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DEPARTMENT OF VETERANS AFFAIRS

Programmatic and Management Challenges Facing the Department

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Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss some of the major challenges facing the Department of Veterans Affairs (VA) and some of the options for deficit reduction through changes in VA benefits and programs.

VA has a profound effect on the welfare of our nation's 26 million veterans. In fiscal year 1996, VA's approximately 222,000 workers—nearly 1 for every 120 veterans—delivered a wide array of medical, disability compensation, pension, housing, insurance, education, and burial services in more than 1,000 facilities at a cost of over $38.1 billion.

Two years ago, we testified before this Subcommittee that VA was at a crossroad in the evolution of its health care system.[1] The average daily workload in its hospitals had dropped almost 56 percent during the preceding 25 years, and further declines appeared likely. At the same time, demand for outpatient care, nursing home care, and certain specialized services was expanding, taxing VA's ability to meet veterans' needs in those areas. We noted at that time that decisions made over the next few years about VA's role in health care would have significant implications for veterans, taxpayers, and private health care providers.

Today, I would like to discuss some of actions taken to increase the efficiency of the VA health care system and VA's progress in addressing the challenges discussed 2 years ago. In addition, I will discuss

- challenges facing the Veterans Benefits Administration (VBA) in administering compensation and pension benefits,
- VA's efforts to implement the Government Performance and Results Act (GPRA) and other recent legislation designed to improve the management of government programs, and
- changes that could be made in veterans' benefits and in the operation of VA programs to help reduce the budget deficit.

My comments are based primarily on the results of reviews conducted during the past several years by this and other divisions of the General Accounting Office.[2]

In summary, significant improvements have occurred in the efficiency of the VA health care system since we last appeared before this

[1] VA Health Care: Challenges and Options for the Future (GAO/T-HEHS/95-147, May 9, 1995).

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

Subcommittee. VA's new management and Veterans Integrated Service Network (VISN) structure clearly values efficiency and customer service. In addition, legislation was enacted (1) expanding eligibility for VA health care (P.L. 104-262), (2) making it easier for VA to contract for and sell services to the private sector (P.L. 104-262), and (3) requiring VA to develop a plan for more equitably allocating resources to its VISNs (P.L. 104-204). These decisions bring with them both solutions to old problems and significant new challenges, such as developing an enrollment process consistent with the priorities established under the eligibility reform legislation and determining when to buy services from the private sector rather than provide them in VA facilities.

VBA also faces multiple challenges. For example,

- the disability rating schedule has not been updated for over 45 years, meaning that ratings may no longer accurately reflect the loss in earning capacity resulting from service-connected disabilities;
- VA faces the prospect of late or inaccurate compensation and pension payments to millions of veterans if it is unable to resolve the "year 2000" computer problem;
- veterans often wait over 2 years for resolution of compensation and pension claims by the time the appeals process has been completed; and
- VA could avoid millions of dollars in overpayments of compensation and pension benefits by strengthening its ability to prevent such payments.

Recent legislation, including GPRA, the Chief Financial Officers (CFO) Act, and the Paperwork Reduction Act, provides a basis for addressing long-standing management challenges. VA has begun to use the legislation to improve its mission performance and results, its financial reporting, and its information resources management. For example, it included strategic plans for its health and benefits programs in its fiscal year 1998 budget submission. VA has been preparing audited financial statements since 1986, well in advance of the requirements imposed by the CFO Act.

Finally, multiple options exist for supporting deficit reduction through changes in VA benefits and programs. Although some of the changes could be achieved through administrative action, others would require legislation. The options include (1) redefining compensation benefits to eliminate compensation for diseases that are not related to military service, (2) imposing higher cost sharing for nursing home and other long-term care services, (3) limiting enrollment in the VA health care system, and (4) closing underused hospitals.

Background

The United States has a long tradition of providing benefits to those injured in military service, but the role of the federal government in providing for the health care needs of other veterans has evolved and expanded over time.

In the nation's early years, the federal role was limited to direct financial payments to veterans injured during combat; direct medical and hospital care was provided by the individual colonies, states, and communities. The Continental Congress, seeking to encourage enlistments during the Revolutionary War, provided federal compensation for veterans injured during the war and their dependents. Similarly, the first U.S. Congress passed a veterans' compensation law.

The federal role in veterans' health care significantly expanded during and following the Civil War. During the war, the government operated temporary hospitals and domiciliaries in various parts of the country for disabled soldiers until they were physically able to return to their homes. Following the war, the number of disabled veterans unable to cope with the economic struggle of civilian life became so great that the government built a number of "homes" to provide domiciliary care. Incidental medical and hospital care was provided to residents for all diseases and injuries.

The modern era of veterans' benefits began with the onset of World War I. During World War I, a series of new veterans' benefits was added: voluntary life insurance, allotments to take care of the family during military service, reeducation of those disabled, disability compensation, and medical and hospital care for those suffering from wounds or diseases incurred in the service.

During World War I, Public Health Service (PHS) hospitals treated returning veterans, and, at the end of the war, several military hospitals were transferred to PHS to enable it to continue serving the growing veteran population. In 1921, those PHS hospitals primarily serving veterans were transferred to the then newly formed Veterans' Bureau.

During the 1920s, three federal agencies—the Veterans' Bureau, the Bureau of Pensions in the Interior Department, and the National Home for Disabled Volunteer Soldiers—administered various benefits for veterans. With the establishment of the Veterans Administration in 1930, previously fragmented services for veterans were consolidated under one agency.

The responsibilities and programs of the Veterans Administration grew significantly during the ensuing decades. For example,

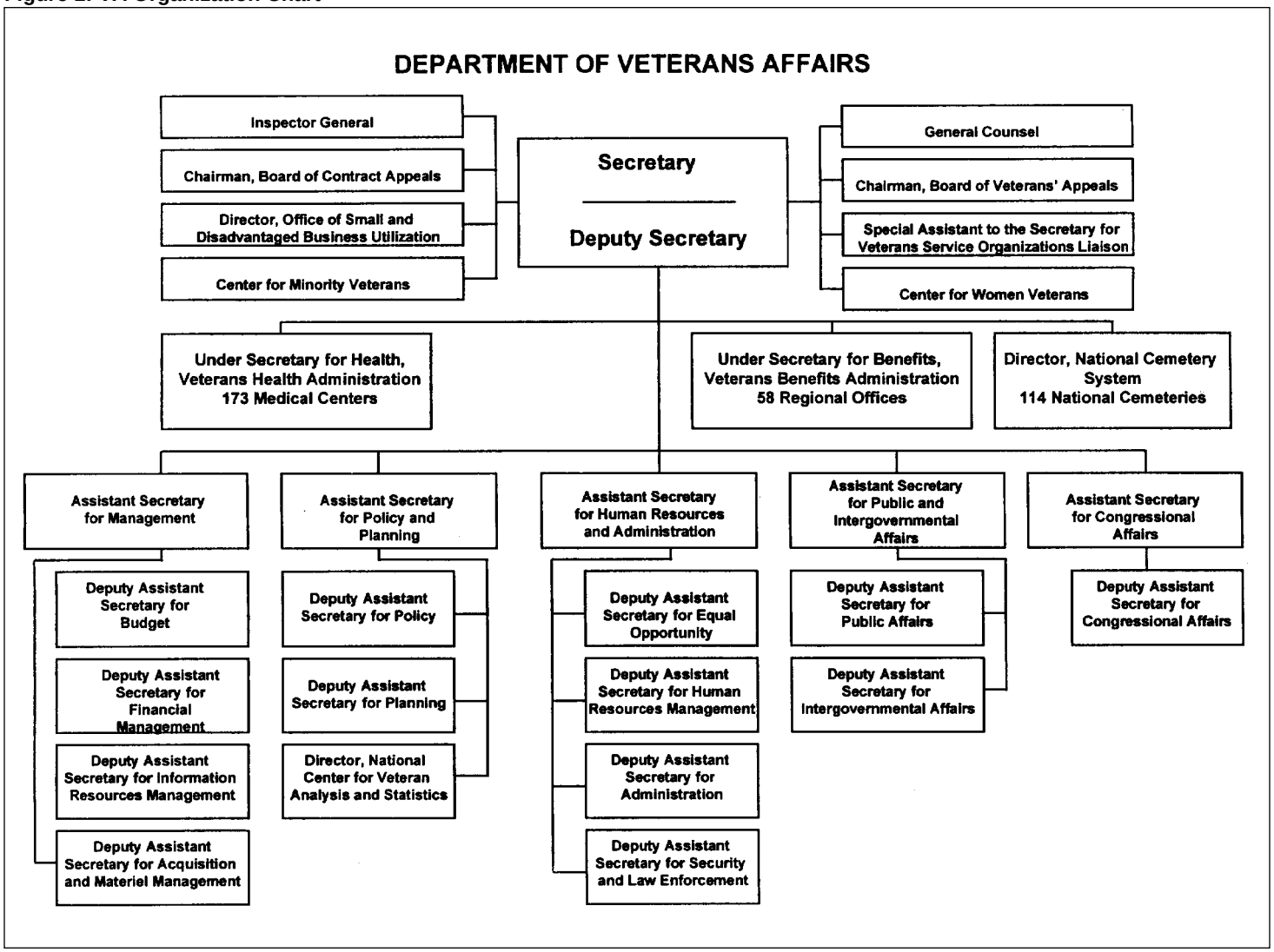
- the VA health care system grew from 54 hospitals in 1930 to include 173 hospitals, more than 375 outpatient clinics, 130 nursing homes, and 39 domiciliaries in 1996;
- the World War II GI Bill is said to have affected the American way of life more than any other law since the Homestead Act almost a century before, and further educational assistance acts were passed for the benefit of veterans of the Korean conflict, the Vietnam era, the Persian Gulf War, and the current all-volunteer force; and
- in 1973, the Veterans Administration assumed responsibility for the National Cemetery System, and VA is now charged with the operation of all national cemeteries, except for Arlington National Cemetery.

