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VA HEALTH CARE

Opportunities to Increase Efficiency and Reduce Resource Needs

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss ways in which the Department of Veterans Affairs (VA) could operate more efficiently and thereby reduce the resources needed to meet the health care needs of veterans in what is commonly referred to as the mandatory care category. With a fiscal year 1995 appropriation of $16.2 billion, VA's system faces increasing pressures to contain or reduce spending as part of governmentwide efforts to achieve a balanced budget.

Our comments today will focus on (1) VA's forecasts of future resource needs, (2) opportunities to operate VA's system more efficiently, (3) differences between VA and the private sector in terms of incentives to become more efficient, and (4) recent VA efforts to reorganize its health care system and create incentives to operate more efficiently.

During the past several years, we have visited over 75 VA hospitals and outpatient clinics to assess operating policies, procedures, and practices. These efforts have resulted in a wide range of recommended actions to improve the efficiency and effectiveness of the VA system. Some involve ways to restructure existing delivery processes to lower costs, while others identify ways to increase the recovery of the costs of health care provided to veterans and others. Our comments are based primarily on the results of these efforts as well as studies done by the Veterans Health Administration (VHA), VA's Office of Inspector General (IG), and others.

In summary, VA's health care system should be able to make a significant contribution toward deficit reduction over the next 7 years. First, the system may not need to expend the level of resources it previously estimated to meet the health care needs of veterans in the mandatory care category. These resources are overstated because (1) VA does not adequately reflect the declining demand for VA hospital care in estimating its resource needs and (2) much of the care VA provides is discretionary (that is, VA is required to provide the services only to the extent that space and resources permit). Second, VA could reduce operating costs by billions of dollars over the next 7 years by completing actions on a wide range of efficiency improvements. Actions are already under way or planned on many of the improvements.

The success of these efforts, however, depends on the extent to which VA and its health care facilities are held accountable for how they spend appropriated funds. Unlike private health care providers, VA's system bears

few of the risks associated with inefficient operating practices and, as such, has little economic incentive to reduce costs. VA managers frequently blame inefficiencies on the law, but this appears to us to be unfair. Historically, VA's central office provided few incentives for facilities to become more efficient. The central office put little pressure on facilities to treat patients in the most cost-effective manner and shifted few resources among facilities to promote efficiency. At the facility level, however, VA managers are often able to find ways to operate more efficiently when they need resources to implement new services or expand existing ones.

Recent changes at VA are starting to create the types of efficiency incentives that have long existed in the private sector. For example, VA's reorganization of its health care facilities into 22 Veterans Integrated Service Networks (VISN) includes several encouraging elements that show promise for providing the management framework needed to realize the system's full savings potential. First, VA plans to hold network directors accountable for VISN's performance by using, among other things, cost-effectiveness goals and measures that establish accountability for operating efficiently to contain or reduce costs. Second, the Under Secretary for Health (1) distributed criteria that could guide VISN directors in developing the types of efficiency initiatives capable of yielding large savings and (2) gave VISN and facility directors authority to realign medical centers to achieve efficiencies. Finally, VHA's plans to develop a capitation funding process could provide greater incentives to improve efficiency, provided data problems are resolved.

Background

The VA health care system was established in 1930, primarily to provide for the rehabilitation and continuing care of veterans injured during wartime service. VA developed its health care system as a direct delivery system in which the government owned and operated its own health care facilities. It grew into the nation's largest direct delivery system.

Veterans' health care benefits include medically necessary hospital and nursing home care and some outpatient care. Certain veterans, however, have a higher priority for receiving care and are eligible for a wider range of services. Such veterans are generally referred to as Category A, or mandatory care category, veterans.

More specifically, VA must provide hospital care, and, if space and resources are available, may provide nursing home care to certain

veterans with injuries related to their service or whose incomes are below specified levels. These mandatory care veterans include those who

- have service-connected disabilities,
- were discharged from the military for disabilities that were incurred or aggravated in the line of duty,
- are former prisoners of war,
- were exposed to certain toxic substances or ionizing radiation,
- served during the Mexican Border Period or World War I,
- receive disability compensation,
- receive nonservice-connected disability pension benefits, and
- have incomes below the means test threshold (as of January 1995, $20,469 for a single veteran or $24,565 for a veteran with one dependent, plus $1,368 for each additional dependent).

For veterans with higher incomes who do not qualify under these conditions, VA may provide hospital care if space and resources are available. These discretionary care category veterans, however, must pay a part of the cost of the care they receive.

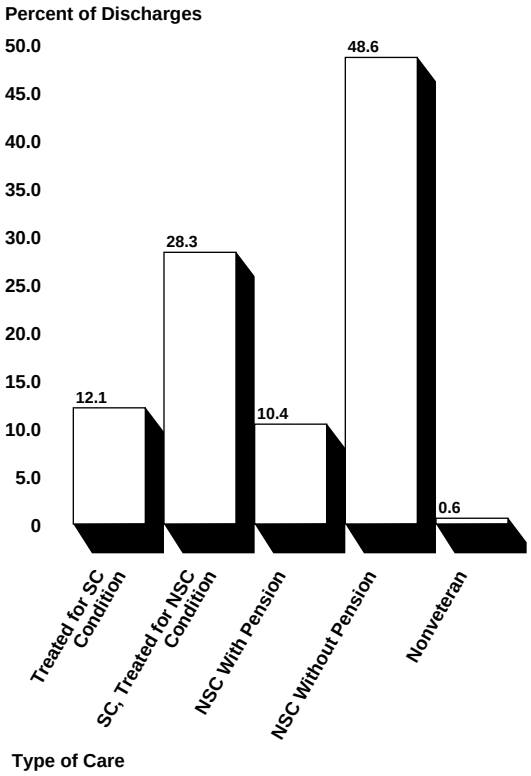
VA also provides three basic levels of outpatient care benefits:

- comprehensive care, which includes all services needed to treat any medical condition;
- service-connected care, which is limited to treating conditions related to a service-connected disability; and
- hospital-related care, which provides only the outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

Separate mandatory and discretionary care categories apply to outpatient care. Only veterans with service-connected disabilities rated at 50 percent or higher (about 465,000 veterans) are in the mandatory care category for comprehensive outpatient care. All veterans with service-connected disabilities are in the mandatory care category for treatments related to their disabilities; they are also eligible for hospital-related care of nonservice-connected conditions, but, with the exception of veterans with disabilities rated at 30 or 40 percent, they are in the discretionary care category. Most veterans with no service-connected disabilities are eligible only for hospital-related outpatient care and, with few exceptions, are in the discretionary care category.

