United States General Accounting Office

GAO

Testimony

Before the Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate

For Release on Delivery
Expected at 2:00 p.m.
Thursday, May 1, 1997

VA HEALTH CARE

Assessment of VA's Fiscal Year 1998 Budget Proposal

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VA Health Care: Assessment of VA's Fiscal Year 1998 Budget Proposal

Mr. Chairman and Members of the Subcommittee:

We are pleased to contribute this statement for the record for the Subcommittee's deliberations on the President's 1998 budget request for the Department of Veterans Affairs (VA) health care system. With a 1997 medical care appropriation of $17 billion and a declining veteran population, VA faces increasing pressure to contain or reduce spending as part of governmentwide efforts to achieve a balanced budget. Last year, we reported that VA's health care system had the opportunity to reduce its operating costs by billions of dollars over the next several years.[1]

VA's 1998 budget proposal requests a medical care funding level of $17.6 billion, consisting of an appropriation of almost $17 billion and a legislative proposal to retain insurance payments and other third-party reimbursements.[2] VA characterizes this as the first step in a 5-year plan to reduce its per patient cost by 30 percent, increase patients served by 20 percent, and finance 10 percent of its expenditures using nonappropriated revenues by the year 2002. VA proposes to use appropriations of about $17 billion over the next 5 years and to supplement this with increases in third-party reimbursements that are estimated to be $1.7 billion in 2002.

Our comments focus on VA's 5-year plan, including the outlook for attaining the stated targets and the potential effects on veterans and others. In addition, as requested by the Subcommittee, we also offer our preliminary observations on VA's progress on two major initiatives: developing a method to more equitably allocate resources and establishing a decentralized management structure to more efficiently and effectively deliver services. We plan to provide the Subcommittee more detailed information on these two initiatives at a later date.

Our comments on VA's budget proposal are based on past and ongoing work to assess operating policies, procedures, and practices of VA hospitals and clinics.[3] We spoke with hundreds of VA officials and examined a wide array of documents, including VA's budget submission, annual reports, and studies done by VA's Office of Inspector General and

[1]VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996) and VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

[2]This includes $123 million of administrative costs for third-party insurance recoveries and $68 million of reimbursements for veterans compensation and pension examinations.

[3]A list of related GAO testimonies and reports appears at the end of this statement.

others. Our comments on VA's decentralized management and resource allocation initiatives are based on information obtained from discussions with officials at headquarters and seven networks as well as a review of documents they provided.

In summary, while VA's budget goals may be attainable, they also carry implications such as limited deficit reduction contributions and potential risks to low-income, uninsured veterans. Achieving increased efficiency is not contingent on either increases in patients served or resources. VA's ongoing efforts to restructure its health care system could yield billions of dollars in savings during the next 5 years. A large part of these savings would be realized through more efficient use of its workforce, which will allow the existing patient base to be served with fewer employees. In fact, sufficient savings could be generated to afford VA an opportunity to increase patients served without new resources or to increase its contribution to deficit reduction. Furthermore, VA can significantly decrease its reliance on appropriated resources by using its existing authority to sell excess capacity to help other federal agencies meet their beneficiaries' health care needs.

VA's proposal to generate billions of dollars in new revenue to serve 20 percent more patients intensifies VA's direct competition with the private sector and potentially leaves low-income, uninsured veterans vulnerable. VA may be able to attain its revenue goals only by attracting thousands of new users who have higher incomes or public or private insurance. And such new VA users are likely to be drawn from private providers who may see their revenue base erode as patients shift to VA care. Moreover, VA may spend unreimbursed resources on these veterans, which could reduce the availability of resources for low-income, uninsured veterans.

VA also faces a difficult challenge as it takes steps to implement a new resource allocation method to improve veterans' access to VA care and a decentralized management structure to improve resource utilization. These initiatives promise improvements in equity and have stimulated significant changes in efficiency. However, VA's challenge will be to adequately monitor these changes to identify and correct unintended effects such as those that limit equity of access.

Background

VA's role in providing for the health care needs of veterans has evolved over time. During its first 50 years, VA predominantly served veterans who had disabilities caused or aggravated by military service and other

low-income, uninsured veterans in need of a health care safety net. Over the past 10 years, VA has also served higher income and insured veterans with nonservice-connected conditions. Over time, however, VA's patient base has been shifting from serving primarily veterans with service-connected conditions to those without service-connected conditions. Currently, VA operates over 750 facilities, including 173 hospitals and over 400 outpatient clinics. These facilities serve 2.6 million of the nation's almost 26 million veterans as well as about 300,000 nonveterans.

