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Report to the Chairman, Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate

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VA HEALTH CARE

Opportunities for Service Delivery Efficiencies Within Existing Resources

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The Honorable Christopher S. (Kit) Bond
Chairman, Subcommittee on VA, HUD,
and Independent Agencies
Committee on Appropriations
United States Senate

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) operates one of the nation's largest health care systems with 173 hospitals, 376 outpatient clinics, 136 nursing homes, and 39 domiciliaries. With a fiscal year 1995 appropriation of $16.2 billion and budget requests of about $17 billion for fiscal years 1996 and 1997, VA's system faces increasing pressures to contain or reduce spending as part of governmentwide efforts to balance the budget.[1]

This report responds to your request for information on ways VA could operate more efficiently, reducing the resources needed to meet the health care needs of veterans in what is commonly referred to as the mandatory care category. Specifically, it addresses (1) VA's forecasts of future resource needs, (2) opportunities to operate VA's system more efficiently, (3) differences between VA and the private sector in efficiency incentives, and (4) recent VA efforts to reorganize its health care system and create efficiency incentives.

Scope and Methodology

During the past several years, we have visited over 75 VA hospitals and outpatient clinics to assess operating policies, procedures, and practices. These efforts have resulted in a wide range of recommended actions to improve the efficiency and effectiveness of the VA system. Some of these actions involve ways to restructure existing delivery processes to lower costs; others identify ways to recover more of the costs of health care provided to veterans and others. This report is based primarily on the results of these efforts as well as studies by the Veterans Health Administration (VHA), VA's Office of Inspector General (IG), and others. We initially presented the results of this work in testimony before your Subcommittee on March 8, 1996.[2]

[1]VA received a medical care appropriation of about $16.6 billion for fiscal year 1996.

[2]VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

Results in Brief

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

The success of these efforts, however, depends on the extent to which VA and its health care facilities are held accountable for how they spend appropriated funds. Unlike private health care providers, VA's system bears few of the risks associated with inefficient operating practices and, as such, has scant economic incentive to reduce costs. VA managers frequently blame inefficiencies on the law, but this appears to us to be unfair. Historically, VA's central office provided few incentives for facilities to improve efficiency. The central office put little pressure on facilities to treat patients in the most cost-effective manner and shifted few resources among facilities to promote efficiency. At the facility level, however, VA managers often can find ways to operate more efficiently when they need resources to implement new services or expand existing ones.

Recent changes at VA are starting to create efficiency incentives that have long existed in the private sector. For example, VA's reorganization of its health care facilities into 22 Veterans Integrated Service Networks (VISN) includes several elements that show promise for providing the management framework needed to realize the system's full savings potential. First, VA plans to hold network directors accountable for 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 to guide VISN directors in developing efficiency initiatives capable of yielding large savings and (2) gave VISN and facility directors authority to realign medical centers to achieve efficiencies. Finally, VHA's plans to develop a capitation funding process could provide greater efficiency incentives, provided data problems are resolved.

Background

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

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

More specifically, VA must provide hospital care, and, if space and resources are available, may provide nursing home care to certain veterans with injuries related to their service or whose incomes are below specified levels. These mandatory care veterans include those who

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

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

VA also provides three basic levels of outpatient care benefits:

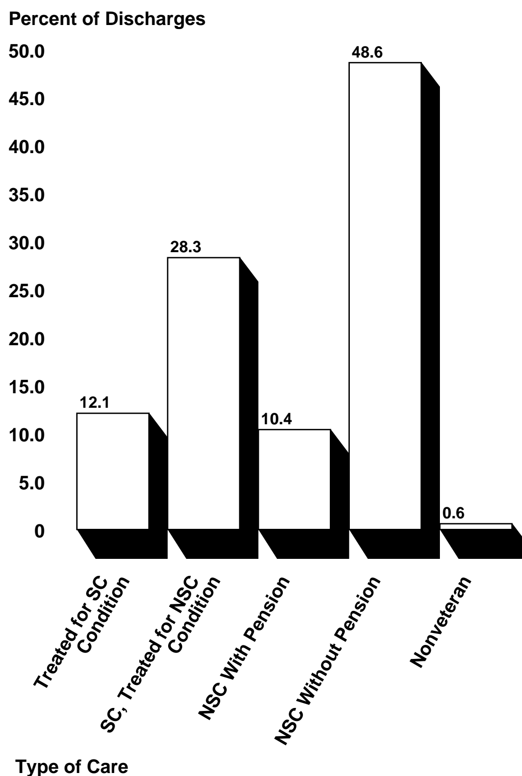
- comprehensive care, which includes all services needed to treat any medical condition;
- service-connected care, which is limited to treating conditions related to a service-connected disability; and

- hospital-related care, which provides only the outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay.

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

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

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

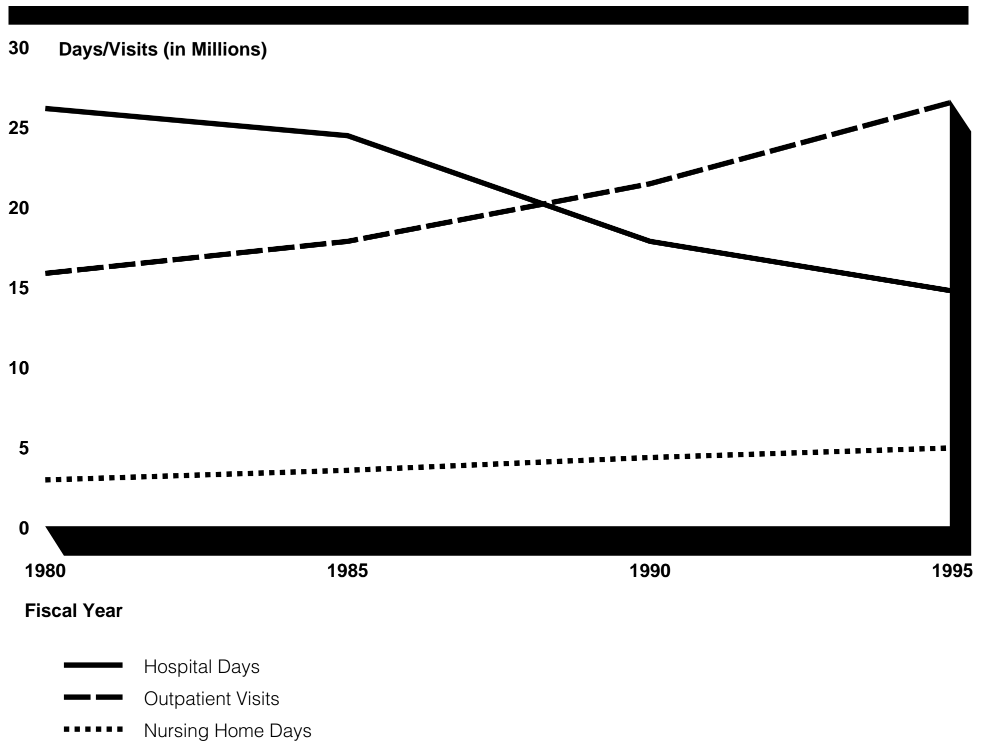


Notes: Data are based on the fiscal year 1995 VA patient treatment file.

SC = service connected; NSC = nonservice connected.

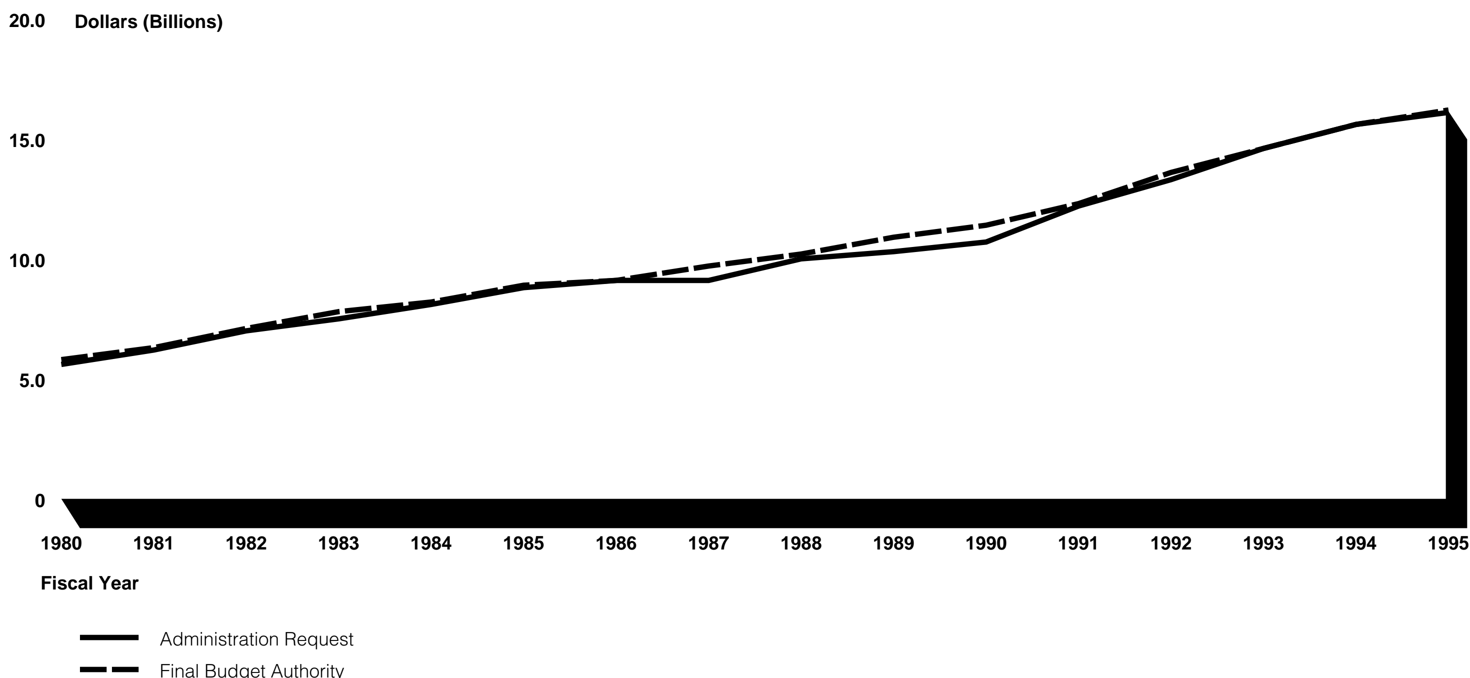
Between fiscal years 1980 and 1995, VA facilities underwent some fundamental changes in workload. The days of hospital care provided fell from 26 million in 1980 to 14.7 million in 1995, the number of outpatient visits increased from 15.8 million to 26.5 million, and the average number of veterans receiving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

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



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

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



Note: Numbers have not been adjusted for inflation.

For fiscal year 1996, VA sought medical care budget authority of about $17.0 billion, an increase of $747 million over its fiscal year 1995 authority. VA expects its facilities to provide (1) about 14.1 million days of hospital care, (2) nursing home care to an average of 14,885 patients, and (3) about 25.3 million outpatient visits. VA is also seeking budget authority of about $17.0 billion for fiscal year 1997.

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

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

to the veteran population through 2002.[3] As used by VA, current services encompass maintaining the currently funded workload, including services to veterans in both the mandatory and discretionary care categories and services to nonveterans.

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

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

- VA did not adequately consider the impact of the declining veteran population on future demand for inpatient hospital care.
- A significant portion of VA resources is used to provide services to veterans in the discretionary care category who are eligible for care only to the extent that space and resources are available.
- Considerable resources are spent on services not covered under veterans' VA benefits.
- Medical centers tend to overstate their workloads and therefore their resource needs.
- VA included resources for facility and program activations in estimating the resources it would need to maintain current services even though such activations would expand current services.[4]
- Services provided to nonveterans through sharing agreements are included in VA's justifications of future resource needs even though the provision of services through sharing agreements is to be limited to sales of excess capacity.

