United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Reform and Oversight, House of Representatives

For Release
on Delivery
Expected at
10:30 a.m.,
Tuesday, May 9, 1995

VA HEALTH CARE

Challenges and Options for the Future

Statement of David P. Baine, Director
Federal Health Care Delivery Issues
Health, Education, and Human Services Division

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the future direction of the Department of Veterans Affairs (VA) health care program. VA, with a $16 billion health care budget, faces increasing pressures to contain or reduce health care spending as part of governmentwide efforts to reduce the budget deficit. It also faces increasing challenges from a rapidly changing health care marketplace. We welcome this hearing as an important step in analyzing the challenges VA faces and exploring options for improving the VA health care system.

My comments this morning will focus both on actions needed immediately to improve the efficiency of VA hospitals and challenges that threaten the long-term viability of the VA health care system. Finally, I will discuss some options for restructuring the VA health care system to respond to those challenges.

During the past several years, we conducted a series of reviews focusing on the relationships between the VA health care system and other public and private health benefits programs and the effects changes in those programs could have on the future of the VA health care system. Similarly, we conducted a series of reviews to identify ways to improve the efficiency and effectiveness of current VA programs. My comments this morning are based primarily on the results of those reviews.[1]

In summary, our work clearly demonstrates that VA lags far behind the private sector in improving the efficiency of its hospitals. Over the last 5 to 10 years we have identified a series of management problems limiting VA's ability to (1) improve the operational efficiency and effectiveness of its hospitals and (2) shift more of its inpatient care to less costly ambulatory settings. Although VA is planning a major reorganization and other initiatives to improve its management capabilities, we remain concerned that some of the actions may not go far enough.

Even if it improves the efficiency of its hospitals, VA is at a crossroad in the evolution of its health care system. The average daily work load in its hospitals dropped about 56 percent during the last 25 years, and further decreases are likely. At the same time, however, demand for outpatient care, nursing home care, and certain specialized services is expanding, taxing VA's ability to meet veterans' needs.

Decisions made over the next few years about VA's role in health care will have significant implications for veterans, taxpayers, and private health care providers. For example,

---

[1]A list of related GAO testimonies and reports is in appendix I.

eligibility for VA care could be expanded or VA could be authorized to treat more nonveterans to increase its hospital work load. Such restructuring would, however, involve a fundamental change in VA's health care mission and would increasingly place VA in direct competition with private sector hospitals for dwindling numbers of patients. On the other hand, changes could be made so that VA services supplement rather than unnecessarily duplicate health care coverage under other programs. Regardless, VA would need to establish priorities for how its limited resources would be targeted.

In the final analysis, a complete reevaluation of the VA health care system appears needed. Absent such an effort, use of VA hospitals will likely continue to decline to a point where VA's ability to provide quality care and support its secondary missions will be jeopardized.

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 with the government owning and operating its own health care facilities. It grew into the nation's largest direct delivery system. For fiscal year 1996, VA is seeking an appropriation of about $17.3 billion to maintain and operate 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. VA facilities are expected to provide inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics are expected to handle 25.3 million outpatient visits.

Over the last 65 years, VA has seen a significant evolution in its missions. In the 1940s, a medical education mission was added to strengthen the quality of care in VA facilities and help train the nation's health care professionals. In the 1960s, its health care mission was expanded with the addition of a nursing home benefit. And in the early 1980s, a military backup mission was added.

The type of veterans served has also undergone an inevitable evolution. VA has gradually shifted from a system primarily providing treatment for service-connected disabilities incurred in wartime to a system increasingly focused on the treatment of low-income veterans with medical conditions unrelated to military service. Similarly, VA once treated an almost exclusively male veteran population but is now striving to meet the privacy and health care needs of increasing numbers of women veterans. Finally, the growth of private and public health benefits programs

has given veterans additional health care options, placing VA facilities in direct competition with private sector providers.

ACTIONS NEEDED TO IMPROVE THE EFFICIENCY OF VA HOSPITALS

Because VA is not subject to many of the cost-containment pressures, such as the Medicare prospective payment system, exerted on private sector hospitals in the last 10 years, it lags far behind the private sector in efforts to improve the efficiency of its hospitals. For example, VA continues to perform most cataract surgery on an inpatient basis years after the private sector has shifted such surgery to an outpatient basis. Similarly, VA's lengths of stay continue to be significantly longer than those in the private sector.[2]

VA's complex eligibility and entitlement provisions are frequently cited as a primary reason why VA cannot move more care out of hospitals and into ambulatory care settings. However, our work has pointed to management inefficiencies, not eligibility provisions, as preventing VA from shifting much of its current hospital work load to ambulatory care settings.