In 1995, to promote greater efficiency and services to veterans, VA created a new decentralized management structure, forming 22 Veterans Integrated Service Networks (VISN). These networks replaced the previous structure's four regions and expanded local authority. The VISN is now the basic budgetary and decision-making unit of VA's health care system and exercises management authority over VA facilities in its geographic area. This system of networks clearly places value on efficiency and customer service, and the networks are empowered to make a wide range of decisions regarding care delivery options. Under the recently enacted eligibility reform legislation (P.L. 104-262), for example, networks can contract with a broader range of private providers to purchase services at prices lower than VA's costs and generate revenue by selling excess services. In April 1997, VA implemented the Veterans Equitable Resource Allocation (VERA) system to allocate medical care appropriations among the 22 VISNs. VERA is intended to improve the equity of resource distribution throughout VA's health care system.

Efficiency Savings Not Dependent on Increased Number of Veterans Served

Last year, we testified that VA could save billions of dollars over the next 7 years through improved efficiency. As noted before, the Congress subsequently gave VA the two additional tools—eligibility reform and expanded contracting authority—that VA said were key to the success of its efforts to increase efficiency. With these tools, VA can help veterans prevent costly hospital admissions and access lower cost services, regardless of where veterans reside. VA's 1998 budget request, however, suggests that VA will be able to achieve 30 percent efficiency savings over the next 5 years only if it has the additional resources to serve 20 percent more patients.

Over the past 18 months, VA has taken aggressive steps to change the way it operates to reduce costs and improve services to veterans. These initiatives are expected to save billions of dollars by avoiding unnecessary

expenditures. Most of the initiatives involve a resizing and more efficient use of its workforce, which accounts for over $10 billion of VA's medical care budget. For example, VA is shifting patient care from inpatient to outpatient settings as well as reducing average lengths of inpatient stays. It is also consolidating management and clinical services of nearby hospitals to reduce costs. Moreover, VA is exploring opportunities to contract with other health care providers for services at costs lower than VA's.

These restructuring efforts should save billions of dollars without attracting new users as the following examples indicate:

- VA established a pre-admission screening process for hospitals that, if effectively implemented, could save $8.4 billion over the next 5 years.
- VA integrated the management of two or more nearby facilities in 26 different locations, which should result in savings of $230 million over the next 5 years.
- VA shifted substance abuse treatment from an inpatient to an outpatient setting in one service location, which is expected to result in savings of $10 million over the next 5 years.

Currently, VA has teams exploring additional opportunities for streamlining operations and reducing workforce needs. Many of these teams are identifying ways to use lower cost methods for delivering services within individual facilities. For example, many facilities are

- reducing patient bed-days of care, including one location that would close seven medical wards and generate potential savings of almost $50 million over the next 5 years, and
- shifting inpatient surgeries to ambulatory settings, including one location that shifted enough workload among facilities to close two surgical wards and potentially save over $15 million during the next 5 years.

VA also has many teams exploring ways to consolidate services at nearby facilities. Such actions should result in significant savings over the next 5 years as shown by the following examples:

- Facilities in one service area are planning to integrate eight pathology and laboratory medicine services into a single business unit with two central laboratories. This integration is expected to save about $10 million over the next 5 years.

- Facilities in another area are exploring ways to consolidate small purchases into one location, which is expected to save over $20 million during the next 5 years.

Additional savings opportunities could be available in later years from the closing of hospitals whose workloads may be shifted to nearby hospitals that have sufficient unused capacity to efficiently and effectively meet veterans' needs. For example, closing a facility with about 300 beds could save over $100 million in overhead costs alone during a 5-year period.

Efficiency Savings Could Provide Opportunities to Serve More Veterans Without Additional Resources

VA could expand its current patient base if its efficiency savings exceed payroll and other cost increases. These costs are expected to be about $637 million in 1998 and to increase by a rate of about 4 percent a year over the next 5 years.

The effect of VA's efficiency savings is to increase its purchasing power each year. For example, most of the savings are attributable to reductions in VA's workforce, which currently numbers about 189,000 full-time equivalents. VA may need to reduce its workforce by about 6,800 full-time equivalents to realize an annual savings of $637 million. This level of reductions would decrease VA's resource needs by comparable amounts in succeeding years. Thus, an annual appropriation of $17 billion could be sufficient to serve 2.9 million patients in 2002 if efficiency savings and cost increases approximate $637 million a year, on average. Moreover, VA could increase its patient base if its efficiency initiatives yield greater savings.

