implementation under VA's decentralized management structure has been a recurring theme in our reports on VA health programs for many years. In both our 1988 and 1992 Transition Series reports on VA, we identified policy

implementation as one of the problems most needing management attention.

Many of the problems addressed by this Subcommittee have focused on the failure of VA's central office and regional offices to identify and correct problems. For example, the Subcommittee's March hearing on women veterans showed that many of the problems in meeting women veterans' health care needs that GAO originally identified in 1982 still existed 12 years later. Although VA central office directed medical centers to improve the thoroughness of women veterans' physical examinations, our 1994 follow-up showed that the central office had not reviewed and followed up on medical centers' action plans for improving compliance with examination requirements.

The combination of exemptions from federal laws and regulations to be authorized by the Health Security Act and VA medical centers' history of problems in complying with current laws, regulations, and procedures creates significant risks both to the federal government through increased costs and losses to fraud and abuse and to veterans and their dependents through poor monitoring of their health care. VA's plans to give medical centers and health plans greater autonomy would, at least until those medical centers and health plans demonstrate the ability to run a managed care plan, further increase the risks.

CONCLUSIONS

In conclusion, Mr. Chairman, the proposed Health Security Act would alleviate most of the legal barriers to VA's developing competitive managed care plans. It would do so, however, by eliminating a series of internal controls developed over many years to protect both the interests of the government and its citizens. VA health plans would be exempt from important fiscal and quality safeguards, greatly expanding VA's financial liabilities, potentially diminishing VA quality of care and veterans' access to care, and increasing the risk of fraud, waste, and abuse.

The challenge facing the Congress is in deciding whether the benefits to VA competitiveness that would be created through the provisions of the Health Security Act and its amendments outweigh the risks that would be created by those same provisions.

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Mr. Chairman, that concludes my prepared statement. We would be glad to answer any questions that you or the other Members of the Subcommittee may have.

RELATED GAO PRODUCTS

VA Health Care: VA and the Health Security Act (GAO/HEHS-94-159R, May 9, 1994).

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

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

VA Health Care: Veterans' Perceptions of VA Services and Its Role in Health Care Reform (GAO/T-HEHS-94-150, Apr. 20, 1994).

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

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

VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD/93-68, July 27, 1993).

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

VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 14, 1993).

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

Veterans' Health Care: Potential Effects of Health Care Reforms on VA's Major Construction Program (GAO/-T-HRD-93-19, May 6, 1993).

Veterans' Health Care: Potential Effects of Health Financing Reforms on Demand for VA Services (GAO/T-HRD-93-12, Mar. 31, 1993).

Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (GAO/T-HRD-93-7, Mar. 3, 1993).

VA Health Care: Actions Needed to Control Major Construction Costs (GAO/HRD-93-75, Feb. 26, 1993).

Veterans' Affairs Issues (GAO/OCG-93-21TR, Dec. 1992).

VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

VA Health Care: Demonstration Project Concerning Future Structure of Veterans' Health Reform (GAO/T-HRD-92-53, Aug. 11, 1992).

VA Health Care: Alternative Health Insurance Reduces Demand for VA Health Care (GAO/HRD-92-79, June 30, 1992).

(406091)

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES
Chairman Evans to Department of Veterans Affairs

**HONORABLE LANE EVANS**
**HOUSE VETERANS' AFFAIRS COMMITTEE**
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

**PREHEARING QUESTIONS ON VA EMPLOYEE TRAINING**

**BARRIERS AND RISKS: VA HEALTH CARE COMPETITIVENESS AND THE HEALTH SECURITY ACT**

**JUNE 29, 1994**

**Question 1:** Identify the most critical education and training needs of VA employees. How does VA plan to provide this training? For which employees is each type of identified training intended? How many employees will receive each type of training, how long will it take for all employees to complete this training and what is the total cost for this training?

**Answer:** Health Care Reform (HCR) will cause the VA employee education and training system to respond to new requirements in a constantly changing, competitive environment. Programs will concentrate on the urgent need for preparing employees to assume new roles and to facilitate the evolution of a new corporate culture. VA's ability to compete successfully under Health Care Reform depends on employees being current with developments in medical science and health care technology as well as the state, federal, and accreditation mandates (e.g. Occupational Safety and Health Administration, Nuclear Regulatory Commission, Joint Commission on Accreditation of Healthcare Organizations, and College of American Pathologists). Employees need the skills necessary to function in a managed care competitive environment. The Department of Veterans Affairs (VA) must develop and maintain a customer focused work force to ensure patient satisfaction.

This new agenda will be accomplished by an education and training system that is locally based to ensure that local priorities are addressed, but is also part of a network that will address corporate level training needs. The network will coordinate needs identified at groups of sites and address them efficiently and cost effectively on a systemwide basis which avoids duplication. The network will have an array of modalities available to address these needs in the best educational format including satellite television, computer aided instruction, and workshops.

Office of Academic Affairs (OAA) has identified systemwide educational needs related to health care reform through needs assessments conducted in November, 1993 and February, 1994. In November, every VA medical center (VAMC) was surveyed concerning its employee and leadership education needs. In February, exit interviews were conducted with members of each of the VA HCR work groups concerning their vision of systemwide education needs in their HCR area. Both surveys were consistent in identifying the following 11 major thematic domains where education and training are needed:

Primary/Managed Care
Marketing
Customer Service
Fiscal/Business/Contracting
Decision Support System/Decentralized Hospital Computer Program/
Information Resources Management
Environmental Management

Quality Management/Total Quality Improvement
Management Education
Patient Health Education/Prevention
Basic Benefits Package
Supplemental Benefits Package

These areas are the focal points for Veterans Health Administration (VHA's) educational programs. All VHA field facilities will be resurveyed in July to reaffirm that these will continue to be the key areas and to ask each VAMC to prioritize these areas as to urgency for educational interventions, and as to target groups of employees for education in each subject area. Meanwhile, the Office of Academic Affairs (OAA) is designating centers of expertise in these domains and conducting systemwide training and National Training Programs in several of these areas.

While we have listed domains of training we believe are vitally important based on needs assessments, VA cannot specify types of training, numbers of employees needing various types of training, estimated length of time for training to be completed, and cost until HCR legislation actually passes. VA has the capability to reach all employees needing various types of training because of its excellent educational infrastructure and the ability to use long distance learning technology such as satellite broadcasts, audio conferences, video tapes, and print.

**Question 2:** Identify current VA employee education and training programs and activities and provide the goal(s) or objective(s) and cost of each.

**Answer:** The Veterans Health Administration (VHA) Employee Education System operates from two major and converging foci. The first is VAMC-defined educational needs of employees; the second is nationally identified educational programs/priorities for employees. These two sources of educational needs identification -- top-down and bottom-up -- generate a vast panoply of education demand each year involving employees from groundskeeper to medical center director, and programs ranging from advanced cardiac life support training, to facility asbestos removal techniques, to AIDS counseling training, to construction management reorganization training.

1. Local Education Programs:

For VAMC defined needs, funds are provided directly to each medical center for employee education programs, courses, meetings and career development of its choice. Each facility has an Associate Chief of Staff for Education or Education liaison and a facility-wide Education Committee, with members such as the Personnel Training officer, the Associate Chief of Staff for Nursing Education, and all service chiefs. This committee does a facility-wide educational needs assessment each year and prioritizes the facility/employee education needs. For instance, there may be a need to train two new pump technicians for the heart-lung machine to replace departing employees (this is a 3 month $10,000 course to which the selected employees will be sent), and a need to train all employees in clinical areas about the dangers of tuberculosis exposure. In addition, a new Decentralized Hospital Computer Program (DHCP) package or fiscal management system may necessitate concentrated training of quality assurance, medical administrative or fiscal service employees.

Facilities use general operating revenues for employee education and receive funding from the Office of Academic Affairs (14) in several "pots;"

some from congressionally mandated programs and others from more flexible education funds. These funds include:

a) Tuition Support ($11.2 million/FY94) - provides tuition funding for courses taken at accredited educational institutions by VHA employees to improve employee on-the-job performance. Eligibility is limited to 17 VA shortage occupations as designated annually by the Secretary.

b) Tuition Reimbursement ($5.6 million/FY94) - provides funding for nursing series employees (Licensed Practical Nurse, Associate Degree nurse, RN, BA, MS, Ph.D.) for job-related course work. Tuition paid by the employee is reimbursed by VHA up to $2,000 per year. Continued VA employment - one year for each year of course work - is required.

c) Core Pit ($8.8 million /FY94) - Funds earmarked for education are provided to each VAMC as .001 tuition and meeting registration and .007 travel funds to meet medical center employees' education needs. These funds may be used for employees' attendance at key national educational meetings in their disciplines, local courses (either academic or commercially sponsored), courses put on by the VAMC itself, or to send employees to courses given at one of the 10 VHA regional education centers.

d) VAMC General Funds Expenditures ($112 million /FY93) - Local trainers (Personnel Trainer, Information Resources Management Service Chief, Associate Chief of Staff/Nursing Education, etc.), and persons especially trained at train-the-trainer (TTT) national sessions (e.g., AIDS and TQI (TTT)) also provide extensive in-service training at the local station. VAMC supported FTE and station funding expended for education are reported annually on the Cost Distribution Report (CDR).

2. National Employee Education Programs - ($11.4 million/FY94)

Simultaneously, nationwide VHA training needs are identified (e.g., 4 hours of sexual harassment training for every employee per Secretary Brown's October, 1993 mandate; laparoscopy training for VA general surgeons; National Performance Review (NPR) training in labor-management partnerships for personnel staff and medical center leadership). These needs are met by a VHA budget set-aside which funds the creation of each nationwide program to meet the training need in all VAMCs and reach all employees who are the target audience for that particular program. National Training Programs (NTP) are funded by VHA corporate funds ($4.9 million /FY94) and by funds from individual programs with a training need. ($6.5 million/FY94).

For instance, the Medical Care Cost Recovery (MCCR) program funds over $2 million in employee training annually as part of the deductible costs from the 3rd party payer revenue generated by the MCCR program. National training program needs, once identified, could be met by contracted programs, by paying VHA employees to attend private sector or other federal agency programs, or by VHA created programs. Because of the unique culture of VHA and the need to adapt programming to VAMC specific focus, most National Training Programs (NTPs) are produced by VHA's employee education system.

3. Employee Education Infrastructure

The Employee Education System (the NETwork or National Education and Training network) is the third component in the VHA employee

education system. VAMCs identify "bottom-up" educational needs and try to meet those needs in so far as possible with local staff trainers, and education support funds sent from the annual appropriations. Corporate VHA identifies national training needs ("top down") which require common programming to reach a target employee audience all over the country, and the NETwork sits in the middle as an education infrastructure prepared to assist corporate and local VHA in meeting those needs.

The NETwork consists of 10 regionally dispersed Education Centers, authorized by PL 92-541 in 1971, which are staffed by educators and program specialists, as well as administrative, computer-learning and logistical support staff. Each Education Center has access to conference and teaching space. Some have quarters for students on VA grounds to reduce per diem costs. These centers present programs in a variety of educational formats such as symposia, conferences, workshops, teleconferences, video instruction, self-instructional products, train-the-trainer sessions, computer assisted remote learning, and satellite TV broadcasts.

Each Education Center is paired with a Cooperative Health Manpower Education Program (CHEP). The CHEPs were authorized by PL 96-151 in 1979 as part of Area Health Education Centers (AHECs), and are located in small, rural VAMCs where they provide a model for VA-community collaboration in creating community-wide health care employee education programs to meet local needs common to all health providers in the community. These programs are supported by federal (VA) and private sector funds.

The Education Centers are supported by three National Production Centers which prepare educational materials, videos and educational TV programs as requested by the Centers. The NETwork ($21 million/FY94) stands ready to assist VHA in all aspects of employee education. Through this NETwork, VHA facilitates coordination of common needs, assures economies of scale, maintains and fully utilizes scarce educational equipment for long-distance learning and assists in the process of creating a national VHA corporate culture across a widely dispersed and increasingly independent health care delivery system.

All VAMCs are provided with full service medical libraries whose purchases of journals, texts and cataloging services are nationally coordinated to achieve purchasing economies and organized sharing; with receive-only satellite TV equipment for receipt of medical educational programming; and with medical media, slide production and other instructional media resources to assist in local teaching. In addition, training funds are provided to Special Centers of Excellence mandated by Congress for their unique educational programs needs (Geriatric Research, Education, and Clinical Centers, Center of Excellence in Substance Abuse Treatment and Education, Chaplain School).

4. Leadership/Career Development Training ($23.1 million/FY94) - A series of programs are funded from the corporate level to support career development of VA employees, and to provide a training system which will ensure a pipeline of trained personnel for all service level positions in both administrative (Title 5) and clinical (Title 38) series. A separate training program exists, beginning with an assessment center (Associate Director Training Program), to evaluate GS 13/14s and to prepare future medical center directors and assistant directors.

Leadership training programs not specifically in the career development track include:

- Women's Executive Leadership (WEL)

- Leadership VA

- Mid-Level Administrative Manager Training

- Executive Development Courses

- VHA Senior Management Conference. American Hospital Association, American College of Healthcare Executives , Fiscal Officers Conference, Human Resources Managers' Conference, Associate Directors Forum, etc.

- New Clinical Service Chief Management Training

- New Chief Of Staff Training

(The programs are further discussed in responses to Question 16.)

Question 21 requests information on VA training programs from 1989 - 1994 and seems directed at examining the relative allocation of educational resources to Title 38, Title 5, supervisory and wage grade employees.

VHA does not collect employee training information in this format. Programs are distinguished as:

a) Leadership Development (obviously supervisory level employees);

b) Career Development (aimed at all levels, Title 38/Title 5);

c) VAMC local programs (targets all employees as needed, Title 38 and Title 5);

d) National Training Programs (aimed at all employees in a particular programmatic target population - e.g. - Prosthetics Training Programs for Medical Administration Service GS 4,5,6 prosthetics clerks);

e) Grow-Your-Own Programs (for employee advancement within non-supervisory positions - e.g., nursing assistant/LPN or AD nursing employees supported for courses toward RN degree in Title 38);

f) NETwork programs: aimed at local, area and national program needs; such as (1) the National Training Program (NTP) for all Construction Management (CM) employees to assist them in CM reorganization; and (2) courses for environmental services employees on OSHA regulations, on-the-job safety, asbestos abatement, etc. Many of these employees are wage-grade. In the Health Care Reform Issues Awareness Program, OAA is preparing a special video tape to discuss issues relevant to non-supervisory, wage-grade, and GS 4-8 employees.

VHA programs are designed for VA employees' education needs. Target audiences of employees are not chosen based on appointment authority or necessarily grade level, but by job-related training needs. Funds for education are not administered by occupational series, but by major program areas of : (1) local VAMC funding; (2) National Training Program funding ; (3) leadership and career development funding; and (4) NETwork personnel and equipment support. Attachment A to this answer provides some specific examples of programs produced and employees reached by the NETwork Education Centers in 1992. Similar data can be

retrieved for 1989-94 if the Committee desires, but the general trends are similar from year to year.

**Question 3:** Identify each VA employee education and training program or activity which has been discontinued or disbanded during the last 12 months and evaluate the effectiveness of each such program. Explain why each program or activity has been discontinued or disbanded and identify current programs or activities which have similar or identical goal(s) or objective(s) to those of each discontinued or disbanded program. Identify the employees for whom each discontinued or disbanded program was intended.