VA's eligibility provisions were amended in 1973 to specifically authorize the provision of ambulatory care to any veteran--regardless of income or other factors--when that care would obviate the need for hospital care. The eligibility provisions would, for example, allow VA to perform cataract surgery on an outpatient basis to obviate the need for inpatient care.

Our work over the past 5 to 10 years has identified a series of recurring management problems limiting VA's ability to improve both the efficiency of its health care system and services to veterans. Specifically, VA lacks

-- oversight procedures to effectively assess the operations of its medical centers,

-- systems to shift significant resources between medical centers to provide consistent access to VA care,

-- information systems capable of effectively coordinating patient care between VA facilities, and

-- a corporate culture that values economy and efficiency.

---

[2]An unpublished VA study reported the average length of stay in VA hospitals to be 10.6 days in 1991 compared with 6.8 days in private sector hospitals.

VA has a number of initiatives to address these problems and strengthen management while further decentralizing control.

Central Office Oversight

VA's central office lacks much of the systemwide information that it needs to effectively (1) monitor the performance of its medical centers, (2) ensure that corrective actions are taken when problems are identified, and (3) identify and disseminate information on innovative programs developed by its medical centers. For example, VA did not know

-- How many veterans are denied health care services because of a lack of resources and what types of veterans are being denied care?

-- Which VA facilities have excess capacities that they are able to sell to the Department of Defense or the private sector?[3]

-- How long veterans wait to see a doctor when they go to a VA medical center without a scheduled appointment and how long they have to wait for an appointment for specialty care?

-- How many VA medical centers have mammography equipment?

-- What controls VA medical centers have over the distribution of controlled substances?

In each case, VA's central office was unable to provide the data, and special surveys of its medical centers were required to obtain basic performance information.

With a decentralized management structure, managers in VA's central office should have systems to monitor field facilities to ensure that veterans receive high-quality services. In cases where the central office has monitored field facilities' operations, it has made some progress in ensuring that policies were properly implemented and problems were corrected. For example, systemwide improvements resulted when the central office became actively involved in ensuring that medical facilities properly validated the

[3]VA medical centers are authorized to enter into affiliation agreements with nearby medical schools. Through these agreements, VA centers and medical schools may share excess services as a means of improving the efficiency of operations. This can be done through joint acquisition of equipment or contracts that require one party to reimburse the other for costs of services shared. In addition, VA can enter into sharing agreements with military health care facilities.

credentials of their physicians and controlled inventories of addictive prescription drugs. But monitoring is the exception rather than the rule. Frequently, VA officials indicate that they lack sufficient resources to monitor field facilities' operations.

Even when monitoring occurs, VA has not held medical center directors accountable for ensuring that policies are implemented and corrective actions taken. For example, problems in improving the thoroughness of women veterans' examinations persist more than 10 years after they were first identified. VA's central office required medical centers to submit corrective action plans for improving the thoroughness of the examinations, but even when medical centers submitted inadequate plans, the central office did not follow through to notify medical centers of its findings.

Finally, VA's central office should be serving as an information exchange, identifying and evaluating locally developed programs and methods and disseminating best practices to other medical centers. For example, in our most recent report on women veterans' health care, we noted that several medical centers had developed innovative approaches to address the long-standing problem of inadequate physical examinations.[4] We recommended that VA identify and disseminate information on best practices, but when we followed up 2 years later, no action had been taken.[5] VA officials said they were not sure what we meant by "best practices."

Resource Allocation

VA's methods of allocating resources to its medical centers have historically been based on inpatient work load, creating incentives for medical center directors to provide care on an inpatient rather than outpatient basis. The incomes and service-connected status of veterans using the facilities are not considered in making the allocations.

VA could reduce inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and demographic makeup of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from medical centers that have sufficient resources and, therefore, do not ration care. Such resource shifts could mean, for example, that some higher-income veterans at those medical centers might not

---

[4]VA Health Care for Women: Despite Progress, Improvements Needed (GAO/HRD-92-23. Jan. 23, 1992).

[5]VA Health Care for Women: In Need of Continued Attention (GAO/T-HEHS-94-114, Mar. 9, 1994).

obtain care in the future. But the shift could also mean that some veterans with lower incomes who had not received care at other medical centers might receive care in the future.

From a veteran's perspective, VA's development of a strategy to deal with resource shortfalls on a more equitable basis systemwide seems preferable. We recommended in 1993 that VA modify its system for allocating resources to its medical centers so that veterans with similar economic status or medical conditions would, to the extent practical, be provided more consistent access to outpatient care.[6]

Although VA created a new resource allocation system, the Resource Planning Methodology (RPM), like its predecessor, the Resource Allocation Methodology (RAM), places limits on the amount of resources that can be shifted between medical centers. Less than 2 percent of resources has been shifted between medical centers under VA's resource allocation methods. More importantly, RPM allocates resources based on prior work load without any consideration of the incomes or service-connected status of that work load. We are currently reviewing RPM to determine why it does not shift more resources between medical centers.

