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Health, Education and Human Services Division

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The Honorable Tim Hutchinson
Chairman, Subcommittee on Hospitals
and Health Care
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

This letter responds to a May 12, 1995, request from your staff for a list of potential options to enable the Department of Veterans Affairs (VA) health care system to contribute toward deficit reduction without adversely affecting the current level of services provided to veterans with service-connected disabilities or low incomes.

Enclosed are brief descriptions of 14 potential options to achieve budgetary savings in the VA health care system without adversely affecting the current level of services to veterans with service-connected disabilities or low incomes. Each option is based on related GAO reports and testimonies. While most of the savings could be achieved through administrative actions, several, such as increased cost sharing, would require congressional authorization.

Copies of this letter are also being provided to the Ranking Minority Member, Subcommittee on Hospitals and Health Care; the Chairmen and Ranking Minority Members of the House and Senate Veterans' Affairs Committees; and the Secretary of Veterans Affairs. Copies will be made available to others upon request.

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If you have any questions about the options or need additional assistance, please call Jim Linz, Assistant Director, on (202) 512-7110.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

Enclosure

OPTIONS FOR COST SAVINGS IN VA HEALTH CARE

SHIFT CARE TO ALTERNATIVE SETTINGS

VA hospitals too often serve patients whose care could more efficiently be provided in alternative settings such as ambulatory care. The major veterans service organizations noted in their 1996 Independent Budget that VA could reduce its hospital inpatient workload by up to 44 percent, with savings of about $2 billion, if it treated patients in alternative settings.

Management inefficiencies prevent VA from shifting much of its current hospital workload to ambulatory care settings. VA's proposed reorganization of its health care facilities into 22 veterans integrated service networks provides the vehicle for addressing these inefficiencies quickly. In addition, VA's resource planning methodology is intended to provide incentives for VA facilities to provide care in the most cost-effective setting. If successful, these actions should enable VA to provide services to veterans with fewer resources.

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

ADOPT STATE VETERANS' HOME CHARGING POLICIES

VA could offset a larger portion of its nursing home and domiciliary costs if the Congress authorized it to adopt charging policies similar to those that most states use to offset the costs of operating their state veterans' homes. VA recovers less than one-tenth of 1 percent of its costs to provide nursing home and domiciliary care in VA and community facilities. In comparison, eight states visited by GAO used copayments to offset from 4 to 43 percent of state home operating costs. If VA had offset similar percentages, its recoveries would have been between $43 million and $464 million in 1990.

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

AUTHORIZE ESTATE RECOVERIES

VA could offset a significant portion of its nursing home and domiciliary care costs if it had the same authority states have to operate estate recovery programs under Medicaid. The potential for recovering nursing home and domiciliary costs through estate recoveries may be greater for veterans than for Medicaid recipients because (1) home ownership--the primary asset of most elderly persons--is significantly higher among elderly VA hospital users than among Medicaid nursing home users and (2) veterans living in

VA facilities generally contribute much less to the cost of their care than do Medicaid recipients, allowing veterans to build larger estates.

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

INCREASE COPAYMENTS

VA requires less cost sharing for inpatient care than most major health benefits programs. In fact, free inpatient medical and surgical care, including hospital room and board, diagnostic tests and other hospital services, and physicians' and surgeons' services, is provided to over 95 percent of VA inpatients. Most other major health programs typically require significant cost sharing for inpatient care, including professional charges and hospital expenses. Even the higher income, nonservice-connected veterans required to make copayments will generally pay less at VA hospitals than they would in community hospitals under Medicare.

VA also provides free outpatient care to veterans in the mandatory care category, while most private insurance and Medicare require participants to satisfy an annual deductible and make copayments for outpatient services. VA charges veterans in the discretionary category a flat fee ($26 per visit) regardless of the services provided, while most health programs impose copayments as a percentage of the cost of services provided.