In 1989, the Department of Veterans Affairs was established as a cabinet-level agency. VA's major benefits programs are divided among

- the Veterans Health Administration (VHA), headed by the Under Secretary for Health;
- the Veterans Benefits Administration, headed by the Under Secretary for Benefits, which administers compensation for service-connected disabilities, pensions for low-income war veterans, education loans, life insurance, and home loans; and
- the National Cemetery System, headed by a Director.

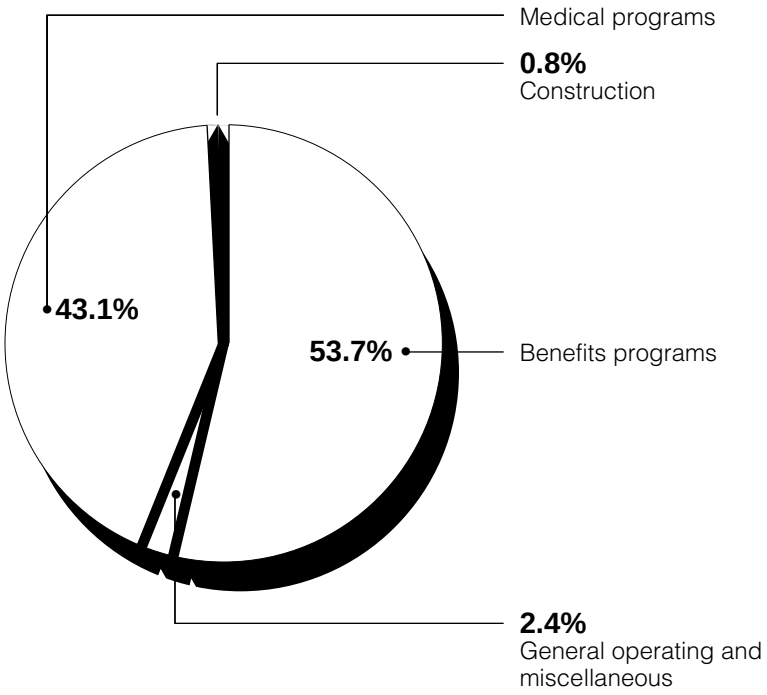
Figure 1 shows the organizational structure of VA.

Figure 1: VA Organization Chart



For fiscal year 1998, VA is seeking an appropriation of about $40.1 billion. Of this amount, about 54 percent is for benefit programs, primarily for compensation and pension payments, and 43 percent for medical programs. (See fig. 2.)

Figure 2: VA's Fiscal Year 1998 Appropriation Request



VA's budget authority is split between mandatory programs ($22.4 billion) and discretionary programs ($18.7 billion). Mandatory programs include compensation and pension payments, certain readjustment benefits, housing benefits, and life insurance programs. Discretionary programs include medical care, construction, the National Cemetery System, and departmental administration.

VA's fiscal year 1998 budget request includes two major proposals affecting its health care program. First, VA proposes legislation to allow it to retain recoveries from private health insurance and veteran copayments. Currently, most such recoveries are returned to the Treasury; VA is allowed to retain enough funds to offset the costs of its recovery program. Second, VA proposes to test the feasibility of billing Medicare for health care services provided to higher-income veterans who have Medicare eligibility, commonly referred to as Medicare subvention. These initiatives would, VA believes, allow it to support a 30-percent lower unit cost for its health care services, serve 20 percent more veterans, and obtain 10 percent of the VA health care budget from nonappropriated sources by fiscal year 2002.

VHA Has Made Significant Progress in Improving the Efficiency of Its Health Care System

In our testimony 2 years ago, we pointed out that VA lagged far behind the private sector in improving the efficiency of its health care system. Specifically, we said that the VA system lacked

- oversight procedures to effectively assess the operations of its medical centers,
- systems to shift significant resources among medical centers to provide consistent access to VA care,
- information systems capable of effectively coordinating patient care among VA facilities, and
- a corporate culture that valued economy and efficiency.

VA has made significant progress in improving the efficiency of its health care system. For example, it has consolidated management of nearby hospitals to reduce administrative costs, increased the use of ambulatory surgery, and reduced average lengths of stay. Under the leadership of the Under Secretary for Health, VA has a new emphasis on both economy and efficiency and customer service.

Performance Measures Developed to Hold Managers Accountable

Two years ago, we told you that VA's central office lacked much of the systemwide information it needed 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. Since then, VA has established a new decentralized management structure and established performance measures to hold managers accountable for improving efficiency and ensuring the quality of services.

VA reorganized its health care facilities into 22 VISNs. This reorganization contains several elements that hold promise for providing the management framework needed to realize the system's full potential for efficiency improvements. First, VA plans to hold network directors accountable for VISNs' performance by using, among other things, cost-effectiveness goals and measures that establish accountability for operating efficiently to contain or reduce costs. Second, the Under Secretary for Health (1) distributed criteria that could guide VISN directors in developing the types of efficiency initiatives capable of yielding large savings and (2) gave VISN and facility directors authority to realign medical centers to achieve efficiencies. Finally, VHA developed a new method for allocating funds to its VISNs with the intent of creating additional incentives to improve efficiency.

Consistent with the requirements of GPRA, VHA established five basic goals for its health care system. These goals are to

- provide excellence in health care value,
- provide excellence in service as defined by customers,
- provide excellence in education and research,
- be an organization that is characterized by exceptional accountability, and
- be an employer of choice.

Under each goal, VHA established objectives and performance measures for gauging progress toward meeting both the specific objectives and overall program goals. For example, VHA's performance measures include goals to

- decrease the number of bed-days of care provided per 1,000 unique users by 20 percent from the 1996 level,
- increase the percentage of patients reporting their care as "very good to excellent" by 5 percent annually,
- enroll 80 percent of patients in primary care, and
- increase the number of medical care residents trained in primary care.

Contracts with individual VISN directors reflect these goals and performance measures. In addition, each VISN has developed a business/strategic plan. The plans are generally organized around the five broad goals.