Information Systems

Major improvements in both the quality of VA's services and the efficiency with which they are provided depend on VA managers' ability to get the right information at the right time. As we pointed out during last year's health reform debate, without accurate and complete cost and utilization data, VA managers cannot effectively make such decisions as when to contract for services rather than provide them directly and how to set prices for services it sells to other providers or how to bill insurers for care provided to privately insured veterans.[7]

Accurate utilization data also are essential in monitoring patient care both to help ensure quality and to prevent abuse. For example, a recent study by VA researchers identified 35 veterans who had been admitted to VA hospitals 2,268 times over a 5-year period at an estimated cost to taxpayers of $6.5 million. The researchers noted that VA doctors cannot easily tell when patients are moving from hospital to hospital because VA medical centers do not have a centralized patient information system.

---

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

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

VA is in the process of implementing a new Decision Support System (DSS) that uses commercially available software. This system can provide data on patterns of care and patient outcomes as well as their resource and cost implications. While DSS has the potential to significantly improve VA's ability to manage its health care operation, the ultimate usefulness of the system will depend not on the software but on the completeness and accuracy of the data going into the system. One longstanding problem with VA's information and financial systems is that medical centers frequently enter incomplete or inaccurate data or both. We are currently assessing VA's efforts to implement DSS including efforts to improve the reliability of data going into DSS.

VA Culture

VA operates not as a centrally managed health care system but as individual medical centers competing with each other to provide as wide a range of services as possible. Medical center directors' performance is generally judged by what new facilities, services, and equipment they bring to the medical center. Little thought is given to the availability of services and equipment at nearby VA facilities or in the private sector.

To address this problem, VA plans to reorganize its health care facilities into geographic networks known as Veterans Integrated Service Networks (VISN) to trim unnecessary management layers, consolidate redundant medical services, and use available community resources. Two important parts of the reorganization of VA facilities into 22 VISNs are plans to establish performance measures and hold VISN directors and medical center directors accountable for implementation of policy directives.

Because of the current lack of effective central office oversight of medical center operations, we view the establishment of VISNs as an important step by VA in increasing oversight of medical center operations, holding medical center directors accountable for implementation of policy directives, and taking corrective actions on problems identified.

CHALLENGES THREATENING THE FUTURE VIABILITY OF VA'S HEALTH CARE SYSTEM

Although actions to improve the efficiency of VA's hospitals are an important first step in addressing current operational problems, VA faces many other major challenges in a rapidly changing healthcare marketplace. For example:

-- A continuing decline in patient work load threatens the economic viability of VA hospitals.

-- Veterans have unequal access to health care services because of complex VA eligibility requirements, limited outpatient facilities, and uneven distribution of resources.

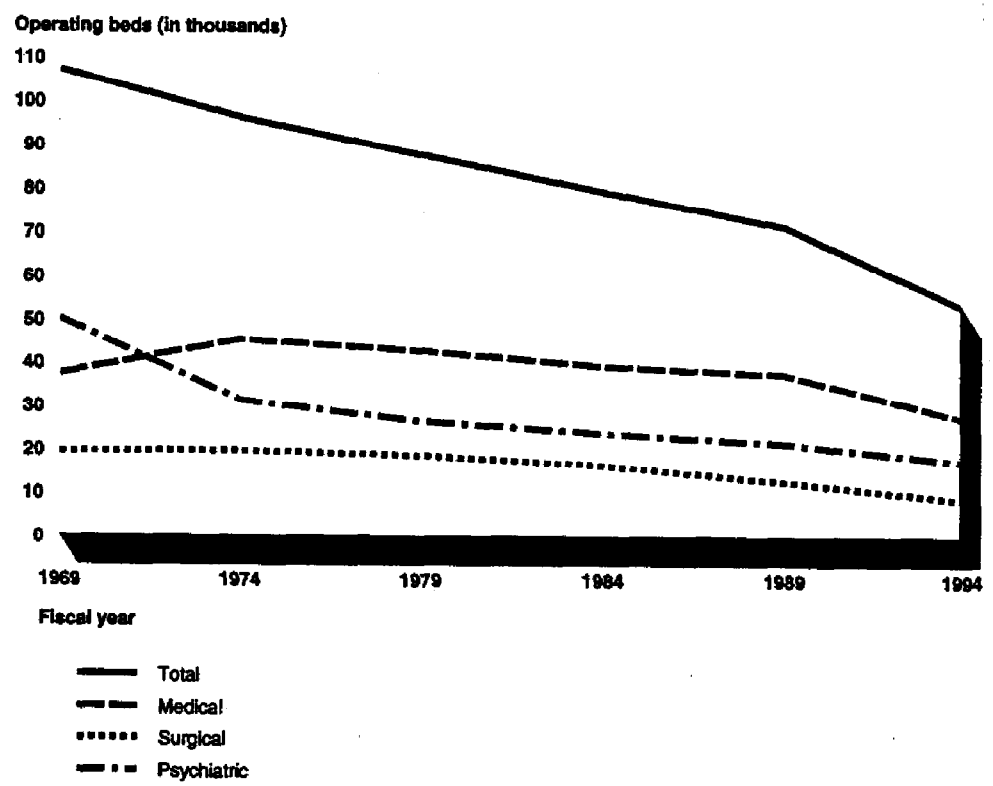
-- Needs of special care populations are not always met.