Adding Resources Further Enhances VA's Opportunity to Serve More Veterans

VA's 1998 budget proposes reinvesting all efficiency savings and using additional resources to expand its patient base. VA expects to add a total of $5.8 billion in new resources over the next 5 years (from public and private insurers and others), starting with $737 million in 1998 and increasing to $1.7 billion in 2002. VA expects that these additional resources will allow it to increase the number of veterans served by 587,000, which would increase its patient base from 2.9 million to 3.5 million in 2002.

If the targeted resource levels are attained, VA appears capable of attracting 587,000 new users by 2002. Recent expansion of VA's contracting authority and veterans' eligibility for care should facilitate creation of new access points, referred to as community-based outpatient clinics, which

along with VA's efforts to improve accessibility of existing hospital-based clinics are likely to attract new workload.

For example, VA has opened or developed plans to open 86 new community-based clinics over the last 3 years. These clinics provide only primary care and refer veterans to VA hospitals for more specialized care. Last month, we surveyed the 12 clinics that had at least 2 years' operating experience and found that they had attracted 3,000 new veterans. These clinics experienced the largest growth in their initial year and smaller growth in subsequent years. VA estimates that the remaining 74 clinics will serve over 128,000 users a year but has not estimated how many will be new VA users. Twenty-two of the new clinics estimated that between 5 and 60 percent of the patients served will be new users, while the rest expected to serve no new users or were unsure whether new users would be served.

Although it plans to open many more clinics, VA told us that it is too early to estimate how many or where they will be located. Our analysis suggests that VA could need between 1,200 and 1,800 additional clinics to attract 587,000 new users if each clinic attracts between 250 and 500 new veterans. The first 12 clinics averaged 250 in their initial years. These clinics also appear to provide an affordable way for VA to attract new users.

In addition, VA's efforts to improve veterans' access to existing facilities should also attract new users. These initiatives include expanding primary care by extending operating times for hospital-based clinics to night and weekend hours as well as ways to reduce waiting times. For example, one hospital-based clinic reported enrolling 3,000 new veterans for care during the first year after having made such accessibility improvements.

Expanding VA's Resource Base Poses Challenges

VA's revenue goal of $1.7 billion in 2002 includes estimated recoveries of about $902 million from private insurance, $557 million from Medicare, and $178 million from federal agencies and others. Attaining these targets may present a challenge as VA would probably have to attract thousands of new revenue-generating veterans. VA has provided, however, little information on the numbers of new veterans needed to meet revenue goals or how much of the revenue will come from inpatient or outpatient services. This lack of information creates uncertainties about VA's ability to achieve its revenue goals.

Increasing Recoveries From Private Health Insurance May Be Difficult

VA currently serves insured veterans and recovers some or all of its costs of care from insurers. Presently, VA returns all recoveries to the Treasury, except those needed to cover VA's billing and collection costs. In 1996, VA deposited $455 million into the Treasury and used $119 million for administrative costs. VA's recovery of $574 million represents a decline in recoveries from 1995, despite an increase in the number of users.

VA's ability to increase future recoveries from its current insured patient base is uncertain for several reasons:

- Veterans are increasingly covered by health maintenance and preferred provider organizations from which VA generally cannot recover.
- As an increasing proportion of VA users become eligible for Medicare, their private health insurance becomes secondary, so potential recoveries drop.
- As VA shifts from inpatient to outpatient settings, insurance recoveries decrease and the cost of recovery increases.
- VA found that Medigap insurers have been paying VA too much, which will result in decreased future recoveries and refunds of about $150 million a year.
- VA's authority to recover from private health insurance for care provided to service-connected veterans for non-service-related conditions expires September 30, 1998.

As a result, to meet its revenue projections of $902 million from private insurance, VA will probably have to focus its marketing efforts on attracting veterans with fee-for-service private health insurance. In addition, the Congress would need to extend VA's authorization to recover for certain services provided to service-connected veterans.

VA officials told us that they do not know how many veterans in their 2.9 million patient base have insurance or how many insured veterans receive billable care. This lack of information on key elements affecting its projections creates considerable uncertainty about the number of new insured users VA would need to attract in order to generate its target revenues.