VA Plans to Implement a New Method for Allocating Resources

Two years ago, we testified that 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 medical center. Although VA had developed a new resource allocation system, the Resource Planning and Management (RPM) system, we pointed out that the system had shifted few resources among medical centers and allocated resources on the basis of prior workload without any consideration of the incomes or service-connected status of veterans who make up that workload.

Last year, Public Law 104-204 directed VA to prepare a resource allocation plan that would ensure similar access to VA care for veterans who have similar economic status and eligibility priority, taking into account expected workload and promoting the efficient use of resources to the extent feasible. VA developed the Veterans Equitable Resource Allocation (VERA) system in response to the congressional requirement. Next month,

VA plans to begin shifting resources among VISNs using the new system. The system is based on calculations of the cost per veteran-user in each VISN. VISNs that have the highest costs per veteran-user will lose funds, while VISNs with the lowest costs per veteran-user will get additional funds. Adjustments are included for the higher labor costs in some VISNs and for differences in the costs of medical education, research, equipment, and nonrecurring maintenance.

We applaud VA's efforts to develop a simple, straightforward method for allocating resources. However, we have the same basic concern about VERA that we had about RPM. That is, VA has not determined the "right" amount of dollars that need to be shifted to ensure equity of access. Our concern is based on the fact that VA has not adequately determined the reasons for differences between VISNs in costs per veteran-user. Without a better understanding of why the costs vary, VA cannot, with any certainty, determine the appropriate amount of resources to shift among VISNs.

VA data can give starkly different pictures of the comparability of veterans' access to VA care depending on the basis used for the comparison. For example, basing a comparison of equity of access on the percentage of the total veteran population in a VISN that is provided VA services would suggest that veterans in the Sunbelt generally have better access to VA care than do veterans from the Midwest and Northeast. Over 17 percent of veterans in VISN 18 (Phoenix) received VA services in fiscal year 1995, compared with about 8 percent of veterans in VISN 4 (Pittsburgh). Similarly, about 14 percent of veterans in VISN 9 (Nashville) received VA health care services in fiscal year 1995, compared with about 8 percent of those in VISN 11 (Ann Arbor). Such data could suggest the need to shift resources from VISNs where VA has a high market share of the veteran population to VISNs where VA has lower market shares.

On the other hand, the higher market shares might be justified because of differences in the demographics of the veteran populations. For example, there may be more low-income, uninsured veterans in the Sunbelt states who rely on VA for their health care. Similarly, differences in health status of users or a decision to provide a higher intensity of services to a smaller population might justify differences in market share. For example, to the extent that a higher proportion of the total veteran population is composed of Category A veterans (primarily veterans with service-connected disabilities or low incomes), a higher market share of the total veteran population might not reflect an inequity. We are

attempting to develop data on the demographics of the veteran population by VISN to better understand the basis for differing market shares.

Other VA data suggest that VISNs in the Northeast and Midwest may receive more than their fair share of VA resources. For example, VISN 18 received $3,197 per veteran served in fiscal year 1996, compared with $4,829 per veteran served in VISN 4. Similarly, VISN 9 received $4,071, compared with $4,360 in VISN 11.

Both VERA data and data from prior allocation models suggest that differences in efficiency are a major factor in the variation in spending per veteran-user. Veteran-users in VISN 3 (the Bronx) are hospitalized over three times as often as are veterans in VISN 18. In addition, VA found that VISNs that have higher costs per veteran-user also tend to have more doctors and nurses per patient, and provide more bed-days of care per patient than the VISNs with lower costs per veteran-user.

While differences in efficiency may help explain the wide variation in spending per veteran-user and justify some shifts in resources to increase equity, VA has not adequately explored other factors that might justify a portion of the higher costs or explain why certain VISNs have lower costs per veteran-user. In developing VERA, VA determined that differences in the age of veteran-users were not a significant factor explaining cost differences between VISNs. It did not, however, explore the role other factors, such as the following, may have played in the cost variations.

- Differences in the percentage of veteran-users receiving compensation for service-connected disabilities or low-income pensions for nonservice-connected disabilities could affect a VISN's cost per veteran-user. These costs could be affected because veterans with (1) service-connected disabilities rated at 50 percent or higher or (2) nonservice-connected pensions use a higher volume of services than higher-income veterans with nonservice-connected disabilities. For example, we found that among veteran-users living within 5 miles of a VA outpatient clinic, nonservice-connected veterans receiving low-income VA pensions used an average of 17 visits per user, compared with an average of 11 visits for other nonservice-connected users.[3]
- Differences in veteran-users' health insurance coverage could also affect a VISN's cost per veteran-user because veterans with public or private health insurance may use VA care to supplement services they obtain from private

[3]VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

sector providers rather than rely on VA for comprehensive care. For example, we found that only about half of the Medicare-eligible veterans using VA health care relied on VA for all of their care. As a result, VISNs serving higher percentages of Medicare-eligible and privately insured veterans could expect to have lower costs per veteran.[4]

- Finally, differences in the extent of incidental use of VA services could affect cost per veteran-user. Incidental use could artificially decrease the VISN's average cost of care for veterans who regularly use VA and overstate the VISN market share of the veteran population.

VA also has not developed data showing that the VISNs with lower than average expenditures per veteran-user need additional funds. In other words, it has not determined how much an efficient and well-managed VISN should be spending on each veteran-user. VISNs' draft business/strategic plans generally discuss how they will use the additional funds. Those plans have not, however, been reviewed and approved by central office.

Some VISN plans indicate that the additional funds will be used to reduce waiting times or increase the number of staff per patient. Others, however, indicate that the funds will be used to attract additional users. Giving additional funds to a VISN with no strings attached appears to enable VISNs with the largest market shares of the veteran population to further expand their market share. This does not appear to be consistent with the efficient use of resources that was one of the objectives of Public Law 104-204.

The simplicity of VERA and the variety of health care needs and coverages of veterans also create the potential for VISNs to focus their marketing efforts on those individuals least likely to use extensive health care services. In fact, VERA gives VISNs financial incentives to focus their marketing efforts on attracting veterans with limited health care needs. VA officials told us that they are aware of the potential for gaming and have performance indicators in place that will allow them to detect any unusual activity that might suggest gaming. For example, VHA said that it will be monitoring to identify

- unexpected increases in basic care workload,
- significant changes in the special care workload,
- inappropriate movement of special care services from inpatient to outpatient settings,
- fluctuations in numbers of high-cost procedures,

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

- increases in waiting times, and
- changes in customer satisfaction.

One way to develop a resource allocation system that would be consistent with the provisions of Public Law 104-204, easy to administer, and less subject to gaming would be to base the allocation on the veteran population in each VISN, with adjustments based on the numbers of veterans in each of the priority categories for enrollment in the VA health care system. To lessen the incentive for VISNs to target enrollment toward younger, healthier veterans with private insurance, separate rates could be established for various categories of veterans, on the basis of VA's historical cost and utilization data. We are currently developing data to more fully explore this option.

VA recognizes that VERA is not a perfect system and is continuing to explore options for improving its resource allocation methods. For example, VA, like GAO, is developing data to more fully explore the potential effects of population-based allocations. It plans, however, to go forward with allocations using VERA through fiscal year 1998 in order to provide needed financial incentives for certain VISNs to focus on efficiency improvements. Otherwise, allocations tied to historic budgets might delay needed efficiency improvements until another allocation method could be developed.

VA Continues to Implement Its Decision Support System but Concerns Continue

Without accurate and complete cost and utilization data, VA managers cannot effectively decide when to contract for services rather than provide them directly, how to set prices for services it sells to other providers, or how to bill insurers for care provided to privately insured veterans. Accurate utilization data are also essential to help ensure quality and to prevent abuse.

Since February 1994, VA has been phasing in at its facilities a new Decision Support System (DSS) that uses commercially available software to help provide managers 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 operations, 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. If DSS is not able to provide reliable information, VA facilities and VISNs will either continue to make decisions on the basis of unreliable information or spend valuable time and resources developing their own data systems.

Two years ago, we recommended that VA identify data that are needed to support decision-making and ensure that these data are complete, accurate, consistent, and reconciled monthly.[5] VA plans to begin implementing DSS at the final group of VA facilities this month. VA still, however, has not adequately focused on improving the completeness and reliability of data entered into the feeder systems. It has, however, started to reconcile DSS data on a monthly basis.

