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VA HEALTH CARE

Capital Asset Planning and Budgeting Need Improvement

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VA Health Care: Capital Asset Planning and Budgeting Need Improvement

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss management of health care assets within the Department of Veterans Affairs (VA). Over the next few years, VA could spend about 1 of every 4 health care dollars operating, maintaining, and improving buildings and land at 181 major delivery locations nationwide--in all, over 4,700 buildings and 18,000 acres of land.

Last June, you asked us to examine VA's capital asset [1] planning and budgeting processes based in part on your concerns about the aging of Va's assets, declining veteran populations in most states outside the Sunbelt, [2] declining need for hospital beds, and limited construction budgets. [3]

My comments this morning are based on

- visits to 78 VA locations,
- visits to VA's headquarters and 22 regional offices,
- discussions with over 400 VA officials,
- review of hundreds of VA planning documents,
- review of industry asset management practices, and
- GAO studies completed over the past several years. [4]

In summary, VA's asset plans indicate that billions of dollars might be used operating hundreds of unneeded buildings over the next 5 years or more. This is because VA does not systematically

- evaluate veterans' or asset needs on a market (or geographic) basis or
- compare assets' life-cycle costs and alternatives to identify how veterans' needs can be met at lower costs.

[1]Capital assets are generally defined as land, structures, equipment, and intellectual property (including software) that have a useful life of 2 years or more. This statement focuses solely on VA's land and structures, primarily buildings.

[2]There is no commonly accepted definition of the Sunbelt; one definition includes Alabama; Arkansas; Arizona; Florida; Georgia; Louisiana; Mississippi; New Mexico; Oklahoma; South Carolina; Texas; Southern California; and Clark County, Nevada.

[3]The Chairman, Committee on Veterans' Affairs, House of Representatives, also requested this examination for the same reasons.

[4]See Related GAO Products listed at the end of this statement.

In our view, VA could enhance veterans' health care benefits if it reduced the level of resources spent on underused or inefficient buildings and used these resources, instead, to provide health care, more efficiently in existing locations or closer to where veterans live.

Over the last 2 years, VA has significantly improved its budgeting process for major capital investments. This process, however, still relies too heavily on

- inconsistent or incomplete information,
- imprecise decision criteria, and
- qualitative (rather than quantitative) measurement standards.

This results in subjective asset-management judgments, based on individual viewpoints, rather than objective decisions, based on systematic assessments of proposed investments' benefits, costs and risks.

VA's capital asset decision-making also appears to be driven more by the availability of resources within VA's different appropriations rather than the overall soundness of investments. VA, for example, sometimes decides that leasing alternatives should be used, instead of construction, to obtain needed space, because money is more readily available in the appropriation that funds leases than in the construction appropriation. As a result, VA sometimes spends millions of dollars more than would be needed to build or buy an asset.

Furthermore, VA's reliance on construction appropriations could be reduced if VA is given legislative authority to use

- proceeds from the disposal of unneeded assets to invest in more appropriate ones, or
- some or all of operational savings or third-party collections attributable to capital investments.

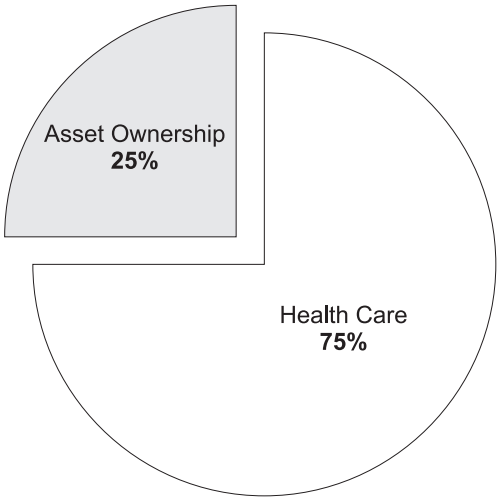
VA Has a Diverse Portfolio of Health Care Assets

Within VA, the Veterans Health Administration (VHA) has primary responsibility for health care asset management. VHA has divided its 181 delivery locations into 22 geographic regions, which have between 6 and 12 major delivery locations. Each region, referred to as a Veterans Integrated Service Network, has a director and small staff, which perform a wide range of activities, including asset planning and budgeting.

Each network director has developed a 5-year business plan.[5] These plans indicate that assets will continue to operate at the 181 locations essentially as they do today. In so doing, VHA's cost of asset ownership could be as much as $20 billion or more during this period, primarily for operations[6] and maintenance costs.

Historically, VHA's medical care appropriation has funded over 95 percent of VHA's asset ownership costs; two separate construction appropriations fund the rest. In fiscal year 2000, such ownership costs could be as much as $4 billion or more, accounting for a major slice of VHA's health care budget (see fig. 1).[7]

Figure 1: VHA's Proposed $17 Billion Medical Care Appropriation for FY 2000



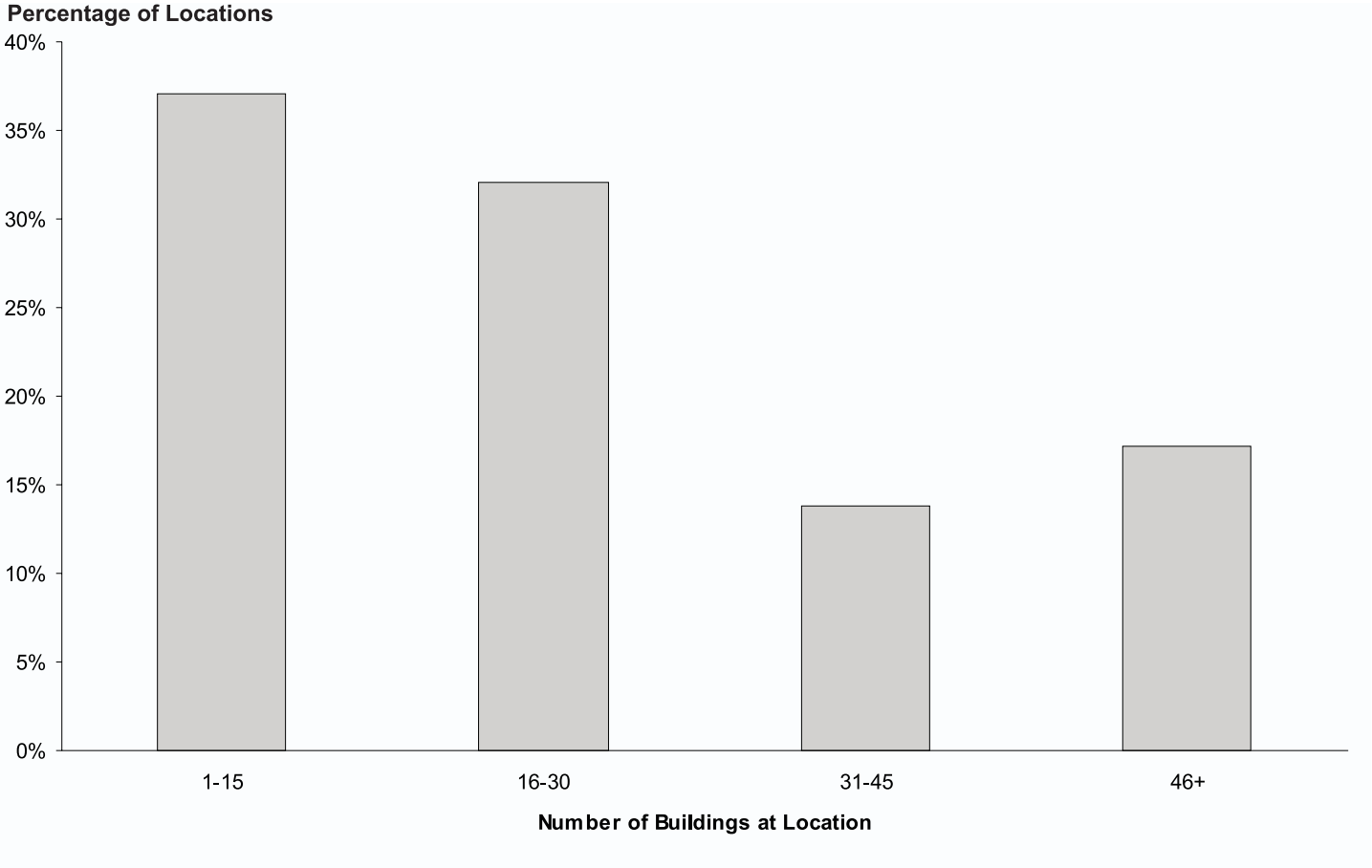
[5]VHA's latest plans cover the period between 1999 and 2003.

