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Testimony

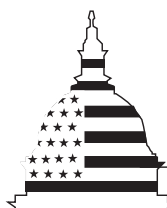
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VETERANS' AFFAIRS

Progress and Challenges in Transforming Health Care

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Veterans' Affairs: Progress and Challenges in Transforming Health Care

Mr. Chairman and Members of the Subcommittee:

We are pleased to contribute this statement for the record for the Subcommittee's deliberations on the fiscal year 2000 budget request for the Department of Veterans Affairs' (VA) health care system. In this request, VA is seeking a funding level of \$18.4 billion to serve 3.65 million veterans.

Between its establishment in 1946 and 1995, VA's health care system grew into our nation's largest direct provider of health care, serving veterans at over 600 locations nationwide. These included 181 locations where VA owned over 4,700 buildings and 18,000 acres of land. VA's system focused primarily on hospital care, using high technology and medical specialization.

VA's system, however, did not keep pace with such societal and industry changes as

- a market-based restructuring of American healthcare, including the rise of managed care;
- a rapid growth in scientific and medical knowledge available to treat illnesses and injuries; and
- an overall aging of the veteran population, including declining numbers of potential system users and evolving medical needs.

In October 1995, VA began to transform its system from a hospital operator to a healthcare provider that relies on community-based, integrated networks of VA and non-VA providers to meet veterans' needs more efficiently and effectively. In January 1997, VA proposed a 5-year plan to operate within a fixed annual appropriation of \$17 billion through fiscal year 2002. To accomplish this, VA planned to reduce per patient costs by 30 percent, increase patients served by 20 percent, and reduce reliance on appropriations by 10 percent.

Since VA's transformation began, we have visited over 100 VA medical facilities and spoken with over 500 officials, as well as many veterans, including representatives of veteran service organizations. We also examined hundreds of documents, including VA's budget submissions and studies done by VA's Office of Inspector General and others. Based on the insights developed during these efforts, our statement today focuses on

(1) VA's transformation progress to date, (2) challenges that remain to be confronted, and (3) the implications for VA's fiscal year 2000 budget.¹

In summary, VA's transformation continues to make significant progress. Over the last 3 years, VA has enhanced benefits and served 500,000 additional veterans, while realizing a nonappropriated revenue surplus of \$496 million that remains available for future use. This was accomplished primarily because VA's management initiatives reduced operating costs by almost \$1 billion. The most notable initiatives involved shifting veterans' care to appropriate settings and reengineering administrative and clinical processes.

This year, however, our work shows that VA's transformation appears to be losing momentum. VA, for example, has prolonged decisions concerning much needed restructuring of aged capital assets, including hospital closures, which could result in unnecessary expenditures of billions of dollars over the next several years. VA's transformation cannot be successfully completed until these and other critical challenges are adequately addressed.

In our view, VA's fiscal year 2000 budget is based on the unduly optimistic expectation that its ongoing transformation will generate needed efficiencies of \$1.4 billion in savings. VA assumes, for example, that employment reductions in fiscal year 2000 will be more than 3 times greater than expected fiscal year 1999 reductions. VA has not taken the underlying management actions—such as aggressively addressing all potential facility integrations and service consolidations—that appear necessary to make a threefold reduction possible. If VA had made such difficult decisions earlier, it might not need to realize this level of savings. Moreover, VA may ultimately need to use less desirable management actions, including large-scale employee furloughs, to operate within its proposed budget. Such actions could adversely affect all veterans' quality of care, especially waiting times. VA could avoid such undesirable outcomes for higher priority veterans if, as the Congress intended, VA uses its new enrollment process to manage access to VA health care services within available resources.

¹For 1996 and 1997 hearings of this subcommittee, we provided assessments of VA's transformation progress. See *VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs* (GAO/T-HEHS-96-99, Mar. 8, 1996) and *VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal* (GAO/T-HEHS-97-121, May 1, 1997).

Background

VA's health care system currently touches the lives of 15 percent of our nation's 25 million veterans. The rest rely on private insurance, other public programs, or their own resources to finance their health care needs.

VA uses hundreds of delivery locations to provide services such as primary care, specialized medical care, mental health, geriatrics, and extended care. In addition, VA supports medical education and research through its affiliation with 107 medical schools, and provides medical backup to the Department of Defense and other federal, state, or local agencies during national emergencies.

VA began its transformation by creating 22 regional offices to make basic budgetary, planning, and operating decisions for veterans living within defined geographical areas; VA's headquarters and over 150 large hospitals made such decisions previously. These offices oversee between 5 and 11 large hospitals, as well as many clinics or other delivery locations.