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

REDUCE OR ELIMINATE CARE FOR VETERANS IN HIGHEST INCOME CATEGORIES

VA could eliminate or reduce services to veterans in the highest income category--generally referred to as the discretionary care category. About 15 percent of the 2.2 million veterans using VA medical centers in 1991 were nonservice-connected veterans with incomes of $20,000 or more. About 11 percent of the single nonservice-connected veterans and 57 percent of the married nonservice-connected veterans using VA medical centers in 1991 had incomes of $20,000 or more. Resources allocated to medical centers having sufficient funds to treat veterans in the discretionary care category could be reduced without affecting services for veterans in the mandatory care category--primarily veterans with service-connected disabilities or low incomes.

VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995); VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9,

1995); VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

STOP/DELAY MAJOR CONSTRUCTION PROJECTS

Average daily inpatient workload in VA hospitals declined by 56 percent between 1969 and 1994 with further declines likely. Changes in the Medicare program and health reforms in individual states could significantly affect future demand for VA care as could reform of VA eligibility. Although the rate of future declines in VA hospital workload depend on the outcome of eligibility and health reform, declines will likely occur even without such reforms because of the declining numbers of veterans and increased enrollment in health maintenance organizations, among other factors. GAO believes that the Congress should proceed cautiously with construction of additional VA health care facilities until reforms of the nation's health care system and VA eligibility take shape.

Delaying building additional VA health care facilities does not have to mean an interruption in meeting veterans' needs. VA could be given expanded authority to provide veterans acute care services in their home communities through contracts with private-sector hospitals, many of which have significant excess capacities.

Veterans Affairs Issues (GAO/OCG-93-21TR, Dec. 1992); Veterans' Health Care: Potential Effects of Health Reforms on VA Construction (GAO/T-HRD-93-7, Mar. 3, 1993); VA Health Care: Challenges and Options for the Future (GAO/HEHS-95-147, May 9, 1995).

INCREASE USE OF COMMUNITY NURSING HOMES AS AN ALTERNATIVE TO NEW VA NURSING HOMES

VA does not effectively use lower cost community nursing homes as an alternative to building VA nursing homes. VA's costs of supporting patients in community nursing homes (about $106 per day) are significantly lower than those for operating nursing homes (about $207 a day). Increased use of community nursing homes could also avoid the costs of building VA nursing homes (about $6 to $19 million for a 120-bed nursing home).

VA, however, has significantly decreased its use of community nursing homes since 1988, while proposing construction of additional VA nursing homes.

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

STRENGTHEN INCOME VERIFICATION

The Congress gave VA authority to use tax records to verify veterans' reported incomes during 1991 and 1992. Because VA did not develop a verification system, it lost an estimated $120 million in copayment revenues for veterans who underreported their incomes to VA. The Congress extended VA's authority to use tax records for an additional 5 years. Effectively using this authority would enable VA to reduce abuse of its copayment requirements, making additional funds available for providing services to service-connected and lower income veterans.

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

IMPLEMENT MULTI-MONTH DISPENSING OF PRESCRIPTION DRUGS

When treating veterans with chronic conditions, VA physicians frequently prescribe drugs for long periods of time. Although VA mail-service pharmacies may fill prescriptions in 90-day quantities, most routinely dispensed drugs in 30-day quantities in 1992. Such dispensing practices are not cost-efficient because handling costs are generally much higher than the cost of the drugs. VA started a study of ways to improve its pharmacy operations but did not include an assessment of optimal prescription dispensing quantities.

Filling prescriptions for veterans with chronic conditions on a 90-day rather than a 30-day basis would reduce dispensing costs and allow VA to provide the same overall quantity of drugs to veterans with fewer personnel. VA has given medical centers considerable discretion to fill prescriptions for chronic conditions on a multi-month basis, but medical centers have been slow to change their dispensing practices.