[6]Asset-related operations include utilities and services such as security, grounds care, fire protection, waste collection, pest management, and custodial work.

[7]VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998) reports that asset operations and maintenance costs for four VA hospitals in Chicago generally represent about 25-35 percent of the hospital's operating budgets. VA officials in headquarters and regional offices who are familiar with hospitals' operating budgets generally agreed that asset costs as a percentage of budgets nationwide could be comparable to the level found in Chicago.

VHA operates and maintains a mix of buildings and land at its 181 medical care delivery locations. Most delivery locations are campus-style, comprising over 16 buildings each, although many locations are urban-style with fewer buildings. (See fig. 2.)

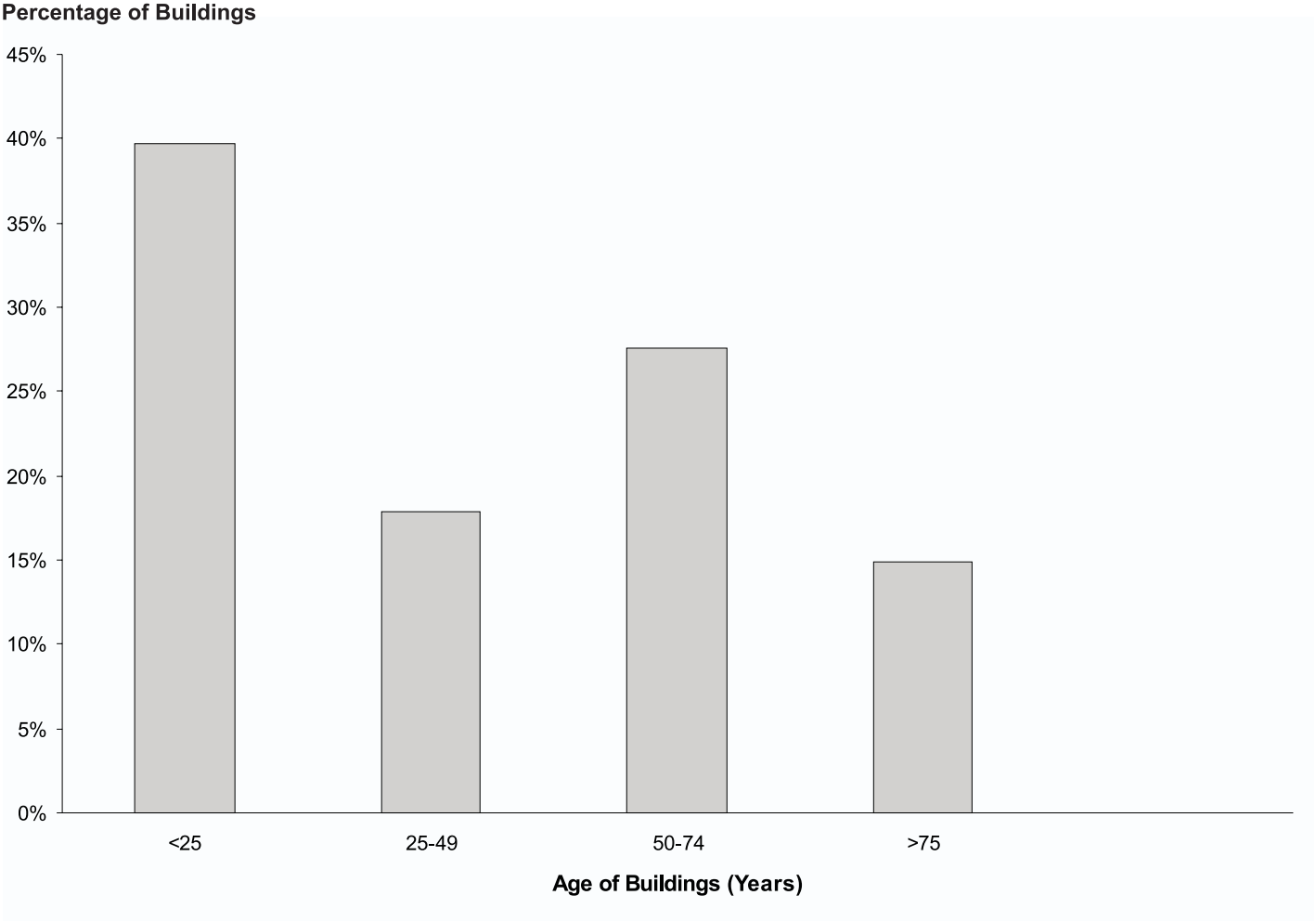
Figure 2: Number of Buildings at VHA's 181 Major Delivery Locations



VHA faces a profound asset management challenge for four primary reasons. First, VHA owns 4,700 buildings, over 40 percent of which have operated for more than 50 years, including almost 200 built before 1900

(see fig. 3). Many organizations in the facilities management environment consider 40 to 50 years to be the useful life of a building. [8]

