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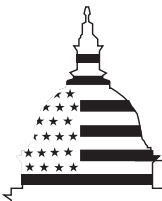
Subcommittee on VA, HUD, and
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VETERANS' HEALTH CARE

Observations on VA's Assessment of Hepatitis C Budgeting and Funding

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Mr. Chairman and Members of the Subcommittee:

We are pleased to contribute this statement for the record of the Subcommittee's deliberations on the President's fiscal year 2002 budget request for the Department of Veterans Affairs (VA). VA's request includes \$171 million so that its Veterans Health Administration (VHA) can continue efforts to serve veterans who have Hepatitis C,¹ a chronic bloodborne virus that is transmissible and can cause potentially fatal liver-related conditions. VA's goal is to screen all previously unscreened veterans during routine clinic visits to VA medical facilities and provide treatment when medically appropriate and desired.²

Last May, the Subcommittee expressed concerns about VHA's use of \$195 million requested for Hepatitis C screening and treatment in fiscal year 2000. The Subcommittee also expressed concerns about VHA's distribution of the requested fiscal year 2001 Hepatitis C funds (\$340 million) to the 22 networks that constitute VHA's health care system;³ specifically, that funding provided to networks may not be adequate.⁴ Subsequently, Senate and House conferees mandated VA to submit a report addressing these concerns.⁵

In response, VA transmitted a briefing paper to your staff on April 10, 2001. Most notably, VA reported that 478,000 veterans were screened and 77,886 veterans were treated for Hepatitis C-related conditions during fiscal year 2000 at an estimated cost of \$100 million. VA also reported that while networks received the \$340 million requested for Hepatitis C activities in fiscal year 2001, the current spending estimate has been reduced to \$151 million.

¹VHA launched its systemwide Hepatitis C initiative in fiscal year 1999 with reported expenditures totaling \$46 million in that year.

²Screening involves assessment of potential risks of exposure to Hepatitis C and Hepatitis C antibody tests for at-risk patients.

³VHA's geographic networks perform a wide range of activities including health care planning and budgeting, as well as management of health care delivery at over 700 VA medical facilities.

⁴H. Rep. No. 106-674, at 11 (2000).

⁵H. Conf. Rep. No. 106-988, at 62 (2000).

As agreed with your staff, we monitored VHA's ongoing efforts to address your concerns. We are providing our observations on VA's response to your concerns relating to the: (1) difference between VHA's reported expenditures for fiscal year 2000 and VA's original budget estimate and (2) distribution of fiscal year 2001 funds requested for Hepatitis C screening and treatment. Our comments are based on work we conducted from July 2000 through April 2001, in accordance with generally accepted government auditing standards. We examined a wide array of VHA budget documents and analyses for fiscal years 2000, 2001, and 2002; interviewed over 100 VHA officials, including financial officers and the Hepatitis C program director; visited nine hospitals located in six networks; and visited two network offices. We also reviewed medical records at the nine hospitals visited.

In summary, VA's briefing paper significantly understates the difference between its fiscal year 2000 budget and reported expenditures. VA's original budget estimated that \$195 million would be used for two activities: screening and antiviral drug therapy. However, VA's reported expenditures of \$100 million included \$50 million for the two budgeted activities and \$50 million for an activity not included in its original budget estimate—treatment of conditions related to Hepatitis C. As a result, while VA's briefing paper suggests that the difference between its original budget estimate and reported expenditures was \$95 million, our analysis shows it was much larger—\$145 million.

In addition, VHA's distribution of fiscal year 2001 funds requested for Hepatitis C (\$340 million) to the 22 networks appears adequate. Each network appears to have sufficient resources to screen all previously unscreened veterans when they visit VA medical facilities during fiscal year 2001, as well as to significantly expand their treatment workloads.

