



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

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Health, Education and Human Services Division

B-265819

September 12, 1995

The Honorable Bob Stump  
Chairman, Committee on Veterans' Affairs  
House of Representatives

Dear Mr. Chairman:

The President proposed an increase in the Department of Veterans Affairs' (VA) health care funding of about \$747 million in fiscal year 1996--to \$17 billion--with subsequent reductions in funding of 2 percent per year over the following 4 years. By contrast, the budget resolution approved by the House of Representatives on May 18, 1995, would have frozen VA health care spending at fiscal year 1995 levels--\$16.2 billion--for 7 years.<sup>1</sup>

The Veterans Health Administration (VHA) assessed the potential impact of the House proposal in terms of budget shortfalls, equivalent medical center closings, and equivalent workload reductions. VHA's calculations indicated that VA would experience a budget shortfall of \$747 million in 1996 and a cumulative shortfall of \$23.8 billion by 2002. The VHA budget office estimated that the predicted shortfall would be equivalent to all of the following:

- closing 6 medical centers in 1996 and 41 by 2002,
- treating 67,000 fewer inpatients in 1996 and 1.8 million fewer by 2002, and
- providing 1.6 million fewer episodes of care in 1996 and at least 41 million fewer by 2002.

The results of these assessments were cited by the Secretary of Veterans Affairs and others in a series of speeches and press releases.

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<sup>1</sup>The Congress adopted the budget resolution on June 29, 1995 providing \$16.2 billion annually for 7 years (H.R. Con. Res. 67, 104th Cong. 1st Sess. 1995). Subsequently, in August 1995, the House of Representatives approved a \$16.8 billion appropriation for VA health care for fiscal year 1996.

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In a June 13, 1995, letter and subsequent agreements with your staff, you asked that we (1) assess the reasonableness of the assumptions and data VA used in developing its calculations, (2) determine whether VA's public statements appropriately noted limitations of the analysis, and (3) compare the potential effects of the President's out-year budget estimates with the effects of the House budget resolution using the VA methodology. To accomplish this, we (1) discussed with VA officials the basis for VA's calculations, (2) reviewed the supporting documentation, (3) reviewed VA's public information releases and speeches, and (4) applied the methodology used by VHA's budget office in assessing the potential impact of the House budget resolution with the President's out-year projections.<sup>2</sup>

We presented the preliminary results of our work to your staff on August 2, 1995. This letter summarizes and expands on the information presented in that briefing. In summary, we found the following:

- VA's calculations, while generally reasonable, overstate the potential impact of the House budget resolution on VA's ability to maintain the current level of VA health care services. VA overstated the funds it would need to maintain its current level of services because it based its projected funding needs on assumptions that there will be (1) an increase in VA workload in fiscal year 1996 that will be maintained in the following years, (2) limited savings from increases in the efficiency with which services will be delivered, and (3) steadily increasing costs, workload, and staffing due to facility activations.
- Public statements by VA officials did not note the above or other limitations of the VA analysis.
- Had VA applied its methodology to the President's 5-year budget estimates, it would have shown that budget

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<sup>2</sup>We limited this analysis to the President's original budget submission. VA officials, including the Under Secretary for Health, told us they were not consulted in the development of the President's revised 10-year deficit reduction plan and were not aware of the VA provisions in the plan.

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shortfalls in the out-years would potentially result in more medical center closings and greater reductions in patient services than would the House proposal.

VA CALCULATIONS WERE GENERALLY REASONABLE BUT WERE SENSITIVE TO THE UNDERLYING ASSUMPTIONS

The VHA budget office calculations appear to be generally reasonable, but three of the assumptions made in applying the methodology to future years are questionable. To determine the number of medical centers that might have to be closed, the budget office reviewed the operating costs of medical centers with about 300 beds--the average number of beds per medical center is 308. It made adjustments to recognize the cost of care currently provided in nursing homes and domiciliaries as well as the care provided on an outpatient basis. We were able to trace all of the data used in the budget office's calculations back to supporting documents. VHA officials said that the method used in developing the calculations is one that has been used on several occasions for internal matters.

In applying the methodology to future years' budgets, the budget office made certain important assumptions. First, it assumed that VA health care costs would increase by about 5 percent per year because of inflation. While VA's calculations are sensitive to the inflation adjustment chosen, VA's assumption of a 5-percent rate of medical care inflation is--according to a Congressional Budget Office analyst--reasonable and conservative.