Figure 3: Age of VHA Buildings

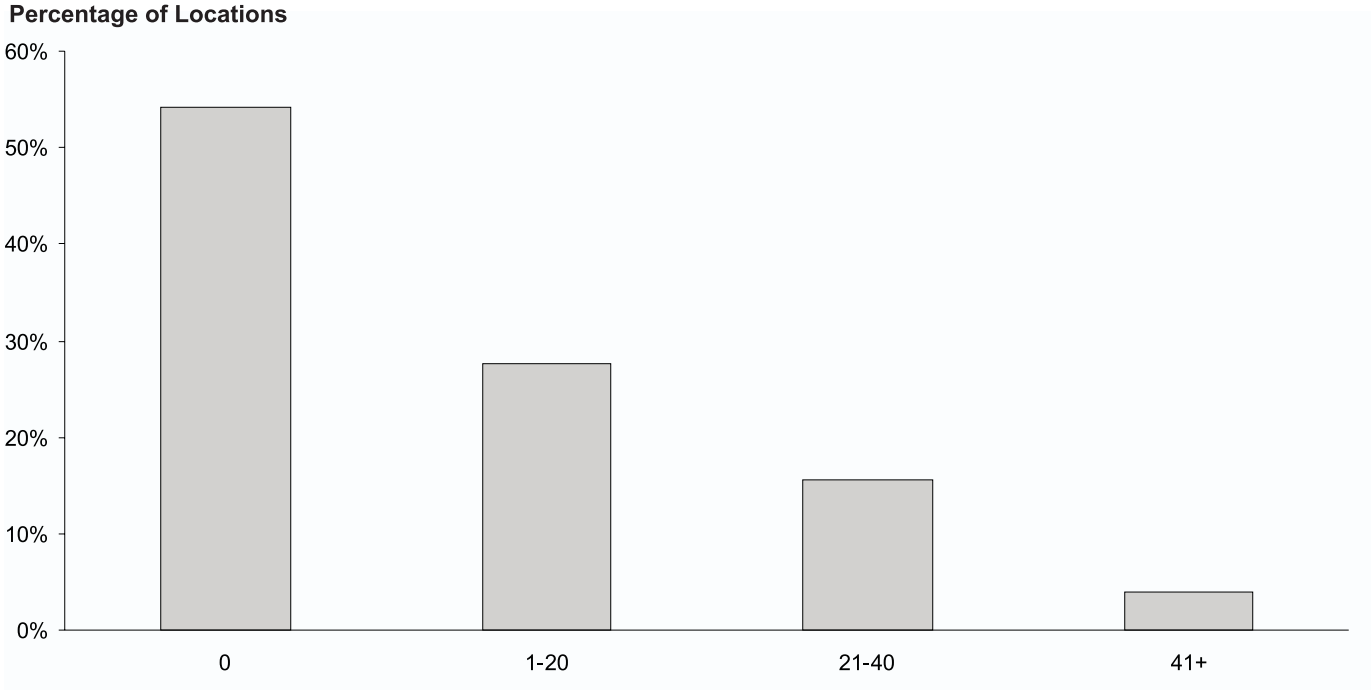


Second, over 1,600 buildings (almost one-third) have historical significance, according to VA's inventory of historical and cultural

[8] Price Waterhouse, Independent Review of the Department of Veterans Affairs' Office of Facilities Management, Final Report (June 17, 1998).

resources (see fig. 4). Historical significance is based partly on a building's age, but it also considers architectural features and history. These buildings are either formally listed or are eligible for listing on the National Register of Historic Places and all are equally protected by law. This requires VHA to comply with special procedures for maintenance and disposal. Almost half of VHA's 181 locations have historic buildings.

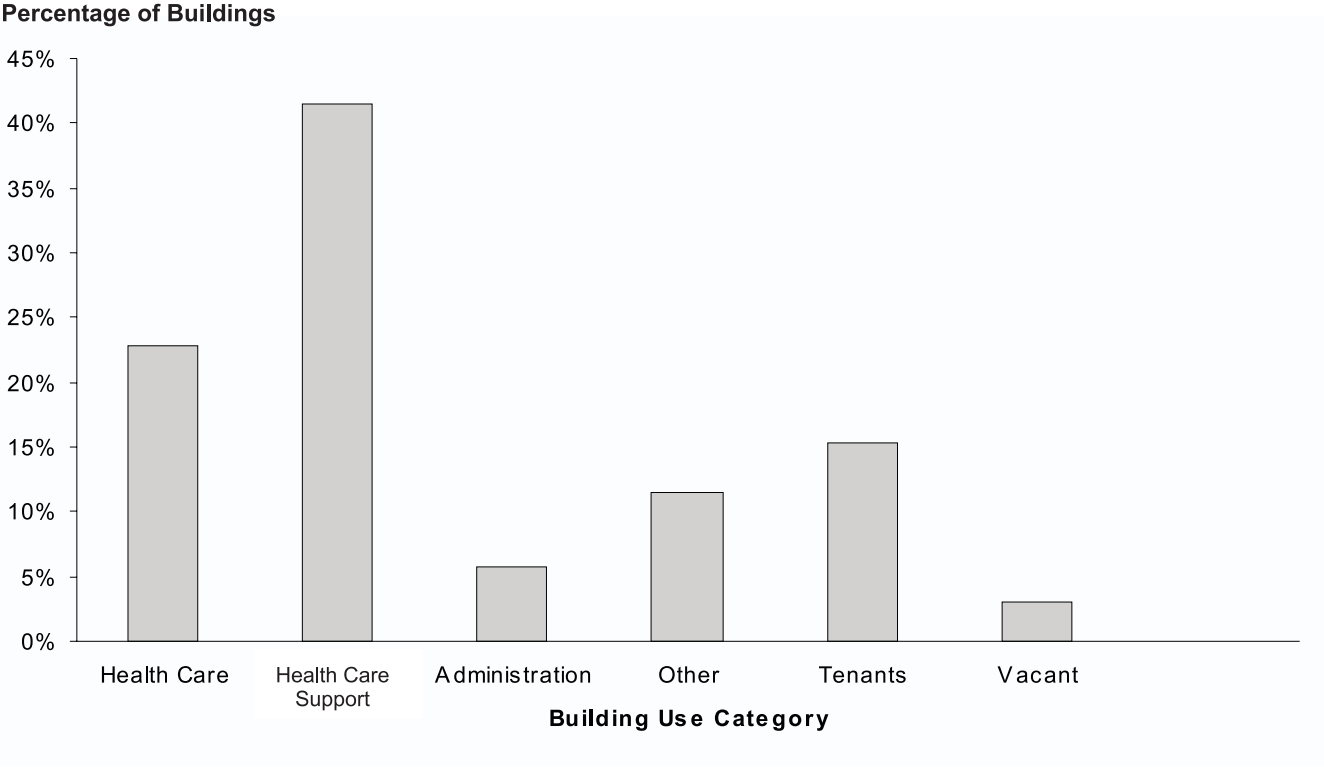
Figure 4: Number of VHA's Historic Buildings



Third, VHA uses fewer than 1,200 buildings (about one-fourth) to deliver health care services to veterans (see fig. 5). The rest are used primarily to support health care activities,[9] although many have tenants or are vacant. Of note, VA has over 5 million square feet of vacant space, which can cost as much as $35 million a year to maintain.