The primary focus of VA's transformation is to reduce reliance on large hospitals by developing local or regional networks that provide a continuum of care grounded in ambulatory settings. To encourage this transformation, VA implemented a new resources allocation process that bases funding decisions on user populations rather than facilities.

In addition, the Congress passed the Veterans Health Care Eligibility Reform Act of 1996, which furnished tools that VA said were key to a successful transformation and provided VA the means to develop its 5-year financial plan, including

- new eligibility rules which allow VA to treat veterans in the most appropriate setting;
- introduction of managed care principles, such as a uniform benefits package, which allows VA to provide a continuum of services, including preventive medicine; and
- an expanded ability to purchase services from private providers and to generate revenue by selling excess services to nonveterans.

At that time, both the Congressional Budget Office and we concluded that such reforms could generate additional demand for services, primarily due to increased use of outpatient services. The Congressional Budget Office also estimated that rising utilization would, by extension, produce dramatic cost increases, potentially billions of dollars.

To address such concerns, the Eligibility Reform Act also required VA to implement a veterans' enrollment system to manage access in relation to available resources. It established seven priority categories, with the highest priorities given to veterans with service-connected disabilities.

Each year, VA is to enroll veterans in those priority categories for which there are sufficient resources to provide care that is timely and acceptable in quality. The act also requires VA to maintain capacity for veterans with special disabilities, including treatment for spinal cord injury, blindness, amputation, and mental illnesses.

At VA's request, the Congress also authorized VA to retain all collections from third parties (including recoveries from insurance companies and certain tort claims), copayments, and per diems, beginning July 1, 1997. VA is to deposit these collections in a Medical Care Collections Fund and use them to supplement appropriations to meet veterans' health care needs. VA may spend these funds in the year collected or any subsequent year.

VA Has Taken Major Steps Forward in Its Transformation

As part of the transformation, VA's networks have implemented hundreds of management initiatives that have significantly enhanced the efficiency and effectiveness of VA's health care system.² For example, during fiscal years 1996 through 1998, VA reduced inpatient workload by 38 percent and bed days of care per 1,000 veterans by 47 percent. This allowed over 20,000 hospital beds to be closed and numerous administrative and clinical services to be consolidated.

At the same time, VA used savings from its efficiencies to finance improvements in veterans' access to, and quality of, care. For example, VA served an additional 500,000 veterans, in part, by opening over 183 new community-based clinics, creating about 1,000 primary care teams, and purchasing specialty care from private providers. VA's performance indicators suggest that the quality of care is improving overall. Veterans' rating of ambulatory care quality has risen and the reported numbers of problems have fallen.

VA appears on track toward meeting its goals of reducing per-patient costs, serving more veterans, and increasing nonappropriated revenue sources by fiscal year 2002. Compared with its fiscal year 1997 baseline, VA projected and realized the results shown in table 1 for fiscal year 1998 (year 1 of VA's 5-year plan).

²VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

Table 1: VA's 5-Year Goals

30-20-10 initiatives	VA fiscal year 1998		VA fiscal year 2002
	Results	Goal	Goal
Reducing per-patient costs	10%	6%	30%
Serving more veterans	9%	5%	20%
Increasing nonappropriated funding	4%	4%	10%

More importantly, VA expects to have more resources available in fiscal year 1999 than its 5-year plan projected, as shown in table 2.

Table 2: Comparison of VA's Estimates for Its FY 1999 Budget

Funding	VA's 5-year plan's projection for FY 1999 (1/97)	VA's current FY 1999 estimate (1/99)
Appropriated	\$17.0 billion	\$17.3 billion
Other sources	\$.9 billion	\$ 1.1 billion
Total	\$17.9 billion	\$18.4 billion

Because of efficiency savings, VA needed to spend, in fiscal year 1998, only \$170 million of its medical care collections. This allowed VA to carry forward about \$496 million for use in fiscal year 1999.

VA's management initiatives that contributed to these dramatic results include

- establishing primary care as the dominant delivery model;
- shifting medical care from inpatient to outpatient settings;
- consolidating administrative and clinical services; and
- establishing networks of VA and non-VA providers.

Establishing Primary Care as Dominant Delivery Model

VA established primary care case management to help ensure that patients are served in the most appropriate settings and resources are coordinated and best organized to address patients' specific medical conditions.

Before 1995, primary care providers managed less than 20 percent of VA's patients. Since then, VA has successfully oriented veterans to the principal concept of primary care. VA, for example, reports that close to 80 percent of veterans responding to its annual patient survey are aware that one provider or primary care team has responsibility for managing their

medical care. This, in effect, relieves high-cost specialists from day-to-day patient management responsibilities.

