Department of Veterans Affairs

Office of Inspector General

AUDIT OF THE AVAILABILITY OF HEALTHCARE SERVICES IN THE FLORIDA/PUERTO RICO VETERANS INTEGRATED SERVICE NETWORK (VISN) 8

Inadequate capacity in some of the network's clinical services has restricted the availability of care to veterans. The Veterans Health Administration needs to revise its resource allocation strategies to ensure more effective network funding distributions and availability of services to veterans.

Report No.: 99-00057-55
Date: August 13, 2001

Office of Inspector General
Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to:

Under Secretary for Health (10)
Director, Veterans Integrated Service Network (10N08)

Audit of: Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8

1. The audit examined the provision of healthcare services to veterans enrolled for medical care in the Florida/Puerto Rico Veterans Integrated Service Network (VISN 8). The specific objectives of the audit were to determine:

- Whether the services described in the Department of Veterans Affairs (VA) Medical Benefits Package (MBP) were accessible to all VISN 8 enrollees.
- What VA medical services priority group 7 veterans used and what impact that usage had on providing timely care to all enrolled veterans.
- What strategies and steps VISN management used to integrate services and facilities, and allocate resources under the Veterans Equitable Resource Allocation (VERA) system.

Use of VA prescription services by priority group 7 veterans was addressed in a separate report - *Audit of Veterans Health Administration (VHA) Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans, Report No. 99-00057-4 dated December 20, 2000.*

2. VISN 8 includes five VA medical centers (VAMCs) and one integrated veterans health system (two formerly independent medical centers that have merged). In addition, there are 34 outpatient clinics located throughout Florida, South Georgia, Puerto Rico, and the U.S. Virgin Islands [10 multi-specialty clinics and 24 primary care community-based outpatient clinics (CBOC)]. The VISN plans to open 3 more multi-specialty clinics and 13 CBOCs in Fiscal Year (FY) 2001. VISN 8 has an annual operating budget of over $1.3 billion and employs approximately 13,500 employees. The VISN serves a veteran population of approximately 1.7 million and about 305,000 veterans received VA healthcare during FY 2000. This includes approximately 48,000 priority group 7 veterans who do not have compensable service connected disabilities and have incomes and net worth above the statutory threshold for free care and who agree to pay specified co-payments. An additional 30,000 non-veterans and veterans not formally enrolled, also received care at VISN facilities.

3. VISN 8 management needs to improve access to care for the veterans they serve and the Veterans Health Administration (VHA) needs to improve the allocation of healthcare resources among all 22 VISNs. The following key findings were identified:

- The inventory of network clinical services provides enrolled veterans most of the services described in VHA's MBP. For those services the network does not provide (including transplant programs and inpatient care for the seriously mentally ill), services are available at VA facilities outside of the network and at private/public facilities within Florida.

- The network is unable to provide veterans timely access to some clinical services because of clinic overcrowding. We found that 91 clinical services (about 10 percent of the 939 clinical services in the network's clinical inventory) had excessive patient waiting lists. For example, patients were required to wait up to 730 days for appointments in a sleep disorder program clinic at VAMC Bay Pines. Clinical service chiefs reported that an additional 39 clinical services were overcapacity (i.e., the time allotted for appointments was shortened and significant overtime was used to meet VHA waiting time standards.)

- Priority group 7 veterans represent 21.3 percent of total veteran enrollment in VISN 8 and 15.6 percent of all veterans who used VA healthcare services during FY 2000. This workload, which is not fully funded under the VERA system, has contributed to clinic overcrowding and excessive patient waiting time.

- The network's resource allocation process for individual facilities does not address the disparities that exist between facilities in the number of overcrowded clinics and extent of waiting lists. Currently, any increases in the VISN's VERA funding are shared equally by facilities with unit costs below the average unit costs of comparable facilities. Our review of clinic overcrowding and excessive patient waiting times showed the need for the network to include a measure of clinic capacity as part of its resource allocation process. This would allow for the number and extent of waiting lists and delayed appointments to be taken into consideration in determining funding allocations to individual facilities.

- The network has implemented facility and service level integrations to achieve improved efficiencies, and resource allocations among the network's facilities are accomplished in a manner consistent with the processes and incentives used in the current VERA system. However, additional actions are needed to meet VHA standards for timely access to care.

4. We concluded that VISN 8 does not have sufficient resources to provide timely access to all clinical services for all veterans who are currently enrolled and who are expected to enroll in the next several years. VISN workload projections show that demand will increase from 305,273 patients in FY 2000 to 400,875 by FY 2005. If additional resources are not available, the network will not be able to make lasting improvements to clinic timeliness and overcrowding.

5. To improve the allocation of resources, VHA should include priority group 7 veterans in the VERA resource allocation model. Currently, only priority groups 1 through 6 are fully included in the VERA allocation strategy. Including priority group 7 workload would more closely align the VERA model with the patient enrollment system and help to ensure that all patient workload is considered in resource allocation decisions. Improved network monitoring of clinic utilization and more equitable resource distributions among network facilities is needed to address the disparities we found among facilities.

We recommend that the Director, VISN 8:

- Improve the monitoring of clinical services and capacities at each medical facility.
- Improve resource distributions among medical facilities by including a measure of clinic utilization as part of the allocation criteria.
- Monitor the timeliness of those clinics identified by the audit as overcapacity, and their progress in reducing patient waiting times and scheduling delays.

We also recommend that the Under Secretary for Health incorporate all enrolled priority group 7 veterans in the VERA resource allocation model so that funding decisions consider the total number of veterans enrolled and treated.

6. The Director, VISN 8 concurred with our recommendations to improve veteran access to care in VISN 8 and provided acceptable implementation plans. The Under Secretary for Health deferred responding to our recommendation to include priority group 7 veterans in the VERA system until other options are considered. VHA's Office of Policy and Planning will establish a work group to fully study issues relating to geographic means test/price adjustments and the impact of healthcare delivery for all veteran priority groups.

7. We recognize that modification of the VERA model involves significant policy and budget considerations for the Department that require careful review. We also recognize that allocation of the estimated $1.48 billion budget resources associated with treating priority group 7 veterans among the networks will not result in equitable access to care unless VHA considers all patient demand for VHA healthcare services in its decisions. Accordingly, we will consider our recommendation to modify the VERA system unresolved until VHA's study of options is completed and specific implementation actions are provided that meet the intent of our recommendation.

