

**STATEMENT OF  
ROBERT H. ROSWELL, M.D.  
UNDER SECRETARY FOR HEALTH  
DEPARTMENT OF VETERANS AFFAIRS  
BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
UNITED STATES HOUSE OF REPRESENTATIVES  
SEPTEMBER 30, 2003**

Good afternoon Mr. Chairman and Members of the Subcommittee.

I am pleased to be here this afternoon to present the Administration's views on two bills, H.R. 2379, the Rural Veterans Access to Care Act of 2003, and H.R. 3094, the Veterans Timely Access to Health Care Act. The sponsors of both bills have introduced the measures in an effort to improve access to VA health care facilities by certain veterans. However, we believe both bills, if enacted, will actually be harmful to existing efforts to improve access to VA care. We strongly oppose both measures.

**H.R. 3094**

Mr. Chairman, I will begin by discussing H.R. 3094. This bill would establish a 30-day standard as the maximum length of time that a veteran would have to wait to receive an appointment for primary care in a VA facility. It would also direct that we establish a standard for the maximum length of time that a veteran would have to wait to actually see a provider on the day of a scheduled appointment. If the Secretary finds that any particular VA geographic service area fails to substantially comply with the time standards, facilities in that area would have to contract for the care of a veteran in each instance that they are

unable to meet the standards. The contracting requirement would be mandatory for veterans who are within enrollment priority group 1 through 7, and discretionary for those within priority group 8.

To determine whether geographic service areas substantially meet the time standards for access to care, the bill would require the Secretary to carry out a one-time examination of waiting time data for the entire system, segregated by geographic service area. The review would be of data for the first quarter of the calendar year after enactment of the bill, presumably January, February, and March of calendar year 2004. By July 1<sup>st</sup> of the same year, the Secretary would have to issue a determination regarding compliance with the standard in each service area. If the compliance rate for any area is below 90 percent, then facilities located in that area would be subject to the requirement that they contract for care whenever they are unable to meet the standards.

The bill would also require that we submit two reports to the Committees on Veterans' Affairs of the Congress. The first would be an annual report providing an assessment of our performance in meeting the timeliness standards. The second report, however, would have to be made quarterly, and would have to include very detailed waiting-time data for each geographic service area. The bill would require these quarterly reports to include the number of veterans in each geographic service area waiting for care, distinguished by primary care and specialty care. It would require the data to be broken down by length of waiting time distinguishing between those waiting under 30 days, 30-60 days, 60 days to 4 months, 4-6 months, 6-9 months, over one year and those who cannot be scheduled at all. The quarterly report requirement would continue through the year 2010.

Mr. Chairman, in our view, H.R. 3094 has the potential for dramatically increasing demand for VA care, overwhelming our ability to provide care in VA operated facilities. At this point in time, we don't believe any of our VISNs would

be able to comply with the 30-day standard for 90 percent of patients seeking primary care during the first quarter of 2004. Thus, if the bill were enacted, every VA facility would be forced to offer veterans desiring a primary care visit, the opportunity to receive that care in the private sector on a contractual basis. We believe that huge numbers of veterans who now choose to receive their primary care in the private sector would likely avail themselves of this new benefit. That is particularly the case with veterans who have significant out-of-pocket costs in the private sector, or limitations on the availability of prescription medication. This enhanced demand would have the effect of draining appropriated funds out of VA operated facilities to pay for contract care, potentially requiring that we further curtail enrollment in the VA system.

As you know, it is quite common for a primary care physician to refer a patient to a specialist for further examination or treatment. Physicians seeing patients on a contract basis under this bill would have to refer those patients to a VA physician specialist unless a particular veteran is eligible for fee-basis care in the private sector. Most of these veterans would not be eligible for such fee-basis care. We would anticipate that the increased demand for primary care generated by the measure would dramatically increase demand for specialty care. That would further exacerbate waiting time problems in VA, generate complaints from veterans seeking more timely specialty care, and potentially require further curtailment of enrollment. The Administration preliminarily estimates that the increased demand for VA health care resulting from enactment of the bill could run into the billions.

Another serious flaw in this bill is that it would require VA to trigger the contracting requirement based upon a one-time snapshot of waiting times in the

VA system, presumably during the first quarter of 2004. The bill provides no mechanism for the reassessment of a geographic service area, or for the termination of the special contracting authority.

The bill does not differentiate between an initial primary care appointment and a follow-up appointment, which may be scheduled based on the provider's judgment. The bill makes no allowances for clinical appropriateness of or need for a primary care appointment within 30 days. It also does not take into account patient convenience or agreement.

Although the bill is not precisely clear on the matter, it appears to direct that we create a standard for the length of time a veteran would have to wait to see a provider on the day an appointment is scheduled, and require contracting for care when we are unable to substantially comply with the standard. The rationale for this is unclear to us. Waiting times on the day of appointment are better addressed through performance measures than through a standard arbitrarily designated in law or regulation. We would not turn away a patient because he or she had to wait 40 instead of 20 minutes because of the attention needed by the provider to treat a patient with an earlier appointment or to respond to an emergency situation. Unanticipated delays while waiting to see the provider are not unusual in the health care arena. It is also not clear how the day of service standard would or could be implemented or satisfactorily monitored.