To enhance primary care access, VA has established over 1,000 primary care teams at large medical facilities and opened over 183 community-based outpatient clinics. These clinics provide primary care closer to veterans' homes, especially those living in underserved, often remote, areas. Currently, VA has approved 272 community clinics to open in fiscal years 1999 and 2000 and expects to open about 200 more by fiscal year 2003.

Shifting Medical Care to Outpatient Settings

Advances in medical technology and practices, for example, have afforded VA significant opportunities to shift medical care to outpatient settings. Because of such new technologies as laser, endoscopic, and other less invasive surgical techniques, many surgeries are now performed in a doctor's office or outpatient clinic or require shorter lengths of stay when performed in hospitals.

In addition, changes in medical practice and the development of psychotherapeutic drugs to treat mental illness have led to fewer and shorter hospital admissions for psychiatric patients and to the deinstitutionalization of many long-term psychiatric patients.

VA has implemented management initiatives to identify patients who can be served more cost-effectively in alternatives to inpatient settings, including treatment of many chronically and catastrophically ill patients at home rather than in a hospital.

Before 1996, VA had no systemwide external preadmission screening program or other utilization review programs to ensure that patients are treated in the most appropriate settings. In that year, we recommended that VA develop such programs.³ Subsequently, VA implemented management initiatives to

- review 100 percent of planned admissions to determine patients' appropriate level of care and
- perform continuing stay reviews to determine the appropriateness of each additional day of hospitalization.

³VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

During fiscal years 1996 through 1998, VA's inpatient workload declined 38 percent and bed days of care per 1,000 patients dropped by 47 percent. This allowed VA to close 20,000 hospital beds, a 40-percent reduction.

This decrease in inpatient usage has been matched by major increases in VA's outpatient care workload. During fiscal years 1996 through 1998, VA's outpatient visits increased 19 percent. Of note, VA performed over 90 percent of certain surgeries, including colonoscopies, arthroscopies, cystoscopies, breast biopsies, and cataract surgeries, on an ambulatory basis in fiscal year 1998.

Consolidating Administrative and Clinical Services

VA also has implemented a variety of initiatives that consolidated duplicate or underused services. VA, for example, integrated the management teams of two or more large medical facilities in 24 markets; this effort involved a total of 50 facilities. VA also consolidated many other administrative and clinical services at these facilities, which saved millions of dollars in unneeded operating costs.⁴

Based on our work, VA appears to have an opportunity to achieve even more significant savings by consolidating duplicate or underused services. This is because VA still operates 17 large medical facilities that compete with these newly integrated facilities in 10 markets, as well as operating 44 large facilities in 19 other markets that compete with each other to serve veterans.

Recently, we recommended, and VA agreed, that veterans' needs should be assessed in these 40 markets and steps taken to integrate, consolidate, or close unneeded services. This could result in billions of dollars in additional savings over the next 5 years that could be reinvested to improve veterans' access to high-quality care.⁵

Establishing Networks of VA and Non-VA Health Care Providers

VA has implemented important initiatives to establish integrated networks of VA and non-VA providers. VA has made the most progress by far in establishing new community-based clinics. Some notable progress, however, has been made purchasing inpatient care from private hospitals

⁴VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997).

⁵VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

or military facilities, as well as developing joint ventures and sharing agreements with the Department of Defense.

About half of VA's new community clinics operated through contracts with non-VA providers during fiscal years 1996 through 1998. These clinics helped to reduce VA's costs and improve access because they are located closer to veterans' homes. VA expects these clinics primarily to refer veterans to VA facilities for specialized diagnostic procedures, treatment, or hospital admissions, although referrals may also be made to other non-VA providers.

In addition, some VA hospitals located in rural areas have contracted to provide inpatient care with non-VA hospitals. These initiatives, according to VA, have been successful from a cost-efficiency perspective and also have received high satisfaction scores from veterans.

At the close of fiscal year 1998, VA and the Department of Defense had negotiated almost 1,000 facility-level sharing agreements covering more than 10,000 services ranging from laundry, blood, and laboratory services to major medical and specialty care services. There are also four joint ventures under way for the construction and operation of medical facilities, with four additional agreements near completion.

We are currently reviewing these sharing agreements to assess the benefits for veterans, military members, and beneficiaries, as well as efficiency savings for VA. Recently, the Congressional Commission on Servicemembers and Veterans Transition Assistance reported that opportunities exist for greater sharing and partnering between VA and the Department of Defense. Of note, the Commission made several recommendations, including the development of a joint, clinically based formulary and joint procurement of future information technology.

Further Transformation Progress Will Require VA to Confront Formidable Challenges

As VA's transformation proceeds through its fourth year, it now turns to face the most onerous challenges it has encountered to date. These include

- closing unneeded hospitals,
- restructuring capital assets,
- restructuring VA's medical education role,
- maintaining capacity to serve special disabilities,
- improving resource allocations,

- improving revenue collections, and
- implementing an enrollment process.