**Answer:** VA employee education and training programs are based primarily on assessments of employee learning needs. Data from these needs assessments provide information about target audiences needing training in particular content areas. These data are used to develop educational programs which may extend over several years until the target audience is reached. When that happens, the program is said to have been completed (but not disbanded or discontinued). National Training Programs completed to date in FY 1994 include the following:

| Title of Program | Target Audience |
|---|---|
| Primary Care in Ambulatory Care | 4 person teams from Ambulatory Care Services in each VAMC |
| Hospice Care | 4 person teams from 90 VAMCs |
| Nursing Home Care of the Mentally Ill | 6 person teams from selected VA Nursing Home Care Units |
| Medical Ethics | 1 representative from the Ethics Advisory Committee at each VAMC |
| Medication Management in the Elderly | Chief of Pharmacy and 1 individual from the P & T Committee in each VAMC. |

There are no current National Training Programs that have similar or identical goals or objectives to these completed ones.

VHA continually re-evaluates educational programs and operating units in its employee education system to assure their relevance and the value of their contribution to education missions and, more recently, to health care reform. In the answer to Question 7 we outline various changes being made in the Office of Academic Affairs (OAA) Education Network and in other VHA programs to improve and streamline education efforts.

**Question 4:** For each program or activity listed in response to Question #2, identify the employees for whom the program is intended, the number of employees who have and have not yet received this training, the maximum number of employees who can receive this training annually and the annual cost per employee for this training.

**Answer:** See Response to Question 2.

**Question 5:** Identify duplication among current VA employee education and training programs and activities, describe VA's plans to eliminate this duplication, identify the training programs which will remain after duplication is eliminated, provide the goal(s) or objective(s) of each remaining program and describe possible cost savings from duplication elimination. Will possible cost savings be used to provide employee education and training?

**Answer:** As described in the answer to Question 2, the Veterans Health Administration Employee Education system identifies needs and provides education and training to meet those needs from both a local and a national focus. Currently, both national and local needs are met through efforts from the Office of Academic Affairs Employee Education NETwork, the Office of Administration's Health Care Recruitment and Retention Office and the Office of the Assistant Secretary for Human Resources and Administration, VAMC Human Resources Service training activities. Through the planning efforts begun by VA's own Health Care Reform Task Force, VA will further focus its efforts to provide training, education and career development for VA employees. The Acting Under Secretary for Health has recently appointed a VHA Education Task Force to analyze VHA career development programs in the light of health care reform. It is expected that the recommendations of this group will further improve the system and assist VA in meeting the challenges of health care reform.

Since the VHA education system is needs-based and involves careful coordination of the needs of local VAMCs into area-wide programs wherever possible, much potential for duplicative effort is eliminated. On the other hand, some programs must be repeatedly given until all employees have benefited from them, or must be repeated because job turnover is high in some occupational categories.

Most of employee education does not rely on fixed programs in the sense of organizational units; when we use the word program, we mean an educational course which may be given once or repeated several times for different VAMCs or area-wide audiences.

Only the Career Development portion of VHA education has some organizationally structured programs, such as Associate Director Training Program, or the various management training efforts which were institutionalized over the last decade. For instance, the Health Care Management and Education Center (HCMEC), the management training centers at Richmond and Kansas City, the education programs developed at the New Orleans Recruitment and Retention Center and the Career Field Intern Program. These programs are all being reevaluated by the Under Secretary's Education and Training Task Force with an eye to avoiding redundancy and strengthening the career development programs of VHA to make them more responsive to health care reform imperatives. Resources will be redirected within the Career Development Area as needed to realize the goals established by these advisory committee and VHA policy.

**Question 6:** Identify deficiencies in current VA employee education and training programs including employee needs not met by current programs. Describe VA's plans to eliminate these deficiencies. Identify the expected additional cost of programs to meet unmet employee training and education needs and to eliminate the identified deficiencies.

**Answer:** See Response to Question 1.

Based on two needs assessments about HCR training needs conducted during the past year, VHA has identified the following potential HCR related training areas: Primary/Managed Care, Marketing, Customer

Service, Fiscal/Business/Contracting, Information Systems, Environmental Management, Quality Management/Total Quality Improvement, Management Education, Patient Health Education/Prevention, Basic Benefits Package, and Supplemental Benefits Package. However, VHA cannot specify exact training needs until HCR legislation actually passes. When the legislative requirements are known, VHA will then form planning committees of content experts to recommend target audiences and educational methodologies. VHA will then be able to estimate costs associated with these new training requirements under HCR.

**Question 7:** Identify the specific goals of VA's planned restructuring of existing employee education and training. How will restructuring support a reformed health care system? Provide the expected cost and target date for completing this restructuring?

**Answer:** VHA is not planning any large-scale restructuring of employee education. There is no "expected cost" or target date for completion of a "restructuring." The employee education system of VHA by-and-large works well to identify VHA needs for employee education at both the local and the national level and to meet these needs within constrained resources. Local stations have great autonomy in planning and supporting training to meet local needs. Within funds provided for education and utilizing additional operating funds, VAMCs support extensive training both with local facility staff, through community/private sector and joint activities, and through VAMC programs supported and/or produced by their area Education Center. Funds are available annually to send staff to meetings and courses all over the country to augment and enhance their job skills. Career development funds are provided for courses designed to enhance skills and reach the next academic degree in 17 shortage clinical disciplines, for nursing series employees, and in 33 administrative career ladder training programs. Courses and programs with multi-institution applicability are produced at the Education Centers to achieve economies of scale.

Meanwhile, systemwide employee education needs are identified and programs are designed and delivered, either through the Education Centers, single national courses or long distance learning modalities such as satellite TV broadcast to each VAMC. In addition, systemwide career development occurs through the following:

- Nationally focused, year-long administrative training programs in 33 fields;
- An Associate Director training program;
- 3-week seminars for new clinical service chiefs and chiefs of staff;
- A vast array of management development courses/programs in both the federal and private sector for which the VA supports participants; and
- VA designed departmentwide programs such as Leadership VA and OPM's Women Executive Leadership (WEL) program.

There are areas of relative weakness in the current employee education system, and under the pressure of impending Health Care Reform VHA has reassessed its employee education system. The following improvements are now underway:

1) Career development field internship program has been returned to Academic Affairs central office management after numerous complaints of

drift and poor administration. An Advisory Committee will be convened to examine strengths/weaknesses and advise on future directions.

2) NETwork streamlining has taken place. For instance, there were 2 entire centers devoted to dental education only; one of these has been closed and the other will assume all dental education plus a broader array of programs in other specialty fields (such as prosthetics). NETwork Education Centers are being renamed and given a common purpose and focus on all employees, not just subsets of employees. A unit called the Health Care Management Education Center (HCMEC) was created by the previous Chief Medical Director to coordinate management education in VHA. While the idea may have been sound, the implementation did not achieve expected results and this unit has been closed and its resources redirected to management education in other venues.

3) A departmentwide committee is currently examining VA leadership training to identify opportunities to integrate and consolidate the three agencies training activities.

4) These adjustments to the employee education have not involved changes in resources nor changes in the major foci or programmatic areas of VHA employee education. Since needs assessment, rather than fixed programming drives VHA education initiatives, the system remains flexible and receptive to new needs and does not require major restructuring to adapt to changes in health care delivery, administrative innovations or even as sweeping a change as health care reform.

Questions 10 & 11 refer to costs and the changes in these under "restructuring." The annual expenditures for employee education are not expected to change much under a steady state system employing over 200,000 people. VHA employee education does not invest the 1.5 percent of personal services costs recommended by President Clinton at all VAMCs, or in all settings, but incremental resources will be sought for employee training as non-appropriated sources of income become available. For instance, training of all employees in customer service and a VHA-wide acculturation to a helping, supportive approach to patients, enrollees and their families will be a vast education project for VA.

The base resources for employee education, needed now and needed after health care reform transition education is completed, should approximate 1.5 percent of VHA's personal services budget, to meet major competing industry standards. Additional resources are expended in the health care industry job related training because the skill and knowledge base of medicine changes so rapidly.

VHA maintains a very good administrative cost/program delivery cost ratio. This efficiency will continue. For instance, only 10 percent of FTE are in administrative support of the Office of Academic Affairs NETwork; 90 percent of these staff create and teach programs. Similarly, at VAMCs a single secretary or Administrative Assistant supports a staff of educators.

In the future, resources will continue to be allocated by the process of needs assessment, prioritization, and efforts to achieve as much of what is needed as possible given limited resources. Advisory Boards and ad hoc committees will continue to be crucial in helping to set priorities, as will the Secretary, the Under Secretary for Health and the leaders of each VA hospital or clinic who intimately know the needs and career aspirations of their employees and who work with their Station Education Committee to meet those needs.

**Question 8:** In addition to restructuring existing employee education and training, describe other actions VA plans to take to enhance employee education and training to support a reformed health care system. Describe the goal or purpose and expected cost of each action.

**Answer:** See Response to Question 1.

**Question 9:** Identify the various entities throughout VHA which currently support or provide employee educational and training activities and describe the employee educational and training activities each supports or provides. Identify the total resources devoted to employee education and training program and activity by each entity and the resources devoted to program administrative employees and program delivery employees by each entity.

**Answer:** See Response to Question 2.

**Question 10:** Identify the various entities throughout VA which will support or provide employee educational and training activities, including supervisory and executive career development, after planned restructuring and describe how resources will be allotted among employee education and training programs and activities. Describe the employee educational and training activities each entity will support or provide and identify the total resources to be provided for each program or activity. Explain why this is the most effective/cost-efficient use of resources. For each entity, identify the resources which will be devoted to program administrative and program delivery.

**Answer:** See Response to Question 7.

**Question 11:** Identify the annual cost of VA training and education programs after restructuring and describe the methodology to be used to allocate resources among education and training programs and activities prior to and following restructuring.

**Answer:** See Response to Question 7.

**Question 12:** Describe how the training and education needs of VA employees are identified and prioritized.

**Answer:** Education and training needs of VA employees are identified at the local, regional, and national levels annually. At the local level VAMC Education Committees review educational needs from each Service. Services prioritize their own needs, and these needs are then prioritized at the hospital level. Some VAMCs conduct hospital-wide assessments; the results are then categorized/prioritized by the Education and Training Committee to determine training needs. The creation of new patient care services (e.g., Spinal Cord Injury clinics) or new fiscal or administrative mandates (e.g., Decision Support System) automatically creates new education needs as does the addition of new patient care equipment or technologies.

VHA's Education Centers also conduct educational needs' assessments of facilities in their catchment areas. These data are examined for recurring needs at multiple facilities which can best be met by Education Center sponsored area-wide programming.

Nationally, VA's Office of Academic Affairs (OAA) staff survey and interview senior level officials each year to determine educational needs and priorities for national programs and VHA corporate educational needs (e.g., EEO, OSHA regulations). OAA staff synthesize these data; consider

external influences on the Department such as JCAHO, new technology, and other Departmental needs; and recommend National Training Programs to the Office of the Under Secretary for Health. This Office designates certain areas for systemwide training.

**Question 13:** For each current VA employee education and training program, describe the procedure used to identify or select the employees to receive this training and the number of employees who participate annually in each education and training program.

**Answer:** Since most VHA employee education participants are employed within VA medical centers, identification and selection of participants most often occurs at the medical center level. Decisions are typically made by those most closely involved with the program for which an individual initiative is intended. Factors normally considered in making such decisions include:

- Needs assessment results;
- Program content/target audience (e.g. an HIV counseling program may be targeted to physicians, psychologists and social workers who counsel HIV patients and their families);
- Individual staff deficiencies and/or personal development plans; and
- Ability to provide coverage for staff away at training.

In most instances, the procedure used to identify or select employees involves the use of a program announcement or brochure outlining program objectives and proposed target audience.

The nature of the educational need being addressed along with available resources drive the decision regarding the number of employees who can be reached and the format of an educational offering. For those systemwide programs that attendance is limited, appropriate VACO officials may also be involved in the selection process. If, however, the need for employee training on a particular topic is widespread across the workforce of each VA medical center and will involve large numbers of employees, a train-the-trainer effort, videotape or satellite conference may be used to address the need. In those instances, little or no screening is necessary, and all employees receive the needed training.

The number of employees who participate annually in programs is provided in the response to Question 2.

**Question 14:** Provide the basis for determining the effectiveness of current employee education and training programs and rank programs in terms of effectiveness.

**Answer:** VA employs a variety of measures to determine the effectiveness of current employee education and training programs. In both formative and summative evaluations the most frequent measure we use is a questionnaire which participants complete at the end of each training program. Participants provide information about program relevance and usefulness, faculty, facilities, and suggestions for improvement. These data are invaluable in providing information about changes needed in courses which are to be repeated and about talented faculty for potential use in future programs.

In selected National Training Programs (NTP), VA uses 3-6 month follow-up reports and conference calls to ask participants about progress in action

plans participants developed during conference attendance. Information gleaned from these conference calls and reports is used to provide information to participants about effective strategies for use at the local level to achieve program objectives, identify model sites, and identify sites needing additional support.

VA has also used systemwide surveys in summative evaluations to determine effectiveness of educational methodology and/or impact at the facility level. AIDS Train-the-Trainer, HIV/Substance Abuse, and Health Care Problems of the Elderly National Training Programs are examples of programs using such surveys.

In addition, we use indirect measures to evaluate program effectiveness. The Department's dramatic improvement in JCAHO scores is an indirect measure of the success of its multi-year JCAHO Survey National Training Program. The Engineering and Training Service Center has used cost avoidance/cost reduction in evaluating its programs. If VAMC Engineering staff are not trained to maintain and operate equipment and utilities, service contracts must be utilized. The Engineering and Training Service Center has found that as a result of training, certain service contracts have been avoided, and over $6 million in cost savings has been achieved.

The Medical Care Cost Recovery (MCCR) program has used the dollars collected by the MCCR program each year as a measure of its success in training MCCR employees to provide billing and achieve third party insurance cost recovery. Within three years of initiating the MCCR training program, VHA cost recovery went from $148 million to $506 million.

VA does not rank programs. Evaluation is done by learners on objectives unique to their respective programs. Ranking would be inappropriate because our intent is to gather data to improve education, not compare different programs. Each training program is based on a determination of the needs of special groups of potential learners. The program is then tailor-made to the needs of this subgroup. There would be little value in comparing a training program for dentists which focuses on recognition of oral malignancies with a program for pharmacists which focuses on the implementation of unit dosage system in Pharmacy Service. Some programs are one hour long; others may run five days.

Each program is evaluated by each participant (based on program objectives) in compliance with a variety of educational accreditation bodies such as the Accreditation Council for Graduate Medical Education, American Nursing Association, etc.

Although changes in employee performance on the job are the final desired outcome from most employee education interventions, job performance and especially clinical care outcome assessment are difficult to measure directly. Measurements of the relationship of education to behavior change in these areas is currently the subject of intensive research in the Health Care Research and Development field. VHA is participating actively in such research. For instance, the Minneapolis Education Center has a grant from the Agency for Health Care Policy Research (AHCPR) to compare the relative effectiveness of different educational intervention strategies to teach the new AHCPR practice guidelines on bedsore management and prevention. They will determine which method of teaching bedsore guidelines results in the lowest rate of bedsore prevention/healing. Such research improves education interventions and addresses questions about teaching effectiveness that are equally relevant in the private and public sector.

**Question 15:** Which categories of employees consistently have little or no access to education, training and development activities? Explain this reduced access.

How will these employees be provided greater/equal access to education, training and development activities following restructuring?

**Answer:** See Response to Question 7.

**Question 16:** How are VA managers/executives currently being prepared to assume greater administrative roles and responsibilities? What percent of VA managers/executives have received this preparation?

