United States General Accounting Office

GAO

Report to Congressional Requesters

October 1996

VA HEALTH CARE

Improving Veterans' Access Poses Financial and Mission-Related Challenges

GAO/HEHS-97-7

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-274205

October 25, 1996

The Honorable Christopher S. Bond
Chairman, Subcommittee on VA, HUD
and Independent Agencies
Committee on Appropriations
United States Senate

The Honorable Bob Stump
Chairman, Committee on
Veterans' Affairs
House of Representatives

The Department of Veterans Affairs (VA) operates one of the nation's largest health care delivery systems, including over 170 hospitals and over 200 free-standing clinics. Veterans must often travel long distances to receive care at these facilities. In 1995, VA established a policy encouraging its hospitals ". . . to employ all means at their disposal, and within available resources, to improve access to VA care for eligible veterans."[1] Subsequently, many hospitals either planned or established new, free-standing outpatient clinics referred to as access points.[2] An access point may be a VA-operated clinic or a VA-funded or VA-reimbursed private clinic. Access points provide primary care to veterans and generally refer those needing specialized services or inpatient stays to VA hospitals. This report responds to your request for us to examine VA's policy for establishing access points. It discusses the legal, financial, and mission-related implications of VA's efforts to establish access points.[3]

To develop this information, we relied on previous GAO reports for information on veterans' use of VA medical facilities. (See the Related Products section at the end of this report.) We also reviewed VA directives and statutory authorities for their role and relevance in establishing access points. To obtain more detailed information, we selected three VA hospitals that had established new access points—Big Spring and Amarillo in Texas and West Side in Chicago. We selected Big Spring because it had proposed

[1]Department of Veterans Affairs, Veterans Health Administration (VHA), VHA Directive 10-95-017 (Feb. 8, 1995).

[2]Access points are now referred to as Community Based Outpatient Clinics (CBOC) per VHA Directive 96-049 (Aug. 7, 1996), which superseded VHA Directive 10-95-017.

[3]On April 24, 1996, we testified on this issue before the Subcommittee on Hospitals and Health Care, Committee on Veterans' Affairs, House of Representatives (see VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996)). This report expands on our testimony from that hearing.

7 of the 15 new access points submitted for congressional approval. We chose Amarillo because it had established the first contract access point in 1994. To contrast Big Spring's and Amarillo's access points, which are in rural areas, we selected West Side because its new access point is in an urban area.

We visited these hospitals and three of their new access points. During these visits, we interviewed VA hospital officials and reviewed records relating to the operations of their access points. We also conducted telephone interviews with officials at six other hospitals that had also proposed new access points. In addition, we conducted a telephone survey of 115 veterans who had used new access points. We also interviewed VA headquarters officials and representatives of local and national veterans service organizations to obtain their views regarding VA's efforts to enhance primary care accessibility. We did our review from March 1995 to July 1996 in accordance with generally accepted government auditing standards.

Results in Brief

VA's new access points represent a proactive effort to transition from a direct delivery system to an integrated network of VA-operated hospitals and VA and non-VA outpatient providers. In so doing, 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 legal, financial, and mission-related issues.

To begin with, VA ignored important limitations in its legal authority to provide primary care to veterans. VA's Under Secretary for Health has testified[4] about the need to reform VA's contracting authority and veterans' eligibility for VA health care. On October 9, 1996, the President signed legislation—the Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262)—that expands VA's authority to contract for the provision of such care and veterans' eligibility to receive primary care services.

From a financial standpoint, VA hospitals will be affected by access points in several ways. First, hospitals must finance access points within their existing budgets; this will generally require reallocating resources among current activities and services. In time, access points should allow VA hospitals to serve current users more efficiently; however, efficiencies

[4]Statement of Kenneth W. Kizer, Under Secretary for Health, VA, before the Committee on Veterans' Affairs, United States Senate (May 8, 1996).

may not generate enough savings to offset the increased costs associated with caring for increased numbers of veterans attracted to the new clinics but who would otherwise not have used VA's facilities.