Although the draft business/strategic plans developed by the 22 VISNs generally discuss goals and timetables for implementing DSS throughout the network, they identify no plans for improving the completeness and accuracy of the data feeding into DSS.

The VA Health Care System Continues to Face Major Challenges

In our testimony 2 years ago, we focused on four major challenges facing VA because of a rapidly changing health care marketplace. Specifically, VA was faced with

- unequal access to health care services because of complex VA eligibility requirements, limited outpatient facilities, and uneven distribution of resources;
- a continuing decline in the number of hospital patients that threatened the economic viability of its hospitals;
- unmet needs, including the acute care needs of uninsured veterans not living close to a VA hospital, and the needs of special care populations such as those who are blind, paralyzed, or suffering from post traumatic stress disorder; and
- the growing long-term care needs of an aging veteran population.

Significant progress has been made in addressing the first challenge—improving veterans' access to VA outpatient care. The remaining challenges, however, remain largely unchanged. In fact, VA's progress in improving the efficiency of its hospitals has accelerated the decline in hospital workload, heightening the need to address the future of VA hospitals. In addition, VA's plans to attract new users focus primarily on attracting insured and higher-income veterans with other health care options rather than on addressing the unmet needs of veterans with service-connected conditions and low-income veterans.

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

Progress Has Been Made in Improving Access to Outpatient Care

The first major challenge facing VA health care 2 years ago was the uneven access to health care caused by complex VA eligibility requirements, limited outpatient facilities, and uneven distribution of resources. We noted at the time that veterans' ability to obtain needed health care services from VA frequently depended on where they lived and the VA facility that served them.

During the past 2 years, much progress has been made in improving veterans' access to care.

- Eligibility for VA health care was expanded, eliminating the hard-to-administer "obviate the need for hospitalization" provision that limited most veterans' access to routine outpatient care. All veterans are now eligible for comprehensive inpatient and outpatient care subject to the availability of resources.
- VA established community-based outpatient clinics (CBOC) to improve veterans' access to outpatient care. Until 1995, VA required its hospitals to meet rigid criteria to establish outpatient clinics apart from the hospitals. These criteria included a minimum number of veterans to be served in a clinic and a minimum distance that clinics had to be from the VA hospitals. In encouraging its hospitals to consider establishing CBOCs, previously known as "access points," VA eliminated many of its restrictions concerning the workload and location of proposed clinics. In addition, VA policy now encourages hospitals to provide care not only in VA-operated facilities, but also by contracting with other providers. Although only 12 CBOCs were operational by September 1996, plans had been developed to establish hundreds of additional clinics.
- VA's contracting authority was revised to make it easier for VA to buy services from private providers and to sell services to the private sector. Previously, VA's authority was restricted primarily to purchasing services from and selling services to other government health care facilities and VA's medical school affiliates. Using its expanded contracting authority, VA is moving quickly to establish additional CBOCs.

Efficiency Improvements Accelerate Decline in Hospital Use

The second major challenge facing VA health care 2 years ago was the declining use of VA hospitals. Between 1969 and 1994, the average daily workload in VA hospitals declined by about 56 percent. VA reduced its operating beds by about 50 percent, closing or converting to other uses about 50,000 hospital beds.

VA now finds itself increasingly a victim of its own success and faced with what to do with so much unused inpatient infrastructure. As VA's efforts to increase the efficiency of its health care system gained momentum during the past 2 years, the decline in VA hospital use accelerated. Between fiscal years 1994 and 1996, the average daily workload in VA hospitals dropped over 20 percent (from 39,953 patients in 1994 to 31,679 in 1996). Operating beds dropped from 53,093 in 1994 to 45,798 in 1996.

Hospital use in the VA system varies dramatically. Last year, we reported that the Northern California Health Care System, a part of VISN 21, was supporting the hospital care needs of its users with about 2 beds per 1,000 users.[6] Some VISNs, however, have over 20 hospital beds per 1,000 veteran-users. As a result, further significant declines in operating beds are likely as the variation in hospital use is reduced. For example, VISN 5 (Baltimore) estimates that its acute hospital beds will have decreased by 58 percent by fiscal year 2002 (from 1,087 in fiscal year 1995 to 460 in 2002).

Recent VA actions to establish preadmission reviews for all scheduled hospital admissions and continuing stay reviews for those admitted—actions we have advocated for over 10 years—should further reduce hospital use. VA may not realize the full potential from these reviews, however, unless physicians' incentives to minimize inappropriate inpatient care are increased. VISN 5 (Baltimore), for example, uses its reviews primarily for data collection, evaluation, and monitoring. The program does not act as a gatekeeper, and inpatient care is not denied on the basis of results of the preadmission reviews. Reviews at the VISN 5 hospitals in Martinsburg, West Virginia, and Washington, D.C., show that over 50 percent of patients admitted since the program was initiated did not need acute hospital care.

As workload continues to decline at VA hospitals, VA's investment in its hospital infrastructure increasingly detracts from its ability to shift resources to other needs, such as expanding access for veterans living long distances from VA facilities.

[6]VA Health Care: Travis Construction Project Is Not Justified (GAO/HEHS-96-198, Sept. 3, 1996).

Veterans More Likely to Have Unmet Needs for Specialized Care Services Than Acute Care Services

The third major challenge that faced VA health care 2 years ago was identifying and addressing the unmet health care needs of veterans. With the growth of public and private health benefits programs, more than 9 out of 10 veterans now have alternate health insurance coverage. Still, about 2.6 million veterans had neither public nor private health insurance in 1990 to help pay for needed health care services. Without a demonstrated ability to pay for care, individuals' access to health care is restricted, increasing their vulnerability to the consequences of poor health. Lacking insurance, people often postpone obtaining care until their conditions become more serious and require more costly medical services.

Most veterans who lack insurance coverage, however, are able to obtain needed hospital care through public programs and VA. Still, VA's 1992 National Survey of Veterans estimated that about 159,000 veterans were unable to get needed hospital care in 1992 and about 288,000 were unable to obtain needed outpatient services. By far the most common reason veterans cited for not obtaining needed care was that they could not afford to pay for it.

While the cost of care may have prevented veterans from obtaining care from private sector hospitals, it appears to be an unlikely reason for not seeking care from VA. All veterans are currently eligible for hospital care, and about 9 to 11 million are eligible for free care. Other veterans are required to make only nominal copayments.

Many of the problems veterans face in obtaining health care services appear to relate to distance from a VA facility. For example, our analysis of 1992 National Survey of Veterans data estimates that fewer than half of the 159,000 veterans who did not obtain needed hospital care lived within 25 miles of a VA hospital. By comparison, we estimate that over 90 percent lived within 25 miles of a private sector hospital.

Of the estimated 288,000 veterans unable to obtain needed outpatient care during 1992, almost 70 percent lived within 5 miles of a non-VA doctor's office or outpatient facility. As was the case with veterans unable to obtain needed hospital care, those unable to obtain needed outpatient care generally indicated that they could not afford to obtain needed care from private providers. Only 13 percent of the veterans unable to obtain needed outpatient services reported that they lived within 5 miles of a VA facility, where they could generally have received free care.

Veterans' needs for specialized services cannot always be met through other public or private sector programs. Frequently, such services are either unavailable in the private sector, or are not extensively covered under other public and private insurance. Space and resource limits in VA specialized treatment programs can result in unmet needs, as in the following cases.

- Specialized VA post-traumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist, particularly for inpatient treatment. Although private insurance generally includes mental health benefits, private sector providers generally lack the expertise in treating war-related stress that exists in the VA system.
- Inadequate numbers of beds are available in the VA system to care for homeless veterans. For example, VA had only 11 beds available in the San Francisco area to meet the needs of an estimated 2,000 to 3,000 homeless veterans.
- Public and private insurance do not provide extensive coverage of long-term psychiatric care. Veterans needing such services must either rely on state programs or the VA system to meet their needs.
- VA is a national leader both in research on and treatment and rehabilitation of people with spinal cord injuries. Similarly, it is a leader in programs to treat and rehabilitate the blind. Although such services are available in the private sector, the costs of such services can be catastrophic.