-- An aging veteran population has an increasing need for nursing home and other long-term care services.

VA Hospital Usage Declining

VA has experienced a dramatic decline in its hospital work load. Over the past 25 years, the average daily work load in VA hospitals dropped by about 56 percent (from 91,878 in 1969 to 39,953 in 1994). VA reduced its operating beds by about 50 percent, closing or converting to other uses about 50,000 hospital beds. The decline in psychiatric beds was most pronounced, from about 50,000 in 1969 to about 17,300 beds in 1994. (See fig. 1.)

Figure 1: Operating Beds in VA Hospitals (1969-94)



A number of factors could lead to a continued decline in VA hospital work load. For example:

-- The number of veterans with health insurance coverage is expected to increase, which will likely decrease demand for VA acute hospital care. Almost all veterans become eligible for Medicare when they turn 65 years old, even if they were employed in jobs that did not provide health insurance.

-- The nature of insurance coverage is changing. For example, increased enrollment in health maintenance organizations (HMO)--from 9 million in 1982 to 50 million in 1994--is likely to reduce the use of VA hospitals. Veterans with fee-for-service public or private health insurance have a financial incentive to use VA hospitals to avoid copayments and deductibles. This financial incentive is largely eliminated when they join HMOs because there is little or no cost sharing. Proposals to expand Medicare beneficiaries' enrollment in HMOs could thus further decrease the use of VA hospitals.

-- 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 by one-half over the next 50 years. The downsizing of the military will likely make the decline even more dramatic. With fewer new veterans entering the system, the veteran population will decline more rapidly, and the percentage of veterans 65 years old and having Medicare coverage will increase. In addition, many veterans leave the VA system when they become Medicare-eligible.

-- VA hospitals too often serve patients whose care could be more efficiently provided in alternative settings. The major veterans service organizations noted in their 1996 Independent Budget that a recent study indicated that VA could reduce its hospital inpatient work load by up to 44 percent if it treated patients in more appropriate settings.

VA's Under Secretary for Health recently testified that it will not be that many years before acute care hospitals become primarily intensive care units taking care of only the sickest and most complicated patients, having switched all other medical care to other settings, including ambulatory care settings, hospices, and extended care facilities.[8]

---

[8]Statement of Dr. Kenneth W. Kizer, Under Secretary for Health, VA, before the Subcommittee on Hospitals and Health Care, House Committee on Veterans' Affairs, April 6, 1995.

Needs of Special Care Populations Are Not Always Met

Although demand for VA acute hospital care is declining, the health care needs of veterans needing specialized services are not always met because of space and resource limits in specialized treatment programs. For example:

-- Specialized VA post-traumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist particularly for inpatient treatment.

-- A sufficient number of beds are not available to care for homeless veterans. VA has only 11 beds available in the San Francisco area to meet the needs of an estimated 2,000 to 3,300 homeless veterans.

-- VA substance abuse programs are near capacity.

Increased Demand for Nursing Home Care

As the nation's large World War II and Korean War veteran populations age, their health care needs are increasingly shifting from acute hospital care toward nursing home and other long-term care services.

Old age is often accompanied by the development of chronic health problems, such as heart disease, arthritis, and other ailments. These problems, important causes of disability among the elderly population, often result in the need for nursing home care or other long-term care services.

About 32 percent of veterans are 65 years old or older, with the fastest growing group of veterans being those 85 years old or older. This older group raises concerns because the need for nursing home and other long-term care services increases with the age of the beneficiary population. Over 50 percent of those over 85 years old are in need of nursing home care compared with about 13 percent of those 65 to 69 years old.

VA has set a goal of meeting the nursing home needs of 16 percent of veterans needing such care. Between 1969 and 1994, the average daily work load of VA-supported nursing home patients more than tripled (from 9,030 to 33,405). With the veteran population continuing to age rapidly, VA faces a significant challenge in trying to meet increasing demand for nursing home care.

