THE DEPARTMENT OF VETERANS AFFAIRS PROPOSED HEALTH CARE BUDGET AMENDMENT FOR FISCAL YEAR 2006

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

JULY 21, 2005

Printed for the use of the Committee on Veterans' Affairs

Serial No. 109-18

22-697.PDF

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001

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THE DEPARTMENT OF VETERANS AFFAIRS PROPOSED HEALTH CARE BUDGET AMENDMENT FOR FISCAL YEAR 2006

WEDNESDAY, JULY 21, 2005

U.S. House of Representatives,
Committee on Veterans' Affairs,
Washington, D.C.

The Committee met, pursuant to notice, at 2:08 p.m., in Room 334, Cannon House Office Building, Hon. Steve Buyer [Chairman of the Committee] presiding.

Present: Representatives Buyer, Moran, Miller, Boozman, Bradley, Brown-Waite, Turner, Evans, Filner, Snyder, Michaud, Herseth, Strickland, Hooley, Berkley, and Udall.

The Chairman. The full Committee on the House Veterans' Affairs will come to order. It is July 21, 2005.

The purpose of this hearing is to continue the oversight of the VA health budget process for fiscal years 2005 and 2006.

By mutual agreement with the Ranking Member, Mr. Evans, prior to the hearing, Mr. Evans and I will make brief opening remarks and members will be recognized for their statements and questions under the five minute rule.

We are here this morning to bring accountability to this process. This is the very reason I elected to serve in this capacity as Chairman of this Committee, to bring accountability and credibility to this process.

We owe our veterans a dignified, predictable, responsive process that provides quality care and benefits today and into the future. Accountability and credibility will ensure that we have that process, one that veterans and taxpayers can trust.

On June 30th, as we met here to determine what resources the administration needed to care for America's veterans, I said "As Chairman, getting the VA budget right is about the most important thing I can do. Without a good budget, how can we provide good care for our nation's veterans? So, we are going to get the budget right." That is what we are going to do.

I am deeply disappointed at the recent series of events that led up to this hearing today. A few weeks ago before this Committee at a hearing regarding the budget modeling, we were informed about the VA's shortfall. We subsequently asked the Secretary to let us know what he needed. He promptly returned with a number of $975 million, which you provided, Dr. Perlin, from your staff.

Before the day was out, the House of Representatives voted the money that was requested to the penny, requested to us on a written transmittal from the President of the United States.

As it turns out, that number now appears to be incorrect. Later we were told in fact that the true number for fiscal year 2005 may in fact require an additional $300 million more than what was originally stated.

I am interested in your testimony today about circulation of that number and what it means.

Later the administration delivered a $1.977 billion budget amendment for fiscal year 2006 to correct shortfalls in the VA's budget for next year.

In order for Congress to exercise its constitutional role to care for veterans, we need to rely on you to provide us timely and accurate information.

I hold you, the senior management of the VA's Health Administration, responsible for providing us that information. To date, I have not been pleased with some of the responses.

I am disappointed by more than just numbers. We have discovered the VA's inability to forecast demand. We have been briefed on the in excess of $325 million in the account receivables yet to be collected. The appointment backlogs continue to grow.

Although, I will pause and say it is the doctors, the nurses, the hospital personnel of VHA who are the true heroes, to also include our volunteers. They care for our wounded and sick veterans every day in our hospitals and clinics throughout the VA system. I cannot help but feel as though they also are not being well served.

I intend to push the bureaucracy at the VA to help change it and make it more responsive to the needs of our nation's veterans. This Committee will ensure that veterans will receive their care.

This Committee will hold you, Dr. Perlin, and members of your staff, accountable for this system.

This Committee will take action to ensure the system works and that it serves our nation's veterans and their families, from our oldest survivors of World War I to the most recently returned soldier, sailor, airman, Marine, Coast Guardman returning from Iraq, Afghanistan, the war on terror, and other places around the world and domestically, to also include our new veterans.

That is what we are going to talk about this afternoon.

At this point, I will yield to Mr. Evans for his opening remarks.

MR. EVANS. Mr. Chairman, the last time we talked here, I expressed my anger over the inability of this Administration to level with us and level with America's veterans as well. Today, I am still angry, but frankly, I am mostly puzzled.

The administration's revised request for fiscal year 2006 still fails to fully address the needs of the VA for the upcoming fiscal year. At this late date, the administration still submits a request that relies upon policy proposals that have been overwhelmingly and repeatedly rejected by Congress. Why is this Administration still not leveling with us?

The philosophy put forth is one to drive veterans out of the system, to kick needy veterans out of long term health care because they don't have enough beds to serve the veterans, and to gloss over the real mental health care needs of our veterans.

We ask our men and women who serve to be willing to sacrifice all that they can give. To honestly tell us what resources you need to care for them is the least you can possibly do for them.

This is an important hearing at this time. Mr. Chairman, I appreciate your setting this time this afternoon to hear these issues. Thank you. I yield back the balance of my time.

[The statement of Lane Evans appears on p. 47]

THE CHAIRMAN. Thank you, Mr. Evans.

We will hear testimony from Dr. Perlin, the Under Secretary for Health, Department of Veterans' Affairs.

Your written testimony will be submitted for the record, and you are now recognized for five minutes.

STATEMENT OF JONATHAN B. PERLIN, M.D., UNDER SECRETARY FOR HEALTH; ACCOMPANIED BY LAURA J. MILLER, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT; AND JIMMY A. NORRIS, VETERANS' HEALTH ADMINISTRATION CHIEF FINANCIAL OFFICER, DEPARTMENT OF VETERANS' AFFAIRS

STATEMENT OF JONATHAN B. PERLIN

DR. PERLIN. Mr. Chairman, Ranking Member Evans, members of the Committee, thank you for your continuing support and ongoing dialogue regarding the interaction of budget forecasting and finances of the Veterans' Health Administration.

Accompanying me today are Ms. Laura Miller, Deputy Under Secretary for Operations and Management and Mr. Jimmy Norris, our Chief Financial Officer in VHA.

Mr. Chairman, considering our budget planning and the request for fiscal year 2005 supplemental appropriations, as well as continuing

resource needs for health services for 2006, I'd like to discuss what facts underlie the need for a fiscal year 2005 supplemental request.

VA requested a supplemental appropriation in the amount of $975 million for fiscal year 2005 in June of this year. That supplemental request was needed because our expected forecasted growth, based on the actuarial model, was 2.3 percent, and VA discovered in March 2005 that the actual growth had accelerated through mid-year 2005 to 5.2 percent.

This was a difference of 2.9 percent above the original projection. This higher than anticipated demand for VHA services was a major factor driving our need for a supplemental appropriation.

Mr. Chairman, as we discussed during your June 23rd hearing, VA uses an actuarial model to forecast patient demand and associated resource needs. Actuarial modeling is the most rational way to project resource needs of a health care system like VHA.

As I noted at that hearing, that's the approach used by the private sector. Unlike the private sector, however, with the projections used to formulate budgets for the next year or even the next open season, the Federal budget cycle requires budget formulation using data two and a half to three and a half years ahead of actual budget execution.

For example, the data used to formulate the budget in fiscal year 2005 was derived from health care utilization data in fiscal year 2002. In this case, the last full year of data before the Department's fiscal year 2005 budget formulation process began.

Our actuarial model forecasted 2.3 percent annual growth in health care demand in fiscal year 2005. We discovered that growth had accelerated through mid-year 2005 to 5.2 percent above 2004. This constitutes a substantial increase in workload and resource requirements.

As a result, our increased medical care costs in 2005 are $975 million based on increased patient demand and increased utilization of health care services.

With respect to 2006, I believe that an additional $1.977 billion above the President's budget request is needed to continue to provide timely, high quality care to enrolled veterans. This includes for 2006 $300 million to replenish carry over funds that are being used in fiscal year 2005 to cover the increased average cost per patient.

It also includes $677 million to cover an estimated two percent increase in the number of patients expected to seek care in 2006; $400 million to recognize the expected cost of providing more intensive treatment, and $600 million to correct for the estimated cost of long term care.

The administration has come forward to Congress with a proposal to provide VA with these additional resources. The total need for both years is $2.952

billion, comprising a fiscal year 2005 supplemental request of $975 million and a fiscal year 2006 budget amendment of $1.977 billion.

These amounts assume enactment of the policies in the President's budget. If Congress does not accept any of the policies in the President's budget, additional resources to offset the cost of policies not enacted will be needed still.

While the 2.9 percent variance among the number of patients projected is far better than the variances that occurred under the previous system, when VA budgets were projected simply by inflating an historical base, it is clear that we need to improve the models and methodologies' performance, and we will work with you to improve not only the model and methodology, but the overall process. Indeed, we must.

Planned improvements of the model include obtaining access to data on VA enrollees' use of Medicaid, Tricare, and military treatment facilities, integrating VA's long term care model into the actuarial model, and modeling additional services, such as dental care.

In addition, we need to continue the progress already made with DOD to better engage them in data sharing and projections regarding OIF and OEF returnees.

To address the average three year time lag in the budget process, we need to also better consider trends in the economy and environment that might not yet be incorporated into past data and then into the model.

We can incorporate those and they can be provided to adjust our budget formulation process.

Since VA is a low or no cost provider, we must better anticipate the effects on our system as the other health care options to veterans become more costly.

Perhaps more importantly, the Secretary has committed to quarterly reviews with this Committee to address resource needs in light of VHA's most current operational experience.

Mr. Chairman, members of the Committee, in closing, I believe the resources requested in the supplemental appropriation for fiscal year 2005 proposed by the administration and the President's budget amendment for fiscal year 2006 reflect the commitment and support by the administration to the veterans of this nation in meeting the increased demand for VHA health care services.

Thank you for your support of veterans and VA, and for the opportunity to testify before you on this complex issue.

[The statement of Jonathan B. Perlin appears on p. 48]

THE CHAIRMAN. Thank you for your testimony, Dr. Perlin.

Dr. Perlin, have you briefed the Secretary of Veterans' Affairs on VHA's monthly performance reviews for the past 15 months as Acting Under Secretary for Health and now as the confirmed Under Sec-

retary for VHA?

DR. PERLIN. Mr. Chairman, the monthly performance review is held with the Deputy Under Secretary presiding, and the Deputy Secretary in turn discusses outcomes of the monthly performance review with the Secretary.

THE CHAIRMAN. At each of these briefings, how is then the Deputy Secretary briefed on the forecast budget requirements and actual budget execution?

DR. PERLIN. Mr. Chairman, the monthly performance review has virtually for number of veterans using the system, the number of patients as well as the number of enrollees, a column that shows the actual performance, the actual numbers.

There is a lag time of one to two months, depending on how quickly we have the monthly performance review, and that is tracked against both the previous year, as well as against plan.

THE CHAIRMAN. What is the role of the VA's corporate chief financial officer and the chief network officer in formulating and preparing the monthly review?

DR. PERLIN. The VHA's chief financial officer has the role of actually consolidating the data used to put the book together from VHA to provide to the Deputy Secretary. The execution of the resources, the line direction for that is provided by the Deputy Under Secretary for Operations and Management, formerly entitled the chief network officer.

THE CHAIRMAN. When did you inform the Deputy Secretary of a divergence between the 2005 budget and the monthly performances?

DR. PERLIN. That is really the key point. As we testified, with a lag of about 30 to 60 days, April and May, it was apparent that not only were the numbers of actual veterans tracking above projection, but that this was going to begin to have some impact on budget and not tracking with budget.

I believe that would be the April/May monthly performance review when that began to diverge.

THE CHAIRMAN. Have you been able to decipher why there was such a spike in May?

DR. PERLIN. Historically, usually there is sort of a seasonable trend in the number of veterans that come to us, but this was an unusually high number that came at this point in the year.

What was apparent during the month of May was we were beginning to diverge not only in terms of the numbers of veterans seeking care, but in terms of the consumption of resources, such as use of capital dollars, non-recurring maintenance, non-critical equipment, for the actual operations, paying for the cost of care for those patients.

THE CHAIRMAN. When you sent this letter to Congress talking about you are going to have to move $600 million, that was in April when you informed the Appropriations Committee?

DR. PERLIN. Yes, I believe, Mr. Chairman, there was a letter from the Secretary informing the Appropriations Committee Chairman and Ranking Member of the desire to reprogram $600 million of capital, and I believe some other administrative dollars for reprogramming as well.

THE CHAIRMAN. What we have is this moving target. You inform Congress of $600 million to reprogram, and in the latter part of June, the testimony is the shortfall is $975 million. Then we come back after a July break and we say oops, now there could be another $300 million that may be necessary.

Is there another number that's about to hit us? You know what I'm saying? This thing is tracking upward and is going to continue to track upward? Then what it does is it leads us to make sense next week to say, all right, fine, Senate, you chose this $1.5 million number. Is that where this thing is taking us? Besides, if you don't use the extra monies, they are carried over into 2006, which affects your budget amendment that you bring to us.