From its roots as a system to treat war injuries, VA health care has increasingly shifted toward a system focused on the treatment of low-income veterans with medical conditions unrelated to military service. In fiscal year 1995, only about 12 percent of the patients treated in VA hospitals received treatment for service-connected disabilities. By contrast, about 59 percent of the patients treated had no service-connected disabilities. About 28 percent of VA hospital patients had service-connected disabilities but were treated for conditions not related to those disabilities. (See fig. 1.)

Figure 1: VA Hospital Users by Purpose of Treatment, FY 1995

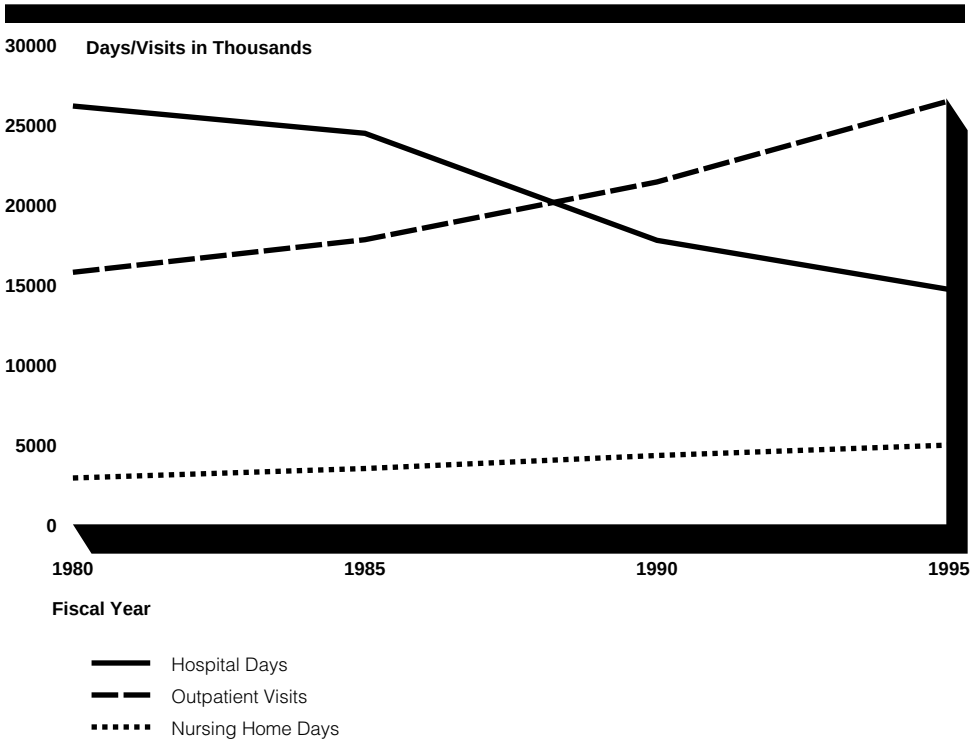


Notes: Data are based on the fiscal year 1995 VA patient treatment file.

SC = service connected; NSC = nonservice connected.

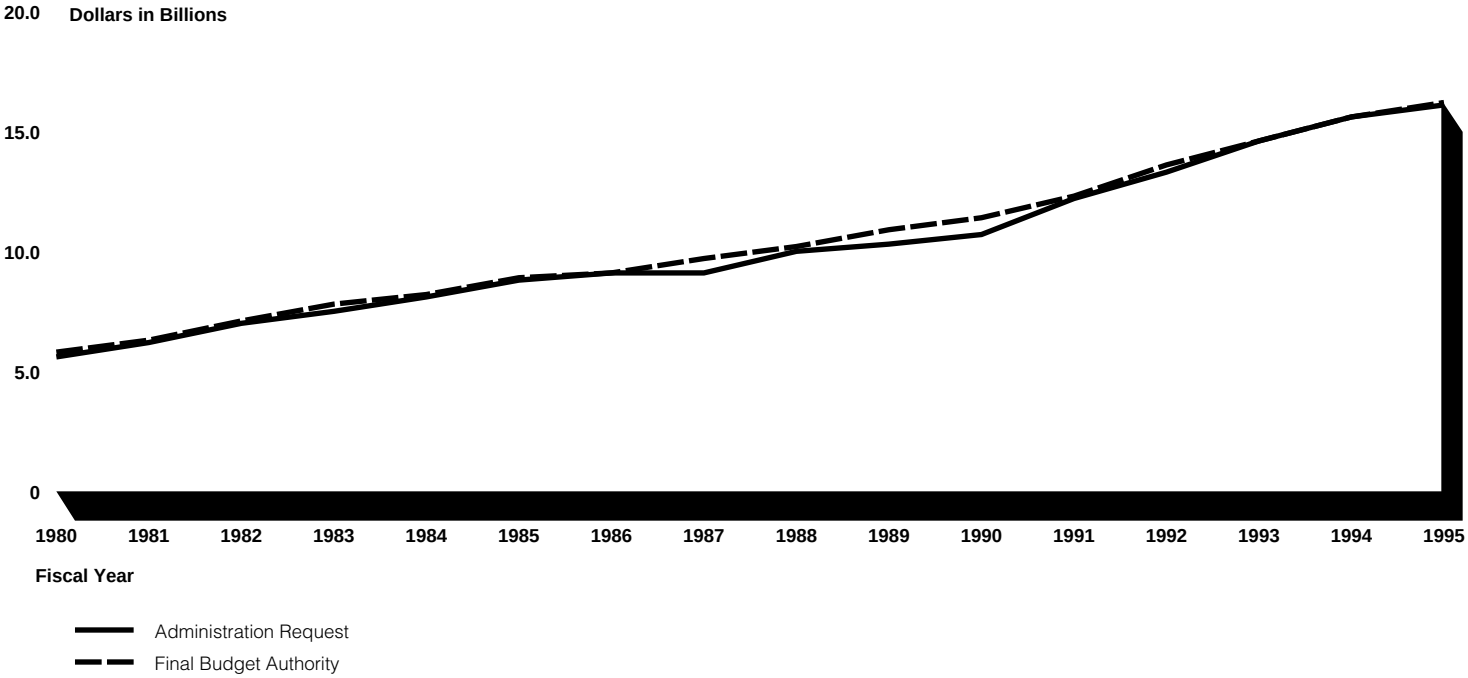
Between fiscal years 1980 and 1995, VA facilities underwent some fundamental changes in workload. The days of hospital care provided fell from 26 million in 1980 to 14.7 million in 1995; number of outpatient visits increased from 15.8 million to 26.5 million; and the average number of veterans receiving nursing home care in VA-owned facilities increased from 7,933 to 13,569. (See fig. 2.)