Declining Veteran Population Will Reduce Future Resource Needs

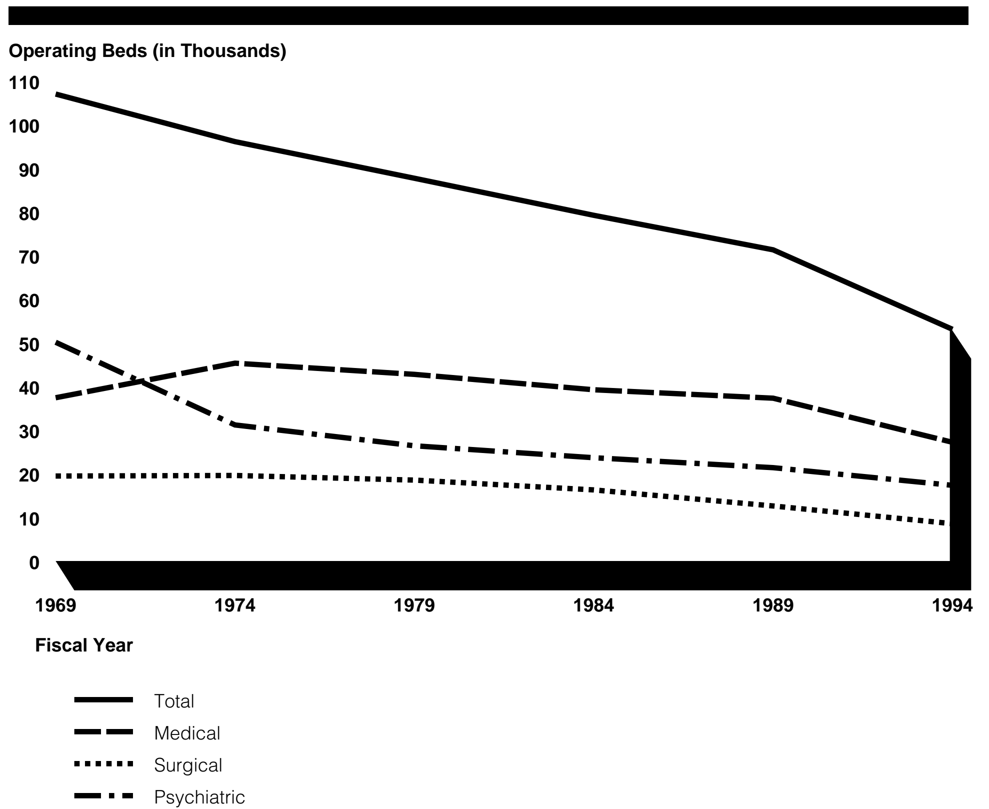
In estimating the resources it will need to maintain current services over the next 7 fiscal years, VA assumed that the number of hospital patients it treats will remain constant. The number of hospital patients VA treats, however, actually dropped by 56 percent over the past 25 years and should continue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

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

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

About 50,000 VA hospital beds were closed or converted to other uses. The decline in psychiatric beds was most pronounced: from about 50,000 beds in 1969 to 17,300 beds in 1994. (See fig. 4.)

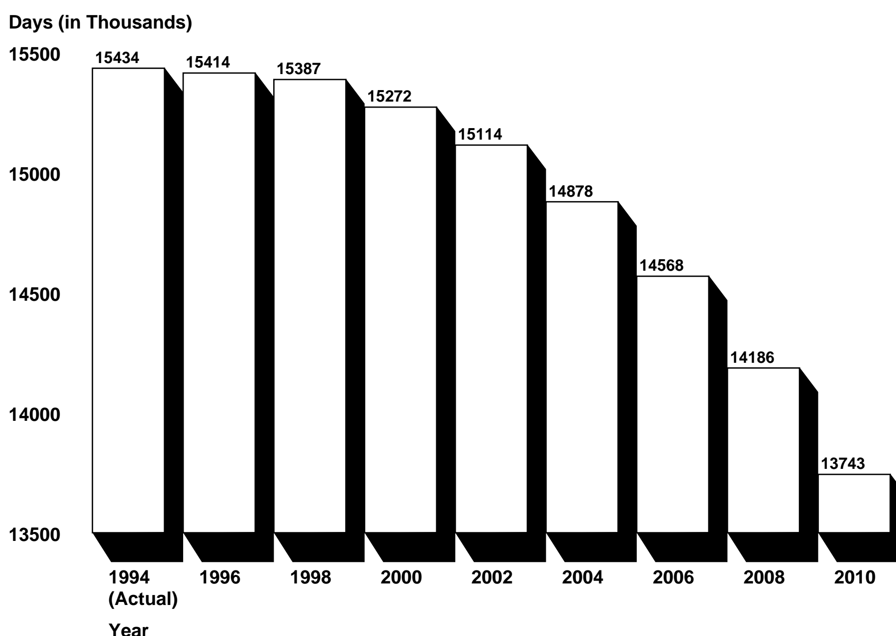
Figure 4: Operating Beds in VA Hospitals, FY 1969-94



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

Our projections are adjusted to reflect older veterans' higher usage of hospital care.[5]

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



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

Much VA Care Is Discretionary

VA has underestimated the extent to which its health care resources are spent on services for veterans in the discretionary care categories. Specifically, about 15 percent of the veterans with no service-connected disabilities who use VA medical centers have incomes that place them in the discretionary care category (that is, care may be provided to the extent that space and resources permit) for both inpatient and outpatient care by inpatient eligibility standards. In addition, VA incorrectly reported outpatient workload using inpatient eligibility categories, overestimating the amount of outpatient care subject to the availability of space and

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

resources. VA does not, however, differentiate between services provided to veterans in the mandatory and discretionary care categories in justifying its budget request. As a result, the Congress has little basis for determining which portion of VA's discretionary workload to fund.

A portion of VA's workload involves treating higher income veterans with no service-connected disabilities. In fiscal year 1991, about 10.7 percent of the 555,000 veterans receiving hospital care in VA facilities were veterans with no service-connected disabilities with incomes of $20,000 or more.[6] Of those using VA medical centers in 1991 for both inpatient and outpatient care, about 11 percent (91,520) of the single veterans with no service-connected disabilities (832,000) and 57 percent (227,430) of the married veterans with no service-connected disabilities (399,000) had incomes of $20,000 or more. Among married veterans with no service-connected disabilities who used VA medical centers, 15 percent (59,850) had incomes of $40,000 or more.[7]

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

Extensive Resources Spent on Noncovered Services

The VA IG further reported that about 56 percent of discretionary care outpatient visits provided services that were not covered under the veterans' VA benefits. Most veterans' outpatient benefits are limited to hospital-related care. An estimated $321 million to $831 million of the approximately $3.7 billion VA spent on outpatient care in fiscal year 1992

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

[7]In 1991, veterans without dependents were in the mandatory care category for inpatient hospital care and hospital-related outpatient care if they had incomes below $18,171; the income threshold increased by $3,634 for one dependent and $1,213 for each additional dependent.

may have been for treatments provided to veterans in the discretionary care category that were not covered under VA health care benefits.[8]

Medical Centers Tend to Overstate Workload

VA medical centers frequently overstate the number of inpatients and outpatients treated and therefore the centers' resource needs. VA has long had a problem with veterans failing to keep scheduled appointments. Once an outpatient visit is scheduled, however, medical center staff enter it into VA's computerized records, and it is counted as an actual visit unless staff delete the record.

VA's IG identified problems in the reporting of both inpatient care and outpatient visits at several medical centers. For example, the IG found that 9 percent of the visits at the Milwaukee VA medical center and 7 percent of the visits at the Murfreesboro medical center were not countable in the workload because the appointments were not kept.[9] Similarly, a 1994 VA IG report found that actual surgical workload at the Sepulveda VA medical center was 37 percent lower than reported.[10]

According to VHA, it acted in October 1992 to eliminate false workload credits. Facilities must now physically "check in" each patient to receive workload credit.

A September 1995 VA IG report, however, found that VA outpatient workload data are still overstated. In a nationwide review, the IG found that one out of three reported visits represented overreporting of workload data. Specifically,

- 6 percent of the reported visits either did not or appeared not to have occurred,
- 15 percent of the reported visits represented one or more clinic stops that either did not or appeared not to have occurred, and
- 14 percent of reported visits had inconsistencies in reporting of clinic stops.

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

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

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

Resource Needs for Activations Appear Overstated

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

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

In addition, the funds VA seeks for activations may be overstated because the activations planning process is not integrated with the resource planning and management (RPM) system workload forecasting process. VA sought about $108 million and 1,509 FTEs in its fiscal year 1996 budget submission to support a projected increase in the number of veterans seeking care. These estimates, based on workload forecasts developed through RPM, reflect historical trend data that could include workload increases resulting from prior years' facility and program activations. In other words, the resources requested for workload increases projected using RPM likely include resources for some of the estimated workload to be generated through fiscal year 1996 activations. VA sought an additional $208 million for facility activations on the basis of the separate activations planning process. VA officials agree that some double counting may have occurred because of the separate planning processes but believe that the duplication is minimal.

In commenting on a draft of this report, VHA said that it modified budgeting for activations requirements in 1997. The medical care request no longer includes "line item" requests for the activation of specific projects. The networks will activate projects from within the level of resources provided in their total 1997 medical care budget allocations.

VA Includes Sharing Agreement Workload in Budget Justification

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

Health resources sharing, which involves the buying, selling, or bartering of health care services, benefits both parties in the agreement and helps contain health care costs by better utilizing medical resources. For example, a hospital's buying an infrequently used diagnostic test from another hospital is often cheaper than buying the needed equipment and providing the service directly. Similarly, a hospital that uses an expensive piece of equipment only 4 hours a day but has staff to operate the equipment for 8 hours can generate additional revenues by selling its excess capacity to other providers.

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

In fiscal year 1995, VA sold about $25.3 million in specialized medical resources to private-sector hospitals and about $33.0 million in health care services to the military health care system. Although VA facilities received separate reimbursement for the workload generated through these sharing agreements, the workload was nevertheless included in VA's justification of its budget request.

In commenting on a draft of this report, VHA said that VA provided care to about 45,000 unique sharing agreement patients in 1994. VHA said that even though its base workload counts do include sharing, the levels are small and its inclusion of sharing makes no material difference in VA's workload presentations. VHA said that no appropriated funds are requested for the sharing workload because it is supported by reimbursements from DOD and other sharing partners.

VHA also said that RPM excludes data for sharing patients in developing changes in both unique patients and cost per unique patient. The actual patient counts for the last year are straightlined in all RPM projections.

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

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

In the past 5 to 10 years, VA's IG, VHA, the Vice President's National Performance Review, we, and others have identified many opportunities to

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

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

Use Lower Cost Methods for Delivering Health Care Services

Following are among the many opportunities to achieve savings through changes in the way VA delivers health care services to veterans, allowing VA facilities to provide services of equal or higher quality at a lower cost.