Budget Differences Not Adequately Explained

Our assessment identified differences in both Hepatitis C activities that were included in VA's original fiscal year 2000 budget: screening and antiviral drug therapy. VA budgeted \$195 million for these activities, but only spent \$50 million, a \$145 million difference. However, VA's briefing paper shows only a \$95 million difference because VA's reported expenditures include \$50 million for activities not specifically budgeted, such as treatment of conditions related to Hepatitis C. (See table 1.) We believe that management decisions could have contributed to lower than expected screening and treatment expenditures, in addition to the factors VA cited.

Table 1: Differences Between Fiscal Year 2000 Budget Estimates and Expenditures

Budgeted activity	Budget estimate (Dollars in millions)	Reported expenditure	Difference
Screening for Hepatitis C virus	\$21	\$14	(\$7)
Antiviral drug therapy	174	36	(138)
Subtotal			(145)
Not specifically budgeted activity			
Treatment for related conditions	0	50	50
Total	\$195	\$100	(\$95)

Source: GAO analysis of VHA data.

Screening Expenditures One-Third Less Than Estimated

VA expended \$14 million for Hepatitis C screening—one-third less than the amount budgeted for fiscal year 2000. VA’s budget assumed that almost 985,000 veterans would be screened for Hepatitis C exposure at an average cost of \$21 per veteran. However, VHA estimates that only 478,000 veterans were screened at a cost of \$30 per veteran—a shortfall of over 50 percent.

VA’s briefing paper reported that two factors caused this workload difference. First, VA points out that the budget estimate may have been unrealistically high because it was based on “untested assumptions” concerning the number of veterans who use the VA health care system who would need to be screened for Hepatitis C. Second, VA noted that the number screened may be underreported due to inadequate data systems.

While VA’s reasons are valid, management decisions also could have contributed to the lower than expected number of veterans who were screened, causing the screening workload assumption to appear unrealistically high. For example, VHA decided to include Hepatitis C funds as part of its general medical care resource distribution process, without clearly communicating how much was available for screening and treatment of the Hepatitis C virus. As a result, network and medical facility staff we interviewed were generally unaware that they had received \$21 million in funding that VA had requested for increased Hepatitis C screening. Network budget officers, medical center managers, and clinical

staff told us that they thought VHA did not receive additional funding to support increased Hepatitis C activities. Those who thought funds were available were unsure of the amount.

Such perceived funding inadequacies appear to have caused some local managers to adopt a cautious approach regarding who to screen and when. At the sites we visited, we noted that while some facility directors instructed providers to screen all users, others limited screening to selected clinics or left it to individual providers to decide who should be screened. Our review of medical records at these sites confirmed that some facilities had limited screening to certain clinics and that some providers had screened few veterans for Hepatitis C.

In addition, such situations may have occurred because headquarters managers failed to establish performance targets for networks, which could be used to monitor Hepatitis C screening and treatment workloads. Although VHA promised in its fiscal year 2001 budget request to establish such performance targets, none have yet been adopted. VA's briefing paper states that meaningful and measurable indicators will be identified and incorporated into performance goals for its 2003 budget request.

Also, VHA's efforts to evaluate or track performance were further hampered by a lack of basic data on the numbers of veterans screened. Notably, after VHA introduced a system to track screening at medical facilities late in fiscal year 2000, the reported number of veterans screened increased dramatically at many facilities we visited. Providers told us the tracking system was a powerful incentive to increase the number of veterans screened.

Treatment Expenditures One-Fifth of Estimate

For antiviral treatment, VA spent \$36 million—one-fifth of the amount budgeted for fiscal year 2000. VA's budget assumed that nearly 17,000 veterans would be treated and that 70 percent would complete a 12-month antiviral drug therapy regimen. VA reported, however, that 4,455 veterans received antiviral drug therapy and that most dropped out of treatment before 6 months.