Finally, because VA has not developed a strategic plan for expanding veterans' access to its medical care system, it is difficult, if not impossible, to accurately gauge the number of access points that VA will need or the effect that they will have on VA's mission. While establishing access points could result in a modest increase in accessibility for a limited number of current users, they could also dramatically change VA's role as a direct health care provider by significantly increasing the number of new veterans using VA services. In essence, our work suggests that the growth potential will be limited only by the availability of resources, veterans' willingness to use VA hospitals or VA-sponsored services, and providers' availability and willingness to contract with VA hospitals.

Background

VA operates one of the nation's largest health care systems at a cost of more than $16 billion a year. The system has 173 hospitals and 220 clinics that are geographically remote from a VA hospital. VA hospitals typically operate these clinics themselves and staff them with VA personnel. Since its inception in 1930, the VA health care system has developed into a direct delivery system, with the government owning and operating its own health care facilities, in response to a time when there was virtually no public or private health insurance.

Traditionally, many veterans traveled long distances to use VA facilities. About one-half of all veterans live more than 25 miles from a VA hospital, including 6 percent who live more than 100 miles from one. Over one-third of all veterans live 25 miles or more from a VA clinic.[5] Currently, VA serves about 10 percent of the 27 million veterans eligible for care including many who travel long distances. Other veterans have often said that they do not use VA facilities for their health care because they live too far from the nearest hospital or clinic.

Until 1995, VA required its hospitals to meet rigid criteria to establish outpatient facilities located apart from the hospitals. These criteria included a minimum number of veterans to be served in a clinic and a minimum distance that clinics must be from the VA hospitals. For example, community-based clinics were required to (1) have a projected workload

[5]See VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995) and VA Health Care: Exploring Options to Improve Veterans' Access to VA Facilities (GAO/HEHS-96-52, Feb. 6, 1996).

of at least 3,000 visits annually, (2) be 100 miles or 3 hours travel time away from the nearest VA facility, and (3) have more than one-half of the counties in the targeted veteran population in health manpower shortage areas.

In anticipation of national health care reform, VA determined that it needed to expand its ability to provide outpatient care, especially for veterans who are geographically distant from VA hospitals. The Amarillo VA hospital is recognized as the first facility to establish access points. Amarillo's first access point began operations in January 1994.

In February 1995, VA encouraged all its hospitals to consider establishing access points, like those that Amarillo operates. In doing this, VA eliminated many of its restrictions concerning the workload and location of proposed clinics. In addition, VA policy encouraged hospitals to provide care not only in VA-operated facilities, but also by contracting with other providers.

VA gave hospital and veterans integrated service network (VISN) directors the authority to propose and approve access points. When developing new access points, directors are to consider the (1) eligible veteran population, (2) services to be provided, (3) costs of available alternatives, and (4) sources of funds. To date, nine VA hospitals have opened 12 access points (see fig. 1).

Figure 1: VA Medical Centers and Their Access Points

VISN directors have considerable freedom to develop their own goals and objectives as well as their own implementation strategies; however, they are encouraged to discuss plans with interested parties as well as inform VA headquarters. Each of the 12 new access points generally shares four common operating characteristics. They each have a (1) designated health care provider, (2) prescribed package of medical services, (3) target veteran population, and (4) predetermined cost.

VA staff operate four of the access points and contract with county or private clinics to operate the remaining eight. During a veteran's initial visit, access points that have contracted with VA "enroll" the veteran in the facility. The contract access point agrees to care for the veteran for 1 year. For that care, the access point is paid a capitated fee—a one-time payment to cover the veteran's care for a 12-month period, regardless of how many times the veteran seeks care.

When new access points are established, VA encourages veterans currently receiving VA health care to enroll along with veterans who have not previously received care. However, some VA hospitals have limited enrollment to veterans with service-connected conditions or current VA users. As of March 1996, the 12 access points had enrolled nearly 5,000 veterans. Veterans receive primary care at access points comparable to that available during visits to a private physician's office. With the exception of emergencies, enrolled veterans are referred to VA hospitals, not local hospitals, for inpatient or specialized care.

