

GAO

Report to the Chairman, Subcommittee
on VA, HUD, and Independent Agencies,
Committee on Appropriations
U.S. Senate

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VA HEALTH CARE

Resource Allocation Has Improved, but Better Oversight Is Needed





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

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The Honorable Christopher S. (Kit) Bond
Chairman
Subcommittee on VA, HUD, and Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) provides health care services to about 2.6 million veterans annually, but veterans nationwide have traditionally not had equitable access to these services. A shift of the veteran population from the northeastern and midwestern to the southern and western regions of the country without appropriate reallocation of VA resources has created inequities in access to service. We have previously reported on some of the difficulties VA faces in equitably allocating approximately \$17 billion annually for veterans' health care to address access issues.¹

The Congress enacted legislation in 1996 requiring VA to develop a plan for equitably allocating resources to ". . . ensure that veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to such care regardless of the region of the United States in which such veterans reside."² In response, VA implemented the Veterans Equitable Resource Allocation (VERA) system on April 1, 1997, as part of a strategy to improve equity of access to veterans' health care services. VERA allocates resources to the 22 regional VA health care networks, known as Veterans Integrated Services Networks (VISN). (See app. I for a map of the VISNs.) Because each network allocates resources to its hospitals and clinics, networks play a vital role in ensuring that veterans have equity of access to health care services.

You have expressed concern about whether VERA equitably allocates resources to the networks and whether VA oversight efforts adequately ensure that shifts in resources improve veterans' equitable access to services. In this report, which expands on preliminary information presented in our May 1997 statement for the record for a hearing held by

¹See Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable (GAO/HEHS-96-48, Feb. 7, 1996).

²Section 429 of P.L. 104-204.

your Subcommittee,³ we assess VA's (1) implementation of VERA, (2) monitoring of changes in health care delivery resulting from VERA, and (3) oversight of the network allocation process used to give veterans equitable access to services. To examine these issues, we reviewed VA documentation explaining the VERA model and VISN allocation process and interviewed VA headquarters officials and officials from seven VISNs. In addition, we analyzed data (1) used for the fiscal year 1997 VERA allocations, (2) on veteran demographics at the VISN level, and (3) used to measure VISN performance. We also relied on our 10 years of work reviewing VA's resource allocation process.⁴ For a complete description of our scope and methodology, see appendix II.

Results in Brief

VERA shows promise for correcting long-standing regional funding imbalances that have impeded veterans' equitable access to services. Specifically, VERA allocates more comparable amounts of resources to the 22 networks for high-priority VA health service users—those with service-connected disabilities, low incomes, or special health care needs—than the resource allocation process it has replaced. As a result, if fully implemented as planned, VERA could substantially shift funding among regions by fiscal year 1999. In addition, VA continues to explore ways to improve VERA's capacity to more equitably allocate resources in the future. Among the improvements being considered are better measures of network workloads and adjustments for justifiable differences in network costs for providing health services.

Although it is early in VERA's implementation, we found that VA headquarters has not established an adequate monitoring system to identify changes in workload and medical practices that could negatively affect allocation equity and the appropriateness of care that veterans receive. In addition, VA headquarters lacks the information to adequately review networks' planned facility allocations or their impact on veterans' equitable access to services. VISNs we contacted are using varying methods to allocate resources to facilities. For example, some VISNs allocate resources on the basis of the number of veterans using a facility; others negotiate changes in funding for programs or services from the preceding fiscal year to reach a new allocation. VISNs, however, lack criteria on how to develop methods to give veterans equitable access.

³VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal (GAO/T-HEHS-97-121, May 1, 1997).

⁴GAO/HEHS-96-48, Feb. 7, 1996; VA Health Care: Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets (GAO/HRD-89-93, Aug. 18, 1989); and VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management (GAO/HRD-87-123BR, Aug. 31, 1987).

To address these deficiencies, we have identified corrective actions for VA to take to enhance its ability to ensure that resources are allocated to improve veterans' equitable access to health care services and ensure that the care received is appropriate. These actions include improving the timeliness and thoroughness of overseeing changes in health care delivery resulting from the allocation process to the networks and to the facilities.

Background

The VA health care system is one of the nation's largest direct health care delivery systems. VA operates 173 hospitals, over 400 outpatient clinics, 133 nursing homes, and 40 domiciliaries. VA provides health care services to veterans with and without service-connected disabilities on a priority basis defined by the level of service-connected disability, income, and other factors. About 10 percent of the nation's veterans use VA health care services. To provide these services in fiscal year 1998, VA requested a medical care appropriation of almost \$17 billion. In addition, VA requested a legislative change to authorize it to retain private health insurance and Medicare reimbursements. The Congress has responded by authorizing VA to retain private health insurance payments and certain other payments in the Balanced Budget Act of 1997.⁵ VA estimates this would provide an additional \$468 million in fiscal year 1998 after deducting administrative costs for collections. The Balanced Budget Act of 1997, however, does not authorize VA to receive Medicare reimbursements.

In 1995, VA began a major reform of its health care services to become more cost efficient and improve the quality and accessibility of its health care. VA is reforming its system to better align VA health delivery and financing with major changes in the national health care industry such as expanding primary care and emphasizing outpatient care, while de-emphasizing inpatient care.

VA is trying to reform its health care delivery by restructuring the managing and financing of its services. A major element of VA's restructuring is the creation of 22 VISNS in 1996 as the basic budgetary and decision-making unit of VA's health care system. VISNS have responsibility for making a wide range of decisions about care delivery options, including contracting with private providers for health care services and generating revenue by selling excess services.

⁵P.L. 105-33 §8023 (1997).

VERA Improves Resource Allocation to Regional Networks

VERA shows promise for improving the equity of veterans' access to care because it makes VA's allocation of resources to networks more equitable. VERA allocates resources to the 22 networks on the basis of the number of high-priority veterans served. It also includes incentives for networks and their facilities to serve additional veterans. If fully implemented in fiscal year 1999 as planned, VERA could substantially shift regional allocations. VA continues to explore refinements to improve VERA's equitable resource allocation.

VERA Improves Equity of Regional Resource Allocations

VERA was designed to allocate resources for services provided in a network whose costs VISN management can control. For the fiscal year 1997 allocation, VERA was designed to allocate 88 percent of the \$17 billion medical care appropriation to the 22 regional networks.⁶ VERA allocates resources on the basis of two key components: network workloads and national capitation rates. Workloads are the estimates of the number of high-priority veterans a network can serve. High-priority veterans—commonly referred to as Category A veterans—are those with service-connected disabilities, low incomes, or special health care needs. The networks in turn allocate these resources to their facilities.