Figure 2: Changes in VA Facilities' Workload, FY 1980-95



During this same time period, VA's medical care budget authority grew from about $5.8 billion to $16.2 billion. (See fig. 3.)

Figure 3: VA Medical Care Budget Authority, FY 1980-95



Note: Numbers have not been adjusted for inflation.

For fiscal year 1996, VA sought medical care budget authority of about $17.0 billion, an increase of $747 million over its fiscal year 1995 authority, to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA expects its facilities to provide (1) about 14.1 million days of hospital care, (2) nursing home care to an average of 14,885 patients, and (3) about 25.3 million outpatient visits.

On July 29, 1995, the Congress adopted a budget resolution providing VA medical care budget authority of $16.2 billion annually for 7 years (fiscal years 1996-2002). The budget resolution would essentially freeze VA spending at the fiscal year 1995 level.

VA estimated that such a freeze would result in a cumulative shortfall of almost $24 billion in the funds it would need to maintain current services

to the veteran population through 2002.[1] As used by VA, current services encompasses maintaining the currently funded workload, including services to veterans in both the mandatory and discretionary care categories and services to nonveterans.

Resources Needed to Meet Needs of Veterans in Mandatory Care Category Are Overstated

The resources VA facilities will need over the next 7 to 10 years to provide hospital and certain outpatient care to veterans in the mandatory care category are, in our view, overstated for the following reasons:

- VA did not adequately consider the impact of the declining veteran population on future demand for inpatient hospital care.
- A significant portion of VA resources is used to provide services to veterans in the discretionary care category who are eligible for care only to the extent space and resources are available.
- Considerable resources are expended on services that are not covered under veterans' VA benefits.
- Medical centers tend to overstate their workloads and therefore their resource needs.
- VA included resources for facility and program activations in estimating the resources it would need to maintain current services even though such activations represent an expansion over current services.[2]
- Services provided to nonveterans through sharing agreements are included in VA's justifications of future resource needs even though the provision of services through sharing agreements is to be limited to sales of excess capacity.

Declining Veteran Population Will Reduce Future Resource Needs

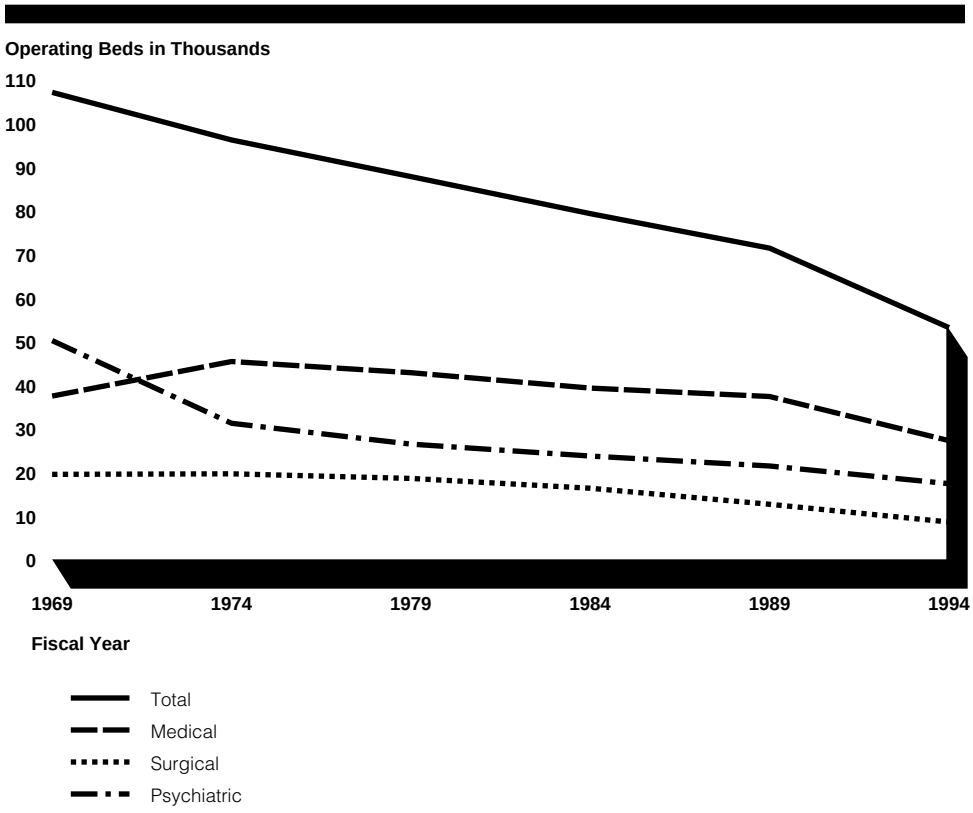
In estimating the resources it will need to maintain current services over the next 7 fiscal years, VA assumed that the number of hospital patients it treats will remain constant. The number of hospital patients VA treats, however, actually dropped by 56 percent over the past 25 years and should continue to decline in the future. In addition, because of the declining demand for inpatient care over the past 25 years, the number of operating beds in the VA health care system declined by about 50 percent between 1969 and 1994. About 50,000 VA hospital beds were closed or converted to

[1]In September 1995, we reported that VA overestimated the potential budget shortfall because it assumed that there would be (1) an increase in the VA facility workload in fiscal year 1996 and that it would be sustained during the entire 7-year period, (2) limited savings achieved through improvements in the efficiency with which services are provided by VA facilities, and (3) steadily increasing costs, workload, and staffing due to opening or expanding facilities. (Medical Care Budget Alternatives (GAO/HEHS-95-247R, Sept. 12, 1995.)

[2]Activations include opening new facilities and expanding existing facilities and programs through modernization and new construction.

other uses. The decline in psychiatric beds was most pronounced from about 50,000 beds in 1969 to 17,300 beds in 1994. (See fig. 4.)