- Providing 90-day rather than 30-day supplies of low-cost maintenance prescriptions enabled VA pharmacies to save about $45 million in fiscal year 1995. The savings resulted because VA pharmacies handled over 15 million fewer prescriptions. Although VA encouraged its medical centers to implement multimonth dispensing in response to our January 1992 report, not all potential savings have occurred because medical centers have been slow to adopt multimonth dispensing.[11]

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

- Purchasing services from community providers when they can provide the care at a lower cost could also produce savings. VA has encouraged its medical centers to establish “access points” to improve accessibility for veterans and encourage the shift to primary care. Access points can be established as VA-operated outpatient clinics as well as through contractual or sharing agreements. To date, only a few medical centers have established such access points, but many others are developing plans. Early indications are that access points established through contracts with community providers can often provide services at lower cost than VA outpatient clinics. The ultimate effect of access points on overall VA spending depends, however, on such issues as the extent to which the access points attract new users and to which current users increase their use of VA services in response to improved accessibility.
- VA should save over $225 million in 7 years by adopting Medicare fee schedules. VA’s IG compared the amount paid by VA under its fee-basis program with Medicare fee schedules and found that VA paid more than the Medicare rate in over half of the cases reviewed. VA plans to adopt Medicare fee schedules for both its outpatient fee-basis payments and for payment of inpatient physician and ancillary services at non-VA hospitals.[12,13] VA expects to begin using Medicare fee schedules by July 1996.
- By establishing primary care teams, VA hospitals should be able to reduce veterans’ inappropriate use of more costly specialty clinics and achieve significant savings in staff costs. As we reported in October 1993, VA hospitals allow many veterans to receive general medical care in specialty care clinics after their conditions are stabilized. Transferring such veterans to primary care clinics in a timely manner would allow lower cost primary care staff to meet their medical needs rather than higher cost specialists.[14]
- By purchasing specialized medical care services, such as positron-emission tomography scans and lithotripsy, from community providers rather than buying expensive, but seldom used, equipment, VA could reduce its cost of providing such services while it improves accessibility of such care for veterans. For example, although the Albuquerque VA medical center treated only 24 veterans for kidney stone removal in fiscal years 1990 through 1992, the hospital purchased a lithotripter, equipment that breaks up kidney stones so that they can be

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

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

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

eliminated without surgery, at a cost of almost $1.2 million. During its first year of operation, 34 veterans received treatment. A private provider in the same city offered lithotripsy services for $2,920 a procedure. Thus, the hospital could have met the 34 veterans' needs at a cost of about $100,000 compared with its expenditure of $1.2 million plus operating costs. Although the hospital sold lithotripsy services to more nonveterans than it provided to veterans, the hospital has used the equipment at less than one-fifth of its normal operating capacity.[15]

- VA also expects to save costs by establishing a national drug formulary. Historically, each VA facility has established its own formulary—that is, a list of medications approved for use for treating patients. VA noted that establishing a national formulary should increase standardization, decrease inventory costs, heighten efficiency, and lower pharmaceutical costs through enhanced competition. VA has not estimated the possible savings, but it could save $100 million if using the national formulary could reduce the cost of purchasing medications by 10 percent. In commenting on a draft of this report, VHA said that $100 million probably overstates the possible savings. Savings realized through volume-committed contracting would, in VHA's opinion, be offset by the costs of new therapies. (See VHA's comment 17 in app. II.) VHA also identified several additional actions it has taken to improve the management of pharmaceuticals over the last 6 years. These include establishing a pharmacy benefit management function to reduce overall health care costs through appropriate use of pharmaceuticals. (See VHA's comment 19 in app. II.)
- VA expects to save $168 million in 6 years by phasing out and closing its supply depots and establishing a just-in-time delivery system for medical care supplies and drugs as recommended by the Vice President's National Performance Review. The depots were closed at the end of fiscal year 1994, and contracts for just-in-time delivery of drugs are in place. Actions to award just-in-time contracts for medical supplies and subsistence items are expected to be completed by July 1996.

Consolidate Underused or Duplicate Processes

Following are examples of several nationwide initiatives that VA has under way to integrate, consolidate, or merge duplicate or underused services. Such actions should save additional costs over the next 7 years.

- By creating several bulk processing facilities to fill mail order prescriptions, VA will reduce its handling costs by two-thirds, saving about $26 million in fiscal year 1996. As we reported in January 1992, VA was

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

mailing prescriptions to veterans from over 200 locations, resulting in uneconomically small workloads and labor-intensive processes. As of March 1996, VA had four operating bulk processing facilities using newly designed automated equipment and processes; another three facilities were not yet operational. Prescription workload is being transferred systematically from VA hospitals to the new bulk processing centers.[16] When fully operational, these facilities could save about $74 million a year.

- By consolidating 14 laundry facilities over a 3-year period, VA expects to achieve one-time equipment and renovation savings of about $38 million as well as recurring savings of about $600,000 per year. Under a management improvement initiative, VA identified facilities for integration that were scheduled for or had requested funding for new equipment or renovation. Five of the 14 consolidations were completed in 1995; the remaining 9 are scheduled to be completed in the next 2 years.
- An internal VA Management Improvement Task Force predicted in 1994 that VA could save up to $73 million in recurring personnel costs by integrating management of VA facilities. Among other things, the task force recommended that the administrative and clinical management of 60 facilities be integrated into 29 partnerships. The task force expected that these facility integrations could reduce service and staffing duplication, integrate clinical programs, achieve economies of scale, and free resources to invest in new services. As of March 1996, about one-third of the recommended integrations had been approved. VA allows the facilities, however, to reinvest the savings into providing more clinical programs. Examples of reinvestment include buying equipment, building expansions or renovations, opening access points, and increasing specialty and subspecialty clinics. Our ongoing work for this Subcommittee will assess the extent to which these and other management improvement initiatives recommended by the task force have been implemented and are saving measurable costs.

Reduce Nonacute Admissions and Days of Care

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

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

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

have been avoided.[17] Since then, several studies by VA researchers and the IG have found similar inefficiencies.

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

- VA facilities do not have financial incentives to make the transition to outpatient care;
- the VA system, unlike private-sector health care, does not have formal mechanisms to control nonacute admissions, such as mandatory preadmission review; and
- the VA system, unlike private-sector health care, has a significantly expanded social mission that may influence the use of resources for patients.[18]

A 1993 study by VA researchers reported similar findings. At the 24 VA hospitals studied, 47 percent of admissions and 45 percent of days of care in acute medical wards were nonacute; 64 percent of admissions and 34 percent of days of care in surgical wards were nonacute. Reasons cited for nonacute admissions and days of care included nonavailability of outpatient care, conservative physician practices, delays in discharge planning, and social factors. Although the study cited VA eligibility as contributing to some inappropriate admissions and days of care, the study recommended only minor changes in VA eligibility provisions. Rather, it suggested that VA establish a systemwide utilization review program. VA, however, has neither established an internal utilization review program nor contracted for external reviews focusing on medical necessity.[19]

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

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

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

[19] VA established a systemwide utilization review program in October 1993. The program, however, focuses primarily on quality of care reviews.

In commenting on a draft of this report, VA's Under Secretary for Health said that VA is currently assessing the use of preadmission reviews systemwide as a way to encourage the most cost-effective, therapeutically appropriate care setting. He said that several facilities have adopted some form of preadmission review already and their programs are being reviewed.

The Under Secretary also said that VHA is implementing a performance measurement and monitoring system that contains several measures for which all network directors and other leaders will be held accountable. Several of these measures, such as the percentage of surgeries done on an ambulatory basis at each facility and implementation of network-based utilization review policies and programs, will, he said, move the VA system toward efficient allocation and utilization of resources.

Close or Convert Underused Hospitals

If the actions discussed so far are taken to reduce the number of nonacute admissions and days of care provided by VA hospitals, the demand for care in some hospitals could fall to the point where keeping such hospitals open is no longer economically feasible. VA has taken over 50,000 beds out of service in the past 25 years but has not closed any hospitals because of declining utilization.[20]

Although closing wards clearly saves money by reducing staffing costs, the cost per patient treated rises because the fixed costs of facility operation are disbursed to 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. Closing hospitals and contracting for care, however, entail some risk. Allowing veterans to get free hospital care in community hospitals closer to their homes could result in increased demand for VA-supported hospital care, offsetting any savings achieved through contracting.

The feasibility of closing underused hospitals was demonstrated when VA recently closed the Sepulveda VA medical center, which was damaged in an earthquake, and transferred the workload to the West Los Angeles medical center. VA's IG found that the reported numbers of inpatients treated at both Sepulveda and West Los Angeles had declined significantly over the prior 4-year period and that the declining workload may have been even greater than VA reported because the facilities' workload reports were

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

overstated. VA does not plan to rebuild the Sepulveda hospital but plans to establish an expanded outpatient clinic at the site.

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

The only other hospital VA has closed in the last 25 years is the Martinez VA medical center. Like Sepulveda, it was closed because of seismic deficiencies, and its workload was transferred to other VA medical centers. Although VA did not rebuild Sepulveda, it plans to build a replacement hospital for Martinez as a joint venture with the Air Force at Travis Air Force Base. Funds for the construction, however, have not been appropriated.

Actions to Enhance Revenues

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

By establishing appropriate prices for services sold to nonveterans through sharing agreements, VA can generate revenues used to serve veterans. In response to our December 1994 report on recovering the full costs of lithotripsy services at the Albuquerque VA medical center, VA recently encouraged its facilities to ensure that they price services provided to nonveterans to fully recover all costs and to include a profit when appropriate.[21] For example, the Albuquerque medical center increased its price for basic lithotripsy services to nonveterans by over 125 percent. The new price could generate over $300,000 a year in additional revenues for the hospital.

By verifying veterans' reported income, VA expects to generate about $46 million in copayment revenues between January 1, 1996, and June 30, 1997. In a September 1992 report, we found that VA had not taken advantage of the opportunity to verify veterans' incomes through the use of tax records. Through our own review of tax records, we identified over

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

100,000 veterans who may have owed copayments. In 1994, VA began routinely using such data to determine veterans' copayment status.[22]

Lack of Incentives Can Hinder Further System Efficiencies

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

VA Facilities Bear Little Risk From Providing Inappropriate Care

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

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

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

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

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

Finally, unlike private-sector health care providers, VA has no external preadmission screening program or other utilization review program to provide incentives to ensure that only patients who need a hospital level of care are admitted and that patients are discharged as soon as medically possible. VA gives private-sector hospitals providing care to veterans under its contract hospitalization program incentives to limit patients' lengths of stay by basing reimbursement on Medicare prospective payment rates. VA does not, however, give its own hospitals the same incentives by basing their payments on the Medicare rates.

Veteran, Rather Than VA, Bears Financial Risk

Unlike under private health insurance and Medicare, in the VA system, the veteran is at risk of being denied care, rather than VA being at risk of losing funds, if a VA facility runs out of resources. Because it bears little risk, the VA system lacks a strong incentive to operate efficiently.

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

Unlike private health providers, however, the VA system does not guarantee the availability of covered services. As a result, the ability of veterans to get covered services depends on resource availability. If a VA facility is inefficient and the resources allocated to the facility are not sufficient to meet anticipated workload, the VA facility is allowed to deny (that is, ration) services to eligible veterans. In 1993, we reported that 118

VA medical centers reported rationing some types of care to eligible veterans when the centers lacked enough resources.[23]

VA Facilities Find Efficiencies When They Need Funds for New Programs

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

For example, VA's Under Secretary for Health encouraged hospitals to take all steps within their means to improve the geographic accessibility of VA care. But he told the hospitals that they would have to use their own resources to do this. Over half of VA's hospitals quickly developed plans to establish so-called access points. For example, the Amarillo VA medical center identified ways to save over $850,000 to pay for the establishment of access points:

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

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

on a fee-for-service basis. The hospital recently signed a contract with a private-sector hospital to provide each series of radiation treatments at a capitated rate based on Medicare's reimbursement schedule. Officials are currently negotiating similar contracts for other medical services.