Uneven Access to Outpatient Care

Veterans' ability to obtain needed health care services from VA frequently depends on where they live and which VA facility they go to. VA spends resources providing services to high-income insured veterans, who have no service-connected disabilities, while low-income uninsured veterans have needs that are not being met. About 191,000 low-income uninsured veterans with no apparent health care options indicated in a 1987 VA survey that they had never used VA health care, in part, because they were not aware that they were eligible.

Although not the primary reason for VA being slow to shift care from hospital to outpatient settings, the complexity of VA eligibility rules affects VA's efficient delivery of health care to veterans.

Any person who served on active duty in the uniformed services for the minimum amount of time specified by law and who was discharged, released, or retired under other than dishonorable conditions is eligible for at least some VA health care benefits. VA uses a complex priority system based on such factors as the presence and extent of any service-connected disability, the incomes of veterans with nonservice-connected disabilities, and the type and purpose of care needed, to determine which veterans receive care within available resources.

In general, VA provides cost-free priority medical care to veterans who have (1) service-connected disabilities; (2) a special status, such as being a former prisoner of war or a World War I veteran; or (3) incomes below a specified level (mandatory care category). If space and resources are available after caring for these veterans, VA provides care to other veterans; that is, those veterans with nonservice-connected disabilities and incomes above the specified level (discretionary care category).

Only those veterans with service-connected disabilities rated at 50 percent or more--about 450,000 veterans--are entitled to comprehensive outpatient services. VA's eligibility rules impede the provision of efficient health care to other veterans in that they may not be eligible for preventive services or treatment of medical conditions until such conditions, if left untreated, warrant hospital care or specialized outpatient treatment. This makes it difficult for VA to consistently apply the eligibility rules. As a result, eligibility for treatment depends greatly on what outpatient clinic the veterans visit.

Although considerable numbers of veterans have migrated to the Western states, there has been little shift in VA resources and

facilities. As a result, facilities in the Eastern states are more likely to have adequate resources to treat all veterans seeking care than facilities in Western states, that frequently are forced to ration care to some or all higher-income veterans as well as many veterans with lower incomes.

Using a questionnaire, we obtained information from VA medical centers on their rationing decisions. The medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within the centers. For example, higher-income nonservice-connected veterans could receive care at 40 medical centers that did not ration care, while 22 other medical centers rationed care even to veterans with service-connected disabilities. Some centers that rationed care by either medical service or medical condition turned away lower-income veterans who needed certain types of services while caring for higher-income veterans who needed other types of services.[9]

Finally, VA does not provide veterans access to outpatient care comparable to what they would get under other public or private health benefits programs. Veterans must generally travel to one of VA's 376 outpatient clinics to obtain routine outpatient treatment. Frequently veterans must travel long distances to obtain outpatient care. For example, veterans in Charlotte, North Carolina, must travel about 50 miles to the nearest VA outpatient clinic. Under other public and private health benefits programs, however, beneficiaries generally have access to a broad range of providers within a few miles of their homes.

OPTIONS FOR RESTRUCTURING THE VA HEALTH CARE SYSTEM

Because of the major challenges facing the VA health care system, VA and the Congress are at an important crossroad in the evolution of the system. A major restructuring of the system appears warranted. Options for such a restructuring might include

-- consolidating hospital services or converting hospital beds to other uses,

-- retargeting VA resources to better meet the health care needs of VA's current target populations,

-- expanding eligibility to transform VA into a comprehensive health care system competing with private sector providers,

---

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

-- expanding care for nonveterans,

-- strengthening cost sharing for nursing home care, and

-- expanding use of private nursing home providers.

Consolidating Hospital Services

VA and the private sector have reacted very differently to declining inpatient work load. In the private sector, hundreds of hospitals have closed over the last 5 years; more than 10,000 beds were taken out of service in 1994 alone.[10] VA, however, has not closed any hospitals because of declining utilization.[11] In fact, VA plans to add new hospitals in Florida, Nevada, Hawaii, Alaska, and California as part of joint ventures with the Department of Defense.[12]

To survive in such a competitive environment, private sector hospitals have increasingly (1) merged into hospital systems; (2) expanded horizontally to include such related health care facilities as nursing homes, ambulatory surgery centers, and home health agencies; (3) joined forces with HMOs to ensure a steady stream of patients; and (4) formed alliances with other hospitals to share high-cost services and equipment to prevent costly duplication.

Similar changes are needed in the VA system if it is to become more efficient and capable of competing with private sector hospitals. VA's recently announced plan to reorganize its medical centers into 22 VISNs is, among other things, an attempt to strengthen planning on a network rather than facility basis. In addition, VA envisions consolidating high-cost services in fewer facilities.