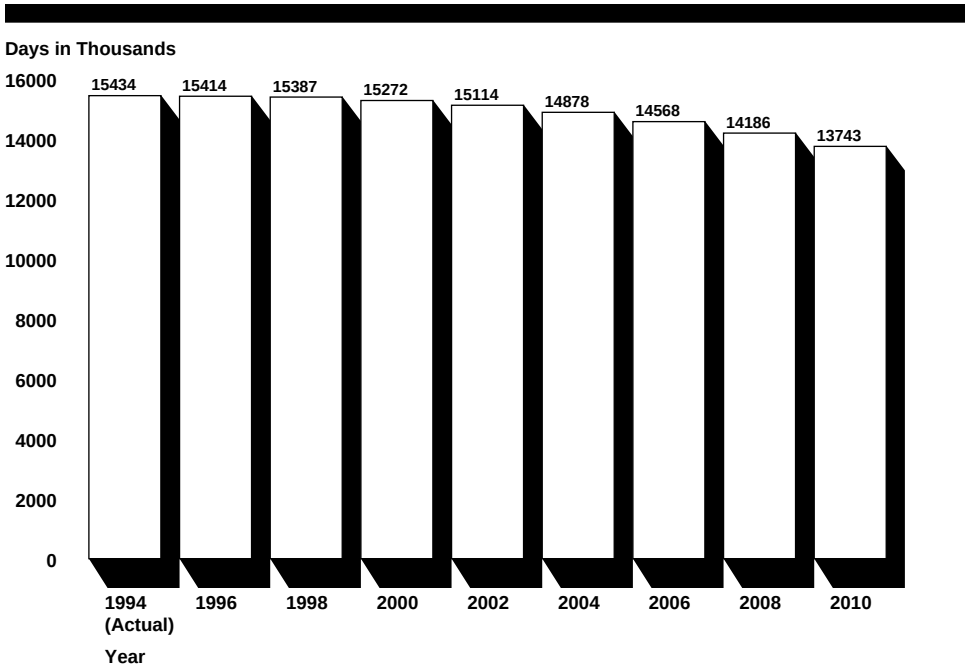
Figure 4: Operating Beds in VA Hospitals, FY 1969-94



Further declines in operating beds are likely in the next 7 to 10 years as the veteran population continues to decline. If veterans continue to use VA hospital care at the same rate that they did in 1994—that is, if VA continues services at current levels—days of care provided in VA hospitals should decline from 15.4 million in 1994 to about 13.7 million by 2010. (See fig. 5.) Our projections are adjusted to reflect the higher usage of hospital care by older veterans.[3]

[3]The declining veteran population will lead to significant declines in VA acute hospitalization even as the acute care needs of the surviving veterans increase. The veteran population is estimated to decline from about 26.3 million in 1995 to just over 20 million in 2010. Although the health care needs of veterans increase as they age, the overall decline in the number of veterans will more than offset the increase and should lead to a further reduction in the number of days of VA hospital care. In addition, many veterans leave the VA system when they become Medicare-eligible.

Figure 5: Projected Age-Adjusted Days of VA Hospital Care, 1994-2010



Source: Based on VA annual reports, fiscal years 1980-94, and VA projections of the veteran population by age through 2010.

Much VA Care Is Discretionary

VA has underestimated the extent to which its health care resources are spent on services for veterans in the discretionary care categories. Specifically, about 15 percent of veterans using VA medical centers have no service-connected disabilities and have incomes that place them in the discretionary care (that is, care may be provided to the extent that space and resources permit) category for both inpatient and outpatient care. In addition, VA incorrectly applied inpatient eligibility categories to its outpatients, thus overestimating the amount of outpatient care that is subject to the availability of space and resources. VA does not, however, differentiate between services provided to veterans in the mandatory and discretionary care categories in justifying its budget request. As a result, the Congress has little basis for determining which portion of VA's discretionary workload to fund.

A portion of VA's workload is composed of higher-income veterans with no service-connected disabilities. In fiscal year 1991, about 10.7 percent of the 555,000 veterans receiving hospital care in VA facilities were veterans with

no service-connected disabilities with incomes of $20,000 or more.[4] Including both inpatient and outpatient care, about 11 percent (91,520) of the single veterans with no service-connected disabilities (832,000) and 57 percent (227,430) of the married veterans with no service-connected disabilities (399,000) using VA medical centers in 1991 had incomes of $20,000 or more. Among married veterans with no service-connected disabilities who used VA medical centers, 15 percent (59,850) had incomes of $40,000 or more.[5]

In March 1992, VA's Inspector General estimated, on the basis of work at one typical VA outpatient clinic, that about half of the patients and about one-third of the visits veterans made to VA outpatient clinics should have been classified as discretionary rather than mandatory care. This occurred because VA was applying inpatient eligibility provisions to its outpatients. While VA is required to provide needed hospital treatment to the 9 million to 11 million veterans in the mandatory care category, over 90 percent of those veterans are in the discretionary care category for outpatient care other than for services related to treatment of a service-connected disability.

Extensive Resources Spent on Noncovered Services

The VA Inspector General further reported that about 56 percent of discretionary care outpatient visits were to provide services that were not covered under the veterans' VA benefits. Most veterans' outpatient benefits are limited to hospital-related care. An estimated $321 million to $831 million of the approximately $3.7 billion VA expended on outpatient care in fiscal year 1992 may have been for treatments provided to veterans in the discretionary care category that were not covered under VA health care benefits.[6]

Medical Centers Tend to Overstate Workload

VA medical centers frequently overstate the number of inpatients and outpatients treated and therefore their resource needs. VA has long had a problem with veterans failing to keep scheduled appointments. But once an outpatient visit is scheduled, it is entered into VA's computerized

[4]VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

[5]In 1991, a veteran without dependents was in the mandatory care category for inpatient hospital care and hospital-related outpatient care if he or she had income below $18,171; the income threshold increased by $3,634 for one dependent and $1,213 for each additional dependent.

[6]VA Office of Inspector General, Audit of the Outpatient Provisions of Public Law 100-322, Report No. 2AB-A02-059 (Washington, D.C.: Mar. 31, 1992).

records and counted as an actual visit unless action is taken at the medical center to delete the record.