In early 1996, VA notified the Congress that 47 hospitals (including 5 of the 9 hospitals that already had access points) were ready to open an additional 58 access points. Another 200 were under development and could be operating by December 1996. Subsequently, the 22 VISN directors began developing 1-year tactical, 2- or 3-year strategic, and 5-year target plans. VA expects that new access points will be an important element of the networks' tactical/strategic plans.

VA has drafted guidance to be used by VISN directors when planning for new access points. This draft guidance states that the intent of access points is to primarily enroll current users who find it difficult due to location or medical condition to travel to a VA facility. Toward this end, the guidance suggests that directors provide a more thorough analysis of such key factors as eligible veteran population, costs, and source of funds when submitting proposals to establish new or realign existing access points. For example, directors are to complete a workload analysis that describes

and distinguishes those patients that will be redirected from the existing service population and those that are new. The guidance also provides a specific set of desirable characteristics that should be considered when siting an access point, including that it be generally within 30 minutes travel time of veterans' residences.

Inappropriate Statutory Authority Cited as Basis for Establishing Access Points

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 were not recognized by VA in establishing and operating the access points we visited.

At those access points we visited, many veterans received primary care contrary to applicable statutory limitations and priorities on their eligibility for such services. As authority for operating contract access points, however, VA relied 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 . . . only if such an agreement will obviate the need for a similar resource to be provided in a [VA] health care facility."

Specialized medical resources are equipment, space, or personnel that—because of cost, limited availability, or unusual nature—are unique in the local medical community.

VA officials asserted 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. The absence of a VA facility close to veterans in a particular area does not make primary care physicians unique in the local medical community, within the meaning of the statute. 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 on to authorize contracting for the operation of access points. However, both the types of services available and the classes of veterans eligible for care under this authority are more limited than those under the authority upon which VA relies (38 U.S.C. 8153).

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 posthospitalization 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 prehospitalization 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 disabilities are eligible for all care needed to treat those conditions. Those with disabilities rated at 30 or 40 percent are eligible for care of nonservice-connected conditions at contract access points to complete treatment incident to hospital care. Furthermore, veterans with disabilities rated at 20 percent or less and 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 required to assess each veteran's eligibility for care on the merits of his or her 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. A bill has been passed in the Congress that, if signed by the President, would authorize VA hospitals to establish contract access points and provide more primary care services to veterans in the same manner as the access points are now doing.

Financial Implications of Establishing Access Points

Access points have significant financial implications for VA hospitals, veterans, and non-VA health care providers. In general, VA hospitals will probably experience these effects only after access points have operated for a few years. In contrast, veterans and non-VA providers could experience financial effects immediately.

VA Hospitals Must Reallocate Existing Resources to Fund Access Points

VA hospital directors are likely to experience a series of financial challenges as they establish new access points. Initially, VA hospitals must finance access points within their existing budgets; this generally will require reallocating resources among other activities and services with no net change in their respective budgets. Over time, however, VA hospitals may incur significant cost increases to provide care to veterans who would otherwise not have used VA's facilities. We have suggested that these additional increases at least in the near term may be offset if these new clinics enable hospitals to conserve money by serving users more efficiently.[6]

To date, the nine VA hospitals have funded new clinics by using money saved from hospital-based staff reductions and other hospital-based efficiencies. At one hospital, officials are financing their new clinics by using funds saved by reducing the hospital staff. They estimated savings in excess of $900,000 by eliminating the equivalent of 15.5 positions. Another hospital expects to save up to $400,000 by reviewing patients' use of prescription medications. At other hospitals, such reviews have reduced the number of prescribed medications and have achieved cost savings in procuring, storing, and dispensing drugs.

Savings can also be achieved by reducing the staff involved in primary care at the hospitals. Officials at one hospital told us that if a sufficient number of veterans currently receiving care at their hospital can be enrolled in access clinics, they can reduce the size of their primary care staff and use the resulting savings to fund additional access points. Each

[6]We issued correspondence to the Senate Appropriations Subcommittee on VA, HUD and Independent Agencies that describes how VA hospitals finance access points. See VA Clinic Funding (GAO/HEHS-95-273R, Sept. 19, 1995).

primary care team at the hospital treats approximately 1,500 patients; consequently, for every group of 1,500 patients they can shift to access points, the hospital can eliminate one hospital-based primary care team.