Legislation enacted last year that expanded VA's ability to contract with private sector facilities and providers gives VA an opportunity to better meet the health care needs of low-income veterans and those with service-connected conditions who previously were unable to obtain needed care because VA facilities were geographically inaccessible.

Two years ago, we suggested that the VA health care system retarget resources used to provide care for higher-income veterans with nonservice-connected conditions toward lower-income veterans and those with service-connected conditions whose health care needs were not being met.[7] VA, however, through its current legislative proposals, appears to be focusing its marketing efforts on attracting higher-income veterans with other health care options rather than using its expanded contracting authority to target its available resources toward meeting the needs of service-connected and uninsured veterans who lack other health care options.

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

Data from VA's Income Eligibility Verification System show that about 15 percent of the veterans using VA facilities who have no service-connected disabilities have incomes of $20,000 or more. VA could use the resources spent to provide services to such higher-income nonservice-connected veterans to strengthen its ability to fulfill its safety net mission. For example, the resources could be used to

- expand outreach to medically underserved populations, such as homeless veterans;
- expand programs that address special care needs; or
- contract for hospital and other service for lower-income, uninsured veterans who do not live near VA facilities.

Our review of the draft strategic plans developed by the 22 VISNs, however, found little mention of plans to conduct outreach to veterans with limited health care options or special care needs. Nor did these plans specifically address expanding services for low-income uninsured veterans.

The establishment of additional community-based outpatient clinics will address the unmet needs of some uninsured veterans. Most of the resources spent on CBOCs, however, will likely be spent on veterans who have other health care options. This reduces the resources available to provide services to uninsured veterans.

The legislative proposals contained in VA's fiscal year 1998 budget request would target veterans with other health care options. VA claims that it will be able to cut its per-user costs by 30 percent only if it is given funds to expand the number of veterans it serves by 20 percent and allowed to keep all of the funds it recovers from private health insurance and Medicare. The new users VA anticipates attracting either have private health insurance or are higher-income Medicare beneficiaries. The proposal to allow VA to keep all medical care cost recoveries could create strong financial incentives for VA to market its services to veterans who have no service-connected disabilities as well as private insurance.

Similarly, VA is seeking authority to bill and retain recoveries from Medicare for services provided to higher-income Medicare-eligible veterans. Like recoveries from private health insurance, such Medicare subvention would create incentives for VA to market services to higher-income veterans with both Medicare and Medigap coverage rather than to lower-income Medicare-eligible veterans.

VA's proposals create the potential for its receiving duplicate payments for services provided to privately insured and Medicare-eligible veterans. In other words, unless changes are made in how VA develops its budget request, it would receive both an appropriation to cover its costs of providing services to privately insured and higher-income Medicare-eligible veterans and payments from insurers and Medicare to cover those same costs.

Although the 22 VISNs' draft strategic plans discuss efforts to increase market share and attract new users, few plans contain any mention of targeting marketing efforts to veterans potentially having the greatest need for VA services—veterans with service-connected disabilities and those with low incomes and no health insurance.

Long-Term Care Needs of an Aging Population

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. But Medicare and most private health insurance cover only short-term, post-acute nursing home and home health care. Although private long-term care insurance is a growing market, the high cost of policies places such coverage out of reach of many veterans. As a result, most veterans must pay for long-term nursing home and home care services out of pocket until they spend down most of their income and assets and qualify for Medicaid assistance. After qualifying for Medicaid, they are required to apply almost all of their income toward the cost of their care.

About a third 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 particular 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 of age are in need of nursing home care, compared with about 13 percent of those 65 to 69 years old.

VBA Faces Multiple Challenges

VBA also faces several important challenges in administering VA compensation and pension programs. Specifically,

- the disability rating schedule has not been updated for over 45 years and no longer reflects the lost earning potential resulting from some disabilities;

- VA, like other federal agencies, could be unable to issue compensation and pension checks at the beginning of the year 2000 unless it is able to reprogram its computers to recognize the next century;
- veterans frequently wait over 2 years for resolution of disability compensation and pension claims; and
- hundreds of millions of dollars in overpayments of compensation and pension benefits are made because VBA does not focus on prevention.

Updating the Disability Rating Schedule

VA's disability program is required by law to compensate veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during military service. These injuries or conditions are referred to as "service-connected" disabilities. Veterans with such disabilities are entitled to monthly cash benefits under this program even if they are working and regardless of the amount they earn.

In fiscal year 1995, VA paid about $11.3 billion to approximately 2.2 million veterans who were on VA's disability rolls at that time. Over the past 50 years, the number of veterans on the disability rolls has remained fairly constant.

The amount of compensation veterans with service-connected conditions receive is based on the "percentage evaluation," commonly called the disability rating, that VA assigns to these conditions. VA uses its "Schedule for Rating Disabilities" to determine which rating to assign to a veteran's particular condition. VA is required by law to readjust the schedule periodically on the basis of "experience."

Since the 1945 version of the schedule was developed, questions have been raised on a number of occasions about the basis for these disability ratings and whether they reflect veterans' current loss in earning capacity. Although the ratings in the schedule have not changed substantially since 1945, dramatic changes have occurred in the labor market and in society. VA has done little since 1945 to help ensure that disability ratings correspond to disabled veterans' average loss in earning capacity. Basing disability ratings at least in part on judgments of loss in functional capacity would help to ensure that veterans are compensated to an extent commensurate with their economic losses and that compensation funds are distributed equitably.

Addressing the Year 2000 Computer Problem

VA, like other federal agencies, faces serious problems with its computer systems that will occur in the year 2000. This year, we added the "year 2000 computer problem" to our list of "high-risk" federal management areas.[8] Unless agency computers are reprogrammed, the year 2000 will be interpreted as 1900. This could create a major problem for VA, beginning in January 2000, with its monthly processing of over 3 million disability compensation and pension checks, totaling about $1.5 billion, to veterans and their survivors. Unless the "year 2000" problem is corrected, VA's computer system for processing these checks will either produce inaccurate checks, or produce no checks at all. VA would then have to process the checks manually, causing severe delays to veterans and survivors in receiving their benefits.

VA needs to move quickly to (1) inventory its mission-critical systems; (2) develop conversion strategies and plans; and (3) dedicate sufficient resources to conversion, and adequate testing, of computer systems before January 1, 2000. We recently published draft guidance for agencies to use in planning, managing, and evaluating their efforts to deal with this problem.[9] We are currently reviewing VBA's efforts to deal with the "year 2000" problem and plan to report to the Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, this spring.

Improving Claims Processing for Compensation and Pension Benefits

Slow claims processing and poor service to customers have long been recognized as critical concerns for VA. As early as 1990, VA began encouraging regional offices to develop and implement improvements in their claims processing systems; but instead of decreasing, processing times and backlogs increased. At the end of fiscal year 1994, almost 500,000 claims were waiting for a VA decision. About 65,000 of these claims were initial disability compensation claims. On average, veterans waited over 7 months for their initial disability claims to be decided; if veterans appealed these decisions, they could wait well over 2 years for a final decision.

In 1995, we reported that VA needed better assessments to guide its claims processing improvements.[10] We stated that VA had not developed adequate

[8]1997 High-Risk Series: Information Management and Technology (GAO/HR-97-9, Feb. 1997).

[9]Year 2000 Computing Crisis: An Assessment Guide (GAO/AIMD-10.1.14, Exposure Draft, Feb. 1997).

[10]Veterans' Benefits: Better Assessments Needed to Guide Claims Processing Improvements (GAO/HEHS-95-25, Jan. 13, 1995).

evaluation plans to allow it to judge the relative merit of its various initiatives. Without such information, VA will not have a sound basis for determining what additional changes, if any, should be made and for guiding future improvement efforts. In addition, VA did not have a formal mechanism to disseminate information about the content and effectiveness of various regional office initiatives to allow other regional offices to learn from the experiences.