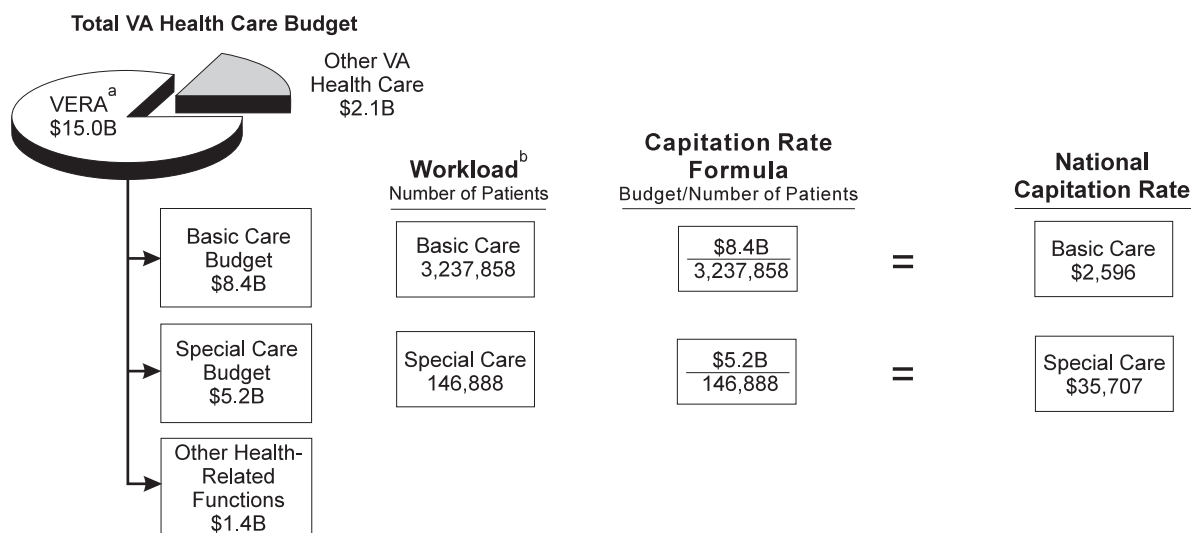
VERA provides more comparable levels of resources to each network for each high-priority veteran served than the process it replaced, which allocated resources primarily on the basis of facilities' historical budgets.⁷ VERA provides more comparable levels of resources by classifying patients on the basis of the cost of their health care into two workload groups—basic care and special care. Basic care patients generally receive routine services that are less expensive than those received by special care patients. Special care patients often have complex or chronic conditions, such as spinal cord injuries, advanced acquired immunodeficiency syndrome (AIDS), chronic mental illness, or end-stage renal disease or require care in settings such as nursing homes (see app. III for complete

⁶Headquarters allocated most of the remaining 12 percent (about \$2 billion) on the basis of other criteria. Several activities are funded this way, including prosthetics, state veterans' homes, and readjustment counseling. Headquarters funds these activities directly for several reasons, including buying power leverage gained through central purchasing or legal requirements or because the activities are VA-wide responsibilities beyond the scope of any one network's operations.

⁷Since the mid-1980s, VA has used several allocation methods, including the Resource Allocation Methodology and the Resource Planning and Management system. (See [GAO/HEHS-96-48](#), Feb. 7, 1996.) These methods, however, were never fully implemented partly because stakeholders lacked confidence in the equity of their allocations.

list of special care patient classifications).⁸ The VERA special care category also includes some adjustment for age to account for expected changes in the age distribution of veterans in a network. VERA determines a national capitation rate for each workload group. (See fig. 1 for fiscal year 1997 capitation rates.)

Figure 1: Establishing VERA National Capitation Rates, Fiscal Year 1997



^aFiscal year 1997 amounts are based on the proportion of fiscal year 1996 funds used for each category.

^bWorkload numbers reflect the number of unique individuals served over several years. VA determined that annual service use numbers do not reflect longer term use patterns. In fiscal year 1996, VA provided health care services to 2.6 million veterans.

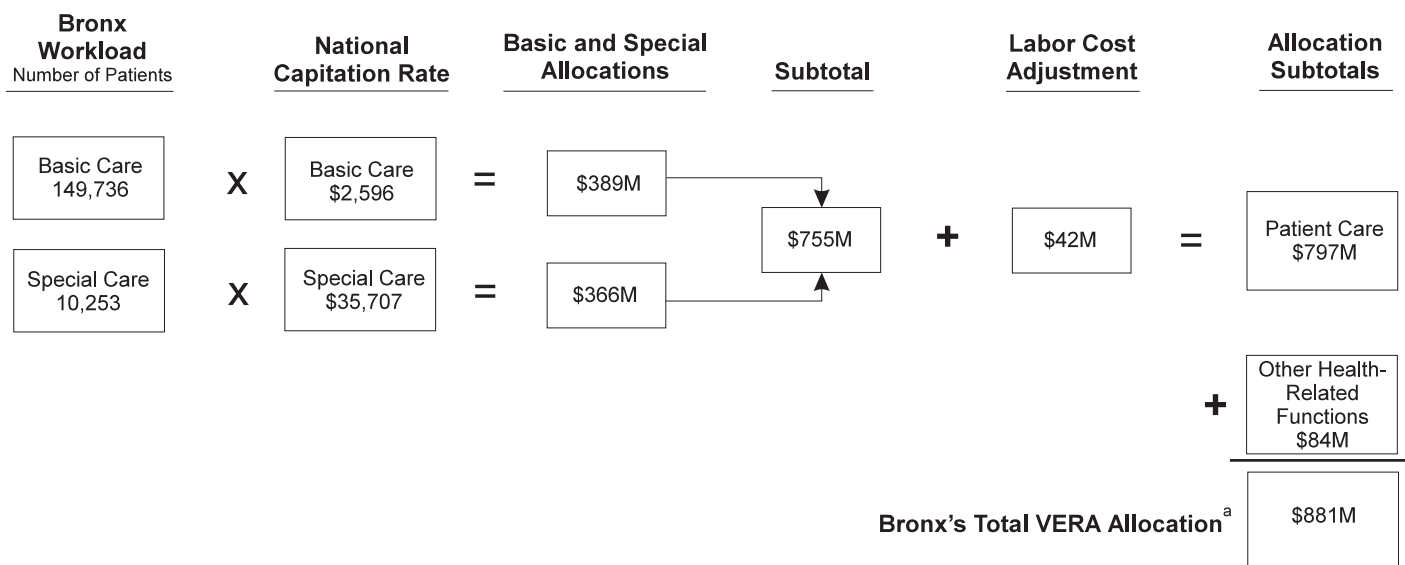
Source: Veterans Equitable Resource Allocation System Briefing Booklet, VA, Mar. 1997.

VERA allocations to each network are based primarily on patient workloads and the two national capitation rates. To account for differences in regional labor costs, VERA increases patient allocations for networks with

⁸VA considered using separate groups for the population included in the special care classification. It ran simulations—for example, with four patient groups: transplants, extended care, special care (that is, spinal cord injury, rehabilitation, and AIDS), and chronic mental illness—but this more complex method had little effect on network allocations.

higher labor costs and reduces them for networks with lower labor costs.⁹ In addition, each VISN receives funding for other health-related functions, including research support, education support, equipment, and nonrecurring maintenance. Funding for these activities is determined using national cost estimates for each activity and each network's workload in that activity. (See fig. 2 for an example of how a network allocation is made.)

Figure 2: VERA Allocation for VISN 3 (Bronx), Fiscal Year 1997



^aExcludes non-VERA allocations.

Source: Veterans Equitable Resource Allocation System Briefing Booklet, VA, Mar. 1997.

