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

Health, Education and Human Services Division

B-254664

April 20, 1995

The Honorable Lane Evans
Ranking Minority Member
Subcommittee on Compensation, Pension,
Insurance, and Memorial Affairs
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

The Department of Veterans Affairs' (VA) health care system faces an uncertain future in today's rapidly changing health care marketplace. Among the most significant changes that could affect VA is the rapid growth of managed care in both public and private health care programs.

As part of last year's health care reform debate, you asked us to identify barriers that could impede VA's efforts to develop and market competitive managed care plans. We presented the preliminary results of our work at your June 29, 1994, hearing on the administration's proposed Health Security Act.[1] We reported that multiple barriers hinder VA's efforts to establish competitive health plans and that VA officials believe legislative action, such as the veterans health care provisions contained in the Health Security Act, would be necessary if the Congress wants VA to compete with private-sector health plans.[2] However, many other barriers could, we reported, be addressed through administrative actions. Enclosure 1 contains a listing of these barriers.

Following the demise of health care reform legislation near the end of the 103rd Congress, we agreed with your office to refocus our efforts on determining what VA is doing to address barriers to managed care through administrative actions. To identify VA's efforts to address barriers through such actions, we provided VA officials with a list of the 33

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[1]See Veterans' Health Care: Efforts to Make VA Competitive May Create Significant Risks (GAO/T-HEHS-94-197, June 29, 1994).

[2]The Health Security Act would have authorized VA to restructure its health care facilities into a series of managed care plans to compete with private-sector plans.

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barriers identified through our earlier work and obtained both oral and written comments from them on the actions taken. (Enclosure 2 contains VA's written comments.) In addition, to determine whether actions taken through the administration's National Performance Review (NPR)[3] addressed any of the barriers, we reviewed the NPR recommendations, particularly those relating to customer service, contracting, and personnel systems, to determine their applicability to VA. We then assessed the implementation status of these recommendations as discussed in our December 1994 report on NPR.[4]

This letter discusses VA's administrative actions and other actions taken as part of NPR.

VA'S EFFORTS TO ADDRESS BARRIERS ARE INCOMPLETE

Although VA has a series of planned and ongoing initiatives to overcome barriers and implement managed care practices in the VA health care system, its plans (1) do not address some barriers, (2) often lack specificity on what actions will be taken, or (3) do not indicate when actions will be completed. Planned and ongoing administrative efforts identified by VA officials include the following:

-- Establishing primary care as a priority. In an October 1993 memorandum, the Veterans Health Administration (VHA) urged its medical center directors to develop primary care teams. Under VA's recently developed customer service standards, a single VA provider or team will have overall responsibility for coordinating a veteran's care. According to VA officials, many VA medical centers have developed teams of professionals, including physicians and nurse practitioners, who function as case managers or gatekeepers.

-- Comparing VA's quality of care standards with Medicare, federal health maintenance organization (HMO), National

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[3]NPR, under the direction of the Vice President, is a major management reform initiative by the administration intended to identify ways to make the government work better and cost less.

[4]Management Reform: Implementation of the National Performance Review's Recommendations (GAO/OCG-95-1, Dec. 5, 1994).

Committee for Quality Assurance (NCQA),[5] and state standards. This effort will help ensure that VA can comply with such external quality standards that might be applied to VA in the future. Where differences exist, VA plans to identify the changes needed to enable it to comply with external standards. VA officials had not believed that applying the standards established by other governmental entities to VA facilities was necessary or appropriate. However, VA officials now recognize that to participate in these programs and obtain external funding, it would likely have to comply with external standards. VA also initiated preliminary discussions with the Health Care Financing Administration (HCFA) regarding Medicare and Medicaid certification of VA facilities.

-- Identifying construction and renovation projects needed to upgrade VA facilities. In October 1993, VA's central office asked all medical centers to identify any construction and renovation projects that they would need to enable them to be competitive with private-sector managed care plans. VHA's Strategic Planning and Policy Office compiled a prioritized inventory of requested projects, ranging from improving patient amenities to new bed towers. According to the office's Assistant Director, more than 1,400 projects were submitted with a value in excess of $3.3 billion.

This list does not, however, give an accurate picture of the capital investment that would be needed to make VA health plans competitive with private-sector health plans. This is because regions were given a limit on the value of projects they could submit. The nationwide effort was intended to be capped at $3.3 billion because that figure represented the amount of the VA investment fund contained in the administration's proposed Health Security Act.

-- Implementing a new resource allocation system, the Resource Planning Methodology (RPM), intended to provide incentives for medical facilities to provide care in the most cost-efficient setting. VA officials note, however, that VA has limited control over some circumstances that affect the distribution of resources, such as uncertain funding and political difficulties in closing facilities or changing the mission of an individual facility.

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[5]NCQA is an independent, nonprofit institution that reviews and accredits managed care organizations. Founded in 1979, NCQA's primary function is to develop and apply oversight processes and measures of performance for managed care plans.

-- Increasing the number of primary care physicians in VA residency programs and offering financial incentives and retraining for specialists willing to convert to primary care. VA medical centers can offer up to $15,000 in special pay to improve recruitment and retention of primary care physicians. VA officials acknowledge that they cannot address the shortage of primary care physicians in the near term even by designating primary care as a nationwide scarce specialty. VA officials note that because both the private and public sectors face a nationwide shortage of primary care physicians, VA may be at less of a competitive disadvantage.

Some barriers, particularly those affecting VA contracting and personnel matters, would require a combination of legislative relief and VA administrative action to fully resolve. For example, if the Congress gave VA authority to sell its services to private-sector providers, VA would still have to improve its cost and utilization data to ensure that it set rates sufficient to recover its costs.

However, for several barriers that could be addressed at least partially through administrative action, VA did not identify any planned actions. For example, VA officials recognized the need for systems to determine the eligibility of service-connected veterans with disabilities rated at zero percent and nonservice-connected veterans as well but did not identify any plans for addressing the barrier. Similarly, VA officials indicated that the issue of granting admitting rights to non-VA physicians must be addressed but did not identify any specific plans to do so.