Attaining Medicare Recovery Target May Be Difficult

VA proposes to collect about $557 million from Medicare in 2002 for services provided to about 106,000 additional higher-income veterans who are covered by Medicare. VA currently attracts only about 1 out of every 100 higher-income Medicare-eligible veterans—about 41,000 veterans in 1992. It thus appears questionable whether VA will be able to attract an

additional 106,000 higher-income Medicare-eligible veterans by the year 2002.

VA expects to recover from Medicare, on average, about $5,300 for each of the 106,000 additional Medicare-eligible veterans it expects to serve in 2002, a target amount that seems achievable based on average Medicare spending levels per patient nationwide. However, it may be difficult for VA to achieve this collection rate if Medicare-eligible veterans use primarily VA services that are not covered by Medicare, such as prescription drugs, inpatient psychiatric care, and long-term nursing home care. Our assessment of Medicare-eligible veterans' use of VA services in 1994 suggests that most of these veterans use VA, at least in part, for services not covered by Medicare.[4]

Increasing Recoveries From Other Sources Appears Attainable

VA proposes to collect $178 million in 2002 through sales of excess services to federal agencies, affiliated medical schools, and others. This amount represents over a 300-percent increase over VA's collections of $43 million in 1996.

Since 1966, the Congress has expanded VA's authority on several occasions to sell excess services in an effort to encourage VA facilities to generate revenues in addition to those appropriated. Over the last 5 years, VA's sales have increased by about 37 percent, with most sales to the Department of Defense (DOD) and affiliated medical schools. Last September, the Congress took another step to expand VA's ability to generate revenue by authorizing VA to sell excess health care services to any health care plan, insurer, or other provider.

VA could meet or exceed its goal of $178 million in 2002 if it markets its excess capacity to other federal agencies. DOD and VA reached agreement in 1995 that VA can provide health care services to active duty and retired members of the military and dependents enrolled in DOD's TRICARE program. While some VA facilities have become TRICARE providers, most have not. Similarly, few VA facilities have generated revenue by serving beneficiaries of other federal agencies, such as the Indian Health Service and the Bureau of Prisons, even though these agencies have expressed interest in buying VA's excess services.

[4]Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

Expanding VA's Resource Base May Place Some Veterans and Others at Risk

Over the last 25 years, VA has served an increasing number of veterans without service-connected conditions, generally those low-income veterans in need of a health care safety net. During the last 10 years, VA has also served higher-income and insured veterans with its resources that were in excess of those needed to provide care to service-connected and low-income veterans.

Allowing VA to retain nonappropriated revenues may change VA's perspective. This is because the veteran population is, in effect, likely to represent two distinct groups—non-revenue-generating veterans and revenue-generating veterans. Within this later group are several potential target populations: privately insured veterans; Medicare-eligible veterans; higher-income veterans; and higher-income, privately insured, or Medicare-eligible veterans.

Non-Revenue-Generating Veterans May Be at Risk of Having Access Limited

VA may encounter difficulty attaining its revenue goals unless a significant number of new users have higher incomes or insurance. This could create a strong incentive for VA to market services to attract revenue-generating rather than non-revenue-generating veterans. This incentive could manifest itself in several ways, including where VA decides to locate new community-based outpatient clinics. For example, VA recently proposed locating a community-based clinic in a homeless shelter that VA expects could attract 2,040 new users in need of VA's safety net and therefore not likely to generate revenue. By contrast, VA has also proposed opening a new clinic in one of the country's more affluent counties. While the clinic is intended to improve access for current users, it is also expected to attract patients who could ultimately generate revenue.

Non-VA Providers May Be at Risk of Losing Workload

Marketing VA services to generate revenue has the potential to draw higher-income insured veterans from private providers who may then see their revenue base erode, depending on the number of patients who shift to VA care. If VA has to aggressively attract new users who are now receiving health care elsewhere, it will intensify the competition between VA and other state, county, and private providers for a larger share of a shrinking veterans' health care market.

VA's success in attracting revenue-generating patients will be likely to result in a shifting of health care costs from other financing organizations to VA and to exacerbate financial hardships for those competing health care providers that have excess capacities. For example, our interviews

with 115 veterans using new access points last year revealed that 70 percent had Medicare coverage, 50 percent had private insurance, and 7 percent had Medicaid.[5] Most said they paid for their own primary care or used insurance coverage to obtain care at other providers before they switched to VA care.