Second, it assumed that 75 percent of the costs associated with workload reductions would be saved because certain overhead costs at facilities, such as heating and maintenance, would not decrease in direct proportion to workload declines. Like the inflation adjustment, the savings rate used in the calculations has a significant effect on the estimated cost reductions resulting from workload decreases. The higher the savings rate, the greater the cost reductions that would result from workload reductions.

Third, the budget office assumed that VA's workload, measured in terms of numbers of unique veterans provided care, would increase in fiscal year 1996 and then remain

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constant over the remainder of the 7-year period. The Secretary of Veterans Affairs stated that VA's experience has been that use of a straight-line approach in projecting workload is the safest and most reliable. The Secretary noted that although the veteran population has declined over the past 10 years, the number of individual patients treated has increased as the population ages and VA expects that trend to continue.

In our opinion, the number of individual patients treated may not be the best indicator of workload. The volume and mix of services provided by VA facilities are also important measures of workload, and these measures show a shifting from high-cost inpatient care to less-costly outpatient settings. From 1988 to 1994, the number of veterans treated in VA hospitals declined by 16 percent, while the number of outpatient visits increased by 8 percent. Furthermore, while the veteran population is older, and older veterans tend to use significantly more health care services, increased use of health care services by older veterans is more than offset by the reduction in use of VA hospital services caused by the decline in the overall number of veterans.

VA also said that the straight-line workload assumption was conservative because Medicare reforms could increase demand for VA medical services. While we agree that changes in Medicare could affect demand for VA care, it is unclear whether they would increase or decrease demand for VA services. To the extent reforms result in more Medicare-eligible veterans enrolling in health maintenance organizations or other managed care plans with little or no beneficiary cost-sharing, then use of VA services might decrease. On the other hand, imposing higher Medicare deductibles and copayments under the existing fee-for-service system could drive more veterans to the VA system to avoid high out-of-pocket costs.

The fourth assumption VHA's budget office made in estimating the potential effects of the House budget resolution on VA operations in the out-years was that there would be no change in the efficiency with which VA delivers health care services beyond changes expected to occur in fiscal year 1996. VA assumed recurring savings of about \$335 million resulting from a series of management improvements outlined

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in the President's budget submission, but no further savings from increased efficiency for fiscal years 1997 through 2002.

We believe this assumption is unreasonable given VA's current efforts to improve efficiency. First, on October 1, 1996, VA plans to begin implementing a new management structure composed of geographic networks of facilities that will replace the current field management system. This new concept is called the Veterans Integrated Service Networks (VISN) and is based on existing and foreseeable patient referral patterns, medical resource distribution, availability of services, and geographic boundaries. Similarly, VA has started implementing a new resource allocation method, the Resource Planning and Management (RPM) system, intended to give medical centers incentives to provide care in the most cost-effective setting. Because these initiatives are being phased in, significant savings are not likely to occur until sometime after fiscal year 1996.

The final assumption VA made in estimating its "current services" budgets for the 7-year period was that it will continue to incur additional costs and add staff associated with facility activations (opening new facilities and expanding existing facilities through modernization and new construction). Such costs, coupled with the costs added for treating the projected increase in workload, account for almost 25 percent of the budget shortfall VA calculated. For example, in 2000, VA's projected "current services" budget of \$20.9 billion includes increases of over \$993 million and 10,000 full-time-equivalent employees for facility activations.

As a result, the budget shortfalls--and the related workload, staffing, and facility reductions--that VA calculates are actually measured based on the difference between the costs of the expanded level of services VA would like to provide and the fiscal year 1995 funding level. In our opinion, the projected shortfalls should be measured as the difference between the inflation-adjusted cost of providing the level of services that existed in fiscal year 1995 and the fiscal year 1995 funding level. By assuming increased costs and staffing associated with expanding facilities and programs above the current services level and

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then using such higher costs and staffing levels to project budget shortfalls, VA's calculations overstate the potential medical center closures and workload and staffing reductions by about 25 percent.

VHA budget officials emphasized that their calculations were intended to be only a budget exercise and were not intended to reflect the policy decisions that would be made if the House proposal were adopted. They noted that VA had not decided how it would respond to any budget shortfalls in future years.