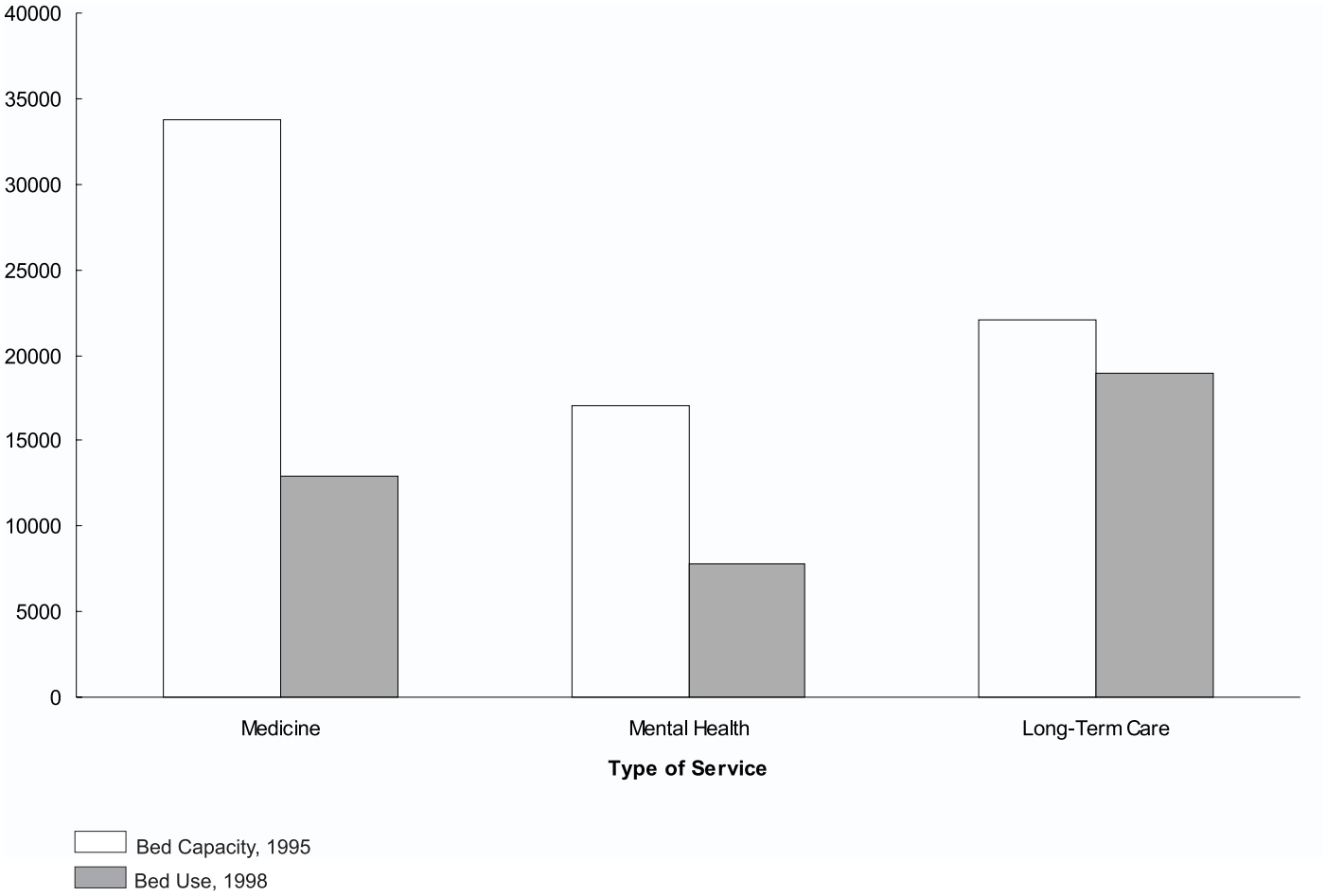
[9]Health care support buildings include warehouses, engineering shops, laundries, fire stations, day care centers, and boiler plants.

Figure 5: Types of VHA Building Use



Fourth, VHA's health care buildings have significant unused inpatient capacity (see fig. 6). For example, while VHA operated about 73,000 beds in fiscal year 1995, in 1998, veterans used fewer than 40,000 beds a day, on average. The greatest underutilization (about 21,000 fewer beds a day) occurred in acute medicine, where usage was about 38 percent of potential capacity.

Figure 6: VHA's Unused Inpatient Capacity



VHA's ongoing efforts to improve operating efficiency, coupled with a rapidly evolving health care market, suggest that bed use may continue declining. Declining demand for inpatient care is not unique to VHA. Community hospitals, for example, have tens of thousands of unused beds. Overall, about 26 percent of community hospitals' 873,000 beds in 1995 were unused. Like VHA, the number of unused community hospitals' beds may also increase, given the rapidly evolving health care market. [10]

[10] VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

VHA's Asset Planning Needs to Be Improved

The Office of Management and Budget (OMB) encourages federal agencies to develop long-term "asset plans" as part of their capital planning process and to use these plans, among other things, to justify budget requests to the Congress.

To obtain the best use of capital resources, OMB guidelines suggest that agencies should conduct market-based assessments to determine asset needs.[11] These include

- assessing a target population's needs,
- evaluating the capacity of existing assets,
- identifying any performance gap (excesses or deficiencies),
- estimating assets' life-cycle costs, and
- comparing such costs to other alternatives for meeting the target population's needs.

State and private organizations have also found that using such planning processes has yielded positive results.[12]

Currently, VHA's planning focuses individually on each of its 181 delivery locations, even though most locations operate in markets that include two or more VA locations.[13] Also, VHA does not systematically assess all life-cycle costs or logical alternatives for meeting veterans' needs before deciding that capital investment is warranted.

VHA's investment planning focuses primarily on identifying asset improvements that should be done over the next 5 years. For its current planning period (1999-2003), VHA estimates high-priority improvements to cost over $1.8 billion.[14]

[11] Capital Programming Guide, Version 1.0 (Washington D.C.: OMB, July 1997).

[12] Executive Guide: Leading Practices in Capital Decision-Making (GAO/AIMD-99-32, Dec. 1998) and VA, Capital Inve$tment$: Survey of Best Practices (Washington D.C.: VA, May 1998).

[13] A market, for purposes of this statement, is defined as a geographic area generally within 75 miles of an existing VHA major delivery location.

[14] A VHA consultant advised VA in a February 12, 1999, report that an additional $1.9 billion could be needed to seismically rehabilitate over 890 buildings. VHA is currently reviewing this report and expects to revise its 5-year planning as appropriate.

If VHA followed OMB's guidance, in our view, planning would focus on assets needed to meet veterans' needs in 106 markets. These markets include

- 66 with a single VHA location and
- 40 with multiple VHA locations (between two and nine).