In addition, planned actions sometimes address only part of the problem. For example, VA identified plans to improve its information and accounting systems through the purchase of commercial software but did not identify any plans to address its long-standing problems with ensuring accurate and consistent input of work load and cost data at the medical center level.

In still other areas, VA officials did not clearly define existing barriers and identify specific actions to overcome them. For example, they did not examine VA procurement practices to identify specific barriers and determine if current practices could be streamlined within existing laws. Similarly, they did not examine VA personnel policies and practices to see how they could be improved under existing authority. Instead of identifying the "pain points" with current procedures, officials plan to seek broad exemptions from federal personnel and contracting laws and, thus,

possibly remove important internal controls designed to prevent fraud and abuse.

SEVERAL BARRIERS ADDRESSED THROUGH GOVERNMENTWIDE REFORM EFFORTS

Recent governmentwide reform efforts initiated in response to NPR will help overcome several contracting, personnel, and other barriers to VA managed care. The Congress also addressed one barrier--restrictions on contracting for direct patient care services--through the Veterans' Benefits Improvements Act of 1994.

NPR developed 384 recommendations directed toward individual agencies and governmentwide policies and procedures related to areas such as personnel and procurement.[6] Although many of the NPR recommendations are currently being evaluated and have not been implemented, actions taken on four NPR recommendations--affecting contracting, personnel, customer service, and customer surveys--have begun to address some of the barriers to VA managed care.

Improving Federal Procurement Practices

-- The Federal Acquisition Streamlining Act of 1994 promotes federal purchasing of commercial items, allows state and local governments to use federal supply contracts, and authorizes multiyear contracts for civilian agencies.

-- Executive Order 12931, "Federal Procurement Reform," directs heads of executive agencies to implement NPR reform principles, such as focusing on measurable results and meeting customer needs.

-- An executive memorandum on streamlining procurement through electronic commerce, signed by the President on October 26, 1993, requires among other things that electronic commerce be implemented for appropriate federal purchases as quickly as possible. For VA, electronic commerce could include the use of electronic media for contracts, solicitation, invoicing, and purchase orders. VA could also authorize fund transfers for compensation and pension benefits or direct deposit of checks.

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[6] From Red Tape to Results: Creating a Government That Works Better and Costs Less, report of the National Performance Review (Washington, D.C.: 1993).

-- The Office of Management and Budget (OMB) and the Small Business Administration are coordinating outreach and training activities to inform small businesses about changes in government procurement policies, including new statutory requirements applicable to purchases made using simplified acquisition procedures.

VA officials agreed that these efforts will help alleviate some contracting problems. They believe, however, that further contracting flexibility would be needed if the Congress wants VA to develop and market competitive managed care plans. For example, VA believes it would need additional authority to develop provider networks and participate in joint-venture arrangements with private-sector entities to provide more convenient access for its beneficiaries and share equipment that might not be feasible for VA to obtain on its own.

Improving Personnel Management Governmentwide

-- Executive Order 12871 established the National Partnership Council--comprised of members from federal agencies, employee organizations, and neutral parties--to identify changes needed to implement the NPR human resource recommendations. The Council issued its report on January 31, 1994, but as yet no legislative proposals have been proposed.

-- The Office of Personnel Management (OPM) initiated action to abolish the Federal Personnel Manual and create a more flexible hiring and promotion system.

-- OPM is preparing to eliminate governmentwide requirements for agency grievance and appeals procedures that provide workplace due process for employees. Agencies will then be responsible for developing alternate dispute resolution methods and options for the informal disposition of employment disputes.

According to VA officials, NPR personnel initiatives are a step in the right direction, but do not give VA sufficient flexibility to establish the alternate personnel systems that VA believes it would need if the Congress wanted it to market competitive managed care plans. For example, NPR classification and pay proposals retain the existing general schedule framework for paybanding and pay-for-performance decisions. In contrast, VA believes it would need market-based pay systems linked to prevailing local conditions if it is to compete with private-sector managed care plans.

Improving Customer Service

The administration, in September 1993, issued Executive Order 12862, "Setting Customer Service Standards." The order requires all agencies that provide services directly to the public to, among other things, survey customers, establish service quality standards, measure performance against the standards, and address customer complaints. To improve VA's customer service focus, the Secretary charged VA with "putting veterans first." The August 1994 customer service plan reflected much of the feedback that VA received through customer surveys. VA established specific standards for medical care, such as a maximum waiting time of 30 minutes for a scheduled appointment, the availability of urgent care 24 hours a day, and a maximum 30-day wait for an appointment with a specialist or for a new patient.

As part of its customer focus, NPR also recommended that VA provide bedside telephones for hospital patients. According to VA officials, the Secretary has made the installation of bedside telephones a priority for VA in its efforts to improve services for veterans.[7] Through a joint effort among VA, volunteers from labor organizations, and large companies, bedside telephones have been installed in about half of VA hospitals as of March 1995. VA plans to have bedside telephones in all VA hospitals by 1996.

Improving Customer Surveys and Contracting for Services

Finally, in response to an NPR recommendation to OMB regarding the Paperwork Reduction Act of 1980, OMB published a resource manual for customer surveys, which explains techniques for developing customer surveys and a generic clearance process to expedite approval. In early 1994, VA obtained OMB approval for generic customer service surveys so long as (1) VA's surveys remain within the information collection burden caps set by OMB and (2) VA periodically reports to OMB on the overall program. As a result, VA officials no longer view the Paperwork Reduction Act as a significant barrier to their managed care initiatives.