PUBLIC STATEMENTS ON POTENTIAL BUDGET EFFECTS  
WERE NOT ALWAYS APPROPRIATELY QUALIFIED

Though VHA budget officials stated that the calculations did not represent actions that would necessarily be taken, several public statements characterized them as such. During the spring and summer of 1995, the Secretary of Veterans Affairs discussed the potential impact of the House proposal in a series of speeches. In three May 1995 speeches, the Secretary cited the results of the budget office calculations as if they reflected policy decisions to close medical centers, provide care to fewer veterans, and provide fewer episodes of care to veterans if the House proposal were adopted. For example, one of the Secretary's speeches stated that "the recent House and Senate resolutions would force VA to:

- Freeze all VA construction;
- Eliminate 53,000 doctors, nurses, and other professionals;
- Close 35 to 41 hospitals;
- Deny care to 916,000 veterans;
- Make poor veterans pay more for their medications;
- Stop compensation to some incompetent veterans;
- And redefine Service connections."

In subsequent speeches, the Secretary noted that VA would have to consider these actions. Even these speeches, however, did not reveal the limitations of the VA analyses.

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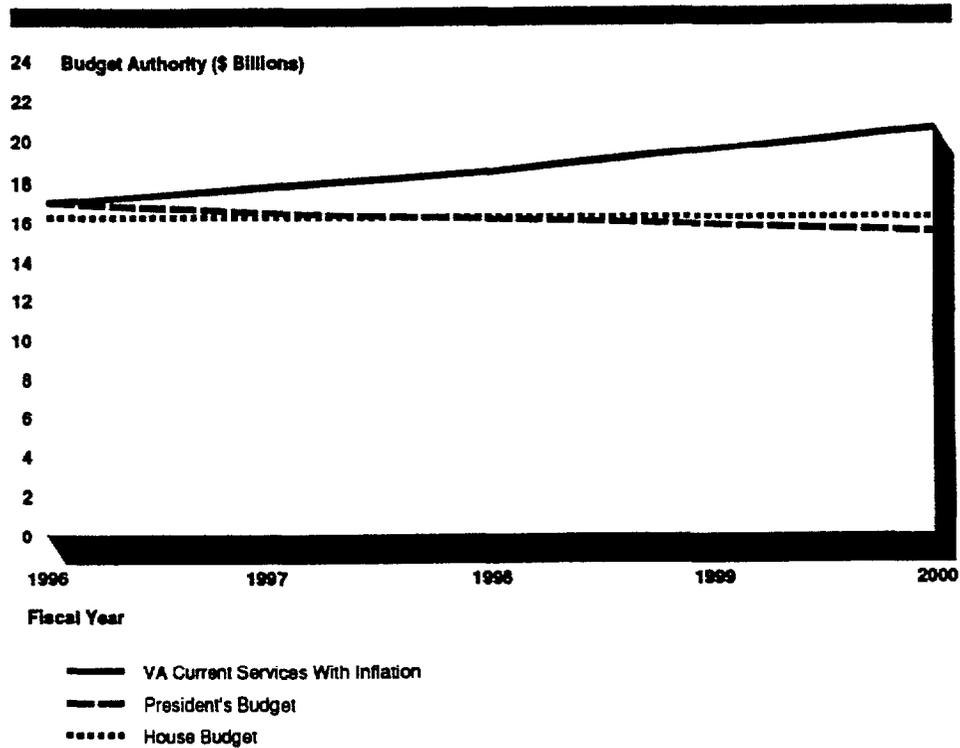
PRESIDENT'S OUT-YEAR BUDGET PROVIDES FOR  
GREATER REDUCTIONS THAN HOUSE PROPOSAL

VA officials stated that they did not apply the same methodology to assess the potential effects of the President's out-year budget proposal because the Secretary has an understanding with the President that the budget will be reevaluated annually. The Secretary of Veterans Affairs stated that he lacks confidence that the Congress will be similarly willing to annually renegotiate the funding levels in the 7-year budget resolution. In addition, he stated that VA was concerned about indications from the Appropriations committees that they would adhere closely to the funding levels in the budget resolutions.

Under the President's budget proposal, total VA medical care funding for the period 1996 through 2000 would be \$336 million less than the amount provided in the House proposal. Figure 1 shows the estimated funding levels under the President's and the House's proposals and the budget office's estimate of the budget authority VA would need to maintain its current services, assuming inflation of 5 percent per year.

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Figure 1: Alternative Budget Proposals



Using VA's methodology for estimating the equivalent effects of such a shortfall shows that under the President's budget, by 2000 VA would

- close 36 medical centers (6 more than under the House proposal);
- treat 963,000 fewer hospital, nursing home, and domiciliary patients (12,500 fewer than under the House proposal); and
- treat 21.7 million fewer outpatients (283,000 fewer than under the House proposal).

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The enclosure shows the equivalent effects of the various budget levels for the period 1996 through 2000.