VA is proposing a redesign of its claims processing system that would incorporate several initiatives. VA has conducted a business process reengineering effort on its compensation and pension claims processing system. VA has also established claims processing goals that include completing original compensation claims within 53 days by eliminating unnecessary tasks, reducing the number of hand-offs involved in the process, making information technology changes, and providing additional training for rating specialists. However, it is unclear at this time how successful these initiatives will be, how they will be evaluated, and how regional offices' experiences will be shared. VBA officials told us that the claims backlog has been reduced from 500,000 to about 326,000 as a result of VBA's actions.

Preventing Overpayments

Despite its responsibility to ensure accurate benefit payments, VA continues to overpay veterans and their survivors hundreds of millions of dollars in compensation and pension benefits each year. For example, at the end of 1996, VA's outstanding overpayments exceeded $500 million.

VA has the capability to prevent millions of dollars in overpayments but has not done so because it has not focused on prevention. For example, we reported in April 1995 that VA did not use available information, such as when beneficiaries will become eligible for Social Security benefits, to prevent related overpayments from occurring.[11] Furthermore, VA did not systematically collect, analyze, and use information on the specific causes of overpayments that would help it target preventive efforts.

VA has taken actions in response to our 1995 report, but some actions have not been completed. For example, VA has installed programming changes that will identify beneficiaries who will soon become eligible for Social Security benefits. However, it has not completed its analysis of other

[11]Veterans' Benefits: VA Can Prevent Millions in Compensation and Pension Overpayments (GAO/HEHS-95-88, Apr. 28, 1995).

causes of overpayments nor developed strategies for targeting additional preventive efforts.

VA Is Responding to Recent Legislative Management Reform Requirements

The Congress, through recent legislation, established a framework to help federal agencies (1) improve their ability to address long-standing management challenges and (2) meet the need for accurate and reliable information for executive branch and congressional decision-making. This framework includes

- GPRA, which is designed to improve federal agencies' performance by requiring them to focus on their missions and goals, and on the results they provide to their customers—for veterans and their families;
- the CFO Act of 1990, as amended by the Government Management Reform Act, designed to improve the timeliness, reliability, usefulness, and consistency of financial information in federal agencies; and
- the Paperwork Reduction Act of 1995 and the Clinger-Cohen Act of 1996, which are intended to improve agencies' ability to use information technology to support their missions and improve performance.

VA has begun to implement these acts, which can help it (1) develop fully integrated information about its mission and strategic priorities, (2) develop and maintain performance data to evaluate achievement of its goals, (3) develop accurate and audited financial information about the costs of achieving VA's results-oriented mission, and (4) improve the relationship of information technology to the achievement of performance goals.

Improving Mission Performance and Results

GPRA requires that agencies consult with the Congress and other stakeholders to clearly define their missions. It also requires that they establish long-term strategic goals, as well as annual goals linked to them. They must then measure their performance against the goals they have set and report publicly on how well they are doing. In addition to ongoing performance monitoring, agencies are expected to identify performance gaps in their programs, and to use information obtained from these analyses to improve the programs.[12] Under GPRA, VA and other federal agencies must complete strategic plans by September 30, 1997.

[12]Executive Guide: Effectively Implementing the Government Performance and Results Act (GAO/GGD-96-118, June 1996) and Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

While VA has not yet completed its GPRA strategic plan, its fiscal year 1998 budget submission to the Congress includes some of the elements of the GPRA planning process. The budget submissions for both of VA's largest components—VHA and VBA—included strategic planning documents. Both the VHA and VBA plans included overall mission statements; identification of customers and stakeholders; program goals and objectives; and performance measures related to the goals and objectives.

VHA's strategic plan, as stated in its fiscal year 1998 budget submission, is based on five goals developed in March 1996 by the Under Secretary for Health.[13] VHA then attached objectives and performance measures to each goal. For the first goal—"Provide Excellence in Healthcare Value"—VHA stated three objectives: (1) deliver the best health care outcomes at the lowest cost to the largest number of eligible veterans, (2) change VHA from a hospital-based to an ambulatory-based system, and (3) establish primary care as the central focus of patient treatment. To measure progress toward achieving VHA's goals, it proposed eight performance measures. For the second objective, for example, VHA plans to increase the percentage of appropriate surgical and invasive diagnostic procedures performed on an ambulatory basis from 52 percent in fiscal year 1996 to 65 percent in fiscal year 1998.

VBA's strategic planning process began in July 1995, with definitions of its mission, goals, and core performance measures. As stated in the fiscal year 1998 budget submission, VBA's mission is to "provide benefits and services to veterans and their families in a responsive, timely and compassionate manner in recognition of their service to the nation." To accomplish this mission, VBA has set out four goals: (1) improve responsiveness to customer needs and expectations, (2) improve service delivery and benefit claims processing, (3) ensure the best value for the available taxpayers' dollar, and (4) ensure a satisfying and rewarding work environment. The plan is then broken down by VBA's major program areas. For example, the Compensation and Pension program area has performance indicators to measure progress in meeting VBA's goal of improving service delivery and benefit claims processing by

- reducing the processing time for original compensation and pension claims from 144 days in fiscal year 1996 to 53 days in fiscal year 2002 and
- raising the accuracy rate for original compensation claims from 90 percent in fiscal year 1996 to 97 percent in fiscal year 2002.

[13]Under Secretary for Health, VA, Prescription for Change (Washington, D.C.: VA, Mar. 1996).

We are currently reviewing VA and other agencies' initial implementation of GPRA. As required under the legislation, we will report by June 1, 1997, on GPRA implementation and the prospects for governmentwide compliance.

We would be happy to assist the Congress in reviewing draft and final VA submissions under GPRA, including strategic plans, performance plans, performance reports, evaluations, and related VA performance information.

Improving Financial Management and Accountability

The CFO Act was designed to remedy decades of serious neglect in federal financial management and accountability by establishing a financial management leadership structure and requirements for long-range planning, audited financial statements, and strengthened accountability reporting. The act created CFO positions and a financial management structure at each of the major agencies. The CFO Act, as expanded in 1994, requires VA, as well as other major agencies, to prepare annual financial statements, beginning with those for fiscal year 1996.

VA has established a sound financial management structure; in addition to the Assistant Secretary for Management, who serves as CFO, VHA and VBA each has a CFO. Also, VHA plans to have a CFO position in each of its 22 VISNs. VA met the requirement to prepare, and have audited, annual financial statements beginning with those for fiscal year 1986.

VA's response to the CFO Act has led to a number of financial management improvements, including

- the installation of VA's Financial Management System, which gives VA, for the first time, an integrated financial management system;
- improvements in reporting of receivables and property management, due to the implementation of the financial management system, that resulted in the first issuance by a VA Inspector General of an unqualified opinion on VA's Statement of Financial Position on September 30, 1996;[14] and
- the consolidation of debt collection activities at VBA's Debt Management Center in St. Paul, Minnesota, to take full advantage of debt management tools.

[14]Office of Inspector General, VA, Audit of Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 1996 and 1995, 7AF-G10-051 (Washington, D.C.: VA, Feb. 25, 1997).

The Inspector General's audit of VA's fiscal year 1996 financial statement disclosed six internal control weaknesses that expose VA to significant financial risks:

- errors in accounting for property, plant, and equipment, which could result in a future qualification of opinion if not corrected;
- errors by medical facilities in recording estimated amounts of unbilled services and in estimating uncollectible amounts;
- failure to cancel approximately $69 million in open obligations that should have been cancelled before the end of the fiscal year—funds that could have been reprogrammed and used for other valid needs if they had been identified before the appropriations expired;
- an outdated data processing system for VA's life insurance programs that has the potential to adversely affect the complete and accurate processing of insurance transactions and the integrity of the financial information generated by the system;
- insufficient VA management emphasis on, and oversight of, VA data processing facilities to ensure that data processing systems are protected from unauthorized access and modification of data; and
- lack of an integrated financial accounting system for VA's Housing Credit Assistance Program which, when coupled with the complexities of accounting requirements under credit reform, increases the risk of financial reporting error.