VA's Proposal Could Lower Contribution to Deficit Reduction

VA's proposal to retain revenue generated from nonappropriated sources would also affect VA's contribution to deficit reduction. VA currently returns recoveries to the Treasury, which, in effect, reduces the government's cost of VA health care. For example, VA expects to return $438 million in 1997, which would reduce the amount of government resources needed to serve VA's patient base from its appropriated amount of $17 billion to $16.6 billion. By contrast, under VA's proposal it would retain insurance recoveries of $590 million in 1998, increasing the government's cost to finance VA health care to $17.6 billion, or $1 billion more than in the previous year.

In addition, VA's proposal to reinvest efficiency savings and use additional nonappropriated resources to increase the number of patients served could affect VA's contribution to deficit reduction. For example, VA would need an appropriation of $17 billion a year to serve 2.9 million users if savings equal payroll and inflation costs between 1998 and 2002. By contrast, VA may be able to contribute up to $1 billion more in 2002 toward deficit reduction if annual efficiency savings exceed cost increases by $200 million, on average, over the 5-year period and such excess savings are returned to the Treasury.

New Allocation Method and Decentralized Management Show Promise, but Risks Exist

VA is using a new resource allocation method and a decentralized management structure to address two long-standing issues: equity and efficiency. These initiatives are intended to improve the equity of veterans' access to care and produce cost savings.

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

Allocating Resources Equitably Seems Achievable With New Methodology

VA is using the Veterans Equitable Resource Allocation (VERA) system to allocate 88 percent of the $17 billion medical care appropriation to the 22 networks. This approach is a major shift away from VA's historical process for two reasons. First, it funds 22 networks rather than hundreds of facilities. Second, it allocates resources on the basis of costs per veteran served rather than on the basis of facilities' historical budgets. Funding networks sends a clear message that each facility is a part of a larger regional enterprise charged, in part, with a mission of achieving equity of access. VERA recognizes that networks are the vehicles for fostering regional change, eliminating redundancies, and facilitating cooperation among medical facilities. Network officials have the authority to tailor their VERA allocations to facilities and programs, within the parameters set by national policy and guidelines, and to integrate services across facilities for equity and other purposes.

The goal of VERA is to provide networks with comparable levels of resources per veteran served. VA implemented VERA in an attempt to allocate patient care resources on the basis of differences in patient needs and regional differences in the price of their care. To do this, VERA classifies patients into two groups—basic care and special care—as a simple case mix adjustment. 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 injury or end-stage renal disease, or require care in settings such as nursing homes. The VERA special care category also includes some adjustment for age to account for the higher medical demands of older population groups.