Although these are goals that we strongly support, VA's early efforts at network planning have not been successful. We recently

---

[10]Statement of William J. Schuler, President and Chief Executive Officer, Portsmouth Regional Hospital, before the House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, April 6, 1995.

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

[12]The Air Force recently withdrew from the planned joint venture in Brevard County, Florida.

reported that VA's central office had not given adequate guidance to its regional offices and medical centers on how to change VA's facility-by-facility construction planning process into an integrated network planning process. As a result, VA overstated its need to increase its extended care capacity. Although our report was issued in December 1994, VA has not taken a position on our recommendations that it revise its strategic planning guidance to better support networkwide rather than facility-by-facility planning.[13]

If VA has difficulty in changing its construction planning to a network basis, VA--however well-intentioned its plans may be--will find it even more difficult to make important decisions about consolidating services and closing underused facilities. One option may be to establish an independent panel, similar to the military base closure commission, to recommend changes.

Special Care Needs of Veterans Should Be Better Targeted

Another option for restructuring the VA health care system would be to retarget resources used to provide care for higher-income nonservice-connected veterans toward service-connected and lower-income veterans whose health care needs are not being met.

About 15 percent (319,000) of the 2.2 million veterans using VA medical centers in 1991 were nonservice-connected veterans with incomes of $20,000 or more. About 11 percent (91,520) of the single nonservice-connected veterans (832,000) and 57 percent (227,430) of the married nonservice-connected veterans (399,000) using VA medical centers in 1991 had incomes of $20,000 or more. Among married nonservice-connected veterans using VA medical centers, 21 percent (84,000) had incomes of $40,000 or more.

VA could use those resources to target the special care needs of veterans and strengthen its ability to fulfill its safety-net mission. For example, the resources could be used to

-- conduct outreach to medically underserved populations, such as homeless veterans;

-- expand programs that address special care needs; or

-- expand services for lower-income, uninsured veterans.

---

[13]VA Health Care: Inadequate Planning in the Chesapeake Network (GAO/HEHS-95-6, Dec. 22, 1994).

Expanding Eligibility for Veterans

While eligibility reform would be needed if the Congress wants VA to provide a uniform set of benefits to all veterans, such an expansion would fundamentally change VA's health care mission and has significant implications for cost and access to care. Currently, veterans' entitlement to care, even for service-connected veterans, is limited to those services that can be provided within available space and resources.

Keeping the resource constraints while broadening the entitlement to services could result in shifting VA resources away from providing services to service-connected and lower-income nonservice-connected veterans in order to provide a wider range of services to higher-income nonservice-connected veterans. In other words, it might decrease services available to service-connected veterans.

On the other hand, eligibility reform that would remove the space and resources constraints would essentially turn VA into an open-ended entitlement program like Medicare. Removing the resource constraints and expanding VA entitlement to free comprehensive health care services to all veterans currently eligible for free care (about 9 to 11 million veterans), as VA proposed last year, could add billions of dollars to VA's health care budget. The cost would depend on the number of veterans taking advantage of such expanded eligibility and the extent to which changes are made in the VA system to make care more accessible to veterans.

One option for limiting the cost of eligibility expansion is the use of cost sharing to offset the costs of the expanded benefits. For example, VA might be authorized to provide veterans any available health care service without changing existing eligibility for free care. In other words, veterans could purchase, or use their private insurance to purchase, additional health care services from VA. Such a change would not, however, significantly strengthen VA's safety-net role because lower-income uninsured veterans would likely be unable to pay for many additional health care services even if VA were authorized to provide them.

Another option would be to expand eligibility to create a uniform benefit package but narrow the scope of services included in the package. In other words, some veterans would receive a narrower range of free services while others would receive additional benefits. This approach, however, would essentially take some benefits away from service-connected veterans with the

greatest disabilities and give additional benefits to service-connected veterans with lesser disabilities and to nonservice-connected veterans.

A third option for paying for eligibility expansions would be to authorize VA to recover from Medicare the costs of services VA facilities provide to Medicare-eligible veterans. Allowing VA to retain recoveries from Medicare without an offset against VA's appropriation, however, would create strong incentives for VA facilities to shift their priorities toward providing care to higher-income veterans with Medicare coverage. More importantly, VA facilities would essentially receive duplicate payments for care provided to higher-income Medicare beneficiaries. Rather than improve the efficiency of the VA system, allowing VA to keep recoveries from Medicare could make the system less efficient by increasing resources available without a commensurate increase in work load. It could also significantly increase the overall costs of the VA system.