The Veterans' Benefits Improvements Act of 1994 suspended restrictions on VA's ability to contract for direct patient

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[7]VA was already developing plans to install bedside telephones. See our report, VA Health Care: Telephone Service Should Be More Accessible to Patients (GAO/HRD-91-110, July 31, 1991).

care services. Section 8110(c) of title 38 of the U.S. Code generally precluded VA from entering into contracts under which VA direct patient care or activities incident to direct patient care would be converted to activities performed by non-VA providers. Under the Veterans' Benefits Improvements Act of 1994 (P.L. 103-446, title XI, section 1103) these requirements were suspended for fiscal years 1995 to 1999. The Secretary of Veterans Affairs must, however, (1) ensure that contractors give priority to former VA employees displaced by award of the contracts and (2) provide to former VA employees all possible assistance in obtaining further federal employment or entrance into job training programs. Because the law was passed late in the 103rd Congress, VA has not yet implemented these provisions.

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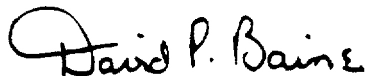
Copies of this letter are being sent to the Chairman and Ranking Minority Member of the House Committee on Veterans' Affairs, the Chairman and Ranking Minority Member of the Senate Committee on Veterans' Affairs, and the Secretary of Veterans Affairs. Copies will be made available to others upon request.

Please call me at (202) 512-7101 if you have any questions or need additional assistance.

Sincerely yours,



David P. Baine
Director, Federal Health Care
Delivery Issues

Enclosures - 2

BARRIERS TO VA MANAGED CARE

This enclosure contains a numbered listing of 33 barriers that could inhibit VA efforts to implement managed care.[1] The barriers were identified in early 1994 through discussions with VA central office and medical center officials, managed care experts from the Group Health Association and American Managed Care and Review Association (two trade associations that represent the managed care industry), NCQA, several private-sector and local government managed care plans, and HCFA.[2] We also visited four VA medical centers--Phoenix, Arizona; Portland, Oregon; Seattle, Washington; and Tucson, Arizona--which represent a mix of older and newer facilities. At each medical center, we interviewed top administrators and toured the facilities to observe patient amenities and barriers that VA officials had identified. Finally, we reviewed studies of and federal laws governing VA's health care system.

The 33 barriers fall into seven general categories: eligibility for VA health care, contracting for goods and services, funding VA health care, marketing and customer service, quality and location of VA facilities, personnel matters, and information and accounting systems.

ELIGIBILITY BARRIERS

1. Relatively few veterans are entitled to the full range of health care services typically provided in a managed care environment. All veterans are eligible for hospital care, but the provision of care to most veterans is discretionary, depending on the availability of space and resources. Only service-connected, low-income, and certain other veterans are entitled to inpatient care. Eligibility for outpatient services--the focus of managed care--is more limited. Only those veterans with service-connected disabilities rated at 50 percent or higher are entitled to comprehensive outpatient services. Most other veterans are entitled only to those outpatient services related to a service-connected condition. In addition, nonservice-connected veterans are eligible for outpatient care only to the extent that the services would obviate the need for inpatient care, are needed in preparation for inpatient care, or are a followup to inpatient care.

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[1]Actions to overcome the barriers are discussed in the letter and enclosure 2.

[2]HCFA administers the Medicare and Medicaid programs and also is responsible for certifying health plans that apply for federal HMO status.

As a result, few veterans can rely solely on VA to meet their health care needs. Generally, veterans must either pay for health care services that they are unable to obtain from VA or carry private health insurance to supplement their limited VA coverage. Without eligibility reform to allow VA to provide veterans the full range of covered health care services, VA would have little chance of attracting veterans to VA health plans.

2. Entitlement to VA care is based on situations that may change, such as veterans' incomes, degree of service-connected disability, and the availability of resources at VA facilities. As a result, a veteran may be entitled to care from VA one month but be denied care the next because of a change either in his or her status or in the availability of resources at the VA facility where he or she seeks care. This differs from a typical private health insurance policy where a person is entitled to all covered services for the entire period covered by the policy. Unless VA is able to guarantee coverage and the availability of health benefits to veterans regardless of changes in income or service-connected disability levels for the full enrollment period, it may be unable to effectively compete against private-sector plans offering such assurances.

3. VA cannot sell supplemental benefit packages. In a competitive managed care environment, health plans often offer supplemental benefit packages or cost-sharing plans to attract potential enrollees who may need the additional coverage. Unless VA has similar authority to market supplemental benefit packages and cost-sharing plans, it could be at a competitive disadvantage.

4. Very few veterans' dependents are eligible for care from VA. As a result, veterans with dependents generally carry private health insurance for their family even if the veterans rely on VA for their health care. To the extent that families prefer to obtain care from the same providers, VA would be at a competitive disadvantage if it is unable to offer family coverage. In addition, if veterans are forced to enroll their families in non-VA health plans because VA does not offer family coverage, the veterans are likely to enroll in the private-sector plans with their families because the cost of their coverage is probably included in the family plan.

Private health insurance generally provides individuals the option of single or family coverage. Dependent coverage is an important option according to managed care professionals because in most families it is the wife who selects insurance coverage for the family. For example, a manager representing one prominent HMO told us that the HMO's philosophy is family coverage and it probably would not contract with VA just to serve veterans' dependents or send its veteran enrollees to VA for treatment.

CONTRACTING BARRIERS

5. Complex federal procurement laws and regulations limit VA's flexibility in procuring goods and services. Medical center administrators cited lengthy delays, excessive paperwork, and multiple layers of review as typical of the VA procurement process. Other VA officials complained about the myriad federal requirements, such as preferences given to minority contractors and small businesses, as impeding their ability to quickly obtain high-quality goods and services. Still others complained about frequent opportunities for delays caused by cumbersome bid protest procedures. Many of these requirements and procedures apply to VA and other federal agency procurement but not to procurement by the private sector. Such requirements could result in the government paying a higher cost.

6. Competitive bidding requirements limit VA's options in procuring goods and services. According to one VA medical center director, using the lowest bidder approach does not work well in health care because the best physicians are typically not the cheapest and such an approach ignores important intangible measures such as continuity of care and working relationships developed over many years. For example, if a health plan has been using a clinical laboratory for several years and has been very satisfied with its service, switching to a new laboratory just to save a few dollars would be very disruptive. Similarly, enrollees would be very upset if they were not allowed to see their customary family doctor anymore because the health plan contracted with a different lower-cost physician.

