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VETERANS' HEALTH CARE

Potential Effects of Health Care Reforms on VA's Major Construction Program

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SUMMARY

GAO believes that the Congress should proceed cautiously with construction of additional Department of Veterans Affairs (VA) facilities until reforms to the nation's health care system and VA eligibility take shape. This is because of the uncertainty surrounding the potential effects of such reforms on demand for VA health care. Any national health care reform that expands insurance coverage among veterans could substantially reduce demand for VA-sponsored care. For example, GAO estimates that under a nationwide universal coverage plan, demand for VA inpatient care could drop 50 percent.

GAO's estimates assume that VA will continue to operate as an independent system that veterans can use to supplement coverage under a national health financing system. If, however, VA is transformed into a series of managed care plans that compete under a reformed national health care system, a serious limitation in the design of VA facilities could affect VA's ability to compete. This limitation is the inability of VA hospitals and clinics to provide the full range of health care services to women veterans and the dependents of veterans. Without design changes to fully accomodate such patients or contracts with private sector facilities or sharing agreements with military facilities to provide such services, VA managed care plans would, in GAO's opinion, be unlikely to attract women veterans and veterans with dependent children under a competitive environment.

Reform of VA's system for determining eligibility for health care could also have dramatic effects on VA utilization. For example, the number of outpatient visits, which totaled about 23 million in fiscal year 1992, could range from 24 million to 57 million depending on the reform proposal adopted.

A limitation on the construction of additional VA capacity, however, does not have to mean an interruption in meeting the health care needs of America's veterans. Rather, the Congress and VA could use the delay as an opportunity to test alternative, managed care, methods of delivering services to veterans that would supplement services available at VA outpatient clinics with inpatient services provided through contracts with private sector hospitals or sharing agreements with military hospitals. Such tests could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than such services could be provided through new construction.

GAO believes that the Congress should consider authorizing VA to conduct such demonstration projects in one or more locations where unused capacity exists in community or military hospitals. Possible locations include Hawaii, northern California, and east central Florida.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) major construction program. Our testimony this morning will focus primarily on factors that could affect the need for and size and design of VA construction projects. These factors are (1) reform of the nation's health care financing system, (2) reform of VA health care eligibility for its beneficiaries, and (3) VA's role under the reformed health care system. In addition, I will discuss the extent to which VA considers construction alternatives, such as the availability of state and community resources, when it determines the need for major construction projects. Finally, I will discuss our recently completed review of the management of VA's major construction program.[1]

We believe that the Congress should proceed cautiously with construction of additional VA capacity because of the uncertain effects of reforms to the nation's health care system and VA eligibility. Such caution, however, does not have to mean an interruption in meeting the health care needs of America's veterans. Rather, a limitation on the construction of new VA medical care capacity could provide an opportunity to test alternative methods of delivering services to veterans, such as the use of managed care. VA's use of alternative delivery methods could, at least on an interim basis, provide veterans acute care services in their home communities years earlier than such services could be provided through construction of new or replacement VA facilities.

Through demonstration projects, VA could determine whether (1) veterans are satisfied with the new methods of providing care and (2) services can be provided closer to veterans' homes without increasing health care costs. As I will discuss later, such demonstrations could be structured in several ways.

BACKGROUND

VA spends about $500 million a year on construction and modernization of health care facilities. In its fiscal year 1994 budget submission, the Administration is seeking about $406 million for VA construction,[2] a decrease of more than $86 million from the fiscal year 1993 level, but about the same amount spent in fiscal year 1992.

Public Law 102-405, enacted in 1992, gives your Committee--and the House Committee on Veterans' Affairs--responsibility for

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[1]VA Health Care: Actions Needed to Control Major Construction Costs (GAO/HRD-93-75, Feb. 26, 1993).

[2]VA is seeking $362,293,000 in new budget authority and transfer/reprogramming from prior appropriations of $44,227,000.

authorizing major VA medical construction projects. Over the years, the Congress and VA have made numerous attempts to control the costs and improve the management of the major construction program. We would like to focus on several issues that could influence your Committee's deliberations as you fulfill your oversight responsibilities.

Determining how construction funds are spent is a complex process. VA develops, and annually updates, a 5-year plan for the construction, replacement, and alteration of medical facilities. The 5-year plan is based on input from each VA medical center as to its deficiencies, maintenance needs, and desired improvements. VA has a complex prioritization methodology that assigns a weighted numerical score to each proposed project based on a series of criteria, such as the type of project (e.g., office space or patient care space) and type of improvement (e.g., correction of life safety deficiencies or modernization). This methodology yields a VA-wide priority list.