(Original signed by:)

MICHAEL SLACHTA, JR.
Assistant Inspector General for Auditing

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RESULTS AND RECOMMENDATIONS

1. Additional Actions Are Needed To Reduce Clinic Overcrowding And Excessive Patient Waiting Times

Clinic overcrowding and excessive patient waiting times have emerged as one of the most visible and problematic issues facing the Veterans Integrated Service Network (VISN) 8. Our audit identified 91 clinical services that have excessive clinic waiting lists. This represents 9.7 percent of 939 clinical services that we confirmed were in the network's current clinical inventory.

We also identified 39 additional clinics (4.1 percent) where the senior clinician reported to us that, in order to meet the Veterans Health Administration's (VHA) patient waiting standards, individual appointments were shortened or significant staff overtime was used that affected employee moral and productivity. Some of these clinics are operating at over 200 percent of what the senior clinician believes is appropriate considering the available resources. Waiting times for access to these clinics ranged as high as 730 days. While patients with critical or urgent conditions are generally seen promptly, other patients must wait months to get an initial appointment.

We found that clinic overcrowding and excessive patient waiting times occurred for a variety of reasons including problems with clinic schedules, hours of operation, staffing, space, or equipment. For most clinics with excessive waiting times, only one or two facilities were involved. However there were seven clinical services with long waiting times at the majority of facilities indicating that solutions to the timeliness and access problems were beyond the resources available to the individual facilities. These clinical services were Optometery, Audiology, Dermatology, Sleep Disorders, Gastroenterology, Contrast Procedures, and Nerve Conduction Studies. Waiting times for appointments to these clinics ranged from two months up to two years, with an overall average wait of almost five months. *(Additional details on our clinic capacities review are presented in Appendix III on pages 15-19.)*

Network management recognizes that, in selected areas, waiting times are a problem and exceed VHA's goal of a 30-day maximum wait for outpatient appointments. The VISN's Fiscal Year (FY) 2001 Strategic Plan shows that, during FY 2000, the average waiting time for an appointment in a specialty clinic was 76 days, where VA's best was 26 days. Goals established for the VISN for FY 2005 include a reduction in waiting time to 25 days. Our review found that network and facility managers and staff are taking a number of actions to achieve this goal. However, we believe that the network's effort to reduce patient waiting times would be further enhanced with improved monitoring of clinical resources and better resource distributions among facilities.

The Network Is Taking Actions To Reduce Clinic Waiting Times

We found that the network's efforts to improve the capacity of its clinics have been extensive. We reviewed the results of several initiatives including strengthening clinic management (e.g., scheduling and patient referral processes), facility and service level integrations, and resource issues (e.g., recruiting and hiring additional staff) and concluded that these efforts have, for some of the network's clinics, been successful in reducing waiting times, although not always to the

extent necessary to meet VHA timeliness standards. In addition, the network continues to pursue other avenues to improve clinic timeliness and reduce overcrowding. The network's overall strategy to reduce waiting times includes three general approaches: (1) increasing the resources that are available for clinics, (2) reducing unnecessary demand on clinic resources, and (3) providing incentives for facility staff to develop local initiatives and solutions.

The VISN FY 2001 Strategic Plan details several specific measures that the network is taking to reduce waiting times. These measures include focusing on new technology to improve timeliness and coordination of care by improving diagnostic capability, increasing access to care VISN-wide, and making patient clinical information available across all sites of care. *(Additional details on the network's actions to reduce clinic waiting times are presented in Appendix III on pages 15-19.)*

The Network Needs To Improve The Tracking Of Clinical Services And Capacities At Each Medical Facility

In support of its annual strategic planning process, the network developed a clinical inventory for each facility showing which services were available. However, because the inventory is updated only annually, its usefulness as a management tool is limited. Based on initial work we completed at VA medical center (VAMC) Bay Pines and the results of questionnaires we sent to the remaining network VAMCs, we questioned the availability of 156 (15.5 percent) of the 1,009 clinical services included in the inventory for these facilities. As a result of our follow up with each facility, we identified 70 clinical services that needed to be removed from the inventory because they were not available. We were able to confirm that 939 clinical services were available in the clinical inventory.

Although all of the discrepancies we identified were reconciled and the network updated the inventory based on the most recent status of each facility's programs, a method needs to be devised to allow network managers to monitor the status of each facility's clinical services and programs and more effectively support strategic planning efforts. Network staff informed us that the inventory in its current format is not workable and needs to be replaced to allow network managers to track the status and capacities of clinical services at each facility. We believe that a new method should also provide for the identification of clinical services that have been formally approved and/or accredited.

Resource Distributions Among Network Facilities Needs To Consider Patient Waiting Times And Scheduling Delays

The network Finance Officers Council determines (with the Executive Leadership Council's approval), how annual funding is distributed among the network facilities. For FY 2001, the process was as follows: (a) the VISN's expected Veterans Equitable Resource Allocation (VERA) distribution was identified, (b) funds needed for network expenses and reserves were established (e.g., terminal leave, VISN office operations, "just-in-case" scenarios, leases, community-based outpatient clinic startups, etc.), (c) each facility is funded at last years "modeled" levels (formerly referred to as "recurring" costs), and (d) increases in the VISN's VERA funding are shared by facilities with unit costs below the average unit costs of comparable facilities. Adjustments are made throughout the year based on circumstances and with the consensus of the Finance Officers Council and concurrence of the Executive Leadership

Council. Each facility also retains 100 percent of its Medical Care Collection Fund collections. Non-recurring maintenance, equipment, etc. are distributed based equally on unique patients and measured workload.

Our review of clinic overcrowding and excessive patient waiting times showed the need for the network to include a measure of clinic capacity as part of its resource allocation process. This would help assure veterans throughout the network more equitable access to care. For example, our review of clinic waiting times and capacity issues at West Palm Beach (WPB) showed that only 3 (2.5 percent) of its 123 clinics had extended patient waiting times (compared with about 10 percent at the other network VAMCs).

The workload mix and history of WPB suggests that its funding position has benefited from its relatively recent activation and less complicated patient workload (i.e., its focus on primary and secondary care rather than tertiary care). As a result, WPB refers its most complicated cases to other VAMCs within the network. Although the VERA based formula that the network uses to measure unit costs makes some adjustment for the relative complication levels of patient care, our review showed that this process does not adequately address the relative capacities of each facility's clinics. The result is more excessive clinic overcrowding and patient waiting times at five of the network's six VAMCs. We believe that funding allocations to network facilities should take into consideration the number and extent of waiting lists and delayed appointments.