VA officials believe that low bidders may meet contract specifications but still provide poor quality goods or services. Also, bid protests can cause lengthy delays in the procurement process. By contrast, competing health plans would be able to purchase goods and services through negotiation with individual contractors rather than formal competitive procurement procedures.

7. VA has limited authority to purchase health care goods and services from private-sector suppliers or to sell its services to other health plans. VA's scarce-medical-resource sharing agreements are limited to other health care facilities, research centers, medical schools, and state veterans' homes. Private-sector facilities are already developing networks through formal and informal agreements with other facilities and providers. Without increased flexibility to establish provider networks, VA may be unable to effectively compete with private-sector plans.

8. VA may be unable to contract to provide services to Medicare beneficiaries and other health plans and facilities unless it complies with oversight requirements established by Medicare, state

agencies, or private insurers. VA facilities are reviewed by the Joint Commission on Accreditation of Healthcare Organizations, but VA does not allow HCFA (which administers Medicare), private insurers, or others to perform utilization or quality-of-care reviews. By contrast, private-sector facilities are generally state-licensed, certified by Medicare, and subject to reviews by private insurers. Similarly, private HMOs must generally meet state licensing and federal HMO requirements and, if they contract with Medicare, Medicare risk-contracting requirements. In a competitive environment, shoppers will use these certifications as quality indicators in selecting a health plan. VA could find marketing its health plans difficult if it cannot demonstrate the plans' compliance with external quality assurance standards. Further, private-sector health plans may be unwilling to purchase services from VA unless VA meets requirements established by the health plans.

9. VA is, in general, prohibited from contracting for direct patient care services, such as nursing services, which are currently provided by federal employees. Private-sector plans, meanwhile, are increasing their use of contract employees--nursing pools in particular--to quickly add capacity during peak periods and help reduce operating costs. VA is currently unable to take advantage of such cost-saving practices and, thus, may be at a competitive disadvantage.

FUNDING BARRIERS

10. VA facilities cannot recover the costs of services provided to Medicare-eligible veterans. About one-half of current VA users are Medicare-eligible. Unlike private-sector health care facilities, however, VA facilities cannot bill Medicare for services provided to Medicare-eligible veterans. Instead, the costs of services provided to such beneficiaries are funded primarily through VA appropriations.

11. Availability of VA care varies from location to location because of uneven resource allocation. The uneven distribution of VA facilities and resources creates unequal access to health care services. Veterans with similar medical conditions or economic status are receiving care at some VA medical centers but not at others. Because the provision of most VA health care is currently discretionary, VA facilities can deny services if they run out of resources. If VA implements managed care plans that offer full benefits, however, VA health plans will have an obligation to provide the full range of comprehensive benefits to all enrolled veterans and their dependents. Accurate resource allocation would be essential to ensure that all VA health plans have adequate resources to provide the full range of items and services to their enrollees.

12. VA must return most third-party recoveries to the Department of the Treasury. This, one VA medical center director pointed out, reduces the incentive for VA medical centers to pursue recoveries from private health insurance. Although VA may retain a portion of the recoveries to offset the administrative costs of operating the recovery program, VA facilities cannot use recoveries to expand facilities or fund additional care for veterans.

13. VA does not have guaranteed funding for its health care system. VA does not get to recover the costs of care provided to Medicare-eligible beneficiaries or keep most recoveries from private health insurance and is almost totally dependent on appropriations to pay for health care services and modernize its equipment and facilities. VA officials believe that the annual funding process is too unpredictable and often too political to support managed care operations. Under the current VA eligibility and entitlement provisions, most VA care is discretionary and shortages of appropriations can result in denial of health care services to veterans in the discretionary care category. Under managed care plans, provision of health care services included in the comprehensive benefit package would no longer be discretionary for any veterans enrolled in VA health plans.

Private-sector health plans obtain funding for all enrollees, either through employer and employee premiums, Medicare and Medicaid payments, or some other source. Without a similar guaranteed source of payment for all VA health plan enrollees, VA health plans might be at a competitive disadvantage.

MARKETING AND CUSTOMER SERVICE BARRIERS

14. VA's ability to conduct market research is restricted by the Paperwork Reduction Act. This act requires that VA obtain OMB approval on any questionnaire, including customer surveys, sent to 10 or more individuals. According to VA managers, obtaining OMB approval is very cumbersome and typically requires several months to obtain. Consequently, local managers are hesitant to conduct customer surveys, even though they are necessary to determine what services VA must offer to be competitive. There are no such restrictions on market research by private-sector health plans.

15. As a federal agency, VA is limited in its ability to advertise its services to the public. VA can prepare informational brochures and public service announcements but is restricted in its ability to advertise in newspapers or on radio or television. Marketing and advertising, however, are becoming much more important functions within health care plans, according to private-sector managers. VA officials attribute part of VA's poor reputation to not being able to build a positive public image through advertising the quality and advantages of VA health care. Without authority to

advertise, VA health plans would be at a great disadvantage in trying to compete with private-sector health plans.

16. VA users generally do not have personal physicians and are not accustomed to accessing care in a managed care setting. While appointments are the norm in most managed care plans, VA has traditionally required veterans to "show up and wait" for treatment at VA hospitals and clinics without appointments. In some cases this could mean waiting all day, not being seen by a physician, and having to return the next day. Waiting rooms in most VA facilities that we visited were crowded. At the Phoenix Medical Center, administrators tried to assign patients to physicians and implement an appointment schedule for their clinics. However, according to the director, too many unscheduled drop-ins overwhelmed the system and caused them to abandon the personal physician and scheduled appointments program.