VA's failure to aggressively confront these challenges could result in the unnecessary expenditure of billions of dollars over the next several years.

Closing Unneeded Hospitals

The success of VA's strategies to transform its health care system—shifting inpatient care to more appropriate settings, establishing primary care in community clinics, and improving efficiency through staff reductions, service consolidations, and bed closures—has produced excess inpatient capacity at most VA hospitals. As VA's transformation continues, VA's need for a large number of full-service hospitals will continue to diminish, thereby challenging VA to make difficult decisions concerning hospital closures.

VA and the private sector have reacted very differently to declining inpatient workload. In the private sector, over 500 hospitals were closed as health care practices were transformed. As we have reported, VA instead has chosen to reduce operating beds at its hospitals or shift services such as inpatient surgery among hospitals.⁶ This approach often leaves VA operating only a small part of most hospitals' inpatient capacity.

VA demonstrated the feasibility of closing underused hospitals when it closed the Martinez, California, hospital because of earthquake concerns. VA replaced it with a modern outpatient clinic supplemented by existing VA inpatient locations and contract care, efficiently meeting veterans' needs in that market. VA reports that veterans' satisfaction with these changes is high, including satisfaction with quality of care.

At a March 1996 hearing before this Subcommittee, VA stated that it would look to close additional facilities; since then, VA in essence has closed four hospitals by shifting inpatient care to other VA locations or contracting with non-VA providers. In each location, VA continues to provide outpatient care as well as nursing home care in three locations.

Last year, we reported that VA could save \$20 million a year and care could be improved if veterans were served at one less location in Chicago.⁷

⁶VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

⁷VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998) reports that asset operations and maintenance costs for four VA hospitals in Chicago generally represent about 25 to 35 percent of the hospitals' operating budgets.

Veterans' benefits, for example, could be enhanced if VA used the savings to purchase primary care closer to veterans' homes. In response to our recommendation, VA agreed to initiate a market-based assessment of its health care delivery in the Chicago market. This market assessment is scheduled for completion soon.

VA is to be commended for its willingness to study how it could improve its efforts to meet veterans' needs in this market. The extent to which VA is committed to taking action on the basis of study findings remains uncertain, however. Last month, VA stated publicly that no additional hospitals will be closed in fiscal years 1999 or 2000. This decision seriously threatens the continued progress of VA's health system transformation.

Restructuring Capital Assets

VA's massive, aged infrastructure could be the biggest obstacle confronting VA's ongoing transformation efforts. VA's challenges in this arena are twofold: deciding how its assets should be restructured, given the dramatic shifts in VA's delivery practices, and determining how a restructuring can be financed in a timely manner.

VA spends a major part of its health care budget—about 1 out of every 4 health care dollars—to operate, maintain, and improve its facilities, generally referred to as the costs of asset ownership. Without a major restructuring, billions of dollars will be used in the operation of hundreds of unneeded VA buildings over the next few years.

VA's transformation has largely ignored this capital asset dilemma, as VA's plans call for assets to continue operating over the next 5 years essentially as they do today. Given VA's current and proposed budgets, it seems inevitable that VA's ownership of unneeded assets will eventually compromise veterans' health care services. On the other hand, restructuring its capital assets could reduce budget pressures or generate revenues that could be used to enhance veterans' health care benefits.

Recently, we recommended that VA's capital asset planning should be based on rigorous market analyses, a business tool that has produced positive results in the private sector.⁸ Such analyses include the determination of veterans' health care needs in a market, a comparison of life-cycle costs of asset ownership, and alternatives analysis to enable VA to evaluate options for meeting needs in the most cost-effective manner.

⁸VA Health Care: Capital Asset Planning and Budgeting Need Improvement (GAO/T-HEHS-99-83, Mar. 10, 1999).

We identified 106 markets in which VA owns 4,700 buildings and 18,000 acres of land, which it uses to operate 181 major delivery locations. VA has agreed to conduct market analyses in the 40 markets where multiple VA facilities compete with each other to serve veterans (VA operates assets at 115 locations in these markets) as well as 66 markets served by a single VA location.

Until VA completes these market assessments, it will be challenged to make capital investment decisions to ensure that scarce resources are not invested in assets that VA will vacate in a few years. Recently, we recommended, and VA agreed, that more of its capital investment decisions—specifically minor construction and certain nonrecurring maintenance—should be subjected to more rigorous management review. Toward that end, VA plans to institute an improved investment decision-making process that involves top managers' review and approval, based on newly enhanced guidance and criteria for assessing the future of the affected asset within VA's ongoing transformation.