VA's IG identified problems in the reporting of both inpatient care and outpatient visits at several medical centers. For example, the IG found that 9 percent of the visits at the Milwaukee VA medical center and 7 percent of the visits at the Murfreesboro medical center were not countable workload because they represented "no shows."[7] Similarly, a 1994 IG report found that actual surgical workload at the Sepulveda VA medical center was 37 percent lower than reported.[8]

Resource Needs for Activations Appear Overstated

The resources VA believes it needs to maintain current services include resources needed to support new workload generated through activation of programs and facilities. Almost 25 percent of the budget shortfall VA estimated to occur over the next 7 fiscal years under the congressional budget resolution would result from the lack of funds for facility activations and planned workload expansions. Delaying or stopping activations is, however, a difficult political decision, particularly for those projects already under way.

In its analysis of the resources it will need to maintain current services over the next 7 fiscal years, VA assumed that it will continue to incur additional costs, add staff, and attract new users through facility activations. For example, VA's estimate that it will need $20.9 billion dollars in the year 2000 to maintain current services includes increases of over $993 million and 10,000 full-time-equivalent (FTE) employees for activations. In other words, the inclusion of activation costs overstates the resources VA will need in the year 2000 in order to maintain current services by almost $1 billion.

In addition, the funds VA seeks for activations may be overstated because the activations planning process is not integrated with the resource planning and management (RPM) system workload forecasting process. VA sought about $108 million and 1,509 FTEs in its fiscal year 1996 budget submission to support a projected increase in the number of veterans seeking care. These estimates, based on workload forecasts developed

[7]VA Office of Inspector General, Audit of Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin, Report No. 2R4-F03-112 (Washington, D.C.: Mar. 25, 1992) and Audit of Alvin C. York VA Medical Center, Murfreesboro, Tennessee, Report No. 2R3-F03-029 (Washington, D.C.: Dec. 16, 1991).

[8]VA Office of Inspector General, Special Inquiry of Veterans Health Administration Medical Centers Sepulveda and West Los Angeles, CA, Report No. 4R4-A01-111 (Washington, D.C.: Sept. 21, 1994).

through RPM, reflect historical trend data that could include workload increases resulting from prior years' facility and program activations. In other words, the resources requested for workload increases projected using RPM likely include resources for some of the estimated workload to be generated through fiscal year 1996 activations. VA sought an additional $208 million for facility activations based on the separate activations planning process. VA officials agree that some double counting may be occurring because of the separate planning processes, but believe that the amount of duplication is minimal. We are currently exploring the extent of such duplication for this Subcommittee.

VA Includes Sharing Agreement Workload in Budget Justification

VA counts services provided to nonveterans through sharing agreements with military and private sector hospitals and clinics in justifying the resources it will need during the next fiscal year. In other words, VA essentially builds in "excess" resources to sell to the Department of Defense (DOD) and the private sector. VA also bills, and is allowed to retain, the costs of services provided through sharing agreements.

Health resources sharing, which involves the buying, selling, or bartering of health care services, can be beneficial to both parties in the agreement and helps contain health care costs by making better use of medical resources. For example, it is often cheaper for a hospital to buy an infrequently used diagnostic test from another hospital than it is to purchase the needed equipment and provide the service directly. Similarly, a hospital that is using an expensive piece of equipment only 4 hours a day but is staffed to operate the equipment for 8 hours could generate additional revenues by selling its excess capacity to other providers.

To allow federal agencies' resources to be used to maximum capacity and avoid unnecessary duplication and overlap of activities, VA is authorized to sell excess health care services to DOD. In addition, VA can share specialized medical resources with nonfederal hospitals, clinics, and medical schools. Medical resources can be sold to DOD and the private sector only if the sale does not adversely affect health care services available to veterans. As an incentive to share excess health care resources, the VA facilities providing services through sharing agreements are allowed to recover and retain the cost of the services from DOD or the private sector facility.

In fiscal year 1995, VA sold about $25.3 million in specialized medical resources to private sector hospitals and about $33.0 million in health care

services to the military health care system. Although VA facilities received separate reimbursement for the workload generated through these sharing agreements, the workload was nevertheless included in VA's justification of its budget request.

VA's Resource Needs Should Be Further Reduced Through Increased Efficiency

In its assessment of the potential budget shortfall VA would face if its budget were frozen at fiscal year 1995 levels for 7 years, VA assumed that there would be no change in the efficiency with which it delivers health care services beyond the unspecified savings of $335 million expected to occur in fiscal year 1996. VA should be able to further reduce its resource needs by billions of dollars over the 7-year period through improved efficiency and resource enhancements.

During the past 5 to 10 years, GAO, VA's IG, VHA, the Vice President's National Performance Review, and others identified numerous opportunities to

- use lower-cost methods to deliver veterans' health care services,
- consolidate underused or duplicate processes to increase efficiency,
- reduce nonacute admissions and days of care in VA hospitals,
- close underused VA hospitals, and
- enhance VA revenues from services sold to nonveterans and care provided to veterans.

VA has actions planned or under way to take advantage of many of these opportunities. Such actions should reduce VA's resource needs over the next 7 to 10 years by several billion dollars.

Use Lower-Cost Methods for Delivering Health Care Services

Numerous opportunities to achieve savings through changes in the way VA delivers health care services to veterans should allow VA facilities to provide services of equal or higher quality at a lower cost. For example:

- Providing 90-day rather than 30-day supplies of low-cost maintenance prescriptions enabled VA pharmacies to save about $45 million in fiscal year 1995. The savings resulted because VA pharmacies handled over 15 million fewer prescriptions. Although VA encouraged its medical centers to implement multi-month dispensing in response to our January 1992

report, the full potential has not been achieved because medical centers have been slow to adopt multi-month dispensing.[9]

- Purchasing services from community providers when they can provide the care at a lower cost could also potentially result in savings. VA has encouraged its medical centers to establish "access points" that can provide services at lower cost than at VA outpatient clinics and, at the same time, improve accessibility for veterans. To date, only a few medical centers have established such access points, but many others are developing plans to shift care to lower-cost community settings. Although it appears that community providers can often provide services at lower cost than VA, the ultimate effect of access points on overall VA spending depends on such issues as the extent to which the access points attract new users and the extent to which current users increase their use of in response to improved accessibility.
- VA should save in excess of $225 million over a 7-year period by adopting Medicare fee schedules. VA's IG compared the amount paid by VA under its fee-basis program with Medicare fee schedules and found that VA paid more than the Medicare rate in over half of the cases reviewed. VA plans to adopt Medicare fee schedules for both its outpatient fee-basis payments and for payment of inpatient physician and ancillary services at non-VA hospitals.[10,11] VA expects to begin using Medicare fee schedules by July 1996.
- Through the establishment of primary care teams, VA hospitals should be able to reduce veterans' inappropriate use of more costly specialty clinics and achieve significant savings in staff costs. As we reported in October 1993, VA hospitals allow many veterans to receive general medical care in specialty care clinics after their conditions are stabilized. Transferring such veterans to primary care clinics in a timely manner will allow lower-cost primary care staff to meet their medical needs rather than higher-cost specialists.[12]
- By purchasing specialized medical care services, such as PET scans and lithotripsy, from community providers rather than buying expensive, but seldom used, equipment, VA could reduce its costs of providing such services and at the same time improve accessibility of such care for