Conclusion

Almost 10 percent of the network's clinics have excessive patient waiting lists and scheduling backlogs. Although the network has taken significant actions to reduce waiting times, additional measures are needed. These include improved monitoring of clinical resources and changes to the current process of allocating resources among individual facilities so that funding allocations take into consideration the number and extent of waiting lists and delayed appointments.

Recommendation 1:

We recommend that the network Director take the following actions to improve the timeliness of providing VISN clinical services and activities identified by the audit as overcapacity and experiencing excessive patient waiting times and scheduling delays:

a. Improve the monitoring of clinical services and capacities at each medical facility.

b. Improve resource distributions among medical facilities by including a measure of clinic utilization as part of the allocation criteria.

c. Monitor the timeliness of those clinics identified by the audit as overcapacity, and their progress in reducing patient waiting times and scheduling delays.

VISN 8 Network Director Comments

The network Director concurred with the report recommendations 1(a), (b), & (c).

Implementation Plan

The network Director provided the following implementation actions for each recommendation.

1 (a) The VISN 8 Strategic Planning Board agreed at their last meeting that they would begin utilizing the clinical inventory as a tool to monitor the status of each facility's clinical services and programs. The facility planners also made a commitment to update the information in the clinical inventory as it pertains to their individual facility.

1 (b) Currently, we are utilizing the VISN 8 $10 million Incentive Pool for Waits and Delays as an allocation tool that involves clinic utilization. All VISN 8 facilities submitted proposals to decrease waits and delays with timelines for meeting strategies they have defined. We are tracking this on a quarterly basis and allocating resources based on improvements achieved to reduce waiting times.

1 (c) VISN 8 has been monitoring the six clinics in the Medical Center Director's Performance Agreement (i.e., Primary Care, Eye Care, Audiology, Urology, Cardiology and Orthopedics) through the use of the KLF MENU by facility, outpatient clinic and community-based outpatient clinic. Progress reports are being generated on a monthly basis. In addition, we will ask the facility directors to implement a mechanism to track on a quarterly basis their clinics that are over-capacity.

(See Appendix V on pages 23-24 for the full text of the network Director's comments.)

Office of Inspector General Comments

The network Director's implementation actions are acceptable and responsive to the recommendation areas. We consider these report issues resolved and will follow up on planned actions until they are completed.

2. The Veterans Equitable Resource Allocation System Should Include Priority Group 7 Veterans

VISN 8, as well as most other VHA networks, has been experiencing significant increases in the number of patients enrolled and treated. One of the contributing factors to these increases has been VHA's policy of increasing the number of veterans served in order to reduce the average cost per patient. Although this policy was changed in the current (FY 2001) issuance of the Under Secretary's annual performance goals for network Directors, and replaced by a greater emphasis on reducing waiting times, the incentives to increase the number of patients treated will likely continue since the VERA system, as well as the network's own internal allocation process, continues to emphasize and reward lower "unit costs." The following chart depicts the increases in priority group 7 enrollees and enrolled veteran users between FY 1996 and FY 2000, and projections for FY 2005:

	VISN 8	VHA - TOTAL
FY 1996 – Unique Users	237,564	3,012,366
FY 1996 – Unique Priority 7 Users	7,901	107,889
FY 2000 – Unique Users	305,273	3,307,256
FY 2000 – Unique Priority 7 Users	47,688	574,516
FY 2000 – Unique Enrollees	417,899	4,815,590
FY 2000 – Unique Priority 7 Enrollees	88,892	1,142,140
FY 2005 – Unique Enrollees	447,156	5,330,848
FY 2005 – Unique Priority 7 Enrollees	116,779	1,544,376
FY 2005 – Unique Users	400,875	3,701,087

(Data Sources: VHA Planning Systems Support Group, VHA Enrollment Level Decision Analysis, VISN 8 Strategic Plan, VHA Performance Measurement System Intranet, and VHA-KLF Menu.)

As presented in the above chart, the number and proportion of priority group 7 veterans[1] enrolled and being treated at VISN 8 facilities and VHA-wide has increased significantly since FY 1996 and is projected to continue to increase. This increasing utilization of medical resources by non-service connected, higher income veterans will require a similarly increasing share of VHA appropriated budget resources.

The Costs Of Providing Healthcare Services For Priority Group 7 Veterans Are Significant

Once enrolled, all veterans, regardless of their priority group, share equal access to the healthcare services offered in VA's Medical Benefits Package (MBP). However, the current resource allocation strategy, as implemented under the VERA system, does not provide funding for the

[1] Priority group 7 veterans are non-service connected and zero percent non-compensable service-connected veterans with income and net worth above the statutory threshold for free care and who agree to pay specified co-payments. Prior to 1999, most priority group 7 veterans were referred to as Category C.

majority of priority group 7 veterans (an exception is priority group 7 veterans who meet the criteria for "complex care"). Although VISN 8's share of priority group 7 veterans is slightly below the national average (21.3 percent of enrollees in the VISN are priority group 7 veterans versus 23.7 percent nationwide), the impact of providing care to these veterans on VISN 8 as well as all other networks is significant in both costs and in the shear numbers of patients who must be scheduled and examined in the clinic setting. For FY 2000, VHA estimated that total costs for priority group 7 veterans were $946 million nationwide, while for FY 2001, these estimates increase to $1.48 billion. In addition, VHA's enrollment projections reflected in the chart on the previous page indicate that priority group 7 enrollments VHA-wide will increase to over 1.5 million (to approximately 29 percent of total veteran enrollment) by FY 2005, which the VERA model essentially ignores in its resource distribution methodology.

VERA System Excludes Priority Group 7 Veterans

The VERA system was developed to encourage facilities to enroll and treat higher priority veterans, with "excess capacity" used to enroll a limited number of priority group 7 veterans. However, subsequent to the development of the VERA based incentives, revised eligibility rules and VHA's concurrent policy requiring significant overall increases in the number of veterans enrolled has resulted in many networks enrolling large numbers of priority group 7 veterans with the hope that third party insurance billings and veteran co-payments would pay for the cost of their care. This has not been the case, and much of the timeliness problems and overcrowding of clinics we identified in VISN 8 can be traced directly to the enrollment of "unfunded" priority group 7 veterans.