Help this Committee understand this.

DR. PERLIN. Mr. Chairman, that is a very valid concern. It's one that I share. I sat with the Secretary and testified to $975 million at that hearing.

Clearly, my belief is that $975 million is what we need to go forward with for the 2005 replenishment, but during that week, there was a good deal of activity and looking into what the actual consumption was by querying the field, and additional resource consumption came to light.

We could have done a better job. We should have had more timely data. I would concur with what I take is if not implicit, an explicit recommendation to improve the accountability, improve the timeliness, improve the clarity of the tracking of those funds.

I know that in that process, we put the Secretary and we put you and this Committee in a tough situation.

THE CHAIRMAN. Before I yield to Mr. Evans, when you make these separate requests like this, the Senate takes different action. We act on your requests. It becomes a credibility gap. There is an erosion here.

Then there is this corrosive rhetoric that is used out there that has a depreciating effect upon the men and women in uniform and the families, and none of it is healthy.

Right now, I yield to Mr. Evans.

MR. EVANS. Mr. Chairman, at this time, I want to yield to my colleagues. I yield at this time to Mr. Filner.

THE CHAIRMAN. Mr. Filner, you are now recognized for five minutes.

MR. FILNER. I thank the Chairman and I thank the Ranking Member. Mr. Chairman, I appreciated the comments on accountability

and some of the questions. I think we are more than a few months late and more than a few billion dollars short, however, because many of us were raising these exact same issues many, many months ago, and credibility was gone then, not just now.

Dr. Perlin, I have watched this Administration over the last month, the VA, the OMB, the White House, basically show enormous disrespect for our veterans. I can see the insult to the veterans. I see it continuing today, sir.

You continue to talk about a mathematical model as if you are locked up in a little room with only a computer there, and you get figures from three years ago and you plug them in.

Talk to people outside who are in the hospitals. Talk to the veterans. Talk to the VSOs who put together the Independent Budget. Why were they right on the mark? When I go to my VA hospital in La Jolla, why do I see almost 1,000 veterans on a waiting list? I see 300 vacancies in the hospital. I see nurses stations unfilled. I see people waiting a year for a dental appointment. Years for adjudication of their claims, though not in your bailiwick.

All you have to do is ask any veteran and you know there is a problem.

You keep talking about a model as if we are run by a mathematical model that didn't account for a war going on. Don't keep telling us that you are run by a model, which is what you keep doing.

You know there is a war going on. You know people are coming back with PTSD. Talk to them. Get the resources in there. You know there are vacancies. You are still talking about a mathematical model.

I think that is incredibly insulting to the veterans of this nation.

This side of the aisle tried, in fact, to add the resources that you are asking for now, and we kept being shot down by the other side, because it didn't fit into their budget.

Then you come to us today with another request, $1.97 billion for 2006, when you know we have already refused to accept your policy recommendations on raising prescription drug fees and enrollment fees.

You are acting as if, "oh, we didn't know that happened." What about the $1.2 billion to make up for the rejection of fees? Why don't you ask for that now? We have rejected that policy, but you are not coming back with a number to cover those costs.

Mr. Perlin, I don't understand why you are still talking about a model. You are still talking about figures which have no relevancy to reality. You have been found out, and you are still talking about it as if you have not been found out.

Let me ask you specifically. Mr. Bolten, head of the OMB, has testified to the Budget Committee recently.

He said each of the last three years, the VA health care system had

half a billion dollars more than it needed. This is what the administration testified to, a half billion dollars more than it needed.

In the face of waiting lists, in the face of vacancies, in the face of year long waits, do you agree with Mr. Bolten that you had half a billion dollars more than you needed, that was appropriated in the last three years?

Sir, are you aware of that statement?

DR. PERLIN. I'm aware of the statement and I'm aware of the fact that indeed, there were carry overs.

I would like to answer your first question though.

MR. FILNER. That was my first question.

DR. PERLIN. In my statement today, sir, if I may, I did note that if Congress does not accept any of the policies in the President's budget, additional resources --

MR. FILNER. We already turned them down. You are acting as if you don't know that, just like you didn't know the war was going on. Get out of your computer room. Look at the reality. Talk to the veterans who put together this Independent Budget. Talk to us who go to our veterans' hospitals and talk to veterans when we are in our districts.

We hear these stories, and you think we are just politicians who don't know what's going on. We know what's going on. You don't know what's going on.

You better start learning what's going on because you keep testifying as if we don't know what's going on.

The Chairman talked about a lack of credibility. You don't have any now. You continue to talk in the same old model.

Do you know how many people are on waiting lists throughout the nation today, waiting for their first appointment, and how many vacancies there are in staff positions throughout the nation? Do you have that figure?

DR. PERLIN. Sir, there are approximately 25,000 today who are on waiting lists.

MR. FILNER. 25,000? You are still talking about a model? Why don't you talk about how you are going to serve those 25,000?

DR. PERLIN. That's why we came forward with a supplemental --

MR. FILNER. How many vacancies are there, staff vacancies, around the country?

DR. PERLIN. Sir, that's why we came forward with the request.

MR. FILNER. How many staff vacancies?

DR. PERLIN. What I can tell you is we are approximately 7,000 FTEE above what we had predicted, just so we could provide timely services to veterans.

MR. FILNER. That is not the question. I said how many vacancies to serve the veterans do we have now?

I'm told in my VA hospital in San Diego there are 300 vacancies.

You should have a list of every hospital and what their vacancies are. Do you have that?

DR. PERLIN. I could determine what number are available throughout the system. The fact of the matter is, we are approximately 7,000 personnel higher than were predicted.

MR. FILNER. I'm not asking what you predicted. You just told us the model is ridiculous. I want to know how many personnel we need to serve the veterans that we have and who are on the waiting lists. How many short are we?

DR. PERLIN. I'd have to come back.

MR. FILNER. Come on, Dr. Perlin. This is what your job is. How many veterans we have to serve, do we have the facilities, do we have the personnel to serve them? You don't even have those figures? How are you going to come up with the right number if you don't even have these figures at your disposal?

I can tell you in my hospital what the figures are. That tells me how much money I need in the San Diego Medical Center. You should know that for every medical center.

Your statement was completely irrelevant to the needs, and you don't even have the information to answer the basic questions.

I would yield back.

DR. PERLIN. We have 127 vacancies in your hospital at San Diego.

MR. FILNER. How many in the whole country?

DR. PERLIN. I don't know. I do know San Diego because your office requested that information.

MR. FILNER. I know that figure. I want to know what the figure is for the whole country. How are you going to serve the veterans if you don't know how many vacancies there are?

THE CHAIRMAN. I thank the gentleman for yielding back his time. I appreciate your being responsive to Mr. Filner's question, and please get that in a timely manner to him.

MR. FILNER. For the record, he is not responsive.

THE CHAIRMAN. I would appreciate it, Dr. Perlin, if you would be responsive to the gentleman from California's request.

DR. PERLIN. Yes, sir.

THE CHAIRMAN. I also think it would be very helpful in being responsive to his question when he made reference to the model.

You had already testified previously that the model is also used in the private sector, and there were concerns about the data and the assumptions.

We are now getting into this and beginning to understand it a little bit better. You are also now having to deal with trying to get it right for 2005. We have to get this done before we leave for the August break. We have an 2006 budget amendment, and you are preparing the 2007 budget as we sit here.

I think it would be very helpful to this Committee and responsive

to Mr. Filner's questioning, to know what changes you are making with regard to input of new data or changes in the assumptions.

Obviously, you took something into account by giving us an 2006 budget amendment and as you are working on 2007.

I think that would be the best thing to be responsive to Mr. Filner's concern.

DR. PERLIN. Thank you, Mr. Chairman, for the opportunity to be very clear on how the model needs to be improved. In fairness, this is how we identify what resource needs are for veterans and how we work together to identify a budget.

As I stated, the formulation process to budget execution has an inherent lag time. It's been arbitrary, that end of year data from the preceding year has been used. For instance, the 2005 budget was predicated on end of year 2002.

One of the things that we are working with the actuary to do is move those data so they are rolling. Perhaps the most recent 18 months, so it is a little bit closer to reality.

We also know that veterans receive care in other environments, Medicaid, Tricare, military treatment facilities. We also know they have dental needs and long term care, and all five of those categories, Medicaid, Tricare, MTF direct care, dental care, long term care, have previously been excluded from the model. We are working with the actuary to include those.

We are also looking to deconstruct how we failed in terms of getting it right this year. We had discussion previously on better sensitivity to separating service members as they become veterans.

We are working with the Department of Defense to get more timely information, not just about separation data in general, but about the activation and predicted separation rates of Reserve members who may be called up and then become eligible for care.

We believe those will be a number of features that will improve this model.

You may say I'm still skeptical. How can you rely on a set of methodologies given the experience that we have had. The truth of the matter is we used to use the historical process. We used to just plus up on the historical base.

Once we were off by ten percent in 2002. Unfortunately, we were short. The previous year, we were off by 11 percent. That year, it was in VA's favor. Those degrees of variance or error are substantially more.

I would tell you that the model is not inherently bad. The challenge is in the lag time and some of the additional data.

I understand Mr. Filner's concerns that the model doesn't operate in isolation. These are real people coming to real VA, and we have a real time obligation to get it right. That is why Secretary Nicholson was absolutely passionate about --

MR. FILNER. What is the difference if you get it right if OMB says you have too much money anyway? They are the ones making the final decisions.

You didn't answer my question if you agreed with his assessment that you had half a billion dollars more than you needed.

THE CHAIRMAN. I need to ask for regular order.

Thank you for the answer to the question.

Mr. Miller, Subcommittee Chairman on Disability Assistance and Memorial Affairs, is now recognized.

MR. MILLER. Thank you, Mr. Chairman. I associate myself with most of the remarks of my colleague, Mr. Filner.

Dr. Perlin, are you embarrassed? Are you embarrassed by what's happening?

DR. PERLIN. I am embarrassed with what's happening.

MR. MILLER. Here today we celebrate the 75th anniversary of the VA, and all the good that the administration has done, and you have members of this Committee so angry about what's going on.

This is one of those Committees where everybody tries as best they can to de-politicize what's going on because our ultimate goal is serving the veterans.

Politics will always creep into it, but the decisions and votes that I make are based on the information that you testify to and you provide and the administration does.

I find it hard to believe that if you do these quarterly reviews, that the information that you forecast through this model on is so stagnant, that it's causing the problem.

I think something that a lot of us probably want to know because it has affected every member on this Committee and every member of this Congress is when did VHA stop dis-enrolling beneficiaries that hadn't been to the VA within a two year period? We are all hearing that from our veterans. If you will answer that first.

DR. PERLIN. Yes, sir. I will need to check because this has been a long-standing policy that if someone doesn't come for a period of two years, we open up the slot for the primary care provider to new veterans. I believe that has been a policy. I will find out for you the date on which we began that.

We require a primary care provider on average to have a panel of approximately 1,200 patients, and we want to make sure that we always open capacity for the newest patients, and that was the rationale behind that decision.

MR. MILLER. You say it's a policy. My next question is under what authority do you have to make that decision and when that decision was made, did you in fact inform Congress that you were going to be doing that?

Real quick, I'll tell you how we were informed. We got letters from veterans that came in and gave them to us. That is the notification

that was made to us.

DR. PERLIN. Sir, I should be very careful in the terms. It's not enrollment. It's empaneling with a particular care provider, primary care provider. We do open the slot if the veteran does not come to that primary care provider after a period of two years.

MR. MILLER. How was Congress notified that you were taking those steps? At what point?

DR. PERLIN. I don't know. I would have to find that out for you, sir.

MR. MILLER. On page three of your testimony in the second paragraph, you said "These amounts assume enactment of the policies in the President's budget, and if Congress does not accept any of the policies in the President's budget, additional resources to offset the cost of those will still be needed."

Explain that a little further.

MR. PERLIN. Sir, in the budget that the VA put forward, there were four policies. One, requesting an enrollment fee. One for an increase of prescription co-pay. Both of those policies were Priority 7 and 8 veterans. As well as two long term care policies, one associated with state veterans' homes and one associated with VI.

The total monetary effect of those or appropriation effect of those was approximately $1 billion, and absent enactment of that, in addition to the $1.977 billion that we have come forward with the presidential budget amendment request for, an additional $1 billion would be necessary.

MR. MILLER. Surely, you are not implying that this Congress is the reason for the shortfall.

DR. PERLIN. No, sir.

MR. MILLER. Because this Committee has said no to several of those recommendations. I don't even understand why the inference is even in your testimony, because that has already been brought forward for authorization, and the answer was no.

DR. PERLIN. Yes, we understand that.

THE CHAIRMAN. Mr. Michaud, you are now recognized.

MR. MICHAUD. Thank you, Mr. Chairman.

Dr. Perlin, I believe part of the reason why you are spending so much time here with us is because the VA and the administration has failed to level with Congress and with our veterans. If you would tell us what you actually really need, then we could work in a bipartisan manner to try to address that.