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

ELIMINATE DISPENSING OF OVER-THE-COUNTER DRUGS

VA, unlike many other health benefits programs, provides coverage of some over-the-counter drugs such as antacids and aspirin. These drugs are among the drugs most frequently dispensed by VA pharmacies. Eliminating coverage of over-the-counter drugs would save both the costs of the drugs and the costs of dispensing them.

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

RECOVER FULL COSTS OF SERVICES SOLD TO NONVETERANS

VA facilities frequently treat nonveterans to increase use of excess services and generate revenue. Without better systems for determining the cost of care, however, such an approach could result in funds appropriated for veterans health care being used to pay for care for nonveterans. For example, we recently reported that the Albuquerque, New Mexico, medical center was selling lithotripsy services to nonveterans at prices well below cost. In 1993, the Albuquerque medical center did not recover about $91,000 of the costs for contract procedures provided to nonveterans. If they charged appropriate rates, the additional revenue could be used to offset budget reductions.

VA Health Care: Albuquerque Medical Center Not Recovering Full Costs of Lithotripsy Services (GAO/HEHS-95-19, Dec. 28, 1994); VA Health Care: Challenges and Options for the Future (GAO/T-HEHS-95-147, May 9, 1995).

CONSOLIDATE MAIL-SERVICE PHARMACIES

VA operates too many mail-service pharmacies, which rely on labor-intensive processing of veterans' prescriptions. In 1992, all but 3 of VA's 229 outpatient pharmacies provided mail service. By contrast, private-sector mail-order pharmacies generally provide nationwide service to corporate, union, and government employers. These private mail-service pharmacies operate in a highly structured environment, using centralized dispensing practices, and achieve cost savings through economies of scale.

VA has developed and tested a pilot mail-service pharmacy and is establishing additional consolidated pharmacies. Completion of these efforts should enable VA to maintain or expand prescription workload with significantly fewer staff and resources.

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

CONSOLIDATE UNDERUTILIZED SERVICES IN NEARBY VA MEDICAL CENTERS

To survive in a highly competitive environment, private-sector hospitals have increasingly formed alliances with other hospitals to share high-cost services and equipment to prevent costly duplication. The VA system must make similar changes to become more efficient. For example, VA operates four hospitals in the Chicago area offering overlapping services. By consolidating services, VA could reduce costs and improve efficiency.

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

SUSPEND LOCALITY-BASED PAY ADJUSTMENTS

VA's procedures for surveying local salary rates for nurses fell well short of the standards established for surveys conducted by the Bureau of Labor Statistics. As a result, VA's salary rates could easily be substantially higher than justified. At 82 percent of VA medical centers, registered nurses and certified registered nurse anesthetists' salaries for one or more pay grades increased by 20 percent or more as a result of locality-based adjustments. GAO cited the locality-based pay system as a material internal control weakness because of the multiple problems identified in VA's rate-setting methods.

Locality-based pay was implemented to improve VA's ability to recruit and retain nurses at a time of nationwide nursing shortages. Currently, however, many markets have a surplus of nurses, decreasing the need for locality-based adjustments.

VA Health Care: Problems in Implementing Locality Pay for Nurses Not Adequately Addressed (GAO/HRD-93-54, May 21, 1993).

RESTRUCTURE VA'S AMBULATORY CARE SYSTEM

VA's ambulatory care procedures cause many veterans with nonurgent conditions to arrive unscheduled at screening clinics and receive care on a first-come, first-served basis. This frequently results in uneven workload, which can cause higher staffing levels and associated costs than would otherwise be needed. VA can reduce its staffing costs by using telephone assistance networks to handle veterans' routine medical needs, such as advice about prescriptions or previously diagnosed conditions, or by allowing veterans to schedule initial screening visits.

Also, VA's operating policies allow too many veterans to receive general medical care in specialty clinics after their medical conditions have been stabilized. This results in higher staffing costs for specialists than would be needed if veterans were referred to general medicine clinics where primary care physicians could provide the needed level of follow-up care.

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

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