Assess the effectiveness of this preparation and provide the basis for this assessment. Provide the per capita and annual total cost of this preparation, identify the entities which provide this preparation and the resources provided to each entity for this purpose.

**Answer:** These questions seek a description of the VHA system for management training and an evaluation of its strengths, weaknesses and new directions under health care reform. To answer this question, some definitions are helpful.

First, VHA **Management Training** refers to educational programs which are offered to employees in management positions throughout VHA to provide them with job-related skills and to assist their on-the-job performance. Courses of this nature are continually being given throughout VHA and are included in the lists of courses/participants in the answer to Questions 2, 4, 9 & 21. Zenger-Miller management training has been introduced to VHA and, as is usual in VHA's approach to courses offered by outside vendors, VHA is developing internal Zenger-Miller master trainers within its NETwork system to be able to offer this middle management training package widely within VHA. New service chiefs receive a three week set of seminars on management techniques at their level through a NETwork program, as do all new Chiefs of Staff.

Various local "management training" initiatives have been started over the last few years by individual hospital directors (Richmond, 1985-91), regional directors (Kansas City, 1990-94) and the Chief Medical Director (1991-94, HCMEC). These efforts have been reviewed recently and have been or are being discontinued since they were not coordinated with VHA-wide programming, did not evaluate or integrate their programs with VHA leadership goals, and did not clearly improve management training. Their resources are being redirected to broadly supported management training initiatives.

Second, VHA maintains **Career Development** programs, defined as programs which seek to provide the training/education and academic degree coursework needed by VHA employees who wish to advance along their career line. In order to remain competitive and enhance recruitment/ retention efforts, VHA supports career development initiatives for employees in shortage occupational categories. The VHA career development program has grown in response to congressional initiatives (e.g., nursing shortage of 1987-1991) and to lack of candidates of suitable diversity. VHA is now moving to provide overall career development policy. The fragmentary nature of programs was highlighted by VA's Health Care Reform Task Force; recommendations for consolidation, coordination and overall policy formulation across all employee disciplines were emphasized. Currently an Under Secretary Task Force on Employee

Education and Training is re-examining VHA programs with a view to further improvements.

Third, VHA maintains a series of **Leadership** programs focused on developing future Medical Center Directors and Associate Directors, and on identifying employees with future leadership potential from all GS 11-14 ranks for participation in the Departmental-wide programs of leadership development -- Leadership VA and Women's Executive Leadership (WEL). VHA also provides an Executive Development Program which supports seminars and coursework from other federal agencies and the private sector for its senior leadership in their job-related education. These offerings include the courses of the Federal Executive Institute's Health Care Executive Programs and such prominent business/organization schools as Yale, Michigan and Wharton. A Departmentwide Task Force, under Assistant Secretary Eugene Brickhouse is completing a survey and analysis of all VA-wide leadership training and is expected to identify opportunities for consolidation, areas which need expansion and opportunities for coordination between the three agencies.

VHA has sponsored the Associate Director Health Care Management Training Program (AD/HCMTP) since 1975 to prepare high potential mid-level managers to enter the hospital administration career field at the Associate Director level. The AD/HCMTP is primarily an experiential program but also provides participants with structured learning opportunities. Each trainee spends twelve to eighteen months in an assignment at a medical center under the supervision of the medical center director. Trainees also attend several seminars designed to provide in-depth coverage of medical center operations and development of leadership skills. Trainees are certified upon successful completion of the program and prior to their first appointment. Entry in the AD/HCMTP is highly competitive. The program is annually announced throughout VA and occasionally external candidates are solicited. Applicants are screened by a rating and ranking panel and the best qualified also participate in an assessment center. Out of several hundred applicants each year, approximately twenty are selected to participate. The AD/HCMTP is the primary feeder group for VHA's hospital administrators. Of the current 169 medical center directors all but twelve have participated in this program. Among these there are several physicians who completed a similar program for physician executives. About forty percent of the current cohort of directors possess advanced degrees including more than thirty with Master's Degrees in health care administration.

Question 18 asks the advantages and disadvantages of a unified management/executive development program Department-wide. In this reply we have tried to distinguish **leadership** and executive development from **management**. VA currently provides Department-wide leadership/executive development courses and even government-wide executive training is provided. VHA believes that management training and career development at the lower ranks (below SES, GS 13/15, Senior Title 38) is so discipline specific and related to the specifics of health care as an industry that it cannot be provided in Departmentwide or governmentwide educational initiatives. Some human resource management techniques may be common to all disciplines (and these are already taught across disciplines) but much of health care management is domain specific and requires training unique to the health care industry. For this reason, VHA has put its focus in management education and career development on discipline specific field internships and the academic course-work needed to acquire the credentials needed for advancement in the knowledge and skill intensive areas of health care delivery. Much of the education and training needed to advance in a health care career is not provided by the employer in the health care field, but must be acquired from legitimate academic

institutions which certify and credential health care workers. VHA does not try to replicate or displace this process, but instead requires the same standards and credentials needed for advancement within a health care discipline as does the private sector. When VHA has particular shortages or inadequate diversity in its employment in a given discipline, it provides tuition support or grants towards the acquisition of the requisite training to current employees as part of its recruitment, retention and grow-your-own program educational initiatives.

**Question 17:** How will VA managers/executives be prepared to assume greater administrative roles and responsibilities after restructuring? What percent of VA managers/executives will receive this preparation? Identify the entities which provide this preparation, the resources to be provided to each entity for this purpose and the total resources to be devoted to this preparation.

**Answer:** See Response to Question 7.

**Question 18:** Discuss the advantages and disadvantages of a unified management/ executive development system throughout VA. Will planned restructuring bring about a unified management/executive development system throughout VA? How?

**Answer:** See Response to Question 16.

**Question 19:** Describe in detail the costs and accomplishments of VA's multi-year Total Quality Management (TQM) and Continuous Quality Improvement (CQI) programs. Provide detailed information on the cost efficiencies and service delivery improvements which have resulted from these programs.

**Answer:** TQM is a philosophy that espouses organizational values that have been proven to increase efficiency and effectiveness. Included among these are continuous improvement, data driven decision-making, customer focus, and empowerment of employees. Veterans Health Administration (VHA) has been implementing TQM using a three-phased approach. The first phase began in FY 1992 and involved 13 VA medical facilities. It was devoted to learning how to apply TQM principles and techniques in a health care environment, and the 13 Phase I sites were appropriately called "pilot" sites. Late in FY 1992, 25 medical facilities were added in Phase II. In late FY 1993, over 100 medical facilities were added to VHA's TQM roster in a final Phase III. To date, almost all VA medical facilities are involved in implementing TQM principles and techniques. VHA has spent about ten million dollars for training and consulting in quality improvement related topics over the last three to four years. Anecdotal evidence of improved service to veterans abounds. A tiny sampling of quality activity from competition finalists for the prestigious Robert W. Carey Quality Award, the Department's highest award for quality, illustrates the kind of results VA medical facilities are achieving by applying TQM techniques and principles.

**Albany, New York, VA Medical Center** (1993 Carey Award overall winner) developed a clinical pathway for total hip replacement that reduced in-hospital length of stay and improved patient and staff satisfaction.

**Canandaigua, New York, VA Medical Center** (1993 Carey Award Honorable Mention) received "Commendation" status from Joint Commission on Accreditation of Healthcare Organizations.

**Kansas City, Kansas, VA Medical Center** (1992 Carey Health Care Category winner) developed a peer review process recognized as a

"model" and used to improve numerous aspects of patient care such as significant decreases in lengths of stay and mortality rates.

**Indianapolis, Indiana, VA Medical Center** has developed a program whereby employees volunteer time to assist in feeding patients.

**Oklahoma City, Oklahoma, VA Medical Center** reorganized Cardiology Clinic and reduced waiting time dramatically for new cardiology appointments.

**Dayton, Ohio, VA Medical Center** achieved a substantial improvement in the timeliness of administration of thrombolytic therapy.

**San Diego, California, VA Medical Center** achieved a significant decrease in cases of aspiration pneumonia.

**Tuscaloosa, Alabama, VA Medical Center** achieved significant improvements in numerous measures of patient satisfaction including staff courtesy, medications and special needs.

**White City, Oregon, Domiciliary** reduced patient injury incidents by over half in the past two years.

**Question 20:** Describe VA initiatives (not described in other responses) which prepare the Department and its employees to meet the demands of health care reform.

**Answer:** During the past year VHA identified Primary/Managed Care, Marketing, Customer Service, Fiscal/Business/Contracting, Information Systems, Environmental Management, Quality Management/Total Quality Improvement, Management Education, Patient Health Education/Prevention, Basic Benefits Package, and Supplemental Benefits Packages as potential training areas. During the past year VHA conducted the following HCR related training:

- 7 satellite broadcasts for top managers about current HCR directions and potential implications for VA. Examples of content areas included managed care/primary care, information systems, quality management, state directions, etc.;
- A National Training Program (NTP) on models of primary care for representatives from every VAMC Ambulatory Care Service;
- An Executive Communications NTP with a segment on marketing for approximately 50 VAMC Medical Directors;
- An AIDS NTP with a segment on primary care for AIDS clinical care providers;
- A Laparoscopy Training for Cholecystectomy NTP to help VAMCs be competitive with community hospitals;
- A JCAHO Survey Training NTP to maintain accreditation and provide a necessary ingredient for competition;
- A program on Managed Care for representatives from every VAMC in Region I. VHA video taped this program and distributed its systemwide; and
- TQI training throughout the system to emphasize the importance

of the customer and the importance of data and measurement in continuous quality improvement.

As mentioned in the responses to Questions 1 and 6, VHA will identify additional training when HCR legislation passes. VHA will use such legislation to define exact content areas. This will enable VHA to specify target audiences and educational methodologies.

**Question 21:** Provide information on VA training programs for the period fiscal year 1989 through fiscal year 1994 to date. Include the number and type of staff (non-supervisory, managerial/executive) trained and the dollars spent for each type of training for title 38 employees. If no data is available, please explain why.

Provide the same information for title 5 and wage grade employees.

Are title 38 and title 5 funds separately administered and how are expenditures for title 38 and title 5 and wage employees training tracked?

**Answer:** See Response to Question 2.

**Question 22:** Discuss the training provided by internal sources and by external sources (designate whether instructor was DVA permanent employee or contractor). Provide information by type of course (non-supervisory, supervisory, etc.), number of courses/programs, employees trained and dollars spent.

How is money for training disseminated to the regions/hospitals? How does VA ensure that training money disseminated to the components (HQ and regions) is spent on training?

**Answer:** All of our education and training programs are designed to provide the best possible content experts, planners and faculty commensurate with available resources.

If the focus of a program is entirely VA-specific, the faculty would be exclusively VA employees. For example, a program on Resource Planning Management (RPM) requires the use of VA faculty. Similarly, the expertise for a course on marketing is not likely to be found within the VA; therefore, outside experts are essential. Over time, however, the expertise can be institutionalized. TQI is an example of a program that required extensive outside consultation for development and implementation early on, but moved almost totally to VA staff as trainers as VHA moved from 20 pilot VAMCs to TQI training in 150 other medical centers. In other instances, course content might dictate a combination of internal and external faculty. For example, a national training program this year, entitled "Primary Care: A Foundation of Managed Care in Health Care Reform," involved 13 VA faculty and 3 external faculty.

The Cooperative Health Manpower Education Programs (CHEPs) are an excellent example of a combination of internal and external resources. CHEPs operate at the VA medical center level by creating educational partnerships between their host VAMCs, and community education, health care and health related institutions. In CHEP sponsored programs, faculty, staff, funds, and training facilities are contributed by a variety of public and private entities with similar educational needs.

With regard to dissemination of training funds, CORE PIT (Postgraduate and Inservice Training) funds are allocated annually directly to each medical center based on a formula incorporating such variables as personal

services dollars, FTE and distance from the VAMC to providers of employee education. Regions do not receive training funds from Office of Academic Affairs. National Training Programs and regional Education Center programs, which draw their employee audiences from the medical centers, are funded directly from VACO for the programs they offer to VHA employees.

At the end of the fiscal year, each medical center reports to Office of Academic Affairs the number of employees receiving training, number of educational episodes, and dollars used for those episodes.

Question 2 Attachment A

# *Program Activities And Employees Educated Through VHA NETwork Centers*

## *FY 1992*

*Office of Academic Affairs*
*June 1994*

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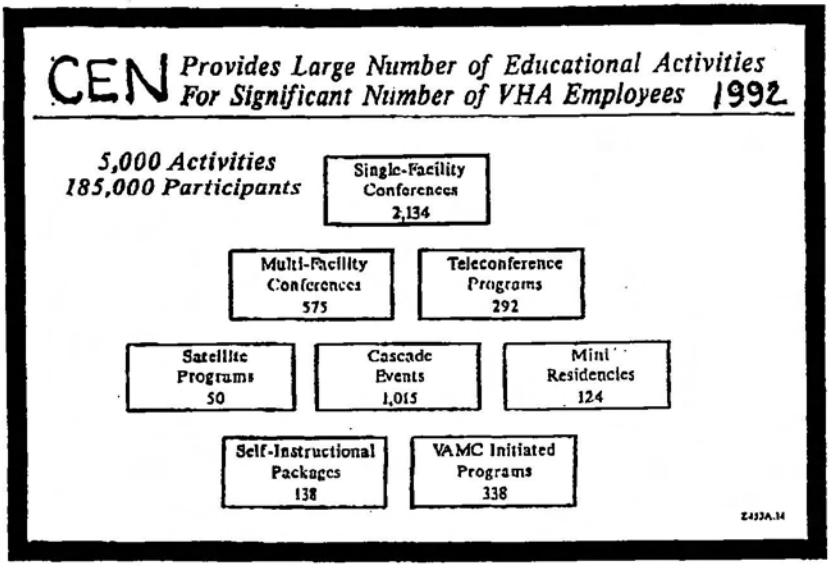
*The NETwork*- National Employee Education & Training NETwork consists of 10 Education Centers - formerly called Regional Medical Education Centers (RMEC-7); Engineering Training Center (ETC-1); Dental Education Center (DEC-1), and Continuing Education Center (CEC-1)

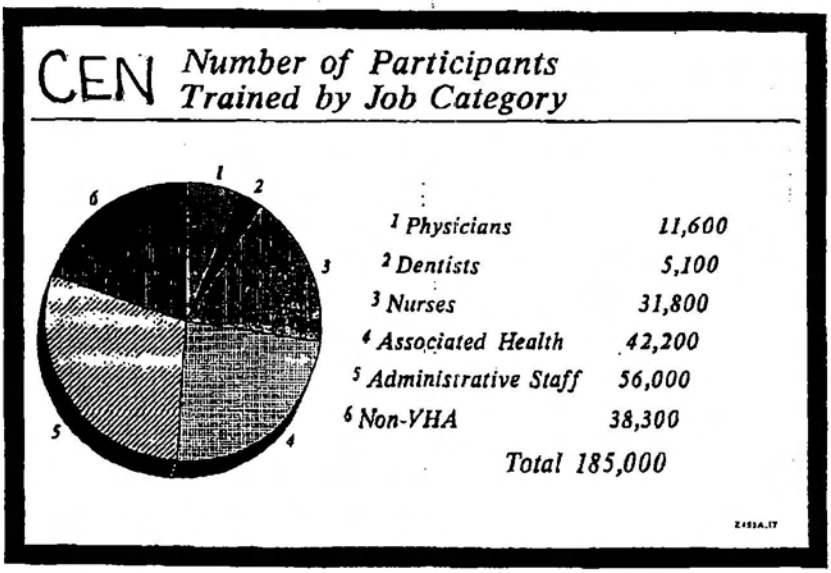
Collectively, at the time this presentation was made, they were termed the CEN-Continuing Education Network, which also included the National Production Centers (LRN-3)**LRS, RLRS? and Cooperative Health Education Programs (CHEP-9) in rural communities.