It goes back to the same questions that we keep asking over and over again, and we don't get answers on, what is the original dollar figure that you asked for. We never seem to get the answer.

You have been around for a while. Secretary Nicholson, when he was here, he said he was only there for a few months, he did not know, but what was the number that you have asked OMB for?

DR. PERLIN. The challenge now is, of course, that their assumptions

were off. We have had very good dialogue with OMB on exactly what are our needs, based on our missed estimation in 2005 and 2006.

MR. MICHAUD. That's not my question. My question is what was that number. I don't care whether assumptions were off or not. It gets back to the very fundamental issue of whether or not you are requesting enough but OMB is not providing enough.

It gets back to a question that Mr. Filner had asked dealing with Mr. Bolten's comments that you requested more money than what you actually need. Mr. Filner's question was "do you agree with Mr. Bolten's assumption?" Have you asked for more money than what you need? Yes or no?

DR. PERLIN. In previous years, sir?

MR. MICHAUD. Do you agree with Mr. Bolten's statement that VA has asked for more money than they actually need?

DR. PERLIN. I'm not sure that was his statement. I don't mean to be argumentative. I think he represented the fact that we carried over money in those years.

MR. MICHAUD. I quote "There has been three consecutive years preceding this one in which there was more money requested by the administration and more money appropriated by Congress for the medical care portion of veterans' services than was actually needed in that year. The appropriations have exceeded the VA's medical care needs in the preceding three years by over half a billion dollars in each of the preceding years."

My question is do you agree with that, that you have asked for more money than you need, and then the other question is do you support the provisions that allow you this two year authority for a portion of your funding?

DR. PERLIN. I would say that we requested what we felt we needed in all years. In terms of your second question, the two year authority, I believe you are referring to the supplemental appropriation.

MR. MICHAUD. The authority as far as the two year, using that carry over of money. You are allowed two years to use it. Do you agree with that language, and if so, why?

DR. PERLIN. Yes, sir. I think it gives us increased flexibility to spend responsibly. We want to make sure that given the shortfall that we are experiencing that we execute resources as quickly as possible, but never make decisions that are simply to execute funds before an arbitrary time period. We want to make sure they go in the best interest of veterans.

MR. MICHAUD. My next question, and I mentioned it when Secretary Nicholson was here, when he first testified before the Committee, and it was a question that I brought up because the Bangor Daily News in Maine has reported that VISN 1 had a budgetary shortfall for fiscal year 2005. This was in January and February, when they actually mentioned there was a shortfall. They clearly knew back then there

was going to be a shortfall.

My question is -- as a result of my meeting last week with the VA, I've learned there has been incidents where VISNs have actually been borrowing from one another for shortfalls, and VISN 1, which is Maine, they have been forced to borrow money.

My question is how is this borrowing coordinated through the VA headquarters, and do you track it from year to year?

DR. PERLIN. Congressman, it is not unprecedented to transfer funds from one network to another or to think allocations are absolutely perfect, I think, would be overly ambitious. It's good, but it's not perfect. We do periodically correct it when we need to.

Let me ask Ms. Miller to comment on how that is managed.

MS. MILLER. Thank you, sir. You are accurate in that Network 1 had the need for some funds for some non-recurring maintenance projects that were urgently needed and had utilized their non-recurring maintenance money for operations.

Working through central office, they did coordinate to utilize funds from another network until the 2006 budget, at which time they would return those funds.

MR. MICHAUD. The second part of that question, if I might, Mr. Chairman, is do you track that from year to year, and what was that total dollar amount, and how are you ever going to make that up if you are borrowing? Are you going to make it up with the additional funding in the upcoming budget cycle?

MS. MILLER. Sir, this is an unusual situation. I'm not aware of this occurring on an ongoing basis. This is the only one that I am aware of in the recent past. We will track it. There is an expectation that those funds would be returned, and presumably, that would come out of the 2006 budget allocation.

MR. MICHAUD. You said you will track it, but have you been tracking it all along?

MS. MILLER. Since there haven't been any other situations that I'm aware of, we have not had the need to really track.

MR. MICHAUD. What effect, if I may, Mr. Chairman -- if the money is going to be paid back say from VISN 1, what effect is that going to have on that fiscal year's budget, if they have to pay back from a previous year. It must have some effect on the services they are going to be able to provide veterans, particularly since we have seen a shortfall in the care and in funding.

MS. MILLER. You're correct, Congressman, that there will be an impact on their 2006 budget, but the issue was felt to be a timing issue in terms of moving forward with some projects that the network felt could not wait until fiscal year 2006.

MR. MICHAUD. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you. Mr. Bradley, you are recognized.

MR. BRADLEY. Thanking you, Mr. Chairman, Mr. Evans, for the

leadership that you are displaying on this issue, trying to get to the bottom of the problem, trying to rationally solve the problem.

We all get in a lather once in a while on this Committee, but I have to commend both of your gentlemen for really sticking up for the veterans and trying to resolve the problem.

It would appear to me just in looking at some of the big budget holes that have come up, long term care is something that when you look out in the future, a three year model ought to do a much better job of estimating the cost of long term care, but that is something that a model, I would think, can adjust for.

What the model evidently can adjust for, which makes sense, is the fact that we have had several hundred thousand people on the ground in that three year period. It would seem to me that is why, if we are going to solve this problem, you need to look a little bit outside the box of your model.

Mr. Filner brought this up. That being the Independent Budget. When Secretary Nicholson was here, I asked him whether the VA was starting to discuss the parameters of the Independent Budget with the authors of that budget to try and resolve this, to bring a little bit more transparency in, unfortunately, a little bit more credibility to this issue.

This isn't a question. It's more of a statement. I would just urge you to think outside the box, especially where there is an issue of now just moving targets of 975 and 1.5, and now the 2006 budget.

We are just left scratching our heads. The authors of the Independent Budget have seemingly done a much better job of anticipating what these costs are. It would seem appropriate, especially given the moving target nature of this, that if our goal here is to solve the problem, and I think it is, and that's why I commended the Chairman and the Ranking Member, and certainly the members on the other side of the aisle want to solve the problem, we want to solve the problem.

There are some experts out there that I think you ought to be talking to, and really talking to at great length and in great detail.

Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you. Ms. Hooley, may I make this statement? Dr. Perlin, Congress also has to deal with the military health delivery system and that model has been very challenging. They have testified here also with you.

Congress made a decision as we moved into the war that we would fund over and above from the supplemental. We have not done that as a policy decision with regard to the VA.

This is in fact your job, to receive. It is rather mind boggling, I think, to all of us here, that surge in capacity, and how DOD transfers these patients to you, whether it's a soldier, sailor, Marine, airman or Coast Guardman coming off active duty to new veteran status, or in particular, the ones right down there in Bethesda that go to your VA

for rehab and then you seek reimbursement.

How all that wasn't taken into account in a model is mind boggling to us. We are appreciative that you are going to be very responsive to this in your new models.

Thank you, Mr. Bradley, for bringing it up.

Ms. Hooley, you are now recognized.

Ms. Hooley. Thank you, Mr. Chair, and thank you so much, and Ranking Member, for having this hearing, and to Mr. Bradley, we do get in a lather but it's because every single person in this room cares about what happens to our veterans.

When I'm out speaking to groups and I'm talking about veterans' health care, let me tell you some of the things I say. I'm not an expert in this area, but here's what I talk about when we talk about costs.

I say we just haven't kept up with costs, and the reason we haven't kept up with costs is first of all, health care costs are going up faster than the cost of living. Also, because of the war, there are more people coming into the system. And as our veterans' population ages more, it becomes more expensive. There is more long term health care.

We have not lost as many lives in the war, but there have been a lot of wounded. Some of those are going to be extraordinarily expensive, and they are going to be severely damaged, and that is going to cost us more money. The cost of modern prosthesis has gone up.

Those are all factors that we haven't taken into account when we look at the VA budget. We need to increase funding to give adequate care to our veterans.

My question is of just those things that a lay person talks about, those are the things that all of us know happen. How much of those are in your model? How much credence do you give all of that?

Dr. Perlin. Thank you for that very insightful question. The previous question from Mr. Bradley and Chairman Buyer's comments that there are returning troops and a large number have come to VA, fortunately, most have not had significant physical injury. Some have had particularly egregious trauma.

Ms. Hooley. Right.

Dr. Perlin. Given what we know now, and I think it's fair criticism to say we should not look at life through a model but through the lens of the patients that we are taking care of.

We figure that in, and the numbers that I bring to you today, what this Administration put forward in terms of the supplemental and the President's budget amendment, we looked specifically at the new prosthesis to make sure that any returning service member who needs state-of-the-art new equipment gets the state-of-the-art new equipment.

Those things have not historically been figured into the model. In fact, they have been called non-model items. I can assure you that they will be scrutinized, and at the risk of being repetitive, I think

that's why Secretary Nicholson is so passionate about meeting with this Committee quarterly to be able to discuss with the Chairman and Ranking Member the realities of what is going on in real time.

MS. HOOLEY. Do we take into account the fact that health care costs are going up faster than cost of living?

DR. PERLIN. Absolutely. The actuarial model figures in any trends in health care inflation, figures in new technologies. It doesn't necessarily figure in those things that are unique to the service we provide, like prosthetics.

MS. HOOLEY. The fact that we have an aging veterans' population as well, which is going to cost us more in long term health care and just health care in general?

DR. PERLIN. Yes, ma'am. The model looks at 55 different services being delivered, and to call it a ``model'' implies it's a black box of some kind, it's a computer, you push a button. It's not.

It's a set of very rigorous methodologies. It looks at age of the patient and geography, technologies.

MS. HOOLEY. I have a little bit of a problem with the model, only because it didn't even recognize we were in a war.

I just have to get this out because I'm very slow to get angry. There is not much that really really makes me angry. I am probably as angry as I ever get. That is the waiting lists. We are not talking about seven and eight priority veterans. I'm talking about waiting lists that are a year and a half/two years to get hip replacements or knee replacements or hip surgery.

I happen to have had knee surgery. Anybody that I know that has had that kind of surgery, they wait until the last minute, until they really can't stand it any longer, and then they go in and have surgery.

I can't imagine what it would be like if I needed hip replacement or knee surgery and when I got to the point of needing that surgery, I then had to wait another year or year and a half or two years, and the pain that one person would go through.

I think that is so egregious and outrageous. We shouldn't do that to people, I don't care who they are, but certainly not to our veterans.

My question is when are we going to shorten those lists for those people waiting for that kind of surgery?

DR. PERLIN. Right now, with enactment of that supplemental and the additional request for 2006. In each of the two years, a portion of those dollars are directed at reducing -- eliminating those waiting lists.

MS. HOOLEY. Are they going to reduce the waiting lists or are they going to eliminate the waiting lists? What do I tell my veterans that are waiting for those kinds of operations that are at the point that they can't stand the pain any longer, and it's not because of the doctors and the nurses and the VA hospitals. They do a wonderful job.

They can only do with what they have.

DR. PERLIN. They will receive that care with better timeliness than in any other health sector.

MS. HOOLEY. No waiting lists, six months, three months, what are we talking about?

DR. PERLIN. Let me be clearer. Our goal, despite more veterans, and I would agree with you, there should be no veteran who has to wait, but despite these cases, the actual number of veterans seen within 30 days of the desired appointment date, both primary and specialty care, is beyond 94 percent for specialty care and 95 percent for primary care.

That's the goal, to have all veterans seen within 30 days, and no veterans waiting over 90 days.

I've just been benchmarking that with other countries and other health plans. If we could get to all those veterans being seen in those time parameters, VA would be the number one in the world.

MS. HOOLEY. That's where I want it to be. Thank you.

DR. PERLIN. Thank you for your support.

THE CHAIRMAN. Dr. Boozman?

DR. BOOZMAN. Thank you, Mr. Chairman.

I've been a pretty active member of the Committee since I've been here for the last four years and sat through many budget hearings, both here and privately and this and that.

Again, I've really been supportive in giving the system what was asked for.

My hospital has been affected in the same way as many have, with the longer -- quality of service is excellent if you are fortunate enough to get in in a reasonable length of time.

Also, the lower priority folks, you know, who haven't been there in a while, get the "we will be glad to see you in 18 months" rhetoric.

I guess my question regards a couple of things. First of all, I know there are other hospitals that aren't in that situation. We are the fifth fastest growing regions in the country right now, and yet with the growth, they have actually had physicians pulled to meet our growth, which doesn't make a lot of sense.

How do you determine that? Is that a political decision, where the dollars are going? What is the rationale behind what hospitals that are getting the dollars and those that aren't getting funded to meet growth in demand?

The second part of my question, is that you have come to us again. You said I need this amount of money. I'm very supportive of that.

Mr. Filner and I had the opportunity to visit when we were congratulating the VA on its 75th anniversary. On the Floor, I said I'll support whatever it takes to get this thing right.