Establishment of Service Networks Should Lead to Increased Emphasis on Efficiency

In 1995, the Under Secretary for Health proposed criteria for potential service realignment that would facilitate the types of changes needed to achieve efficiency comparable with private-sector hospitals and clinics. For example, he encouraged VHA directors to identify opportunities to

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

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

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

Understanding facility or VISN cost variations necessitates improving the information VA has on its hospitals' operating costs. Although the automated Decision Support System (DSS) that VA is implementing has potential to be an effective management tool for improving the quality and cost-effectiveness of VHA operations, VA has not developed a way to verify the accuracy of the cost and utilization data going into DSS. Some of the data provided to DSS from other VA information systems are incomplete and inaccurate, limiting VA's ability to rely on DSS-generated information to

make sound business decisions.[24] VA has recognized the need for accurate cost and utilization data for DSS and has a special project team developing ways to improve the system's input data.

Conclusions

Given VA's overstatement of future resource needs, the system does not need to spend as many resources as previously expected. Moreover, because the possible magnitude of future efficiency savings was not factored into VA's assessments of future resource needs, VA's system may have more discretionary resources available than expected. This suggests that an operating goal of $16.2 billion a year may be achievable. In any event, it seems likely that the impact of such funding levels would not, by necessity, result in the budget shortfalls that VA estimated.

Although actions to improve VA's efficiency are planned or under way that could yield enough savings to enable VA to contribute billions of dollars toward deficit reduction in the next 7 years without affecting current services, VA provides little information to the Congress on those savings and how they are reinvested. Essentially, VA reinvests these savings in new programs and expanded services without giving the Congress the chance to use all or a part of the savings to apply to the deficit.

Billions of dollars could be saved by establishing an independent external preadmission certification program similar to those used by most private health insurers. Similarly, by creating financial incentives for VA medical centers to discharge patients as soon as their medical conditions allow, VA could significantly reduce unnecessary days of hospital care.

Although VA has changes under way that should help create financial incentives to provide care in the most cost-efficient setting, it will take time for the new VISN directors to achieve significant savings. The directors have been in their positions for only a few months so it is too early to tell how successful they will be in increasing efficiency. It is important that VA complete its implementation of clear mechanisms and useful management data by which to hold VISN directors accountable for workload, efficiency, and other performance targets. Without such mechanisms and improved data, the VISN structure holds some risk for further decentralizing VHA authority and responsibility for achieving efficiencies.

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

Recommendations

We recommend that the Secretary of Veterans Affairs do the following:

- Establish an independent, external preadmission certification program for VA hospitals.
- Provide the Congress, through future budget submissions, data on the extent to which VA services were provided to veterans in the mandatory and discretionary care categories for both inpatient and outpatient care.
- Include in future budget submissions (1) information on costs saved through improved efficiency and (2) plans to either reinvest savings in new services or programs or use the savings to reduce the budget request.

Agency Comments

By letter dated May 10, 1996 (see app. I), the Under Secretary for Health said that VA appreciates our positive acknowledgment of its efforts to restructure the VA health care system but disagrees with many of our findings, conclusions, and recommendations. In VHA's opinion, the report presents outdated information that does not accurately reflect the current direction of VA health care.

Overall Comments

VHA said that our analysis is particularly inadequate as a basis for projecting future resource requirements for VA medical care. Specifically, VHA said that our report

- does not adequately consider all factors that affect VA's future resource needs,
- incorrectly states that VA does not adequately consider the declining veteran population in forecasting future resource needs, and
- unfairly bases comments about the extent to which VA resources are spent on discretionary care on work done by the VA IG at one facility.

As discussed in the following paragraphs, we do not find VHA's comments convincing.

All Factors Not Considered

Our analysis, VHA said, places too much significance on the findings of our September 1995 review of VA's response to a congressional request (a static assessment of different funding proposals and their effect over future years) in concluding that VHA's forecasting of future resource needs is overstated. Our September 1995 analysis was, VHA said, a fragmented discussion of efficiencies that did not consider other factors. Resource needs are projected on the basis of assessment of inflation, current

workload, new efficiencies, health care technology, and VA health care system deficiencies.

Our analyses were, by necessity, limited to review of the estimates of future resource needs developed by VA. We tried to obtain the basis for the 5-year projections of resource needs in VA's fiscal year 1996 budget submission, but VA officials, including the Under Secretary for Health, said that they had no part in developing the estimates. VHA offered no estimates of its future resource needs beyond those included, either during our review or in its comments on this report.

VHA said that it recognizes that further management efficiencies can and must be achieved in future budget years to continue to provide quality health care. Our report, VHA said, does not recognize the efficiencies included in VA's fiscal year 1996 budget request. In this request, VA assumed that management efficiencies would save $335 million. The Congress increased this savings amount by an additional $397 million in administrative savings that have no impact on patient care. This results in $732 million in permanent administrative savings in fiscal year 1996.

Our report does recognize that VA planned to achieve unspecified savings of $335 million in fiscal year 1996. In addition, we have added a discussion to reflect the final appropriation action approved after this report was sent to VA for comment. The reductions, however, will not necessarily be achieved without impacting patient care. Because VA does not have a plan to achieve the needed savings, VA facilities may achieve these savings by reducing patient care.

VA Does Consider Impact of Declining Population

VHA said that VA's model for projecting hospital workload explicitly considers not only the change in the size and age of the veteran population, but also changes in observed hospital use rates over time. VHA said that one of the more misunderstood variables relates to the change in the veteran population versus the number of veterans who use VA for their health care services. According to VHA, although the veteran population is declining, the number of veteran users is expected to increase. VHA said that although the number of hospital admissions declined by 19 percent between 1980 and 1995, the number of outpatient visits increased by 53 percent in the same period.

Figure 2 shows the increases in demand for outpatient care from 1980 to 1995. Such data do not, however, adequately reflect changing resource needs. The savings from the decreased demand for inpatient hospital care

should more than offset the costs of meeting the increased demand for outpatient care. Between fiscal years 1980 and 1995, the number of days of hospital care provided in VA facilities declined from 26.1 million to 14.7 million, a decrease of over 11 million days of care. During the same period, outpatient visits to VA clinics increased from 15.8 million to 26.5 million, an increase of 10.7 million visits. Because an outpatient visit is 2-1/2 to 3-1/2 times cheaper than a day of inpatient hospital care, savings from the declining inpatient workload should have more than offset the costs of the increased outpatient workload VA experienced over the 16-year period.

The increase in demand for outpatient care is also consistent with what we have been saying about VA's efforts to (1) improve accessibility of VA health care through access points and (2) expand outpatient eligibility. Expanding eligibility, as was done in 1973 with outpatient eligibility to include services that would obviate the need for hospital care, has historically resulted in increased demand for outpatient services. For example, in its fiscal year 1975 annual report, VA includes a figure showing the "relationship of workload to the progressive extension of legislation expanding the availability of outpatient services." Similarly, in its comments, VA noted that the number of VA outpatient clinics grew by 72 percent between 1980 and 1995. In other words, the number of clinics was growing faster than the number of visits, which VA says grew by 53 percent in the same time period.

Report Inappropriately Relies on Work at One Location

VHA said that our conclusions that a significant portion of VA resources go to discretionary care and that services provided are not covered under veterans' VA benefits are based on two IG reports that reviewed the work of one satellite outpatient clinic and one VA medical center.

Our conclusions are based both on our own work and on a series of IG studies. The IG's report discussed problems at two facilities—the Allen Park VA medical center and the Columbus, Ohio, outpatient clinic. The Allen Park facility was, the IG report notes, ". . . selected as the review site in consultation with VHA program officials because it was considered to be a typical outpatient environment in an urban tertiary care facility." Although our report cited only one IG report, the IG has found lax enforcement of eligibility provisions at many other medical centers.

One of the recommendations in the IG's report was that VHA conduct reviews of each facility's outpatient workload to identify the proportion of visits properly classified as mandatory, discretionary, and ineligible using

the definitions relevant to current law. VHA, however, as of May 1996, has not conducted the recommended reviews.

VHA also said that our estimate of the percentage of VA users in the discretionary care category was inaccurate. According to VHA, only 3 percent of VA inpatients and less than 5 percent of both inpatient and outpatient users were discretionary in fiscal year 1995.

Our estimate better reflects the extent to which care is provided to veterans in the discretionary care category. VA's estimate is apparently based on unverified data provided by veterans when they apply for care; such data underestimate veterans' incomes. We compared VA's fiscal year 1990 treatment records with federal income tax records and found that about 15 percent of the veterans with no service-connected disabilities who used VA medical centers had incomes that placed them in the discretionary care category for both inpatient and outpatient care.[25]

Our review showed that VA may have incorrectly placed as many as 109,230 veterans in the mandatory care category in 1990. Tax records for these veterans showed they had incomes that should have placed them in the discretionary care category. We estimated that VA could have billed as much as $27 million for care provided to these veterans.

Although data from our study are now 6 years old, data from VA's own tax record reviews are yielding similar results. VA has now established its own income verification program. Its initial review found that about 18 percent of veterans with no service-connected conditions underreported their income. VA's matching agreement with the Internal Revenue Service indicates that VA expects its comparison of fiscal year 1996 treatment records with tax data to generate about $30.5 million in copayment collections for care provided to veterans who were incorrectly classified as mandatory care category veterans. Accordingly, we believe our estimate—and VA's own data—show that about 15 percent of veterans with no service-connected disabilities who use VA medical centers are in the discretionary care category for both inpatient and outpatient care.

VHA also said that they do not believe that extrapolating data from a single facility to the VA system nationwide is appropriate. According to VHA, our report states that "systemwide, 56% of discretionary care outpatient visits did not meet eligibility criteria in 1992, and may have resulted in $321 million to $831 million being potentially used to provide outpatient

[25]GAO/HRD-92-159, Sept. 15, 1992.

care to veterans in the discretionary care category who may not have been entitled to that care."

What our report actually says is that the VA IG further reported that about 56 percent of discretionary care outpatient visits provided services that were not covered under the veterans' VA benefits . . . . We state that an estimated $321 million to $831 million of the approximately $3.7 billion VA spent on outpatient care in fiscal year 1992 may have been for treatments provided to veterans in the discretionary care category that were not covered under VA health care benefits.

Nowhere in the report do we suggest that the problem is one of "entitlement." No veteran, whether in the mandatory or discretionary care category, is entitled to care from VA. The issue is one of eligibility. The IG report found that veterans in the discretionary care category for outpatient care received treatments that they were not eligible for regardless of whether VA had the space and resources to provide the services. In other words, these veterans received services that were not needed to prepare for, to follow up after, or to obviate the need for hospital care.

According to VHA, this report and the IG reports demonstrate the need for eligibility reform. In VHA's opinion, the law needs to be amended to enable VA to provide care so that veterans are treated in the most appropriate, most efficient, and most cost-effective setting. VHA said that this is an instance where, despite statements to the contrary in this report, the law contributes to the system's inefficiencies by perpetuating complicated outpatient eligibility criteria. VA needs the outpatient eligibility reform tool to achieve the best patient and system outcomes.

Although we agree with VHA that eligibility reforms are needed, VA's efforts to expand eligibility are not effectively targeted toward meeting the health care needs of veterans within available resources. Our concerns about current proposals to expand eligibility were expressed in our recent testimony before the Senate Committee on Veterans' Affairs and will be explored more fully in a forthcoming report.

VHA said that our report's statement that medical centers frequently overstate the number of inpatients and outpatients treated is no longer true. VHA said that it improved its information systems and eliminated false workload credits in response to the IG reports.[26] Before this, facilities

[26]Since October 1, 1992, no automatic workload credit has been granted for scheduled outpatient visits, and facilities must physically check in each patient to receive such credit.

could obtain automatic workload credit for all scheduled visits unless action was taken to indicate that a patient failed to appear. We revised the discussion in our report to reflect the actions taken in response to the IG's reports. We also added a discussion of a September 1995 VA IG report showing continued problems in VA facilities' reporting of outpatient workload.