While overall VHA funding levels will not be directly affected by including priority group 7 veterans in VERA (since VHA's budget and spending authority is developed through a separate process), strategic planning will benefit by considering the total workload, costs, and capacities of VA's healthcare system. We estimate that this will result in at least $1.48 billion annually (the FY 2001 estimated cost of providing care to priority group 7 veterans) in more effective funding distributions to VHA's 22 VISNs.

Since VERA does not fund care for the majority of priority group 7 veterans workload, the financial impact of this workload in some VISNs has resulted in VHA withdrawing funds from other networks in order to fund supplemental requests from those networks that have higher than average priority group 7 enrollments and associated workload. This occurred in January 2001 when 18 of the 22 networks were required to return funds totaling $131.174 million in order to provide funding to 4 networks that required supplemental funding, due primarily to high levels of priority group 7 workload that was not funded by VERA.

VHA's decision to fund priority group 7 veterans by taking back funding that was allocated through the VERA process effectively acknowledges that limiting priority group 7 access to excess capacity and the ability to generate additional funds through insurance billings has not worked. VISN 8's share of this funding redistribution was $10.95 million, which will further adversely impact the network's ability to reduce the number of its overcapacity clinics.

Conclusion

Given the increases in the enrollment levels of priority group 7 veterans, and the significant "unfunded" costs of providing these veterans with healthcare services, we believe that workload for priority group 7 veterans should be included in VERA. This will allow funding distributions for all networks to be based on the total number of veterans who are enrolled for care and treated.

Recommendation 2:

We recommend that the Under Secretary for Health include priority group 7 veterans in the VERA system to allow funding distributions for all networks to be based on the total number of veterans who are enrolled for care and treated.

Under Secretary for Health Comments

The Under Secretary for Health deferred responding to our report recommendation to include priority group 7 veterans in the VERA system until other options are considered.

Implementation Plan

The Under Secretary advised that he has requested VHA's Office of Policy and Planning establish a work group to fully study the issues of geographic means test/price adjustments and the impact on healthcare delivery to all veteran priority groups. Since there are geographic differences in the cost of living that can influence a veteran's ability to obtain healthcare, the study will evaluate the impact a "variable means test" would have on healthcare delivery for all veteran groups. Findings and recommendations of this work group are to be submitted to the Under Secretary by September 2001.

(See Appendix VI on pages 25-26 for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

Based on the Under Secretary's response, we consider the recommendation unresolved until VHA's study of options is completed and specific implementation actions are provided that meet the intent of our recommendation. We will follow up on VHA's planned study of options until it has been completed.

We recognize that these issues represent significant policy and budget considerations for the Department that require careful review of any acceptable alternatives. We also recognize that effective allocation of the estimated $1.48 billion in annual budget resources associated with treating priority group 7 veterans will continue to be hampered unless the system of allocating resources among networks includes all veterans who use VHA healthcare services.

Where appropriate, we revised the report in response to the Under Secretary's comments. However, we need to clarify some of the comments provided concerning priority group 7 veteran workload and the withdrawal of funds from networks.

Although the Under Secretary "agree(s) that national cost estimates for priority group 7 veterans are not insignificant", his comments indicate that priority group 7 veterans account for an estimated 25 percent of all enrollees but only about half that number actually use VA healthcare services and that priority group 7 veterans represent a very small segment of all patients using VHA's outpatient facilities. However, our review of available VHA data shows that priority group 7 workload is substantial with these veterans accounting for over 17 percent of all patients using VHA healthcare services of all types at a significant estimated cost to VHA of $1.48 billion in FY 2001.

The Under Secretary's comments indicates disagreement with a statement in the report regarding the withdrawal of funding from some networks in order to fund other networks supplemental requests. Specifically, the report states that the supplemental funding was needed because VERA does not fund care for priority group 7 veterans workload, and that VHA withdrew funds from some networks in order to fund the supplemental requests from those networks that have higher than average priority group 7 workload. Although the Under Secretary's response indicates that the decision to provide supplemental funding to the 4 networks in January 2001 was not based on considerations of the levels of priority 7 workload, our review showed that these networks had significantly higher proportions of priority 7 workload than the remaining 18 networks from which the funds were derived. For example, during FY 2000, priority 7 veterans represented 34.3 percent of the total enrollees for facilities in these 4 networks and 26.6 percent of the total number of actual users of healthcare services. For the remaining 18 networks, priority group 7 veterans represented less than 15.8 percent of the total number of actual users of healthcare services. This translates into a 68 percent higher proportion of priority group 7 workload for these 4 networks than the remaining 18 networks.

While the Under Secretary's comments do not specifically address the basis for the specific amounts of the supplemental funding provided to the 4 networks, we were advised by a member of VHA's Executive Leadership Board that the supplemental funding was needed as the result of aggressive recruiting, enrollment, and treatment of priority group 7 veterans. We believe that, unless the VERA system is modified to include all eligible veterans, some facilities and networks will continue to aggressively recruit and enroll priority group 7 veterans with the expectation that VHA will have no choice but to provide supplemental funding outside of the formal VERA allocation system. This in turn could create greater disparities in veteran access to care and fundamentally undermine the integrity of the VERA system.

The Under Secretary's response also indicates disagreement with the amount of funds we reported had been withdrawn from the 18 networks. Specifically, the report states, "…in January 2001, 18 of the 22 networks were required to return funds totaling $133.9 million…" The Under Secretary's response indicates that the amount was actually $131.174 million and that $43.174 million of this was due to a congressional rescission (leaving $88 million as the actual amount of the supplemental provided to the 4 networks). We have revised the report to reflect the figure presented by the Under Secretary. The figure we cited in the report was based on a January 23, 2001 memorandum from VHA's Chief Financial Officer to all network Directors. This memorandum clearly outlines the scenario for the withdrawal and specifically exempts the 4 networks receiving the supplemental funding from the rescission. In effect, this required the remaining 18 networks to not only provide the $88 million in supplemental funding for the 4 networks but to further supplement the 4 network's funding by making up for their part of the rescission.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The audit examined the provision of healthcare services to veteran enrollees in the Florida/Puerto Rico Veterans Integrated Service Network (VISN 8) in accordance with the Department of Veterans Affairs (VA) Medical Benefits Package (MBP)[2]. The specific objectives of the audit were to determine: (1) whether the services described in VA's MBP were accessible to all VISN 8 enrollees, (2) what VA medical services priority group 7 veterans used and what impact that usage had on providing timely care to all enrolled veterans, and (3) what strategies and steps VISN management used to integrate services and facilities, and allocate resources under the Veterans Equitable Resource Allocation (VERA) system. Issues concerning the extent of priority group 7 veterans use of VA prescription services were discussed in a separate report to the Under Secretary for Health *(Audit of Veterans Health Administration (VHA) Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans, Report No. 99-00057-4*).