I guess my second part reflects Ms. Hooley's concerns. If we approve this amount of money for 2006 and we have the 2005 funding

issues, when am I going to see the quality of the service that we have had for many years in the Fayetteville VA?

When are we going to see that or are we going to see it go back to what I consider normal, that we have worked so hard for many years to get to that level. Now, all of a sudden, we are much below the standard that I see when I pour through the budget thing that you put out as far as your waiting times and quality.

DR. PERLIN. Congressman, let me begin by thanking you for your support of VA and veterans. Thank you also for your acknowledge of the quality of care.

I think one of the pieces in context that I would be remiss if I didn't provide is as evidenced this past week in U.S. News and World Report which referred to VA care as the top notch health care delivery system.

There are waiting lists. In Fayetteville, you have indicated it is the fifth fastest growing area of the country. Indeed, the numbers that I have, over the past five years, the growth has been as high as 28.76 percent growth in Fayetteville alone, which is significantly higher than the numbers we have been citing about the annualized growth of the entire system.

You asked is there a fair distribution mechanism to make sure resources get to hospitals and the dollars should follow the patients. They haven't been following fast enough. My goal with the resources that you are generously supporting is to make sure that the waiting lists are worked down so that all veterans get care and VA performance, as I mentioned.

Thirty days for primary care and 30 days for specialty care for 95 and 94 percent of all veterans, respectively, and no veterans waiting over 90 days, and under no circumstances a veteran with an emergency or need of urgent services ever waiting.

That is our goal, and that's what I intend to do with the resources.

DR. BOOZMAN. Again, with a growth of 28.6 at Fayetteville, which is significantly higher than other VA hospitals, why would you actually reduce physicians at the Fayetteville VA versus some place else? How are those decisions made?

DR. PERLIN. I think any decision to change personnel is made as a balance. I don't know the particular situations or what type of physicians. Sometimes, you know, you hire a doctor in lieu of someone who is doing maintenance. Sometimes you consolidate, instead of a doctor, you might hire two nurse practitioners or physician assistants.

I don't know the particular instances at Fayetteville, but I'd be pleased to look into it.

DR. BOOZMAN. With the money that you are asking me to approve now, to support you with, will we go back to the level of service shortly that we experienced, or do you need to ask us for some more money? That's my question.

Is this enough. Do you need more. That's what I want.

Dr. Perlin. Thank you for your support. Given this process, I think you all would fully understand that I have no desire to be back here in this chair asking for more.

[Laughter.]

DR. PERLIN. I have scrutinized to the best of my ability the data that have come forward looking at the needs for prosthetics, the needs of returning service members, and the needs of the veterans who don't fall into one of those unique categories, but go to every VI and clinic throughout the country, that do we have the right resources.

We have debated and discussed, and I am confident with funds in lieu of policy and with the supplemental, and with the President's budget amendment, that gets us to being able to provide not just the highest quality of care, but timely and good service as you have requested and veterans deserve.

DR. BOOZMAN. Thank you.

THE CHAIRMAN. If I may, Mr. Strickland, what I have done is I have asked staff to pull recently received from the VA, the estimated waiting list as of July 15, 2005 for new enrollees and established patients. They are over 30 days.

Mr. Strickland, if I may, as a follow up here off Ms. Hooley and Dr. Boozman, as I look at this, and I just shared this with Mr. Filner, in Charleston, you have estimated 1,638 patients. In Cleveland, 56. In Indianapolis, 287. Minneapolis, 807. Palo Alto, 3,789. Richmond, 1,093. San Diego, 621, of which 527 is dental. In Tampa, 2,650.

I'm sure we could take this out and put them across your entire spectrum, and I think the question that has been asked by two members of this Committee is, you have asked for additional funds, Congress is prepared to give you those funds, of which you are then contracting out to take these lists down, and the question that I think the members are trying to get to is, are these the resources that you believe are necessary to take this waiting list down?

DR. PERLIN. As I say, I come forward with as much confidence as I can possibly have that these are the resources to take down not only the waiting lists, but also veterans who are waiting beyond our service time frame of 30 days, the list you have just provided.

THE CHAIRMAN. All right. There will be follow up. You know you are going to be back here in the Spring.

Mr. Strickland, you are now recognized.

MR. STRICKLAND. Thank you, Mr. Chairman. Dr. Perlin, and Laura Miller -- someone I've known for a long time, used to be in my great state of Ohio -- and Mr. Norris.

I feel for you. I really do. I think you have a very heavy responsibility. I think you are probably trying to do your best under really

difficult circumstances.

But I'm looking at your testimony, and I want to go back to this statement, after you laid out the financial needs, the budget numbers, you say "These amounts assume enactment of the policies in the President's budget. If Congress does not accept any of these policies in the President's budget, additional resources to offset the cost of those will still be needed."

That statement causes me to think that you are not dealing with us in good faith. How many times does this Congress on a bipartisan basis have to say no to those requests before you assume it is a settled matter, and that it is insulting to us that you would bring us numbers based upon the possibility of that happening. It's not going to happen.

The Republicans aren't going to let it happen. We Democrats aren't going to let it happen. Forget it. Bring us budget numbers that don't make those assumptions.

Don't you think that's a fair thing for us to ask?

DR. PERLIN. It is absolutely fair given the clear voice of the entirety of this Committee. The 1.977 does not include the President's policies that were in the budget. That is, as I mentioned earlier, an additional $1 billion.

I apologize for the semantics of that statement, even the tone of the expression, but you have asked for clarity on what the numbers are. 1.977 is additional.

From the congressional budgeting perspective, $1 billion is in lieu of those proposed policies, for a total of $2.977 billion.

MR. STRICKLAND. You are asking for a sufficient amount of money without assuming there may be these other sources of revenue such as an user fee and the like? Is that what you are telling me?

DR. PERLIN. If the policy proposals are not enacted, we need $1 billion additional.

MR. STRICKLAND. They are not going to be enacted. Why would that continue to be a part of the budget request?

DR. PERLIN. I think we are agreeing with the numbers. In lieu of them being enacted, the dollar figure is $1 billion, recognizing the sentiment of this, the Senate, and both Appropriations Committees. The amount of $1 billion plus $1.977 billion for a total of $2.977 billion.

MR. STRICKLAND. Is that what you are asking for?

DR. PERLIN. That is the figure that I believe will be necessary, sir.

MR. STRICKLAND. But is that what you are asking for?

DR. PERLIN. Yes, that is what I am here identifying the need for.

MR. STRICKLAND. So, we can assume that the next time we get a budget request, those requests for user fees and increased costs for medicines will not be in it?

DR. PERLIN. I know that the sentiment of this Committee has for a

number of years --

MR. STRICKLAND. It's the sentiment of the Congress, this Committee, certainly, but the Congress.

Dr. Perlin, you are probably not responsible for this, but how can we believe that you are bringing us numbers and you are doing that in good faith when you are doing this?

That puzzles me.

DR. PERLIN. I'm giving you an exact dollar figure in lieu of what the budgetary effect of those policies would be. I think I'm providing that very candidly, what the dollar value is.

MR. STRICKLAND. Do you support those proposals? In your position, do you support those proposals to have an user fee and increase co-payments for medicines?

DR. PERLIN. This was part of the President's budget that the VA brought forward. We testified to that effect.

MR. STRICKLAND. That's why I say I have sympathy for you, because I think you find yourselves in a position where you are having to take orders from someone. Maybe it's OMB. Maybe it's the President himself. I doubt it.

I doubt that a decision of this specificity would go all the way up to the President of the United States, but someone is doing the President a disservice if we continue to get a budget from the President that has these requests that the Congress has thoroughly and totally rejected.

It just makes me wonder if we can believe or trust or accept in good faith anything that we get from the administration or from this department. I feel kind of sad about it, quite frankly.

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

THE CHAIRMAN. Thank you. Ms. Brown-Waite, you are now recognized.

MS. BROWN-WAITE. Thank you very much, Mr. Chairman.

First of all, I'd like to request that an opening statement that I have be admitted into the record.

THE CHAIRMAN. It shall be entered, hearing no objection.

[The statement of Ginny Brown-Waite appears on p. 52]

MS. BROWN-WAITE. Thank you. When I saw Secretary Nicholson wasn't here, I figured he was begging for his old job back at the Vatican. It probably was a lot easier than being the VA Secretary.

I have a few questions about veterans' health care in general. I certainly agree that veterans' health care is top notch.

Do you all do any comparisons, for example, of number of surgeries that your doctors perform versus out there in the other realm of medical care, i.e., the for profit or not for profit entities?

The reason why I ask this is, and Ms. Hooley, you might want to hear this. I had a veteran who had a very aggressive jaw cancer. He

was put on a very long waiting list for surgery. When I inquired, I was told that the oncologist does one surgery a week. One surgery a week. I said I want that in writing, because if he does one surgery a week, I know about eight oncologists who want his job.

Could you all provide a comparison of caseload with the private sector? It's amazing because when I did that, he suddenly got the surgeries scheduled for three weeks later.

The other question that I have is does the VA treat non-veterans, not spouses, but non-veterans? I will wait for your answer.

DR. PERLIN. Your question on veterans is very complex. There are a couple of categories of people who fall into not necessarily veterans. CHAMPVA is a program that is for beneficiaries of 100 percent service connected veterans, alive or deceased. That would include many non-veteran spouses and children in that program.

VA will also provide humanitarian care. VA also provides care --

MS. BROWN-WAITE. Would you define ``humanitarian care?'' This may be where we are going.

DR. PERLIN. Sure. Let me give you a personal example. I may be one of the few VA physicians to have delivered two babies, non-veterans. The women were there and I was in the emergency room. They were ready to deliver. That was essentially a circumstance that was unavoidable. The care was provided.

An individual who has a medical emergency in the parking lot or hallway, we would provide care for.

MS. BROWN-WAITE. I appreciate that. I'm sure the women who were about to deliver appreciated that.

Where I'm going with this is I have several VA facilities in my area. I'm not going to name the particular VA facility. I was there on a tour, saw a wonderful demonstration of a piece of equipment, kind of a contraption that you get hooked up onto for walking purposes, for anybody who had spinal cord injury. There was a very young girl there using this machine.

I asked if she was a veteran. I guess when you get to be my age, everybody looks young. They said no, she wasn't a veteran. She was in a car accident.

My question is are we using VA resources that should be used for veterans for the civilian population? I'm not making a judgment as to whether it's good, bad, or indifferent. I think we need to know where these VA dollars are going.

Everyone of us goes home and hears stories about veterans not being cared for.

DR. PERLIN. Our first priority -- our system is there for veterans. I believe I could surmise what facility you are talking about, and I believe another program, which happens to be a research program, a research program to improve the research, and when grants are obtained, NIH, for example, or from industry, they can be open to

non-veterans as well, as part of a research program.

I would imagine, because that is not a standard therapy, it's very state-of-the-art, evaluative research, that was the circumstances under which you saw that individual. I actually believe it was at the same place I saw two veterans who essentially regained their walking because of that research. It's truly incredible.

MS. BROWN-WAITE. It is an incredible program. My question is are veterans getting first dibs at it. Lord only knows, we have enough veterans with spinal cord injuries as a result of this war. I want to make sure that we are using these dollars for people who have served our country.

That is what your organization is all about. That is what we believe we are funding.

DR. PERLIN. I would fully agree with you. The circumstances, as I say, was likely one of a research grant, but the priority has to be always to veterans.

MS. BROWN-WAITE. Thank you. Mr. Chairman, I would just like to make a request. You had said you expected to see him back here in the Spring. It looks as if we are not going to be out of here October 1st, so we might want to get an update on exactly where the money is going and what they are doing and how the service levels are changing before the Spring, so whatever time you deem appropriate.

I think we really need to follow up and make sure that the veterans are being served and that they are being served in a timely manner with the additional appropriations that we are providing.

THE CHAIRMAN. Before I respond to this, we will continue our oversight here. Some things are going to be very telling for us as we work through 2005, as we are into the October time frame, we are going to know a lot of things.

We are going to know about this 2006 budget amendment, is that even going to be enough. Dr. Perlin and his staff will be putting together an FY 2007 budget request. We are going to be working with VHA on a bipartisan basis to ensure that with regard to the data and the assumptions, that they are done in a manner for which we also agree. I think that just needs to be done.

We can work cooperatively with you and we can have these updated briefings, and we can bring you back here and brief the members with regard to the data lists and what the changes are going to be. Put us in a comfort zone.

Where you are right now with the Committee is called earning back the trust. I think that is probably pretty accurate.

Ms. Berkley, you are now recognized. Did that satisfy the gentlelady's request?

MS. BROWN-WAITE. Yes.

MS. BERKLEY. Thank you, Mr. Chairman. First, welcome again. I don't envy your position and I don't hold you responsible for this. I

don't think it is your credibility at stake here.

I'd like to follow up on Mr. Strickland's line of questioning because I think we need to get this on the record. I don't mean to put you on the hot seat but we are going to be revisiting this again. I just don't relish that idea.