VERA creates incentives for networks to serve more high-priority veterans. Because allocations are based on high-priority veteran workload, networks serving more high-priority veterans compared with other networks gain resources under VERA; those serving fewer such veterans compared with others lose resources. This takes place because all networks receive the same national capitation rates for the workload they serve.

⁹Because differences in energy costs by network were minimal, VA did not adjust for these costs in VERA.

Network officials have responded to VERA's incentives by increasing the number of high-priority veterans served, according to officials we contacted. For example, VISN 2 (Albany) facilities had served 7,442 high-priority veterans through the first half of fiscal year 1997 whom they had never served before, officials told us. Similar efforts are under way at the other VISNS we contacted.

In addition, VERA has incentives for reducing costs. Because network allocations are based on a national standard (the national capitation rate), networks have an incentive to keep their costs below the national rate. Networks that are more efficient (that is, with patient costs below the national capitation rate) have more funds available for local initiatives. However, those with patient care costs above the national capitation rate (that is, less efficient networks) must increase efficiency to have such funds available.

Network and medical center officials are taking a variety of actions to reduce costs because of VERA's incentives and other VA initiatives, they said. These officials represented networks gaining and losing resources under VERA. Among these actions are providing more care on an outpatient basis, decreasing more costly inpatient care; reducing lengths of stay in nursing homes; and expanding primary care to prevent or postpone the need for more costly care. In addition, some networks are developing plans to reduce duplication by integrating the management structures of nearby hospitals or consolidating the delivery of certain services into one location.

VERA Shifted Few Resources in 1997, but Full Implementation Would Shift Substantially More

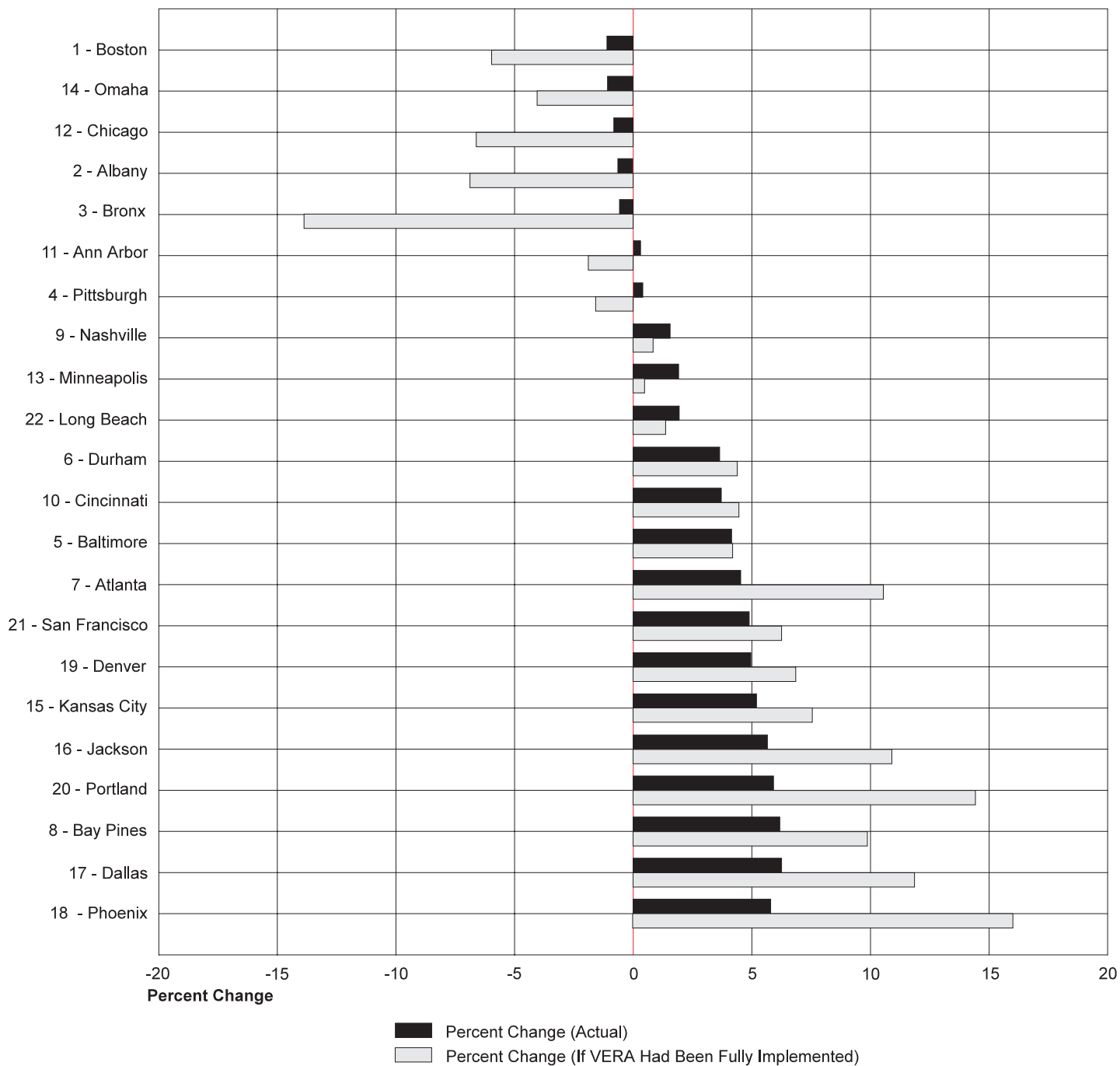
Although VA began phasing in VERA in fiscal year 1997, VA did not shift substantial amounts of resources among networks. VERA's immediate impact was lessened because its adjustments to network allocations only affected budgets for the second half of the fiscal year and caps were placed on the amount of funds moved. Networks with reduced funding needed time for management to implement less costly ways of providing quality care while improving access, VA officials said. Networks gaining funding needed time to plan for and use new funds to provide the best quality and most cost-efficient services.

The partial implementation of VERA in fiscal year 1997 moved resources from the Northeast and Midwest, where per veteran costs have been higher than the national average, to the South and West, where per veteran costs have been lower than the national average. Five networks received

less funding in fiscal year 1997 than in fiscal year 1996 and 17 received more. The largest network reduction in fiscal year 1997 was about 1 percent, and the largest increase was about 7 percent (see fig. 3).

Figure 3: Changes Resulting From VERA Allocations, Fiscal Years 1996-97

VISN



(Figure notes on next page)

Note: These numbers include all six VERA expenditure categories: basic care, special care, research support, education support, equipment, and nonrecurring maintenance.

Sources: Veterans Equitable Resource Allocation System Briefing Booklet, VA, Mar. 1997 and Budget Office, Veterans Health Administration.

If VA had fully implemented VERA in fiscal year 1997, it would have substantially shifted funding among the networks, ranging from a reduction of 14 percent to an increase of 16 percent when compared with fiscal year 1996 allocations (see fig. 3). VA plans full implementation of VERA in most networks by fiscal year 1998, although networks whose resources will be reduced most may not have full implementation until fiscal year 1999. However, two of the networks expected to absorb the largest reduction under VERA—VISN 3 (Bronx) and VISN 1 (Boston)—have plans to fully absorb all reductions by fiscal year 1998 if VA headquarters agrees to their plans. VISN 2 (Albany), by contrast, plans to phase in reductions through fiscal year 1999.