Scope and Methodology

Audit work was performed at VA Central Office, Washington, D.C. and at VISN 8 headquarters in St. Petersburg, Florida. Site visits were also made to VA medical centers (VAMC) in San Juan, Puerto Rico and at Bay Pines, West Palm Beach, Tampa, Gainesville, and Lake City, Florida. Also, VAMC Miami was included in a survey of network clinical services, but a site visit was not completed due to electrical fire damage that had closed the facility.

Our initial fieldwork began with an assessment of a VISN-wide clinical inventory developed by the network's management staff as part of its strategic planning process. This inventory listed specific clinical services and activities that were reported for each of the VISN's facilities. We surveyed the listed clinical services at each VAMC and selected services that required follow-up review. These included: (1) services where survey results indicated an inconsistency with the network's clinical inventory (e.g., the existence of the service could not be initially confirmed), and (2) services where the clinical service chief provided us with an initial assessment indicating the existence of waiting lists, scheduling backlogs, or other capacity and timeliness problems.

We compared the healthcare services listed in the MBP with services confirmed by the audit as available at each of the network's facilities and determined that the network's clinical inventory of services provides enrolled veterans with most of the healthcare services enumerated in VHA's MBP. For those services that it cannot provide (including transplant programs and inpatient care for the seriously mentally ill), services are available at VA facilities outside of the network and at private/public facilities within Florida. The audit was performed in accordance with generally accepted Government Auditing Standards.

[2] VA's MBP specifies the healthcare guaranteed to all enrolled veterans. Although the Veterans Millennium Health Care and Benefits Act expanded some services (e.g., maternity, emergency services, adult day healthcare), policies concerning implementation of these services were still being decided at the time of the audit.

BACKGROUND

The Veterans Integrated Service Network (VISN)

In March 1995, the Under Secretary for Health submitted a plan to Congress reorganizing VHA's field management structure. The plan was required under 38 USC §510(b) since it eliminated the then four regional field management offices and reassigned those personnel and functions. The purpose of the reorganization was to improve the integration of resources and service delivery by increasing the autonomy, flexibility, and accountability of field management. Specifically, the plan detailed the replacement of 4 regions, 33 networks, and 159 independent medical centers with 22 VISNs that report directly to the Office of the Under Secretary for Health.

Each VISN consists of a geographic area encompassing the population of veteran beneficiaries. VISN geographic boundaries were established after a review of patient referral patterns and the types of facilities needed to provide primary, secondary, and tertiary care to the veteran population.

Conceptually, the VISN is the basic budgeting and planning unit of the veterans healthcare system with emphasis on integrating ambulatory services with acute and long-term inpatient services. Each of the 22 VISN Directors' has the authority and responsibility for the following:

- Ensuring that a full range of services is provided, to include specialized services and programs for disabled veterans.
- Developing and implementing VISN budgets.
- Area-wide (population-based) planning.
- Consolidating and/or realigning institutional functions.
- Maximizing effectiveness of human resources available to the VISN.
- Moving patients within and outside the VISN to ensure receipt of appropriate and timely care.
- Contracting with non-VA providers for medical and non-medical services, as needed.
- Maintaining cooperative relationships with other VA field entities, such as Veterans Benefits Administration regional offices and national cemeteries.

Resource Allocation And Financial Planning

The VISN 8 budget committee is referred to as the network Finance Officers Council (NFOC). It is comprised of Finance Officers from each of the network's VAMC's. The NFOC determines, with the Executive Leadership Council's (ELC) approval, the distribution of available funding to the network's facilities. The minutes of this council contain the discussions/recommendations affecting resource distributions and redistributions. Evidence of the network's allocations to facilities is contained in what are referred to as "bridge documents" and describe: (1) the approach used to allocate funds, (2) the rationale for the size of the network's reserve and how the allocation of reserves to facilities is determined, (3) how the network's allocation scheme supports each of the Under Secretary for Health's resource allocation principles, and (4) how the

network's allocation process ensures equitable veterans access to healthcare as defined in P.L. 104-204.

The NFOC determines with the ELC's approval, the distribution of available funding to network facilities. For FY 2001, the process was as follows: (a) the VISN's expected VERA distribution was identified, (b) funds needed for network expenses and reserves were established (e.g., terminal leave, VISN office operations, "just-in-case" scenarios, leases, CBOC startups, etc.), (c) each facility is funded at last years "modeled" levels (formerly referred to as "recurring" costs), and (d) increases in the VISN's VERA funding are shared by facilities with unit costs below the average unit costs of comparable facilities. Adjustments are made throughout the year based on circumstances and with the consensus of the NFOC and concurrence of the ELC. Each facility also retains 100 percent of its Medical Care Collection Fund collections. Non-recurring maintenance, equipment, etc. are distributed based equally on unique patients and measured workload.

Facility Missions

Each medical facility within the network has an approved mission based on the identified needs of the population it serves and available resources. If a patient needs a clinical resource that is unavailable at his/her local VA facility, they are referred to a network facility that has the necessary capability or they are referred to another VA network or a private provider. The following briefly describes each of the network VAMC's clinical missions:

Bay Pines - A General Medical and Surgical (GM&S) primary and secondary care hospital with a Nursing Home Care Unit (NHCU) and Domiciliary (DOM). Satellite activities include a multi-specialty Outpatient Clinic (OPC) at Ft. Meyers and Community Based Outpatient Clinics (CBOC) at Sarasota, Clearwater, and St. Petersburg, and in Manatee, Charlotte, and Collier counties.

North Florida/South Georgia Veterans Health Care System – A GM&S tertiary care hospital at Gainesville and GM&S primary, secondary and extended care hospital at Lake City, both with NHCUs. Integration of the two hospitals was approved in September 1997 with the final stages (service reorganizations) occurring this year. Satellite activities include multi-specialty OPCs at Jacksonville, Daytona Beach, and Tallahassee and CBOCs at Ocala and Valdosta, and in Cirus County.

Miami – A GM&S tertiary care hospital with a NHCU. Satellite activities include a multi-specialty OPC at Oakland Park, an Outreach Center in Miami, and CBOCs at Homestead, Key Largo, Key West, and Pembrook Pines.