On July 14th, Joshua Bolten, who is the director of OMB, sent a letter requesting additional monies for the VA to the President. In that letter, he explained about the 2005 supplemental and then he talked about the 2006 budget amendment.

When you add up the numbers of the $300 million expected to carry over and the $677 million increase, which I think is low balling it, but we will go with that number, for $100 million for the increase in the cost per patient, and another $600 million to correct for the estimated cost of long term care, which I think is probably ball park, we get to the 1.977, which is what Mr. Bolten recommends to the President to bring forward to the United States Congress.

Your testimony today talks about the total needed for both years, comprising the 2005 supplemental request of 975 and the 2006 budget amendment of 1.977. Then you go onto say, as Mr. Strickland pointed out, these amounts assume enactment of the policies in the President's budget.

Now, I think we are all pretty uniform in our belief and our knowledge that this has already been voted down. It's not going to be brought forward. If it's brought forward, it's going to be voted down.

According to your oral testimony, we are going to need an additional billion in addition to the 1.977. Mr. Bolten, the director of OMB, who should know better, has proposed to the President that he bring forward a number that is $1 billion short of what reality tells us we are going to need to satisfy the cost of providing service to our veterans; is that correct? Yes or no?

DR. PERLIN. No.

MS. BERKLEY. Not correct?

DR. PERLIN. No. I think everyone in this room understands the likelihood of those provisions being enacted. I think the director also appreciates that Congress, both Houses, have really not only understood they are not going to be enacted, but understood the need to replace the funds in lieu of those. He fully anticipates that as the one piece, and the 1.977 is the second piece.

MS. BERKLEY. In the letter that accompanied, I'm assuming, the documentation to the White House, the OMB recommended to the White House that they forward to the United States Congress, "I carefully reviewed this proposal and am satisfied that this is necessary at this time. I, therefore, join the Secretary of the VA in recommending that you transmit this amendment to Congress."

The reality is it is going to cost an extra billion dollars to care for our vets.

DR. PERLIN. I believe that is assumed.

MS. BERKLEY. But not in this letter to the President.

The actual number is $2.977 billion?

DR. PERLIN. Yes, ma'am; it is.

MR. STRICKLAND. Will my colleague yield just a second?

This just gets to the idea of good faith and credibility. Why wasn't that billion a part of the request?

I yield back to my friend. It's frustrating.

THE CHAIRMAN. Ms. Berkley?

MS. BERKLEY. I'm anxious to hear Mr. Perlin's response, although I would say that this gentleman doesn't do policy, he does numbers. The policy of the VA or the OMB is to continue this myth that they are going to be able to generate revenue on the backs of the veterans, which Congress has already made very clear isn't going to happen.

I don't think this gentleman is in a position to answer that question because he crunches the numbers. He doesn't do the policy. I don't want to put words in your mouth.

I do have another question. Could you answer Mr. Strickland very quickly?

DR. PERLIN. I'm sorry. I can't speak for OMB. Your very first words were you don't envy my position. I would like this body to know that there is not a day that I don't realize what an incredible privilege it is. and I do hope that I represent that in terms of helping our veterans.

MS. BERKLEY. You do. It's pretty apparent you are not in this for the money. None of us are. I know you truly serve your country, and I appreciate that.

This is what is concerning me. I got word while I'm here in Washington that OMB is all over my VA facilities such as they are, limited as they are, in Las Vegas right now, asking the same questions they asked five years ago, four years ago, three years ago, two years ago, and last year, and before the CARES study was initiated, before it was completed, before it was brought to bed or sent to bed, and before we had a VA appropriation that came out of this Congress, that provided for the funding for a medical center that we are in desperate need of.

It worries me that with this shortfall, they are going to take money out of the capital budget, and to me, if we start robbing Peter to pay Paul, the people that I represent, my veterans, are going to be in a world of hurt.

I left this Committee, you may have noticed, for a few minutes. I had 200 Boy Scouts waiting to have a picture taken with me. I was out for 15 minutes. Believe me, this is not enough water to rehydrate. It is hot out there.

While I am walking back here, I am thinking of my 80 year old veterans that are standing -- we are having a heat wave in Vegas right now. This is the 21st day of over 118 degrees. I have 80 year

old veterans that are standing in the heat waiting for a shuttle to take them from location to location to location to get their health care needs met.

My biggest concern, Dr. Perlin, is that we are going to start taking money out of the capital budget to cover the costs of the health care. Can you give me assurances that is not going to happen?

DR. PERLIN. I believe strongly in the need of the hospital in Las Vegas. It is a very poor way of doing business right now, shuttling between the multiple clinic sites. I could not be more passionate about support for that hospital.

I would be remiss to speculate what I know or don't know, but the budget I've brought forward assumes resources for operations and preservation of capital, to the best of my knowledge.

MS. BERKLEY. Thank you. Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you. I now yield to Mr. Evans.

MR. EVANS. Thank you, Mr. Chairman.

Dr. Perlin, would you please break out the $1.97 billion request for us?

THE CHAIRMAN. Break out the $1.97 billion budget request for 2006 is Mr. Evans' question, a detailed break out, if you have it, please.

DR. PERLIN. Thank you, Ranking Member Evans. Let me break that out, and I will start at the highest level and then break it down to smaller groups.

Let me start with $677 million. Of the $1.977 billion, $677 million is in anticipation of increased workload. It's clear that the model did not predict the level of utilization of VA and more veterans came in. That is a piece of the workload.

In actually proportionately smaller dollar figures, there are a group of returning service members, and again, it's been well discussed today that we needed to do better in terms of anticipating the returning service members from OEF and OIF, in that $677 million are resources as well to care for returning veterans of OEF and OIF.

Included in that $677 million, as has also been pointed out today with respect to the waiting lists, we need to make sure that we work down those waiting lists, that we contract or hire or do what is necessary to get back on being within all the types of targets for timely care that veterans deserve and you have the right to expect.

That's the first part, the $677 million.

The second group of funds relate to long term care. Let me tell you that it falls into two pieces. Part of it was that the 2006 budget was constructed with an error built into it.

At some point, it anticipated that the census would be lower in 2005 going into 2006, and that required additional resources. As well, there was a technical error in the total to provide the long term care services necessary, $600 million.

In addition, one of the things that has been apparent, both in the

recent look at our budget and looking forward, is that the veterans coming to VA, in addition to there being more veterans, they are using more services. They are using more services perhaps because they are not getting those services in other environments. Perhaps they are using newer and more expensive pharmaceuticals.

The measures, such as relative value units, things that measure procedures and time spent with patients, per patient, is actually higher.

$400 million of the $1.977 billion is for that increased utilization of services per veteran in 2006. That gets us up to $1.677 billion. The $300 million is actually attributable to similar increases in utilization, but to replenish the carry over and make whole the 2006 budget, getting us to the total of $1.977 billion.

THE CHAIRMAN. Mr. Evans yields back. Let's do the math here real quick. Based on Mr. Evans' question here, $1.677 plus the $300 million, if we approve 975 and then you say you need another 300, if the House, over the next few days, say we were to take the Senate's number of 1.5, you now have $200 million over and above a present mark for 2005. We replenish now. We have an 2006 budget amendment.

When we hear Senator Hutchinson in the Senate say if the House will take our 1.5, then the 2006 budget amendment comes down 300. That is where she gets that from; right?

DR. PERLIN. Yes, sir.

THE CHAIRMAN. I got it. Thank you. Ms. Herseth, you are now recognized.

MS. HERSETH. Thank you, Mr. Chairman. Before I pose a couple of questions about long term care as I did in our last hearing, as you break that down for the $1.977 billion Administration budget request, as my colleagues have spun out here, the additional $1 billion, if the legislative changes aren't made on user fees and co-pays, which everyone, I think, has acknowledged isn't going to happen for fiscal year 2006 and likely beyond, separate from the concerns that have been raised procedurally about how this request came forward and how you are calculating it, where does the $1 billion go?

Where does the additional $1 billion that you have indicated will be needed if those legislative changes aren't made, where is the bulk of that billion dollars going?

DR. PERLIN. Thank you, Congresswoman, for that question. I can't attribute that to a particular activity. It would restore the budget value of the cost reductions that those policies would have had. It would go to the general care of veterans, as would be represented in the formulation of the overall 2006 budget.

MS. HERSETH. Is it my understanding that by law, the VA is required to provide long term care for service connected disabled veterans who are 70 percent or greater service connected disabled, as space allows?

DR. PERLIN. I believe that's correct.

MS. HERSETH. My understanding is space is available, but staff is not. Is that true?

DR. PERLIN. I would have to look at particular sites. For 70 percent or greater service connected veterans, if we don't have staff, those veterans, I believe, are eligible for contracted community nursing home care as well.

We owe those veterans the care, whether or not we have staff, and if there is an issue, I would be pleased to look into it.

MS. HERSETH. Given some of what has already been stated in terms of the VA medical centers and what I would hope would be the quality of care in terms of the long term care provided, the preference here would be to have adequate resources for adequate staff, so we didn't have to contract out to perhaps community long term care facilities that may or may not be at the same quality standards.

DR. PERLIN. Let me thank you and agree with you. I know our quality is exceptional in the nursing homes that we have. As a clinician who has practiced in two VA's, Washington and Richmond, frequently a decision is often made by somebody in the family, if that's a consideration. As proud as I am of that, I know many veterans' families choose to have the veteran close by.

MS. HERSETH. When we talked about how we broke down the $975 million request for fiscal year 2005 a few weeks ago, I asked a little bit about the long term care. That was the second largest line item, I think, in how it was broken down.

At the time, you informed me there was a partnership or research undertaken with the Department of Veterans' Affairs and Duke University, I believe, because there may have been either a technical error in the model or perhaps not an useful model to project long term care needs.

Has there been any new information you can provide us? If we are going to be signing off on the assumptions in a model, it would be nice to know the progress of that research so we are ready for the long term are where we have seen an increase in health care costs as well.

DR. PERLIN. Thank you, Congresswoman, for that question. You are absolutely right. Previously, VA did not use an actuarial model to project care. That was part of the problem. We now contract with Duke University, and that has been running in parallel with the Millman.

We wanted to make sure that we integrate that in all of our projections, but it is a new tool to use. I believe it will be more accurate.

MS. HERSETH. It's a new tool that wasn't used in the fiscal year 2005 projections or for fiscal year 2006, but will be for fiscal year 2007?

DR. PERLIN. I will have to check and find out to what degree it may apply to 2006. I think there has been some experimental work to

validate on a small scale, a particular state or network, but not the entire formulation of the budget to this point.

MS. HERSETH. You do anticipate that you will be ready to do that as you generate a proposal in terms of VA needs for fiscal year 2007?

DR. PERLIN. I believe so. I think I should get you the full details for the record so that I don't misstate. My understanding is it is now ready to be used at scale.

MS. HERSETH. I would appreciate that and think other members of the Committee would as well, in light of the Chairman's objective for where we may be as we get more information in the Fall. That is an integral part of the additional information that we should have.

Thank you. Thank you, Mr. Chairman. I yield back.

THE CHAIRMAN. Thank you for your contribution. Dr. Snyder? You are now recognized.

DR. SNYDER. Thank you, Mr. Chairman.

Dr. Perlin, what is your medical specialty?

DR. PERLIN. Internal medicine. I also have a Ph.D. in pharmacology.

DR. SNYDER. I'm always curious about this. You said it was a privilege for you to have that job. I consider it a privilege that we have you working for the VA system. I appreciate you doing it.

When you prepared for this hearing today, do they still do that silly stuff where you have to have your written statement signed off on by OMB?

DR. PERLIN. Yes. The statements, all testimony is cleared through the Office of Management and Budget.

DR. SNYDER. Isn't that like the silliest thing you have ever heard of? You don't have to clear that statement with OMB.

[Laughter.]

DR. PERLIN. It is a complex process.

DR. SNYDER. That's being polite.

I apologize for being late. It would probably be kind of like the movie Groundhog Day for you, that I will ask you questions you have already dealt with.

I am still perplexed from our last hearing, and you and I have not sat down and talked about this, on this whole actuarial model and why it has to run two and a half and three and a half years behind. I don't know anything in business that runs two and a half and three and a half years behind.

Have you all had discussions in these last two or three months where you have said, you know, let's target, six months from now, we are going to have a model that will have an 8.37 month turn around time. You couldn't make a living in business with a three and a half year modeling time.

What direction are we going in with that?

DR. PERLIN. I think that's a very good point, and we have had discussions about more frequent runs of the model to make sure we are tracking closer to reality.

DR. SNYDER. Is that model something that is contracted out? Is that a proprietary formula and process?

DR. PERLIN. Yes. There are parts that are proprietary and it is contracted out to Millman, the actuary, who has extensive background. Her organization supports managed care organizations, health plans, as well as some other public programs, including Medicaid, and I believe they also do some work for the Department of Defense.