[9]VA Health Care: Modernizing VA's Mail-Service Pharmacies Should Save Millions of Dollars (GAO/HRD-92-30, Jan. 22, 1992).

[10]VA Office of Inspector General, Audit of Fee-Basis Payments for Inpatient Medical Care, Report No. 5R3-A05-108 (Washington, D.C.: Sept. 29, 1995).

[11]VA Office of Inspector General, Audit of Fee-Basis Payments for Outpatient Medical Care, Report No. 5R3-A02-063 (Washington, D.C.: May 25, 1995).

[12]VA Health Care: Restructuring Ambulatory Care System Would Improve Services to Veterans (GAO/HRD-94-4, Oct. 14, 1993).

veterans. For example, although the Albuquerque VA medical center treated a total of only 24 veterans for kidney stone removal in fiscal years 1990 through 1992, the hospital purchased a lithotripter, a machine that breaks up kidney stones so that they can be eliminated without surgery, at a cost of almost $1.2 million. During its first year of operation, 34 veterans received treatment. A private provider in the same city provided lithotripsy services for $2,920 a procedure. Thus, the hospital could have met the 34 veterans' needs at a cost of about $100,000 compared with its expenditure of $1.2 million plus operating costs. Although the hospital sold lithotripsy services to more nonveterans than it provided to veterans, the hospital has used the equipment at less than one-fifth of its normal operating capacity.[13]

- VA expects to also achieve savings by establishing a national drug formulary. Historically, each VA facility has established its own formulary—that is, a list of medications that are approved for use for treating patients. VA noted that establishing a national formulary should increase standardization, decrease inventory costs, heighten efficiency, and lower pharmaceutical costs through enhanced competition. VA has not estimated the potential savings, but could realize a $100 million savings if using the national formulary can achieve a 10-percent reduction in the cost of purchasing medications.
- VA expects to save $168 million over a 6-year period by phasing out and closing its supply depots and establishing a just-in-time delivery system for medical care supplies and drugs, as recommended by the Vice President's National Performance Review. The depots were closed at the end of fiscal year 1994, and contracts for just-in-time delivery of drugs are in place. Actions to award just-in-time contracts for medical supplies and subsistence items are expected to be completed within the next 4 months.

Consolidate Underused or Duplicate Processes

VA also has several nationwide initiatives under way to integrate, consolidate, or merge duplicate or underused services. Such actions should result in additional savings over the next 7 years. For example:

- By creating several bulk processing facilities to fill mail-order prescriptions, VA will reduce its handling costs by two-thirds, providing a savings of about $26 million in fiscal year 1996. As we reported in January 1992, VA was mailing prescriptions to veterans from over 200 locations resulting in uneconomically small workloads and labor-intensive processes. To date, VA has four operating bulk processing facilities using

[13]VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994).

newly designed automated equipment and processes; another three facilities are not yet operational. Prescription workload is being transferred systematically from VA hospitals to the new bulk processing centers.[14] When they are fully operational, these facilities could save about $74 million a year.

- By consolidating 14 laundry facilities over a 3-year period, VA expects to achieve one-time equipment and renovation savings of about $38 million as well as recurring savings of about $600,000 per year from operational efficiencies. Under a management improvement initiative, VA identified facilities for integration that were scheduled for or had requested funding for new equipment or renovation. Five of the 14 consolidations were completed in 1995; the remaining 9 are scheduled to be completed within the next 2 years.
- An internal VA Management Improvement Task Force predicted in 1994 that VA could save up to $73 million in recurring personnel costs by integrating management of VA facilities. Among other things, the task force recommended that the administrative and clinical management of 60 facilities be integrated into 29 partnerships. The task force expected that these facility integrations could reduce service and staffing duplication, integrate clinical programs, achieve economies of scale, and free resources to invest in new services. To date, about one-third of the recommended integrations have been approved. To the extent that measurable savings occur, however, VA allows the facilities to reinvest the savings into providing more clinical programs. Examples of reinvestment include equipment, construction projects, opening of access points, and increasing specialty and subspecialty clinics. Our ongoing work for this Subcommittee will assess the extent that these and other management improvement initiatives recommended by the task force have been implemented and are achieving measurable savings.

Reduce Nonacute Admissions and Days of Care

Establishing preadmission certification procedures for admissions and days of care similar to those used by private health insurers could save VA hundreds of millions of dollars by reducing nonacute admissions and days of care in VA hospitals.

VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings, such as an outpatient clinic or nursing home. In 1985, we reported that about 43 percent of the days of care that VA medical and surgical patients spent in the VA hospitals reviewed could

[14]GAO/HRD-92-30, Jan. 22, 1992.

have been avoided.[15] Since then, a number of studies by VA researchers and the IG have found similar problems.

For example, a 1991 VA-funded study of admissions to VA acute medical and surgical bed sections estimated that 43 percent (+/- 3 percent) of admissions were nonacute. Nonacute admissions in the 50 randomly selected VA hospitals studied ranged from 25 to 72 percent. The study suggested several reasons for the higher rate of nonacute admissions to VA hospitals than to private sector hospitals, including the following:

- VA facilities do not have the necessary financial incentives to make the transition to outpatient care;
- VA, unlike the private sector, does not have formal mechanisms to control nonacute admissions, such as mandatory preadmission review; and
- VA, unlike the private sector, has a significantly expanded social mission that may influence the use of resources for patients.[16]

A 1993 study by VA researchers reported similar findings. At the 24 VA hospitals studied, 47 percent of admissions and 45 percent of days of care in acute medical wards were nonacute; 64 percent of admissions and 34 percent of days of care in surgical wards were nonacute. Reasons cited for nonacute admissions and days of care included nonavailability of outpatient care, conservative physician practices, delays in discharge planning, and social factors. Although the study cited VA eligibility as contributing to some inappropriate admissions and days of care, the study recommended only minor changes in VA eligibility provisions. Rather, it suggested that VA establish a systemwide utilization review program. VA, however, has not established an internal utilization review requirement nor contracted for external reviews.

