United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, April 24, 1996

# VA HEALTH CARE

# Efforts to Improve Veterans' Access to Primary Care Services

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GAO/T-HEHS-96-134

# VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) efforts to improve veterans' access to health care. VA operates one of our nation's largest health care systems, including 173 hospitals and 220 clinics. Last year, VA spent about $16 billion serving 2.6 million veterans.

Traditionally, almost all veterans seeking care have used VA-operated facilities. VA's hospitals and clinics, however, are often located hundreds of miles from each other. As a result, about half of all veterans live over 25 miles from a VA hospital, including 6 percent who live over 100 miles away; and over a third live more than 25 miles from a VA clinic. Veterans have frequently indicated that they do not use VA health care because they live too far from the nearest hospital or clinic.

To improve veterans' access to health care, VA recently empowered network[1] and hospital directors to employ all means at their disposal, within available resources, to establish new access points. VA defines an access point as a VA-operated clinic or a VA-funded or -reimbursed private clinic, group practice, or single practitioner that is geographically distinct or separate from the parent facility. In general, access points are to provide primary care to all veterans and refer those needing specialized services or inpatient stays to VA hospitals.

In using access points to restructure their direct delivery systems into integrated service-delivery networks, VA directors have considerable freedom to develop their own goals and objectives as well as their own implementation strategies. To date, 9 hospitals have opened 12 new access points. Recently, VA notified the Congress that 47 hospitals (including 5 of the original 9) are ready to open an additional 58 access points. Another 200 are under development and could be operating by this December.

Of the 12 new access points, VA staff operate 4 and contract with county or private clinics to operate the remaining 8. Contract access points are paid an annual fee per patient in advance to serve enrolled veterans according to an agreed-upon benefit package.[2] Most have encouraged all veterans currently receiving VA health care to enroll in new access points along with veterans who have not previously received care. However, some have limited enrollment to only veterans with service-connected conditions or

[1]VA realigned the 173 hospitals into 22 service networks, each consisting of between 5 and 12 facilities.

[2]VA patients are generally a fraction of the total patient population these providers serve.

current VA users. To date, the 12 access points have enrolled nearly 5,000 veterans.

At your request,[3] we have reviewed VA's efforts to establish access points and will provide you with a report this summer. Today, we would like to discuss some legal, financial, and equity-of-access issues facing VA managers as they strive to establish new access points. Finally, we will highlight several options to address these issues.

Our comments today are based on visits to 3 VA hospitals that operate 6 new access points; interviews with 115 veterans now using them; and discussions with officials of the other 6 hospitals that are now operating new access points. We also reviewed a wide range of records and documents provided by these facilities. We have discussed the results of our work with the Deputy Under Secretary for Health as well as other VA officials and representatives of veterans' service organizations.

In summary, in establishing new access points, VA has identified what could be a cost-effective way to enhance the availability of health care for current users, especially those residing in underserved areas. Doing this, however, has raised some important issues that VA has not yet adequately addressed. For example, VA is not adhering to statutory limitations that govern what services VA may provide and who may be served. As a result, veterans are receiving more services than current statutes allow. Also, creating hundreds of new access points may attract more veterans than network and hospital directors can finance within their existing budgets.

Empowering local hospital directors to establish new access points provides an opportunity to ensure that similarly situated veterans are afforded equal access to VA care. However, access inequities may continue, given that directors are establishing new access points without clear, consistent criteria for targeting new locations and populations to be served.

[3]Subsequently, Senator Bond, Chairman of the Subcommittee on VA, HUD, and Independent Agencies, Senate Committee on Appropriations, also asked us to examine VA's efforts.

## Inappropriate Statutory Authority Being Used to Improve Primary Care Access

Historically, the Congress has limited VA's authority to provide medical care to veterans, expanding it in a careful and deliberate manner. Although VA's authority has increased significantly over the years, important limitations have not been recognized by VA in establishing and operating new access points.

At the access points we visited, many veterans receive primary care contrary to applicable statutory limitations and priorities on their eligibility for such services. As authority for operating contract access points, VA relies on a statute (38 U.S.C. 8153) that permits it to enter into agreements "for the mutual use, or exchange of use, of specialized medical resources when such an agreement will obviate the need for a similar resource to be provided" in a VA facility. Specialized medical resources are equipment, space, or personnel that—because of cost, limited availability, or unusual nature—are unique in the medical community.

VA officials assert that primary care provided at access points is a specialized medical resource because its limited availability to veterans in areas where VA facilities are geographically inaccessible (or inconvenient) makes it unique. One significant aspect of VA's reliance on this authority is that it effectively broadens the eligibility criteria for contract outpatient care, thus allowing some veterans, who would otherwise be ineligible, to receive treatment.

In our view, this statute does not authorize VA to provide primary care through its access points. Nothing in the statute suggests that the absence of a VA facility close to veterans in a particular area makes primary care physicians unique in the medical community. The purpose of allowing VA to contract for services under the specialized medical resources authority is not to expand the geographic reach of its health care system, but to make available to eligible veterans services that are not feasibly available at a VA facility that presently serves them. Furthermore, contracting for the provision of primary care at access points does not obviate the need for primary care physicians at the parent VA facility.

VA has specific statutory authority (38 U.S.C. 1703) to contract for medical care when its facilities cannot provide necessary services because they are geographically inaccessible.

This authority could be relied upon to authorize contracting for the operation of access points. However, contract care provided under this authority is available only for specified services and classes of veterans

that are more restrictive than those under 38 U.S.C. 8153, upon which VA relies.

For example, under 38 U.S.C. 8153, a veteran who has income above a certain level and no service-connected disability is eligible for pre- and post-hospitalization medical services and for services that obviate the need for hospitalization. But under 38 U.S.C. 1703, that same veteran is not eligible for pre-hospitalization medical services or for services that obviate the need for hospitalization.

If access points are established in conformance with 38 U.S.C. 1703, VA would need to limit the types of services provided to all veterans except those with service-connected disabilities rated at 50 percent or higher (who are eligible to receive treatment of any condition).

All other veterans are generally eligible for VA care based on statutory limitations (and to the extent that VA has sufficient funds). For example, veterans with service-connected conditions are eligible for all care needed to treat those conditions. Those with disabilities rated at 30 or 40 percent are eligible for care of non-service-connected conditions at contract access points to complete treatment incident to hospital care. Furthermore, veterans with disabilities rated at 20 percent or less, as well as those with no service-connected disability, may only be eligible for limited diagnostic services and follow-up care after hospitalization.

Most veterans currently receiving care at access points do not have service-connected conditions and, therefore, do not appear to be eligible for all care provided. VA is to assess each veteran's eligibility for care on the merits of his or her unique situation each time that the veteran seeks care for a new medical condition. We found no indication that VA requires access point contractors to establish veterans' eligibility or priority for primary care or that contractors were making such determinations for each new condition.

Last year, VA proposed ways to expand its statutory authority and veterans' eligibility for VA health care. Several bills have been introduced that, if enacted, should authorize VA hospitals to establish contract access points and provide more primary care services to veterans in the same manner as the new access points are now doing.

## VA's Ability to Finance Access Points Within Existing Resources

VA hospital directors are likely to face an evolving series of financial challenges as they establish new access points. In the short term, hospitals must finance new access points within their existing budgets; this will generally require a reallocation of resources among hospitals' activities. Over the longer term, VA hospitals may incur unexpected, significant cost increases to provide care to veterans who would otherwise not have used VA's facilities. These costs may, however, be offset somewhat if access points allow hospitals to serve current users more efficiently.

So far, VA hospitals have successfully financed access points by implementing local management initiatives, unrelated to the access points, which allow the hospitals to operate more efficiently. For example, one hospital director estimated that he had generated resources for new access points by consolidating underused medical wards at a cost savings of $250,000.

To date, most directors have concluded that it was more cost-effective to contract for care in the target locations than operate new access points themselves. Essentially, they have found that it is not cost-effective to operate their own access points for a relatively small number of veterans. For example, one hospital that targeted 173 veterans for an access point concluded that this number could be most efficiently served by contracting for care. By contrast, private providers seem willing to serve small numbers of veterans on a contractual, capitated basis because they already have a non-VA patient base and sufficient excess capacity to meet VA's needs.

The longer-term effects of new access points on VA's budget are less certain. This is because VA has not clearly delineated its goals and objectives; nor has it developed a plan that specifies the total number of potential access points, time frames for beginning operations, estimates of current and potential new veterans to be served, and related costs. Of these, key cost factors appear to be the magnitude of new users and their willingness to be referred to VA hospitals for specialty and inpatient care. Costs could potentially vary greatly depending on whether VA hospitals' primary objective is to improve convenience for current users or to expand their market share by attracting new users.

In theory, VA hospitals could improve access for all current users within their existing budgets. Through careful planning, it appears that hospitals' staffing costs can be reduced in proportion to the costs of new access points. For example, one hospital employs 5 primary care teams that, on

average, each spend about $300,000 a year to provide primary care to about 1,500 veterans. This hospital can reduce the number of teams to 4 once it enrolls 1,500 veterans at new access points closer to their homes. These newly established access points could be cost-effective if their total costs are the same or lower than the VA hospital's costs—$300,000 or less in this case.

VA hospitals, however, could experience significant budget pressures if new access points modestly increase VA's market share. For example, VA currently serves about 2.6 million of our nation's 26 million veterans. To date, 40 percent of the 5,000 veterans enrolled at VA's 12 new access points had not received VA care within the last 3 years. Most of the new users we interviewed had learned about the access points through conversations with other veterans, friends, and relatives or from television, newspapers, and radio.

VA's access points may prove more attractive to veterans in part because they overcome barriers such as geographic inaccessibility and quality of care. About half of the veterans who have used VA health care in the past, and a larger portion of the new users, said that it matters little whether they receive care in a VA-operated facility. In fact, almost two-thirds of the new users indicated that if hospitalization is needed, they would choose their local hospital rather than a distant VA facility.

Veterans will also generally benefit financially by enrolling in new VA access points. For example, prior VA users will save expenses incurred traveling to distant VA facilities as well as out-of-pocket costs for any primary care received from non-VA providers; most said that they use both VA and non-VA providers. New VA users will also save out-of-pocket costs, with low-income veterans receiving free care and high-income veterans incurring relatively nominal charges.

Also, about 80 percent of the new users have alternative health care coverage, and most of the rest said that they paid for their own primary care. Most prior VA hospital users also have alternative coverage that they may use to obtain primary care from non-VA providers. Based on our interviews with veterans using new access points, we learned that 70 percent of the veterans had Medicare coverage, 50 percent had private insurance coverage, and 7 percent had Medicaid coverage. VA will act as an intermediary and bill private insurers to recover the cost of providing care. Previously, the insurers would have paid the local providers directly, but

now VA pays the contract provider a capitated rate and then bills the insurer to recover its costs on a fee-for-service basis.

The combination of these factors could lead to VA attracting several hundred thousand new users through its access points. This may force VA to turn veterans away if sufficient resources are not available, or it may cause VA to seek additional appropriations to accommodate the potential increased demand.

Currently, VA is to provide outpatient care to the extent resources are available. When resources are insufficient to care for all eligible veterans, VA is to care for veterans with service-connected disabilities before providing care to those without such disabilities. Furthermore, when VA provides care to veterans without service-connected disabilities, it is to provide care for those with low incomes before those with high incomes.

Presently, most of the nine hopsitals encourage current and new users to enroll in their new access points. For example, the 3 hospitals we visited had enrolled 1,250 veterans in new access points. Of the 1,250, about 20 percent had service-connected disabilities, including about 4 percent rated at 50 percent or higher. Of the remaining 80 percent, most had low incomes, including about 10 percent who were receiving VA pensions or aid and attendance benefits.

## Creating New Access Points Can Address Long-Standing Equity Concerns

Inequities in veterans' access to VA care have been a long-standing concern. For example, about three-fourths of veterans (both those with service-connected conditions and others) using VA clinics live over 5 miles away, including about one-third who live over 25 miles away.

Establishing new access points gives VA the opportunity to reduce some of these veterans' travel distances. Although VA provided general guidance, it left the development of specific criteria for targeting new locations and populations to be served to network and hospital directors. Directors have several options when targeting new locations and populations to be served. For example, they could target those current users or potential new users living the greatest distances from VA facilities.

VA's 12 new access points operate in a variety of locations, including 3 areas that are more than 100 miles from a VA facility; 6 areas between 50 and 100 miles from a VA facility; and 3 areas less than 50 miles from a VA facility (including 1 large urban area located 8 miles from a hospital). Most

have improved convenience for existing users and attracted new users as well. However, two new access points have served only current VA users, while another one has served only new users.

## Concluding Observations

VA's plans to establish access points could represent a defining moment for its health care system as it prepares to move into the 21st century. On one hand, VA hospitals could use a relatively small amount of resources to improve access for a modest number of current or new users, such as those living the greatest distances from VA facilities or in the most underserved areas.

On the other hand, VA hospitals could, over the next several years, open hundreds of access points and greatly expand market share. There are over 26 million veterans and 550,000 private physicians who could contract to provide care at VA expense. VA's growth potential appears to be limited only by the availability of resources and statutory authority, new veteran users' willingness to be referred to VA hospitals, and other health care providers' willingness to contract with VA hospitals.

Although VA should be commended for encouraging hospital directors to serve veterans using their facilities in the most convenient way possible, VA has not established access points in conformance with existing statutory authority. In our view, under current statutes, new access points should be VA-operated or provide contract care for only those services or classes of veterans specifically designated by VA's geographic inaccessibility authority. While legislative changes are needed to authorize VA hospitals to provide primary care to veterans in the same manner as the new access points are now doing, such changes carry with them several financial and equity-of-access implications.

In addition, VA has not developed a plan to ensure that hospitals establish access points in an affordable manner. If developed, such a plan could articulate the number of new access points to be established, target populations to be served, time frames to begin operations, and related costs and funding sources. It could also articulate specific travel times or distances that represent reasonable veteran travel goals that hospitals could use in locating access points.

Given the uncertainty surrounding resource needs for new access points, such a plan could also articulate clear goals for the target populations to be served. Hospitals could be directed to provide care at new access

points in accordance with the statutory service priorities. If sufficient resources are not available to serve all eligible veterans expected to seek care, new access points that are established would serve, first, veterans with service-connected disabilities and then, second, other categories of veterans, with higher income veterans served last. Finally, this approach could provide for more equitable access to VA care than VA's current strategy of allowing local hospitals to establish access points that serve veterans on a first-come, first-served basis and then rationing services when resources run out.

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

## Contributors

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