Actions Will Be Taken to Establish a Preadmission Certification Program

VHA agreed with our recommendation that it establish an independent, external preadmission certification program for VA hospitals. VHA said that policies and processes for preadmission review are being developed by a task force charged with reviewing and revising VHA's existing utilization review policy. The preadmission review will, according to VHA, identify the appropriate level of care for both inpatient and outpatient care, appropriate alternatives to care, and a system of referral and arrangement of alternative care.

Although we found VHA's agreement to pursue establishment of an external preadmission certification program encouraging, we do not believe VHA's action fully responds to our recommendation because it provides no time frames for completing development and implementation of the program. In addition, it does not indicate how compliance with the findings of the external reviews will be enforced. Because VA facilities currently incur no financial risk from providing inappropriate care, external preadmission certification requirements may not be effective unless coupled with a financial penalty for noncompliance with the review findings.

Recommendations and VA promises to establish effective utilization review mechanisms to help prevent inappropriate days of hospital care date back over 10 years. Because of the hundreds of millions of dollars wasted from VA's past failure to address this problem, we believe VA needs to develop and follow a specific timetable to implement an external preadmission certification program and develop plans to place VA facilities at financial risk if they admit patients not requiring a hospital level of care.

VHA Does Not Plan to Provide the Congress Information on Savings

VHA did not agree with our recommendation that it include (1) information on savings achieved through improved efficiency and (2) plans to either reinvest savings in new services or programs or use the savings to reduce the budget request. The recommendation is, VHA said, unrealistic. Although VHA is moving rapidly to implement several management initiatives, such as those discussed in this report, VHA said it cannot predict the extent of

possible savings or accurately predict future costs. VHA said that VA will be better able to predict savings when the VISNs are fully operational but probably not to the level of detail that our recommendation seems to require.

Providing the Congress information on factors, such as inflation and creation of new programs, that 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. Because VA facilities are essentially allowed to keep any funds they generate through efficiency improvements and seek additional funds to compensate for the effects of inflation, the true rate of increase in VA's medical care appropriations is understated.

VA Does Not Plan to Give the Congress Detailed Information on Workload

Finally, VHA did not agree with our recommendation that it provide data to the Congress on the extent to which VA services are provided to veterans in the mandatory and discretionary care categories for both inpatient and outpatient care. According to VHA, VA does not have accounting systems that would allow VA to differentiate between mandatory and discretionary care. Developing accounting systems capable of such differentiation would, VHA said, be extremely difficult and may not be cost-effective given the complexities of outpatient eligibility. For example, one outpatient visit may comprise several clinic stops, across which outpatient eligibility may vary. These complexities, according to VHA, make it very difficult to efficiently and meaningfully track mandatory and discretionary care. Future data systems, such as the DSS and resource allocation systems, may, VHA said, improve the identification of patient care costs. The difficulties in identifying mandatory versus discretionary care categories will, according to VHA, remain until eligibility laws are amended.

Without information on the extent to which VA resources are used to provide services to veterans in the priority categories established under VA law, the Congress lacks the basic information needed to guide decisions about what portion of VA's discretionary care workload to fund. In addition, it lacks the basic information it needs to ensure that resources are equitably allocated to VISNs to ensure that veterans have reasonably equal access to VA benefits regardless of where they live.

If VHA is applying the eligibility rules established under Public Law 100-322—as VHA maintained in its comments it has instructed its facilities to do—it should be relatively easy to develop a reporting system to

capture the results of those decisions. VA has, for years, indicated that it may include data on mandatory and discretionary care in its resource allocation system in DSS and in other data systems but has never detailed any plans to accomplish this task. VA needs to promptly decide how to gather such data and set realistic milestones for implementing the changes needed to provide the Congress and VA managers the data they need to effectively assess VA medical care budget needs. By not developing such data, VA makes it exceedingly difficult for the Congress to consider reductions in its budget request because the Congress does not know whether its reduction would affect provision of services to veterans in the mandatory care category for inpatient care.

According to VHA, in fiscal year 1995, less than 3 percent of VA inpatients and less than 5 percent of both inpatient and outpatient users were discretionary by inpatient eligibility standards. VHA said that any savings available from no longer treating any discretionary care category veterans defined by inpatient eligibility would be relatively very small.

The data VA cites are apparently based on unverified information provided by veterans at the time of application. As discussed in this report, many veterans underreport their income to VA to qualify for free care. VA expects to recover about $30.5 million in copayments in fiscal year 1996 through its recently established income verification program.

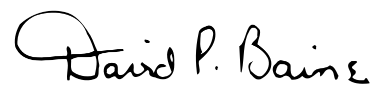
VHA provided additional comments in an attachment to its May 10, 1996, letter. Those comments are addressed in appendix II and changes have been made in the body of the report as appropriate in response to the additional comments.

We are sending copies of this report to the Chairmen and Ranking Minority Members, Subcommittee on VA, HUD, and Independent Agencies, House Committee on Appropriations; the House and Senate Committees on Veterans' Affairs; the Secretary of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others upon request.

This report was prepared under the direction of Jim Linz and Paul Reynolds, Assistant Directors, Health Care Delivery and Quality Issues. Please call Mr. Linz at (202) 512-7110 or Mr. Reynolds at (202) 512-7109 if you or your staff have any questions. Other evaluators who made

contributions to this report include Katherine Iritani, Linda Bade, and Walt Gembacz.

Sincerely yours,



David P. Baine
Director, Health Care Delivery
and Quality Issues

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Abbreviations

DOD	Department of Defense
DSS	Decentralized Support System
FTE	full-time equivalent
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
IG	Office of Inspector General
NCCC	National Cost Containment Center
PBM	Pharmacy Benefit Management
RPM	Resource Planning and Management System
UM	utilization management
UR	utilization review
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Comments From the Veterans Health Administration

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

MAY 1 0 1996

In Reply Refer To: 10/105E

Mr. David P. Baine
Director, Health Care Delivery
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United States General Accounting Office
Washington, D. C. 20548

Dear Mr. Baine:

We have reviewed your draft report, *VA HEALTH CARE: Opportunities for Further Service Delivery Efficiencies Within Existing Resources*, Report No. GAO/HEHS-96-121, and appreciate your positive acknowledgment of our efforts to effect a major restructuring of the VA health care system. These unprecedented changes, currently underway or being planned, will create a more efficient and cost effective VA system. You recognize many of these efforts in your discussion of the reorganization of the field into Veterans Integrated Service Networks (VISNs); Headquarters restructuring; development of operating indicators and performance measures; efforts to improve veterans' access to care in the most medically appropriate setting; and, the numerous initiatives we are undertaking to effect operational efficiencies and savings. Each of these actions will contribute to a more cost effective, patient centered health care system. Despite these positive points, the report presents information that is outdated and that does not accurately present the current direction of VA health care. This prevents our agreeing with many of your findings, conclusions and recommendations.

Your analysis is particularly inadequate as a basis for projecting future resource requirements for VA medical care. We disagree with the majority of the findings and conclusions presented. Our reasons for this are several. First, you do not sufficiently consider all the factors that affect our future resource requirements. Resource needs are projected based on assessments of inflation, current workload, new efficiencies, health care technology and VA health care system deficiencies. Your analysis, however, places an inordinate amount of significance on the findings of your September 1995 review of VA's response to a Congressional request (a static assessment of different funding proposals and their effect over future years) in concluding that VHA's forecasting of future resources is overstated. Your September 1995 analysis was, however, a fragmented discussion of efficiencies that did not consider these other factors.

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VA recognizes that further management efficiencies can and must be achieved in future budget years in order to continue to provide quality health care. Your report, however, does not recognize the efficiencies included in VA's FY 1996 budget request. In this request, VA assumed management efficiencies of $335 million. The Congress increased this by an additional $397 million in administrative savings that have no impact on patient care. This results in $732 million in permanent administrative savings in FY 1996.

Second, as part of your discussion of VHA's forecasting of future resource needs, you state that VA has not adequately considered the impact of the declining veteran population on future demand for hospital care. We believe your comments are unfounded. VA's model for projecting hospital workload explicitly takes into consideration not only the change in the size and age structure of the veteran population, but also changes in observed hospital use rates over time.

One of the more misunderstood variables relates to the change in the veteran population versus the number of veterans who use VA for their health care services. Although veteran population is declining, the number of veteran users are projected to increase. For example, from 1987 to 1995, the veteran population decreased from 27.8 million to 26 million, however, for that same period, the number of patients using the VA system increased from 2.5 million to 2.9 million. Additionally, from 1980 to 1995, the numbers of hospital admissions and beds have decreased by 19 percent and 40 percent, respectively. However, the number of outpatient visits and outpatient clinics have increased by 53 percent and 72 percent, respectively, during the same period. To the extent we know other similar cost variables, we will be better able to consider their impact when formulating the budget. Otherwise we will strive to be as innovative and cost efficient as we can to minimize the impact of these other variables on total cost.

Third, you conclude that a significant portion of resources go to discretionary care, and that services provided are not covered under veterans' VA benefits. You base this conclusion on two VA Office of Inspector General reports which considered the work of one VA satellite outpatient clinic and one VA medical center. Further, you state that systemwide, 56% of discretionary care outpatient visits did not meet eligibility criteria in FY 1992, and may have resulted in $321 million to $831 million being potentially used to provide outpatient care to veterans in the discretionary care category who may not have been entitled to that care. This statement is also based on Inspector General generated data from a single facility that was extrapolated to the entire system. We do not believe it is appropriate to present the situation at a single facility as a systemwide condition. Neither is it appropriate to assume the savings presented

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are applicable systemwide. What the discussions in this report and the Inspector General reports demonstrate is not the potential savings or VA's inability to apply the law. Rather, it demonstrates the clear need to amend the law to enable VA to provide care so that veterans are treated in the most appropriate, most efficient, most cost effective setting. This is an instance where, despite statements in your report to the contrary, the law contributes to inefficiencies in the system by perpetuating complicated outpatient eligibility criteria. VA needs the outpatient eligibility reform tool in order to achieve the best patient and system outcomes.

Your statement that because medical centers frequently overstate the number of inpatients and outpatients treated, they overstate resource needs, is based on several VA Inspector General reports from 1991 and 1992. (It should be noted that although those workload counts may have skewed the resource allocation system, which had a cap on the redistribution of resources, there was no effect on the relationship of this workload to overall budget requirements.) This presentation leaves the impression that VA has not acted to improve its information systems, and that the situation existing in 1991 and 1992 persists. At the time of those reports, facilities could obtain automatic workload credit for all scheduled visits unless action was taken to indicate that a patient failed to report. That is no longer the case. In response to the findings in the Inspector General reports, VA took action to eliminate false workload credits. Since October 1, 1992, there has been no automatic workload credit and facilities must physically "check-in" each patient to receive credit.

In response to the recommendations, we concur with your recommendation to establish an independent, external preadmission certification program for VA hospitals. Policy and processes for preadmission review are currently being developed by a task force charged with reviewing and revising VHA's existing utilization review policy. The preadmission review will identify the appropriate level of care for both inpatient and outpatient care, appropriate alternatives to care, and a system of referral and arrangement of alternative care.

We do not concur with your recommendation to include (1) information on savings achieved through improved efficiency and (2) plans to either reinvest savings in new services or programs or use the savings to reduce the budget request because it is unrealistic. We are currently restructuring and streamlining the VA health care delivery system to be more efficient, and we recognize the future will require further innovative management. We have been able to begin actions that will promote future efficiencies and savings, many of which you cite in your report. Although we are moving rapidly to implement these initiatives, at this time we cannot predict the extent of potential savings or accurately predict future costs. We will be better able to do this when the VISNs are fully

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operational, but probably not to the level of detail this recommendation seems to require.