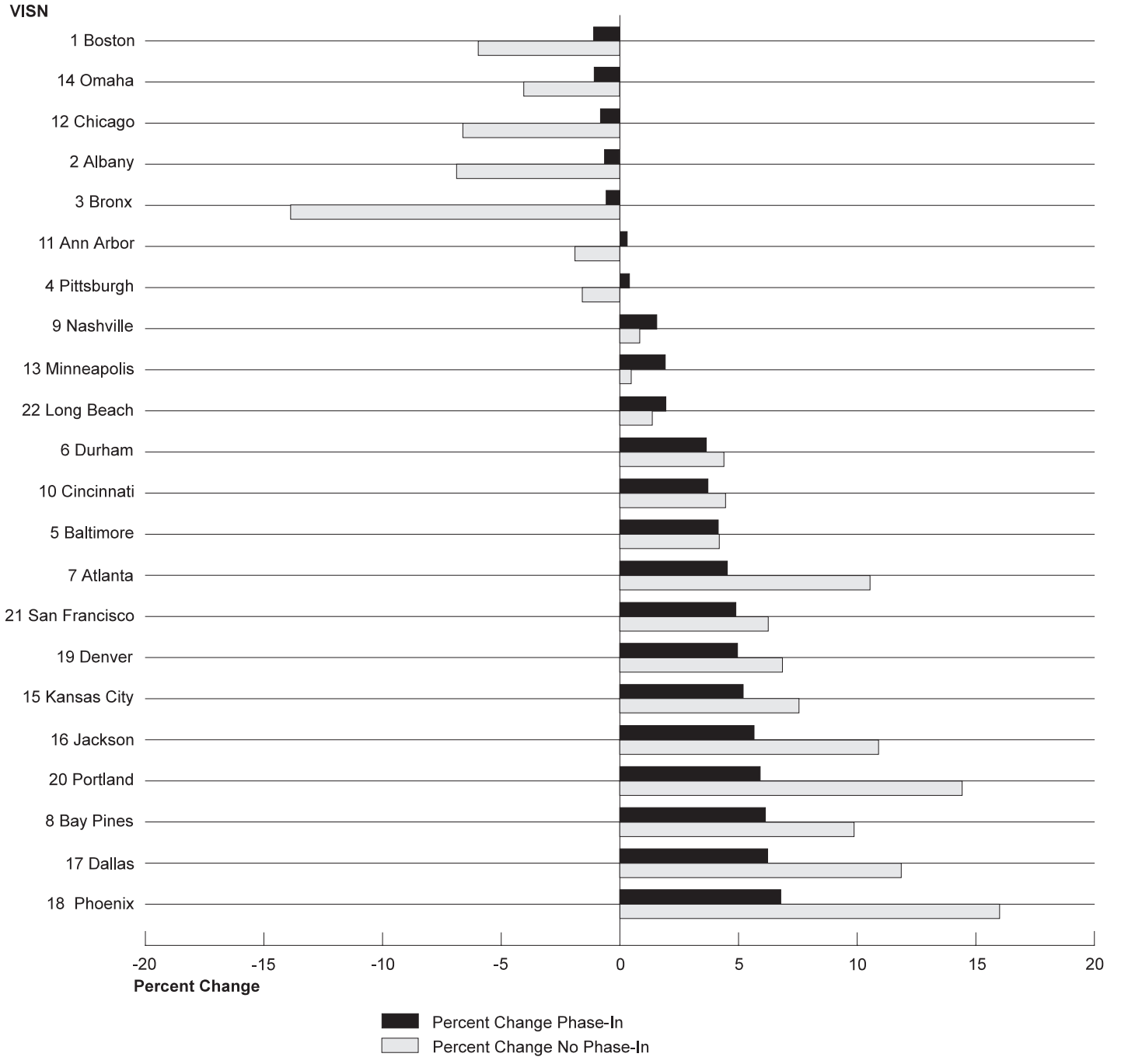
VERA allocates resources to networks based on two key components: network workloads and national prices. VA patient workloads are the estimates of the number of patients—basic and special—a network may serve. VA also calculates workloads for research support, education support, equipment, and nonrecurring maintenance. To determine a national price for each workload category, VERA divides national resources available by the national workload for that category. VERA allocates funds to a network by multiplying the network's workload numbers by their respective national prices. In addition, VERA adjusts for differences in regional labor costs for patient care.

To the extent that VERA allocates comparable levels of patient care resources for each veteran served, it provides incentives for networks to obtain these resources by increasing workload and decreasing costs.

Networks that increase their patient workload relative to other networks gain resources under VERA; those whose patient workloads decrease relative to others lose resources. Networks that are more efficient, that is, have patient care costs below the national price, have more funds available for local initiatives. However, those with patient care costs above the national price (that is, less efficient networks) must increase efficiency to have such funds available. Thus, these incentives can result in cost savings and enhanced access for veterans. VERA will not be fully implemented until fiscal year 1999. As a result, few resources will move among networks this year. (See fig. 1.) Five VISNs will receive fewer dollars and 17 will receive more.[6] VERA generally moves 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. If VA had fully implemented VERA this year, shifts in funding among the networks would have ranged from a reduction of 14 percent to an increase of 16 percent.

[6]In VA's Veterans Equitable Resource Allocation System Briefing Booklet, March 1997, VA shows that 6 networks will lose funds and 16 will gain funds in fiscal year 1997. However, VA excludes allocations for equipment and nonrecurring maintenance. We included those amounts in our calculations to show the impact of VERA more fully. Neither we nor VA includes funds not allocated by VERA in these comparisons.

Figure 1: Changes Resulting From VERA Allocations (Fiscal Years 1996-97)



(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.

VERA, like any allocation model, has limitations. First, VERA may shift some resources inappropriately because it may not fully account for justifiable differences in regional cost variations. Although VERA adjusts for differences in regional case mix with its basic and special care patient categories and adjusts the allocations for differences in regional labor costs, it assumes that all the remaining differences are based on differences in efficiencies. While inefficiency is a major factor in these cost differences, other factors may play a role. For example, to the extent that veterans are sicker and need more health care services in different parts of the country, additional case mix adjustments may be necessary to fully explain regional cost differences. As we have said in the past, VA needs to provide more information on why costs vary throughout the country.[7] VA officials told us they plan to examine this further.