VERA will incorporate the most current VISN workload and national capitation data each year to allocate resources. These data will reflect changes in the number of veterans served and any changes in VA appropriations. As a result, some VISNs that received reduced allocations under VERA in fiscal year 1997 could receive increased allocations in future years if the number of veterans they serve increases significantly. Alternatively, some networks that gain resources in 1997 could lose resources in future years if the number of veterans they serve does not keep pace with those served by other VISNs.

VA Continues to Explore Ways to Improve VERA Allocations

VA is exploring several options for improving allocations. First, it is exploring whether it can better measure workload and determine capitation rates to improve equity of resource allocation. Because most of VERA's allocations are based on patient care capitation and workload measures, these two measures are the ones most likely to contribute to any inappropriate resource shifting.

VA continues to examine the method for setting capitation rates by trying to better account for differences in regional costs for each veteran served. We have previously noted the importance of such an examination.¹⁰ VERA

¹⁰See [GAO/HEHS-96-48](#), Feb. 7, 1996; Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department ([GAO/T-HEHS-97-97](#), Mar. 18, 1997); and [GAO/T-HEHS-97-121](#), May 1, 1997.

assumes that all differences in regional costs—after adjusting for the basic and special care case mix and differences in labor costs—result from differences in efficiencies. Although differences in network efficiencies play a major role, to the extent that any of the remaining differences do not result from efficiencies, VERA may allocate some resources inappropriately. For example, some of these differences could result from differences in veterans' health status not captured by VERA's case mix. VA's recently released data on veterans' self-reported physical and mental health status, however, tend to support VERA's regional shift in allocations.¹¹ Veterans in northeastern and midwestern VISNs, which received reduced funds under VERA, tended to report being healthier than veterans in southern VISNs, which gained funds under VERA. VA officials are planning to examine whether using such data will improve the case mix adjustment.

In addition to capitation, VA is examining whether workload measures can be improved. VA officials are examining the possibility of determining workload on the basis of a VISN's population of high-priority veterans rather than on past users as VERA did for fiscal year 1997.¹² To do this, however, VA would need to know why veterans choose to use or not use VA health services so it could adjust the population workload numbers, according to VA officials. VA could consider, for example, adjusting for veterans' private health insurance coverage or access to non-VA health providers.

Usage rates for high-priority veterans vary widely among VISNs. They range from 25 percent in VISN 4 (Pittsburgh) to 45 percent in VISN 18 (Phoenix) of the eligible beneficiaries on the basis of data from fiscal years 1994 to 1996. (See fig. 4.) Whether veterans have private insurance or access to non-VA health providers are important variables in predicting use of VA services in networks, VISN officials said. Our previous work also showed that health insurance status affects usage of VA health care services: we found that uninsured veterans were eight times more likely to use VA services than insured veterans.¹³ State-level insurance data also suggest that veterans' usage rates vary with insurance coverage. States included in VISNs such as VISN 4 (Pittsburgh) and VISN 11 (Ann Arbor), which have lower rates of veteran use of VA health care services, have proportionally fewer

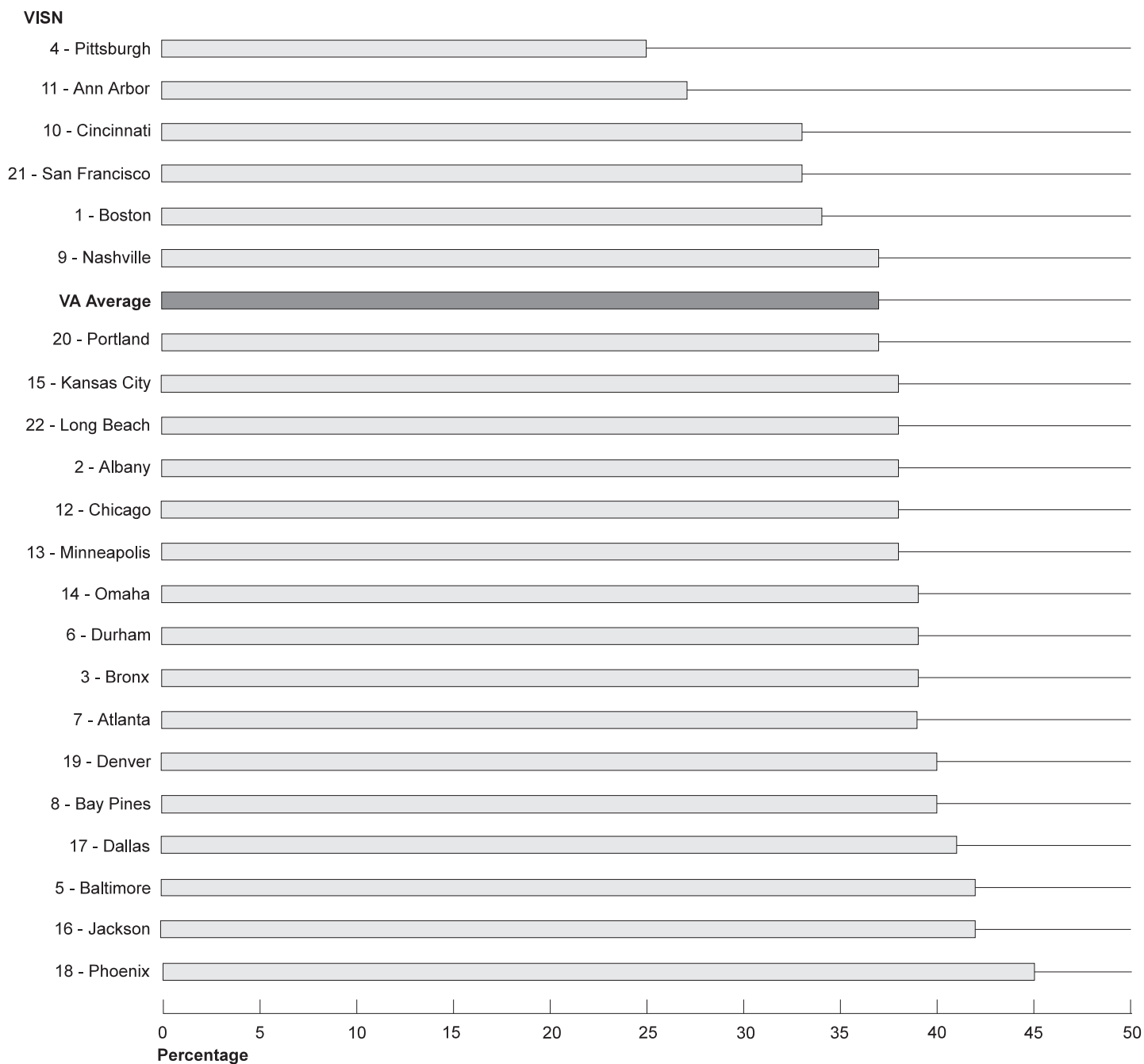
¹¹Health Status of Veterans: Physical and Mental Component Summary Scores (SF-36V), 1996 National Survey of Ambulatory Care Patients, VA (Washington, D.C.: 1997).

¹²VA officials told us they implemented VERA using veteran user data for the VISN workload indicator because they believed the data to be the best measure of probable users of VA health care available pending further study.