We also do not concur with your recommendation that in future budget submissions we provide data to Congress on the extent to which VA services were provided to veterans in the mandatory and discretionary care categories for both inpatient and outpatient care. VA does not currently have accounting systems in place that will allow us to differentiate between mandatory and discretionary care. Given the complexities of outpatient eligibility, developing accounting systems capable of differentiating between the care would be extremely difficult and may not be cost effective. The amount of discretionary care delivered is quite confusing without careful referencing of either inpatient or outpatient eligibility.

Based on inpatient eligibility, all Category A veterans are mandatory for inpatient care and only Category C veterans are discretionary inpatients. In FY 1995, less than 3% of VA inpatients and less than 5% of both inpatient and outpatient users were discretionary (Category C) by inpatient eligibility standards. Consequently, any savings available as a result of no longer treating any discretionary (Category C) veterans defined by inpatient eligibility would be relatively very small. Also, one outpatient visit may be comprised of several clinic stops, across which outpatient eligibility may vary. This variability, due to the complexities of outpatient eligibility criteria, makes it very difficult to efficiently and meaningfully track. Future data systems, such as the Decision Support System, and resource allocations systems may improve the identification of patient care costs. The difficulties in identifying mandatory versus discretionary care categories will remain until eligibility laws are amended.

Thank you for the opportunity to review the draft report. In addition to the comments provided, we are also enclosing detailed comments on additional issues identified in our review. If you have any questions on our comments, please contact Paul C. Gibert, Director, Management Review Service, at 565.6397.

Sincerely,

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Enclosure

Evaluation of Additional Veterans Health Administration Comments

VHA's additional comments noted on the following pages are copied from the enclosure that accompanied VHA's May 10, 1996, letter to us. References to page numbers in our draft report have been changed to refer to the appropriate page numbers in our final report. Each VHA comment is followed by our evaluation.

VHA Comment 1

[This comment responds to GAO's reporting on page 2 that facilities receive scant pressure to effect efficiencies but do so when they want to implement new services or expand existing ones.]

Headquarters normally makes a commitment to support a facility's budget before the beginning of the fiscal year starts. However, 1996 is an exception in that the initial allocation of resources are delayed due to the uncertainty as to the outcome of the Congressional action for the fiscal year. This budget provides incentives for the facility to figure out how to operate during the year at a lower per-unit-of-service cost. Any savings that the facility can make during the year after meeting savings targets can be put back into either enhancing the level of service in specific areas or into expanding services. In addition to a prospective budget, the Central Office, for the past three years, established facility budgets using per-capita prices for five different risk groups. While some of these groups include bed-service care; e.g., the extended care group, the largest risk group, basic care, has no inpatient/outpatient designation. In this risk group, a facility receives budget credit based solely on the number of patients that they will care for times a single average price. A significant amount of information is provided facilities and VISNs on their relative cost, casemix [sic] and productivity. This peer comparison is structured to promote the treatment of patients with the most appropriate care in the most cost-effective manner. In developing the 1997 allocation prices, VHA will be developing incentives for shifting to ambulatory care.

The Resource Allocation Methodology (RAM), which was used to make adjustments to medical centers' budgets during fiscal years 1985-1990, provided more workload credit for inpatient care. Over the years, VHA has tried to remedy the situation. In 1995, under the Resource Planning and Management (RPM) system, VHA changed the structure of the workload classification system to promote primary and ambulatory care. As VHA is preparing for the FY 1997 budget allocation, the Capitation Advisory Panel will be making recommendations to provide incentives in the resource allocation system for ambulatory surgery. As VHA develops a

capitation-based resource allocation system for FY 1998, it will continue its ongoing efforts to promote incentives for ambulatory care.

GAO Evaluation

We believe VHA has taken these remarks out of context. We reported that, historically, VA's central office provided few incentives for facilities to become more efficient. Furthermore, the report goes to say that recent changes at VA are starting to create the types of efficiency incentives that have long existed in the private sector. The remainder of this section of the report discusses the kinds of changes, such as capitation funding and establishment of performance measures, VA is making to create efficiency incentives.

VHA Comment 2

[This comment responds to GAO's reporting on page 10 that many veterans leave the VA system when they become eligible for Medicare.]

This is misleading, because while a VA study of inpatients only (Feitz) reveals some VA inpatients do leave VA upon reaching age 65, many do return in the following years, especially as outpatients (Hisnanick). A large proportion (46 percent) of VA unique patients across both inpatient and outpatient care are Medicare eligible.

GAO Evaluation

We did not mean to imply that all veterans leave the VA system or even that those who leave the system discontinue all use of VA services. We have revised the wording in the final report to state that many veterans reduce their use of the VA system when they become eligible for Medicare.

When veterans have both Medicare and VA coverage, they overwhelmingly use Medicare. In 1990, for example, almost 62 percent of Medicare-eligible veterans used Medicare but no VA services during the year; 7 percent used VA but no Medicare services; and 8 percent used a combination of both Medicare and VA services. About 24 percent did not use services under either program.

While most Medicare-eligible veterans rely primarily on private-sector providers participating in Medicare for their health care needs, Medicare-eligible veterans do, as VHA points out, and as we have pointed out in previous reports, account for about half of VA's workload.[27]

[27]See, for example, Veterans Health Care: Most Care Provided Through Non-VA Programs (GAO/HEHS-94-104BR, Apr. 25. 1994) and Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

VHA Comment 3

Throughout the report, you continually shift your statements from inpatient care to outpatient care without adequately differentiating them. This is at times confusing or misleading.

GAO Evaluation

Changes have been made in the final report to clarify discussions of inpatient and outpatient care as appropriate.

VHA Comment 4

Pages 10 & 11. Your discussion seems to hinge on comments made in a VA Inspector General report (report no. 2AB-A02-059, dated March 31, 1992), regarding outpatient provisions of Public Law 100-322. VHA finds it inappropriate to base these specific findings and conclusions upon findings in the Inspector General report, which were based on one tertiary care facility. This certainly cannot be deemed to represent the system as a whole, nor can it be assumed that the same concerns identified at this location, and a satellite outpatient clinic also cited in the Inspector General report, would necessarily be found at all other VA health care facilities.

GAO Evaluation

The IG's report discussed problems at two facilities—the Allen Park VA medical center and the Columbus, Ohio, outpatient clinic. The Allen Park facility was, the IG report notes, "...selected as the review site in consultation with VHA program officials because it was considered to be a typical outpatient environment in an urban tertiary care facility." It was selected as a typical tertiary care facility because VHA had previously expressed concern that the findings at the Columbus outpatient clinic did not represent conditions at a typical tertiary care outpatient clinic.

One of the recommendations in the IG's report was that VHA conduct reviews of each facility's outpatient workload to identify the proportion of visits properly classified as mandatory, discretionary, and ineligible using the definitions relevant to current law. VHA, however, was unwilling to conduct such reviews, which might possibly have disproved the IG's findings or shown the problems to be isolated to a few facilities. As of May 1996, VHA still has not conducted the recommended reviews.

Although we focused on a single IG report in our testimony, the IG found lax enforcement of eligibility provisions at many other medical centers.[28] In addition, our recent work on VA access points found no indication that VA requires access point contractors to establish veterans' eligibility or priority for care or that contractors were making such determinations for each new condition.

Perhaps the strongest evidence to suggest that the IG's work and our work on access points represent the system as a whole is VHA's recent comments to the Ranking Minority Member of the Senate Committee on Veterans' Affairs on our March 20, 1996, testimony on eligibility reform.[29] According to VHA,

> "...VA physicians generally practice with little real regard for the illogical eligibility rules. Indeed, it appears to me as if these rules are more of a hassle factor than anything else—bureaucratic barriers to be circumvented in one way or another in the interest of taking care of patients. In fact, over the last 7 years VHA has provided approximately 200 million outpatient visits and about 7 million hospital admissions, but there has not been one instance where an administrator or practitioner has been reprimanded for violating the eligibility rules, despite several GAO and IG reports finding 'varying interpretations of the statutory outpatient eligibility criteria,' incorrect coding of mandatory visits, physicians 'not consistently involved in required clinical examination to determine eligibility status,' and other such things."

VHA Comment 5

Nowhere in the Inspector General audit does it state that "VA incorrectly applied inpatient eligibility categories to its outpatients," which insinuates that administratively, VHA field facilities used inpatient eligibility criteria to determine a veteran's eligibility for outpatient care. It is repeatedly implied that veterans were provided outpatient care under the auspices of the "obviate-the-need for hospital care" criterion. In the Inspector General's opinion, some of these veterans did not medically fit their definition of "obviate-the-need for hospital care," because many of these individuals were treated for chronic conditions.

[28]See, for example, Audit of Selected Activities Department of Veterans Affairs Medical Center Muskogee, Oklahoma, Report No. 3R6-A99-053, VA Office of Inspector General (Washington, D.C.: Feb. 19, 1993); Audit of Medical Center Fort Lyon, Colorado, Report No. 1R5-F03-026, VA Office of Inspector General (Washington, D.C.: Jan. 23, 1991); and Audit of VA Medical Center Denver, Colorado, Report No. 1R5-F03-050, VA Office of Inspector General (Washington, D.C.: Apr. 5, 1991).

[29]The comments were provided in a May 10, 1996, letter from the Under Secretary for Health to the Ranking Minority Member of the Senate Committee on Veterans' Affairs.

GAO Evaluation

VA is mixing up the IG's two distinct findings, one of which concerns an administrative determination of the veterans' priority for care and the other of which deals with the medical determination of whether outpatient care was needed in preparation for, as a follow-up to, or to obviate the need for hospital care. With respect to the administrative determination of veterans' priorities for care, the IG found that VA was not reporting outpatient workload according to the mandatory and discretionary care categories established under the Public Law 100-322 and was instead reporting workload on the basis of the mandatory and discretionary care categories set in 1986 by Public Law 99-272 and still applicable to hospital care. We have, however, clarified the wording in the final report to indicate that VA was incorrectly reporting workload.

VHA Comment 6

The Inspector General report implies that VHA may be providing outpatient care to veterans who are otherwise eligible for discretionary care, but not to the outpatient care they are receiving. However, there is disagreement as to whether or not this statement is true, in that in some cases VA provides care that clinical staff deem to be mandatory under the "obviate-the-need" criterion, but which some do not see as clearly meeting the administrative definition of mandatory as defined in Public Law 100-322. This appears to be what you are referring to when stating that VA is incorrectly applying inpatient eligibility categories, although one has nothing to do with the other.

GAO Evaluation

We were careful in our report to distinguish between the IG's two major findings. First, the IG reported that VHA's budget plans do not accurately reflect statutory definitions for outpatient eligibility according to the mandatory and discretionary care categories defined in Public Law 100-322. Second, the IG reported that VA has not adequately defined the conditions and circumstances under which outpatient treatment may be provided to obviate the need for hospitalization. When we discuss veterans obtaining care for which they were not eligible, we are not discussing differences between being in the mandatory and discretionary care category. These categories define priorities for care, not eligibility for care. What we are referring to is providing veterans eligible for only hospital-related care services that are not needed in preparation for, as a follow-up to, or to obviate the need for hospital care.

VHA Comment 7

Policy directives are in place to guide administrative staff on the eligibility provisions of Public Law 100-322. These directives spell out mandatory versus discretionary outpatient medical care from an administrative perspective. The Inspector General, and by extension GAO, through its use of the Inspector General report, are concerned with the fact that "obviate-the-need for hospital care" is not clearly defined. This leads, in their opinion, to providing inappropriate care to veterans, who are determined eligible, based on their need for care to obviate the need for hospital care. Eligibility under this criterion is a medical decision and not an administrative decision.

GAO Evaluation

We agree that interpreting the obviate-the-need criterion is a medical decision. That fact does not, in our opinion, preclude issuance of guidelines intended to bring greater consistency to those medical decisions or independent reviews to determine compliance with those guidelines.