Another potential issue is that basing VERA on veteran-users may result in underallocation of funds in areas with low usage rates. If these rates result from past inequities in access to services, VERA may need to incorporate population-based data on veterans with highest priority for receiving services rather than relying solely on user data.[8] However, other factors, such as number of veterans with health insurance coverage, could also affect usage rates. Because adequate data were not available and VA wished to implement VERA as quickly as possible, it did not include population data in VERA. VA continues to examine the utility of doing so.

VERA's incentives for lower per veteran costs and higher workload numbers could lead to unintended consequences if not properly monitored and corrected. In our discussions and visits with network and medical center officials, we found efforts under way to increase the number of veterans served. VA indicators for the first quarter of fiscal year 1997 generally show increases in the number of high-priority veterans (that is, Category A veterans) seen, and the increases for some networks are dramatic. We have concerns about whether the data accurately depict

[7]Veterans' Health Care: Facilities' Resource Allocations Could Be More Equitable (GAO/HEHS-96-48, Feb. 7, 1996) and Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department (GAO/T-HEHS-97-97, Mar. 18, 1997).

[8]Category A veterans have the highest priority for receiving VA health care services. Included in Category A are veterans with service-connected disabilities and those with service-connected disabilities whose incomes fall below certain thresholds.

changes in workload. If the data are reliable, we are concerned that some networks may be inappropriately increasing their workload numbers to get more resources under VERA. For example, networks may be increasing workload by increasing the number of one-visit patients. This may be good primary or preventive care, or it could distort VERA allocations because only minimal services are provided to get credit for increased workload. In the short time since the indicators were published, however, we have been unable to determine the accuracy of the data and the services the new users received. VA officials told us that they recognize the importance of monitoring, identifying, and correcting unintended consequences. They said they will monitor data used in the allocation model, including workload increases, to ensure that they reflect changes at the network and medical center levels that are consistent with VA-wide policy and guidance.

Although VERA is a step toward a more equitable allocation of resources, it does not specifically address equitable access to services. Networks are ultimately responsible for allocating funds to ensure that veterans have equal access to VA services. Each of the networks we contacted differs in how it allocates funds. 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. Still another includes a feature in its allocation method that provides payment for each additional veteran served. VA officials told us they will examine these processes to ensure that different allocation mechanisms increase equity of access to services while addressing other national VA goals.

Networks Have Made Significant Progress, but Decentralized Management Poses Oversight Challenges

VA has taken a page from private sector organizations and empowered the network directors by delegating broad decision-making authority over network budgets, facility staffing, health care delivery, and administrative functions. This has resulted in notable accomplishments at VA, including significant cost savings and improvements in access.

Decentralized decision-making at VA places a premium on effective headquarters guidance and monitoring of VISN activities. The challenge is to ensure that networks have a common understanding of VA-wide goals and legislative requirements while permitting them flexibility in how to achieve the goals. The challenge in monitoring network performance is to have reliable, appropriate, and timely indicators to ensure that problems are identified and corrected.

VA has provided guidance to managers and staff since the beginning of its reorganization. For example, the Under-Secretary for Health issued two volumes, "Vision for Change" and "Prescription for Change," delineating the type of organization he intended VA to become and the goals VA would strive to attain. Network and medical center staff told us that these publications and other communications, such as monthly meetings between network and headquarters managers, help develop their understanding of the structural and operational changes being made.

VA's new performance measurement process also plays an important guidance role by underscoring VA-wide organizational priorities. These measures include key indicators such as reduced bed-days of care and an increased percentage of surgeries performed on an ambulatory basis. The measures are the main components of the network directors' performance agreements. In networks we visited, medical center directors' performance agreements also included these measures. Medical center directors we contacted told us that network directors were exercising closer oversight of their progress in achieving VA-wide goals than had occurred under previous organizational structures.

Another strategy for reducing unnecessary variation has been the use of clinical practice guidelines. These are intended to enhance the quality and appropriate utilization of health care services by reducing variations in the way a health condition—for example, stroke—is treated. Networks are required to adopt 12 practice guidelines by the end of fiscal year 1997. They can choose from those identified by headquarters or other sources.