¹³See VA Health Care: Alternative Health Insurance Reduces Demand for VA Health Care (GAO/HRD-92-79, June 30, 1992).

uninsured veterans. On the other hand, states in VISN 18 (Phoenix) and VISN 16 (Jackson), which have higher rates of veteran use of VA health care services, have proportionally more uninsured veterans.¹⁴

¹⁴See Health Insurance: Sources of Coverage and Characteristics of Veterans and Nonveterans, National Center for Veteran Analysis and Statistics, VA (Washington D.C.: Sept. 1994).

Figure 4: High-Priority Veteran Usage Rates, Fiscal Years 1994-96

(Figure notes on next page)

Note: We calculated rates by dividing the 1996 population of high-priority veterans in a network into the unduplicated count of high-priority users in that network for fiscal years 1994 to 1996.

Source: Policy, Planning, and Performance Office, Veterans Health Administration.

VA plans to systematically survey veterans on why they choose to use VA health care services, officials told us. This survey will also provide information for refining VERA for VA's use as it implements an enrollment system for veterans' health care in fiscal year 1999,¹⁵ officials said. If this option is adopted, VERA workload would become population based rather than user based. The differences in allocations, if any, would depend on the adjustments made to the population base for why veterans use or do not use VA services. VA is also considering other refinements to VERA, including possible improvements in VERA's adjustment for regional differences in labor costs, regional equipment costs, and nonrecurring maintenance costs. Although VA has considered possible changes to VERA to account for the impact of third-party health insurance payments that the Congress has authorized, VA plans no change before it has experience in collecting and using these funds.

VA's Monitoring of Changes Resulting From VERA's Incentives Is Inadequate

VA headquarters officials do not adequately monitor some of the important changes under way in VA health care delivery resulting from VERA's incentives and other VA initiatives. Although officials have begun to address this issue, they lack timely and detailed indicators of certain changes occurring in health care delivery. As a result, it is difficult for VA to ensure that VERA's capacity to allocate resources equitably is not compromised and that veterans receive appropriate health care.

Because workload and capitation drive VERA allocations, key indicators to monitor are changes in the number of basic and special care patients VISNs serve and changes in medical care practices that could significantly affect VISN per patient costs. Such information is needed to identify significant changes that could affect VERA's future resource allocation or the appropriateness of care veterans receive. For example, some networks, according to officials, are increasing workload by thousands of veterans and changing the way they provide care in response to VERA's incentives. Such changes could significantly increase future allocations to their VISNs and reduce allocations to others and result in new medical care practices

¹⁵P.L. 104-262 requires that VA establish and operate a system of annual patient enrollment by Oct. 1, 1998.

for certain conditions. With adequate information, VA headquarters can promptly assess the extent to which such changes are consistent with VERA's purpose and take corrective actions when they are not. VA also can examine the appropriateness of care veterans receive when medical care practices change significantly, such as when length of stay for inpatient services decreases dramatically, and take corrective action if necessary. Such analyses would also enable VA to distribute information to all VISNs on best practices and problems identified.

VERA data systems cannot promptly track changes in workload and medical care practices. The data lag more than a year after services have been provided. For example, until July 1997, fiscal year 1995 was the most recent year for which VERA data systems could provide information on workload and medical care practices. Several data validation processes cause lags in data availability. VA officials told us that the delays result mainly from the need to determine the patient classification in the VERA model for each veteran served and the need to allocate patient costs among VISNs when patients receive services in more than one VISN. They said that hospital delays in posting information on the services provided to veterans partly account for the time lag.

VA, however, has developed some indicators beyond the VERA system to more promptly track changes in health care delivery. The most applicable of these indicators for monitoring VERA is the change in high-priority veteran workload, which VA began to report in fiscal year 1997 as part of its new quarterly reports on VISN performance. Nonetheless, this measure is inadequate for assessing the impact of workload changes on future VERA allocations because it cannot classify these veterans into VERA's basic and special patient care workload measures.

Moreover, VA does not monitor other changes in service delivery that are critical to assessing networks' responses to VERA's incentives. For example, VA has not been monitoring changes in the number of one-time users of VA health care. Networks have an incentive under VERA to increase the number of one-time users, whose cost of care is significantly below the national capitation rate. Providing one-time services to a veteran is one of the most advantageous ways to increase workload, VA officials told us. Although VISNs incur relatively fewer costs for each patient served, VERA still allocates the full capitation amount for each one-time patient. As networks respond to VERA's incentives and VA's initiatives to increase primary care along with its associated preventive services, VA does not

know the extent to which the number of one-time users is increasing.¹⁶ To the extent that some networks increase these visits disproportionately, future VERA allocations could be substantially affected. In addition, monitoring unusual increases in the number of one-time users could raise issues that require further investigation.

Moreover, VA lacks measures for monitoring changes in special patient category services, which include the most expensive services VA delivers. Monitoring these changes is important because of VERA's incentives to reduce the cost of patient care and because the special care population is particularly vulnerable. VISNS may reduce costs for this care in several ways. One way is to serve more patients with existing resources. For example, some VISNS are increasing the number of patients served in VA-operated nursing homes without increasing the number of beds or staff available by reducing patients' average length of stay.

In fiscal year 1996, lengths of stay varied considerably by VISN. (See table 1.) VISNS with longer lengths of stay have the greatest incentive to reduce lengths of stay, while increasing workload. Although VERA does not prescribe how networks should respond to its incentives, some network and hospital officials told us they had initiatives under way to increase nursing home workload, decrease lengths of stay, and lower costs by reducing staffing. Under certain circumstances, officials said, they would use other funds to pay some of the costs of VA-operated nursing home care.

¹⁶In fiscal years 1993 to 1995, one-time users of basic care accounted for about 23 percent of VA's workload.

Table 1: VA-Operated Nursing Home Use, Fiscal Year 1996

VISN	Average months of care per patient	Patients served per bed over 12-month period
18 (Phoenix)	2.44	4.47
20 (Portland)	2.67	3.71
13 (Minneapolis)	2.82	3.93
21 (San Francisco)	3.03	3.65
15 (Kansas City)	3.43	2.91
22 (Long Beach)	4.09	2.51
11 (Ann Arbor)	4.13	2.50
6 (Durham)	4.29	2.52
17 (Dallas)	4.32	2.31
19 (Denver)	4.62	2.39
9 (Nashville)	4.82	2.12
14 (Omaha)	4.93	2.25
12 (Chicago)	4.99	2.08
8 (Bay Pines)	5.05	2.09
2 (Albany)	5.08	2.27
1 (Boston)	5.16	2.17
5 (Baltimore)	5.49	2.03
16 (Jackson)	5.56	1.94
10 (Cincinnati)	5.85	1.95
4 (Pittsburgh)	6.74	1.71
3 (Bronx)	6.83	1.68
7 (Atlanta)	7.81	1.46
National	4.71	2.30

Note: VA also funds care in community nursing homes under VERA, but comparable data are not available.

Source: Our calculations are based on VA's Summary of Medical Programs, Oct. 1, 1995, through Sept. 30, 1996.