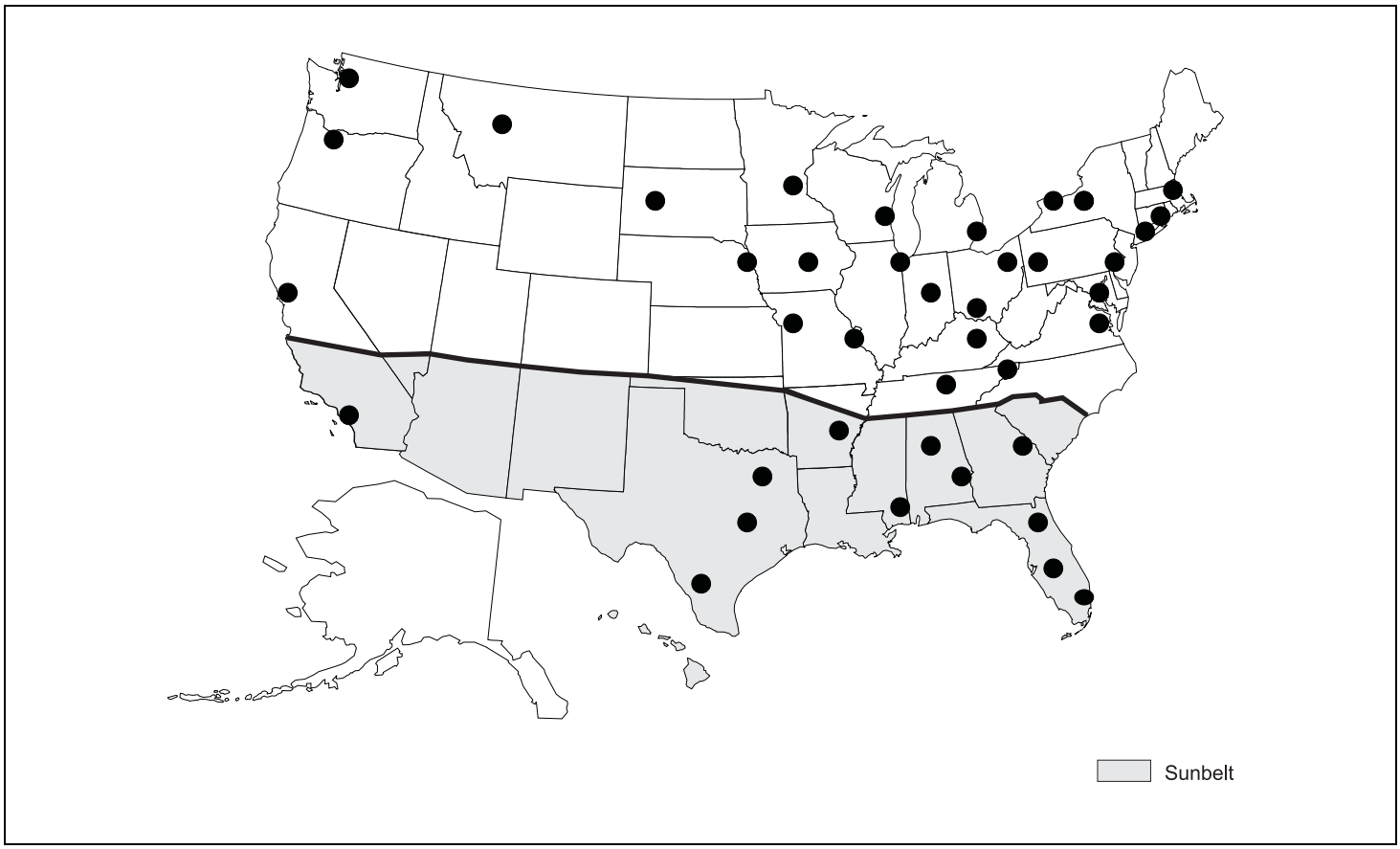
VHA's 40 multiple-location markets yield great opportunities for asset restructuring and benefit enhancements for veterans. This is because they have 115 delivery locations that

- have utilization significantly below inpatient capacity and
- compete with other VA locations to serve rapidly declining veteran populations.

Nationwide, the number of veterans (25 million) is declining and their average age (58) increasing. VHA estimates that the veteran population will number 16 million by the year 2020, a 36-percent decline from today's level.

The veteran population in some geographic areas, such as the Sunbelt, is expected to experience smaller declines. Other areas, such as the Northeast or Midwest, are expected to experience larger population declines. Most of VHA's multiple-location markets are in these latter two areas. (See fig. 7.)

Figure 7: VHA's 40 Multiple-Location Markets



We estimate that VHA spends about $2.7 billion a year to operate and maintain more than 3,000 buildings and 10,000 acres in the multiple-location markets. In addition, VHA plans to invest over $1.2 billion to improve these assets over the next 5 years. This represents a demand on VHA's health care resources because most locations in these markets have delivery capacity that VHA considers functionally obsolete, including

- inpatient capacity not up to industry standards (such as patient privacy),
- substandard outpatient capacity (such as undersized examination and operating rooms), and
- safety concerns (such as seismicity).

The Chicago market, for example, has four delivery locations, comprising 126 buildings that cost over $160 million a year to operate and maintain.

Last year we reported[15] that VHA could save $20 million a year and care could be improved if veterans were served in one less location. Veterans' benefits, for example, could be enhanced if VHA used the savings to purchase primary care closer to veterans' homes.

VHA has eight other markets like Chicago that have four or more delivery locations competing to serve the same veterans; these markets have a total of 42 VHA locations. If these other markets are similar to Chicago in that veterans needs could be met with one fewer location, VHA could save $160 million annually.

VHA has opportunities for additional savings in these markets, as well as its other 31 multiple-location markets, by

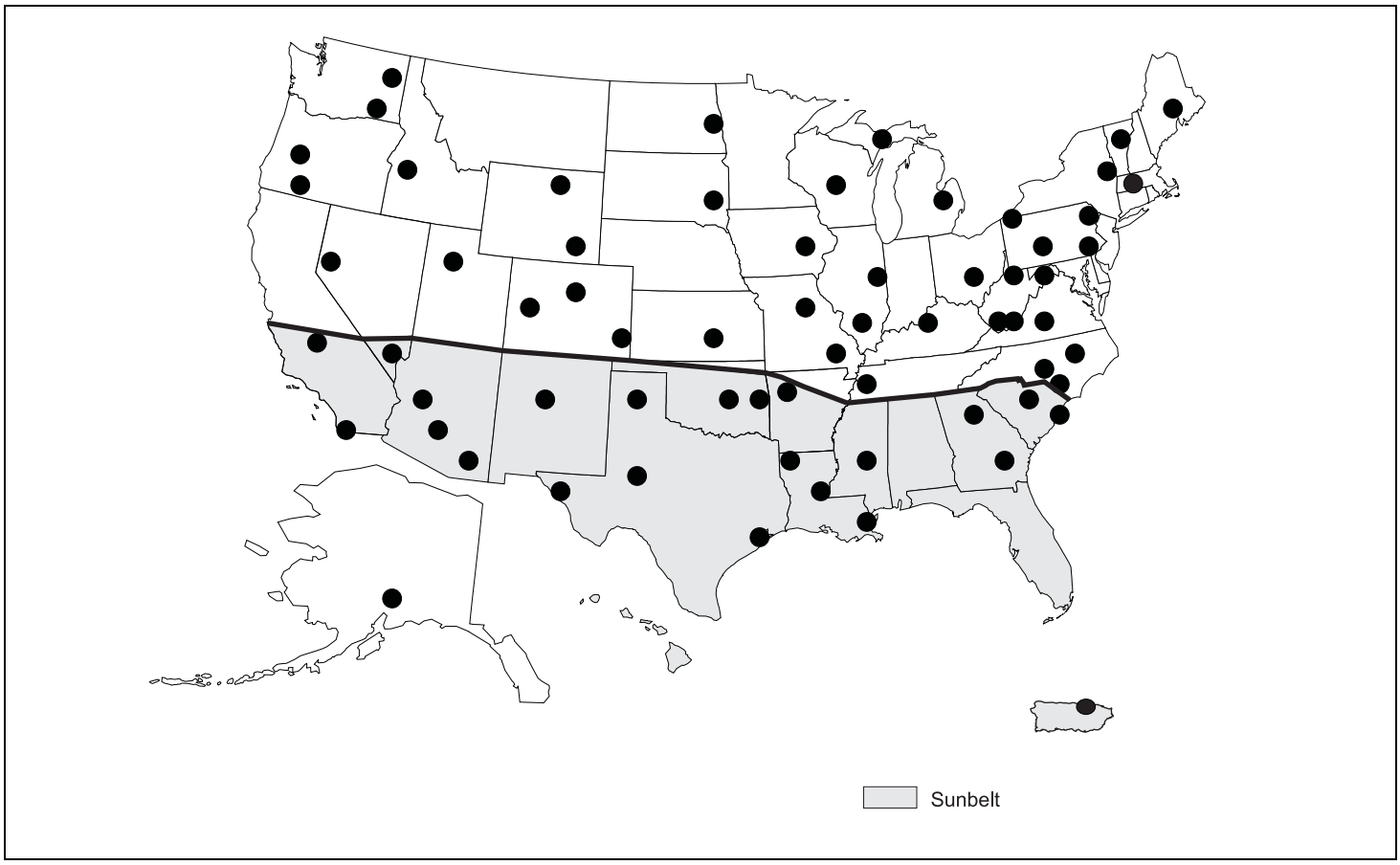
- partnering with other public or private providers,
- purchasing care from such providers, and
- replacing obsolete assets with modern ones.