Providing national guidelines but offering networks discretion on when to follow these guidelines can create opportunities for local innovation but problems for national oversight. If discretion results in variation across the system, it will be difficult for VA to assess the impact of the guidelines. Network flexibility may produce tension between headquarters and networks. For example, officials in one network we visited told us that they preferred the American Medical Association guidelines to the national diabetes guidelines VA adopted.

Headquarters, network, and medical center officials told us that national guidance had not been sufficiently clear on whether to notify headquarters of significant program changes at the network level. They told us that they had not always been clear on what constituted "significant" changes. In a few instances, headquarters officials were not notified of impending network-initiated changes such as closure of a surgical program at a

medical center. In May and September 1996, headquarters issued guidance for networks on prior notification and consultation with headquarters for network actions such as restructuring clinical services—including closures of major programs—and proposed changes to special emphasis programs such as those for spinal cord injury and prosthetics. VA has additional measures planned to ensure that headquarters is involved in significant network-initiated program changes.

Performance measures and standards developed by headquarters are the key components of VA's monitoring process. Headquarters holds network directors accountable for making progress toward VA goals by including measures and standards of performance in the directors' contracts. Headquarters lengthened its list of measures for fiscal year 1997; it now includes about two dozen indicators. In networks we visited, directors are monitoring medical centers on these measures as well.

Concluding Observations

VA's 1998 budget presents the Congress with a fundamental choice about the future course of VA health care, a choice that will have an effect on veterans, other health care providers, and efforts to achieve a balanced federal budget. In general, VA's proposal to reinvest all savings and generate additional nonappropriated revenues may intensify the direct competition between VA and other providers. By contrast, a decision to limit VA's retention of nonappropriated revenues will set VA on a course to becoming a more cost-efficient safety net for those non-revenue-generating veterans who have no other health care options.

Currently, there is insufficient information to understand the full implications of VA's budget proposal. VA states that the key elements of its proposal—namely, a 30-percent per patient cost reduction, a 20-percent increase in veterans served, and a 10-percent reduction of its reliance on appropriations—are inexorably linked but, in our view, this is not so. It seems plausible that any number of different scenarios could occur, depending on the magnitude of cost savings that VA will realize through its ongoing restructuring.

For instance, VA could operate as a health care safety net for several years, with an appropriation of about $17 billion or less, given VA's progress in identifying and implementing efficiency savings. Such efficiency savings could equal or exceed the potential nonappropriated revenues that VA estimates it can generate over the next 2 years if authorized to do so. For this reason, there appears to be time to obtain critical information from VA

and others so that VA's budget proposal may be more clearly understood and fully debated. In this regard, several critical issues could be addressed, including the following:

- Should VA reinvest all efficiency savings to expand the number of patients served? If so, should VA's expansion be limited to certain target groups of veterans, such as service-connected, low-income, or uninsured veterans in need of a health care safety net?
- Should VA use nonappropriated revenue sources to help finance increased services to higher-income and insured veterans who have no service-connected conditions or continue relying solely on appropriated resources to finance increased services for service-connected and low-income veterans without service-connected conditions?
- Should VA reinvest savings in excess of those needed to maintain its current patient base in order to serve more veterans or should it return some or all of the excess savings as a contribution toward deficit reduction?

It would be less difficult to make such choices at this time if VA had provided a road map that clearly articulated (1) what operational changes would be needed to move along its newly proposed competitive course and (2) what consequences such competition would have for veterans and others. For example, additional information would be helpful about how different choices may affect (1) service-connected veterans and those in need of VA's safety net; (2) VA's existing hospitals, clinics, and other facilities; (3) VA's workforce; and (4) other health care providers.

Delaying a decision on VA's legislative proposals until such critical information is available—including a plan describing how the system will look and operate in 2002—may result in a better legislative decision on VA's budget proposal. It will also afford VA and the Congress time to better assess how VA's future resource needs may be affected by the new decentralized management and resource allocation initiatives.

VA's new resource allocation process and decentralized management structure hold promise for improved operational efficiencies and equitable access. Responding to VERA's incentives and VA's goals, local managers are already producing substantial savings and increasing the number of veterans served. VA, however, needs to continue examining how price and workload data are determined under VERA to improve equity of resource allocation. VA also needs to carefully monitor the impact of VERA's incentives on network and facilities performance. This is particularly

important given the variation resulting from local managers' flexibility in the decentralized system. We believe that identifying and correcting problems is essential to the success of VA's proposed 5-year plan.

Contributors

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