San Juan – A GM&S tertiary care hospital with a NHCU. Satellite activities include multi-specialty OPCs at Ponce and Mayaguez and CBOCs at Arecibo, St. Croix, and St. Thomas.

Tampa – A GM&S tertiary care hospital with a NHCU. Satellite activities include a Healthcare Center at Orlando (which includes a multi-specialty OPC, a NHCU, and a DOM), muti-specialty

clinics at Brevard and Port Richey, and CBOCs at Lakeland, Brooksville, Sanford, and Zephyrhills.

West Palm Beach – A GM&S primary & secondary care hospital with a NHCU. Satellite activities include CBOCs at Ft. Pierce, Delray Beach, and Stuart.

Patient Enrollments And Workload

Overall, the network's outpatient workload increased 54 percent between FY 1996 and FY 2000. During the same period, hospital bed days of care decreased 36 percent, while hospital inpatients treated decreased by 18.6 percent. The decrease in bed days of care exceeded the reduction in hospital inpatients treated due to shorter lengths of stay (-13.7 percent). Hospital operating beds were reduced by 42 percent between FY 1996 and FY 2000. Enrollment and unique patients treated for VISN 8 and VHA as a whole for FY 2000 and projections for FY 2005 are shown in the following table:

Enrollments For & Users Of VA Healthcare - FY 2000 and FY 2004								
	PRIORITY GROUP							
	1	2	3	4	5	6	7	Total
VHA-Wide								
FY 2000								
Enrollments	492,426	344,809	628,860	167,923	1,948,536	90,896	1,142,140	4,815,590
Percent of Total	10%	7%	13%	3%	40%	2%	24%	
Active Users	441,491	264,535	434,690	145,848	1,397,736	48,440	574,516	3,307,256
Percent of Total	13%	8%	13%	4%	42%	1%	17%	
FY 2005(projected)								
Enrollments	404,138	319,140	631,112	108,839	2,232,494	90,749	1,544,376	5,330,848
Percent of Total	8%	6%	12%	2%	42%	2%	29%	
Active Users	Priority groups not broken down							3,701,087
VISN 8								
FY 2000								
Enrollments	50,108	29,143	56,003	15,489	171,643	6,621	88,892	417,899
Percent of Total	12%	7%	13%	4%	41%	2%	21%	
Active Users	46,271	23,690	41,723	13,862	128,370	3,669	47,688	305,273
Percent of Total	15%	8%	14%	5%	42%	1%	16%	
FY 2005								
Enrollments	Priority 1 through 6 not broken down						116,779	447,156
Active Users	Priority groups not broken down							400,875

(Data Sources: VHA Planning Systems Support Group and VHA Office of Policy and Planning Enrollment Level Decision Analysis.)

RESULTS OF CLINIC CAPACITIES REVIEW

Some Veterans Were Not Receiving Timely Care At VISN 8 Medical Clinics

The Veterans' Health Care Eligibility Reform Act of 1996 required VA to ensure that veterans enrolled in VA's healthcare system receive timely care. VA's goals for outpatient care are that patients (1) receive an initial, non-urgent appointment with primary care within 30 days of requesting one; (2) receive specialty care appointments within 30 days of referral by a primary care provider; and (3) be seen within 20 minutes of their scheduled appointments. VA refers to these goals as the "30-30-20" goals. We focused on how long it took new patients to obtain a scheduled outpatient appointment and not the time spent in the waiting room to see a provider.

Our review found that about 10 percent of VISN 8 specialty clinics have excessive waiting times for new patient appointments. An additional 39 were identified where the senior clinician reported that, in order to meet VHA's patient waiting standards, individual appointments were shortened or significant staff overtime was used that affected employee moral and productivity. While patients with critical or urgent conditions are generally seen promptly, other patients must frequently wait months to get an initial appointment.

Our work was based on responses to a structured questionnaire sent to 6 of the 7 VAMCs in VISN 8 (except for Bay Pines where we did the initial survey work). The questionnaire requested information on clinical services listed in the network's clinical inventory of services for these facilities. The information requested for each clinic included an assessment by the senior clinician as to whether the clinic was over-capacity and evidence to support this assessment including; waiting times, scheduling delays, over-booking of appointments, too-short appointment time-slots, excessive employee overtime, and high employee turnover rates. After receipt of the responses, we visited every facility except VAMC Miami (due to a recent electrical fire) to follow-up on any significant clinic capacity and waiting time problems identified in the responses. We interviewed staff from each clinic to verify the information provided in the response and obtain any documentation available to support capacity and timeliness issues. The results found that the primary care clinics were not over capacity and generally able to schedule new patients within VHA's 30-day standard. However, many specialty clinics were found to be experiencing capacity and timeliness problems as shown in the following chart.

VISN 8 OVER CAPACITY AND UNTIMELY CLINICS							
		Untimely Clinics					
VA Medical Center	**Number Clinics Surveyed**	**Waits 31-60 Days**	**Waits 61-90 Days**	**Waits Over 90 Days**	**Total Waits Over 30 Days**	**Over Capacity Clinics**	**Total**
Bay Pines	138	5	1	5	11	4	15
Gainesville	144	11	5	4	20	6	26
Lake City	72	3	4	2	9	3	12
Miami	165	11	1	4	16	4	20
San Juan	137	4	5	5	14	5	19
Tampa	160	7	4	7	18	17	35
West Palm Beach	123	2	1	0	3	0	3
Totals	**939**	**43**	**21**	**27**	**91**	**39**	**130**

In total, of the 939 clinical services we confirmed were included in the network's clinical inventory, 91 (9.7 percent) had waiting times for new patient appointments in excess of the 30-day standard. Thirty-nine additional clinics (4.1 percent) were identified as over-capacity based on assessments by the clinic's senior clinician that, in order to meet VHA's patient waiting standards, individual appointments were shortened, or significant staff overtime was used that affected employee moral and productivity. There were seven clinical services with appointment waiting times in excess of 2 months at several medical centers (Optometery, Audiology, Dermatology, Sleep Disorders, Gastroenterology, Contrast Procedures, and Nerve Conduction Studies). This indicates the need for a coordinated network-level approach to reduce waiting times for these services. Details of untimely and overcapacity clinics by location and clinical service are summarized on pages 18-19.