Improving Information Management and the Use of Information Technology

The Paperwork Reduction Act of 1995 provides basic guidance to federal agencies on acquiring and managing information resources. It is based on the concept that information resources should support agency missions and performance. It requires that information resources management plans delineate the resources that are needed and explain how the agency plans to minimize the paperwork burden on the public and the cost to the government of collecting information. The Clinger-Cohen Act of 1996 reinforces this guidance, and adds requirements designed to promote the use of information technology to better support agencies' missions and performance. It is primarily concerned with the need to ensure that agencies have systems to prioritize information technology investments. Clinger-Cohen also requires that a qualified senior-level chief information officer be appointed to guide all major information resource management activities. Both acts require agencies to set goals, measure performance, and report on progress in improving the efficiency and effectiveness of

information management in general, and the acquisition and use of information technology in particular.

VA has made efforts to improve its information management systems, including the appointment of the Assistant Secretary for Management as VA's Chief Information Officer. The Clinger-Cohen Act requires, however, that information resources management be the primary function of an agency's chief information officer. This is not the case in VA, because the Assistant Secretary for Management is not only VA's Chief Information Officer, but is also responsible for its Offices of Financial Management, Budget and Acquisition, and Materiel Management. The Office of Management and Budget (OMB) has questioned whether information management is the "primary function" of the Assistant Secretary for Management, and whether VA is in compliance with the Clinger-Cohen Act. In August 1996, OMB asked VA to reevaluate the placement of its chief information officer function and report within a year on how it will come into compliance with the Clinger-Cohen requirement.

VBA's information technology efforts have yielded some improvements in its hardware and software capabilities. However, our reviews of information management in VBA have identified problems that need to be addressed. One is the need for VBA to develop credible strategic business and information resources management plans.[15] VBA has undertaken several initiatives to improve claims processing efficiency and reduce its large backlog of unprocessed claims. But it has done so without an overall business strategy clearly setting forth how it would achieve its goals. Instead, VBA has used stopgap measures to deal with its claims processing problems. While these measures have improved processing times and reduced the claims backlog, VA needs to find other solutions.

Another challenge for VBA is to do a better job of managing its information technology development projects as investments. Our reviews of VBA's information technology initiatives show that VBA lacks the critical cost, benefit, and risk information to determine whether investments it is considering are worthwhile.[16] The next step would be to determine what it needs to meet its information resource management priorities. VBA needs to develop the tools needed to follow a three-phased management approach for selecting, controlling, and evaluating information

[15]Veterans Benefits Modernization: Management and Technical Weaknesses Must Be Overcome if Modernization Is to Succeed (GAO/T-AIMD-96-103, June 19, 1996).

[16]VBA Information Technology Investment (GAO/AIMD-97-10R, Oct. 18, 1996).

technology-related projects. It also needs to develop a process to rank and prioritize information technology investments as a consolidated portfolio.

A third challenge for VBA is to improve its software development capability. Once agencies have identified their top priority information technology projects, they must be able to determine whether the project should be developed in-house or contracted out. Our review of VBA's software development capabilities found that, on a scale of software development maturity, VBA was in the "least mature" category.[17] Thus, VBA cannot reliably develop and maintain high-quality software within existing cost and schedule constraints. This, in turn, places VBA's information technology modernization efforts at significant risk. We made several recommendations to address this issue. These recommendations and VA's responses follow:

- Obtain expert advice on developing high-quality software. VBA is working with the Air Force, under an interagency agreement, to implement this recommendation.
- Develop a plan to achieve a higher level of software development maturity. VBA has developed such a plan and has taken other actions to improve software development maturity.
- Require that future software development contracts specify that services be obtained from contractors with at least a level 2 (on a scale of 1 to 5, with 5 being the highest level) rating. According to VBA, it plans to award a general software contract with a provision regarding the necessary software development skills.

Options for Reducing the Budget Deficit Through Changes in VA Programs and Benefits

We periodically report to the Congress on options for reducing the budget deficit. Our latest report, issued March 14, 1997, identified a series of potential changes in veterans' benefits and VA programs that could contribute many billions of dollars toward deficit reduction over the next 5 years.[18] Some of the options involve management improvements that could be achieved by the agency. Others, however, would require fundamental policy changes in veterans' benefits, including changes in entitlement programs.

[17]Software Capability Evaluation: VA's Software Development Process Is Immature (GAO/AIMD-96-90, June 19, 1996).

[18]Addressing the Deficit: Budgetary Implications of Selected GAO Work for Fiscal Year 1998 (GAO/OCG-97-2, Mar. 14, 1997).

Eliminate Veterans' Disability Compensation for Nonservice-Connected Diseases

During 1996, VA paid approximately $1.7 billion in disability compensation payments to veterans with diseases neither caused nor aggravated by military service. In 1996, the Congressional Budget Office (CBO) reported that about 230,000 veterans were receiving about $1.1 billion annually in VA compensation for these diseases. Other countries we contacted do not compensate veterans under such circumstances. If disability compensation payments to veterans with nonservice-connected, disease-related disabilities were eliminated in future cases, 5-year savings could, CBO estimated, exceed $400 million.

Eliminate Certain VA Contracts With State Approving Agencies

In fiscal year 1994, VA spent more than $1 billion in educational assistance benefits to more than 450,000 beneficiaries. In addition, it spent over $12 million on contracts with state approving agencies to assess whether schools and training programs offer education of sufficient quality for veterans to receive VA education assistance benefits when attending them. An estimated $10.5 million of the $12 million paid to state approving agencies was spent to conduct assessments that overlapped assessments performed by the Department of Education. CBO estimated that at least $50 million could be saved over the next 5 years if the Congress directed VA to discontinue contracting with state approving agencies to review and approve educational programs at schools that have already been reviewed and certified by Education.

Impose Cost Sharing for Veterans' Long-Term Care Services

State veterans' homes recover as much as 50 percent of the costs of operating their facilities through charges to veterans receiving services. Similarly, Oregon recovers about 14 percent of the costs of nursing home care provided under its Medicaid program through estate recoveries. In fiscal year 1990, VA recovered less than one-tenth of 1 percent of its costs for providing nursing home care through beneficiary copayments.

Potential recoveries appear to be greater within the VA system than under Medicaid. Home ownership is significantly higher among VA hospital users than among Medicaid recipients, and veterans living in VA nursing homes generally contribute less toward the cost of their care than do Medicaid recipients, allowing veterans to build larger estates.

If the Congress authorized VA to increase cost sharing for VA nursing home care by adopting cost sharing requirements similar to those imposed by most state veterans' homes and implementing an estate recovery program similar to those operated by many states under their Medicaid programs,

billions of dollars could be saved through the increased revenues. For example, if VA recovered 25 percent of its costs of providing nursing home care through a combination of cost sharing and estate recoveries, it would save about $3.4 billion over the next 5 years.

Establish Independent Preadmission Certification

VA hospitals too often admit patients whose care could be more efficiently provided in alternative settings, such as outpatient clinics or nursing homes. Our studies and those of VA researchers and the VA Inspector General have found that over 40 percent of VA hospital admissions and days of care were not medically necessary.

Private health insurers generally require their policyholders (or their physicians) to obtain authorization from them or their agent prior to admission to a hospital. Failure to obtain such preadmission certification can result in denial of insurance coverage or a reduction in payment.

We have recommended that VA establish an independent preadmission certification program.[19] Although VA, in September 1996, required its VISNs to establish a preadmission review program, the review programs are run by the hospitals rather than by external reviewers and do not provide any direct financial incentive for facilities to adhere to the decisions of their reviewers. While the preadmission reviews are likely to have some effect on inappropriate admissions, they may not be effective unless coupled with a financial penalty for noncompliance with review findings.

CBO estimated that if VA were to establish precertification procedures similar to those used by private health insurers which, result in a 40-percent reduction in admissions and days of care, VA's medical care spending could be reduced by $8.4 billion over 5 years.

Delay Funding of Veterans' Medical Facilities

Historically, VA has submitted a budget request for hundreds of millions of dollars in major health care construction projects. The requests have typically included construction or renovation of one or more hospitals.

