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VETERANS AFFAIRS

Accessability of Outpatient Care at VA Medical Centers

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SUMMARY

GAO recently issued two reports addressing veterans' access to outpatient care at the 158 medical centers operated by the Department of Veterans Affairs (VA). GAO found that veterans with similar medical conditions or economic status were receiving care at some centers but not at others. As a result, veterans were frequently confused or frustrated when they were turned away by VA centers without receiving needed medical care.

VA medical centers' interpretations and use of statutory eligibility and rationing criteria varied widely for two reasons. First, because of inadequate VA guidance, medical center staff, too often, rely primarily on subjective judgments when deciding who is eligible for outpatient care. Second, consistent with VA's decentralized management philosophy, medical center staff make rationing decisions based on locally developed policies.

GAO recommended that the Secretary of Veterans Affairs propose to the Congress alternative eligibility criteria that produce more predictable eligibility decisions or provide better guidance to centers so that physicians may make more consistent eligibility determinations. GAO also suggested that the Congress consider whether to direct the Secretary to modify VA's system for allocating resources to medical centers so that veterans with similar medical or economic status are, to the extent practical, provided more consistent access to outpatient care.

VA reviewed GAO's draft reports and generally agreed with the findings and conclusions. VA officials recognize that inconsistencies exist in veterans' access to care systemwide and have indicated a willingness to implement corrective actions as GAO recommended.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss veterans' access to outpatient care at the 158 medical centers operated by the Department of Veterans Affairs (VA).

In recent years, witnesses testifying before both this Subcommittee and the House Committee on Veterans' Affairs have questioned whether veterans have access to VA health care when they need it. In response to these concerns, you asked us to examine (1) how VA determines veterans' eligibility for outpatient care, (2) how VA rations such care, and (3) what happens to veterans who are turned away.

As you know, veterans' eligibility for VA outpatient care, by law, is based primarily on a veteran's medical condition or status during military service. Veterans are entitled to receive care for disabilities related to military service. Their eligibility for treatment of conditions unrelated to service disabilities generally depends on whether care is required to "obviate the need for hospitalization". VA may ration care when resources are not sufficient to serve all eligible veterans; consequently, eligible veterans may be turned away without receiving needed medical care for nonservice-connected conditions. Generally, those with the highest incomes are to be turned away first.

As we recently reported to you, VA medical centers' interpretations and use of statutory eligibility and rationing criteria vary widely. As a result, veterans with similar medical conditions or economic status are receiving care at some centers but not at others. Unfortunately, Mr. Chairman, we are unable to tell you--from a systemwide perspective--how many veterans are turned away from VA medical facilities. This is because VA's management systems do not include reliable information on those veterans who leave VA facilities without receiving needed care. We can tell you, however, that VA's current eligibility and rationing practices, too often, confuse and frustrate veterans.[1]

While totally consistent application of any eligibility criteria is difficult, if not impossible, to achieve, we believe that VA medical centers should become more predictable in their eligibility decisions. Currently however, because of inadequate VA guidance, medical center physicians are relying primarily on subjective judgments when deciding who is eligible for outpatient care. We recommend that the Secretary of Veterans Affairs either develop and propose to the Congress an alternative eligibility criteria which produces more predictable eligibility decisions, or

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[1]VA Health Care: Variabilities in Outpatient Care Eligibility and Rationing Decisions (GAO/HRD-93-106, July 1993).

VA Health Care: Veterans' Efforts to Obtain Outpatient Care from Alternative Sources (GAO/HRD-93-123, July 1993).

provide better guidance to centers so that physicians may achieve more consistent determinations when interpreting the current criteria.

Consistent with VA's decentralized management philosophy, medical center staffs are making rationing decisions based on locally developed policies. However, it is unclear whether the Congress intends that rationing decisions be made on a local or systemwide basis.

From a veteran's perspective, it seems preferable that VA develop a strategy to deal with resource shortfalls on a more equitable basis systemwide. Therefore, we suggest that the Congress consider directing the Secretary of Veterans Affairs to modify VA's system for allocating resources to the medical centers. Resources should be allocated so that veterans with similar economic status or medical conditions are, to the extent practical, provided more consistent access to outpatient care.

Now I would like to describe, in more detail, the variabilities in medical centers' eligibility and rationing practices and veterans' efforts to obtain needed medical care elsewhere when VA centers do not provide it.

SUBJECTIVE ELIGIBILITY JUDGMENTS CAUSE INCONSISTENT ACCESS TO CARE

VA has broadly defined the statutory eligibility criterion relating to obviating the need for hospitalization. Guidance to medical centers says that eligibility determinations

> "... shall be based on the physician's judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated, would reasonably be expected to require hospital care in the immediate future..."

To assess medical centers' implementation of this criterion, we used medical profiles of six veterans developed from actual medical records and presented them to 19 medical centers for eligibility determinations. At these 19 centers, interpretations of the criterion ranged from permissive (care for <u>any</u> medical condition) to restrictive (care only for certain medical conditions).

For example, five centers used a permissive interpretation and determined that all six veterans would be eligible for outpatient care. In contrast, three centers interpreted the criterion more restrictively and determined that only two veterans would be eligible for care. The other 11 centers used more middle-of-the-road interpretations.

From a veteran's perspective, such varying interpretations mean that their access to VA care will depend greatly on which center they visit. For example, none of the six veterans was consistently determined to be eligible or ineligible for care by all 19 centers; that is, each of the 6 veterans would be eligible for care at some medical centers and ineligible at others. For example, if one veteran we profiled had visited all 19 medical centers, he would have been determined eligible by 10 centers but ineligible by 9 others. In contrast, another veteran would have been eligible at all but 2 of the 19 centers.

Officials at VA's headquarters and medical centers agreed that the "obviate the need for hospitalization" criterion is an ambiguous and inadequately defined concept. A headquarters official stated that, because the term has no clinical meaning, its definition can vary among physicians or even with the same physician. A medical center official noted that the criterion

> "... is so vaguely worded that every doctor can come up with one or more interpretations that will suit any situation... Having no clear policy, we have no uniformity. The same patient with the same condition may be denied care by one physician, only to walk out of the clinic the next day with a handful of prescriptions supplied by the doctor in the next office..."

With thousands of VA physicians making eligibility decisions each working day, the number of potential interpretations is, to say the least, very large.

LOCALLY DEVELOPED RATIONING POLICIES CAUSE INCONSISTENT ACCESS TO CARE

The Congress established priorities for VA to use in providing outpatient care when resources are not available to care for all veterans. VA has delegated rationing decisions to its 158 medical centers; that is, each must independently make choices about when and how to ration care. However, VA does not systematically monitor medical centers' rationing procedures or practices.

Using a questionnaire, we obtained information from VA's 158 medical centers on their rationing practices. In fiscal year 1991, 118 centers reported that they rationed outpatient care for nonservice-connected conditions and 40 reported no rationing. Rationing generally occurred because resources did not always match veterans' demand for VA care. Of the 118 centers,

- -- 69 rationed care only to higher income veterans,
- -- 27 rationed care to higher and lower income veterans, and
- -- 22 rationed care to higher and lower income veterans, as well as those who also have service-connected disabilities.

When the 118 centers rationed care, they also used differing methods. Some rationed care according to economic status, others by medical service, and still others by medical condition. The method used can greatly affect who is turned away. For example, rationing by economic status will help ensure that veterans of similar financial means are served or turned away. On the other hand, rationing by medical service or medical condition helps ensure that veterans with similar medical needs are served or turned away.

The 158 medical centers' varying rationing practices resulted in significant inconsistencies in veterans' access to care both among and within the centers. For example, higher income veterans frequently received care at many medical centers, while lower income veterans or those who also have service-connected disabilities were turned away at other centers. Some centers that rationed care by either medical service or medical condition sometimes turned away lower income veterans who needed certain types of service while caring for higher income veterans who needed other types of service.

VA could reduce such inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and demographic make-up of eligible veterans requesting services at each center. In effect, VA would be shifting some resources from the 40 medical centers that had sufficient resources and therefore, did not ration care in 1991. Such resource shifts could mean, for example, that some higher income veterans at those centers might not obtain care in the future. But, it could also mean that some veterans with lower incomes who had not received care at other medical centers might receive care in the future.

MOST VETERANS GAO SURVEYED OBTAINED CARE FROM ALTERNATIVE SOURCES

As you requested, we examined veterans' efforts to obtain care from alternative sources when VA medical centers did not provide it. To do this, we visited 6 medical centers and identified 198 veterans who applied for care during the first 6 months of fiscal year 1992 and were turned away without receiving all needed care.

We selected the centers and the veterans judgmentally because VA's management systems do not maintain reliable information on veterans who did not receive needed care. This information could be obtained only through discussions with officials at medical centers and reviews of veterans' medical and administrative records. Because of these data limitations, our work provides a "snapshot" view of what happened to the 198 veterans, but it cannot be applied to other veterans seeking outpatient care at the 6 centers or at other centers nationwide.

Through discussions with the 198 veterans, we learned that 85 percent obtained needed care after VA medical centers turned them away. Most obtained care outside the VA system, but some veterans returned to VA for care, either at the same center that turned them away or at another center. Inability to pay was most often cited by veterans as the reason they did not obtain care elsewhere. The 198 veterans surveyed needed varying levels of medical care. Some requested medications for chronic medical conditions, such as diabetes or hypertension. Others presented new conditions that were as yet undiagnosed. In some cases, the conditions, if left untreated, could be ultimately life threatening, such as high blood pressure or cancer. In other cases, the conditions were potentially less serious, such as psoriasis.

VA staff face difficult medical and administrative choices each time they consider turning away a veteran needing care. Should they provide all diagnostic testing, knowing that the tests are likely to be repeated wherever the veteran goes to get care? Or should they minimize the tests provided, knowing that they will be unable to provide care, if needed? VA centers exercise wide latitude in making these decisions when providing outpatient care to veterans.

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In summary, Mr. Chairman, veterans are too often being made to feel like they are participating in a health care lottery where their chances of receiving care are heavily dependent on which center they visit, which physician examines them, or which day of the year they need care. As a result, veterans are understandably confused and frustrated about whether they will receive VA care when they need it.

Physicians, too, are uncomfortable with the current system. They continually have to decide whether to deny care to veterans before determining how best to meet veterans' medical needs. Too often, physicians are required to judge, without adequate guidance, whether veterans' conditions will, if left untreated, deteriorate and result in hospitalization. This places physicians in a very unenviable position--relying on subjective judgments to make difficult eligibility decisions or ignoring statutory requirements in order to serve veterans' needs.

VA is credited with operating the nation's largest health care system. However, the widespread inconsistencies in veterans' access to outpatient care at VA's 158 medical centers suggests that the centers are operating more as independent providers than as integrated components of a nationwide system. While serving in the military, veterans operated under a consistent set of rules that were, for the most part, clearly understood. It seems reasonable for veterans to expect that VA's delivery of health care benefits

earned as a result of military service should operate in a similar manner.

As you know, Mr. Chairman, VA reviewed our draft reports and generally agreed with our findings and conclusions. VA officials recognize that inconsistencies exist in veterans' access to care systemwide and have indicated a willingness to implement the corrective actions we have recommended. In general, VA plans to provide an eligibility reform proposal for consideration by the Congress and, in fiscal year 1994, to implement a new resource allocation process--actions that VA officials believe will address the types of service variabilities we found.

This concludes my prepared statement. We will be glad to answer any questions you and members of the Subcommittee have.

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