This *NETwork* produces requested programs and educational activities and materials for use at VAMC local education programs and at area-wide programs given at the Education Centers. In 1992, over 5000 activities were held at the Education Centers for 99,500 participants. These activities included some National Training Programs and a small portion of career development/leadership training courses, but did not include educational programs/training conducted at VAMCs without NETwork assistance or educational/ training activities in the private sector made available to VA employees through VA funding.



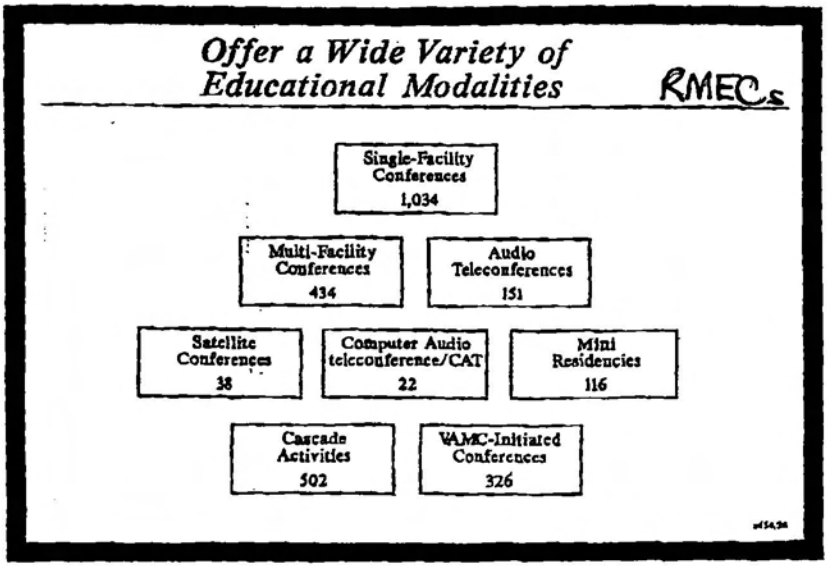

- The CEN puts on nearly 5,000 activities (conferences, workshops, etc.) for over 185,000 participants each year as well as providing considerable consultation, service and product development.
- This points out that the CEN provides a large volume of education and training to a huge number of VHA employees. It has the capability of impacting the entire work force.
- The CEN collectively puts on:

  2,134 .... Conferences - single facility
  575 .... Conferences - multi-facility
  292 .... Teleconference programs
  50 .... Satellite programs
  1,015 .... Cascading events
  124 .... Mini-residencies
  138 .... Self-Instructional Packages
  338 .... VAMC-Initiated Programs



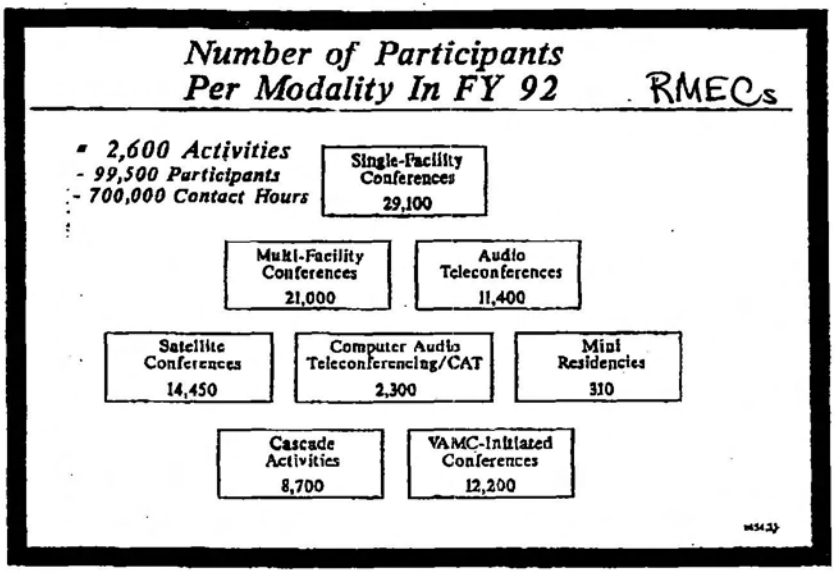

**In 1992, the CEN Trained:**

| | |
|---|---|
| 11,600 | Physicians |
| 5,100 | Dentists |
| 31,800 | Nurses |
| 42,200 | Associated Health |
| 56,000 | Administrative Staff |
| 38,300 | Non-VHA |




- This slide shows the variety and the number of activities offered by the RMEC System.

434 . . . . . multi-facility conferences, some of which were National Training Programs (NTPs)
1034 . . . . . single facility conferences
151 . . . . . teleconferences
38 . . . . . satellite conferences
326 . . . . . VAMC-Initiated conferences
502 . . . . . Cascade activities
116 . . . . . mini-residencies
22 . . . . . Computer Audio Teleconference (CAT) events




- The number of activities conducted by RMECs and CEC in 1992 totaled 2,600. These activities were provided to 99,500 participants for more than 700,000 contact hours.
- The number of participants reached by these educational modalities is shown below:

  21,000 .... at multi-facility conferences (including NTPs)

  29,100 .... at single-facility conferences

  11,400 .... at teleconferences

  14,450 .... at satellite conferences

  2,300 .... at computer-audio teleconferencing events

  12,200 .... at VAMC initiated conferences

  8,700 .... via cascading program

  310 .... in mini residencies

  Note: Each time a person attends a program, he or she counts as a participant.

## *Number of Participants by Topical Area*

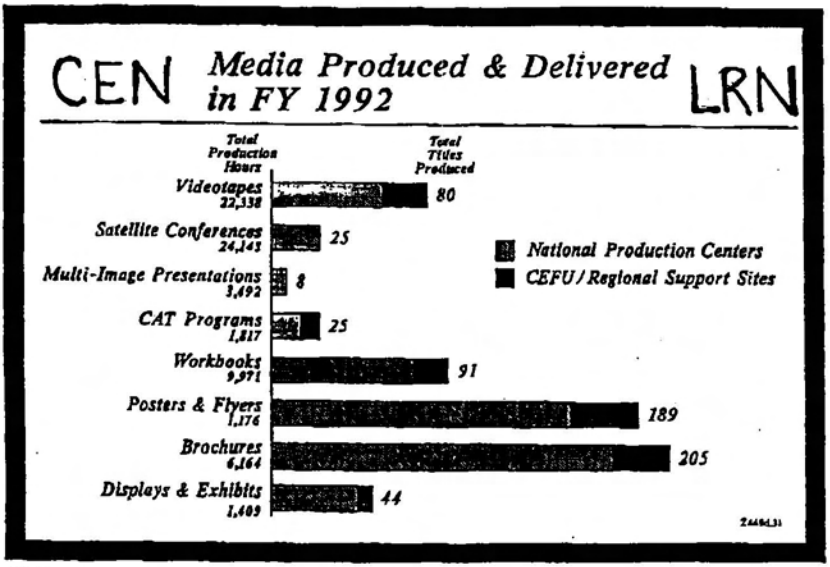
RMECs

| | *RMEC* | *CEC* |
|---|---|---|
| *Executive Development* | *1,000* | *500* |
| *Management* | *13,700* | - |
| *Mental Health* | *1,000* | *500* |
| *Substance Abuse & PTSD* | *10,200* | *3,300* |
| *DHCP* | *6,600* | *1,200* |
| *AIDS/HIV* | *6,300* | - |
| *Geriatrics* | *5,800* | *800* |
| *Quality Assurance* | *4,500* | *2,800* |
| *Legal/Ethical* | *4,500* | *900* |
| *Medical* | *3,500* | - |
| *Nursing* | *3,000* | - |
| *OSHA* | *2,100* | - |
| *MCCR* | - | *6,500* |
| *Special Veterans* | *170* | *800* |

**A more definitive breakdown of selected topic areas reflects the following:**

***Number of Participants***

| | RMEC | CEC | Total |
|---|---|---|---|
| Executive development | 1,000 | 500 | 1,500 |
| Management | 13,700 | | 13,700 |
| Mental Health | 1,000 | 500 | 1,500 |
| Substance Abuse & PTSD | 10,200 | 3,300 | 13,500 |
| DHCP | 6,600 | 1,200 | 7,800 |
| AIDS/HIV | 6,300 | | 6,300 |
| Geriatrics | 5,800 | 800 | 6,600 |
| Quality Assurance | 4,500 | 2,800 | 7,300 |
| Legal/Ethical | 4,500 | 900 | 5,400 |
| Medical | 3,500 | | 3,500 |
| Nursing | 3,000 | | 3,000 |
| OSHA | 2,100 | | 2,100 |
| MCCR | | 6,500 | 6,500 |
| Special Veterans | 170 | 800 | 970 |




SLIDE 13.

- Services requested and provided are impressive, not only in terms of quality but quantity. For example: 25,722 slides were created; 10,772,279 pages were printed; 100,452 negatives were processed; 22,595 prints were developed; 23,105 packages were distributed; and, 3,200 minutes of video were edited to list just a few examples. These production activities equated to 57 videotapes; 25 satellite video conferences, 8 multi-image presentations; 15 CAT programs; 176 brochures; 73 instructional workbooks, as well as hundreds of other products and services produced by the National Production Centers. In addition, 23 videotapes; 10 CAT programs; 29 brochures; 18 instructional workbooks; and many other products and services were produced by the CEFU/Regional Support Sites.

NOTES:

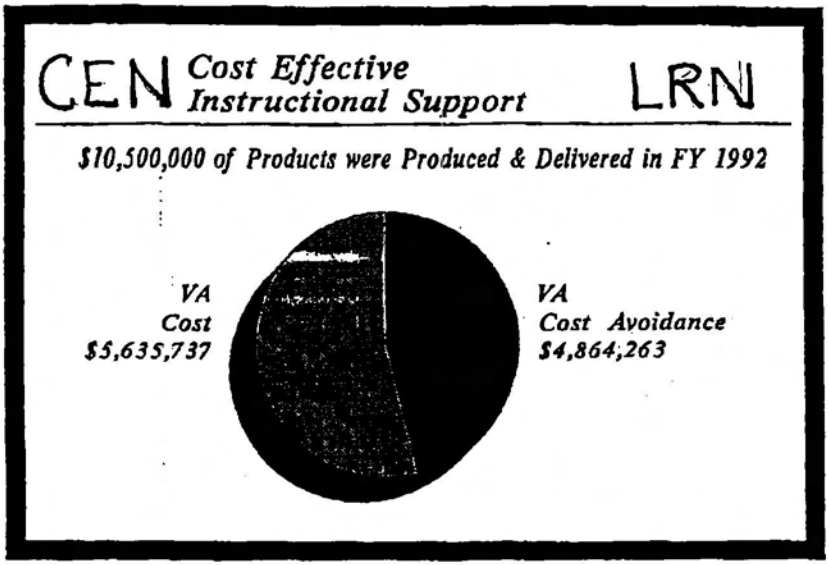
1. LRN products distributed in FY 1992 –

| | National Production Centers | | CEFU/Regional Support Sites | |
|---|---|---|---|---|
| | Items | Hours | Items | Hours |
| Videotapes | 57 | 20,727 | 23 | 1,611 |
| Satellite Conferences | 25 | 24,143 | 0 | 0 |
| Multi-Image Presentations | 8 | 3,492 | 0 | 0 |
| CAT Programs | 15 | 1,379 | 10 | 438 |
| Workbooks | 73 | 9,771 | 18 | 200 |
| Posters & Flyers | 154 | 1,581 | 35 | 195 |
| Brochures | 176 | 5,289 | 29 | 875 |
| Displays & Exhibits | 37 | 1,317 | 7 | 92 |

LRN -1992 (cont'd)

2. Production Activities - FY 1992

| | Number | Hours | % Total |
|---|---|---|---|
| Slides Produced (Computer/Art) | 25722 | 5217.6 | 4.60% |
| Slides Produced (Photo Copystand) | 74624 | 2962.4 | 2.61% |
| Design Comps Prepared | 1231 | 4042.5 | 3.56% |
| Illustrations, Color | 1127 | 5368.5 | 4.73% |
| Illustrations, B&W | 2899 | 2533 | 2.23% |
| Pages Prepared for Print | 16006 | 18166 | 16.01% |
| Video Shoots - Remote | 67 | 5393.5 | 4.75% |
| Video Shoots - Local/Studio | 268 | 7174 | 6.32% |
| Photo Shoots - Remote | 63 | 367 | 0.32% |
| Photo Shoots - Local/Studio | 833 | 1210.8 | 1.07% |
| Slide Dupes/Copied | 18905 | 932.3 | 0.82% |
| Color Prints | 9623 | 797 | 0.70% |
| B&W Prints | 12972 | 1038.7 | 0.92% |
| Film Processed - Color Frames | 82463 | 2231 | 1.97% |
| Film Processed - B&W Frames | 17989 | 1283 | 1.13% |
| Slides Imaged (Frames) | 19074 | 1876 | 1.65% |
| Transmissions Received | 2653 | 841 | 0.74% |
| Pages Imaged (photo-typeset) | 8758 | 731 | 0.64% |
| Laser Prints | 93410 | 568 | 0.50% |
| Stat Prints | 1281 | 223.6 | 0.20% |
| Color Thermal Prints | 1291 | 65 | 0.06% |
| Dye Sublimation Prints | 800 | 66 | 0.06% |
| B&W Electrostatic Copies | 33354 | 407 | 0.36% |
| Color Electrostatic Copies | 1460 | 58 | 0.05% |
| Impressions Printed - One Color | 10178290 | 2193 | 1.93% |
| Impressions Printed - Two Colors | 503435 | 358 | 0.32% |
| Impressions Printed - 3+ Colors | 55749 | 583 | 0.51% |
| Minutes of Videotape Edited | 3152.75 | 8875 | 7.82% |
| Minutes of Multi-Image Programming | 108 | 1044 | 0.92% |
| Minutes of Audio Edited | 450 | 855 | 0.75% |
| Pages of Script Prepared (Writing) | 3227 | 9176 | 8.09% |
| Pages of Manuscript Prepared (Writing/Editing) | 5604 | 7202 | 6.35% |
| Videotapes Duped | 16434 | 1716.5 | 1.51% |
| Audio tapes Duped | 2009 | 340 | 0.30% |
| Animation Frames | 19627 | 2297 | 2.02% |
| Pages Typed | 19812 | 3713.85 | 3.27% |
| Packages Mailed | 23105 | 2221 | 1.96% |
| Exhibits/Displays Prepared | 42 | 659 | 0.58% |
| Minutes of CAT Tapes Edited | 207 | 218 | 0.19% |
| Workshop/Convention A/V Support | 32 | 2782 | 2.45% |
| Searches | 771 | 771 | 0.68% |
| LR Consultation | | 4896 | 4.31% |
| | Total | 113453.25 | |




SLIDE 18.