By reducing the length of stay in nursing homes, a VISN could serve more patients with the same resources, and VERA would allocate more funds to the VISN because of the increased workload. For example, according to VA, the cost of serving one patient for a year in a VA-operated nursing home bed was about \$80,000 in fiscal year 1996. But in fiscal year 1997, VERA would only allocate \$35,707 for this patient. If the length of stay were 4 months, however, a VISN could serve three patients and VERA would allocate \$107,121 at the fiscal year 1997 capitation rate.

Monitoring such changes is important because it can help managers identify whether changes are consistent with VA-wide goals or corrective action is needed. If monitoring reveals that nursing home discharges are increasing, this may indicate progress toward meeting VA's goal of reduced reliance on inpatient services. If a VISN is serving more patients, it may also indicate increased veterans' access. Meanwhile, however, managers need to monitor whether the changes significantly affect future allocations and the appropriateness of services provided. For example, hospital officials in VISN 4 (Pittsburgh) told us they were working to significantly lower their nursing homes' lengths of stay. If VISN 4 reduces its length of stay to that of VISN 18 (Phoenix), it could serve more than 3,000 additional nursing home patients annually, and VERA would allocate significantly more resources to it. Monitoring the likelihood of such a resource shift is important because such a shift would reduce the resources available to other networks for future allocations. Monitoring is also important to ensure that changes in the care provided this vulnerable, special care population are appropriate. For example, monitoring would help VA identify issues to examine such as whether patients with reduced length of nursing home stay receive appropriate discharge planning and other needed services.

VA headquarters is considering improving the timeliness and detail of indicators used for monitoring changes in allocations and VA health care delivery, officials said. Among these improvements are the availability of VERA workload data during the fiscal year in which they are collected and monitoring changes in the number of special care patients and one-time users and in the services provided to certain special care populations.

VA Oversight of Networks' Allocation Decisions Is Inadequate to Ensure Equitable Access to Services

VA's decentralized management structure gives VISNs the responsibility for allocating the resources VERA provides. VISN resource allocation methods are crucial to veterans' equitable access to services. These methods determine the extent to which services are available to veterans and their equity of access in using the services. Headquarters' guidance and oversight of these VISN allocations are not adequate, however, because they have not identified criteria for VISNs to use in forming their allocation methods for achieving equitable access to services.

VISNs are responsible for allocating resources to achieve equitable access to health care services for veterans in their respective geographic areas. A VISN may shift resources to underserved areas in its network by providing additional funding to facilities located there, by establishing community-

based outpatient clinics (CBOC), or by contracting out for services.¹⁷ However, if VISNS do not take steps to improve equity of access through their resource allocations, the promise of VERA may not be realized.

The seven networks we contacted have various funding allocation methods. One funds its facilities using a flat rate for each veteran user. Another uses a combination of historical funding and negotiation with medical center management regarding new initiatives. Two others include a feature in their allocation methods for each new veteran served. One pays prospectively on the basis of targets for increased patients. The other pays retrospectively after the veteran has received services. Several VISNS are continuing to develop and evaluate their resource allocation methods.

Differences in VISN allocation methods may be appropriate to account for characteristics specific to each VISN. These include differences in facility missions, veteran users' health needs, and the geographic dispersion of the population served. For example, if a VISN has some facilities that mainly provide low-cost primary and outpatient care and others that provide a large volume of expensive inpatient care, the VISN allocation methods will need to account for these differences in missions and associated costs. VISNS, however, may allocate resources—regardless of whether they shift funds among facilities—in such way that they make little improvement in equity for underserved veterans.

VA has provided little oversight of networks' allocation of resources to their facilities. Documents headquarters has distributed to the networks provide no guidance nor do they specify criteria that networks should consider in allocating resources to their facilities. These documents only describe the budget items included in VERA allocation and those allocated separately by headquarters. Furthermore, headquarters has done little to monitor network efforts to improve veterans' equitable access to services. Although headquarters has required each VISN to report changes in allocations they made to each facility, including a report of funds used for addressing equity of access, the instructions for this report do not explain what this category is intended to capture or how VISNS should determine the amount of funds per facility they report for this purpose. The information submitted by VISNS did not provide enough detail, VA officials told us, to determine the impact of network actions on equity of access, and VA has no other system in place to monitor such actions or their impact.

¹⁷See VA Health Care: Improving Veterans' Access Poses Financial and Mission-Related Challenges (GAO/HEHS-97-7, Oct. 25, 1996).

Conclusions

VERA is an important step forward in equitably allocating resources to networks. VERA's major contribution is to base allocations to the 22 networks on comparable resources for veteran users. Because VERA was only partially implemented in fiscal year 1997, however, major shifts in funding among networks have not occurred. If fully implemented as planned in fiscal year 1999, these shifts may be substantial. By continuing to examine possible improvements to VERA while it is being phased in, VA is studying the right issues such as refinements in its workload and capitation measures.

VA has not established an adequate monitoring system, however, to identify changes in workload and medical practices that could compromise VERA's ability to allocate resources in the future or affect the appropriateness of services delivered. Networks and their facilities are making and planning significant changes in response to VERA's incentives and related VA initiatives. Among these changes are reductions in lengths of stay, increases in number of veterans served, changed staffing patterns, more primary care, and more outpatient care. Headquarters' monitoring efforts are not keeping pace with the changes occurring in the networks. Headquarters does not have sufficiently detailed or timely information available to enable it to identify and work with VISNs to correct problems as they occur. For example, VA has no data on changes in VERA workload measures and some key medical practices occurring in fiscal year 1997. As a result, headquarters cannot properly assess the impact or appropriateness of these changes. Without adequate monitoring, VA will have difficulty assuring its stakeholders that changes in allocations are appropriate and not adversely affecting veterans.

Headquarters oversight of VISN allocations to their facilities is also inadequate. The methods VISNs use to allocate resources are crucial to achieving the equitable access to services that VERA makes possible. VISN allocation methods determine the extent to which services are available to veterans and their equity of access in using the services. VISNs are using various methods to allocate their resources in fiscal year 1997. VA headquarters, however, has not provided VISNs with adequate national guidance for making allocation decisions, developed criteria to review and approve these decisions, or implemented monitoring to assess the impact of these decisions on equitable access to services. Without such guidance, review, and monitoring of the VISN allocation process, headquarters cannot ensure that VERA's potential for creating equitable access to services will be realized. VA headquarters can provide guidance and oversight to VISNs to achieve equitable access to services without being so prescriptive that it

compromises the discretion of VISN management to adapt local programs to local needs.

Recommendations

We recommend that the Secretary for Veterans Affairs direct the Under Secretary for Health to

- develop more timely and detailed indicators of changes in key VERA workload measures and medical care practices to maintain VERA's ability to equitably allocate resources in the future and help ensure that veterans receive the most appropriate care and
- improve oversight of VISNs' allocation of resources to their facilities by (1) developing criteria for use in designing VISN resource allocation methods, (2) reviewing and approving these methods, and (3) monitoring the impact of the methods on veterans' equitable access to care.