By contrast, all fee-for-service health plans participating in the Federal Employees Health Benefits Program are required to operate a preadmission certification program to help limit nonacute admissions and days of care.

[15] Better Patient Management Practices Could Reduce Length of Stay in VA Hospitals (GAO/HRD-85-92, Aug. 8, 1985).

[16] For example, VA facilities may admit patients who travel long distances for care or keep veterans in the hospital longer than medically necessary because they lack a social support system to assist them after discharge.

Close or Convert Underused Hospitals

If the actions discussed above are taken to reduce the number of nonacute admissions and days of care provided by VA hospitals, the demand for care in some hospitals could fall to the point where it is no longer economically feasible to keep the hospital open. VA has taken over 50,000 beds out of service over the past 25 years but has not closed any hospitals because of declining utilization.[17]

Closing wards clearly results in some savings through reduced staffing costs. But, with fewer patients over whom to spread the fixed costs of operating the facility, the cost per patient treated rises. At some point, it may become less expensive to close the hospital and provide care either through another VA hospital or through contracts with community hospitals. Closing hospitals and contracting for care, however, entails some risk. Allowing veterans to obtain free hospital care in community hospitals closer to their homes could result in increased demand for VA-supported hospital care, offsetting any savings achieved through contracting.

The feasibility of closing underused hospitals was demonstrated when VA recently closed the Sepulveda VA medical center after it was damaged in an earthquake and transferred the workload to the West Los Angeles medical center. VA's IG found that the reported numbers of inpatients treated at both Sepulveda and West Los Angeles had declined significantly over the prior 4-year period and that the declining workload may have been even greater than VA reported because the facilities' workload reports were overstated. VA does not plan to rebuild the Sepulveda hospital but plans to establish an expanded outpatient clinic at the site.

The IG concluded that West Los Angeles had sufficient existing resources to care for the hospital needs of veterans formerly using the Sepulveda hospital. Savings from the closure have been limited, however, because Sepulveda staff were temporarily reassigned to the West Los Angeles medical center.

The only other hospital VA has closed in the last 25 years was the Martinez VA medical center. Like Sepulveda, it was closed because of seismic deficiencies and its workload transferred to other VA medical centers. Unlike Sepulveda, however, VA plans to build a replacement hospital. Funds for the construction have not yet been appropriated.

[17]Two VA hospitals, in Martinez and Sepulveda, California, were closed because of structural problems. VA plans to replace the Martinez hospital but not the Sepulveda hospital.

Actions to Enhance Revenues

In addition to actions to improve the efficiency of its operations, VA should generate millions in additional revenues by (1) setting more appropriate prices for services sold to private sector providers and (2) determining whether veterans should be required to contribute toward the cost of their care.

By establishing appropriate prices for services sold to nonveterans through sharing agreements, VA can generate revenues that can be used to serve veterans. In response to our December 1994 report on recovering the full costs of lithotripsy services at the Albuquerque VA medical center, VA recently encouraged its facilities to ensure that they price services provided to nonveterans so as to fully recover all costs, and to include a profit where appropriate.[18] For example, the Albuquerque medical center increased its price for basic lithotripsy services to nonveterans by over 125 percent. The new price could generate over $300,000 a year in additional revenues for the hospital.

By verifying veterans' reported income, VA expects to generate about $46 million in copayment revenues between January 1, 1996, and June 30, 1997. In a September 1992 report, we found that VA had not taken advantage of the opportunity to verify veterans' incomes through the use of tax records. Through our own match against tax records, we identified over 100,000 veterans who may have owed copayments. In 1994, VA began routinely using such data to determine veterans' copayment status.[19]

Lack of Incentives Can Hinder Further System Efficiencies

Although cost savings can and are being realized, the VA health care system lacks overall incentives to further increase efficiency. Unlike private sector hospitals and providers, VA facilities and providers bear little financial risk if they provide (1) expensive medically inappropriate care or (2) services not covered under a veteran's VA benefits. Unlike private health insurance, where the insurance company bears most of the risk, the veteran, rather than VA, bears most of the financial risk for veterans' health benefits. However, when VA facilities are given an incentive, such as the desire to fund new programs, they appear to be able to identify opportunities to achieve savings through efficiency improvements.

[18]GAO/HEHS-95-19, Dec. 28, 1994.

[19]VA Health Care: Verifying Veterans' Reported Income Could Generate Millions in Copayment Revenues (GAO/HRD-92-159, Sept. 15, 1992).

VA Facilities Bear Little Risk From Providing Inappropriate Care

Private insurers increasingly require their policyholders to obtain prior authorization from an independent utilization review firm before the insurers will accept liability for the hospital care. Frequently, this authorization also sets a limit on the number of days of care the insurer will cover without further authorization regarding the medical necessity of continued hospitalization. Because compliance with these requirements directly affects their revenues, private sector hospitals pay close attention to them.

Similarly, the Medicare program has, since 1982, paid hospitals a fixed fee based on the patient's diagnosis. The fixed fee is based on the national average cost of treating the patient's condition. If the hospital provides the care for less than the Medicare payment, it makes a profit. But if the hospital keeps the patient too long, is inefficient, or provides unnecessary treatments, then it will suffer a loss. This creates a strong incentive in the private sector to discharge Medicare patients as soon as possible.

Those same financial incentives to increase efficiency and provide care in the most cost-effective setting are largely absent in the VA system. Even in those cases in which a private health insurer's preadmission certification requirement applies, the hospital's revenues are not affected by failure to obtain such certification. A VA hospital that admits a patient who does not need a hospital level of care incurs no penalty. In fact, facility directors often indicated that VA's methods of allocating resources to its medical centers favored inpatient care.