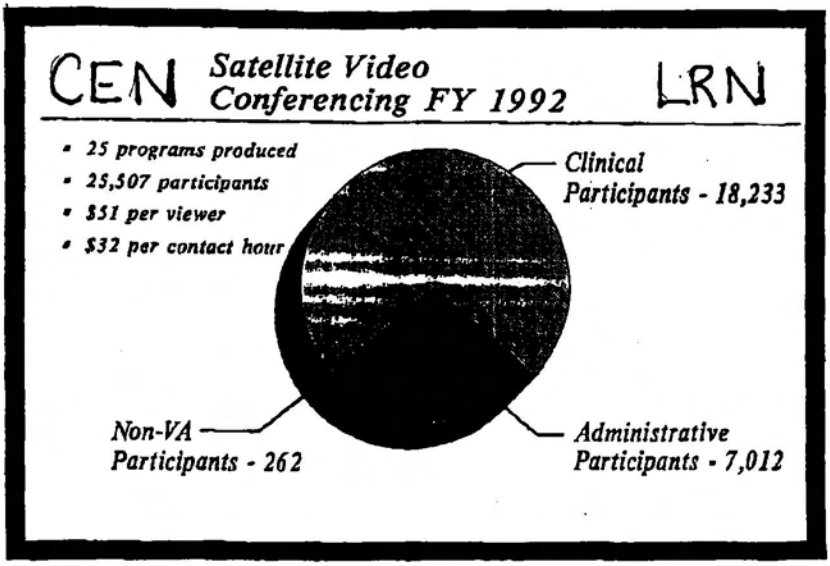
- The most dramatic way to examine the value of LRN production to the VA and the CE Network is to compare current in-house production costs to commercially available materials. In FY 1992 the LRN produced $10,500,000 worth of projects and programs for only $5,635,737 – a direct tangible cost avoidance of $4,864,263. Even though this cost avoidance is significant, the actual tangible cost avoidance is even higher than estimated since other services provided by the LRN are not included in the estimate; however, all LRN operating, salary and travel costs have been included. The cost avoidance of providing the volume and scope of other services was not included because of the difficulty in estimating costs accurately. Intangible and tangible benefits of employing learning resources staff with medical and administrative knowledge, fast turn-around capabilities, access to specialized high tech-media and library resources *in-house* have also not been valued. Finally, the synergistic value of having LRNs at VAMCs is also not estimated; national production facilities expend 30% of their resources to support VAMC clinical, research and administrative programs – cost estimates previously noted are based on products and activities, delivered at the national level only.

NOTES:

LRN provide cost effective instructional support & production –

- $10,500,000 worth of services were produced in FY 92 for only $5,635,737 – a cost avoidance of $4,864,263

Continued:




SLIDE 19.

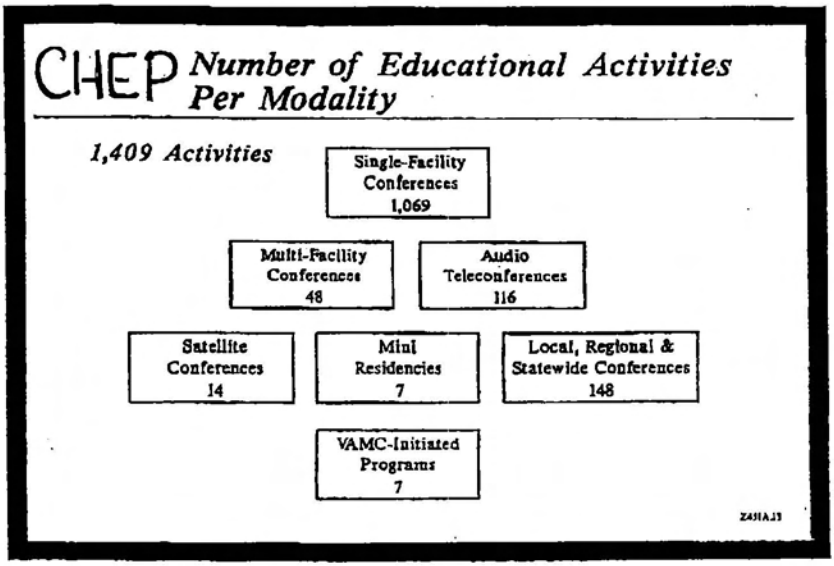
- Since FY 1990 the LRN has operated the VHA Satellite Television Network. In FY 1992 the LRN developed and delivered 25 high quality satellite video conferences to 25,507 participants. Of these participants 7,012 were administrative, 18,233 clinical and 262 non-VHA or other VA departments. The cost for this training, considering all expenses - equipment, salary, production, space, supplies, consultants, printing, etc. was $51 per participant. The cost per contact hour of training was $31.88. Instructional media remains the least costly way to reach a large number of staff quickly and efficiently. Mediated education also ensures that a quality and consistent message is delivered uniformly in a timely manner. Satellite video conferences, when compared to face-to-face programs that required travel, are significantly less expensive. Workshops requiring travel, exclusive of all other costs (media, consultants, etc.), cost from $500 - $1,500 per participant. Satellite video conferences, including all expenses, cost from $15 - $50 per program or only 3% of workshop attendance.

NOTES:

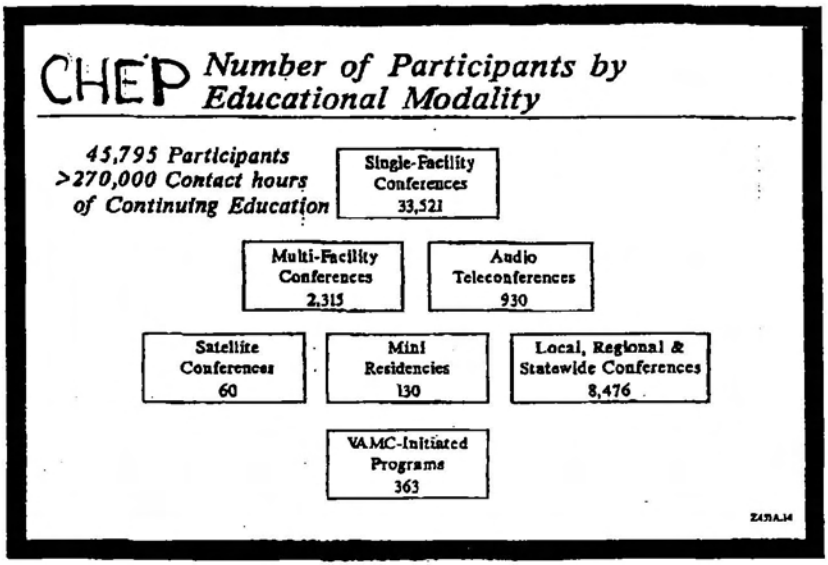
LRN instructional media is cost efficient –

- **25,507 VA employees received training via VHA's Satellite Network in FY 1992**
  - Administrative participants 7,012
  - Clinical participants 18,233
  - Non-VA participants 262
  - **Cost per participant - $51** (costs include production, salary, equipment depreciation, space, supplies, consultants, video contracting & printing)
  - Cost per hour for participating VA employee - $31.88 (all costs considered)

*Projects were distributed to all health care facilities through the LR Library Network &/or to trainers or services in the field as well as VACO*




- In FY92 the CHEP system sponsored 1,409 activities for 45,795 participants; VHA and non-VHA attendees.
- CHEP activities are tailored to the needs of VHA and community constituency and include a wide variety of educational modalities including:
  - Single-facility conferences
  - Multi-facility conferences
  - Audio teleconferences
  - Video Satellite conferences
  - Mini-residencies
  - Local, regional, and statewide educational conferences
  - VAMC-initiated programs




- Although CHEPS offer programming in all of the above modalities, the largest efforts are devoted to single facility conferences which typically involves both VHA and community collaboration and sponsorship. In FY92, the CHEP system conducted:

| | | # Participants |
|---|---|---|
| 48 | multi-facility conferences | 2,315 |
| 1,069 | single-facility conferences | 33,521 |
| 48 | co-sponsorships | 8476 |
| 116 | teleconferences | 930 |
| 14 | satellite conferences | 60 |
| 7 | VAMC-initiated programs | 363 |
| 7 | mini residencies | 130 |
| 1,409 | Total | 45,795 |

## CHEP *Top Four Content Areas*

| *Content Area* | *No. Activities* | *No. Participants* |
|---|---|---|
| *Nursing* | *405* | *12,637* |
| *Geriatric* | *118* | *3,884* |
| *Medical Care* | *110* | *3,232* |
| *AIDS/HIV* | *72* | *4,414* |

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- A more definitive breakdown of primary content reflects the following number of participants by the top four content areas addressed by CHEPs:

| Content Area Area | Number of Activities | Number of Participants |
|---|---|---|
| Nursing | 405 | 12,637 |
| Geriatrics | 118 | 3,884 |
| Medical Care | 110 | 3,232 |
| AIDS/HIV | 72 | 4,414 |

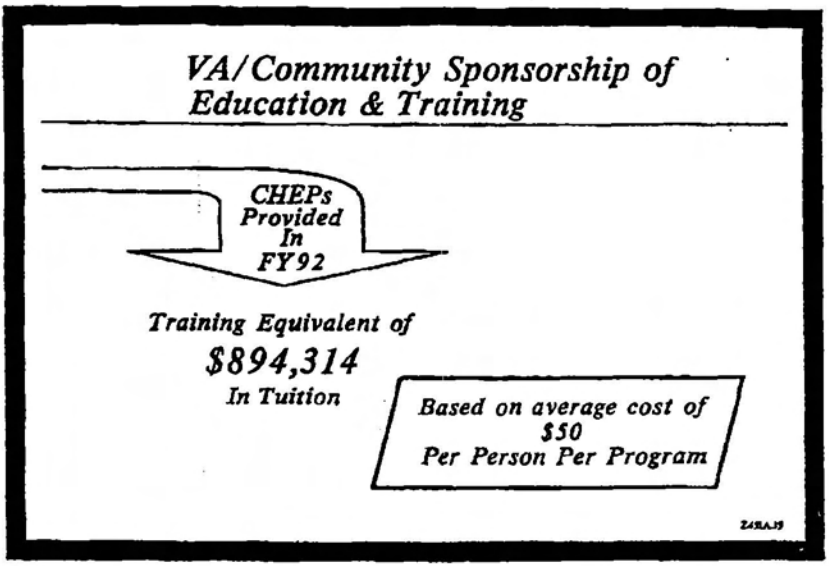
## CHEP *Occupational Categories of Participants*

| | |
|---|---|
| *Physicians* | *1,291* |
| *Dentists* | *66* |
| *Nurses* | *4,920* |
| *Associated Health* | *6,646* |
| *Administrative* | *4,798* |
| *Total VA* | *17,721* |
| *Non-VA* | *28,074* |
| *Total Participants* | *45,795* |

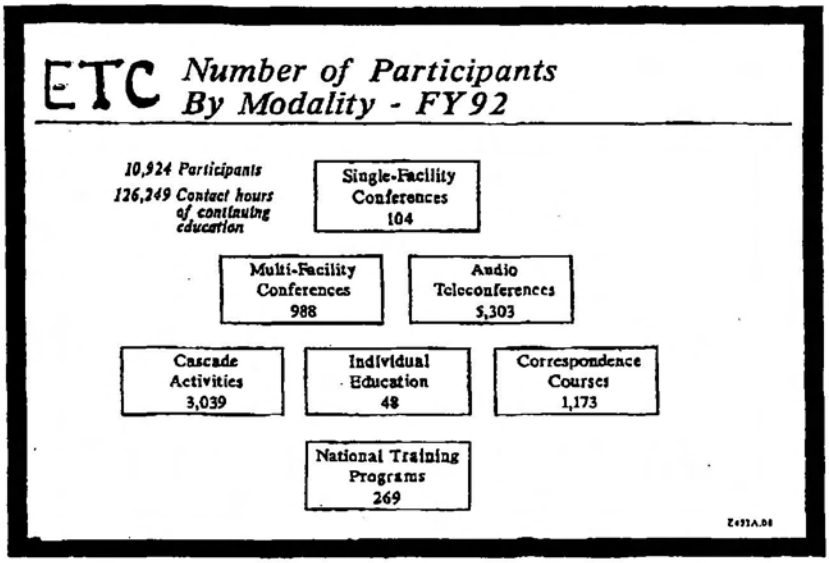
*VA Participants*
*73% Clinical*
*27% Administrative*

- It is also significant that 73% (12,923) of the VA participants were clinical staff as compared to 27% (4,798) administrative. CHEPs also served a total of 28,074 clinical and administrative non-VA attendees.
- A more definitive breakdown follows:

| | |
|---|---|
| Physicians | 1,291 |
| Dentists | 66 |
| Nurses | 4,920 |
| Associated Health | 6,646 |
| Administrative | 4,798 |
| Non-VA | 28,074 |

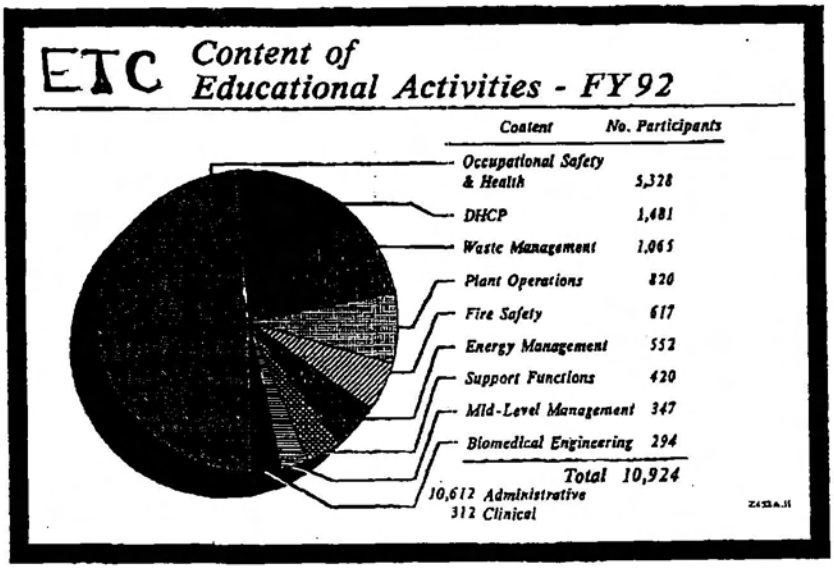



- One important feature of the CHEP System is the return the VA receives from the VA-community sponsorship of education and training. In FY92, CHEPs provided training equivalent to $894,314 in tuition to VA employees. This is based on an average cost of $50 per person per program, which is far below the tuition cost of non-VA-sponsored continuing education.