DR. SNYDER. It is possible to say good news/bad news. The bad news is we ain't going to do this any more. The good news is you have a chance to bid on a contract to have an 8.5 month model. Isn't that right? You can just throw that out there and see what people come up with?

DR. PERLIN. Yes. We could do it cyclically. We do it cyclically for each successive budget as well.

DR. SNYDER. What reporting requirements do you have to make to Congress, not just budgetary, but reporting requirements you have to make to Congress regarding access of care and quality of care?

DR. PERLIN. I consider it our responsibility to Congress reporting on anything that is asked of us. In fact, we have not formalized the particular document, but I believe when the Secretary intends to meet with this Committee quarterly, that he would put down a selection of markers.

Let me share with you, if I may, what I look at. I look at six measuring baskets. I look at the quality of care. I look at things that are every patient specific, access to care, satisfaction with the services, measures of restorational function.

I look at a measure called community health, which is a basket for those other areas, effectiveness in research and academic mission, and then cost effectiveness.

I would submit those would be the things that we should be sharing with you as well.

DR. SNYDER. When you all sat down and looked at those things in whatever your most recent time frame was to look at those prior to all these budget shenanigans, did not anything stick out for you there that told you, you know, maybe our three and a half year, two and a half year actuarial model didn't reflect things that jumped out.

Did you notice that -- I'll make something up -- our patient satisfaction rate went down because of waiting times. Our doctor satisfaction rate went down because they say I'm seeing the same number of patients but they are more complex now, and I'm having to work two hours overtime, or our waiting times, especially at clinics, our waiting times for new patient appointments.

Is that not done in such a way that something would leap out to give you like the canary in the mine, something is happening out there, our models may be off?

DR. PERLIN. Yes. The area that is leaping out most prominently, as we have been discussing, and people have indicated, are waiting lists. That indicator is showing that we have the need for these additional resources.

DR. SNYDER. With the Chairman's indulgence, my question -- I'm sorry I missed the discussions earlier.

The last time that you looked at that, did you not have a discussion that said waiting times are way up compared to where they were a year ago, or our model must be wrong?

Did you all have that discussion or just with a world so divorced, the budget analysis and the model were so separate from your quality and access control evaluations, that you didn't put those two together, or somebody didn't put those two together?

DR. PERLIN. We actually review the tracking to plan at the monthly performance review, and that was really the indicator that triggered these discussions to begin with.

The question is how in the future can we avoid getting to this point, even better, making sure there is a better match of resources and needs. That is our task now.

DR. SNYDER. Thank you.

THE CHAIRMAN. Mr. Evans and I were up here talking based on Ms. Herseth's question, so if you could help us here.

You have the budget you submitted to us, that included the enrollment fees and increase in co-pays. Congress right now lacks any political will, it appears, to do anything on these.

You submit to us an 2006 budget amendment for the 1.97. That amendment is added onto your budget, so overall, before Congress, is the enrollment fees and the increase in co-pays.

Congress elects not to act on those. What you said to Ms. Herseth is that your need then is approximately $3 billion, right, if we back those out?

When the House passed its appropriation $1 billion over and above your mark, the House basically bought that out.

DR. PERLIN. Yes.

THE CHAIRMAN. Right? Not doing the fees and the co-pays.

DR. PERLIN. Exactly.

THE CHAIRMAN. When you come to us and ask for the $1.97 billion, that's what you need now from Congress, over and above the House's mark; correct?

DR. PERLIN. Yes, sir.

THE CHAIRMAN. I just wanted to make sure we were right on that. Mr. Filner?

MR. FILNER. Thank you, Mr. Chairman.

I'm glad you are here, Dr. Perlin. You have brought this whole Committee together. When the Republicans are associating themselves with my remarks, you have done a remarkable job.

[Laughter.]

MR. FILNER. I thank you for that. I'm not in the camp that has said you're not responsible. You are responsible for what goes here. You are accountable.

We are still living in an unreal world here. I think all this talk about the model is irrelevant, frankly. That's what technicians do. Then you have to live in the real world, and that's your job.

You can have someone doing a model. Then you have staff say, "oh, we have a war going on, did you take that into account? We have Hepatitis C now. We didn't know about that last year."

That's your job, and you didn't do it. We all knew there was a problem before you found it. We all knew there were freezes on hiring, either verbally or in memos. People in your Administration send them to us. There are freezes on enrollment. There are freezes on maintenance.

THE CHAIRMAN. That's shocking.

MR. FILNER. Right. Everybody knew it. I don't know how you can continue to say we just found out about it. We all knew about it. The question is again, how we are going to deal with it.

I'm going to ask you again, directly, because when I say the model is irrelevant, not only is it irrelevant because you have to test it against the real world, but the OMB seems to have a far greater impact, no matter what your model says.

You asked for a figure for fiscal year 2006 from OMB. What was that figure relative to what OMB recommended to the Congress? That would be a more fair test of your model.

DR. PERLIN. As I said before, there is a good bit of additional knowledge now in terms of where we are with the model.

MR. FILNER. Either answer the question or say you don't want to, but don't give us this bureaucratic nonsense.

I want to know what figure you sent up to OMB. Mr. Principi answered that question. He said they gave us $1.2 billion less than we asked for. Mr. Nicholson said, oh, I don't know, I wasn't there. You were there. What figure did you ask for?

DR. PERLIN. Obviously, this Committee has discussed the challenge and my desire to answer your question directly.

MR. FILNER. So, you can't answer it directly? All right. You are probably better than you are appearing because you probably asked for a higher figure, so you are taking all the blame for something that may be not your fault.

How many people are on the waiting lists for how long, and what

are you going to do about it? How many staff vacancies exist for how long, and what are you going to do about it? What is the maintenance backlog, and how are they going to be fixed and in what time frame?

This is what we do in our own house, what we do in our own budget. If my son needs dental work, I'm saying I don't care what the model shows my salary is, I have to figure out when he's going to get his dental work. We have an emergency, and I have to put the money there. What does that do to the rest of my budget and how are we going to make it up?

We all do that every single day in our household accounts, as well as anybody who owns a business. We are just boggled by the fact that you can't do this simple thing.

Give us that information, and give us a time line for doing it. Nobody questions anybody's motivation here or your concern for veterans. Everybody in your agency is concerned. I know that.

You are forced to give us bureaucratic nonsense that is not in accord with the real world, and you become an uncredible spokesman, and the Administration becomes uncredible, because you are talking in a green eye shade world out there, and somebody is putting this model out and human intellect has no role here.

I would like to see, the next time you testify, some of those measures, not these big baskets you are talking about. Tell us. Why do we have to come out and tell you how many people are on the waiting lists? You should tell us, and say what you are going to do about it.

DR. PERLIN. Sir, those are our data.

MR. FILNER. When I asked you, you didn't know it. I asked you earlier how many vacancies exist in our hospitals and how many people are on the waiting lists. You didn't know. You didn't tell me.

DR. PERLIN. I couldn't memorize the exact number of vacancies, but I do know the exact number on the waiting lists.

MR. FILNER. If there were vacancies in my agency, I could tell you the exact number. I could tell you. It's my job to eliminate those vacancies. It's my job to eliminate the waiting lists. It's my job to eliminate the maintenance backlog. That's your job. Our job is to support you in that, and you are not giving us any way that we can support you because you are not giving us any data.

I yield back.

THE CHAIRMAN. Thank you. Mr. Michaud?

MR. MICHAUD. Thank you very much, Mr. Chairman. I, too, want to thank both you, Mr. Chairman, and Ranking Member Evans, for having this hearing. Mr. Chairman and Ranking Member, I agree with both of you that getting the VA budget right is very important to me, and I will work with you both to make sure we do that.

I just want to follow up, Dr. Perlin and Ms. Miller, on a question earlier about VISNs borrowing money to make ends meet, and the response that they would have to pay that back.

It's my understanding that in VISN 1, they actually did borrow $11 million. My concern is with the capital needs and the increased amount of veterans coming back from Iraq and Afghanistan, if they had to borrow before and they have to pay that money back without additional funding, my concern is what is going to happen to VISN 1.

Have you looked at the specifics on why they borrowed the money and if they have to pay it back, are they going to be able to meet the needs for our veterans in VISN 1?

The other part of that question is under the CARES process, because of the access issue, it recommended either four or five clinics, since Maine is such a rural state, in Maine, plus a CBOC.

When you look at the borrowing they have to do, the shortfalls, whether or not that's going to ever come to fruition.

MS. MILLER. I think the issue of the borrowing money was really a timing issue more than anything else because the specific projects, which I've seen a list of, which did total about $11 million, were felt to be needed sooner than could be managed by waiting for the 2006 budget.

Certainly, with the supplemental and with the discussions that are going on now about the 2006 amendment, I think that changes the scenario for the network, and more than likely would minimize the need for that loan.

MR. MICHAUD. My next question is to Dr. Perlin. The VA keeps referring to the highest priority veterans and the core group veterans. Do these definitions apply to the veterans that are on Priority 7 lists?

DR. PERLIN. Congressman, there is a policy or directive that emphasized a priority in terms of access to care for veterans who were 50 percent or greater service connected. By definition, that would not include the Priority 7's or Priority 8's in the system.

All veterans are meant to be served within our performance goals, which are 94 percent within 30 days for primary and 93 percent within 30 days for specialty care.

Our actual performance is even higher, though as your colleagues have alluded to, I do know and do track, because those are our data, our waiting lists, where that is not the case.

MR. MICHAUD. In response to the funding shortfall, in January 2003, there was suspended enrollment in Priority 8 veterans. The fiscal year 2006 budget request fails to provide any additional funding at all for Priority 8 veterans. Is that going to be the policy from here on out of the VA and the Administration, just to leave Priority 8 veterans out there?

DR. PERLIN. The budget request would serve those Priority 8 veterans who are currently in the system. The budget request does not anticipate reopening enrollment to Priority 8 veterans.

MR. MICHAUD. Is that going to be the policy, that as long as the

Administration is in office, we will never open for Priority 8's new enrollment?

DR. PERLIN. I would be remiss to speculate on that.

MR. MICHAUD. No additional funding is anticipated for any new enrollments in Priority 8's?

DR. PERLIN. Yes, sir. That is correct.

MR. MICHAUD. Thank you. Thank you, Mr. Chairman.

THE CHAIRMAN. Dr. Snyder?

DR. SNYDER. Thank you, Mr. Chairman.

Dr. Perlin, in your exchange with Congressman Filner, the discussion about the waiting lists, did you say you had some numbers in mind with regard to waiting lists? I assume that was one of the things you and I were talking about, one of the six things you follow is waiting lists.

DR. PERLIN. Absolutely.

DR. SNYDER. Do you have numbers in mind?

DR. PERLIN. Yes, sir. There are approximately 25,000 veterans waiting for appointments to be scheduled at this moment.

DR. SNYDER. Both primary care and specialty?

DR. PERLIN. For their first new primary care visit.

DR. SNYDER. First new primary care visit.

DR. PERLIN. The numbers that Congressman Filner quoted were actually those veterans who were waiting beyond our target of serving those veterans within 30 days. I track those for the entire system, for the network, for the facility, and even the community based outpatient clinic.

It is something that I am very acutely aware of because one of the reasons we track those is not because it is a bureaucratic or abstract number, it is real service to real veterans.

DR. SNYDER. That should be the kind of thing, as you and I were talking earlier, that as you follow on month to month and year to year, you start seeing a trend going in the wrong direction, it should say to you maybe our modeling is not working, our actuarial model.

DR. PERLIN. Yes, sir. That is the sort of thing that tells us either things are working or they aren't. In fact, between that point, January of 2003, when that enrollment decision was made, and there were 176,000 veterans without appointments scheduled, and 317,000 veterans waiting over six months for care, that was worked down to a low of about 5,000.

I actually think -- this is not a question of performance, it's a question of the lag between the time a veteran enrolls and when he gets his first appointment. I think the minimum is going to be somewhere around 5,000, and that's just that period of time between enrollment and their first visit, so we are beyond that perfect steady state of getting veterans care as soon as they enroll.

DR. SNYDER. When you have looked at reasons, and you listed some

in your written statement, I think, about why the model didn't work, have you all thought some beyond kind of the world of the veterans' health care system as to why it might not be tracking as well as you may have thought it did in the past?

For example, it occurs to me that we have seen an erosion in the last few years of employer based health care. There may be veterans who no longer have employer based health care, so they had to start coming to the VA.

Or they may have been in an employer based health care system or got priced out of the market because of preexisting conditions, had to come to the VA, and then you make reference to a more complicated patient, or that certain retirees, their retiree health care system, more companies are dropping that.

Have you all looked at why you think you may be having more complicated patients and that the patients require more visits? Are those some of the things that have occurred to you all?

DR. PERLIN. Dr. Snyder, that is something that in fact I did allude to in my statement, and one of the things we need to improve, the conditions that we are tracking, health insurance coverage, coverage for particular services and pharmaceutical coverage.