Network Actions Taken To Reduce Waiting Times

The VISN 2001 Strategic Plan details several specific measures that the network is taking to reduce waiting times including focusing on new technology to improve timeliness and coordination of care by improving diagnostic capability, increasing access to care VISN-wide, and making patient clinical information available across all sites of care. The plan includes strategies to achieve the following:

- Continuing to build on Institute for Healthcare Improvement initiatives for improving scheduling and timeliness.
- Hiring and/or contracting for more specialists and technical support staff.
- Increasing the mix of mid-level providers and administrative support staff.
- Freeing up staff through consolidation of selected services in geographic areas.
- Reducing inappropriate referrals to specialty clinics, for improved utilization management.
- Using tele-health/medicine capabilities to expand services provided to veteran patients both to improve quality and access to care.
- Creating an incentive pool of $10 million to encourage the development of proposals aimed at reducing waiting times. Criteria are currently being developed for facilities to make proposals on how they will reduce waiting times and delays in care. Funds are initially allocated based on these proposals but removed if plans/goals are not met.
- Renovating infrastructure within medical centers and outpatient clinics to streamline patient care delivery by mitigating functional deficiencies and creating additional rooms per provider.
- Addressing challenges imposed by inadequate capital infrastructure and difficulty in acquiring VA-owned satellite clinics resulting in $12 million in annual lease costs and the need to spend $100 million in next 3 years to address various space and functional problems in both VA owned and leased satellite clinics.
- Capitalizing on opportunities for improved services such as contracting for services with the private sector (e.g., contract hospital care in east central Florida), facility integrations and service consolidations between neighboring VA facilities, and further expansion of primary care.
- Developing a tool for accurate documentation of clinic waiting times and obtaining an accurate measure of waiting times (also a national goal for VHA).

- Simplifying the Veterans Information Systems and Technology Architecture System Scheduling Package that currently allows clinic setup options, but is not flexible in managing the changes in clinic schedules required on a daily basis, and improve the overall scheduling process by reducing "no-shows" and improving "open access."

Facility Management Actions Taken To Resolve Clinic Overcapacity Problems

During the course of the audit local facility management took various actions to correct timeliness and overcapacity problems for some clinics, such as reducing the length of appointments, increasing the number of hours and days the clinics are open, recruiting replacement staff, and adding additional staff, space, and/or equipment. In some cases, plans for improved timeliness were in the process of being developed. While these actions are appropriate and did result in the reduction of some clinic waiting times, they were frequently short-term and reactionary in nature and do not address the underlying problem, which we believe to be the large number of "unfunded" priority group 7 veterans that the clinics are required to enroll and treat.

Summary Of Untimely And Overcapacity Clinics

The chart on pages 18-19 shows the detailed results of our review by location and clinical service. The "CAP %" column shows the percent the overcapacity clinic was working. The "WT DAYS" column shows the number of days it took for a new patient to get an initial appointment. A "+" indicates that the measure of clinic overcapacity or waiting days exceeded a certain level, because a precise figure was not available.

APPENDIX III

VISN 8 OVERCAPACITY CLINIC RESULTS														
	BAY PINES		GAINESVILLE		LAKE CITY		MIAMI		TAMPA		WEST PALM		SAN JUAN	
	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS
Allergy Treatment		365										40		
Cardiac Telemetry									125					
Cardiology Services			133	60			125		125					
CCU									150					
Dermatology Services		240	150	90	100+	90			100+					90
Echocardiology	100+								150	60				
EKG	100+													
Cardiac Electophysiology									100+					
Endo. and Metabolism	164													
Endoscopy (Diagnostic)			133	50		180			125	45				
Gastroenterology	100+	45					200	180	125	60			175	72
Hematology Services			200	60									150	
Immunology Services				60										
Infectious Diseases			100+											
Internal Medicine Beds									125					
MICU Stepdown Unit			55											
Nephrology Services	111	90		75										
Oncology	140	45											150	
Pacemaker Implants										120				
Pulmonary Medicine		60	125	60						60			160	64
Rheumatology Services								90						155
Sleep Disorders Program		730	125	75			150	180		240				
Ambulatory Surgery							125							
Endoscopy (Broncho)									100+					
Hand Surgery							150	50	100+					
Neurosurgery			113	80+				60	125	45				
Ophthalmology							175		100+			30+		
Otolaryngology (ENT)			150				110	60						
Podiatry					150	110								
Surgery (Cardiac)				60										
Surgery (General)			200	49			125	60						
Surgery (Orthopedic)							125		100+					
Surgery (Plastic)									100+					
Surgery (Urology)							200	50	125				180	60
Behavioral Medicine				60										90
Geropsych Clinic/ Day Tx										120				
Mental Health Clinic												67	125	
Neuropsychology			175	120				45						
PRRTP-Psych Residl Rehab Tx						50								
PTSD Clinical Team / Day Tx			160	60			200	60						
Substance Abuse (OP) / Day Tx			125	60										
Consult Services (Neuro)			125	180										
EMG								150						

APPENDIX III

VISN 8 OVERCAPACITY CLINIC RESULTS														
	BAY PINES		GAINESVILLE		LAKE CITY		MIAMI		TAMPA		WEST PALM		SAN JUAN	
	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS	CAP %	WT DAYS
Movement Disorders Program									150	180				
Neuro-immunology		30+												
Chronic Pain Program						75							200	180
Incentive Therapy							150	60						
Kinesiotherapy					200									
Nerve Conduction studies						75	200	120	185	75				53
Occupational Therapy					100+									
Physiatry													150	49
Physical Therapy			125	60	150				200	90				33
Blind Rehab Center														250
Multiple Sclerosis		30+	125	180										
Comm. Home Health Program	200													
Geriatric Primary Care Clinic									200+					
HBPC			100+											
Homemaker/HHA								45						60+
Contrast Procedures						60				120				120
CT Scanner			125			60			100+					
Mammography				90										
MRI			125						100+					
Ultrasound									133	75				
Radioimmuonassay									133					
Dental Implantology									200	120				
Endodontics													150	
Oral/Maxil. Surgery									200	90				
Periodontics									125	60				
Prosthodontics									150	60				
Optometry		210			150	90	125	60						
Prosthetics/orthotics lab									150					
Dysphagia Team													175	
Audiology		120		300					125	100			200	102

MONETARY BENEFITS IN ACCORDANCE WITH IG ACT AMENDMENTS

REPORT TITLE: Audit of the Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN) 8

PROJECT NUMBER: 1999-57-D2-184

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Cost Avoidance
2	Better use of funds (FY 2001) by including priority group 7 veterans in the VERA system allowing the funding for all networks to be based on the total number of veterans who are enrolled for care and treated.	$1,480,000,000[3]	
Total		$1,480,000,000	

[3] VHA estimated cost of care for priority group 7 veterans reflected in FY 2001 Enrollment Level Decision Analysis.