**The total number of participants by modality in FY-92 were:**

| | |
|---|---|
| Single facility | 104 |
| Multi-facility | 988 |
| Audio teleconference | 5,303 |
| Cascade | 3,039 |
| Individual education | 48 |
| Correspondence Courses | 1,173 |
| NTP's | 269 |
| | 10,924 |




**The content of the 712 educational activities is broken down as follows:**

| | # Participants |
|---|---|
| Occupational Safety & Health | 5,328 |
| DHCP | 1,481 |
| Waste Management | 1,065 |
| Plant Operations | 820 |
| Fire Safety | 617 |
| Energy Management | 552 |
| Support Functions | 420 |
| Mid Level Management | 347 |
| Biomedical Engineering | 294 |
| Total | 10,924 |

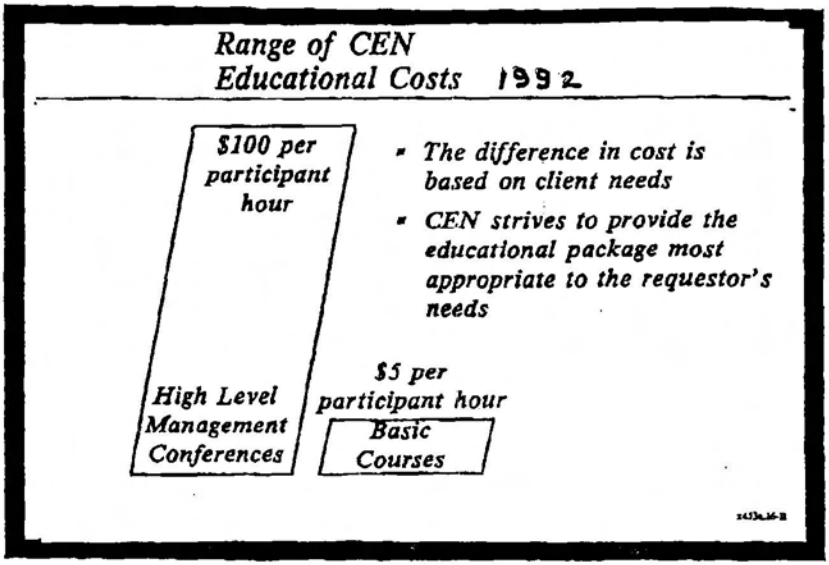
of these activities, the number of participants were:

| | |
|---|---|
| Administrative | 10,612 |
| Clinical | 312 |

## VHA *Cost Avoidance* EMPLOYEE EDUCATION

- *CHEPs provided training equivalent of $900,000 in FY 92*
- *ETC estimated cost avoidance of over $6 million in FY 92*
- *LRS estimated cost avoidance of over $5 million in FY 92*

- In FY92 the CHEPs provided training equivalent to $900,000 in tuition for VA employees. The ETC and the LRSs estimated cost avoidance for FY92 at over $6 million and $5 million dollars, respectively.




- Educational costs vary considerably, especially when you include travel costs. For example, the Senior Management Conference, a one-time event in terms of content and faculty, costs over $100 per participant credit hour. Travel accounts for nearly 2/3 of this cost since participants travel from throughout the country to a single site and stay for several days.
- On the other hand, basic courses held at a VAMC for local participants cost less than $5 per participant credit hour. These courses are replicated many times usually by local faculty who have been trained by the RMECs.
- The question of cost is important, but the appropriateness of the cost is even more important. The CEN strives to provide the educational package needed by the respective client at the best possible price.
- Medical center training is less cost/participant than either Education Center based training or National Meeting based training, because there are no employee travel/per diem costs. Long distance learning modalities (video, TV etc) also reduce cost/participant and UHA is investing in these modalities wherever appropriate to enhance employee education while continuing to reduce costs/participant.

**HONORABLE LANE EVANS, CHAIRMAN**
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**
**COMMITTEE ON VETERANS' AFFAIRS**

**QUESTIONS SUBMITTED FOR THE RECORD**
**DEPARTMENT OF VETERANS AFFAIRS**

**HEARING**
**BARRIERS AND RISKS: VA HEALTH CARE COMPETITIVENESS AND THE HEALTH SECURITY ACT**

**JUNE 29, 1994**

**Question 1:** Why are GAO's concerns about risks from VA reform implementation "premature"?

**Answer:** GAO's concerns about risks from VA reform implementation are "premature" because VA does not have in place its health reform staff or organizational structure. The issues GAO is raising related to risks will be addressed as soon as the organization is in a position to do so. Furthermore, VA does not yet know what effect national health care reform will have on VA's patient population. Some geographic areas may see an increase in demand while others might experience a decrease in demand. Many variables will influence a veteran's choice of health plan enrollment. However, the Department's goal is to become a model for an integrated, full-service, nationwide health care system that provides quality, and cost effective care in direct response to veterans needs.

**Question 2:** If VA administrative and health care professionals are "unrivaled" in "dedication and compassion," explain why the adoption of a "customer service orientation that will prevail at all levels of the organization," is the key initiative identified by VA as being critical to success in a competitive environment?

**Answer:** Customer service can be used synonymously with the terms member service and consumer affairs. Customer service refers to the departmental personnel responsible for helping members with any problems, handling member grievances and complaints, tracking and reporting patterns of problems encountered, and enhancing the relationship between the members of the plan and the plan itself. Managed care plans are complicated. A system to monitor and track the nature of customer contacts, and a mechanism for members to express concerns about their care, are paramount to providing quality care.

To compete in national health care reform the VA will not only have to provide quality care but will have to learn how to sell and market itself. Our culture must change to one that is even more responsive to our customers' needs and wants.

**Question 3:** Earlier this year VA reported it could begin immediately to make many health reform changes without new legislation.

What health care reform changes can VA implement without new legislation? For each change, describe VA progress to date.

**Answer:** Many of the needed changes in the VA's health care delivery system can be implemented without the enactment of national health care reform legislation. For example, establishing a more decentralized management structure and more responsive management systems in VA can be

accomplished based on current authorities to help position VA for the future. Furthermore, VA is developing a systemwide plan to make customer service principles and behaviors an expectation of the culture. Customer identification, creating a new service environment, and customer service standards are key components of the plan.

In addition, VA will be issuing a contract to conduct local market research and business planning to enhance our knowledge and understanding of the patient and veteran population, private sector market practices, trends, and factors that will affect our success in the marketplace. VA medical centers will be convening focus groups and administering survey questionnaires across the country in order to capture an accurate demographic mix of veterans and a comprehensive assessment of health care concerns as they relate to health care reform. This research will help evaluate how well VA is satisfying the needs of veterans today, what services/benefits will be offered to veterans under a VA health plan, how much these services/benefits will cost, and what are the relative strengths and weaknesses of these services/benefits when compared to the competition. Results should indicate which health care components VA should emphasize and which need to be improved to make a VA health plan more marketable.

The Department has also begun examining the relationship between VA medical centers and state insurance commissions, and to what extent medical centers will be subject to state regulatory influence, and the impact that regulation will have on setting competitive premiums.

Finally, VA has conducted a national survey of veterans to identify their perceptions of VA health care and their propensity for enrolling in a future VA health plan. Findings from this survey revealed that 67 percent of current users of the health care system and 27 percent of non-users would consider choosing a VA health plan over other insurers. This survey represents the first assessment of our national marketplace and will be a factor in developing independent estimates for veteran enrollment in a VA health plan. While these estimates will need to be validated and strengthened by additional research at both the national and local level, they do offer a sharp contrast to the GAO study findings.

**Question 4:** Identify the competitive health care market performance standards VA plans to meet.

Compare VA's performance today to these market based standards.

**Answer:** VA intends to meet national performance standards for managed care organizations including indicators of management performance (productivity measures, length of stay, occupancy rate), financial performance (cost per patient, facility cost), quality of care (quality report cards), and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.

To date, VA has made strides in several of the above areas that will favorably impact our ability to market managed care to veterans. Examples of these measures include:

- Findings of the External Peer Review Program ( a program that uses community standards applied by board certified, non-VA physicians to assess the quality of care) reveal that care in VA medical centers meets or exceeds community standards in at least 95 percent of the cases reviewed.

- All VA medical centers and outpatient clinics are surveyed and maintain full accreditation by the JCAHO, and since 1991, the overall JCAHO hospital accreditation program (HAP) grid scores for VA medical centers have averaged at least 5 points higher than private sector hospitals.

- A comparison of post operative mortality in over 500,000 patients for 118 surgical procedures in VA and private hospitals demonstrated that health care delivery is comparable between VA and private sector facilities.

- Following inception of a program that collects, analyzes and distributes validated risk adjusted mortality rates and information to VA cardiac surgeons, VA experienced a 4 percent decrease per year in mortality over a 6 year period or a 24 percent overall decrease in risk adjusted cardiac mortality. Private sector open heart surgeons have praised and are beginning to emulate the VA's risk adjusted program to decrease their own mortality rates.

VA continues to seek improvements in patient satisfaction, access to care, and timeliness of care. Toward this end, we have revamped our Customer Feedback Program in order to measure and report back to medical centers the perceptions of veterans in many key areas that they have told us are important to them. This data will not only tell VA how it is doing in satisfying its customers, it will also allow VA to respond more quickly to the market.

**Question 5a:** Explain why VA disagrees with GAO's conclusion that provisions of the Health Security Act relating to VA create significant risks of higher cost to the government and increased exposure to fraud and abuse?

**Answer:** Higher cost is a possibility, given the extent to which we attract service-connected and low-income veterans who enroll in the VA health plan. However, the estimates (including GAO's) vary over 400 percent. VA will be in a better position to determine the number of core veterans who will enroll in a VA health plan after market surveys have been completed. Also, GAO's conclusions do not consider any VA implementation strategies.

**Question 5b:** Why will VA not be competitive in the health care marketplace unless granted all the exemptions from federal regulation provided by the Health Security Act?

**Answer:** The exemptions are necessary, from a competitive standpoint, to relieve VA of various major administrative costs that non-federal providers do not incur. Without these exemptions, VA's costs of furnishing care will be relatively high and could leave VA non-competitive.

**Question 5c:** Which exemptions are most important to VA competitiveness?

**Answer:** See Answer to Question 6.

**Question 5d:** Why does VA need exemptions from requirements that insure quality health care services to be competitive?

**Answer:** VA has extensive programs in place to monitor the quality of care provided and to foster continuous quality improvement. We continually refine our quality management programs to meet changes in the health industry. As an independent Federal Department we should not be subject to another Department's regulatory oversight of one of our primary missions -- providing health care to the nation's veterans.

VA would require exemptions from those requirements that incur significant cost without commensurate value relative to our competition. The VA intends to fully participate in the quality requirements put forth by national or other bodies that are set for all competing health plans. VA will need to show that care provided within its health plan is as of high quality or better quality than the competition.

**Question 5e:** Why does VA need exemptions from requirements to prevent fraud and abuse?

**Answer:** VA is not seeking nor do we need exemptions from requirements to prevent fraud and abuse. VA internally has a more than adequate oversight program.

**Question 5f:** Why does VA need an exemption from bid protests?

**Answer:** Protests delay procurements and increase costs. In most cases, procurements are suspended pending the outcome of the protest. These suspensions delay procurements and VA programs that rely on these procurements. VA's exemplary record handling protests, as evidenced in GAO's annual report which shows no sustained protests on the merits for FY 1993, indicates the Department's ability to timely resolve these matters and further supports our position.

**Question 6:** If the blanket exemptions provided VA by the Health Security Act were not enacted, what specific exemptions are needed for VA to be competitive and why is each of these specific exemptions needed?

**Answer:** The exemptions that VA will need in order to effectively compete in the managed care environment will depend upon whether a required procurement is of provider services, or of other goods or services. Therefore, we have divided our analysis into two parts. Part I pertains to contracting for health care resources. Part II pertains to all other contracting.

**I. Health Care Resources**

Health care resources contracting is most crucial to VA because it has the greatest impact on services to the veteran and, consequently, the ultimate success or failure of VA under health care reform. VA plans will have to respond quickly to changing market conditions and the changing needs of the population they serve. To accomplish these goals, VA will have to enter into hundreds, if not thousands, of contracts. It will be necessary for VA health plans throughout the nation to establish medical care networks with private physicians and hospitals, as well as with other ancillary medical care providers. Additionally, VA health plans may have to enter into contracts for administrative support with managed care companies, financial intermediaries, insurers, benefits' administrators, utilization review companies, consultants, and computer information system companies, as well as contracts for clerical and maintenance help. This list is representative, but not exhaustive, of the types of contracts which VA will require. Current restrictions often inhibit the innovation, timeliness, and risk taking needed for success in the competitive marketplace. The acquisition process must ensure customer satisfaction, rather than serve as an obstacle to achieving desirable customer outcomes.

Under health care reform VA will, for the first time in its history, be offering services such as pediatrics and obstetrics. VA does not have the staff or expertise to provide such services in-house and will have to enter into contracts with private providers. VA may also need to obtain unique or scarce services for a veteran or a veteran's family on an emergency or

expedited basis. Changing populations in the VA's service area may require abrupt shifts in the kinds of services offered.

Current Government contracting statutes and regulations have numerous requirements that increase the period of time from determination of a need to the time a contract is completed. The ability to enter into health care resources contracts quickly is crucial for the success of VA under health care reform.

While current laws and regulations pertaining to competition and procurement policy may be suitable for traditional Government contracting, in many cases they may prove to be too cumbersome and time consuming to allow VA plans to establish medical care networks. Many of the private providers will be physician practice groups that are not familiar with the rules and regulations pertaining to Government contracting. Doing business with the Federal Government is widely known to be complex and difficult to understand by those who are unaccustomed to the Federal Government's many requirements. Preparing a proposal or bid under the current system is also time consuming and costly to these providers. Current statutes and regulations may cause providers to open their books for audit and impose record keeping requirements which they are unwilling to accept. Because of these issues, many contractors are unwilling to enter into contracts with the Federal Government. Moreover, to the extent that dealing with VA is more expensive than dealing with the private sector, providers will pass those additional costs on to VA.

Because of these and other concerns, VA must be exempt from the current VA and Government-wide procurement requirements for obtaining professional health care resources in order to compete. The Secretary would replace the current system with a new system of internal controls and policies that guarantee fairness and promote socio-economic goals.

We have identified the following statutes and regulations which could adversely affect VA's competitiveness when contracting for health care resources:

**Chapter 7 of the Office of Federal Procurement Policy Act** -
41 USC 401 et seq.

This Act establishes uniform procurement regulations, including FAR, and other requirements for procuring agencies. If VA is not subject to this statute, it will not have to follow the FAR which contains numerous requirements which slow down the acquisition process and limit agency discretion. Included in these provisions are the Procurement Integrity Act, 41 USC 423. This law duplicates many existing criminal laws and employee conduct regulations which would be applicable to VA employees and vendors. In addition, this chapter includes Cost Accounting Standards 41 USC 422.

**Chapter 4 of the Federal Property and Administrative Services Act** -
41 USC 251-260

These sections of the law include many procurement provisions which slow the contracting process by requiring competition, defining the kinds of competition that are allowable and restrict agency discretion in contracting. Included within these provisions are the Truth in Negotiations Act, 41 USC 254, the Competition in Contracting Act of 1984, 41 USC 253, Examination of Records by Comptroller General 41 USC 254(c), and Submission of Cost and Pricing Data, 41 USC 254(d).

**38 USC 8110(c)**

Contains restrictions on contracting out for services.

**Subchapter V of Chapter 35 of title 31, United States Code, relating to adjudication of protests of violations of procurement statutes and regulations, and Sections 3526 and 3702 of such title, relating to the settlement of accounts and claims, respectively, of the United States.**

These statutes grant GAO the authority to hear protests against procurements and establish protest procedures. This delays our ability to make award decisions and commence performance of contracts. Awards and performance of contract are automatically suspended if the protest is timely filed. GAO has 90 business days to make a decision from the date the protest is filed. Virtually all of our procurements which are protested are delayed for the full 90 work days.

**Protests to Court of Federal Claims** (Pre-award protests)

28 USC 1491

**Protests to District Courts** (Pre or Post Award)

5 USC 702; 28 USC 1345(a)(2)

**Brooks Act** (Procedures governing ADP acquisitions) - 41 USC 759

**Review of Agency Decisions** (Right of review of agency wrongs by courts of the United States) - 5 USC 702

**Certificate of Competency, Notice, and Sole Source Provisions of Small Business Act** - 15 USC 637 (b)(7), (e), (f), (g), (h)

Under this law the Small Business Administration (SBA) has the exclusive authority to determine the competency of a small business. VA must have the authority to determine whether a proposed provider of health care resources is capable of performing as required.

**II. All Other Contracting Activities**

In addition to provider contracting, VA will also have the need to contract for supplies, such as medical equipment, non-provider services, and space on an expeditious basis.