17. Many veterans have a generally negative view of VA customer service and quality of care. Our recent focus groups consisting of both VA users and nonusers found diverse opinions on VA health care.[3] Some veterans were very satisfied with the care they received from VA and expressed more interest in enrolling in a VA managed care plan. Others, however, reported negative experiences in VA facilities and said that they would be very reluctant to enroll themselves or their families in a VA health plan. Focus group participants were particularly concerned about waiting times and the way they were treated by VA staff. VA's poor reputation may also make purchasing care or offering itself as a provider to other health plans difficult for VA.

FACILITIES AND ACCESS BARRIERS

18. While VA operates one the nation's largest health care delivery systems, VA hospital care is not as accessible as hospital care under other public and private health insurance programs. For example, Medicare has over 6,000 participating hospitals compared with VA's 171 hospitals. As a result, in some states veterans may have to travel hundreds of miles to the nearest VA hospital. In a competitive environment, convenient access to care will be an important criterion that veterans and their dependents use in choosing a health plan. In contrast, officials we spoke with indicated that 5 to 35 miles was the limit enrollees would travel for primary care.

19. VA hospitals are frequently outdated and lack amenities comparable to private-sector hospitals. Most VA hospitals were

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[3] Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform (GAO/HEHS-95-14, Dec. 23, 1994).

built more than 30 years ago, some in the 1920s. Although some VA hospitals are relatively new and some have been updated, many still have four- and six-bed rooms, communal toilets and showers, and lack conveniences such as bedside telephones or televisions. Beyond amenities, older VA facilities face additional structural problems. At the VA facilities that we visited, problems included inadequate space in clinics and nurse stations, poorly designed intensive care units, and inadequate ventilation systems.

20. Requirements under section 510 of title 38, U.S.C., that VA notify the Congress before closing or relocating a VA facility make reacting quickly to market conditions by closing underused or inefficient facilities difficult. Section 510 requires VA to notify the Congress in writing 90 days before reorganizing a field office or 30 days before reorganizing a central office unit. The political nature of an office closure or relocation can hinder VA's efforts to improve administrative operations or put its facilities where they are most needed.

By contrast, private-sector health plans have the flexibility to close facilities or consolidate operations without such delays. Unless VA has such authority, it may be unable to quickly react to changing market conditions, placing its health plans at a competitive disadvantage.

21. VA lacks the outpatient primary care network common in private-sector managed care plans. Veterans must generally travel to a VA hospital or independent outpatient facility to obtain routine outpatient care. By contrast, private-sector plans have developed networks of providers that give their members more convenient access to care, better availability of specialty care, and cost savings through the use of less expensive ambulatory and primary care in an outpatient setting. The lack of such networks will limit VA's ability to provide convenient and cost-effective care.

22. Veterans have a limited choice of providers. By contrast, under most private health insurance, enrollees have a choice of obtaining care from any participating provider or from nonparticipating providers if they agree to pay higher copayments or deductibles. As a result, most individuals are able to keep their same health care providers even if they change health insurance plans.

Other than veterans who are authorized to receive fee-basis care from private providers because of the unavailability of VA care or the geographic inaccessibility of VA facilities, veterans must either obtain all health care services from VA providers or pay for the services themselves. Unless VA authorizes veterans to use out-

of-plan services, VA may find attracting enrollees whose current providers are not included in VA's network of providers difficult.

23. VA facilities are not designed to provide the full range of services likely to be included in the basic benefit package of a managed care plan. For example, VA does not have the ability to provide maternity or pediatric care, and does not generally provide 24-hour emergency care. VA must have the capability to offer the full range of services to all enrollees to be competitive with private-sector plans.

PERSONNEL BARRIERS

24. VA has too many specialists and too few primary care physicians. The director of one VA medical center told us that it needs a ratio of 60 percent generalists to 40 percent specialists to implement managed care. He said that the center's current staffing--20 percent generalists and 80 percent specialists--provides only one-third of the needed generalists. Overall, about 28 percent of VA's physicians are primary care physicians and about 72 percent are specialists. However, VA may have difficulty increasing the number of primary care physicians in the near term because of a nationwide shortage of such physicians.

25. VA managers lack experience in establishing and operating managed care plans. Many new skills, such as negotiating risk contracts, setting premiums, and practicing utilization management, would be needed if VA implements managed care plans. Developing a cadre of experienced managers, however, will likely be an ongoing problem for VA. According to managed care associations, the expansion of managed care plans nationwide has created a shortage of administrators with such expertise.

26. Staff levels established by the Congress limit VA's flexibility to react to local conditions. Title 38, U.S.C., requires that each VA appropriation contain a funded personnel ceiling. Medical center directors at the locations we visited frequently cited staff ceilings as a major obstacle. For example, the director at one VA medical center we visited told us that the center hired a full-time wheelchair repairman because of the high volume of needed repairs. However, due to staff ceiling reductions, it had to lay off the repairman and contract for needed repair work. He said that contracting for the repair work was much more expensive than doing the work inhouse, but doing so did not count against the center's staff ceilings.

By contrast, private health care facilities and health plans can quickly increase or decrease staffing levels to adapt to changing conditions, such as unexpectedly high or low enrollment in a health plan. Further, staffing levels can be based on what is most cost

effective, not on artificial floors and ceilings. Requiring VA to maintain minimum staffing levels would prevent VA from reducing staffing if health plans do not enroll anticipated numbers of veterans. Conversely, setting limits on the number of VA employees could limit VA's flexibility in expanding to meet unexpectedly high enrollments.

27. Federal personnel requirements under titles 5 and 38, U.S.C., make hiring and firing employees and setting pay levels to respond to local conditions difficult. Private health plans have the flexibility to adjust pay rates and offer physicians and other health care providers a wide range of benefits. With a nationwide shortage of primary care physicians and managed care experts, VA's ability or inability to attract sufficient primary care physicians and management expertise could limit the number of veterans it can enroll.