VISN 8 NETWORK DIRECTOR COMMENTS

Date: May 16, 2001

From: Network Director (10N8)

Subj: Draft Report of Audit of the Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network (VISN8)

To: Assistant Inspector General for Auditing (52)

1. This is in response to your April 17, 2001 requesting comments regarding the subject draft audit report. The following are our comments regarding the specific recommendations identified on page 3 and 6 of the draft report:

- **Improve the tracking of clinical services and capacities at each medical facility.**

  The VISN 8 Strategic Planning Board agreed at their last meeting that they would begin utilizing the clinical inventory as a tool to monitor the status of each facility's clinical services and programs. The facility planners also made a commitment to update the information in the clinical inventory as it pertains to their individual facility.

- **Improve resource distributions among medical facilities by including a measure of clinic utilization as part of the allocation criteria.**

  We concur with this recommendation. However, it is not so simple as "a measure" to be able to make a decision on resource distribution. There are several issues that need to be considered to balance supply and demand that need to be factored into the equation. Currently, we are utilizing the VISN 8 $10 million Incentive Pool for Waits and Delays as an allocation tool that involves clinic utilization. All VISN 8 facilities submitted proposals to decrease waits and delays with timelines for meeting strategies they have defined. We are tracking this on a quarterly basis and allocating resources based on improvements achieved to reduce waiting times.

- **Monitor the timeliness of those clinics identified by the audit as over-capacity and their progress in reducing patient waiting times and scheduling delays.**

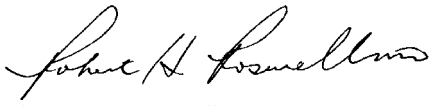
  We concur with this recommendation. VISN 8 has been monitoring the six clinics in the Medical Center Director's Performance Agreement (i.e., Primary Care, Eye Care, Audiology, Urology, Cardiology and Orthopedics) through the use of the KLF MENU by facility, outpatient clinic and community-based outpatient clinic (CBOC). Progress reports are being generated on a monthly basis. In addition, we will ask the facility directors to implement a mechanism to track on a quarterly basis their clinics that are over-capacity. A status report from the Medical Center Director's, which summarizes progress of their respective clinics, will be discussed at the VISN 8 Executive Leadership Board meeting.

VISN 8 NETWORK DIRECTOR COMMENTS

- **We recommend that the Undersecretary for Health include priority group #7 veterans in the VERA system to allow funding distributions for all Networks to be based on the total number of veterans enrolled for care and treated.**

  The inclusion of priority group #7 into the VERA resource distribution methodology was recently discussed during an April 7th VHA Policy Board meeting and is currently under consideration.

2. I appreciate the opportunity to comment on these issues. If you have any additional questions, please contact me at (727) 319-1125.



Robert H. Roswell, M. D.

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs

Memorandum

June 4, 2001

Under Secretary for Health (10/105E)

OIG Draft Report: ***Audit of the Availability of Healthcare Services in Florida/ Puerto Rico VISN 8***

Assistant Inspector General for Auditing (52)

1. The referenced report has been reviewed by appropriate VHA program officials. As you accurately report, VERA currently provides funding and workload credit for those priority 7 veterans in the complex care pricing group. However, inclusion of all priority 7 veterans in the VERA funding distribution is not being considered at this time. We therefore defer concurrence in your recommendation to do so until we first assess the impact of other options under consideration. In this regard, I have requested that VHA's Office of Policy and Planning establish a work group to fully study the issues of geographic means test/price adjustments. Since there are geographic differences in the cost of living that can influence a veteran's ability to obtain health care, we will evaluate the impact a "variable means test" would have on health care delivery for all veteran priority groups. Findings and recommendations of this work group will be submitted to me by September 1, 2001 for further consideration of the strengths and weaknesses of this approach. We will be happy to discuss the status of our deliberations with you at that time.

2. Although your report focuses on VISN 8, you have extrapolated those findings to reflect the system as a whole. We agree that national cost estimates for priority group 7 veterans are not insignificant; however, when viewed in context with current data, we feel that it is necessary to clarify some of your conclusions. For example, in recent congressional testimony about VA's Community-Based Outpatient Clinics (CBOCs), GAO reports that despite initial expectations to the contrary, new higher-income veterans have remained a very small segment (approximately 6%) of all patients using VHA's outpatient facilities, despite their significant increase in number and share of CBOC utilization since 1997. Although priority 7 veterans now account for an estimated 25% of all enrollees, only about half of that number actually use VA health care (24% inpatient; 33% outpatient). Our own enrollment data suggest continued low net cost projections for this priority group as a result of third party collections, low usage of VA health care and marginal costs.

3. One of the audit's supporting statements is incorrect. You indicate that because VERA does not consider priority group 7 workload (in fact, VERA includes priority 7

UNDER SECRETARY FOR HEALTH COMMENTS

Page 2 OIG Draft Report: **Availability of Healthcare Services/VISN 8**

veterans meeting complex care criteria), the financial impact of this workload in some VISNs has resulted in VHA's withdrawing funding from other networks to fund supplemental requests. The report continues, "in January 2001, 18 of the 22 Networks were required to return funds totaling $133.9 million in order to provide funding to 4 Networks that required supplemental funding, due primarily to high levels of priority group 7 workload that was not funded by VERA." This statement is inaccurate on several counts. Networks were required to return $131.174 million. A substantial portion of that amount ($43.174 million) was withdrawn because of a congressional rescission (P.L. 106-554). The remaining $2.708 million for the rescission was taken from VHA Headquarters specific purpose funding. More important is the fact that costs associated with priority group 7 veterans were not among the numerous other needs that were considered in determining supplemental funding levels.

4. Thank you for the opportunity to respond to this report. We will keep you informed about upcoming decisions involving priority group 7 veteran issues. Also attached to this response are some additional comments and clarifications about specific statements in the report that you may want to consider prior to preparation of the final document. If additional information is required, please contact Gregg A. Pane, M.D., Acting Director, Management Review and Administration Service (105E), Office of Policy and Planning (105), at 273-8932.

/s/
Thomas L. Garthwaite, M.D.

Attachment

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