In addition to the statutes that we have already identified, there are other statutes and regulations that have established a bureaucracy through which VA must pass in order to purchase supplies and services and obtain space. GSA is in charge of leasing space for the Federal Government. In some instances, VA has been delegated authority by GSA to lease medical space.

Accordingly, we have identified the following statutes which could adversely affect VA's competitiveness in addition to those cited above:

**Procurement of Health-Care Items** - 38 USC 8125

Places limitations on the ability of medical centers to supply certain health care supplies locally.

**Management and Disposal of Federal Property** - 40 USC 471-544

Identifies GSA as a paramount authority for leasing and disposing of federal-property. These provisions include the requirement by regulation to purchase supplies from Federal Supply Schedules.

**Outleasing Authority** - 38 USC 8122 (a)(1)

Places a 3 year limitation on outleases and requires public notice of intent to outlease.

**Question 7:** Will VA adopt safeguards including internal controls to:

**Question 7a:** Ensure quality patient care?

**Answer:** Neither VA nor any other health care agency can fully "assure" quality patient care. Accurately "assessing" and "improving" the quality of care and then "comparing" that care to the best in practice is a better description of what VA is now doing. The following quality of care monitors are now in place in VA:

The National Patient Feedback Program provides VA administrators, physicians, and others with reliable, timely information on the quality of care and services provided to veterans through a state-of-the-art patient-focused survey process.

The External Peer Review Program (EPRP) evaluates the quality of care delivered and provides diagnosis and procedure-specific information to clinicians, documents the frequency with which the quality of care provided in VA meets or exceeds community standards, identifies opportunities for improvement in the quality of care systemwide and at the facility level, and establishes a data base for comparison of individual VAMC patterns of care.

The Quality Indicator Checklist (QUIC) measures important areas of quality, provides facility managers with comparison data from the national system, and allows VA to focus attention on areas needing systemwide improvement.

The Utilization Management (UM) Program increases the efficiency and appropriateness of services provided and identifies opportunities to improve patient care.

The National Tort Claim Information and Analysis Program identifies possible problem areas in the delivery of care. A sharing agreement with the Armed Forces Institute of Pathology (AFIP) provides nationwide analysis and trending of VA tort claims.

The Patient Incident Review (PIR) Program minimizes risks to patients by identifying, reporting, trending, reviewing and correcting problems leading to patient incidents. The Occurrence Screening Program identifies areas of potential risk which reduce the effectiveness of care. Both programs are optional at the field level.

All VA medical centers are accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), a voluntary organization which establishes standards for health care organizations and performs periodic surveys to assess compliance with the standards. The central focus of JCAHO accreditation is on a facility's actual performance and outcomes. VA clinical laboratories, nuclear medicine laboratories, and limited special function laboratories are accredited by the College of

American Pathologists (CAP). The CAP Program addresses all aspects of quality control.

Lastly, each VA medical center is making the transition into Total Quality Management (TQM), which emphasizes a management philosophy that uses scientific principles of assessment and analysis and empowers all employees to continuously seek improvements in their performance. To the extent that TQM is successfully implemented in VA, it's level of maturity may become the most significant indicator of "assuring" quality patient care.

**Question 7b:** Provide procurement process fairness?

**Answer:** Yes. VA will maximize communication of acquisition opportunities by participating in procurement conferences for vendors and utilizing state-of-the-art technology. VA is a leader in the use of automated systems such as the Electronic Bulletin Board (EBB), which contains information regarding acquisition opportunities. VA will continue to provide and expand acquisition training program opportunities. VA will maximize competition to the fullest extent practicable.

**Question 7c:** Prohibit related party transactions?

**Answer:** Yes. Many safeguards exist currently to prohibit related party transactions. However, we believe additional safeguards are appropriate. Internal controls, such as the VA Office of Inspector General and VA Procurement Working Group, would provide continued emphasis on detecting, and preventing procurement fraud, and on ensuring that sound business practices are followed.

**Question 7d:** Prevent contracting fraud and abuse, kickback schemes and diversion of patient care funds through related party transactions?

**Answer:** Yes. VA has a good record, involving the Offices of Acquisition and Materiel Management, the Inspector General, the General Counsel and program offices to avoid fraud, kickbacks, and other improper procurement related activities. VA will continue this emphasis to ensure the proper use of VA funds.

**Question 7e:** Describe the purpose of the safeguards including internal controls VA intends to adopt.

**Answer:** The purpose of the safeguards and internal controls in place, and those VA intends to adopt, are to ensure procurement fairness, prevent contract fraud and abuse, kickback schemes, diversion of patient care funds, and other misuses of VA funds and resources. These safeguards are designed to avoid, rather than detect abuses and to ensure that VA funds are properly utilized to procure the best possible patient care at the lowest possible cost, and to ensure VA competitiveness in the reformed health care delivery environment.

**Question 8:** What is VA's capacity today to enroll veterans and their dependents in a VA plan.

**Answer:** VA's capacity to enroll veterans and their dependents in a VA health plan will be determined by the number of enrollees and the revenue they bring over time. For VA to remain a viable independent system, it must begin to look beyond its existing patient base and reach out to new users who will balance the current mix of patients thus ensuring fiscal viability. Under the proposed Health Security Act, VA will, for the first time, be able to offer services to all veterans as well as their dependents. As a result, VA will

target its health plan at higher-income veterans and their families and nonservice-connected veterans and their families, all of whom would bring their own funds to pay for health services. We will continue to provide health care to service-connected veterans and to low-income veterans at no cost, a benefit they will be unable to obtain from other insurers.

**Question 9a:** Without accurate cost data on VA services, how will VA correctly determine when it is financially beneficial to VA to provide or purchase services?

**Answer:** The VA has the Cost Distribution Report (CDR) that provides cost data by major bed activity, non-VA workload and outpatient categories. CDR data, when merged with patient treatment files (PTF) can produce a cost for a diagnostic related group (DRG). Currently, the VA uses this data to distribute funds to medical centers and can use this information, with other cost data, to make decisions on whether to provide or purchase services.

**Question 9b:** What steps is VA taking to generate accurate cost data on services it provides, when will VA have this data and how much will VA spend to develop this capability?

**Answer:** The VA has begun implementation of the Decision Support System (DSS). DSS will allow for a much higher degree of accuracy in tracking and distributing cost than any process the VA currently has. The current plan is to have all medical centers operating DSS by the end of Fiscal Year 1996. The estimated cost of bringing DSS on line at all medical centers is $60 million.

**Question 9c:** Describe the methodology VA uses now to determine when it is financially beneficial to VA to contract for services or provide them directly.

**Answer:** Under health care reform VA's methodology for determining when it is beneficial to contract for services will be based upon sound business practices and driven by market conditions. Cost/benefit models will be utilized extensively to assess each VA health plan's population characteristics, utilization experiences, and enrollment projections and on the basis of these indicators contracting decisions will be made.

**Question 9d:** Will all VA plans and facilities be required to use this methodology and how will this requirement be enforced?

**Answer:** The business plan will be the corner-stone of the plans and operations. The basic business plan requirements will be set forth by the Central Office which will retain some monitoring, oversight and approval responsibility for certain levels of the business plan. The requirements will not be totally rigid, as the variability of markets dictates that VA plans have significant flexibility in their approach. The Office of Strategic Planning of the Veterans Health Administration is taking a lead role in developing the content of business plans and defining the procedural approval process for them.

**Question 9e:** Describe the methodology VA will use to determine when it is financially beneficial to VA to sell health care services to other health plans. Will the same methodology be required to be used by all VA plans? How will this requirement be enforced?

**Answer:** Decisions to sell services to other health plans will be an integral part of a business plan which will serve as the blueprint for the operation of a geographically-based VA health plan. Plan and facility managers will be required to assess market conditions and enrollee needs and wants so that

they may then proceed with service initiatives accordingly. Consideration to sell services will be based on market factors such as benefit to enrollees, where the service may otherwise be attained, any excess capacity within the plan, whether or not the service is a market niche for VA, ability to cover costs, and other issues specific to a given plan or market. The methodology of the business plan will be uniform throughout VA. However, the decision to sell a service will be based on a business plan unique to a given market, and may vary from plan to plan. The business plan will also be the basis by which to evaluate performance of the health plan, and accountability will be contained therein.

**Question 10:** VA Secretary Jesse Brown recently said, "We want to be an HMO to our veterans." (Albany, New York Times Union, June 18, 1994)

Will VA comply with the requirements applied to other HMOs?

If VA will not comply with the requirements applied to other HMOs, please explain why VA will not comply with these requirements and describe the purpose of each safeguard and internal control VA plans to adopt in lieu of these requirements?

**Answer:** VA intends to comply with all necessary requirements. We believe VA already meets or exceeds relevant requirements.

**Question 11a:** What is the projected annual dollar value of services VA will purchase from other providers for VA plan enrollees?

**Answer:** VA is unable to answer this question at this time.

**Question 11b:** In the past, VA has paid too much for medical services it bought and failed to receive services it purchased. How will VA avoid repeating these mistakes?

**Answer:** VA has taken a number of steps to tighten policy guidance involving scarce medical specialist services (SMSS) contracts and assure that SMSS contracts are negotiated, approved, and executed in accordance with VA and Federal Acquisition Regulations. On March 11, 1993, the Veterans Health Administration published revisions to its policy manual M-1, part I, chapter 34. This policy directive spells out in detail the rules each VA medical center must follow in using SMSS contract authority. On March 19, 1993, we conducted a national video-teleconference on SMSS contracting, with special emphasis on conflict of interest issues for medical center Directors, Chiefs of Staff, Clinical Service Chiefs, and Chiefs of Acquisition and Materiel Management. Key VACO officials from the Medical Sharing Office, Office of the General Counsel, and Office of Acquisition and Materiel Management (OA&MM) have participated in several OA&MM-hosted symposia dealing with SMSS contracting. In June 1993, we initiated a special one-time review of all SMSS contracts with affiliated institutions to ensure that the contracts were in full compliance with acquisition policy and regulations.

VACO officials are paying close attention to pricing issues when contracts receive required legal and technical review. Certified cost and pricing data are carefully checked to assure that SMSS services are appropriately priced. Non-competitive contracts over $500,000 must receive external audit, either by the Department of Health and Human Services, or by the Defense Contract Audit Agency. Each contract requires performance monitoring mechanisms adequate to ensure that the Department receives the services contracted for. Over the next few months, VA will conduct a series of field station visits to perform follow-up audits of SMSS contracts. These audits will help us assess the

effectiveness of our strengthened controls and identify any remaining weaknesses.

**Question 11c:** When will VA procure services non-competitively?

**Answer:** When VA makes the determination that supplies and services are needed in an expeditious manner to properly serve veterans, VA may procure supplies and services without providing for full and open competition when circumstances warrant such action. VA contracts awarded without providing for full and open competition will be made in accordance with VA internal procurement procedures. When not providing for full and open competition, VA will solicit offers from as many potential sources as practicable based on full assessment of available sources and need for timely action. All business decisions will be fully documented.

**Question 11d:** What are the risks of non-competitive procurement?

**Answer:** A contract awarded without providing for full and open competition may result in inadequate price or technical competition. However, VA will ensure it receives fair and reasonable prices, by obtaining certified cost or pricing data, requesting audits, and conducting cost analyses.

**Question 12:** VA has reported its information systems aren't capable to supporting a managed care organization.

**Question 12a:** How much will it cost for VA information systems to be capable of supporting a managed care organization and how long will it take?

**Answer:** As VA evolves into a managed care organization under health care reform, new and enhanced information capabilities will be required to support both the health care provider organization (the full continuum of care, from medical centers and outpatient clinics through long-term care facilities and community care) and veterans health plans.

From a preliminary assessment, VA has identified functionality that will be needed. We estimate that this new functionality (software, hardware, interfaces to existing applications, software maintenance, software installation, and training) could cost approximately $300 million over three years.

A significant investment in the information technology infrastructure is also required. Telecommunications must be enhanced to provide for the transport of data, both within sites and among the sites (hospitals, outpatient clinics, providers' offices) that will form integrated health care delivery networks. VA also needs to make a significant investment in clinical workstations to capture all the data necessary to support high quality patient care and to establish standards of care, prospective utilization review, and tracking of high cost cases. The cost of the telecommunications upgrade is estimated at about $180 million over three years; the cost of the clinical work stations is estimated at approximately $400 million over three years.

Current cost estimates are approximate and will be refined over the next year.

**Question 12b:** How will VA ensure the accuracy of the data entered into these systems?

**Answer:** Current VA medical center data systems have edits and consistency checks built into them to assure the accuracy of the data. Specifications for new systems will include such checks; any additional checks that are needed will be built in when new systems are interfaced with current systems.

**Question 13a:** Does VA have the information needed to establish accurate premiums?

**Answer:** Enrollment and associated revenues for VA health care under the Health Security Act have been estimated utilizing premium rates provided by the Department of Health and Human Services (DHHS) and Office of Management and Budget (OMB). Under the President's Health Security Plan, premiums would be negotiated with the community Health Alliances and risk adjusted to account for care delivered to very sick, high cost patients including many of VA's current users.

**Question 13b:** How much will it cost and how long will it take for VA to be able to establish accurate premiums?

**Answer:** The VA can estimate what it costs to care for the patients it currently treats. Under health care reform, VA will change from a system treating only sick people to an enrollment system responsible for providing health care services to healthy as well as sick individuals. At that time, experience with the new operating variables under health care reform will permit the development of accurate future premium charges.

**Question 14:** How will VA prevent potential enrollment abuses as identified by GAO? Describe the internal controls VA will use to prevent enrollment abuses. Will all VA plans and facilities be required to use the same internal controls to prevent enrollment abuses and how will VA detect these abuses?

**Answer:** VA's Income Verification Matching system will prevent enrollment abuses.

**Question 15a:** When will VA use a business plan as the basic tool for operational decision-making at all organizational levels?

**Answer:** VA intends to use business planning beginning in FY 1996.

**Question 15b:** When will VA financial management systems provide detailed cost and revenue data at each local facility and nationally?

**Answer:** The VA has the Cost Distribution Report (CDR.) that provides cost data by major bed activity, non-VA workload and outpatient categories. CDR data, when merged with patient treatment files (PTF) can produce a cost for a diagnostic related group (DRG). Currently the VA uses this data to distribute funds to medical centers and can use this information, with other cost data, to make decisions on whether to provide or purchase services.

The VA has begun implementation of the Decision Support System (DSS). DSS will allow for a much higher degree of accuracy in tracking and distributing cost than any process the VA currently has. The current plan is to have all medical centers operating DSS by the end of Fiscal Year 1996.

**Question 16:** What changes have been made in VA culture and what are the results? What further changes will be made?

**Answer:** Beginning in 1990, VA began a systemwide initiative to implement total quality improvement (TQI) throughout all its medical centers. Nearly one-half of the content of that training deals with cultural transformation.

Therefore, significant training has occurred in many medical centers. Most literature written in the quality arena indicates that cultural change is the most difficult piece of the transformation process and usually takes between five and ten years to achieve. Medical centers that began their quality improvements efforts in 1989 and 1990 can demonstrate some significant cultural changes. The types of cultural changes that have occurred differ from medical center to medical center, and reflect local needs and priorities. Typical kinds of changes include: delegation of decision making downward in the organization, changes in rewards and awards , involving individuals responsible for the job in decisions about the best ways to improve processes, more involvement of unions, and increased training in customer service. These changes are beginning to manifest themselves in medical centers that are advanced in TQI. Medical centers such as Albany and Tuscaloosa have won quality awards. Other medical centers are demonstrating lower turnover rates, fewer grievances, fewer EEO complaints, improved employee morale, and better and more efficient care and services. VA plans to continue to train medical centers in TQI, to encourage its implementation, and to support decentralization whenever possible. We believe that over time cultural changes will be evident in all medical centers.