VA officials, including the Secretary of Veterans Affairs, provided comments on a draft of this letter. Their comments have been incorporated where appropriate.

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We are also sending copies of this correspondence to the Ranking Minority Member of the House Committee on Veterans' Affairs and the Chairman and Ranking Minority Member of the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations, because of their expressed interest in the subject. We are also sending a copy to the Secretary of Veterans Affairs. Copies will be made available to others upon request.

Contributors to this letter were James R. Linz, Assistant Director, William Schmidt, and William Stanco. Should you have any questions, please call me at (202) 512-7101 or James R. Linz, at (202) 512-7110.

Sincerely yours,



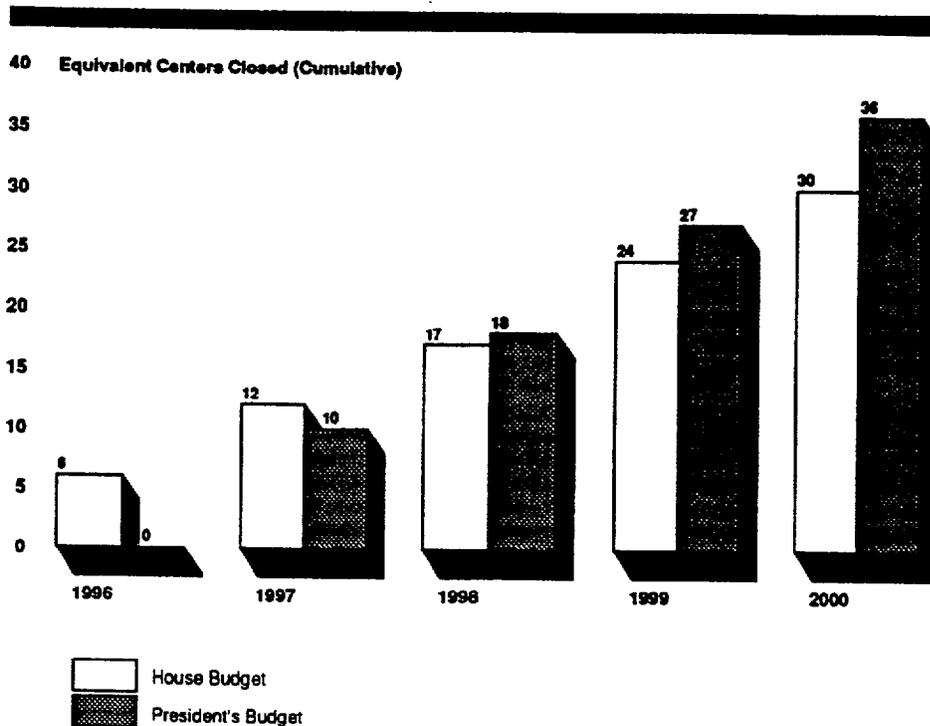
David P. Baine  
Director, Health Care Delivery  
and Quality Issues

Enclosure - 1

COMPARISON OF POTENTIAL EFFECTS OF ALTERNATIVE  
BUDGET PROPOSALS ON VA HEALTH CARE

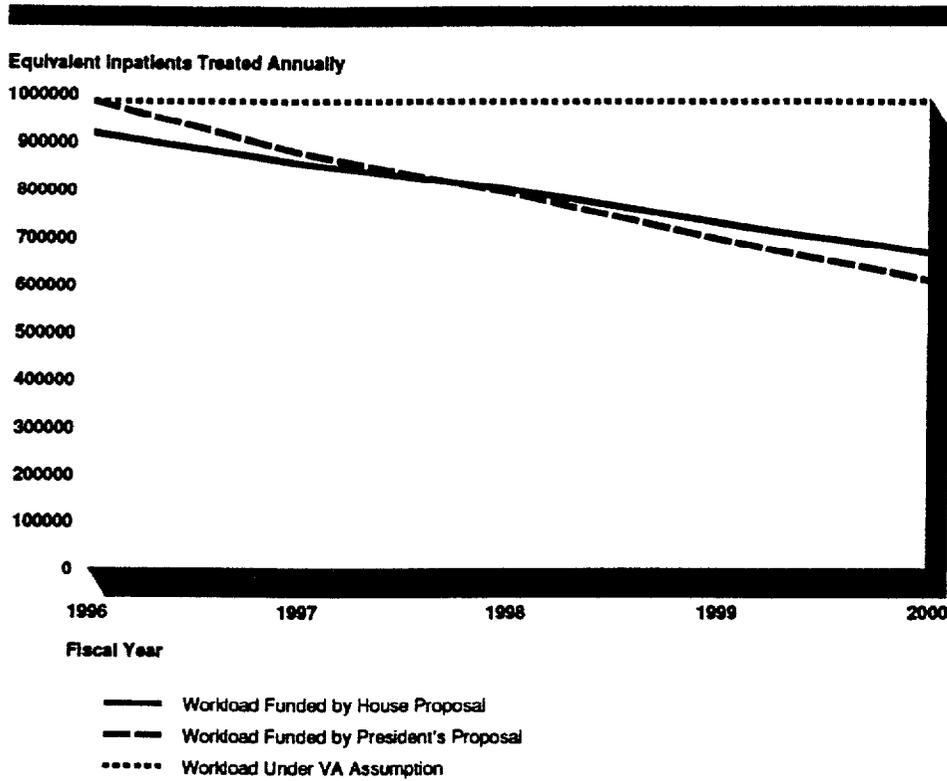
The figures in this enclosure present various comparisons of the President's, House of Representatives', and VA's current services budget projections in terms of the potential impact on VA medical centers and patients served. The estimates are based on the methodology used by VHA's budget office.