VA's briefing paper characterized its budget estimate as being unrealistically high. VA explained that fewer patients received antiviral therapy because of the high number of patients who reject or defer therapy, or who do not qualify as candidates under treatment guidelines. In addition, treatment expenditures were lower because larger than expected numbers of patients were unable to tolerate the frequent side

effects of antiviral drugs, such as anemia, respiratory symptoms, or depression and, therefore, ended treatment prematurely.⁶

VA's reasons seem valid. However, implementation problems relating to VHA's decision to distribute Hepatitis C funding through its general allocation system without alerting networks to the portion budgeted for Hepatitis C activities could also be a major contributing factor. As previously discussed, staff at local facilities we visited perceived that little or no funds had been appropriated to implement VA's Hepatitis C initiative. Providers at some of these facilities told us that this perceived funding shortage was a factor that ultimately could explain the unexpectedly low number of veterans treated. Because of the slowly evolving nature of liver disease caused by the Hepatitis C virus, treatment can frequently be postponed, however, without adversely affecting a patient's health or recovery prospects.

Care for Hepatitis C-Related Conditions Accounts for Half of VA's Reported Expenditures

VHA's budget officials told us that when the budget plan for fiscal year 2000 was originally prepared and submitted to the Congress, Hepatitis C funds were expected to be used solely for screening veterans and providing antiviral therapy. Subsequently, VHA decided to report expenditures for treatment of conditions related to the Hepatitis C virus. Of VA's reported expenditures, \$50 million was used for those purposes.

Our assessment of VHA's records indicates that most of this \$50 million in expenditures involved inpatient care and pharmaceuticals. (See table 2.)

Table 2: Hepatitis C Spending Categories for Treating Related Conditions	
Activity	Reported expenditures (Dollars in millions)
Inpatient services	\$19
Outpatient services	6
Pharmaceuticals	25
Total	\$50

Source: GAO analysis of VHA data documents supporting reported expenditures for fiscal year 2000.

⁶VA supports the research and development of more efficacious antiviral drugs with fewer side effects; it plans to adopt a new interferon formulation for Hepatitis C therapy following recent approval by the Food and Drug Administration.

To gain an understanding of these activities, we reviewed medical records at one medical center in consultation with that facility's Director of Hepatology. This review indicated that inpatient expenditures frequently involved treatment of secondary problems relating to advanced Hepatitis C—including fluid retention in the abdomen, internal bleeding, neurological impairment, and liver cancer. Treatments varied from stabilizing patients' conditions to liver transplants. Our review of medical records indicates that outpatient expenditures frequently involved treatment of conditions that could preclude the use of antiviral drug therapy. For example, because excessive alcohol consumption reduces the effectiveness of antiviral therapy, VHA may provide alcohol use counseling and treatment in order to provide veterans with the best opportunity to benefit from antiviral treatment. Veterans who are intravenous drug users also need counseling and drug treatment before starting antiviral therapy.

VA's briefing paper reported that expenditures for such related medical conditions were probably undercounted for many veterans. To be counted, VHA requires providers to include a Hepatitis C code in its computerized records system when veterans receive inpatient or outpatient services for liver-related conditions, such as cancer; such coding signifies that Hepatitis C was a co-morbid condition. Officials at one network we visited were aggressively trying to improve coding accuracy. Their efforts suggest that more than half of their Hepatitis C-infected veterans received treatments for Hepatitis C-related conditions that were not coded as such. This problem persists systemwide, despite VHA's efforts over the past 2 years to encourage—through training and other educational aids—accurate coding by providers.

VA officials told us that the fiscal year 2002 budget estimate for Hepatitis C of \$171 million includes funding for all these activities: screening, antiviral therapy, and treatment of Hepatitis C-related conditions. This estimate, they said, was developed using the same estimating model that was used to identify the Hepatitis C expenditures reported for fiscal year 2000, rather than the model used to develop fiscal year 2000 and 2001 budget estimates. Also, VA's briefing paper reported that its budget planning process for fiscal year 2003 will include a more comprehensive revision of its Hepatitis C model.

In this regard, VHA proposes the creation of a registry for its patients with Hepatitis C infection. This registry will document important demographic and clinical data, including all inpatient and outpatient care regardless of diagnostic coding of individual episodes of care. VA plans to develop a new software system to interface with existing electronic medical records,

which VHA estimates could become operational by the fourth quarter of fiscal year 2002.