Pharmaceutical coverage, in particular, is something that is quite excellent about VA's care, and we need to look at the effect of what's going on in the broader environment even more carefully, and even more carefully regionally. It's not necessarily consistent across the country, in terms of how that might attract veterans into VA.

DR. SNYDER. I think one of the problems we have as a country is we have not figured out how to do health care, no matter what system you are in, whether you are working for a private business or you are a retiree, or you are on Medicaid, Medicare, or military health care, Tricare.

When one part of the system is struggling, which I think the private sector is, then the Government programs have to step in and make up the slack.

Thank you, Mr. Chairman.

THE CHAIRMAN. Thank you very much. I would like to thank Mr. Evans for his indulgence. I have a series of questions to ask.

Mr. Norris, what do you believe are the critical elements of the monthly performance review briefing?

MR. NORRIS. Thank you for the question, sir. I believe that obviously tracking the expenditures against the planned expenditures and understanding the reasons for the variances for that is important, as well as comparing it to the previous year to see how we are tracking in relation to what we expected to do overall.

I think also looking at the workload, that we want to track against our plan and against the previous year's experience as well.

Those, to me, are the two most important things. However, there

are other areas, too, that one might want to look at.

THE CHAIRMAN. Let's drill it down again to another step. How current is the data at the time of the monthly review?

MR. NORRIS. The financial data are the previous month's end of month data.

THE CHAIRMAN. When you say February, that data is what?

MR. NORRIS. When we do a performance review in March, we would be looking at February data.

THE CHAIRMAN. Thirty days old, approximately,

MR. NORRIS. Probably less than 30 days old at that point, because we would do it some time during the month of March. Two to three weeks old.

The workload data is somewhat more troublesome in terms of timeliness because we have to draw that from several databases, one, we have to wait for patient records to close in the field and those databases to be closed out.

We have to match that with data out of the enrollment files, to establish a priority group level, to ascertain where the growth and changes are occurring, and then we also have to associate it with costs and assign those costs to each of those group levels so that we understand better where the costs and workload are being incurred.

Those data matchings cause us the lag beyond the level of time that we would like. More recently, we have been trying to estimate a month ahead of time or a month in advance of what we actually have solid data on and test that against later when we receive solid data to see if those estimates are in fact good enough for decision making.

THE CHAIRMAN. When you look at these numbers on a monthly basis, do you also then look at these numbers from the previous year?

MR. NORRIS. Yes, sir.

THE CHAIRMAN. When you look at them from the previous year, then you are able to chart a percentage up or percentage down?

MR. NORRIS. Correct.

THE CHAIRMAN. If I were to ask you to graph over the last year, could you tell us what that graph would look like?

MR. NORRIS. We started off fairly normally, and I believe we began to show -- we sort of begin to show slow growth through the early part of the year, and then we saw a fairly significant growth around the January time frame, in the January/February data, which we were looking at in the April/May time frame, and that's when we discovered that the problem was more significant than we had earlier thought it to be.

THE CHAIRMAN. Would you be able to tell me what the surge is in February/March that caused you to recommend this letter be sent to Congress on the reprogramming of funds?

I guess what I'm trying to figure out is is the surge five percent, six percent, over and above 2005 to 2004? If it's five or six percent but it's

based on 2002 data, it's really much greater.

I'm trying to drill right into the numbers to figure out that not only is it the model, but maybe it's our monthly review. I'm trying to understand.

MR. NORRIS. I understand. I think we had projected, using the data from 2002, and the model had projected a workload growth that would be about 2.3 percent over what we experienced in 2004.

In the mid-year review time frame, when we did this in the April/May time frame, we saw the growth was about 5.2 percent at that point, which was higher than we had predicted.

THE CHAIRMAN. Did you break out categories, as Mr. Michaud and Dr. Snyder had asked, regarding categories one through six versus seven's and eight's?

MR. NORRIS. Yes, sir.

THE CHAIRMAN. Can you tell us where that surge was coming from?

MR. NORRIS. Most of the growth was in the priority one through six, actually seeing some leveling out. There is still a bit of growth in the Priority 7's and 8's, but quite naturally because we are not bringing in more Priority 8 enrollees, that population number is fixed.

Really the growth has been in the Priority 1 through 6.

THE CHAIRMAN. Out of the one through six's, were you able to break out what is OIF and OEF?

MR. NORRIS. We had projected in our budget calculations about 23,000 OIF/OEF veterans to use our services in 2005. We are now thinking we are going to see probably around 100,000 this year.

THE CHAIRMAN. Wow. This goes back to your testimony, Dr. Perlin, of almost three weeks ago with regard to this surge, which was not anticipated when this budget was put together; correct?

DR. PERLIN. Yes, sir.

THE CHAIRMAN. Who at VHA is responsible for tracking and trending the spend rate?

MR. NORRIS. I do that, sir.

THE CHAIRMAN. How do you plan to keep track of the budget trends in the future so there is not a repeat of this?

MR. NORRIS. I think we will continue to do all the things that we are now doing in terms of looking at the monthly spend rates against the plan, and obviously, we need to refine our plans somewhat in terms of the phasing of those expenditures throughout the year, and ensure that what we project for a particular month is a little bit tighter fit than we have had in the past.

THE CHAIRMAN. Of the original request, 975, how much of the $975 million can actually be obligated before September 30th?

MR. NORRIS. Sir, that is an excellent question. It obviously depends on a lot of things. One, primarily, it depends on --

THE CHAIRMAN. Let's put it this way. What if, by next Friday, this issue is resolved, and you get your number, it's $975 million to $1.5 bil-

lion. You are going to get a number. The President signs it. Bang.

What can actually be obligated?

MR. NORRIS. We think we can obligate the majority of the $975 million. However, it is dependent on -- some of the repair projects, for example, require a competitive bid process and contracts, et cetera.

To the extent that we are almost now to the point of only having two months left in the fiscal year, to the extent that process drags on they may or may not be able to be awarded and that money actually obligated.

In financial parlay, we could commit that money, commit it to those particular projects, and it would be obligated in early fiscal year 2006.

We think we can obligate a fairly large portion of the $975 million.

THE CHAIRMAN. When DOD reimburses the VA, at what rate is that calculated?

MR. NORRIS. Well, it depends on what the particular service is. We have an agreement with DOD on outpatient rates, that we will exchange services based on the CMAC, that's the CHAMPUS maximum allowable charge rate, less ten percent, which works for us quite well in keeping things simple and encouraging sharing between the two departments.

The inpatient rates are a little bit more problematic in that DOD doesn't have a good inpatient billing rate system yet, which they are working on and we are working with them.

There are rates negotiated locally between facilities based on services available in either department's facility, and the cost that they incur at those local facilities, so they can at least recover their costs.

THE CHAIRMAN. When you testified about this increase in OIF/OEF workload, how will you forecast or predict future workload?

MR. NORRIS. I think one of the things, as Dr. Perlin has stated, we need to get improved data from DOD, which we are working on doing, and getting more current data. I think that's forthcoming.

We will certainly use our most recent experience and looking at hopefully some discharge rates and those sorts of things that would enable us to get better projections of the impact of OEF/OIF or any other deployments around the world.

THE CHAIRMAN. Based on this, Dr. Perlin, how timely is DOD's data on separating OEF/OIF personnel provided to the VA?

DR. PERLIN. It's gotten better. Every couple of months, it's not a defined schedule, we get a computer file that shows separation. I think there are two approaches that I plan to take.

One is to try to get that data even more timely. The other is to be very conservative this year and extrapolate from the experience and anticipate the same or accelerated levels of service members returning.

THE CHAIRMAN. Does DOD provide the post-deployment assessments

as an assessment tool for the VA?

DR. PERLIN. That is a complex question. Normally, those data are available. However, they are not electronic and they are not something that the service member might bring with them.

The answer is if you ask is it available, the answer technically is yes. Is it available in a very practical and simple way? The answer would be no.

THE CHAIRMAN. Ms. Miller, how often do you conference or teleconference with all your VISN directors?

MS. MILLER. I have a weekly phone conference with them and a monthly meeting. That is with all of them as a group. In addition to that, on a quarterly basis, there are individual hour long briefings with each network director.

THE CHAIRMAN. Are there minutes from these meetings?

MS. MILLER. No, sir. There are minutes for the monthly National Leadership Board, which includes all of the chief officers as well as the network directors. There are agenda's for the weekly teleconferences, but there are no minutes.

THE CHAIRMAN. How candid are your VISN directors with you?

MS. MILLER. I would say they are generally pretty candid.

THE CHAIRMAN. What has been the trend in VHA's backlogs in ambulatory and specialty care appointments for the past 12 months?

MS. MILLER. Actually, the trend on the totals is a good trend. It is that we are seeing an increased proportion of the total appointments, the 95 percent in primary care, and the 94 percent in specialty care, within the 30 day time line, an improvement in those that are above 30 days to bring them down below the 90 days, where we have seen a decremental performance is in those who are waiting for their first appointment.

THE CHAIRMAN. Would you please provide to the Committee graphics to support the answer that you have just given me?

MS. MILLER. Yes, sir; I will.

[information requested is found on p. 55]

THE CHAIRMAN. Ms. Miller, have there been any documented cases where returning OIF/OEF service members have been denied care?

MS. MILLER. Sir, not that I'm aware of. We have repeatedly reinforced to the field the importance of providing those services in a timely, compassionate and seamless manner.

THE CHAIRMAN. Do you know of any documented cases where returning OEF/OIF service members have been given an appointment that is more than 30 days?

MS. MILLER. Yes, sir. I do believe there are cases of that type, and I know specifically in the dental arena, we have a backlog of cases. We are working on those with $10 million that has been provided to the field to address that specific issue.

THE CHAIRMAN. What has happened here is individuals, who are very upset, in particular, your critics, what they do is they latch onto the new veteran to say you don't care about them or you are not funding them. You have heard all the rhetoric that's out there.

I'd like for you, Ms. Miller, at your next meeting with all these VISN directors, I want you to go back and ask them this question, please, on whether or not they know of any cases of OIF/OEF service members that have been denied any form of care.

MS. MILLER. Yes, sir.

THE CHAIRMAN. I also would like to know immediate action taken in the field to ensure that any of these soldiers, sailors, airmen, Marines that are returning are beyond 30 days.

MS. MILLER. Yes, sir.

THE CHAIRMAN. At what point were you informed of funding concerns from facilities and VISN directors, that they were having to take actions in the field?

MS. MILLER. Sir, I think when we got into the first of the calendar year, people began to identify that it was going to be a very tight and difficult year.

They began to hold on equipment and NRM purchases until they saw where the year was going, and as we moved along, it became clear that they were going to have to use the NRM and equipment money for operational purposes.

At the same time, they were focusing on advanced clinic access to try and work down the waiting lists and improve productivity, and we were monitoring closely with them compliance on national contracts and pharmaceutical procurements, et cetera, to try to ensure that they were being the most efficient they could be.

THE CHAIRMAN. You said that was in the January time frame?

MS. MILLER. In January and February, early in the year, people began to say, you know, we are seeing this increase, as Mr. Norris said, in the workload, and they began to hold back on moving ahead with their equipment and NRM money.

THE CHAIRMAN. I'm not so certain how that reconciles with Mr. Norris' testimony with regard to the monthly review assessments. Things were tracking fine until they began to see this spike in February/March/April.

If you are hearing from the field that they got crunch problems in January and it's not being reflected in this monthly assessment -- do you two talk?

MS. MILLER. Yes, sir; we do.

MR. NORRIS. Sir, let me clarify. I meant to say, if I didn't say it clearly, there was slight workload increase in the early parts of the year, in the early months, but they weren't alarming at that point. However, as we hit the mid-year point and looking at the January/February data, it was getting to the alarming point.

THE CHAIRMAN. I don't know how to define "alarming." Let me go to you, Ms. Miller.

When was it brought to your attention that facilities were beginning to curtail services?

MS. MILLER. Sir, I don't believe that facilities were curtailing services in that period of time. I think they were acknowledging that things were tight. They were looking carefully at their budget and managing tightly.

They were refraining from moving forward with planned equipment or NRM, as I mentioned. They acknowledged at that point in time that they were not prepared to move forward with some CBOCs, but I'm not aware they were curtailing services, per se.

THE CHAIRMAN. When did facilities start to send out letters of dis-enrollment?

MS. MILLER. I would like to make a distinction between enrollment and appointment. We do not dis-enroll any veteran.

When a facility --

THE CHAIRMAN. If a veteran had not used a facility over the last two years, were letters sent out saying you will be dis-enrolled from the system?

MS. MILLER. Not that I'm aware of, sir.

THE CHAIRMAN. What letters were sent out with regard to appointments?

MS. MILLER. When a facility is unable to provide service in a timely way, within our guidelines, our policy requires them to notify a veteran that they are on a waiting list.

Generally, we find it is not an appropriate thing to provide appointments more than four months out, because often times, that appointment will not be at a convenient time, the veteran will not show for the appointment. It will be a wasted time slot.