28. VA does not generally grant admitting rights to non-VA physicians. If it establishes managed care plans, VA expects to obtain services from a variety of non-VA health plans, group practices, and individual physicians to treat VA enrollees. Unless such contractors' physicians have admitting rights to VA hospitals, they would be forced to either (1) admit their patients to non-VA hospitals where they have admitting rights or (2) turn over control of the patient to VA staff physicians. The latter option would limit non-VA physicians' ability to ensure the quality, necessity, and continuity of care provided to their patients. Similarly, non-VA health plans may be unwilling to contract with VA to care for their veteran enrollees unless VA grants their physicians admitting rights to VA hospitals.

29. VA does not have effective programs to credential and grant privileges to a large number of health care workers. Establishing managed care plans nationwide would require VA to hire or contract with thousands of physicians, nurses, and other health care professionals. Private-sector health plans have procedures for conducting background checks on most health care workers and statistically monitoring the performance of plan physicians. VA does not have the capacity to conduct such background investigations nor does VA gather statistics to monitor the performance of its physicians.

INFORMATION SYSTEMS BARRIERS

30. VA management information systems are not able to produce reliable cost and utilization data. Without such data, VA health plans could not set accurate premiums, determine when to contract for services rather than provide them directly, or set prices for services sold to other health plans that are adequate to recover its costs.

31. VA financial and accounting systems cannot accommodate the myriad revenue sources and expenditures that would occur in a managed care setting. Revenues and expenditures would flow in many directions, both within and outside of VA. VA estimates that health plans could have 30 different revenue streams.

32. VA lacks reliable methods for determining eligibility for VA health care. Unlike private-sector plans that can enroll any individual, specific eligibility criteria would exist for enrollment in VA health plans. This creates an additional burden on VA to establish mechanisms to quickly (1) verify an applicant's eligibility to enroll in a VA health plan and (2) determine whether the veteran is eligible for free care.

33. VA cannot systematically identify veterans' private health insurance coverage. VA does not have a database of veterans' private insurance coverage to allow it to quickly bill other insurers. By contrast, private-sector plans regularly compile information on alternate insurance coverage that their enrollees may have.

LETTER FROM THE DIRECTOR, VA HEALTH CARE TRANSITION OFFICE[1]

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

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In Reply Refer To:
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Mr. David P. Baine
Director, Federal Health Care Delivery Issues
Human Resources Division
General Accounting Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Baine: Dave

I have read your draft list of *Barriers to VA Managed Care* and find that it comprehensively reflects much of what is required by the Department of Veterans Affairs if it is to participate fully in the competitive health care arena as a managed care delivery system. Thank you for the opportunity to provide comments on this draft list.

Generally, I think it is important to note that as a governmental entity, VA is faced with unusual challenges if it is to move its health care delivery system in to the competitive mainstream. We face the rather daunting challenge of providing cost-effective managed health care while fulfilling the public policy responsibilities of the Department. These two efforts are not entirely complementary. However, we believe that in view of the benefits that will accrue to our veteran patients, it behooves the policy makers and the law makers to meet the challenge. Such challenges are not without risks, but the alternative to not taking the risks is a health care system that cannot appropriately meet the health care needs of the nation's veterans.

As you have indicated, most of the barriers you have identified require legislative relief. It is important that this fact be clearly stated, since the absence of legislative relief is itself the most significant barrier VA faces. Without it, VA is unable to fully convert its health care delivery to managed care and cannot offer "health plans" to veterans. Further, I feel that two of these legislative barriers are broader than you have described. Barrier number three indicates that VA cannot sell supplemental benefit packages. Even more fundamental, however, is the fact that VA cannot sell a basic benefits plan. Barrier number ten mentions that VA facilities cannot now generally recover the costs of services provided to Medicare-eligible veterans. Of equal concern, VA cannot recover the costs of service to Medicaid-eligible veterans.

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[1]Formerly known as the Health Care Reform Office.

I am happy to report that the Paperwork Reduction Act, barrier number fourteen, is no longer as significant an impediment. In early 1994, VA received clearance from the Office of Management and Budget freeing VA from seeking individual OMB approval for each survey effort and from the requirement to publish individual survey notices in the *Federal Register*. It only requires that VA remain within the information collection burden cap and periodically report to OMB on the overall program.

Further, with respect to barrier number nine, Public Law 103-446 was signed by the President on November 2, 1994. That law, the Veterans Benefits Improvement Act of 1994, contains a provision that waives the limitations you describe in this barrier for the fiscal years 1995 to 1999 (i.e., Section 8110(c) of title 38).

Beyond needed legislation, several of the barriers can be addressed by VA action. The attachment reflects those barriers and the status of action relative to them. Much of the activity related to the changes envisioned in VA health care delivery are being monitored by the Health Care Reform Office, you may wish to contact them at (202) 254-6700 for clarification or additional information.

I look forward to your final report and to an ongoing dialogue between our offices to cooperatively identify appropriate measures for evaluating VA in light of the rapidly evolving health care environment.

Sincerely yours,

R. A. Perreault
Director, Health Care Reform Office

Enclosure

GAO MANAGED CARE REPORT
BARRIERS WITH VA ADMINISTRATIVE ACTION

- #8 – "...VA could find it difficult to market their health plans if they could not demonstrate their compliance with external quality assurance standards...."

  Heretofore, VA has not viewed it as necessary or appropriate to be governed by standards imposed by other governmental entities, such as state licensing and certification by Medicare. Further, there has been little need/impetus since VA has not participated in programs requiring adherence to such standards. However, the Health Care Reform Office (HCRO) and Health Care Reform Board of Directors (HCRB) have initiated an effort to fully assess how VA compares to Medicare standards. We are also pursuing discussions with appropriate HHS/HCFA officials.

- #11 – "...Currently, the uneven distribution of VA facilities and resources creates unequal access to health care services. ... Because the provision of most VA health care is currently discretionary, VA facilities can deny services if they run out of resources....VA health plans will have a contractual obligation to provide the full range of comprehensive benefits to all enrolled veterans and their dependents. Accurate resource allocation will be essential to ensure that all VA health plans have adequate resources to provide the full range of comprehensive health care items and services to all VA health plan enrollees."