Once VA has developed an asset restructuring plan, it will be challenged to finance needed investments in a timely manner. Toward that end, VA proposes a 5-year demonstration that would allow it to sell, transfer, or exchange up to 30 excess or underutilized properties, deposit proceeds into a new Capital Asset Fund, and use the Fund to invest in more appropriate assets. This proposal is compelling because it would provide VA incentives to dispose of properties no longer needed to meet veterans' needs. VA asserts, and we agree, that disposals are currently a cumbersome and lengthy undertaking with limited benefits to VA, primarily because proceeds' use is limited to improving nursing homes.

Restructuring VA's Medical Education Role

Transforming VA's health care delivery system from an inpatient to an outpatient focus, increasing reliance on primary care, and integrating services in fewer hospitals require VA and medical schools to restructure their affiliation arrangements.

Since VA's medical education program began in 1946, 132 VA medical facilities have affiliated with 107 medical schools to provide training opportunities for medical students and residents. These agreements complicate VA's restructuring efforts, particularly integrating administrative and clinical services across two or more medical facilities.

VA assists in the training of health professionals for its own needs and for those of the nation through its partnerships with affiliated academic institutions. Each year, about 91,000 medical and other students receive some or all of their clinical training in VA facilities. In fiscal year 1999, VA expects to spend \$750 million for education and training of health professionals.

VA also assists in supporting medical research in connection with the provision of medical care and treatment to veterans. The affiliated medical schools are an integral part of VA's research effort. For fiscal year 1999, VA expects to spend \$682 million for research (\$316 million from the medical and prosthetic research appropriation and \$366 million in medical support from the medical care appropriation).

VA's successful transformation to a predominantly primary care model, with its consequent deemphasis of inpatient, specialty care, has direct implications for VA's education role. As previously discussed, VA's management initiatives have decreased inpatient usage by 38 percent and increased outpatient workload by 19 percent. This underscores a need to train more primary care physicians and fewer specialty physicians.

In light of these changes, VA established a Residency Realignment Review Committee and a Research Realignment Advisory Committee. In response to these committees' recommendations, VA set a goal to more equally divide resident training positions between specialty and primary care by 2002; previously, about 70 percent of residents were enrolled in specialty training and 30 percent in primary care. In doing this, VA plans to eliminate 250 specialty positions and shift another 750 to primary care. To date, VA appears on track toward meeting its goals.

As VA's transformation continues, its management initiatives should increasingly involve consolidating programs to eliminate redundancy among nearby VA facilities or the potential closing of facilities. This will, by necessity, increase the potential for conflict between medical schools' best interests and veterans' best interests.

Because VA provides a major source of medical training and research opportunities, medical schools clearly have a vested interest in VA hospitals staying open. As such, it will be difficult to achieve a proper balance between VA's primary mission—serving veterans' health care needs—and its secondary missions—supporting education and research.

VA must take care to prevent stakeholders, such as medical schools, from unduly influencing the ongoing transformation of its health care system.

At present, medical schools have concerns about potential consolidations of VA medical facilities. It seems inevitable that medical schools will need increasingly to share inpatient educational and research opportunities at a single VA facility. VA must work closely with medical schools to ensure that such restructuring is accomplished without compromising VA's efforts to improve its efficiency and effectiveness.

Maintaining Capacity to Serve Special Disabilities

VA is struggling in its efforts to address congressional concerns that it is not appropriately maintaining its level of certain high-cost specialized services as its transformation progresses.

The Congress required VA to ensure that its capacity to provide specialized treatment and rehabilitative services for veterans with certain disabling conditions is not reduced below October 1996 levels and that veterans with these conditions have reasonable access to care. The Congress identified four disabling conditions requiring specialized care: spinal cord dysfunction, blindness, amputation, and mental illness. For this requirement, VA defined mental illness to include only veterans with serious mental illness and included two additional conditions: traumatic brain injury and post-traumatic stress disorder.

VA cites a 2-percent increase in patients served as evidence that it is maintaining capacity to serve special disabilities. But this aggregate measure could mask potential adverse effects experienced by individual services and delivery locations. VA plans to develop outcome measures to reflect the overall capacity of its special disability services.

Last year, we noted that unclear service definitions and cumbersome data systems hindered VA's development of additional outcome measures. As a result, it is difficult to establish a baseline for comparison purposes, assess the accuracy of reporting at the local level, and reconcile differences among individual facilities', networks', and headquarters' data.⁹

To date, VA has designed functional measures for seriously mentally ill patients and patients with a primary diagnosis of substance abuse. VA, however, has generally not performed the program evaluations necessary

⁹VA Health Care: VA's Efforts to Maintain Services for Veterans With Special Disabilities (GAO/T-HEHS-98-220, July 23, 1998).

to determine whether these are the most appropriate or sensitive measures for assessing responses to treatment and changes in health outcomes.