Agency Comments

In an August 21, 1997, letter, the Secretary-designate of Veterans Affairs said that he concurred in principle with the recommendations in our draft report and that VA is taking actions to respond to them (see app. IV). Specifically, he agreed with our recommendation that improvements in monitoring VERA's impact are needed and said that VA is already monitoring the VERA special care classification categories to avert potential problems. Although officials in the Veterans Health Administration's Office of the Chief Financial Officer have begun to review changes in the numbers of special care patients served, as of August 21, 1997, these data were not complete and were unavailable for our review. Furthermore, this effort does not include data to monitor changes in medical practice for veterans receiving special care services. As we note in our report, monitoring changes in special care resulting from VERA's incentives and other VA initiatives is critical for ensuring that veterans receive appropriate care. Similarly, monitoring changes in the number of basic care patients served and the services they receive is needed to ensure appropriate care and access to services.

The Secretary-designate also said that more current data are now available through monthly closing of databases. Although having monthly closings is a step in the right direction, these databases may be incomplete and not verified for accuracy. Even if these data are available, VA still needs additional time to analyze them for use in monitoring workload, cost of care, and medical practice. VA is developing selected quarterly data for

special care monitoring but, as noted above, these data are not yet available.

The Secretary-designate generally agreed with our recommendations about oversight of VISNS' allocation of resources to their facilities. He agreed that common criteria should be provided to VISNS for their allocation processes and stated that these criteria will be provided for fiscal year 1998 allocations. In addition, he noted that VA is developing outcome measures for evaluating VISN performance in achieving equitable access to care. We support these actions because they could significantly improve VA oversight of VISN allocations at the network level. However, the Secretary-designate stated that oversight of the networks should focus on performance outcomes rather than inputs. Although we agree that measuring outcomes is important, we believe headquarters should also review and approve VISN resource allocation methods to ensure that VISNS have the same understanding of the criteria and that variations in methods appropriately apply the criteria. By reviewing methods developed by the 22 VISNS, headquarters would be able to identify possible problems. Such a review could help networks prevent inequitable access to services that might otherwise result from flawed allocation methods.

As arranged with your staff, we are sending copies of this report to the Secretary-designate of Veterans Affairs, interested congressional committees, and other interested parties. We will make copies of this report available to others upon request.

If you have any questions about this report, please call me at (202) 512-7101 or Bruce D. Layton, Assistant Director, at (202) 512-6837. Other major contributors to this report were James C. Musselwhite, Senior Social Science Analyst, and Timothy S. Bushfield, Evaluator.

Sincerely yours,

A handwritten signature in black ink that reads "Stephen P. Backhus". The signature is written in a cursive, flowing style.

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

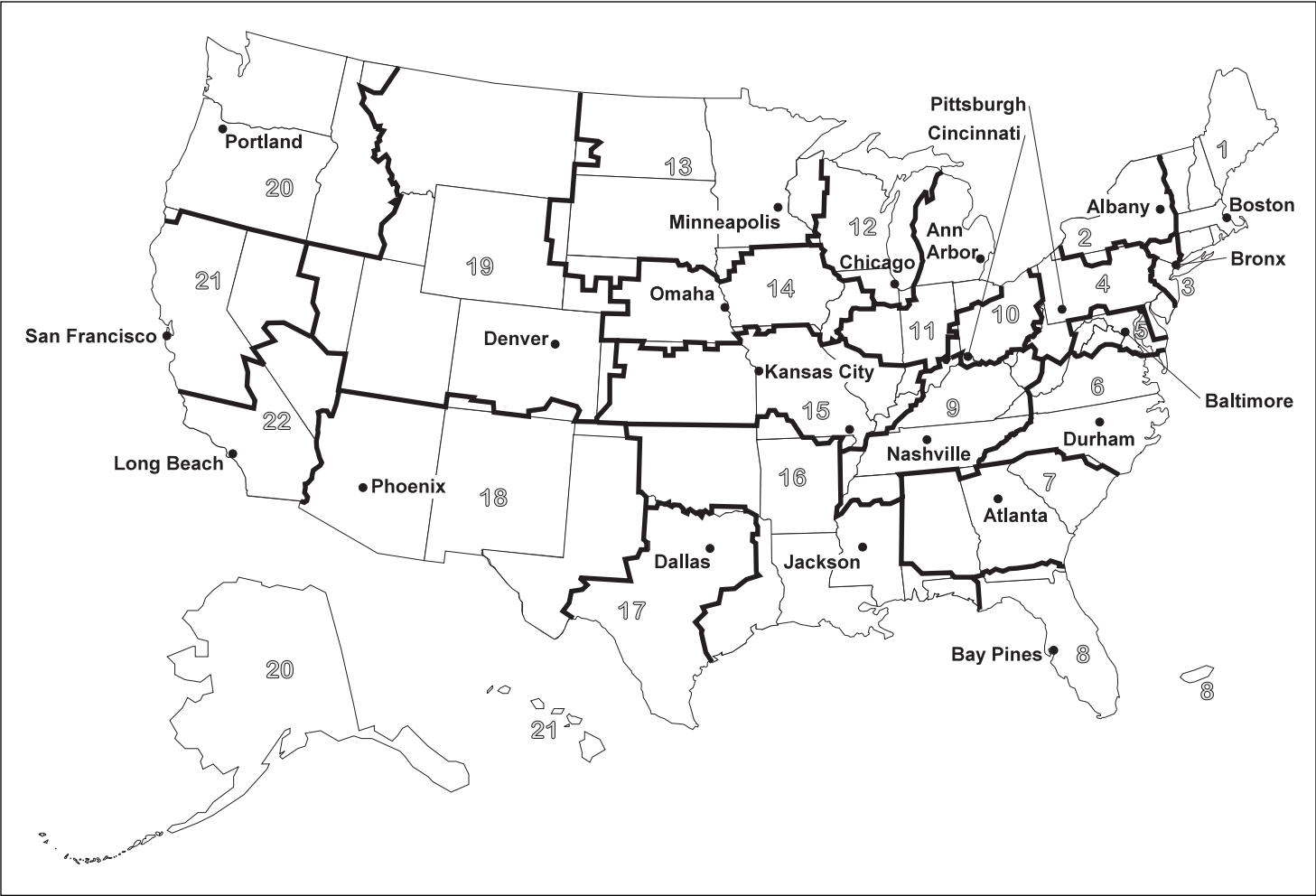
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Abbreviations

AIDS	acquired immunodeficiency syndrome
CBOC	community-based outpatient clinic
VA	Department of Veterans Affairs
VERA	Veterans Equitable Resource Allocation
VISN	Veterans Integrated Services Network

Veterans Integrated Services Networks



Scope and Methodology

We focused our work on VA's resource allocation process, which is intended to improve veterans' equitable access to services. First, we examined how VA allocates resources through the Veterans Equitable Resource Allocation (VERA) system to the 22 Veterans Integrated Services Networks (VISN). Second, we examined how headquarters monitors VERA's impact. Third, we reviewed how headquarters oversees networks' allocation of resources to the facilities in their geographic regions.