Finally, authorizing VA recoveries from Medicare could further jeopardize the solvency of the Medicare trust fund and increase overall federal health care costs regardless of whether VA is allowed to keep all or a portion of the recoveries. This is because such an action would essentially transfer funds between federal agencies while adding administrative costs.

Expanding Care for Nonveterans

One option for increasing the work load of VA hospitals would be to expand VA's authority to provide care to veterans' dependents or other nonveterans. Currently, VA has limited authority to treat nonveterans, primarily providing such services through sharing agreements with military facilities and its medical school affiliates.

Allowing VA facilities to treat more nonveterans could increase use of VA hospitals and broaden VA's patient mix, strengthening VA's medical education and research missions. Without better systems for determining the cost of care, however, such an approach could result in the use of funds appropriated for veterans health care being used to pay for care for nonveterans. For example, we recently reported that the Albuquerque, New Mexico, VA medical center was selling lithotripsy services to nonveterans at prices well below cost.[14]

---

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

In addition, VA would be expanding the areas in which it is in direct competition with private sector hospitals in the surrounding communities. Essentially, every nonveteran brought into a VA hospital is a patient taken away from a private sector hospital. Thus, expanding the government's role in providing care to nonveterans could further jeopardize the fiscal viability of private sector hospitals.

Recovering VA Costs for Providing Nursing Home Care

VA has a goal of providing nursing home care to 16 percent of veterans needing such care. VA could serve more veterans with available funds by (1) adopting the copayment practices used by state veterans homes and (2) establishing an estate recovery program patterned after those operated by increasing numbers of state Medicaid programs.

In fiscal year 1994, VA provided nursing home care to about 31,000 veterans in VA facilities, 29,000 in contract community facilities, and 18,000 in state veterans' homes at a combined federal cost of over $1.5 billion.

All veterans with a medical need for nursing home care are eligible to receive VA-supported care to the extent that space and resources are available. No veteran, however, is currently entitled to nursing home care.

Unlike Medicaid and most state veterans homes, the VA nursing home program has no spend-down requirements and minimal cost sharing. Only higher-income nonservice-connected veterans contribute toward the cost of their care, making copayments averaging $12 a day.

In fiscal year 1990, such copayments offset less than one-tenth of 1 percent of VA's cost to provide nursing home care in VA and community facilities. In comparison, eight states that charge for care offset from 4 to 43 percent of state veterans' home operating costs through copayments. If VA had offset similar percentages, its yearly recoveries would have been between $43 million and $464 million depending on which state copayment provisions were adopted.[15]

VA could also offset a significant portion of its nursing home and domiciliary costs if it had the same authority states were given to operate estate recovery programs. Estate recovery is a

---

[15]VA Health Care: Offsetting Long-Term Care Costs by Adopting State Copayment Practices (GAO/HRD-92-96, Aug. 12, 1992).

process through which a government agency recovers the costs of services provided to a beneficiary by filing a legal claim against the beneficiary's estate. We estimated that estate recovery programs recover 68 percent of the Medicaid nursing home benefits paid for recipients who owned homes in the six states studied.[16]

The potential for recovering nursing home costs through estate recoveries may be greater for veterans than for Medicaid recipients. This is because (1) home ownership--the primary asset of most elderly persons--is significantly higher among elderly veterans than among Medicaid nursing home recipients and (2) veterans living in VA facilities generally contribute much less of their incomes toward the cost of their care than do Medicaid recipients, allowing veterans to build bigger estates.[17]

Expanding Use of Private Nursing Homes

Finally, VA does not make effective use of lower-cost community nursing homes as an alternative to construction and operation of VA nursing homes. Since the early 1980s, we have repeatedly urged VA to increase its use of community nursing homes because (1) VA's costs of supporting patients in community nursing homes (about $106 a day in fiscal year 1994) are significantly lower than the costs of operating VA nursing homes (about $207 a day) and (2) VA could avoid the costs of constructing nursing homes (about $6 to 19 million for a 120-bed nursing home).