Until adequate outcome measures are available, VA continues to use its traditional process measurements, such as number of veterans served and resources expended, including dollars, staffing, and beds. These measures remain important indicators and should be continually reviewed.

Improving Resource Allocation

VA's new resource allocation system is improving the equity of resource allocations among networks. The system's promise for achieving equitable access may not be fulfilled, however, because of VA's inadequate oversight of how resources are allocated within networks and historical access inequities are addressed.

To improve equitable access to care, the Congress enacted legislation in 1996 requiring VA to develop a plan for equitably allocating resources to ensure that veterans with similar economic status and eligibility priority have similar access to VA health care, regardless of the region in which they live. In response, VA began implementing a new allocation process.

Previously, VA allocated resources directly to facilities on the basis of their budget for the previous year. VA's new process allocates funds to the 22 networks based on the number of veterans each serves. Networks, in turn, allocate resources to the facilities in their geographic area.

As we reported to you in September 1997, this new process is correcting long-standing regional funding imbalances that have impeded veterans' equitable access to services.¹⁰ Over the last 2 years, funding has shifted from the Northeast and Midwest to the southern and western regions where more veterans reside. Each network has increased the number of veterans it serves, albeit to varying degrees, and improved current users' access to care.¹¹ VA's management efficiencies were instrumental in achieving this outcome.

VA, however, maintains that networks should not use its new process to allocate resources to facilities and that they should, instead, develop

¹⁰VA Health Care: Resource Allocation Has Improved, but Better Oversight Is Needed (GAO/HEHS-97-178, Sept. 17, 1997).

¹¹VA Health Care: More Veterans Are Being Served, but Better Oversight Is Needed (GAO/HEHS-98-226, Aug. 28, 1998).

allocation methods appropriate to local circumstances. Such resource allocations are the crucial link in VA's allocation strategy to convert resources to services.

In spite of this enormous challenge, VA has done little to ensure that networks achieve equitable allocations. VA says that it has not provided criteria for equitable allocation of resources within networks because developing such criteria would be contrary to its reengineering philosophy, which decentralizes authority and accountability for these allocations to the network directors. In addition, VA has not adequately reviewed the equity of networks' allocations or measured improvements in the equity of veterans' access to care.

Networks we analyzed have not incorporated criteria in their allocations to improve equity in spite of historical inequities they identified. As a result, in spite of the considerable effort VA has invested in its new resource allocation process, resources may not be equitably allocated in many markets.

Monitoring networks' progress in achieving equitable access to care represents a significant challenge. Today, VA does not know what progress, if any, is being made towards equitable access to care for our nation's veterans. This is because VA has neither developed indicators needed to do so nor included equity of access as a performance goal for network managers.

Developing and implementing such indicators will be a major challenge both technically and in obtaining stakeholders' agreement. Without establishing such indicators and monitoring them, however, VA can neither assure stakeholders that equity of veterans' access is improving nor take corrective actions, if needed, to improve resource allocations.

Improving Revenue Collections

VA faces a major challenge increasing its medical care collections from third parties and veterans, as well as reimbursement from sharing agreements with the Department of Defense.

VA's collections grew slightly between fiscal years 1997 (\$520 million) and 1998 (\$560 million). VA's 1998 collections were about 94 percent of its stated goal. For fiscal year 1999, VA set a goal of \$637.5 million. As of March 1999, collections averaged about \$46 million a month, which appears sufficient to meet VA's goal, given that collections were historically

higher during the last quarters of fiscal years 1997 and 1998. VA's fiscal year 2000 budget sets a goal of about \$762 million, and VA expects collections to grow to more than \$1.2 billion by fiscal year 2004.

VA expects such growth for three reasons. First, VA assumes that changing its medical care billing rates to reasonable charges for inpatient and outpatient procedures will increase revenues. VA, however, has neither historical data nor experience to estimate the effect of reasonable charges on revenues.

Second, VA assumes that it will increase its revenues by identifying more insured patients. However, VA finds it very difficult to keep this information current because veterans are not required to tell VA if they have insurance or when changes occur in their insured status.

Third, VA plans to improve its debt collection improvement efforts to boost revenues. In 1998, VA's Inspector General cited uncollected debt as one of VA's significant management problems. To improve medical care debt collection, VA has efforts under way to more aggressively pursue insurance claims, including timely appeals of denied claims. For example, VA is using a centralized approach to monitor claims and is exploring ways to recover debts as an offset to veterans' federal income tax refunds.

Despite a large number of sharing agreements for services between VA and the Department of Defense, several barriers are likely to inhibit effective sharing or prevent new agreements from being reached. These barriers include conflicting agency guidelines, beneficiary perceptions about sharing, and incompatible or unreliable information systems. VA and Defense have recently embarked on a joint initiative to revitalize sharing efforts at the national level for certain critical services.

In its fiscal year 2000 budget, VA again asks the Congress to authorize VA's reimbursement from the Medicare Trust Fund for medical services it provides to Medicare-eligible veterans. VA seeks this authorization anticipating that Medicare reimbursement will become an important source of revenue.

If authorized, VA's efforts to realize such revenues, without adversely affecting veterans, could pose a daunting challenge. Since VA initially proposed receiving Medicare reimbursements, it implemented a new veterans' enrollment process that has significantly increased workload. As such, VA faces considerable uncertainty about its capacity to target another

patient population. Doing so could place veterans' access to care at risk if this increased workload forces VA to choose between serving veterans who have Medicare and those who do not.

Implementing an Enrollment Process

VA faces a significant challenge determining how many veterans to enroll, given the uncertainties surrounding new enrollees' medical needs and VA's available resources.

The Eligibility Reform Act of 1996 required VA to establish and operate a system of annual patient enrollment to manage access to VA health care services within available resources. VA began testing an enrollment process on October 1, 1997, prior to the mandated enrollment date of October 1, 1998. At that time, VA announced its decision to enroll all veterans that apply during fiscal year 1999, that is, for enrollment priorities 1 through 7. As of December 1998, VA enrolled about 3.9 million veterans, according to VA's budget office.

VA is also challenged to assess the impact of its fiscal year 1999 enrollment decision on veterans' health care delivery. VA, for example, lacks the baseline data needed to assess the impact of its fiscal year 1999 enrollment decision on the timeliness of veterans' medical care.

During the course of our ongoing review of VA's enrollment process, almost all of VA's network directors reported that enrollment has increased demand for services. About half cited a slight increase in the waiting times to schedule both primary and specialty care appointments. Over one-third noted that access to care for higher priority veterans (priority groups 1 to 4) has been adversely affected to some extent.

Finally, several directors commented that they are experiencing increased demand by veterans whose primary care is provided elsewhere but who obtain from VA the specialty care and services not covered by their private insurance or Medicare, such as pharmaceuticals, eyeglasses, and hearing aids.

VA is assessing the cost implications of its fiscal year 1999 enrollment decision. VA's data shows that, after the first 3 months of fiscal year 1999, about \$3.6 billion was spent meeting veterans' health care needs. Of this, about half was spent serving veterans in priority categories 1 to 4, and half was spent serving categories 5 to 7. Of note, veterans in category 5 accounted for about 46 percent of the \$3.6 billion.

VA plans to announce its fiscal year 2000 enrollment decision by August 1, 1999. VA, however, publicly stated last month a desire to enroll all veterans who apply and to serve all enrollees in fiscal year 2000. VA's current projections show that about 4.4 million veterans could be enrolled by the end of fiscal year 1999.

VA could find this to be quite challenging because, as the following section discusses, VA's fiscal year 2000 budget does not contain sufficient funding to maintain current service levels (3.6 million veterans), unless VA's transformation produces required savings.

VA Faces a Budget Dilemma in Fiscal Year 2000

VA will be severely challenged to serve all veterans seeking to enroll and maintain quality of care in fiscal year 2000 with an \$18.4 billion budget. This is primarily because VA's budget is based on an unduly optimistic assumption that VA's transformation will save \$1.4 billion in fiscal year 2000. VA's cost estimates also may be significantly understated, given the increased enrollments over the last 6 months and considerable uncertainties surrounding veterans' medical needs.

VA estimates that \$19.23 billion would be needed to maintain current service levels (3.6 million veterans) in fiscal year 2000 if no management efficiencies are realized. By contrast, VA estimates its fiscal year 1999 spending level to be \$18.36 billion. This \$870 million difference involves primarily payroll increases for existing employees, inflation, and other mandatory rate changes.

VA plans to use another \$525 million of its efficiency savings to enhance services. Of this, \$281 million will be used to: treat veterans with hepatitis C (\$135 million); enhance extended care services (\$106 million); and expand services for homeless veterans (\$40 million). In addition, VA proposes that \$244 million be used to expand its benefit package for certain veterans. VA requests congressional authorization to finance emergency care at non-VA facilities for veterans enrolled in priority categories 1 to 3. Currently, only certain veterans with special eligibility have such benefits.

To allow VA to operate within a proposed budget of \$18.4 billion, VA needs to achieve management efficiencies of \$1.4 billion. In general, VA estimates that initiatives could yield about \$514 million in personal services savings, essentially by reducing its employment level by 8,529 full-time equivalents.