  Uneven distribution of facilities and therefore resources are issues within limited VA control due to the political difficulties in closing and consolidating facilities or changing missions. Further, the adequacy of future resources is dependent upon appropriations and legislation which would broaden VA's access to additional revenue streams (as noted in your barrier #13). However, to be prepared, the VA is in the process of implementing a Decision Support System (DSS) which will provide the kind of cost accounting data needed as a basis for appropriate distribution of resources. Additionally, the HCRO recognizes that before VA health plans may enter into contracts with enrollees, we will have to fully assess the reasonable and feasible capacity of those plans in terms of assets and resources, among other considerations. Such an effort is currently underway as a prototype learning experience in Washington and Minnesota states. We also recognize that the incentives of current resource allocation systems need to be reevaluated so as to be consistent with managed care goals.

- #15 -- "As a federal agency, VA cannot advertise its services to the public...cannot pay for advertisements in the print media or broadcast on radio or television...."

  It is our understanding that VA does have the authority to advertise the availability of VA medical services to eligible beneficiaries and to encourage veterans to apply for these services. While all government agencies including VA are prohibited from using appropriate funds to employ "publicity experts" unless the funds were specifically appropriated for that purpose, it is our understanding that the Comptroller General has found that this prohibition is not intended "to interfere with the dissemination of information which an agency is required or authorized by statute to disseminate, or with promotional activities authorized by law." Therefore, the government-wide prohibition would not interfere with the VA authorized advertising just mentioned. VA *policy* however currently limits the use of paid advertising by VA to "specific activities for which a specific designation of budget authority exists." The HCRO is currently seeking to have this policy revised to explicitly authorize paid advertising.

- #16 -- "While appointments are the norm in most managed care plans, VA has traditionally required veterans to 'show up and wait' for treatment at VA hospitals and clinics without appointments."

  It appears that there is some confusion between patients that do not have an appointment and those that are scheduled for a clinic. Patients for specific clinics all have an appointment as would patients in a VA managed care plan. However, as in community hospital emergency rooms, unscheduled patients show up and wait to be seen. To minimize such waits the VA Central Office has recommended that a telephone triage program be established at each medical center. This telephone contact allows each veteran's health problem to be assessed and an appointment to be set up, often precluding unscheduled, walk-ins. Further, VHA has adopted among its customer service standards a commitment to provide veterans with timely access to health care and specific guidance has been provided to facilities for fulfilling this commitment.

- #17 -- "Many veterans have a generally negative view of VA customer service and quality of care....Others, however, reported negative experiences in VA facilities and said they would be very reluctant to enroll themselves, or their families, in a VA health plan. Veterans were particularly concerned about waiting times and the way they were treated by VA staff...."

ENCLOSURE 2

As you may know, the Secretary has charged the VA system with "Putting Veterans First." This effort is reflected in numerous activities at medical facilities designed to improve customer service, and in turn, satisfaction. Among these efforts are the standards VA has established in accordance with the National Performance Review-related Executive Order 12862, *Setting Customer Service Standards:* urgent care provided twenty-four hours a day, a maximum thirty minute wait for a scheduled appointment, a maximum wait of seven days for a primary care provider appointment, a maximum wait of 30 days for a new patient routine appointment, and a maximum wait of 30 day for an appointment with a specialist. Steady progress is underway and total compliance is targeted for 1998.

Further, you have cited your recent focus groups as a source for your findings in this barrier. VA is also using the qualitative tool of focus groups to get a feel for customer service/satisfaction issues. However, it is inappropriate to draw conclusions from this kind of information. Another indicator of satisfaction of which you should be aware is the survey VA recently conducted of 1500 current, former and non users of VA inpatient and outpatient services. This initial assessment indicated that those who use VA for their medical care are satisfied, and in the absence of cost issues, over 66% would choose VA. More importantly, over 67% of those who would choose VA gave quality of service as the reason for this decision. Although non-users indicated a much greater likelihood of selecting a private health plan, the survey suggests that those veterans who use VA, like VA.

- #18 – "While VA operates one [of] the nation's largest health care delivery systems, VA hospital care is not as accessible as hospital care under other public and private health insurance programs.... In a competitive environment, convenient access to care will be an important criteria veterans and their dependents use in choosing a health plan...."

Convenient access is certainly an issue. Contracting legislation (such as is required to overcome barriers #5 and #6) to provide greater flexibility is critical for VA so that we can readily contract for needed care. Additionally, VA is examining expanded use of vehicles such as sharing agreements and enhanced use authorities. Simultaneously, VA officials are initiating preliminary discussions with providers and institutions with whom VA might contract in the future. VA also has available, and is in the forefront of expanding, telemedicine capabilities that offset some limitations concomitant to inaccessible tertiary care facilities. Although still limited, VA has locations that are equipped to transmit high quality digital images allowing diagnosis and consultation from a remote location.

However, with respect to your draft observations on this barrier, it is suggested that current VA hospital care can be measured against hospital care available through an insurance program, such as Medicare. You have compared the number of participating hospitals under Medicare versus in the VA system. Certainly you do not mean to suggest that any Medicare recipient has "convenient access" to all 5000 of Medicare's participating hospitals. A more reasonable comparison might be to a health plan in a particular community. Further, you have cited a 10-mile radius example of maximum acceptable distance for access to routine health care, while some plans do indeed use such a measurement, others use 30 miles, and in some rural examples, substantially greater distances are considered the norm.

- #19 – "VA hospitals are frequently outdated and lack amenities comparable to private sector health plans...."

  Within the funds available for construction and renovation, VA has established priorities relative to health care reform. Further, the Secretary has made the installation of bedside telephones a priority for VA in its effort to improve services for veterans. As you may know, VA had hoped to have available an "investment fund" as contemplated under the President's proposed Health Security Act, which would have been used in part to address the lack of amenities you have described. We continue to hope that such investment funding may be a possibility in the next session of Congress.

- #23 – "VA does not have the ability to provide maternity or pediatric care....VA must have the capability to offer the full range of services to all enrollees in order to be competitive with private sector plans."