There is a policy that says when we cannot provide you with an appointment in a timely way, that we want you to utilize the electronic wait list at the local site and take people off that wait list as expeditiously as possible, but to notify people that in urgent or emergent situations, we would see them immediately.

THE CHAIRMAN. If I wanted an appointment and I couldn't get my appointment for four months, am I being denied a service?

MS. MILLER. You are certainly being delayed in the service and it's not good customer service and it's something that we are trying to overcome, sir.

THE CHAIRMAN. All right. You have testified that you were not informed of facilities that took any actions that may have curtailed services; is that correct?

MS. MILLER. I'm not aware of people, for instance, closing services down.

THE CHAIRMAN. You testified that your VISN directors are candid

with you in these teleconferences?

MS. MILLER. Yes, sir.

THE CHAIRMAN. Of which you don't take minutes. Do you take notes?

MS. MILLER. No, sir.

THE CHAIRMAN. That's clever. When was it brought to your attention that critical maintenance was being deferred? When did your VISN directors talk about deferring maintenance, facilities, equipment?

MS. MILLER. As I testified earlier, early in the calendar year, it became clear that people were going to need to defer equipment and maintenance procurements for operational purposes.

THE CHAIRMAN. When did you then speak to Dr. Perlin about what you are hearing from your VISN directors?

MS. MILLER. I try to keep Dr. Perlin informed on an ongoing basis.

THE CHAIRMAN. That is not responsive. You have testified to January. When you started first hearing this from the field, did you go to Dr. Perlin and tell him what you were hearing from the field?

MS. MILLER. My memory of exactly when is not clear.

THE CHAIRMAN. Notes and minutes would help, wouldn't they?

MS. MILLER. Yes, sir; they would. Early in the year, I would say that I shared that information with Dr. Perlin.

THE CHAIRMAN. Early in the year. I'm not the prosecutor. I don't mean to be interrogating you like one. I assure you that I've prosecuted the greatest wordsmith I ever met in my life, named Bill Clinton.

I've had it. Do you have any follow up questions?

COMMITTEE COUNSEL. Dr. Perlin, just a quick question. Are you in violation of the Anti-defficiency Act in fiscal year 2005?

DR. PERLIN. No, we are not.

THE CHAIRMAN. Mr. Michaud, any further questions?

MR. MICHAUD. No further questions, Mr. Chairman.

THE CHAIRMAN. Thank you very much. This Committee is now adjourned.

I will ask this of you. I'd like for you to conduct an internal review to see if any personnel changes need to be made within the department, and report that to the Secretary.

I would also ask for the GAO to conduct a thorough and comprehensive review of the VA's budget process.

I will ask my colleagues on this Committee to continue to monitor closely this budget process, as you build the 2007 budget, to ensure that the mistakes that were made in 2005 and 2006 are not repeated.

Finally, I intend in the August break, to take personal travel, and I will go to a specific poly-trauma center to see whether or not this allegation that some are making, that OIFs and OEFs are being denied their access to care.

Those are the actions I'm going to take, based on today. The hearing is concluded.

[Whereupon, at 4:27 p.m., the Committee was adjourned.]

APPENDIX

Statement of Honorable Lane Evans
Ranking Democratic Member, Committee on Veterans' Affairs

Full Committee Hearing
July 21, 2005

The last time we gathered here, I expressed my anger over the inability of this Administration to level with us, and level with America's veterans. Today, I'm still angry, but frankly, I'm also puzzled.

The Administration's revised request for FY 2006 still fails to fully address the needs of the VA for the upcoming fiscal year. At this late date the Administration still submits a request that relies upon policy proposals that have been overwhelmingly and repeatedly rejected by Congress. Why is this Administration still not leveling with us?

The VA has acknowledged that it needs an additional $1.2 billion over last week's request. All of us on this Committee want to come together and give you what you need to meet the need of our veterans. But still the Administration refuses to forthrightly ask for what is required.

The Administration still attempts to justify an insufficient budget by advocating for policies meant to drive veterans out of the VA health care system, and thereby save money. These policies are purportedly meant to care for our "highest priority veterans" and "core group veterans." These phrases are meant to lead us to believe that the VA is meeting its commitments to veterans. But we know that this is not the case.

The philosophy put forth is one to drive veterans out of the system, to kick needy veterans out of long-term care beds and to gloss over the real mental health care needs of our veterans.

When I look at the law as it exists today, I don't see "core group veterans" and "highest priority veterans" – I see eligible veterans, and we must move forward to address the needs of these veterans.

The Administration has found it easy to cut off and continue to deny access to an entire group of veterans, men and women who have stormed the beaches of Normandy, fought in the jungles of Southeast Asia, struggled in the deserts, all to protect our freedoms and all that we value.

So let's be up front. Ask for what you need realistically to meet the needs of our veterans, and to accomplish your statutory mission. We ask our men and women who serve to be willing to sacrifice all. To honestly tell us what resources you need to care for them is the least that you can do.

Statement of
Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health
Department of Veterans Affairs
before the
United States
House Committee on Veterans' Affairs

July 21, 2005

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Mr. Chairman and Members of the Committee: Thank you for your continuing support and ongoing dialogue regarding the budget forecasting and finances of the Veterans Health Administration. Accompanying me today are Ms. Laura J. Miller, Deputy Under Secretary for Health for Operations and Management and our VHA Chief Financial Officer, Mr. Jimmy Norris.

Background

Mr. Chairman, in considering our budget planning and the request for a FY 2005 supplemental appropriation as well as continuing needs for health services in FY 2006, I'd like to discuss what facts underlie the need for a FY 2005 supplemental request.

FY 2005 Supplemental Request

VA requested a supplemental appropriation in the amount of $975 million for FY 2005 in June of this year. That supplemental request was needed because our expected forecasted growth, based on the actuarial model, was 2.3 percent. VA discovered in March 2005, that the actual growth had accelerated through mid-year 2005 to 5.2 percent. This was a difference of 2.9 percent

above the original projection. This higher than anticipated demand for VHA services was a major factor driving our need for a supplemental appropriation.

Discrepancy from Projections and Status of Health Care Resources:

Mr. Chairman, as we discussed during your June 23, 2005 hearing, VA uses an actuarial model to forecast patient demand and associated resources needs. Actuarial modeling is the most rational way to project the resource needs of a health care system like the Veterans Health Administration. As I noted at that hearing, this is the approach utilized by the private sector. Unlike the private sector, however, where projections are used to formulate budgets for the next year or even the next "open season," the Federal budget cycle requires budget formulation using data two and one-half to three and one-half years ahead of budget execution.

For example, the data used to formulate the budget for FY 2005 derive from health care utilization in FY 2002; in this case, the last full year of data before the Department's FY 2005 budget formulation began.

Our actuarial model forecasted 2.3% annual growth in healthcare demand in FY 2005. We discovered that growth has accelerated through mid-year 2005, to 5.2% above FY 2004. This constitutes a substantial increase in workload and resource requirements.

As a result, our increased medical care costs in FY 2005 are $975 million based on increased patient demand and increased utilization of health care services in clinical areas.

I believe that an additional $1.977 billion above the President's Budget request is needed to continue to provide timely, high quality care to enrolled veterans in FY 2006. This includes $300 million to replenish carry over funds

being used in FY 2005 to cover the increase in average cost per patient, $677 million to cover an estimated 2.0 percent increase in the number of patients expected to seek care in FY 2006, $400 million to recognize the expected cost of providing more costly treatment; and $600 million to correct for the estimated costs of long-term care.

The Administration has come forward to the Congress with a proposal to provide VA with these additional resources. The total need for both years combined is $2.952 billion, comprising a FY 2005 supplemental request of $975 million and a FY 2006 budget amendment of $1.977 billion. These amounts assume enactment of the policies in the President's Budget. If Congress does not accept any of the policies in the President's Budget, additional resources to offset the cost of those will still be needed.

Planned Improvements:

VA and other Federal agencies like DoD use actuarial modeling to project resource requirements two and one-half to three and one-half years hence. While VA's modeling techniques and methodologies are very advanced, as a consequence of the budget process the "performance envelope" of the model is pushed compared to the private sector, which makes actuarial projections for budgeting for the next year or "open season." Still, the 2.9 percent variance above the number of patients projected is far better than the variances that occurred under the previous system, when budgets were projected simply by inflating an historical base. Nevertheless, we will augment the model's already robust methodologies and work with you to improve the process; indeed we must.

Future planned improvements to the model include obtaining access to data on VA enrollee's use of Medicaid, Tricare, and military treatment facilities; integrating VHA's long-term-care model into the actuarial model, and modeling additional services such as dental care. In addition, we need to continue the progress already made with DoD to better engage them in data sharing and projections regarding OIF/OEF returnees.

To address the average three-year time lag in the budget process, we need to also consider trends in the economy that might not yet be incorporated into past data and the model, but can be adjusted in our budget formulation process. Since VA is a low or no-cost provider, we must better anticipate the effects on our system as the other health care options available to veterans become more costly.

Perhaps, more importantly, the Secretary has committed to quarterly reviews to address resource needs in light of VHA's most current operational experience.

Conclusion

Mr. Chairman, in closing, I believe that the resources requested in the supplemental appropriation for FY 2005 proposed by the Administration and the President's Budget Amendment for FY 2006 reflect the commitment and support by the Administration to the veterans of this nation in meeting the increased demand for VHA health care services.

Thank you for your support of veterans and VA, and the opportunity to testify on this complex issue.

Congresswoman Brown-Waite Opening Statement - CB
Veterans Committee Hearing: Budget Shortfall
July 21, 2005 / 2 p.m. / 334 Cannon

Mr. Chairman, I would like to thank you for holding this hearing today.

I am disheartened to once again learn of a significant veterans' budget shortfall.

I had hoped to avoid the need for hearings in the future.

To have one just weeks after the last is unthinkable.

This Congress has made it clear that we are committed to providing care for our veterans, including the returning servicemen and women who bravely fought in Iraq and Afghanistan.

When a shortfall for 2005 was evident, the House immediately moved to pass a supplemental spending bill.

The VA told us they needed $975 million, and that is what we provided.

I am disappointed that yet again, the VA was one step behind us on the numbers.

Within two weeks, the VA came back with an even bigger number and with even greater needs.

As such, several of my colleagues joined me in writing a letter to the VA and OMB requesting that immediate steps be taken to correct the VA's inaccurate and outdated budget modeling.

We also asked for more timely and open communication with Congress.

What has gone on this year is unacceptable.

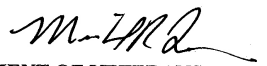
In a time of war, the VA must constantly update their cost projections to account for real-time use of services.

Not doing so is shortsighted and potentially dangerous.

The bottom line is this: **Congress will support our veterans**.

However, we must have open, immediate information from the VA in order to do so.

I look forward to hearing from our witnesses today about what they are doing to fix this problem and meet the needs of current and future veterans.



FULL COMMITTEE HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS PROPOSED HEALTH CARE BUDGET AMENDMENT FOR FISCAL YEAR 2006
CONGRESSMAN MICHAEL R. TURNER (3rd OH)

Thursday, July 21, 2005, 2:00 p.m.
Room 334, CANNON HOUSE OFFICE BUILDING

Mr. CHAIRMAN – I appreciate this opportunity to discuss the administration's budget amendment for the Department of Veterans Affairs.

One of my great concerns is that veterans are provided the opportunity to receive care in VA nursing homes, and that these nursing homes are provided with the resources they need to meet the needs of our nation's veterans.

On July 11, I had the pleasure of hosting VA Secretary Nicholson at the Dayton VA Medical Center in my district. We toured the nursing home at the medical center, and were able to learn about the great service the nursing home provides for veterans in my district.

I understand from information provided to committee members that in developing the FY 2005 budget, the Veterans Administration projected a VA nursing home average daily census level of 8,500. The actual figure is 12,400. The VA nursing home average daily census level for FY 2006 is projected to be 11,500, of which not more than 9,795 is included in the budget. As a result, the administration is requesting an additional $600 million.

Given the vital importance of nursing homes to our nation's veterans, and the importance of the nursing home in Dayton to my constituents who are veterans, can you please explain why the Veterans Administration did not properly project the nursing home average daily census level when formulating the budget for the VA, and what steps will the VA take in making future budget requests to ensure that the nursing home average daily census level is calculated with greater accuracy?

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	1. Percent of Primary Care appointments within 30 days of Veterans DESIRED appointment date during the month (from CREATE date if New Appointment)	2. Percent of 47 Specialty Clinics appointments within 30 days of Veteran's DESIRED appointment date during the month (CREATE date if New Appointment)
July-05	95.9	93.3
June-05	95.3	93.0
May-05	96.2	95.6
April-05	95.1	94.9
March-05	95.1	94.9
February-05	95.1	95.0
January-05	95.1	94.9
December-04	94.7	93.7
November-04	95.1	94.8
October-04	94.7	94.5
September-04	94.1	93.6

O