This presents a formidable challenge, given that an employment reduction goal of 8,529 is significantly higher than the reduction of 3,606 that VA achieved in 1998 or the 2,518 that VA expects to achieve in 1999. Interestingly, VA had initially set goals of 3,978 and 2,607 in its budget requests for fiscal years 1998 and 1999, respectively.

To achieve a personal services savings goal of \$514 million in fiscal year 2000, VA needs to achieve the 8,529 employment reduction before fiscal year 2000 starts, only 5 months from now. The longer VA needs to reach this goal during fiscal year 2000, the greater the number of employees that ultimately must be reduced (to meet its goal) because VA will have to spend some projected savings to pay salaries and benefits in fiscal year 2000.

VA estimates that the remaining \$876 million will be achieved through nonpersonal services savings. If VA is unable to meet its employment reduction goal, it will have to increase nonpersonal services savings beyond this target level. This, too, could prove challenging, given the rapid increases in nonpersonal costs, especially medications and prosthetics.

VA's budget did not specify the nature of the management initiatives. VA's networks, however, have identified over the past year a variety of efficiency initiatives, including additional facility integrations, bed closures, and service consolidations, which reflect necessary shifts in patient care delivery practices. In most cases, these changes will require reductions in force, as well as staffing adjustments through normal attrition, in order to better configure VA's workforce to meet VA's transformation objectives.

VA's networks are currently revising their plans to develop alternative ways to realize savings of \$1.4 billion in fiscal year 2000. At a recent congressional hearing, officials from three networks expressed concerns about their abilities to achieve required efficiency savings. They testified that their plans would likely include significant furloughs of workers, as well as curtailment of proposed service enhancements and delay of services when medically appropriate.

In addition, VA may need to save more than \$1.4 billion because veterans' demand for medical care, as well as the numbers of veterans demanding care, may be significantly higher than VA estimated at the time its fiscal year 2000 budget was developed.

VA's budget, for example, included \$135 million to expand treatment of veterans who have hepatitis C, based on an assumed prevalence rate of 5.5 percent among its veteran user population. VA data, based on a small, unscientific sample, suggests that this rate, and hence treatment costs, could be much higher. To better estimate costs, VA recently conducted a nationwide sample of veterans using VA facilities and expects results to be available shortly.

VA's budget also assumes that an additional 54,000 veterans will be served in fiscal year 2000, bringing the total served to 3.65 million. To date, 3.9 million veterans have enrolled, and VA currently estimates that 4.4 million could enroll by the end of fiscal year 1999.

VA's rapidly rising fiscal year 1999 enrollments could also increase VA's fiscal year 2000 efficiency savings requirements by \$200 million or more. This is because VA plans to carry forward \$216 million of fiscal year 1999 revenue collections to finance fiscal year 2000 health care costs. VA could be required to spend this potential surplus in fiscal year 1999 if newly enrolled veterans require greater-than-expected health care expenditures in fiscal year 1999.

Concluding Observations

VA has made significant progress transforming its health care system but appears to have a long way to go before achieving its goal of operating integrated networks of VA and non-VA providers that efficiently and effectively serve veterans. VA needs to aggressively confront its pending challenges, especially capital asset and medical education restructuring, in order to maintain the impressive momentum generated during its transformation's initial years. Absent this, VA could waste billions of dollars to meet veterans' needs over the next several years.

Meeting veterans' medical needs within VA's proposed spending level will be problematic. To do so, VA needs to achieve significant management efficiencies, but has no clear sense of the true magnitude of its resource needs. To remedy this, VA needs answers to such critical questions as

- How many veterans will enroll for VA health care in fiscal year 2000?
- How prevalent are enrolled veterans' high-cost medical needs, especially for hepatitis C?
- How many management efficiency savings will be realized in fiscal years 1999 and 2000?

- What will the Congress decide to do concerning VA's proposed benefit expansions?

VA's budget dilemma forces it to confront difficult choices concerning its fiscal year 2000 enrollment decision—namely, how many priority categories can be prudently enrolled, given the uncertainty of estimates of potential costs and available resources. VA's current data suggest that sufficient resources may not be available to serve veterans enrolling in all seven priority enrollment categories. VA's uncertainties become more manageable if VA enrolls veterans in the manner the Congress intended—namely, veterans in those priority categories for which there are sufficient resources to provide timely access to high-quality care.

We remain concerned about VA's ability to deal with such uncertainties, primarily because of VA's publicly stated desire to serve all veterans who apply for enrollment. If VA experiences significantly higher costs than it currently estimates or significantly lower efficiency savings, enrolling all veterans who apply could require VA to take actions, such as large-scale employee furloughs, that could adversely affect the quality of care for all veterans.

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