Medical decisions are questioned every day. For example, a primary purpose of utilization review is to examine the reasonableness of a physician's medical decisions. Similarly, a preadmission certification program uses an independent party to evaluate the reasonableness of the medical decisions physicians make to admit their patients to hospitals.

Similarly, practice guidelines are frequently issued setting expectations for how physicians will practice. For example, at our urging, VA issued guidelines defining what constitutes a complete physical examination for women veterans. Those guidelines set expectations that VA physicians will provide women veterans complete cancer screening examinations at recommended intervals. Similarly, as noted elsewhere in its comments, VA recently required its Veterans Integrated Service Network (VISN) directors to establish formularies of medications to guide VA physicians toward prescribing certain drugs.

VHA Comment 8

Page 13. You indicate that because of separate planning processes, there might be double counting, in that the projected new workload may well be associated with the activations. Budgeting for activations requirements in 1997 is modified as the medical care request does not include "line item" requests for the activation of specific projects. The networks will activate projects from within the level of resources provided in their total Medical Care 1997 budget allocations.

GAO Evaluation

We included the updated information in the final report.

VHA Comment 9

Page 13. Although VA facilities received separate reimbursement for the workload generated through those sharing agreements, the workload was nevertheless included in VA's justification of its budget request. In 1994, VA provided care to about 45,000 unique sharing agreement patients. No appropriated funds are requested for this workload since it is supported by reimbursements from DOD and other sharing partners. Even though our base workload counts do include sharing, the levels are small and the inclusion of sharing makes no material difference in our workload presentations. The Resource Planning and Management (RPM) model excludes data for sharing patients in developing changes in both unique patients and cost per unique patient. The actual patient counts for the last actual year are straightlined in all RPM projections. In addition, some of the DOD sharing agreement earnings are for non-patient workload such as pounds of laundry processed, etc.

GAO Evaluation

We have expanded the discussion in our final report to include the information VA provided. Because the workload data VA reported to the Congress included services provided under sharing agreements, VA was, in the past, receiving appropriated funds to pay for services paid for through sharing agreements.

VHA Comment 10

Page 15. VA agrees that there are potential opportunities for savings which will allow VA to operate more effectively and efficiently. We are actively pursuing these opportunities, including most of those initiatives cited in the report. However, it is important to qualify your estimate of billions in savings. It is impossible to project savings for some of the cited initiatives. To do so establishes peg points for reducing VA resources without any real justification.

GAO Evaluation

We agree that estimating precise savings from all of the initiatives included in this report is impossible. That is why we conservatively estimated that VA could save billions through management improvements over a 7-year period. To the extent possible, we have cited estimates developed by VA program officials and the VA IG.

We do not agree, however, that VA should not establish "peg points" for reducing VA's budget request on the basis of planned savings and then monitor management initiatives to determine whether the savings were realized. Effectively determining future resource needs is impossible without tracking savings. In its fiscal year 1997 budget request, VA seeks an increase over the fiscal year 1996 appropriation to offset inflation. The actual increase, however, is really much higher because no offsetting decrease exists in the request to compensate for any management savings likely to occur during the year, such as efficiency improvements expected to occur through full implementation of VISNs.

VHA Comment 11

Assuming a 5 percent compound annual inflation requirement, VA medical care would need to be 40 percent more efficient in order to operate at Congress' straightlined 1995 level of $16.2 billion through 2002. It is highly unlikely that VA could reach these dramatic savings without severely impacting the level of health care currently provided to veterans. These additional savings would be over and above the $10.5 billion in savings that have resulted from the VA medical care budget increasing at a rate less than the Medical Consumer Price Index over the period from 1980 through 1995.

GAO Evaluation

VHA's comparison of increases in its budget with increases in the medical consumer price index are inappropriate. VA's inpatient hospital workload—which accounts for over one-half of VA's medical care budget—declined dramatically between 1980 and 1995, while less costly outpatient workload increased just as dramatically. Comparing the increase in the overall budget with the consumer price index is inappropriate without considering changes in workload over the time period. A more appropriate comparison would be to compare the increase in VA's average cost of hospital, nursing home, and outpatient care with growth in the consumer price index. For example, while VA's medical care budget increased by about 170 percent between 1980 and 1995 (from $6.0 billion to $16.1 billion) the cost of a day of care in a VA hospital increased by over 305 percent (from $154 to $625).

VHA Comment 12

Page 15. You often point out savings expected from reduced acute inpatient care, but seem to ignore large increases needed in outpatient and other non-institutional care programs for current levels of eligible veterans

and the greater use of VA services by veterans despite their population reductions.

GAO Evaluation

We agree that savings from shifting nonacute inpatient care to other settings will be partially offset by increased costs under other programs. We do not agree, however, that shifting nonacute care to outpatient settings will result in large increases in outpatient demand. Veterans who use VA for inpatient care already receive significant amounts of their care as outpatients. For example, in fiscal year 1995, veterans with no service-connected conditions who were hospitalized in a VA facility during the year received, on average, over 15 outpatient visits from VA clinics.

We discuss the increased demand for outpatient care on page 5 of the report.

VHA Comment 13

Page 15. Since 1979, VA medical facilities have had the option to dispense multi-month quantities of locally determined medications to eligible veteran patients. Due to a number of reasons, including budgetary limitations, lack of automation to facilitate implementation, and patient care concerns, only a small number of VA medical facilities implemented such programs in the 1980's. Subsequent to an expressed interest in this program by the Congress and GAO in the early 1990's, additional guidance was distributed to all facilities regarding implementation of the program. Again, due to budgetary and patient care concerns; e.g., psychiatric patients, some facilities have been slow to adopt the program. Despite slow implementation by some facilities, there has been a dramatic increase in the use of this program in recent years. For example, in FY 1994, 9 million fewer prescriptions were dispensed by VA pharmacies due to multi-month dispensing. In FY 1995, this figure increased to 15 million fewer prescriptions, and VHA anticipates further efficiencies in FY 1996. We believe we have implemented this program in a prudent manner, balancing quality of care issues and budgeting issues. In addition, VHA issued analysis and guidance to medical facilities in FYs 1994 through 1996, and will continue to monitor the impact and implementation of the program.

GAO Evaluation

Our report, in reflecting the estimated savings in fiscal year 1995, recognizes the progress VA has made since issuance of our 1992 report. It seems to us, however, that budgetary concerns, rather than slowing implementation of more cost-effective drug-dispensing methods, would

encourage quicker implementation. This is particularly true because essentially no start-up costs are involved in going from a 30-day prescription to a 90-day prescription.

VHA Comment 14

Access points are not alternatives to VA outpatient clinics. They include VA operated outpatient clinics as well as contractual or sharing agreements. The term “access points” was used to reorient managers’ attitudes toward outpatient care; i.e., not as pre- or post-hospital care but as a veteran’s principal contact with the system.

The cost of outpatient treatment would generally be lower than the cost of inappropriate hospital days. The cost of privately provided outpatient care is not necessarily lower than the cost of VA-provided outpatient care. One would expect a facility to arrange for private provision of only those services which can be obtained at less cost.

GAO Evaluation

We have clarified the wording of this part of the final report. Our recent review of access points suggests that VA medical centers that have established access points have generally found that contracting for services is less expensive when an access point serves a relatively small number of veterans. As the number of veterans served by an access point increases, the decision on whether to contract for services or provide them directly becomes more difficult.

VHA Comment 15

The issue of new users attracted to VA by the opening of new clinics is exaggerated. The purpose in establishing access points is to improve access to VA services by veterans, not to expand the system. We acknowledge that establishing access points may result in new users to the system. The net effect does not appear substantial in that between 20 and 30 percent of individuals treated by VA in each year are new to the VA system.

GAO Evaluation

We believe the suggestion that making health care services more accessible does not substantially affect veterans’ use of VA services is naive. Elsewhere in its comments, VHA presented data showing that as the number of VA outpatient clinics increased 72 percent between 1980 and 1995, the number of outpatient visits increased by 53 percent.

Although VA may be correct in stating that 20 to 30 percent of the veterans who use VA services each year did not use VA services the year before, we used a more conservative approach in estimating new users. In our analyses, we considered veterans to be "new" users only if they had not used VA services within the preceding 3 consecutive years. Veterans who had used VA within the 3-year period—about 4 to 5 million veterans nationwide—were considered current users. In other words, we considered only those veterans attracted to the access points who had not sought VA care for over 3 years new users.

VHA Comment 16

Page 17. Your comment that VA could realize potentially $100 million in savings through use of a national formulary is most likely overstated. If the intention is that overall pharmaceutical expenditures be reduced by $100 million through implementation of a national formulary, this is misleading. In all probability, savings realized through volume committed contracts will be offset by new therapies. For example, this year new agents for the treatment of HIV/AIDS have been granted accelerated approval by the Food and Drug Administration. It is estimated that VA expenditures will increase by over $50 million annually for the new HIV/AIDS therapies. It is also very difficult to predict how much lower VA can drive drug prices, keeping in mind that Public Law 102-585 established drug pricing for VA that is much more favorable than for other managed care organizations.

GAO Evaluation

Because VHA could not provide an estimate of potential savings from establishing a national formulary, we included a "ballpark" estimate of what potential savings could be if the formulary allowed VA to save 10 percent of its pharmaceutical costs. We recognize that the estimate has no precision but note that VHA's directive on establishing VISN formularies notes that the advantages of such formularies are decreased inventory, increased efficiency, and lower pharmaceutical prices.

Although savings from establishing VISN formularies or a national formulary may be used to offset increased costs for new therapies or for other uses, we nevertheless believe that the savings, and how they are used, should be accounted for in VA budget submissions.

VHA Comment 17

VA has taken a number of additional actions to improve management of pharmaceuticals in the last six years. VISN network formularies have been established which will evolve into a national formulary, by approximately

April 1997. More important is the approval by the Under Secretary for Health of the Pharmacy Benefit Management (PBM) function as part of the restructured VHA. Basically, the PBM will address (1) contracting for pharmaceuticals to ensure the most efficient and effective contract processes; (2) the most efficient and effective distribution systems for pharmaceuticals (e.g., consolidated mail outpatient pharmacies); and, (3) the appropriate utilization of pharmaceuticals through the issuance of evidence-based disease management protocols, treatment protocols and drug use protocols. VHA is also testing commercial software to compare pharmaceutical utilization against these established protocols and to measure outcomes achieved from drug therapy. In short, the goal of the PBM is to reduce overall health care costs through appropriate use of pharmaceuticals, not reduce the cost of individual pharmaceuticals.

GAO Evaluation

The final report has been revised to indicate that VHA has taken other actions to improve management of pharmaceuticals.

VHA Comment 18

Page 17. VHA had strategically planned to consolidate mail prescription processing through automated technology well before 1992. In fact, through research and development at the VA Medical Center Nashville, TN beginning in 1990, VHA essentially developed the automated prescription dispensing technology that is on the commercial market today. GAO's 1992 report was not the determining factor prompting VA's decision to implement consolidated mail outpatient pharmacies or the timing of their implementation. Timing of the implementation was actually influenced by the development of suitable technology associated with efficient human resources management. Due to the fact that none of the existing mail prescription facilities is operating at full capacity, it is too early for either VA or GAO to estimate annual cost avoidance. Experience to date suggests that substantial savings will accrue. How much savings is also very difficult to estimate due to the fact that technology is continually evolving.

GAO Evaluation

Our report does not indicate that VA's decision to establish consolidated mail service pharmacies was in response to our January 1992 report. Our report, did, however, recommend that VA require pharmacies to maximize the use of 90-day supplies when dispensing maintenance drugs. It also contained recommendations on the location and operation of the bulk processing centers.

We got our estimate of savings from VA pharmacy officials.