Long-term commitments for any major construction or renovation of predominantly inpatient facilities in today's rapidly changing health care environment are accompanied by high levels of financial risk. VA's recent commitment to a major realignment of its health care system magnifies

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

such risk by creating additional uncertainty. In addition, we believe that analyzing alternatives to major construction projects is entirely consistent with VA's suggested realignment criteria. Delaying funding for major construction projects until the alternatives can be fully analyzed may result in more prudent and economical use of already scarce federal resources.

The potential savings of delaying funding for VA hospital construction are uncertain in the absence of an assessment of VA's needs based on its own realignment criteria. CBO estimates that if the Congress did not approve funding of any major construction projects until after VA has completed its realignment, savings totaling more than $1.2 billion could be achieved over 5 years.

VA's fiscal year 1998 budget submission and its recent decision not to pursue construction of a new VA hospital in East Central Florida are consistent with this option. VA is seeking only $48 million for major medical construction for fiscal year 1998.

Close Underused Hospitals

Although VA took over 50,000 hospital beds out of service between 1970 and 1995, it did not close any hospitals on the basis of declining utilization. With the declining veteran population, new technologies, and VA's efforts to improve the efficiency of its health care system, significant further declines in demand for VA hospital care are likely.

While closing wards saves some money by reducing staffing costs, the cost per patient treated rises because the fixed costs of facility operation are distributed among fewer patients. At some point, closing a hospital and providing care either through another VA hospital or through contracts with community hospitals may become less costly than simply taking beds out of service.

Potential savings from hospital closures are difficult to estimate because of uncertainties about which facilities would be closed, the increased costs that would be incurred in providing care through other VA hospitals or contracts with community hospitals, and the disposition of the closed facilities.

Limit Growth of VA Medical Care Account

As discussed earlier, the VA health care system should be able to significantly contribute to deficit reduction during the next 5 years. First,

the system does not need to expend the level of resources that VA has previously estimated to meet the health care needs of veterans. These resources are overstated because VA did not adequately consider the declining demand for VA hospital care in estimating its resource needs and because eligibility for VA care has been reformed—which, according to VA, will allow it to divert 20 percent of its hospital admissions to less costly outpatient settings. Second, VA could reduce its operating costs by billions of dollars over the next 5 years by completing a wide range of efficiency actions. VA recognizes that it can reduce its costs per user by 30 percent over the next 5 years but plans to use the savings to expand its market share by 20 percent.

We recently recommended that VA provide the Congress information on the savings achieved through improved efficiency in support of its budget request. We noted that providing the Congress with information on factors, such as inflation and creation of new programs, which increase resource needs, without providing information on changes that could reduce or offset those needs leaves the Congress with little basis for determining appropriate funding levels. VA, however, has been unwilling to provide such information to the Congress.

One way for the Congress to respond to VA's unwillingness to provide information on savings from improved efficiency would be to limit the VA medical care appropriation at the fiscal year 1997 level for the next 5 years. CBO estimates that this would result in almost $9 billion in savings.

Limit Enrollment in VA Health Care System

Recently enacted legislation expands eligibility for VA health benefits to make all veterans eligible for comprehensive inpatient and outpatient services, subject to the availability of resources. The legislation also requires VA to establish a system of enrollment for VA health care benefits and establishes enrollment priorities to be applied, within appropriated resources. The lowest priority for enrollment is veterans with no service-connected disabilities and high enough incomes to place them in the discretionary care category.

VA, however, does not currently provide the Congress enough information on the types of veterans it serves to enable the Congress to make informed judgments about which portion of VA's proposed workload to fund. We found that about 15 percent of veterans with no service-connected disabilities who use VA medical centers have sufficiently high incomes to place them in the lowest priority category under the new patient

enrollment system. If the Congress funded the VA health care system to cover only the expected enrollment of veterans in higher priority enrollment categories, such as veterans with service-connected disabilities and veterans without the means to obtain public or private insurance to meet their basic health care needs, CBO estimates that $1.7 billion in budget authority, adjusted for inflation, could be saved over 5 years.

Reduce Outpatient Pharmacy Costs

VA pharmacies dispense to veterans over 2,000 types of medications and medical supplies that are available over-the-counter (OTC) through local retail outlets. Such products were dispensed more than 15 million times in 1995 at an estimated cost of $165 million. The most frequently dispensed items include aspirin, dietary supplements, and alcohol prep pads.

Unlike VA, other public and private health programs cover few, if any, OTC products for their beneficiaries. Our assessment of VA's operating practices suggests several ways that budget savings could be achieved. First, VA could more narrowly define when to provide OTC products, reducing the number of OTC products available to veterans on an outpatient basis. Second, VA could collect copayments for all OTC products. CBO estimated that these steps could save over $350 million over the next 5 years.

Extend Expiring Authorities

Legislation initially enacted in 1990 gave VA access to Internal Revenue Service tax data and Social Security Administration earnings records to help VA verify incomes reported by beneficiaries. Since then, millions of dollars in savings have been achieved in VA's health and pension programs as a result of VA's income verification program.

Authority for the program will, however, expire on September 30, 1998. Extending the authority could generate over $115 million in savings between fiscal years 1999 and 2002.

Conclusion

VA is using the management framework created by recent legislation in major restructuring of its health and benefits programs. Both VHA and VBA have developed strategic plans. Those plans, and progress toward meeting the goals contained in them, are included in VA's fiscal year 1998 budget submission. Similarly, VA is a leader in attempting to develop sound financial management, having prepared audited financial statements for over 10 years. However, VA has not fully complied with recent legislation in the area of information management, and it is working with OMB to resolve

differences with respect to its compliance with the Paperwork Reduction Act and the Clinger-Cohen Act.

VA's progress in strengthening its management should help it address the multiple challenges facing its health and benefits programs. Under the leadership of the Under Secretary for Health, the VA health care system has made significant progress during the past 2 years in improving both its efficiency and its image. In addition, actions to expand eligibility, make it easier for VA to buy services from and sell services to the private sector, improve access, and reduce waiting times place VA in a better position to compete with private sector providers for declining numbers of veterans.

VA and the Congress, however, are faced with difficult choices.

- Should VA hospitals be opened to veterans' dependents or other nonveterans as a way of increasing efficiency and preserving the system? What effect would such decisions have on private sector hospitals?
- To what extent should the government attempt to capture market share from private sector providers? Should the government subsidize its facilities in order to capture market share?
- Should some of VA's acute care hospitals be closed, converted to other uses, transferred to states or local communities, or sold to developers?
- Should VA remain primarily a direct provider of veterans' health care or become a virtual health care system in which it contracts with private sector providers rather than operating its own facilities?
- To what extent should the VA system address the unmet needs of uninsured veterans and those with service-connected disabilities?

Decisions regarding these and other questions will have far-reaching effects on veterans, taxpayers, veterans facilities and the VA employees working in them, and private providers.

Because of the historic inefficiency of the VA system, the changes currently taking place provide many opportunities for the VA health care system to contribute toward deficit reduction while still improving services to current users. Limiting the system to current users, however, could facilitate declines in hospital use and lead ultimately to closure of VA hospitals.

The declining veteran population in the United States, in concert with the increased availability of community-based care, makes preserving the current acute care workload of existing VA health care facilities

exceedingly difficult. VA will have to attract an ever-increasing proportion of the veteran population if it is to keep its acute care hospitals open. VA's fiscal year 1998 budget submission outlines its strategy for preserving its hospitals: it wants to increase its users by 20 percent in order to make more efficient use of existing VA facilities. The new users VA is targeting generally have other health care options available to them.

The cost of maintaining VA's direct delivery infrastructure limits VA's ability to ensure similarly situated veterans equal access to VA health care. VA's interest in providing services to veterans in the discretionary care category at VA hospitals and outpatient clinics is likely to limit its ability to provide services to low-income and service-connected veterans through the use of contract care.

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

Contributors

For more information on this testimony, call Jim Linz, Assistant Director, at (202) 512-7110. Greg Whitney also contributed to this statement.

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