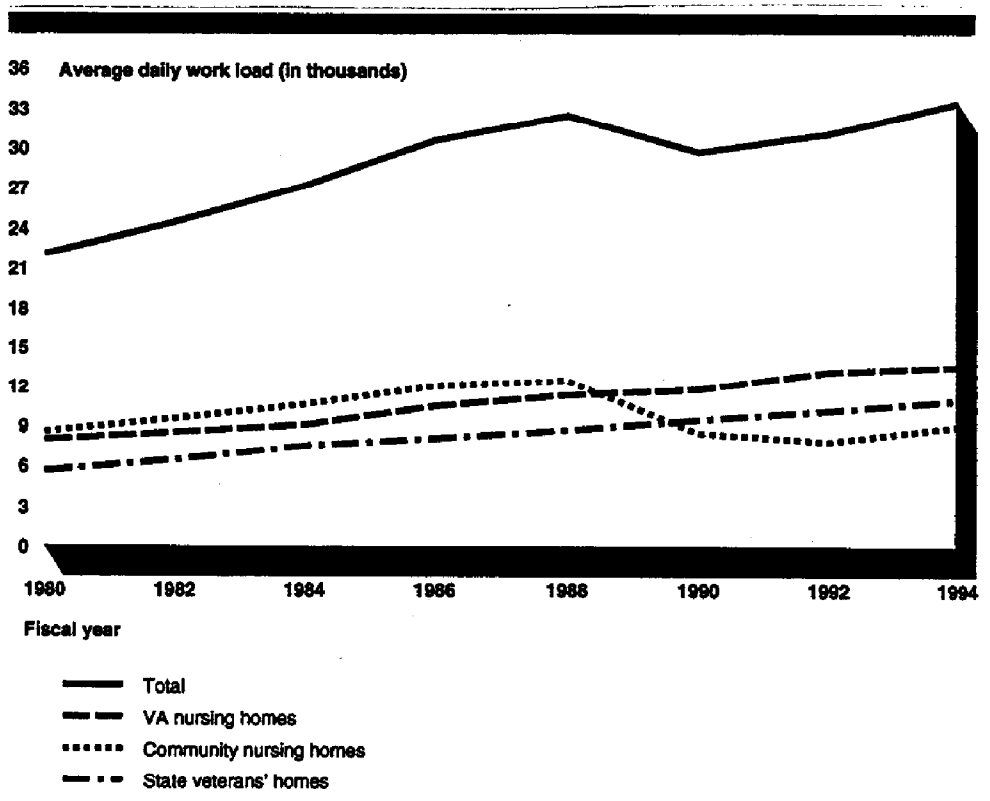
As shown in figure 2, however, VA has significantly decreased its use of community nursing homes since 1988, with a comparable increase in care provided in more costly VA nursing home care units.

---

[16]Medicaid: Recoveries From Nursing Home Residents' Estates Could Offset Program Costs (GAO/HRD-89-56, Mar. 7, 1989).

[17]VA Health Care: Potential for Offsetting Long-Term Care Costs Through Estate Recovery (GAO/HRD-93-68, July 27, 1993).

Figure 2: Average Daily Work Load of VA-Supported Nursing Home Care, By Source of Care (1969-94)



CONCLUSIONS

The VA health care system is at a crossroad--particularly in view of the dramatic changes occurring throughout the nation's health care system. These changes raise many important questions concerning the system:

-- Should VA hospitals be opened to veterans' dependents or other nonveterans as a way of preserving the system?

-- Should veterans be given additional incentives to use VA facilities?

-- Should some of VA's acute care hospitals be closed, converted to other uses, or transferred to states or local communities?

-- Should additional VA hospitals be constructed when use of existing inpatient hospital capacity is declining both in VA and in the private sector?

Decisions regarding these and other questions will have far-reaching effects on veterans, taxpayers, and private providers. We believe that attention is needed to position VA to ensure that veterans receive high-quality health care in the most cost-efficient manner, regardless of whether that care is provided through VA facilities or through arrangements with private sector providers.

- - - -

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

For more information on this testimony, please call Jim Linz, Assistant Director, at (202) 512-7110 or Paul Reynolds, Assistant Director, at (202) 512-7109.

RELATED GAO PRODUCTS

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

VA Health Care: Barriers to VA Managed Care (GAO/HEHS-95-84R, Apr. 20, 1995).

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

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

Veterans' Health Care: Implications of Other Countries' Reforms for the United States (GAO/HEHS-94-210BR, Sept. 27, 1994).

Health Security Act: Analysis of Veterans' Health Care Provisions (GAO/HEHS-94-205FS, July 15, 1994).

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

VA Health Care Reform: Financial Implications of the Proposed Health Security Act (GAO/T-HEHS-94-148, May 5, 1994).

Veterans' Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25, 1994).

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

Homelessness: Demands for Services to Homeless Veterans Exceeds VA Program Capacity (GAO/HEHS-94-98, Feb. 3, 1994).

VA Health Care: Restructuring Ambulatory Care System Would Improve Service to Veterans (GAO/HRD-94-4, Oct. 15, 1993).

VA Health Care: Comparison of VA Benefits With Other Public and Private Programs (GAO/HRD-93-94, July 29, 1993).

Veteran Affairs: Accessibility of Outpatient Care at VA Medical Centers (GAO/T-HRD-93-29, July 21, 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care From Alternative Sources (GAO/HRD 93-123, June 30 1993).

(406102)

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (301) 258-4097 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Mail
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested