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Health, Education and Human Services Division

B-279791

April 28, 1998

The Honorable Lane Evans
Ranking Minority Member
Committee on Veterans' Affairs
House of Representatives

Subject: VA Health Care: Medicare Reimbursement for Services to Veterans

Dear Mr. Evans:

As part of its fiscal year 1998 budget submission, the Department of Veterans Affairs (VA) requested authority to collect, on a demonstration basis, Medicare funding for care provided to high income veterans[1] who are eligible for both VA care and Medicare. VA reported having underused capacity that would allow treatment of additional patients at a lower price than the private sector, which could result in economies for Medicare.

You told us that a variety of alternative proposals are now being considered that would give VA authority to collect Medicare reimbursement for care given to eligible veterans. These include two models of providing health care: (1) a risk-contract health maintenance organization (HMO) model and (2) a fee-for-service model.

The Health Care Financing Administration (HCFA) reimburses Medicare HMOs a fixed rate for each beneficiary enrolled and requires HMOs to provide all Medicare-covered services to enrollees, as medically necessary. This places HMOs at financial risk because costs of enrollees' medical care could exceed Medicare reimbursements, and HMOs are obligated to use other resources to finance such shortfalls. Once enrolled, beneficiaries must obtain their Medicare-covered services from the HMO; beneficiaries may disenroll at their discretion. Medicare's fee-for-service model differs from an HMO model in that (1) beneficiaries are not limited to certain providers from whom they may obtain

[1]High-income veterans are those whose incomes are above a statutory threshold, for example, a veteran with no dependents with an income of $21,611 or more. Income thresholds are higher for veterans with dependents.

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services and (2) HCFA reimburses providers for each Medicare-covered service rendered.

Because you are concerned that veterans now using VA facilities may be adversely affected by some proposals, we agreed to provide you with information on (1) the benefits VA's use of a Medicare HMO demonstration may provide for veterans, (2) the risks such a demonstration may pose for veterans, and (3) how the potential benefits and risks could differ if VA served high-income, Medicare-eligible veterans using Medicare's fee-for-service model. In addition, we examined how potential benefits and risks could differ if VA used a Medicare HMO demonstration to serve low-income,[2] Medicare-eligible veterans who are geographically remote from a medical facility.[3]

To develop our information, we interviewed officials at VA, HCFA, and the Office of Management and Budget (OMB) who will be involved in the development of a Memorandum of Agreement between HCFA and VA if a demonstration is authorized. In addition, we reviewed H.R. 1362; a transcript of a May 8, 1997, hearing on this bill; and the accompanying Committee report. This bill, as reported, requires VA to perform a 3-year demonstration involving up to $10 million of Medicare funds a year to be used for an HMO and up to $40 million a year to be spent on fee-for-service care. The bill requires VA to maintain its historical spending level for high-income Medicare-eligible veterans, generally referred to as a "level of effort." VA may receive Medicare reimbursements only after this spending level has been reached. We discussed this bill with officials of the Congressional Budget Office, who told us that they are now reviewing various alternatives but could not discuss details at this time.

Given the limited available data supporting VA's demonstration request, you agreed that our assessment would be based on VA and HCFA officials' general assumptions about potential key features of a VA Medicare demonstration. Enclosure I provides additional information on a potential VA demonstration

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[2]Low-income veterans are those whose incomes fall below a statutory threshold, for example, a veteran with no dependents with an income less than $21,611. Income thresholds are higher for veterans with dependents.

[3]We assumed a veteran to be geographically remote if he or she resided more than 30 miles from an existing VA facility. This is comparable to criteria used by HCFA and VA for assessing reasonable access for primary care; HCFA, however, permits access to other Medicare-covered services at a distance exceeding 30 miles as long as this reflects patterns of care in the communities served.

serving high-income, Medicare-eligible veterans. Enclosure II discusses a potential demonstration serving geographically remote low-income, Medicare-eligible veterans. We did our work in accordance with generally accepted government auditing standards between February and April 1998.

In summary, because the details of VA's and HCFA's statutory authority to operate a demonstration have not been finalized, it is not possible to predict with certainty how successful VA may be in maximizing benefits and minimizing risks for veterans. Moreover, VA and HCFA will undoubtedly make many financial and service delivery decisions regarding a demonstration that could have a significant impact on veterans' benefits and risks, especially decisions concerning available service capacity, demonstration locations, and VA's level of effort.

MEDICARE HMO DEMONSTRATION FOR HIGH-INCOME VETERANS

A Medicare HMO demonstration could offer such potential benefits as (1) access to VA care for high-income, Medicare-eligible veterans who would otherwise not be served and (2) enhanced access to or quality of care for veterans not enrolled in VA's demonstration. A demonstration, however, could also expose current users to such potential risks as delays in receiving services, denials of care, or reductions in quality of care.

A Medicare HMO demonstration, for example, could result in relatively high benefits and low risks for veterans if VA's expenditures for providing medical care to enrollees are significantly less than Medicare's reimbursements. This could occur if VA uses primarily excess operating capacity to meet enrollees' medical needs. Because VA has already used its appropriated funds to cover staff and other associated costs, new expenditures could be minimal.

A demonstration, however, could result in relatively low benefits and high risks if VA's expenditures for serving enrolled veterans are significantly more than Medicare's reimbursements. This could occur if VA cannot meet enrollees' medical needs using excess capacity and cannot obtain needed care at costs at or below Medicare's reimbursements. Because VA would have to use appropriations to make up the difference or attempt to serve enrollees using existing capacity, veterans may experience delays, denials, or reductions in the quality of care.

In this regard, VA's ability to maximize potential benefits and minimize risks may be greatly affected by the demonstration locations selected. VA could use, for example, a large geographic area such as one of its 22 Veterans Integrated Service Networks to conduct a Medicare HMO demonstration. This could provide a large pool of geographically dispersed enrollees and VA facilities, which could afford VA greater opportunities to match enrollees' medical needs with its unused operating capacity. As a result, VA could minimize new resource expenditures and difficult choices about whether to serve demonstration enrollees or other veterans first if sufficient capacity is not available to serve promptly all veterans seeking VA care.

Conversely, it is also possible that potential benefits could be reduced and risks increased if VA selects a smaller geographic area, such as a 30-mile area surrounding a single VA facility. This could limit VA's opportunities to match demonstration enrollees' needs with unused operating capacity and force VA to make difficult choices between spending additional resources and delaying or denying care to veterans not enrolled in its demonstration.

In addition, benefits or risks for veterans may be greatly affected if VA's level of effort does not accurately reflect the historical level of appropriation spending for high-income, Medicare-eligible veterans. The level of effort, for example, could benefit or create a risk for veterans if it is overstated. Enrollees could benefit because VA would be required to spend more of its appropriation on high-income, Medicare-eligible veterans than it otherwise would. While this would increase access to care for such veterans, it would place other veterans at risk of reduced access because less appropriations would be available to spend for their care. Conversely, if the level of effort is understated, veterans may benefit. This is because VA would have to spend less appropriations on high-income, Medicare-eligible veterans than it previously had, which could free up appropriations to be used for other veterans.

Lastly, risks for veterans could be minimized by VA's efforts to establish safeguards. VA officials, for example, pointed out that some safeguards are available and others could be developed to alert VA, HCFA, and the Congress of undesirable consequences for veterans during a demonstration so that they can be addressed in a timely manner. These safeguards include procedures to (1) assess available operating capacity and link the number of demonstration enrollees to that level and (2) monitor waiting times, care denials, and quality of care on an ongoing basis for veterans who use VA care but are not enrolled in VA's demonstration.

FEE-FOR-SERVICE DEMONSTRATION FOR HIGH-INCOME VETERANS

A VA fee-for-service demonstration offers the same benefit opportunities as a Medicare HMO demonstration, namely increased access to VA health care for high-income veterans who would otherwise not be served, and enhanced services for current users and others. Veterans currently using VA care, however, may not be exposed to the risks of delayed or denied care or reduced quality of care as they would be if a Medicare HMO demonstration was used.

Under a fee-for-service demonstration, VA would have more flexibility to establish safeguards that could help ensure that high-income, Medicare-eligible veterans are served only by using VA's excess operating capacity; that is, VA could individually decline service referrals if it lacked the capacity. In contrast, VA would be obligated under a Medicare HMO demonstration to give medically necessary care to enrolled veterans in either VA facilities or by purchasing care from other providers.

MEDICARE HMO DEMONSTRATION FOR GEOGRAPHICALLY REMOTE LOW-INCOME VETERANS

A Medicare HMO demonstration involving geographically remote low-income veterans could offer the same benefit opportunities and expose current VA users and other veterans to risks of delayed or denied care or reduced quality of care as previously discussed for a Medicare HMO demonstration involving high-income veterans. It could result, for example, in relatively high benefits and low risks for veterans if geographically remote low-income veterans enroll and travel to existing VA facilities that have unused operating capacity available to meet their medical needs.

In contrast, relatively low benefits and high risks could result if VA must expand capacity in remote areas or purchase care from private providers in order to meet enrolled veterans' medical needs. In this regard, VA could experience difficulty maximizing benefits and minimizing risks because veterans who enroll would, by definition, reside in areas remote from VA facilities. This suggests that VA may have to expand capacity or contract for most care, given HCFA's access requirements that HMOs provide Medicare-covered services in a way that reflects the patterns of care in the local community served.

It is uncertain whether VA can establish a network of providers that will meet veterans' medical needs at or below Medicare reimbursements in all remote areas. If not, VA could incur cost overruns, which it would have to cover using

appropriations. Such risks for veterans could be minimized if VA has flexibility to establish an HMO demonstration only in areas where its initial assessments indicate that Medicare reimbursements should cover costs.

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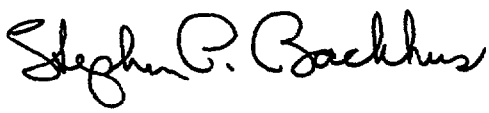
As agreed with your office, because of time constraints, we did not provide a written copy of this report to VA, HCFA, or OMB for review and comment. We discussed its contents with VA, HCFA, and OMB officials who will be involved in the preparation of a Memorandum of Agreement if a demonstration is authorized. These officials agreed in theory with our assessment of the potential benefits and risks for the different VA demonstrations discussed.

As requested by your staff, unless you publicly release its contents earlier, we will make no further distribution of this correspondence until 30 days from its date. At that time, we will make copies available to interested parties on request.

Major contributors to this correspondence were Paul Reynolds, Walter Gembacz, Frederick Caison, and Carolina Morgan. Please call me at (202) 512-7101 if you have any questions or need additional assistance.

Sincerely yours,



Stephen P. Backhus
Director, Veterans Affairs
and Military Health Care Issues

Enclosures - 2

DEMONSTRATION TO USE MEDICARE REIMBURSEMENTS TO SERVE HIGH-INCOME, MEDICARE-ELIGIBLE VETERANS

The information in this enclosure addresses our understanding of how a demonstration could be structured and our assessment of what the potential benefits and risks could be. We developed this information from discussions with VA, HCFA, and OMB officials, a review of VA/HCFA's September 1997 Memorandum of Agreement, and other related documents.

MEDICARE HMO DEMONSTRATION

Regarding potential demonstration structures, we assume that VA would operate a Medicare HMO to serve high-income, Medicare-eligible veterans (1) for a limited time period, such as 3 years; (2) in a limited number of locations, such as three geographic areas; and (3) in compliance with Medicare rules that HCFA applies to private Medicare HMO plans.

VA could, we assume, enroll high-income, Medicare-eligible veterans currently using VA health care, as well as former users and nonusers. Moreover, VA could require all high-income, Medicare-eligible veterans in demonstration areas, including those currently using VA health care, to enroll in VA's Medicare HMO in order to receive VA care; that is, high-income, Medicare-eligible veterans would be denied VA health care if not enrolled.

VA could have four basic choices for providing services to Medicare-eligible enrollees in demonstration areas. These include

- using unused operating capacity in existing VA facilities;
- creating new capacity within existing VA facilities, such as converting unused hospital wards to outpatient clinics;
- creating new VA capacity in remote locations, such as establishing community clinics; and
- contracting for services with non-VA providers.

Regarding Medicare reimbursements, we assume that HCFA would reimburse VA a fixed amount of Medicare funds for each high-income, Medicare-eligible veteran enrolled. In general,

- HCFA could use a rate lower than the per-person rate currently paid to private Medicare HMOs;

- HCFA could reimburse VA for enrolled veterans' care only after VA exceeds its historic spending (level of effort) for high-income, Medicare-eligible veterans;

- HCFA reimbursements could be limited to a predetermined amount, such as $50 million a year for enrolled veterans;

- HCFA reimbursements may be used to serve HMO enrollees, subject to Medicare requirements; and

- HCFA reimbursements may be used to serve veterans not enrolled in the HMO demonstration, if VA's expenditures for enrolled veterans are lower than HCFA's reimbursements.

A MEDICARE HMO DEMONSTRATION COULD BENEFIT VETERANS

VA expects veterans to benefit from a demonstration project in two ways. First, VA intends to use Medicare reimbursements to serve high-income, Medicare-eligible veterans who would otherwise not be served. Second, VA expects to also use such reimbursements to improve services for other veterans, if expenditures for enrollees are less than Medicare reimbursements.

Using a Medicare HMO to Benefit High-Income Veterans

A Medicare HMO demonstration could benefit high-income, Medicare-eligible veterans currently using VA care, as well as former users and those who have never used VA care, if they chose to enroll. VA estimates that about 4 million high-income veterans nationwide are eligible for VA care and Medicare, and that about 82,000 of these veterans used VA care in fiscal year 1997. We estimate that about half of Medicare-eligible veterans using VA receive all care at VA and half at VA and through other providers.[4] Thus, many of these veterans could realize expanded access to VA care if they enrolled in a Medicare HMO demonstration.

The proportion of current users who enroll in a Medicare HMO demonstration could greatly affect the number of other veterans who would benefit. This is because VA officials expect to set a target enrollment level on the basis of available operating capacity and, for example, could give current users priority in the enrollment process. In

[4]See Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994), p. 1.

this case, only a relatively small number of new users could access VA care if most current users enroll or if VA sets an enrollment target that provides only a modest increase over the number of high-income veterans currently served. Conversely, considerably more new users could benefit if relatively few current users enroll.

In this regard, the target enrollment level appears to be dependent on the geographic areas selected for a demonstration. VA officials told us that there are essentially three options. First, VA could select one or more of its 22 networks, which currently serve between 600 and 5,700 high-income, Medicare-eligible veterans; the number of Medicare-eligible veterans in each of these networks is estimated to range between 91,000 and 326,000. Second, VA could select an area surrounding a group of facilities within a network. For example, there are several facilities in the Chicago area. Third, VA could select an area surrounding a single VA facility in a rural or urban area.

Using a Medicare HMO Could Benefit Other Veterans

VA may enhance access to or quality of VA health care for veterans not enrolled in VA's demonstration if expenditures for enrollees are less than Medicare's reimbursements. Such potential benefits appear directly linked to VA's capability to serve enrolled veterans in existing VA facilities. VA, for example, may be able to use a relatively large portion of its Medicare reimbursements for such benefits if most plan enrollees are served using excess operating capacity. This is because VA would receive Medicare reimbursements for enrollees but would have already used appropriated funds to create this capacity.

By contrast, VA's ability to use Medicare reimbursements to benefit veterans not enrolled in VA's demonstration could decrease significantly if VA needs to expand capacity or purchase care from other providers to meet most enrolled veterans' needs. This is because Medicare reimbursements may have to cover the full costs of care for enrolled veterans, leaving little or no reimbursements available to enhance care for other veterans. In other words, Medicare reimbursements may benefit other veterans only if expenditures to meet enrolled veterans' medical needs are significantly lower than Medicare's reimbursement rates.

VA appears capable of meeting many inpatient medical needs of potential enrollees using its existing excess inpatient operating capacity. For example, VA has thousands of underused operating beds in its hospitals as well as considerable unfilled appointment slots involving specialized medical equipment or procedures. VA has already financed the costs of such services using its $17 billion appropriation. Thus, it could have to spend little or no additional resources to deliver such services. To maximize the use of excess capacity, VA officials told us that they expect to assess available capacity before enrollment begins and to link the number of enrollees to that level.

However, VA may have little or no excess operating capacity for many outpatient services, especially primary care. To meet enrollees' needs, VA could use Medicare reimbursements to contract with other providers or hire additional staff. VA also appears to have no capacity to provide some Medicare-covered services, such as emergency room care. VA would have to use reimbursements to contract with other providers for such care.

DEMONSTRATION PROJECT POSES RISKS FOR VETERANS

VA's enrollment of high-income, Medicare-eligible veterans in a Medicare HMO plan in selected geographic areas could place current users at risk of experiencing delayed or denied care in those areas. In this regard, both high-income, Medicare-eligible veterans currently using VA health care, as well as other users, may be at risk.

To create an incentive for Medicare-eligible, high-income veterans who are current VA health care users to enroll in VA's Medicare HMO plan, VA could deny medical services to those veterans who do not enroll. This could mean a loss of VA services for veterans who have previously received VA services on a cost-sharing basis and who do not wish to limit their opportunity to obtain Medicare-covered services from other providers by enrolling in VA's Medicare HMO.

Other veterans may be placed at risk for two reasons. First, VA may find it necessary to spend more resources to meet enrolled veterans' needs than the amount of Medicare reimbursements received. It seems possible that VA would have to use appropriated funds to finance such cost overruns–funds that otherwise would have been used to treat other veterans.

Second, VA could find it desirable or necessary to give preferential treatment to high-income, Medicare-eligible veterans as an incentive to keep them enrolled in the plan. For example, enrolled veterans and others may place demands for care beyond existing facilities' capacities. To avoid spending additional resources to expand capacity or contract for care, VA may delay or deny care for nonenrolled veterans in order to serve enrolled veterans sooner than it otherwise would. To keep enrolled veterans satisfied, it seems essential that VA avoid delaying their care to the greatest extent possible.

VA officials told us that facility managers routinely monitor expenditures and patient satisfaction, which should provide timely warning, if cost overruns or care delays or denials occur. They also indicated that other safeguards may be developed to protect current users against undesirable outcomes as a result of a VA Medicare HMO demonstration.

FEE-FOR-SERVICE MODEL COULD BENEFIT VETERANS AND POSE FEWER RISKS

High-income, Medicare-eligible veterans could participate in a Medicare fee-for-service demonstration in two ways. First, they could apply for care at selected VA facilities in the same way that veterans currently apply. Second, other providers could refer high-income, Medicare-eligible veterans to VA for specific services or procedures. In any event, VA would not guarantee that it would provide all Medicare-covered services. Rather, VA would decide what services to provide on an case-by-case basis.

Essentially, under a fee-for-service demonstration, VA would have the opportunity to provide additional services primarily using its excess operating capacity. As such, any Medicare reimbursements would primarily represent resources that could be used to improve care for other veterans. Moreover, there would appear to be no need to delay or deny care to current users if only excess capacity is used.

VA may, however, have an incentive to serve fee-for-service Medicare veterans in situations where there is no excess operating capacity, because of the opportunity to earn reimbursement providing Medicare-covered services. In some instances, VA may find it desirable to delay care for veterans not eligible for Medicare in order to obtain Medicare reimbursements.

DEMONSTRATION TO USE MEDICARE REIMBURSEMENTS TO SERVE GEOGRAPHICALLY REMOTE LOW-INCOME, MEDICARE-ELIGIBLE VETERANS

The information in this enclosure addresses our understanding of how a demonstration could be structured and our assessment of what the potential benefits and risks could be. In general, our understanding of how a demonstration could be structured is essentially the same as that discussed for a demonstration involving high-income, Medicare-eligible veterans, except as it relates to geographically remote low-income veterans. We developed this information from discussions with VA, HCFA, and OMB officials and our review of related documents.

MEDICARE HMO DEMONSTRATION

Regarding potential demonstration structures, we assume that VA would operate a Medicare HMO plan to serve low-income,[5] Medicare-eligible veterans (1) for a limited time period, such as 3 years; (2) in geographic areas located a minimum distance from existing VA facilities, such 30 miles; (3) in a limited number of such geographic areas; and (4) in compliance with Medicare rules that HCFA applies to private Medicare HMO plans.

VA could, we assume, enroll low-income, Medicare-eligible veterans currently using VA's health care, as well as former users and nonusers. Moreover, VA could require all low-income, Medicare-eligible veterans in the demonstration areas, including those currently using VA care, to enroll in VA's Medicare HMO plan in order to receive VA care; that is, low income, Medicare-eligible veterans could be denied VA care if not enrolled.

VA could have four basic choices for providing services to Medicare-eligible enrollees in the demonstration areas. These include

- using unused operating capacity in existing VA facilities;
- creating new capacity within existing VA facilities, such as converting unused hospital wards to outpatient clinics;
- creating new VA capacity, such as establishing community clinics; and
- contracting for services with non-VA providers.

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[5]Low-income veterans are those whose incomes fall below a certain level, for example, a veteran with no dependents with an income less than $21,611. Income thresholds increase with each subsequent dependent.

Regarding Medicare reimbursements, HCFA, we assume, could reimburse VA a fixed amount of Medicare funds for each geographically remote low-income, Medicare-eligible veteran enrolled. In general,

- HCFA could reimburse VA using a rate lower than the per-person rate currently paid to private Medicare HMO plans;

- HCFA could reimburse VA for enrolled veterans' care only after VA exceeds its historic spending (level of effort) for geographically remote low-income, Medicare-eligible veterans;

- HCFA reimbursements could be limited to a predetermined amount, such as $50 million a year for enrolled veterans;

- HCFA reimbursements may be used to serve Medicare-eligible enrollees, subject to Medicare requirements; and

- HCFA reimbursements may be used to serve veterans not enrolled in an HMO demonstration if VA's expenditures for enrolled veterans are lower than HCFA's reimbursements.

A MEDICARE HMO DEMONSTRATION COULD BENEFIT VETERANS

Veterans could benefit from a demonstration project in two ways. First, VA could use Medicare reimbursements to serve geographically remote low-income, Medicare-eligible veterans who would otherwise not be served. Second, VA expects to also use such reimbursements to improve services for other veterans, if expenditures for enrollees are less than Medicare reimbursements.

Using a Medicare HMO to Benefit Low-Income Veterans

A Medicare HMO plan could benefit geographically remote low-income, Medicare-eligible veterans currently using VA care, as well as former users and those who have never used VA care, if they choose to enroll.

The proportion of current users who enroll in VA's Medicare HMO plan could greatly affect the number of other veterans who could benefit. This is because VA officials could set a target Medicare-eligible enrollment level that is based on available operating capacity and, for example, could give current users priority for enrollment. In this case, only a relatively small number of new Medicare-eligible veterans could access VA care if

most current users enroll or if VA sets an enrollment target which provides only a modest increase over the number of low income, Medicare-eligible veterans currently served. Conversely, considerably more new Medicare-eligible veterans could benefit if relatively few current users enroll.