While this list is the starting point for the budget process, there is no direct link between the priority list and VA's major construction budget request. This is because projects may be in different stages of planning, design, and construction. In addition, construction projects are added to and deleted from the budget submitted by VA throughout the congressional appropriation process. For example, in fiscal year 1991, two-thirds of the projects receiving initial funding were added to VA's budget during the congressional appropriation process.

Let me turn now to some of the potential effects that reform of the nation's health care system could have on VA construction.

NATIONAL HEALTH FINANCING REFORM COULD REDUCE DEMAND FOR CARE IN VA FACILITIES

As we and the Paralyzed Veterans of America have recently testified before this Committee, any program that would expand insurance coverage among veterans could substantially reduce demand for VA-sponsored care. For example, under a nationwide universal coverage plan, we estimate that demand for VA inpatient care could drop by 50 percent. Likewise, use of VA outpatient care could drop by about 40 percent. As we mentioned at your March 31, hearing, these estimates are based only on expected changes in behavior by those veterans without either public or private insurance. Health reforms could also change usage patterns of those veterans already covered by private or public insurance.

Reform of the nation's health care system could also have significant effects on demand for VA-supported nursing home care. Most health care programs, other than VA and Medicaid, currently provide limited coverage for long-term nursing home care. A

reformed health care system that includes long-term nursing home care coverage could lead to a decline in demand for VA-supported care. The extent of the decline in demand for VA care would likely depend on the extent of cost-sharing imposed under any new program.

Conversion of excess hospital beds to nursing home care could also reduce the need for, and cost of, future nursing home construction. This is because VA estimates that it costs about half as much to convert a hospital bed to a nursing home bed as it does to construct a new nursing home bed.[3] In addition, conversions of excess health care capacity to nursing homes can generally be accomplished faster than new construction.

As you can see, health reforms, without changes in VA eligibility, would likely cause a significant decline in demand for VA health care services. Such a decline could create significant excess capacity in VA facilities.

REFORM OF VA ELIGIBILITY COULD AFFECT DEMAND FOR VA SERVICES

Just as reform of the nation's health care system could affect demand for VA health care, so could reform of the VA eligibility system itself. This issue is likely to be the subject of extensive debate before this and other committees in the coming year. The decisions made on eligibility reform, like the decisions on how to reform the nation's health care system, could have a significant effect on future demand for VA health care. Let me explain.

In March 1992, the Deputy Secretary of Veterans Affairs established a task force on eligibility reform, which developed four alternative proposals for reforming VA health care eligibility. The task force predicted widely varying VA workloads depending on which, if any, of the proposals is adopted. For example, the predicted number of inpatient hospital patients treated ranges from 1 million to 3 million, the number of outpatient visits ranges from 24 million to 57 million, and the average daily census of long-term care patients ranges from 70,000 to 593,000.

Our point in mentioning these numbers is not to comment on the merits or costs of the various eligibility reform options. Rather, we want to emphasize the uncertainty that surrounds the future structure of the VA system. Until the Congress decides on eligibility reforms, predicting how many hospital and nursing home beds will be needed in the future or how large outpatient clinics should be is impossible. This uncertainty leads us to conclude

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[3]VA Health Care: Improvements Needed in Nursing Home Planning (GAO/HRD-90-98, June 12, 1990).

that construction of additional capacity should be approached with caution to avoid overbuilding.

VA's ROLE UNDER NATIONAL HEALTH REFORM COULD AFFECT CONSTRUCTION DESIGN

We have discussed the potential effects on demand for VA services assuming that VA will continue to be available as a supplement to other health care coverage. However, VA's role under national health care reform is frequently discussed in terms of restructuring VA into a series of managed care plans that would compete with private sector plans.

At this time, we would like to briefly discuss a limitation in the VA system that could cripple its hopes of effectively competing with private sector plans, and the dilemma this limitation creates for this Committee in deciding whether to proceed with construction of hospitals as currently designed. That limitation is the inability of VA hospitals and clinics to provide the full range of health care services needed by veterans and their families.

If VA facilities are to compete as managed care plans under a national program, they would likely need to develop the capability to serve women veterans and veterans' dependents, either in their own facilities or through contracts with community facilities or sharing agreements with military facilities. As you know, VA has made great strides in improving care for women veterans, but many VA facilities still have difficulty in providing adequate privacy to women patients. More importantly, however, VA will not provide coverage of routine pregnancies, either through its own facilities or contracts. If VA is to attract women veterans in a competitive environment, it will have to better address their health care needs.

Similarly, veterans with dependent children are unlikely to select VA as their sole source of health care because VA has no capability to provide care to children. Without developing such capabilities either in its own facilities or through contracts with community or military facilities, a VA managed care plan would, in our opinion, be unlikely to attract veterans with dependent children.

The limitations in meeting the needs of women veterans and dependent children make a VA managed care plan attractive primarily to single male veterans.

VA's inability to provide a full range of services creates a dilemma concerning the authorization of construction of new hospitals that have already been designed: Should VA proceed with construction or renovation of facilities as designed--that is, with limited capabilities to serve the broader range of patients that

might be covered under a managed care plan--or delay construction until decisions are made on VA's role under national health care reform?

I would like to turn now to one of the recurring factors that we have noticed concerning VA's construction planning process--inadequate consideration of alternatives to new VA construction.

VA DOES NOT ADEQUATELY CONSIDER UNUSED COMMUNITY AND MILITARY RESOURCES

For more than 10 years, we have been recommending that VA consider the availability of community and state nursing homes in its facility construction process. Using such resources to the maximum extent possible is important because care in community nursing homes is about one-half the cost of providing care in VA nursing homes.[4] Care in state veterans' homes is even more cost-effective for VA; VA pays about $22 per day for nursing home care in state veterans' homes and pays 65 percent of the cost of constructing and renovating state homes. In addition, to the extent VA can increase its use of community nursing homes and state veterans homes, it can avoid the costs of constructing VA nursing homes.

While most of our past work has focused on use of state and community nursing homes as an alternative to construction of VA nursing homes, we found during recent reviews of VA's planning for the construction of three medical centers that existing capacities in community and military hospitals appear adequate for meeting VA's acute care needs. One common feature of all three projects is that the veteran population is split between two or more major population centers; thus adequately serving veterans at one VA facility is difficult. I would add that this same feature would contribute to larger declines in demand for VA care under a universal health care insurance plan because veterans would be given health care options closer to their homes.

-- In Northern California, the veteran population is roughly split between the East Bay (Oakland) and Sacramento areas, which are about 70 miles apart. Although there is no VA inpatient hospital capacity in the northern California catchment area as a result of the closure in 1991 of the Martinez medical center, there is significant unused capacity in community hospitals near the Oakland, Martinez, and Sacramento VA outpatient clinics. For example, two private hospitals within 10-15 miles of the Martinez clinic told VA officials in 1991, shortly before the Martinez medical center closed, that they each had adequate capacity

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[4]In fiscal year 1992, average obligations per patient day were $184 for VA nursing home care units and $88 for community nursing homes.

to absorb the entire Martinez medical, surgical, and neurological workload. Similarly, officials at the University of California (Davis) hospital in Sacramento told us that they are expanding the facility and would consider leasing part of the planned bed tower to VA for an indefinite period.

-- In east central Florida, the veteran population is split among three population centers--Orlando, Daytona Beach, and Cocoa/Melbourne. The nearest VA medical centers are in Tampa, about 80 miles west of Orlando, and Gainesville, about 100 miles northwest of Daytona Beach. There are, however, about 2,100 empty community hospital beds in the Orlando and Cocoa/Melbourne areas on any given day, a local health planning agency official told us. Occupancy rates at community hospitals are, he said, frequently below 50 percent. Similarly, a Volusia County (Daytona Beach) official told VA officials in 1991 that an entire 300-bed hospital was available for VA use. Finally, the Orlando Naval Hospital--included on the proposed Department of Defense base closure list--has unused capacity.

-- In Hawaii, about 25 percent of the veteran population lives on the outer islands. Because there is no VA hospital in Hawaii, veterans are authorized to use either the Tripler Army Medical Center, which was renovated in the late 1980's with adequate capacity to meet VA's current and anticipated needs, or community hospitals on Oahu and the outer islands. The administrator of Hawaii's health planning agency told us that there is no shortage of acute care beds in Hawaii. Excess capacity is so prevalent that local officials estimate that it could be as long as 15 years before a certificate of need is approved by the health planning agency for construction of additional acute care capacity.

While none of the three areas I just described has a VA hospital, each area appears to have adequate capacity in its nearby community and military hospitals to meet VA's needs. However, the cost advantages of providing inpatient hospital care in community facilities are not as clear as the advantages of providing nursing home care in community nursing homes. As this Committee has discussed in prior hearings, reliable data are not available to show whether providing care in VA hospitals is less costly than in private sector hospitals.

Mr. Chairman, the Congress faces a dilemma: If VA hospitals are built to meet the current health care needs of veterans in these three areas, the hospitals could have significant excess capacity before they even open. In addition, VA would be faced with the task of designing facilities without knowing what patient population the facility is going to serve--veterans or veterans and

their families. On the other hand, if construction is put off until health care reforms take shape, efforts to meet the health care needs of an aging veteran population would be delayed.

DEMONSTRATION PROJECTS COULD IMPROVE VETERANS ACCESS TO ACUTE CARE WHILE DECISIONS ARE MADE ON REFORMS

One way of dealing with the dilemma of additional VA capacity would be to test alternative means of meeting the health care needs of veterans and improving access to hospital care. For example, the acknowledged excess hospital capacities in the non-VA sector in Northern California, east central Florida, and Hawaii provide excellent opportunities to test the feasibility of contracting for inpatient care at community or military hospitals.

By contracting for such care in hospitals in Orlando, Daytona Beach, and Cocoa/Melbourne, veterans in all three communities could obtain hospital care close to their homes. Similarly, because VA operates Northern California outpatient clinics in Oakland, Sacramento, Martinez, and Redding, VA could contract to meet the inpatient care needs of veterans in each community. Finally, as we pointed out in our report on a possible VA hospital in Hawaii, VA could enter into a joint venture with DOD at the Tripler Army medical center to meet the hospital care needs of veterans living on Oahu and continue to meet the hospital needs of veterans on the outer islands through contracts with community hospitals.[5]

Several treatment options for veterans could be tested. Under one option, VA physicians from an outpatient clinic could obtain patient admitting rights to community hospitals. Such an option was proposed by one of the hospitals offering to care for veterans following the closure of the Martinez medical center. The private hospitals would supply nursing and other personnel. The VA patients could, depending on the contract, be treated on separate wards or interspersed with other hospital patients. Another option would be for VA to contract for space in existing facilities and staff and operate the space itself. Yet another option would be to contract for all inpatient services.

Demonstrations such as these could (1) test the cost-effectiveness of alternative delivery methods and (2) assess differences in veteran satisfaction under the options. An added advantage, if VA is to compete with private managed care plans under national health reform, is that VA would be able to provide the full range of inpatient services, including maternity and pediatric care, through contracts with local hospitals.

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[5]VA Health Care: VA Plans Will Delay Establishment of Hawaii Medical Center (GAO/HRD-92-41, Feb. 25, 1992).

PROBLEMS IN VA's MAJOR CONSTRUCTION PROGRAM

Before closing, I would like to briefly discuss some of the other problems we see in VA's major construction program:

-- First, external factors that may affect demand for VA services, such as insurance coverage and the income of local veterans, are not consistently considered in determining the need for and size of VA projects. This is especially important because of the prospects for national health care reform discussed earlier.

-- Second, VA projects frequently exceed program needs, resulting in too many beds and too much space or designs that are too costly.

The final problem I would like to discuss is the timing of construction funding. When funds for construction of a project are provided before design work is completed--or in some cases before it is started--certain risks are created. First, the project's scope may expand to use available resources, increasing the cost of the project without creating an overrun. Second, if the funds appropriated are not adequate to cover construction costs once the scope of the project is determined and design development is completed, then (1) cost overruns may occur or (2) VA may be unable to award a contract within available funding limits. Finally, if unforeseen problems, such as an underground spring, are identified as the designs are refined, project costs may increase, leading to overruns. In such cases, delaying funding until design development is complete will not necessarily reduce the cost of construction, but would provide the Congress with better initial estimates of construction costs, potentially reducing the incidence of cost overruns.

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In summary, Mr. Chairman, VA, like other federal departments and agencies, is likely to face severe budget constraints during the next several years. Because of the uncertainty concerning the future demand for VA services and the types of services VA will be expected to provide, we believe that delaying most construction of additional capacity until the effects of health care and eligibility reforms can be more fully assessed and VA's role in the reformed health care system is determined would be prudent. Doing so would free up funds for deficit reduction or other purposes without affecting current VA health care services and also prevent construction of VA facilities that could quickly lead to excess capacity or facilities that are not designed to meet VA's role in the reformed health care system.

To prevent construction delays from adversely affecting veterans, the Congress could authorize VA to conduct one or more demonstration projects to test the concept of contracting for acute care services in community facilities in proximity to VA outpatient clinics. Such demonstrations would appear to offer several advantages: (1) they would test a VA managed care structure centered around its outpatient clinics, (2) they would improve access to VA care for veterans in the affected communities, and (3) they would more fully utilize existing hospital beds in the affected communities.

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

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