We anticipate the Department would have tremendous difficulty implementing many provisions of this bill, particularly in the required time frames. The assessment of the VA system early next year would be difficult to achieve, and the reporting requirements imposed by the bill would be quite onerous. In many locations, shortages of providers may make it difficult to carry out the contracting requirements the bill would impose. We would also expect to face difficult issues associated with patient medical records as a result of the

fragmentation of care between VA and the private sector that the bill would foster.

As you know Mr. Chairman, in recent years we have faced unprecedented new demand for services. Unfortunately, we have been unable to provide all enrolled veterans with services in a timely manner, and we have been forced to place many veterans on wait lists. However, significant progress is being made on reducing these wait lists. Just over a year ago we had over 300,000 veterans waiting 6 months or more for an appointment. Today, this number is under 60,000. We have established strategic goals to achieve the level of timeliness indicated in the bill and we expect to reach those goals with your help. However, enactment of H.R. 3094 would only make that effort more difficult.

#### **H.R. 2379**

I next turn to H.R. 2379. This measure would require that beginning with fiscal year 2005, we must make not less than 5 percent of all funds in the Medical Care appropriation available to improve access to medical services for veterans in highly rural or geographically remote areas. The bill would require that we spend the funds to increase access by making greater use of our authority to contract for the care, as well as by using other authorities. Initially, we would have to allocate the set-aside funds equally among all of our geographic service areas, but the Secretary could subsequently reallocate the funds from areas that will not use all funds initially made available. After three years, the Secretary could recommend that Congress adjust the overall percentage of set-aside funds, as well as the percentage of the funds to be made available to each service area.

The bill would require that we promulgate a regulation defining what we consider as a highly rural or geographically remote area so veterans living in the area would benefit from the set-aside. However, the bill would provide that at a

minimum, the definition would have to include any area where the driving time to a VA health-care facility exceeds 60 minutes.

As I stated above, we cannot support this measure. Mr. Chairman, VA has developed a very sophisticated methodology for allocating appropriated funds throughout our system in the fairest way possible. This measure would be very disruptive to that allocation system and be unfair to veterans in other parts of the country.

We also have very serious concerns that the bill could result in significantly increasing our non-VA health care expenditures by essentially forcing VA to increase the number of veterans receiving such care. Often such care is much more expensive than care VA furnishes directly. Moreover, to some extent, this would encourage significant additional demand on our already limited resources due to an increase in the number of veterans attempting to access health care through VA. That could be deleterious to our efforts to reduce already unacceptable waiting times for appointments. We certainly do not want to find ourselves in the unwelcome position of disenrolling veterans in Priority Group 8, and possibly stopping the enrollment of new Priority 7 veterans. However, this bill could lead us in that direction.

I would also point out that VA already has authority to provide many veterans with non-VA care at VA expense due to “geographic inaccessibility” to VA care. In using that authority, VA takes into account the individual veterans needs and ability to get to VA care. This measure would significantly redefine “accessibility” and limit the ability of our field facilities to make these decisions.

Finally, as you know, we are now in the process of carrying out a major health care planning process known as CARES (Capital Assets Realignment for Enhanced Services). During that process, we believe that enactment of H.R. 2379 would be inappropriate and potentially disruptive.

The CARES initiative is the planning process for determining the capacity and placement of VA health care facilities, their accessibility, and the acute care infrastructure necessary to meet the current and future health care needs of veterans. At this time we are at a crucial stage of the process. In August, I submitted a draft National Plan to the CARES Commission, and the Commission is currently conducting a series of hearings to obtain input from the various stakeholders, including, veterans, veterans service organizations, Members of Congress, Senators, and local and State officials. Hearings will continue through October 21, and thereafter the Commission will prepare its own report and recommendations and submit them to the Secretary for his consideration and final decision. The Commission's report and recommendations will be submitted in December, and the Secretary will make his final decision by the end of that month.

The CARES draft National Plan incorporates access criteria that were developed through the application of state-of-the-art methodology that was capable of great precision in measuring access, and detailed information to support planning decisions. The CARES approach involved determining the percentage of enrollees living within specific travel times to the nearest, appropriate VHA facility. The data obtained from the methodology allowed access within each market to be scored with regard to two "thresholds." The first threshold was a minimum *percentage* of enrollees living *within* a specified travel time to obtain VA primary care. The second threshold provided that notwithstanding the percentage of enrollees living within these travel times, the total *number* living *outside* the guidelines could not exceed a specified number. In other words, to qualify as an "access" planning initiative according to the criteria developed for CARES, a market had to first meet a *relative* standard (percentage living within access guidelines) as well as an *absolute* standard (a specified number of enrollees living outside access guidelines).

We believe that these exacting and precise access criteria have enabled VA to develop a cost effective investment strategy to improve access in selected markets and ensure the availability of the acute care infrastructure. We are concerned that enactment of H.R. 2379 could seriously disrupt the months of planning and analysis already invested in the CARES process. By forcing reconsiderations and revisions to the market plans of the 21 Veterans Integrated Service Networks (VISNs), it could result in an unacceptable delay in the Secretary's final decision.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to answer questions about the two bills and our position on the bills.