  We recognize that such capabilities must be available through a VA health plan. However, as is the case under CHAMPVA, VA may provide for those services through contractual arrangements.

- #24 – "VA has too many specialists and too few primary care physicians. However, VA may have difficulty increasing the number of primary care physicians in the near term because of a nationwide shortage of primary care physicians."

  While VA cannot immediately alter the staffing shortages, the primary care specialty has now been designated as a nationwide scarce specialty in VA. This allows medical centers to increase compensation up to $15,000, which may improve recruitment and retention of these physicians. Further, we note that to the extent that VA's difficulty in increasing its employment of primary care physicians is due to a nationwide shortage of same, this would

appear to be true for most providers, which would lessen the competitive gravity of this particular barrier. Also, to the extent that VA remains a significant "trainer" of the nation's physicians, we believe that we can as an institution significantly impact the mix of residency programs and in turn the nationwide availability of primary care physicians, albeit over a period of time. Lastly, you have cited that 23% of VA's physicians are primary care physicians. It would be helpful to have an opportunity to discuss which physician categories you included to reach this percentage. As of yet, there is no industry consensus on the inclusion of some specialties and subspecialties as primary care providers.

- #25 -- "VA managers lack experience in establishing and operating managed care plans. Many new skills, such as negotiating risk contracts, setting premiums, and utilization management, will be needed as VA implements managed care plans...."

  VA recognizes that there is a significant learning curve associated with a move to managed care. The HCRO is planning educational initiatives to broaden the organizational understanding of managed care as appropriate and contingent upon the input and interests of new leadership. Further, we also recognize that there are alternatives to having the skills resident in the organization and we will continue to examine our options for acquiring the necessary expertise.

- #27 -- "Federal personnel requirements under titles 5 and 38 of the U.S. Code make it difficult to hire and fire employees and set pay levels to respond to local conditions.... With a nationwide shortage of primary care physicians and managed care experts, VA's ability, or inability, to attract sufficient primary care physicians and management expertise could limit the number of veterans they can enroll."

  The National Performance Review and National Partnership Council initiatives in the areas of human resources management have addressed some of these concerns. VA is also working with the Office of Personnel Management to initiate demonstration projects in certain program areas. However, legislation will be required to address many of the system-wide problems.

- #28 -- "VA does not generally grant admitting rights to non-VA physicians. VA expects to obtain services from a variety of non-VA health plans, group practices, and individual physicians to treat VA enrollees. Unless such contractors' physicians have admitting rights to VA hospitals, they would be forced to either (1) admit their patients to non-VA hospitals where they have admitting rights or (2) turn over control of the patient to VA staff physicians...."

The HCRO has recognized this as a policy issue that VA must address. It will be among the issues discussed as VA pursues its move to managed care.

- #29 – "VA does not have effective programs to credential and grant privileges to [a] large number of health care workers. Establishing managed care plans nationwide would require VA to hire or contract with thousands of physicians, nurses, and other health care professionals. Private sector health plans have procedures for conducting background checks on most health care workers and statistically monitoring the performance of plan physicians. VA does not have the capacity to conduct such background investigations nor does VA gather statistics to monitor the performance of its physicians."

  The VA has a very thorough system to credential and privilege health care workers. The primary difference from the private sector system is that they frequently have an organization established that credentials and privileges almost all the providers in one community. This would be an excellent resource for VA to use if and when we need to credential many additional health care professionals.

  VA does monitor utilization and care outcomes by physician. This is required to be accredited by the Joint Commission on Accreditation of Hospitals. However, the HCRO is initiating policy discussions with respect to such considerations as physician profiling.

- #30 -- "VA management and information systems are not able to produce reliable cost and utilization data. Without such data, VA health plans cannot set accurate premiums, determine when to contract for services rather than provide them directly, or set prices for services sold to other health plans that are adequate to recover its costs."

  This is an issue which VA is currently addressing. VA contracted with a private provider to install a commercial Decision Support System (DSS) in all VA facilities to provide the necessary data. Further, we expect to learn a great deal more about what it is VA needs in this regard as a result of the prototypes being conducted in Washington and Minnesota states.

- #31 – "VA financial and accounting systems cannot accommodate the myriad of revenue sources and expenditure that would occur in a managed care setting. Revenues and expenditures would flow in many directions, both within and outside of VA...."

  The most sophisticated private sector computer systems are designed to address these issues since revenue and expenditures are the key to their

survival. When we are able to receive funds from multiple revenue streams, it will be possible to add software to DSS to accommodate the need. Further, in anticipation of the establishment of a revolving fund for VA health plans, VA officials are examining the processes that would need to be effected to accomplish the sort of financial transactions you have described. To some extent VA expects to draw on its experience in administering the Medical Care Cost Recovery Program.

- #32 – VA lacks reliable methods for determining eligibility for VA health care....This creates an additional burden on VA to establish mechanisms to quickly (1) verify an applicant's eligibility to enroll in a VA health plan and (2) determine whether the veteran is eligible for free care."

  VHA has reliable methods for determining eligibility for all veterans who are service-connected, other than zero-percent service-connected veterans, through the VBA Hospital Inquiry System (HINQ). Also, the Income Verification Matching Program provides an effective assurance of means testing accuracy. The HCRO recognizes that systems will need to be developed for reliable methods of determining eligibility of zero-percent service connected veterans and non-service connected.

- #33 – "VA cannot systematically identify veterans' private health insurance coverage. VA does not have a database of veterans' private insurance coverage to allow VA to quickly bill other insurers. By contrast, private sector plans regularly compile information on alternate insurance coverage their enrollees may have."

  VA does not have a nationwide database where patient insurance information is maintained, rather it is maintained within each facility's computer system. It is important to note that the VA patient is not required to provide insurance coverage information in order to obtain medical care. Currently, the Medical Care Cost Recovery Program is reviewing the merits of entering into data matching agreements with the Health Care Financing Administration to obtain insurance coverage information from their files. Similar avenues of data matching will also be explored.

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