In this regard, the target enrollment level for low-income, Medicare-eligible veterans appears to be dependent on the geographic areas selected for a demonstration. For example, an area could be selected that is 30 to 50 miles from an existing VA facility, or an area could be selected that is 90 to 120 miles away. As such, a considerably higher number of potential enrollees may live in the area closer to a VA facility than in the more remote area.

Using a Medicare HMO Could Benefit Other Veterans

VA may use Medicare reimbursements to enhance access or quality of VA health care for veterans not enrolled in VA's demonstration. Such potential benefits appear directly linked to VA's capability to serve enrolled veterans using unused operating capacity in existing VA facilities. For example, VA may be able to use a relatively large portion of its Medicare reimbursements for such benefits if most plan enrollees are served using excess operating capacity. This is because VA would receive Medicare reimbursements for those veterans but would have already paid for this capacity using appropriated funds.

By contrast, VA's ability to use Medicare reimbursements to benefit veterans not enrolled in VA's demonstration could decrease significantly if VA needs to expand capacity or purchase care from other providers to meet most enrolled veterans' needs. This is because Medicare reimbursements will have to cover the full costs of care for enrolled veterans, which could leave little or no reimbursements available to enhance care for other veterans. In other words, Medicare reimbursements may benefit other veterans only if expenditures for enrolled veterans are significantly lower than Medicare reimbursement rates.

VA appears capable of meeting many medical needs of potential enrollees using existing excess operating capacity. For example, VA has thousands of unused hospital beds as well as considerable unfilled appointments slots involving specialized medical equipment or procedures. As such, VA has already financed the costs of such services, using its $17 billion appropriation. Thus, it would have to spend little or no additional resources to deliver such services.

VA, however, may have little or no excess operating capacity for many outpatient services, especially primary care. To care for an additional outpatient workload, VA could have to use Medicare reimbursements or appropriated funds to contract with other

providers or hire additional staff. VA also appears to have no capacity to provide some Medicare-covered services, such as emergency room care. VA would have to use the reimbursements to contract with other providers for such care.

DEMONSTRATION PROJECT POSES RISKS FOR VETERANS

VA's enrollment of geographically remote low-income, Medicare-eligible veterans in a Medicare HMO plan could place current users at risk of experiencing delayed or denied care in the demonstration areas. In this regard, both low-income, Medicare-eligible veterans currently using VA, as well as other users, may be at risk.

To create an incentive for geographically remote low-income, Medicare-eligible veterans who are current VA health care users to enroll in a VA Medicare HMO, VA could deny VA medical services to those veterans who do not enroll in the demonstration. This could mean a loss of VA services for veterans who have previously received VA services and who do not wish to limit their opportunity to obtain Medicare-covered services from other providers by enrolling in a VA Medicare HMO.

Other veterans may be placed at risk for two reasons. First, VA may find it necessary to spend more resources meeting enrolled veterans' needs than the amount of Medicare reimbursements received. This could occur because VA may have to develop a contract provider network in remote areas in order to comply with HCFA access requirements (for example, access must reflect local community patterns), and the costs of doing so could exceed Medicare reimbursements. It seems likely that VA would have to use appropriated funds to finance such cost overruns–funds that would have otherwise been used to treat nonenrolled veterans.

Second, VA could find it desirable or necessary to give preferential treatment to geographically remote low-income, Medicare-eligible veterans as an incentive to keep them enrolled in the plan. For example, enrolled veterans and others may require care beyond the capacities of existing VA facilities that meet HCFA access requirements. To avoid spending additional resources to expand capacity or contract for care, VA may delay or deny care for nonenrolled veterans to serve enrolled veterans sooner than it otherwise would. To keep enrolled veterans satisfied, it seems essential that VA avoid delaying their care to the greatest extent possible.

It is uncertain whether VA can establish a network of providers that will meet veterans' medical needs at or below Medicare reimbursements in all remote areas. If not, VA could incur cost overruns, which it would have to cover using appropriations. Such risks for

veterans could be minimized if VA has flexibility to establish an HMO demonstration only in areas where its initial assessments indicate that Medicare reimbursements should cover costs.

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