Figure 1.1: Projected VA Medical Center Closures



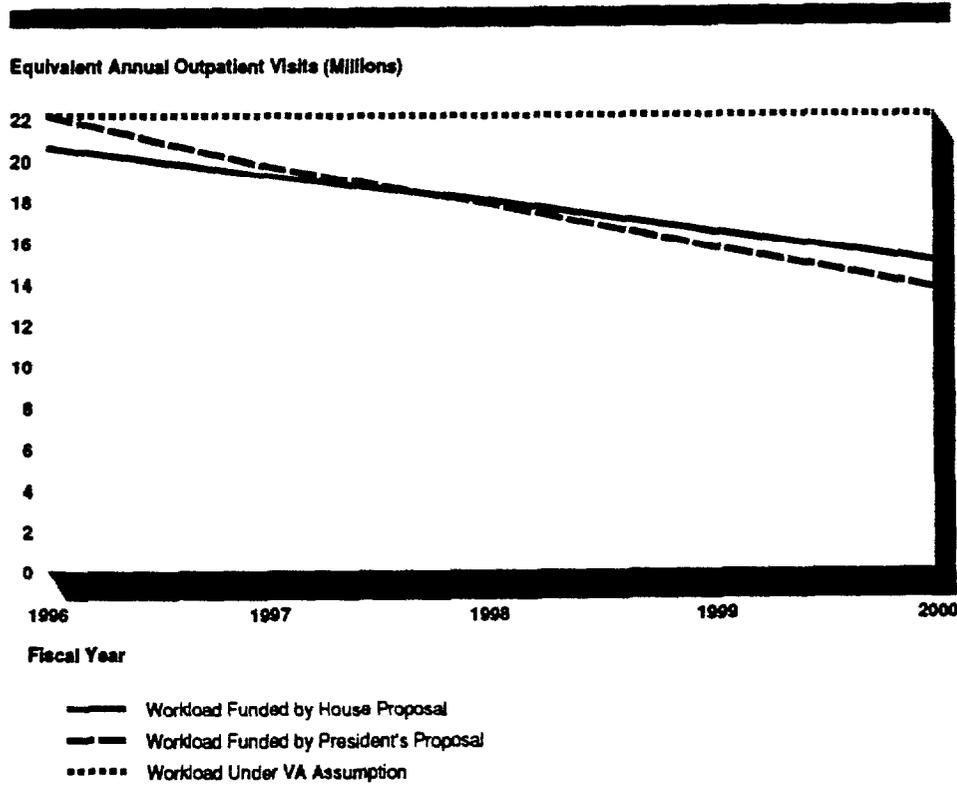
Note: Based on VA methodology.

Figure 1.2: Projected Decline in Inpatients Treated by VA



Note: Based on VA methodology.

Figure 1.3: Projected Decline in VA Outpatient Visits



Note: Based on VA methodology.