VA's current RPM system is attempting to remove the prior incentive to provide care in the hospital rather than an outpatient clinic and create incentives to provide care in the most cost-effective setting. As used during the last two budget cycles, however, the system has done little to create such incentives. Because VA chose to shift few funds between the highest- and lowest-cost facilities, facility incentives to become more efficient were minimal. For fiscal year 1995, VA reallocated $20 million from 32 high-cost to 27 low-cost facilities. VA officials told us that they plan to use RPM to reallocate more money in fiscal year 1996 and to provide VISN directors a "risk pool" of contingency funds to help facilities unable to work within their budgets. It is yet unclear how VISN directors plan on using these funds.

And unlike private sector health care providers, VA has no external preadmission screening program or other utilization review program to provide incentives to ensure that only patients who need a hospital level of

care are admitted and that patients are discharged as soon as medically possible. VA gives private sector hospitals providing care to veterans under its contract hospitalization program incentives to limit patients' lengths of stay by basing reimbursement on Medicare prospective payment rates. VA does not, however, give its own hospitals the same incentives by basing their payments on the Medicare rates.

Veteran, Rather Than VA, Bears Financial Risk

Unlike private health insurance and Medicare, the veteran is at risk of being denied care, rather than VA being at risk of losing funds, if a VA facility runs out of resources. Because it is at little risk, the VA system does not have a strong incentive to operate efficiently.

A private insurer or managed care plan guarantees payment for covered services in exchange for a fixed premium. The insurer or managed care plan thus has a strong financial incentive to make certain that only medically necessary care is provided and that care is provided in the most cost-effective setting. Otherwise, the insurer may suffer a financial loss.

Unlike private health insurance, however, the VA system does not guarantee the availability of covered services. As a result, the ability of veterans to obtain covered services depends on resource availability. If a VA facility is inefficient and the resources allocated to the facility are not sufficient to meet anticipated workload, the VA facility is allowed to deny (that is, ration) services to eligible veterans. In 1993, we reported that 118 VA medical centers reported rationing some types of care to eligible veterans when the centers ran short of resources.[20]

VA Facilities Find Efficiencies When They Need Funds for New Programs

The ability of facilities to find ways to become more efficient when they want to fund a new program, such as establishing an access point clinic, indicates that when they are given an incentive to become more efficient, they do so.

For example, VA's Under Secretary for Health encouraged hospitals to take all steps within their means to improve the geographic accessibility of VA care. But he told the hospitals that they would have to use their own resources to do this. Over half of VA's hospitals quickly developed plans to establish so-called access points. For example, the Amarillo VA medical

[20]VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 16, 1993).

center identified ways to save over $850,000 to pay for the establishment of access points:

- The medical center saved an estimated $250,000 a year by consolidating inpatient medical wards and reducing the number of surgical beds it staffed. As a result of these consolidations, the center eliminated nine nursing positions, achieving a savings in salaries and related benefits. Officials said that the consolidations coincided with declining workloads, attributable to lower admissions and lengths of stay, and as such would not affect the availability or quality of care the center provides.
- The medical center expects to save up to $150,000 by reviewing patients' use of prescription medications. These reviews have led to a reduction in the number of medications provided, resulting in a savings in the cost of procuring, storing, and dispensing the drugs.
- It expects to reduce future pharmacy costs by $250,000 by trying to change patients' lifestyles as a means of reducing cholesterol. Center officials estimate that this approach has reduced the use of lipid-lowering drugs by half. The medical center established health education classes, which teach correct eating and exercise techniques. Before this, physicians had routinely prescribed lipid-reducing drugs to lower cholesterol levels. Officials are planning to establish similar health clinics for patients with high blood pressure and other common conditions that may be effectively treated without prescription drugs.
- The medical center expects to save $200,000 or more by using a managed care contract to purchase radiation therapy services. Radiation therapy involves a series of treatments, which the center has historically paid for on a fee-for-service basis. The hospital recently signed a contract with a private sector hospital to provide each series of radiation treatments at a capitated rate based on Medicare's reimbursement schedule. Officials are currently negotiating similar contracts for other medical services.

Establishment of Service Networks Should Lead to Increased Emphasis on Efficiency

Last year, the Under Secretary for Health proposed criteria for potential service realignment that would facilitate the types of changes needed to achieve efficiency comparable to private sector hospitals and clinics. For example, he encouraged VHA directors to identify opportunities to

- buy services from the private sector at lower costs,
- consolidate duplicate services, and
- reduce their fixed and variable costs of services directly provided to veterans.

VA's assessment of its resource needs over the next 7 to 10 years did not include any projected savings from the increased efficiencies that should result from establishment of VISNs. VISNs should improve facility planning by assessing needs on a network rather than facility basis. This will allow hospitals serving veterans in the same geographic area to pool their resources and reduce duplication.

A planned move to capitation funding should create incentives for facilities to provide care in the most cost-effective setting. However, VA has much to do before it can set appropriate capitation rates. For example, while VA's RPM data show a wide variation in operating costs among facilities VA considers comparable, VA has done little to determine the reasons for these variations. Without such an understanding, there is no assurance that capitation rates can be set at the level that promotes the most efficient operation.

Part of gaining a better understanding of facility or VISN cost variations must involve improving the information VA has on the operating costs of its hospitals. While the automated Decision Support System (DSS) that VA is implementing has potential to be an effective management tool for improving the quality and cost effectiveness of VHA operations, VA has not developed a way to verify the accuracy of the cost and utilization data going into DSS. Some of the data provided to DSS from other VA information systems are incomplete and inaccurate, limiting VA's ability to relay on DSS-generated information to make sound business decisions.[21]

It will take time for the new VISN directors to achieve significant savings. They have been in place for only a few months, so it is too early to tell how successful they will be in achieving increased efficiency. It will be important that VA implement clear mechanisms and useful management data by which to hold VISN directors accountable for workload, efficiency, and other performance targets. Without such mechanisms and improved data, the VISN structure holds some risk in further decentralizing VHA authority and responsibility for achieving efficiencies.

Concluding Observations

Given VA's overstatement of future resource needs, the system does not need to spend as many resources as previously expected. Moreover, the potential magnitude of future efficiency savings not factored into VA's

[21]VA Health Care Delivery: Top Management and Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995).

assessments of future resource needs indicates that VA's system may have more discretionary resources available than was previously expected. This suggests that an operating goal of $16.2 billion a year may be achievable. In any event, it seems likely that the impact of such funding levels would not, by necessity, result in the extent of budget shortfalls that VA estimated.

Mr. Chairman, this completes my prepared statement. We will be happy to answer any questions that you or other Members of the Subcommittee may have.

Contributors

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