VHA Comment 19

Page 19. The 1991 study is based on FY 1986, or ten year old data. The 1993 study is based on 1989 data. In both studies, trained reviewers were instructed to assume all levels of care were available at each VA medical center in the determination of the appropriateness of inpatient services. In the 1991 study, social factors were only considered if documented in the patient's chart. In the 1993 study, reviewers were explicitly instructed not to consider social factors in the determination of the appropriateness of inpatient care. This would, of course, have bearing on the conclusions drawn in the current GAO report.

GAO Evaluation

We reviewed the two studies because VA, the National Performance Review, and the Independent Budget cite them as support for their views that eligibility reform would allow VA to shift 20 to 43 percent of nonacute admissions to outpatient settings. We agree with VA that the assessments of the "appropriateness of inpatient care" under both studies were based on application of medical necessity criteria, not on whether extenuating circumstances, such as nonavailability of an ambulatory surgery program, long travel distance, and eligibility restrictions, might lead to nonacute admissions. A secondary goal of the studies, however, was to provide some insights into the reasons for nonacute care. Our comments are based on the reasons for nonacute admissions identified by the researchers. For example, the 1993 study notes that "hospital reviewers were asked to prioritize up to three reasons for each nonacute admission and day of care." The reviewers, in identifying reasons for nonacute admissions, looked both at the availability of other care settings and social factors. For example, the study notes that "[l]ack of an ambulatory care alternative was the most important reason for nonacute admissions to surgery."

VHA Comment 20

You fault VA for nonacute inpatient admissions. Yet in order to shift much of this nonacute care of mandatory VA inpatients to cost-effective outpatient alternatives when outpatient eligibility is discretionary or limited, VA needs the outpatient eligibility reform tool. VA gets blamed for both the problem and the solution when much of the problem stems from the complexity of or lack of outpatient eligibility in order to achieve the best patient and system outcomes.

GAO Evaluation

As discussed in our March 20, 1996, testimony before the Senate Committee on Veterans' Affairs, we see little basis for linking nonacute admissions to VA hospitals to eligibility restrictions. Rather, nonacute admissions are most often caused by the VA system's inefficiencies, VA's resource allocation systems that have historically rewarded VA medical centers for choosing inpatient over outpatient care, and the system's slowness in developing ambulatory care facilities. VA continues to emphasize expanding hospital capacity over outpatient capacity in its fiscal year 1997 budget submission. VA proposes to spend over $383 million, including about $75 million in fiscal year 1997, to build major hospital capacity in two markets that already have a surplus of private-sector beds.

VHA Comment 21

Your report minimizes the role of outpatient eligibility as a reason for nonacute admissions. The Smith study notes:

> "Practitioner reasons such as conservative practice for admissions and delays in discharge planning for nonacute days of care accounted for 32% of nonacute admissions and 43% of nonacute days of care for medical service. Lack of availability of an ambulatory program for surgery and invasive medical procedures explained 36% of nonacute admissions to surgery and 18% to medicine. Other important reasons for nonacute admissions included social and environmental reasons such as homelessness, and long travel distances to the hospital. Administrative reasons included admissions to permit placement in nursing homes, payment for travel or for disability evaluations.

GAO Evaluation

For the following reasons, we believe the above quotation supports our position that the study did not attribute most nonacute admissions to eligibility problems.

- "Conservative practice was," the study notes, "generally interpreted by reviewers to mean both that no other social, VA system, or regulation [emphasis added] reason was identifiable, and the decision of the practitioner to admit the patient to the acute hospital service was an example of conservative medical practice."
- "Delays in discharge planning" would contribute to nonacute days of care, not to nonacute admissions. Nor were those nonacute days of care the result of eligibility restrictions. Under current law, all veterans are eligible for posthospital outpatient treatment.

- The quotation cites the lack of an ambulatory "program" for surgery and invasive medical procedures, not the lack of patient eligibility for such services as the cause of nonacute admissions.
- Social and environmental reasons such as homelessness and travel distance are unrelated to eligibility restrictions.
- Two of the three administrative reasons cited (admissions to pay travel reimbursement and admissions to perform disability examinations) are not related to eligibility for health care services. The requirement that veterans with no service-connected disabilities be admitted to VA hospitals before they can be placed in community nursing homes is an eligibility-related limitation. The study found that this limitation accounted for 2.5 percent of the nonacute admissions to acute medical wards.

VHA Comment 22

[This comment responds to GAO's reporting that the Smith study recommended only minor changes in VA eligibility provisions, specifically, that VA establish a systemwide utilization program and that VA has not established such a review function.]

The final report of the Smith study, 1993, did not make "minor" recommendations related to outpatient eligibility as you suggest. Of the three recommendations, which follow, two are related to limited outpatient eligibility and its impact upon the development and availability of such care:

A. VA should establish a system-wide program for using the ISD criteria for utilization review with emphasis on identifying the local and systemic reasons for nonacute admissions and days of care and for monitoring the effectiveness of changes in policy.

B. VA physicians need to be encouraged to make greater use of ambulatory care alternatives and to be more effective and timely in planning for patient discharges.

C. VA needs to facilitate the shift of care from the inpatient to the outpatient setting. This should include incentives in the reimbursement methodology for providing ambulatory care, changes in eligibility regulations that promote rather than prohibit ambulatory care, prioritization of construction funds and seed funds for new programs to support the shift to ambulatory care.

GAO Evaluation

VA does not need eligibility reform to implement either of the first two recommendations. VHA agreed with the recommendation made in our report that it establish an independent preadmission certification program to reduce inappropriate admissions to VA hospitals. In addition, VA has, through its emphasis on primary care, encouraged the shift to ambulatory care. Nor does VA need eligibility reform to change its reimbursement methodology to promote ambulatory care (such a change is under way through RPM) or to prioritize construction funds to facilitate the shift toward ambulatory care (VA continues to seek construction funds primarily for hospital construction rather than ambulatory care programs).

Concerning the recommendation to change eligibility “regulations,” the detailed section of the Smith report recommended that legislation be enacted to (1) allow veterans with nonservice-connected disabilities to be placed in VA-supported community nursing homes without first being admitted to a VA hospital and (2) remove limitations on eligibility for outpatient compared with inpatient services such as dental services and provision of needed prosthetic devices. The eligibility reform proposal developed by VA would allow direct admission of nonservice-connected veterans to community nursing homes and the provision of prosthetic devices on an outpatient basis for treating nonservice-connected conditions. The VA proposal would not remove the limitations on provision of dental services on an outpatient basis.

Trying to link the studies discussed here to broader VA eligibility reform is inappropriate because the studies did not contain the types of data needed to make such a link. In other words, the studies did not determine whether the patients inappropriately admitted to VA hospitals had service-connected or nonservice-connected disabilities, the degree of any service-connected disability, whether they were in the mandatory or discretionary care category for outpatient care, or whether they would have been eligible to receive the services they needed on an outpatient basis. Had such information been included in the studies, it would be possible to determine whether a higher incidence of nonacute admissions occurred for veterans eligible for only hospital-related outpatient services than for those eligible for comprehensive outpatient services.[30]

VHA Comment 23

In a more detailed section, the Smith report notes:

[30]This is a limitation in how the studies can be used, not a deficiency in how the studies were conducted.

"The most important reason for nonacute admissions to surgical services in previous VA studies and in this study was the lack of an available ambulatory care alternative. This was also an important reason for nonacute admissions to medical services. These findings support the need to facilitate the shift of care from an inpatient to an outpatient setting."

GAO Evaluation

Elsewhere in its comments, VHA maintains that the reviewers conducting the study were expressly told to assume that all care settings were available. It seems to us to be inconsistent to now cite the study's finding that the most important reason for nonacute admissions to surgical services was the lack of an ambulatory care alternative.

We agree, however, that VA's slowness in developing ambulatory care capabilities is a primary reason for nonacute admissions to VA hospitals. We applaud VHA's recent efforts to expand such capabilities.

VHA Comment 24

One of the four specific detailed recommendations of the Smith study was:

"The eligibility regulations need to be adjusted to encourage outpatient rather than inpatient care. Legislation will be needed to allow contract nursing homes to be reimbursed by VA for patients admitted directly from outpatient status to nursing home care. Limitations need to be removed on eligibility for outpatient as compared to inpatient services such as dental services and provision of needed prosthetic devices."

GAO Evaluation

We cited this recommendation in our report, and we believe we correctly characterize it as suggesting only minor changes in VA eligibility provisions. Rather than recommending a significant expansion of VA eligibility, it recommends three specific changes affecting a relatively small portion of VA benefits—nursing home care, dental care, and prosthetics.

VHA Comment 25

Contrary to the statement in the report, VHA has had a systemwide utilization review (UR) program since October 1993. In planning for this program, VHA's Office of Quality Management initiated a utilization management (UM) pilot study in 1992. The UM pilot study had a two-fold purpose. One, to provide guidance for development of a national policy and data base to assist managers at all levels in VHA to assess the appropriateness and efficiency of resource utilization. Second, to determine the reliability and validity of an appropriateness measure that

facilities could use to determine the extent and causes of these allegedly inappropriate admissions and days of care. The UM pilot study concluded in November 1992. A UR national training program was conducted in the summer of 1993, prior to implementation in October 1993. In addition to the internal UR program, VHA has also actively pursued the potential of external utilization review for national data collection to address system issues.

GAO Evaluation

We have clarified the wording in the final report to indicate that VA does not have a utilization review program focusing on medical necessity. VA's current utilization review program focuses almost exclusively on quality of care.

VHA Comment 26

VHA is currently assessing the use of pre-admission reviews systemwide as a method to encourage the most cost-effective, therapeutically appropriate care setting. A number of facilities have adopted some form of pre-admission reviews already and their models are being reviewed. In addition, VHA is implementing a performance measurement and monitoring system which contains a number of measures for which all network directors and other leaders will be held accountable. Several of these measures, such as percent of ambulatory surgery done at each facility, and implementation of network-based utilization review policies and programs will move the VA system towards efficient allocation and utilization of resources.

GAO Evaluation

We have added a discussion of VHA's current efforts to the final report.

VHA Comment 27

Page 25. With VHA restructuring, resources are allocated to the network director. VISN directors now have both the responsibility and incentive to examine cost variations among facilities within their network. Network directors are at the cutting edge, assessing the current configuration of VA health services and costs in order to make decisions on redirecting resources to achieve a more efficient and patient centered health care system.

GAO Evaluation

We agree that the VISN restructuring and the planned move to capitation funding should lead to an increased emphasis on efficiency, as discussed in the final report.

VHA Comment 28

The National Cost Containment Center (NCCC) was premised on the goal of analyzing costs across the system to identify opportunities for improvement. They have published numerous analyses. In addition, VHA clinical technical advisory groups; e.g., the Chronic Mental Illness group, also analyze costs on a programmatic level.

GAO Evaluation

We recognize that VA has taken some steps, through the NCCC and Technical Advisory Groups, to analyze particular cost variations across the system to identify potential efficiencies. These efforts are a step in the right direction, but VA needs more comprehensive evaluations of unit cost variations, their link to facility performance, and the need for changes to supporting data systems to improve comparisons. Such evaluations and improved data systems will be necessary to ensure a successful transition to a capitation system and provide for the needed accountability in the system for workload, efficiency, and other performance targets.

Related GAO Products

VA Health Care: Approaches for Developing Budget-Neutral Eligibility Reform (GAO/T-HEHS-96-107, Mar. 20, 1996).

VA Health Care: Opportunities to Increase Efficiency and Reduce Resource Needs (GAO/T-HEHS-96-99, Mar. 8, 1996).

VA Health Care: Issues Affecting Eligibility Reform (GAO/T-HEHS-95-213, July 19, 1995).

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

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).

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

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).

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