For example, VHA replaced a seismically deficient building in Martinez, California, with a modern outpatient clinic about 5 years ago. This clinic, along with existing VHA inpatient locations and contract care, efficiently meets veterans' needs in that market. Moreover, VHA reported that veterans' satisfaction is high, including satisfaction with quality of care.

In addition, VHA's 66 single-location markets could yield significant opportunities for restructuring and enhanced benefits for veterans. Like multiple-location markets, many are in geographic areas that have rapidly declining inpatient workloads and veteran populations. (See fig. 8.)

[15]GAO/HEHS-98-64, Apr. 16, 1998.

Figure 8: VHA's 66 Single-Location Markets



We estimate that VHA spends about $1.4 billion to operate and maintain over 1,500 buildings in the single-location markets. VHA also plans to invest about $600 million to improve these assets and bring them up to industry standards. Opportunities to use partnering, contracting, or asset replacements, as potentially lower-cost alternatives are also available, given that other public or private health care providers operate in these markets.

VHA, however, is reluctant to make these business choices. Our work has shown that VHA's environment contains a diverse group of competing stakeholders, who, quite naturally, could oppose some planned changes that they feel are not in their best interests, even when such changes benefit veterans.[16]

Medical schools' reluctance to change long-standing business relationships, for example, has sometimes been a major factor inhibiting VHA's asset management. For example, VHA has tried for over 2 years to integrate clinical services at two of Chicago's four locations with limited success.[17] This is because such restructuring could require two medical schools to use the same location to train residents, a situation that neither supports.

Unions, too, sometimes appear reluctant to support planning decisions that result in a restructuring of services. This is because operating efficiencies often result in staffing reductions. VHA, for example, recently made a capital investment to consolidate food service at one location in New York City in order to reduce expenditures at eight other locations in that market. Two unions' objections, however, slowed VHA's restructuring, although VHA and the unions subsequently agreed on a way to complete the restructuring.

Such stakeholder pressures can lead to decisions that are not in veterans' best interests. Two years ago, a VHA consultant[18] assessed nine options for restructuring two delivery locations located 7 miles apart in the Boston market. Subsequently, VHA had a second consultant[19] study this situation but instructed the consultant to consider only options under which both locations remained open. Ultimately, VA decided to keep both locations open and to provide inpatient care at one facility and establish the other facility as an outpatient care site. VHA's two consultants estimate this will

[16] VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997) and VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

[17] Veterans' Health Care: Chicago Efforts to Improve System Efficiency (GAO/HEHS-98-118, May 29, 1998).

[18] Deloitte & Touche Consulting Group, VA New England Healthcare System Tertiary Healthcare Project–Boston Area (May 1, 1997).

[19] AMA Systems, Inc./McGladrey & Pullen, LLP, Boston Integration Report (Alexandria, Va.: AMA Systems, June 5, 1998).

save $160 million over a 5-year period. The consultants' studies also show, however, that VHA could save as much as $77 million more if veterans' needs are met in one facility. These funds could be used to enhance veterans' benefits, such as by providing services at new community clinics, rather than operating and maintaining unneeded buildings.

To its credit, VHA has initiated a market-based assessment in Chicago, in response to our recommendation. This assessment also includes a multiple-location market in Wisconsin. Unlike Boston, VHA placed no restrictions on options to be considered in this case. These market assessments are scheduled for completion in late spring and, if done properly, could serve as prototypes to be used in assessing VHA's other multiple- and single-location markets.

In this regard, we recommend that VHA develop asset-restructuring plans for all markets to guide its future investment decision-making, among other things. This plan should comply with OMB guidelines and incorporate best practices of industry, as well as those of VHA's 181 delivery locations.

VA's Capital Investment Budgeting Needs to Be Improved

VA and VHA have recently taken positive steps toward establishing an effective centralized budget development process to review and approve high-cost capital investments ($4 million or more) under its major construction appropriation. VHA, however, continues to use a decentralized review and approval of less expensive investments, including major repairs.[20]

VHA's decentralized decision-making is generally done without the level of systematic, rigorous assessments that the centralized process uses. In fiscal year 2000, such decisions account for over 85 percent of investment dollars.

High-Cost Capital Investments

VA uses a two-step process for prioritizing high-cost capital investments. [21]

[20]These involve improvements or alterations, generally referred to as minor construction, and repairs beyond ordinary maintenance, generally referred to as nonrecurring maintenance.

[21]VA, VA Capital Investment Methodolog y Guide (Washington, D.C.: VA, May 1998).

- First, a capital investment panel[22] validates that proposals use reasonable assumptions and adequate data and assigns a numerical ranking score.
- Second, a capital investment board[23] reviews the panel's results and recommends proposals to be included in VA's budget request.

The investment panel, among other things, requires that proposals answer affirmatively what are known as OMB's "Three Pesky Questions" in order for a capital investment to be considered further.[24] These are

- Does the investment in a major capital asset support core/priority mission functions that need to be performed by the federal government?
- Does the investment need to be undertaken by the requesting agency because no alternative private sector or governmental source can better support the function?
- Does the investment support work processes that have been simplified or otherwise redesigned to reduce costs, improve effectiveness, and make maximum use of commercial, off-the-shelf technology?

Next, the investment board scores each proposed investment on how well it addresses 20 decision criteria that are grouped into 5 general categories.[25] The five categories and related weights are[26]

- improved customer service (56 percent),
- return on taxpayer investment (19 percent),
- high performing workforce (14 percent),
- risk (6 percent), and
- comparison to alternatives (5 percent).

VHA submitted 14 investment proposals for building improvements or alterations to VA's capital investment panel for fiscal year 2000 funding

[22]The panel comprises senior staff in each of VA's major organizations: VHA, Veterans Benefits Administration, National Cemetery Administration, and staff offices.

[23]The board comprises the Under Secretaries for Health, Benefits, and Cemeteries; VA's Chief Financial Officer; Information Officer; and Deputy Secretary.

[24]OMB, Capital Programming Guide , Version 1.0 (Washington, D.C.: OMB, July 1997).

[25]Weights are assigned to the criteria using an analytical hierarchy process widely known as pair-wise comparison.

[26]The 5 categories and 20 related decision criteria are listed in app. I.

consideration. The proposals requested a total of $286 million, ranging between $11 million and $28 million.

Using VA's data validation procedures, we assessed 12 proposals' assumptions and data.[27] In general, we found that proposal information was neither uniform nor complete. Few, for instance, identified how many veterans would benefit directly from enhanced services or contained baseline information to demonstrate the magnitude of expected benefits. This occurred primarily because

- VA's guidance is vague and sometimes confusing and
- VHA does not provide information when clearly requested.