**Question 17:** What skills do VA personnel need to establish and operate managed care plans, how will these skills be acquired, how much will this cost, and when do VA personnel need to have these skills?

**Answer:** The skills to establish and operate managed care plans currently exist in VA. Business and systems skills will be attained as needed.

**Question 18a:** Describe VA's customer service plan and customer service standards.

**Answer:** VA's customer service plan is in draft and meets all requirements of Executive Order 12862 "Setting Customer Service Standards." VA has identified its customers as: 1) recently discharged inpatients, 2) outpatients; and 3) long-term care patients. Focus groups have been conducted for all of these groups to identify issues that are important to veterans in these groups. Following the focus groups, survey questionnaires will be developed to measure areas of importance as identified by veterans. After the surveys are tested for validity and reliability, they will be administered once a year, nationally. The data from those surveys will be analyzed and sent back to medical centers in comparative format with benchmark information. Individual medical centers will be responsible for any local surveys conducted between the annual national survey. VA's customer service standards have been developed directly from what veterans told us was important to them. Most of VA's national standards are qualitative in nature; however, each qualitative standard has more than one quantitative measure that underpins it. The data from the quantitative measures that support each standard will be aggregated to give an overall score to each qualitative standard. These standards will be posted at every medical center. VA's Patient Representatives are currently responsible for patient complaints and they will continue to fill this role. VA's customer service plan calls for the publishing of the standards and the measurement of results against the standards. The plan also calls for the publication of a directive and significant education in methods to improve customer service. The plan and new customer feedback program will begin in October of 1994 with a kick-off video. The first annual survey for recently discharged inpatients will be in late September 1994. The outpatient survey is projected to begin in late spring of 1995, and the long- term care survey in the fall of 1995.

Listed below are VA's candidates for customer service standards. (These standards have not yet been approved by VA's policy board or by the Secretary and are, therefore, only draft standards.

1. We will treat you with courtesy and dignity.
2. We will provide you with timely access to health care.
3. A single health care provider will be in charge of your care.
4. We will involve you in medical decisions about your care.
5. We will strive to meet your physical comfort needs.
6. We will provide support to meet your emotional needs.
7. We will take responsibility for coordination of your care.
8. We will provide information and education about your health care that you understand.
9. We will provide every opportunity to involve your family in your care.
10. We will provide smooth transition between your inpatient and outpatient care.

**Question 18b:** What standards has VA established for patient waiting times, will all VA plans be required to achieve these standards and how will VA oversee facility performance and compliance?

**Answer:** VA will have timeliness standards in the following areas:

1. Waiting times for new patients.
2. Waiting times to be seen if a patient has a scheduled appointment.
3. Waiting time to get an appointment with a primary care provider.
4. Waiting times for an appointment with a specialist.
5. Ability to provide for emergency or urgent care 24 hours a day.

At this time the actual timeliness standards have not been finalized. It is anticipated that these standards will have been set by the end of July 1995.

By fiscal year 1998, medical centers and clinics must post all national standards, both qualitative and quantitative. In the interim, each medical center/plan will be given permission to post goals that they reasonably expect to achieve, even if those goals reflect longer waiting times than the national standards. Medical centers/plans will be given the flexibility to shift resources to meet national timeliness standards by FY 1998. Some medical centers/plans may choose to set their standards at a level higher than the national standards.

The annual customer survey is done from a national center which will allow oversight of facility performance.

**Question 19:** Discuss the partnerships VA intends to create with veterans and describe what VA is doing today to create these partnerships.

**Answer:** As we reinvent VA along lines required to make VA a successful player in the coming new health care environment, we have become sensitized to the necessity of joining closer than ever with veterans organizations as representatives of veterans. In drafting the VA plan for National Health Care Reform, we included eleven VSO representatives as participating members. Their clear message was that they wanted to work with VA but that they were seeking expansion of their role to full partnership. They felt they could best participate with us if they could assist us in developing policies that affect veterans and not just in communicating them.

At the Central Office level, we are endeavoring to include VSO representation and solicit their ideas/opinions on issues both formally and informally. Monthly VSO meetings with the Acting Under Secretary for Health have been reformatted and expanded in scope to give VSO representatives an enhanced opportunity for access at the top of VA. In the field, we are encouraging inclusion of VSO representation on local boards and committees.

**Question 20:** What is VA's goal for veteran proximity to VA health care?

**Answer:** VA's goal for veteran proximity is to provide access that is comparable to what is available in the commercial marketplace.

**Question 21:** VA plans to "Implement a mechanism for the exchange and system-wide export of successful customer service initiatives."

Describe this "mechanism" and VA's plan for networking successful customer service initiatives.

**Answer:** VA is in the process of developing a "success story" data base. These success stories will be placed on a CD-ROM product that will allow for "normal language queries." This CD-ROM disk will be sent to every medical center and clinic in the VA system. This will allow for ease of access and retrievability by many. This data base will include customer service success stories. VA is joining the International Benchmarking Network that has been developed by the American Productivity and Quality Institute (APQC). In addition, VA has plans to join the federal interagency group that will be developed in the fall to develop a federal benchmarking database.

**Question 22:** Discuss VA plans for conducting and using market research. How much will this cost?

**Answer:** VA has identified a number of strategies and actions that can be employed to recruit and retain veterans in a VA health plan. Specifically, the following marketing approaches are being considered:

- Conduct marketing research that focuses on preferences among segments of the veteran population;
- Adopt a market based approach that allows VA health plans to tailor pricing, product design, coverage options, and delivery systems to the demands of the local market;
- Develop an integrated direct marketing program that includes telemarketing, mailings, and other initiatives to penetrate target markets;
- Develop and implement a nationally accessible market information system that includes a marketing and sales data base with profile information on competitors products, and on all current and potential enrollees; and.
- Apply segmentation and niche marketing strategies to increase enrollments, and penetrate fiscally important segments, e.g., capture existing military personnel at the time of discharge.

The costs associated with market research will vary from one local VA health plan to the next depending upon the size of the service area, the sophistication of the survey tools employed, and whether the research is

done in-house or under contract. At this preliminary stage of VA health plan development, it is impossible to predict how much market research will cost nationwide.

**Question: 23:** Discuss VA plans and strategy for improving its image. How much will this cost.

**Answer:** VA's goal is to become a model for an integrated, nationwide, full service health care system that provides quality, cost effective care in direct response to veterans needs. To become an attractive provider for veterans and their families we will offer the following services:

- a network of community and VA health care providers who will take care of the entire family's medical needs;
- a competitively priced plan designed to provide veterans a comprehensive benefits package and supplemental benefits and special services that will be tailored to the unique needs of veterans;
- an increasingly customer oriented approach to delivering health care in VA medical facilities and VA contracted providers; and
- a highly respected health care system that compares favorably on quality and performance with the private sector.

With respect to the cost of improving VA's image, at this time it is impossible to predict with any degree of accuracy how much it will cost to make a VA health plan attractive to veterans at either the national or local level.

**Question 24:** Describe the current resources of the Health Care Reform Office. What additional resources are needed by the Health Care Reform Office to plan the more detailed steps required for the transition of VA health care to a competitive health care environment and to achieve the goal of VA health care being the plan of choice for veterans and their dependents? How will these additional resources be used?

**Answer:** The Health Care Reform Office consists of 15 staff detailed from throughout the agency. We are in the process of establishing permanent positions for this staff and approximately 20 more to complete the office. The office will develop and facilitate the implementation process of health care reform including issues surrounding legislation, establishing primary care networks, quality of care, customer service, business and marketing practices, human resources, and information systems.

The Health Care Reform Office is working with VA and VHA elements to provide private sector expertise through contract for market research and business plan development. Funds for this contract are being provided from both administrative and medical care accounts. We expect that the need for consultant support will continue for those areas in which VA has limited expertise, e.g., marketing.

The Health Care Reform Office also requires space and equipment for normal office operations.

**Question 25:** The Subcommittee understands physician assistants have not regularly participated in planning VA health reform even though the approximately 1,100 physician assistants employed by VA can be expected to play an

increasingly important role in the delivery of VA health care as more emphasis is placed on primary care.

How can VA more effectively include physician assistants in VA health care reform planning and related activities and when will VA take these steps?

How does VA plan to improve the utilization of physician assistants as recommended by the Institute of Medicine in the 1992 study Physician Staffing for the VA?

**Answer:** The VA will be utilizing physician assistants (PAs) to help implement health care reform. The number of PAs in VA has grown over the last 15 years from 15 to 1,100 employees. They have been represented by a Field Advisory Group that regularly provides advice to the Under Secretary for Health. Representation on the recent Health Care Reform Task Force was not meant to be occupation specific, but to deal with VA health care as a whole. PAs will play an important role in the delivery of primary care. To enhance this effort VA is planning to issue new guidelines that will allow for more significant PA involvement in health care delivery.

**Question 26:** VA indicated at the hearing that if enrollment exceeds the capacity of a VA health plan, VA will simply expand capacity through contracting and fee-for-service care.

Will VA health plans have the management capacity to credential unlimited numbers of providers, support unlimited contracts, assure quality care and financial solvency of unlimited providers? If not, what is the true capacity VA envisions for its health plans?

**Answer:** We do not agree that VA enrollment will exceed VA capacity. We believe that we have the capacity and the management capability to meet all the health care needs of the VA health care plan enrollees.

**HONORABLE TOM RIDGE**
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**
**COMMITTEE ON VETERANS' AFFAIRS**

**QUESTIONS SUBMITTED FOR THE RECORD**
**DEPARTMENT OF VETERANS AFFAIRS**

**HEARING**
**BARRIERS AND RISKS: VA HEALTH CARE COMPETITIVENESS AND THE HEALTH SECURITY ACT**

**JUNE 29, 1994**

**Question 1:** VA is basically a disability-based health care system. In fact, it rewards disability through compensation payments to veterans, and entrance into its health care system is based on the presence or absence of a disability or illness. Given these facts, how will VA be able to transition into a model which is wellness and prevention based?

**Answer:** VA has moved from an episodic, acute intervention system of patient care to a primary care based system that utilizes as its foundation, prevention and the promotion of wellness. VA has emphasized to all of VA to medical centers the need to transition to a primary care based system of care. Primary care, as the system of choice, will allow veteran patients to have a single provider who will coordinate their care, provide continuity, and assure that the care is accessible and acceptable to the patient. In recognition of the need for special emphasis on prevention, VA has selected a national center for prevention to be located at the Durham VA Medical Center. A significant part of this Center's mission is the provision of the latest information on prevention to all of the medical centers and their providers through each center's preventive medicine coordinator. In an effort to develop more primary care providers, VA and the Office of Academic Affairs is offering special training programs in primary ambulatory care. This project is known as PRIME. We are also sponsoring fellowships in Ambulatory Care. During these programs, special emphasis is placed on longitudinal care of veteran patients and their need for preventive measures and the promotion of wellness.

**Question 2:** How will quality of care that may be contracted out be monitored? (This is especially troublesome in light of the nearly 4,000 FTEE reductions requested by the Administration, since it takes FTEE for effective oversight).

**Answer:** Currently, when patient care services are contracted out, the services performed outside the VA facility are approved by the medical staff and the VA facility has written agreements that the contractor meets applicable JCAHO standards. Additionally, contract nursing homes are inspected by a VA team prior to initiating the contract and all patients in contract nursing homes are seen on a monthly basis by a nurse or a social worker. Annual renewal of contracts with nursing homes requires JCAHO accreditation, state certification, and/or inspection by a VA team.

**Question 3:** The Department of Veterans Affairs serves the needs of approximately 2.4 million veterans each year. The medical care budget for FY 1995 is $16.1 billion. Given the present DVA health care system, what is the maximum number of users the DVA can treat?

**Answer:** VA's capacity to enroll veterans and their dependents in a VA health plan will be determined by the number of enrollees and the revenue they bring over time. For VA to remain a viable independent system, it must begin to

look beyond its existing patient base and reach out to new users who will balance the current mix of patients thus ensuring fiscal viability. Under the proposed Health Security Act, VA will, for the first time, be able to offer services to all veterans as well as their dependents. As a result, VA will target its health plan at higher-income veterans and their families and nonservice-connected veterans and their families, all of whom would bring their own funds to pay for health services. We will continue to provide health care to service-connected veterans and to low-income veterans at no cost, a benefit they will be unable to obtain from other insurers.

**Question 4:** The Health Security Act contains elements of eligibility reform. However, the legislation may not prevail. If H.R. 3600 is not passed, will VA endorse an eligibility reform proposal this congress?

**Answer:** We are confident that Congress will enact, and the President will sign, health reform legislation during this session of Congress. However, should the Congress not enact such legislation, we would endorse an appropriate eligibility reform proposal.

Chairman Evans to United States General Accounting Office

RESPONSES TO QUESTIONS SUBMITTED FOR THE RECORD BY
THE HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

**1. Does GAO support the goals of VA eligibility reform?**

Response: Yes. GAO testified before this subcommittee last year on the need for eligibility reform and also included eligibility reform in the 1992 Transition Series report as one of the key issues confronting the incoming Administration.

**2. Should veterans who enroll in a VA health plan be provided the same set of comprehensive care benefits as veterans who enroll in competing managed care plans?**

Response: Generally speaking, yes. If the reformed health care system establishes a minimum set of comprehensive health care benefits that all competing managed care plans must offer, then VA health plans could be placed at a competitive disadvantage if they do not offer those benefits. This could potentially force service-connected veterans to choose non-VA health plans to obtain certain benefits. To the extent that health plans are allowed to include benefits in their comprehensive benefits package that exceed the minimum requirement, VA does not necessarily need to match such benefits.

**3. Which veterans should be entitled to free comprehensive health care services?**

Response: This is a policy question on which GAO has no position. Our purpose in discussing the cost implications of the free care provisions of the proposed Health Security Act was to help the Congress make informed decisions about where to draw the line on free care. The VA health care system currently serves both as a benefit program to compensate veterans who have made the greatest sacrifices to their country--such as veterans with service-connected disabilities and former prisoners of war--and as a safety net for veterans who lack the resources to pay for health care from private providers.

If the country implements universal coverage the financial need to maintain the safety net mission is largely eliminated because veterans with limited resources would be able to obtain care through virtually any health care provider with no out-of-pocket costs. The decision the Congress faces, then, is whether to preserve VA's role in serving such veterans or refocus the VA system on any remaining health care needs of veterans.

**4. How can the risks associated with VA becoming a competitive health care provider reported by GAO be decreased without reducing VA's ability to compete successfully?**

**Please provide GAO's legislative recommendations for reducing the risks associated with VA becoming a competitive health care provider. Identify each legislative recommendation which reduces VA's ability to compete successfully.**

Response: GAO is submitting suggested language that would provide VA sufficient flexibility to adapt to local conditions without eliminating internal controls intended to ensure the integrity of the procurement process and personnel systems. We believe VA health plans could be held accountable to Medicare HMO standards without reducing VA's ability to compete as managed care plans. If they are unable to meet those standards, we believe the Secretary of

Health and Human Services should have the authority to determine whether waiver of the standards is in the best interest of the government.

Similarly, we believe regional alliances should have the authority to deny participation to VA health plans under certain conditions. If there is no real risk that a VA health plan will be denied Medicare certification or certification as a regional alliance health plan regardless of the number and seriousness of quality or financial management problems that occur, then VA health plans will, in our opinion, have little incentive to correct deficiencies. In other words, they will be isolated from the competitive pressures applied to other health plans.