Figure 1.4: House VA Medical Care Budget Exceeds President's

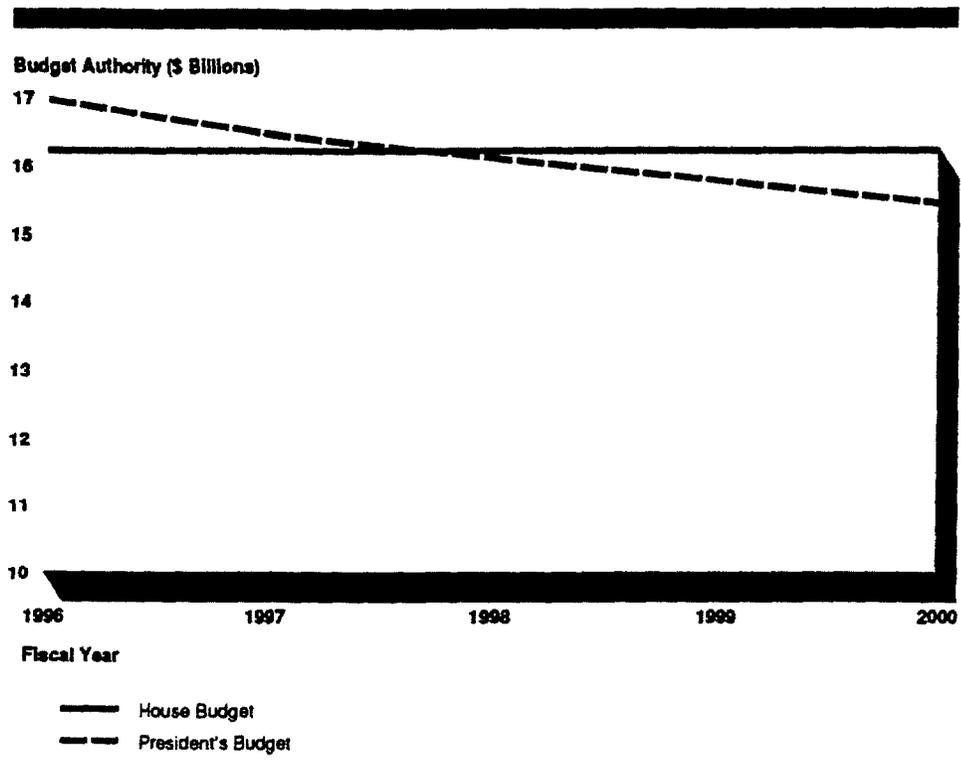
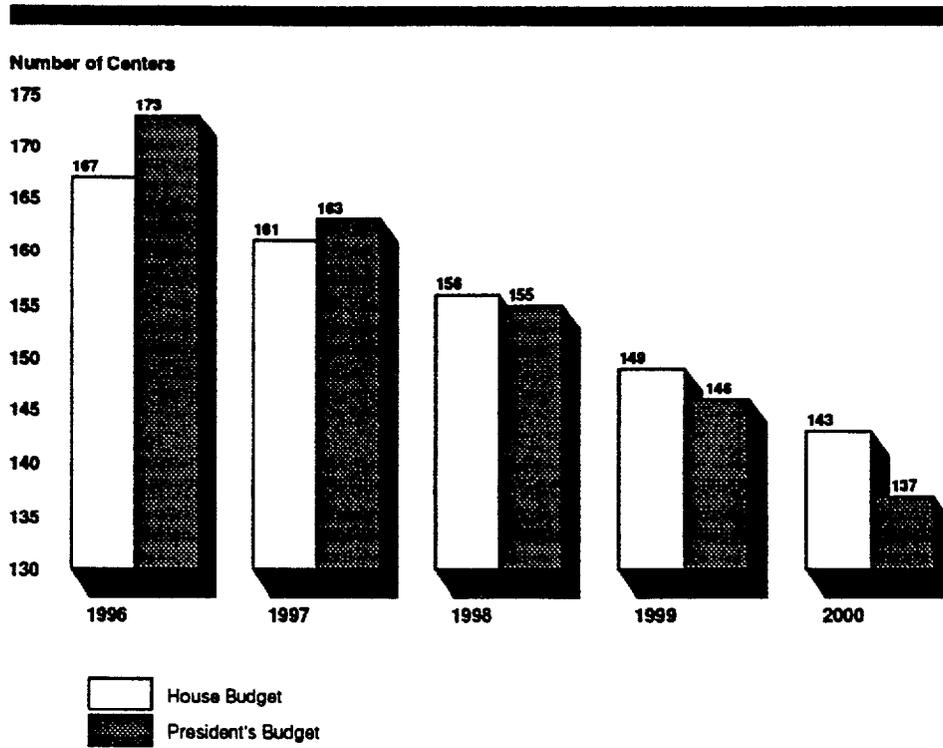


Figure 1.5: Projected VA Medical Centers



Note: Based on VA methodology.

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