VHA'S Year 2001 Funding for Networks' Hepatitis C Activities Appears Adequate

Distributions to 22 networks appear adequate, given that funding levels could support significant expansion of screening and treatment workloads. VA included \$340 million to screen and provide antiviral drug therapy to veterans in its fiscal year 2001 budget request. In November 2000, VHA distributed these funds to the 22 networks as part of their overall patient care funding using its Veterans Equitable Resource Allocation model.⁷ At our request, VA identified amounts that each network received as result of the \$340 million being included in its distribution. These amounts ranged from \$5.7 million to \$28.3 million.

Our assessment shows that amounts distributed to the 22 networks for fiscal year 2001 should allow each network to provide Hepatitis C screenings for all previously unscreened veterans when they visit VA medical facilities for care during fiscal year 2001. Potential screening workloads for each of the 22 networks range between an estimated 70,000 veterans and 298,000 veterans. Networks could spend an estimated \$128 million to screen such potential workloads, leaving \$212 million available to provide antiviral therapy.

This remaining \$212 million appears sufficient to support antiviral therapy workloads for each network at a significantly higher level than fiscal year 2000. Networks, for example, provided a total of 22,275 months of antiviral therapy to 4,455 patients in fiscal year 2000. This workload is the equivalent of 1,856 patient years of care. For fiscal year 2001, networks could double their workloads at a total cost of about \$82 million, leaving \$130 million for further expansion of antiviral treatment workloads or increased treatments for conditions related to Hepatitis C, such as alcohol or drug treatment.

VA recently has reported that its Hepatitis C-related spending estimate for fiscal year 2001 was reduced to \$151 million, which represents VA's best estimate of how much networks are likely to spend for Hepatitis C

⁷VHA used the Veterans Equitable Resource Allocation model to distribute \$17.7 billion (88 percent) of VA's fiscal year 2001 Medical Care Budget to its 22 health care networks, including \$340 million requested for Hepatitis C.

screening and treatment.⁸ VHA budget officials told us, however, that the entire \$340 million originally requested remains available to the 22 networks for Hepatitis C use, should networks' workloads warrant. These funds, however, are not limited to Hepatitis C use.

Concluding Observations

At this time, VA appears unable to develop a budget estimate that can reliably forecast Hepatitis C funding needs. This situation is troublesome, because over the past 30 months, VA has spent over \$145 million previously requested for Hepatitis C activities, but has limited experiential data that can be used to estimate Hepatitis C patients' clinical needs—one of the most critical elements for budget development.

VHA, however, appears to be taking reasonable steps to improve future budget estimates and thereby minimize the potential for large differences. Most notably, VHA's proposed Hepatitis C patient registry could provide critical data needed to improve budgetary estimates, as well as overall program management. VHA, however, estimates that it could take 15 months before this registry becomes operational, which suggests that it may not provide budgetary information in time to help formulate VA's fiscal year 2004 budget. In the meantime, VHA's ongoing efforts to upgrade its data collection systems should help improve budget estimates for fiscal year 2003. These efforts, however, have provided only minimal help in the development of VA's fiscal year 2002 budget for Hepatitis C spending. As a result, it is not possible to conclude with certainty whether VA's \$171 million spending estimate for fiscal year 2002 is appropriate.

VA's budget forecasting uncertainties do not appear to have adversely affected the availability of fiscal year 2001 Hepatitis C funds for the 22 networks. Our assessment shows that, for fiscal year 2001, each network will receive an adequate portion of the \$340 million requested to significantly expand Hepatitis C screening and treatment workloads.

⁸Department of Veterans Affairs, FY 2002 Budget Submission, Medical Programs, Volume 2 of 6, April 2001.

GAO Contact and Staff Acknowledgments

For questions regarding this statement, please call Cynthia Bascetta at (202) 512-7101. Individuals who made key contributions to this testimony include Paul Reynolds, Frederick Caison, and Carolina Morgan.