To address our objectives, we (1) collected and reviewed data on VERA's allocation method; (2) reviewed our previous work that examined VA's resource allocation process (see Related GAO Products); (3) reviewed national and regional veteran population data that could be used in considering alternatives to VERA's method; (4) collected and examined documents on VISN allocations to facilities in VISN geographic areas; and (5) interviewed officials in the Veterans Health Administration's Office of the Chief Financial Officer, Office of Policy, Planning, and Performance, and Office of the Chief Network Officer because of their VERA-related responsibilities. The Office of the Chief Financial Officer designed and is implementing VERA. The Office of Policy, Planning, and Performance collects information on network performance indicators that can be used for monitoring changes resulting from VERA's implementation, and the Office of the Chief Network Officer has overall responsibility for managing and coordinating network activities. We also used information provided by VA's National Center for Veterans Analysis and Statistics, which provides statistical data and analysis of veterans and VA services.

We contacted network directors and other officials, including chief financial officers in seven networks to collect VISN-level data and interview them on VERA's implementation, VISN allocation methods, and the implications for veterans' equity of access to services. We telephoned officials in four networks: VISN 2 (Albany), VISN 3 (Bronx), VISN 18 (Phoenix), and VISN 20 (Portland). We visited three networks: VISN 1 (Boston), VISN 4 (Pittsburgh), and VISN 16 (Jackson). Three of these VISNs would have gained resources if VERA had been fully implemented in fiscal year 1997, and four would have lost resources. (See fig. 3.) We visited seven medical centers in these networks (Brockton/West Roxbury, Northampton, Pittsburgh, Clarksburg, Lebanon, Fayetteville, and Jackson), where we interviewed medical center managers, program directors, physicians, nurses, administrative personnel, and others about VERA implementation and VISN allocations to facilities.

Appendix II
Scope and Methodology

We performed our review between January 1997 and July 1997 in accordance with generally accepted government auditing standards.

VERA Special Patient Classifications

In fiscal year 1997, VERA's special care category consisted of veterans with high-cost health care needs in 29 special care patient classifications. Networks receive a capitation payment for each veteran they serve in one of the classifications. The capitation rate for veterans in the special care classifications was \$35,707. Patients are assigned to only one classification on the basis of cost and other factors. The special care patient classifications are costly because of the type and amount of care required or the type of facility where care is provided. For example, some patient classifications are for patients receiving treatment for a long time period, such as for end-stage renal disease and spinal cord injury, while others are for patients with relatively shorter periods of treatment such as those for organ transplants. A list of the 29 special care patient classifications for fiscal year 1997 follows:¹⁸

- AIDS category III,
- AIDS category IV,
- blind rehabilitation center patients,
- bone marrow transplants,
- community nursing homes,
- domiciliary,
- end-stage renal disease,
- heart and/or lung transplants,
- home care end-stage renal disease,
- hospital-based home care,
- kidney transplants,
- liver transplants,
- low activities of daily living,
- nursing home: behavioral rehabilitation,
- nursing home: clinically complex care,
- nursing home: physical rehabilitation,
- nursing home: rehabilitation,
- nursing home: specialized care,
- other psychosis,
- post traumatic stress disorder,
- schizophrenia and dementia,
- spinal cord injury paraplegic—new injury,
- spinal cord injury paraplegic—old injury,
- spinal cord injury quadriplegic—new injury,
- spinal cord injury quadriplegic—old injury,
- stroke patients,
- substance abuse patients,

¹⁸VA's VERA Handbook, ch. 4.

Appendix III
VERA Special Patient Classifications

-
- traumatic brain injury patients, and
 - ventilator-dependent patients.

Comments From the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

AUG 21 1997

Mr. Stephen P. Backhus
Director, Veterans' Affairs and Military
Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

This is in response to your draft report, ***VA HEALTH CARE: Resource Allocation Has Improved, but Better Oversight Needed*** (GAO/HEHS-97-178). Upon reviewing your report, I am pleased to note that GAO has recognized the impact of the Veterans Health Administration's progress in implementing the Veterans Equitable Resource Allocation (VERA) program. I agree that this is a significant step forward in equitably allocating resources and reducing long-standing regional funding imbalances, as well as providing incentives for serving more high-priority veterans and reducing costs.

I concur in principle with the report's recommendations. The enclosure discusses actions the VHA is already taking to respond to them.

Very sincerely,

A handwritten signature in black ink, appearing to read "Hershel Gober".

Hershel Gober
Secretary-Designate

HG/vz
Enclosure



Putting Veterans First

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT
*VA HEALTH CARE: Resource Allocation Has Improved,
but Better Oversight Needed*
(GAO/HEHS-97-178)

GAO recommends that I direct the Under Secretary for Health to:

develop more timely and detailed indicators of changes in key VERA workload measures and medical care practices to maintain VERA's ability to equitably allocate resources in the future and help ensure that veterans receive the most appropriate care; and

Concur in principle - I agree that more timely data for analyses would better enable VA to assess changes occurring within the health care delivery system. However, the draft report should recognize that VHA is currently analyzing data to determine the potential impact of the eligibility reform legislation. Also, VHA is monitoring the VERA special care classification categories to avert potential problems. Additionally, VHA's Chief Financial Officer and Chief Information Officer are working together to identify areas needing improvement in the data sources that underlie the VERA system. Data referred to in the report as not being available until more than a year after the services were provided are now being made available much sooner through monthly closing of the data bases. This improved availability will enhance VHA's ability to assess changes in cost, quality, and access to care.

improve oversight of VISNs' allocations of resources to their facilities by (1) developing criteria for use in designing VISN resource allocation methodologies; (2) reviewing and approving the resulting methodologies, and (3) and monitoring the impact of these methodologies on veterans' equitable access to care.

Concur in Principle - I believe that the oversight now provided to the VISNs is appropriate and that management's focus should be on performance outcomes rather than on dictating inputs. In the spirit of GPRA and NPR, the VHA is developing such outcome measures. I agree that common criteria for allocation of resources below the network level should be provided. To this end, the VHA is developing criteria that will apply to all networks but will allow consideration of each network's unique characteristics.

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS
TO GAO DRAFT REPORT,
***VA HEALTH CARE: Resource Allocation Has Improved,
but Better Oversight Needed***
(GAO/HEHS-97-178)
(Continued)

The criteria will be available for the fiscal year 1998 allocations. Also, as VHA has done this fiscal year, it will continue to monitor the numbers of patients provided care compared to previous years to ensure that access to quality care is not being compromised.

Related GAO Products

VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal ([GAO/T-HEHS-97-121](#), May 1, 1997).

Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department ([GAO/T-HEHS-97-97](#), Mar. 18, 1997).

VA Health Care: Improving Veterans' Access Poses Financial and Mission-Related Challenges ([GAO/HEHS-97-7](#), Oct. 25, 1996).

VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources ([GAO/HEHS-96-121](#), July 25, 1996).

Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable ([GAO/HEHS-96-48](#), Feb. 7, 1996).

VA Health Care: Exploring Options to Improve Veterans' Access to VA Facilities ([GAO/HEHS-96-52](#), Feb. 6, 1996).

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

VA Health Care: Resource Allocation Methodology Has Had Little Impact on Medical Centers' Budgets ([GAO/HRD-89-93](#), Aug. 18, 1989).

Change in the Delivery of Selected Mental Health Services at Veterans Administration Medical Centers ([GAO/T-HRD-88-22](#), July 14, 1988).

VA Health Care: Resource Allocation Methodology Should Improve VA's Financial Management ([GAO/HRD-87-123BR](#), Aug. 31, 1987).

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