While VA failed one proposal based on its validity assessment, we concluded that no proposal had sufficient data to answer the "pesky questions." Nine, for example, involved investments in multiple-location markets where VHA's analyses of alternatives were incomplete. These included several proposals that failed to systematically address the most logical alternatives, such as other nearby VA locations.

A recently completed capital investment demonstrates the risks that VHA faces when alternatives are not adequately considered. VHA replaced substandard inpatient and outpatient capacity at Newington, Connecticut, at a cost of $45 million. In the midst of construction at Newington, VHA decided to consolidate inpatient care at West Haven, Connecticut, which serves the same veterans in that market.

VHA proposed to invest $14 million of fiscal year 2000 funds to renovate substandard inpatient capacity at West Haven. VHA is currently using the Newington inpatient space to house administrative functions. VHA's decision-making essentially led it to pay inpatient medical space construction costs for office space—at a premium generally considered to be about 60 percent.

By contrast, our assessment of potential alternatives to a proposed high-cost investment in northern California demonstrates the benefits veterans could realize when market-based planning is done. VHA initially proposed construction of a $211 million addition to the Travis Air Force Base

[27] We did not assess two projects that received funding in fiscal year 1999.

hospital. We performed a limited market assessment and recommended that lower cost alternatives be used. [28]

Subsequently, a VHA consultant conducted an extensive market–based assessment. [29] This showed that veterans' needs could best be served if VA, among other things, acquired the former McClellan Hospital at Mather Air Force Base in Sacramento, California, and used contract care in other areas closer to veterans' homes. VHA plans to spend $81 million, savings of $130 million over the $211 million originally proposed.

Using VA's prioritization procedures, we reviewed and scored VHA's proposed investments. We found it difficult to systematically or objectively use VA's decision criteria. This is because criteria definitions are frequently imprecise and seldom defined quantitatively in terms of outcomes or outputs. VA, for example, uses one customer service criterion to measure "increase in customer access." This criterion, however, is defined qualitatively using such measures as "increased convenience" or "less travel time" for veterans. As a result, VA does not have reasonable assurance that it funds first those proposed investments that provide the greatest benefits for veterans at the least risk.

Also, VA's measurement standards are vaguely defined. VA, for example, requires panelists to judge whether expected benefits for each of the 20 decision criteria will have no effect, some effect, significant effect, or very significant effect. However, VA provided little or no quantitative baselines for panelists to use in making these determinations. As a result, subjective judgment must be applied when deciding, for example, whether a projected benefit should be considered to have "some effect" or "very significant effect."

In addition, weights for certain criteria seem low in relation to others. As previously mentioned, customer service has a weighting factor of 56 percent. By contrast, VA used weighting factors of 14, 6, and 5 percent for workforce, risk, and alternatives, respectively. Given VHA's planning

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

[29] Price Waterhouse LLP, The Lewin Group, Inc., and Applied Management Engineering, Inc., Assessment of Veterans' Health Care Needs in Northern California (New York: Price Waterhouse, July 15, 1997).

shortcomings, it seems unusual that risk and alternatives are not afforded much higher values.

To its credit, VA is currently

- considering refinements to the decision criteria and measurement standards,
- offering seminars to improve quality of proposal information, and
- considering revisions to criteria weights.

In our view, to reduce subjectivity and thereby enhance credibility of investment decisions, VA should

- modify written guidelines to describe, in greater detail, minimum quantitative data required for each decision criterion and
- exclude, from the prioritization process, all proposals that fail to meet the information requirements.

Other Capital Investments

VA uses a decentralized approach to budget less expensive capital investments (below $4 million), essentially empowering its 22 network directors to make prioritization decisions. Directors use varying approaches, which are considerably less rigorous than those used for larger projects. For example, VHA generally makes investment decisions without addressing systematically OMB's "three pesky questions" or expected 30-year investment returns. We find this troublesome because such decisions account for over 85 percent of VHA's total investment dollars requested for fiscal year 2000.

Over the last 3 years, VHA has significantly reduced the number of high-cost investment proposals, involving alterations or improvements, submitted for VA's centralized review and prioritization. VHA, for example, submitted 32 proposals for fiscal year 1998 funding consideration, compared with 21 and 14 for fiscal years 1999 and 2000, respectively.

This relatively small number is not attributable to a lack of assets requiring high-cost investments. VHA's planning shows that almost half of the 181 locations need capital investment of $4 million or more, including about 50 with asset needs exceeding $10 million. Overall, individual locations' needs range between $4 million and $38 million.

Instead, the decline in the number of high-cost investment proposals appears influenced by a

- desire to avoid the rigor of VA's centralized process or
- limited availability of resources for high-cost investments.

Some VHA locations, for instance, do not submit proposals to VA's centralized process because they could fail VA's validity assessment or be assigned a low priority. Others believe that there is a better chance of receiving funds through the decentralized process if a high-cost investment is divided into several less expensive investments that can be spread over several years.

Concerns about the availability of funding appear to have merit. For fiscal year 2000, VHA has requested about $425 million for capital investments. Of this, VHA's centralized process made decisions valued at $48 million, and the rest are to be made using VHA's decentralized process. VA had a similar funding pattern in the 2 previous years.

In addition, this has resulted in the disturbing situation whereby VHA's decentralized process approves investments for locations that VA's centralized process has found to be or would consider to be low priority or unsound. VHA's planning, for example, shows that nine investments totaling almost $27 million are to be considered for improvements at Fargo, North Dakota, over the next 5 years or more. VA's centralized process considered this proposed investment to be a low priority, even suggesting that lower-cost alternatives be considered.

Until effective capital asset planning is in place, it is imperative that investment decisions be based on sound economic analyses. Toward that end, we recommend that VA

- use its centralized budget process for a larger share of its investment decisions or
- ensure that the fundamental principles underlying that process are rigorously implemented when making decentralized investment decisions.

Last year, VA's Inspector General recommended that VA and VHA work together to develop policies for, among other things, the types of investments subject to capital programming, dollar thresholds, and

responsibilities for considering alternatives.[30] VA expects to issue the revised policies within the next several weeks.

VA's Appropriations Could Be Restructured

VHA uses widely varying sources of funds to make capital investments. Sometimes, VHA's decisions appear to be based on the availability of funds under a specific appropriation rather than on the soundness of an investment. In such instances, VHA invests more money than it needs to in achieving its objectives.

VHA, for example, may use a medical care appropriation to perform nonrecurring maintenance and to lease building space. Nonrecurring maintenance involves repairs or modifications to existing buildings, including upgrades or replacements of major building systems, such as utilities, security, and health care support, or minor improvements to add space or to make other minor structural changes.

VHA also has two separate construction appropriations that may be used for

- improvements or alterations of $4 million or more and
- improvements or alterations of less than $4 million.

The availability of funding has varied over the last 5 years. Historically, VHA's major construction appropriation was the largest funding source. Currently, it is the smallest funding source, as funds for nonrecurring maintenance, leases, and minor construction have increased while major construction funds have declined precipitously.

VHA has discretion to decide which appropriation to use to meet most asset needs. VHA, for example, may use health care funds to lease new space or construction funds to build a building. Given the limited availability of major construction funds, VHA has recently decided that more costly leasing alternatives should be used to acquire needed assets, because funds are more readily available in the medical care appropriation. For example, VA's Inspector General reported last year that VHA decided to spend $86 million (present value of life-cycle costs) to lease outpatient space in five locations, even though construction of new buildings would

[30] VA, Office of Inspector General, Evaluation of VA Capital Programming Practices and Initiatives, Report No. 8R8-A19-061 (Washington, D.C.: VA, Jan. 28, 1998).

cost $13 million less, an almost 20-percent savings. According to the Inspector General, VHA stated that leases were used because they could be funded using its medical care appropriation.

VHA has asked for funds for two leases in its fiscal year 2000 budget request. VA's Capital Investment Board reviewed and scored these proposed leases. In one instance, the Board instructed that alternatives such as build or buy be more seriously considered. Nonetheless, VA included both leases in its medical care budget request.

In addition, the availability of funds in the minor construction appropriation, along with the less rigorous budget process, provides an incentive to invest in a number of smaller improvements over several years rather than address needs at the same time in one potentially less costly investment. As previously mentioned, VHA plans to use this approach in Fargo as well as many other locations nationwide.

Historically, VHA has used the minor construction appropriation to fund improvements at individual locations over a period of years. VHA, for example, spent about $19 million of minor construction appropriations at Battle Creek, Michigan, over the last 6 years. This money funded improved inpatient and outpatient capacity as well as upgraded major building systems.

Last year VA's Inspector General suggested to VHA that a new approach be considered, and VHA officials indicated that options were being discussed.[31] To facilitate VHA's decision-making, we suggest that the Congress consider restructuring VHA's appropriations into a single capital investment appropriation.

Alternative Financing Methods Could Be Authorized

VA has proposed a new funding source, namely asset disposal revenues, to help fund high-priority investments faster. In addition, VA has other potential funding sources to achieve this objective, such as operational savings through asset restructuring and returns on capital investments. These, however, require legislative action.

[31] VA, Office of Inspector General, Evaluation of VA Capital Programming Practices and Initiatives (Jan. 28, 1998).

In its fiscal year 2000 budget submission, VA proposes a 5-year demonstration that would allow VHA to

- sell, transfer, or exchange up to 30 excess or underutilized properties;
- deposit proceeds into a new Capital Asset Fund; and
- use the Fund to invest in more appropriate assets.[32]

This proposal is compelling for two reasons:

- VA has significant unused or underused buildings, and
- VA lacks incentive to dispose of properties, because funds can, by law, be spent only to construct, alter, or acquire nursing home facilities.

VA's best opportunity, however, to accumulate resources for capital improvements could be operational savings available through asset restructuring. Legislation could authorize VHA to deposit such savings into a capital asset fund. As previously discussed, VA might save $180 million a year, for example, if veterans' needs are met with one fewer location in the nine largest multiple-location markets. Some or all of these savings could be used to finance future capital investments.

Legislative action could authorize VA to accumulate resources in its Capital Asset Fund by charging VHA delivery locations for the costs of improving or replacing assets. VHA could use returns on capital investments, such as operational savings or third-party payments, to pay back some or all of the amount invested over a prescribed number of years.

As previously discussed, VHA's investment proposals are prioritized, in part, on their investment return potential. VHA's Tampa, Florida, proposal, for example, states that operational savings of almost $2 million annually could be realized as a result of planned improvements. This is because Tampa will relocate related services now done on the first, second, and fifth floors, into existing contiguous space on the ground floor, which allows VHA staff to deliver health care more efficiently. A reasonable payback period could be 18 years, given the proposal's $17.5 million cost (18 years times $1 million).

VHA's Murfreesboro, Tennessee, proposal also states that operational savings are expected as a result of the investment. This is because veterans

[32] Each major project or major lease would still be subject to congressional approval.

from two other VHA delivery locations will be referred to Murfreesboro, which, according to its proposal, has unit costs that are about half of those at the other locations. A reasonable payback period for this $12.7 million investment, however, cannot be suggested because Murfreesboro's proposal did not quantify the magnitude of savings expected.

In addition, VHA's Dallas, Texas, proposal, states that a return of $2 million a year could be expected from third-parties, if $24 million is invested to improve that location. This is because Dallas expects such improvements to allow VHA to successfully compete for TRICARE patients. A reasonable payback period could be 24 years (24 years times $1 million).

In addition to addressing high-priority asset needs faster, such funding sources could also provide incentives for more effective capital planning and greater accountability for investment decisions. To realize such benefits, the Congress would need to expand the types of deposits that VHA could make into its proposed Capital Asset Fund or establish a separate revolving fund for this purpose.

Concluding Observations

VHA has the opportunity to reduce significantly the amount of funds used to operate and maintain unneeded or inefficient health care delivery locations and reinvest such savings to enhance care provided to veterans. To do so, VHA needs to develop, and implement, a market-based plan for restructuring assets. Without such restructuring, it seems that VHA's resources might be increasingly shifted to operating and maintaining assets at the expense of veterans' health care needs.

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

VA's Five General Categories and Twenty Decision Criteria

One-VA Customer Service—Priority Weight .56

- Increase in customer access
- Increase in quality of service
- Decrease in waiting time
- Increase in benefit or service provided
- Increase in the number of customers

Return on Taxpayer Investment—Priority Weight .19

- Reduction in cost per customer
- Number of customers affected
- Increase in direct revenue
- Cost-effectiveness analysis

High-Performing Workforce—Priority Weight .14

- Improve recruitment and retention of employees
- Increase in training and development
- Increase in employee morale

Risk—Priority Weight .06

- Risk of achieving projected benefits
- Risk of achieving projected costs
- Risk of adhering to projected implementation schedule
- Risk of obsolescence

Comparison to Alternatives—Priority Weight .05

- One-VA customer service
- Return on investment
- High-performing workforce
- Risk

Related GAO Products

Major Management Challenges and Program Risks: Department of Veterans Affairs (GAO/OCG-99-15, Jan. 1999).

Executive Guide: Leading Practices in Capital Decision-Making (GAO/AIMD-99-32, Dec. 1998).

VA Health Care: VA's Plan for the Integration of Medical Services in Central Alabama (GAO/HEHS-98-245R, Sept. 23, 1998).

Veterans' Health Care: Challenges Facing VA's Evolving Role in Serving Veterans (GAO/T-HEHS-98-194, June 17, 1998).

Veterans' Health Care: Chicago Efforts to Improve System Efficiency (GAO/HEHS-98-118, May 29, 1998).

VA Hospitals: Issues and Challenges for the Future (GAO/HEHS-98-32, Apr. 30, 1998).

VA Health Care: Closing a Chicago Hospital Would Save Millions and Enhance Access to Services (GAO/HEHS-98-64, Apr. 16, 1998).

Budget Issues: Budgeting for Capital (GAO/T-AIMD-98-99, Mar. 6, 1998).

VA Health Care: Status of Efforts to Improve Efficiency and Access (GAO/HEHS-98-48, Feb. 6, 1998).

Department of Veterans Affairs: Programmatic and Management Challenges Facing the Department (GAO/T-HEHS-97-97, Mar. 18, 1997).

VA Health Care: Lessons Learned From Medical Facility Integrations (GAO/T-HEHS-97-184, July 24, 1997).

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

VA Health Care: Effects of Facility Realignment on Construction Needs Are Unknown (GAO/HEHS-96-19, Nov. 17, 1995).

VA Health Care: Need for Brevard Hospital Not Justified (GAO/HEHS-95-192, Aug. 29, 1995).

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