Most VA hospital directors have concluded that it is more cost effective to contract for care in targeted locations than to operate new access points themselves. In many instances it is the only cost-effective option available. One of VA's goals in negotiating contract rates was to obtain a rate that was less than the estimated cost of a VA primary care team providing the same services. While VA does not have a financial system capable of tracking procedure-specific costs, VA hospitals with new access points attempted to estimate VA costs[7] related to primary care services. These hospitals used their cost estimates as the basis to compare bids from clinics interested in establishing VA access clinics.

In areas where the veteran population is too small to justify a VA-operated clinic, contracting may be the only cost-effective method available to provide primary care. VA guidance suggests that 3,000 visits per year are needed to justify a VA-operated clinic. In the rural areas served by most new access points, veteran populations are small. For example, in one area served by an access point, only 173 veterans who use VA health care live there, far below the amount needed to justify a full-time VA clinic. Health providers that have agreed to establish access points to serve veterans on a contractual, capitated basis also benefit because they have an existing nonveteran patient base and excess capacity to meet VA's needs.[8]

Hospitals also plan to finance clinics by using the savings that result from implementing a managed care delivery system. Clinics will have a major role in this system that plans to be based on a strong primary care network with clinics conveniently located near patients. VA contends that by making primary care more accessible, patients will be more likely to seek preventive care and VA hospitals will experience a consequent reduction in specialist and hospital use.

VA believes that veterans should experience an improvement in their health status as VA shifts its emphasis from inpatient to preventive care. VA

[7]The Amarillo VA hospital estimated that it costs $304 a year to provide primary care for a veteran. The Big Spring VA hospital estimated its costs at $277 per year per veteran to provide primary care. In both instances, each facility was able to negotiate a per capita rate less than these costs, even before including an additional 15 percent for VA overhead.

[8]VA patients are generally a relatively small portion of the total patient population served by these providers.

officials anticipate a significant decrease in the use of specialty clinics and diagnostic services as a result of VA focusing on preventive medicine. VA officials contend that veterans who live several hours away from a VA facility do not receive sufficient preventive care. Typically these veterans would wait until their condition worsened before they would seek treatment. Consequently, when veterans ultimately sought care, the care they would then need would be more intensive, more extensive, and more costly. By providing care closer to where veterans live, VA officials predict that veterans will be more likely to seek and receive care before their condition becomes serious.

Additionally, by obtaining their primary care from caregivers in local clinics rather than specialists in VA hospitals, VA anticipates a reduction in the number of diagnostic tests, which are used more frequently by VA specialists than by local primary care givers. If the clinics succeed in improving veterans' health status and reducing the need for specialty and inpatient care, VA hospitals should realize significant cost savings.

If the emphasis on primary care results in a reduction of the number of days of hospitalization, that in turn could result in further medical ward consolidations and fewer hospital-based staff. The majority of savings would result from hospital staff reductions and associated salary and benefit savings. For example, when one hospital consolidated inpatient wards and eliminated 23 beds, it saved an estimated $250,000. These savings were used to finance access clinics.

Over time, the initial savings that VA experiences with access points may ultimately be reversed and expenses may rise. In a recent study,[9] VA researchers compared two groups of veterans who had been discharged from nine VA hospitals. One group of veterans was given traditional VA services following an inpatient stay and the other group received intensive primary care intervention involving close follow-up by a nurse and a primary care physician beginning before discharge and continuing for the next 6 months. After 6 months, the rehospitalization rate was greater for the group receiving the intensive primary care treatment than for the group receiving traditional VA follow-up services. Although the results are preliminary and the veterans involved in the study suffered from serious medical conditions, the implications of this study relative to increasing the numbers of access points should be carefully considered.

[9]"Does Increased Access to Primary Care Reduce Hospital Readmissions?", The New England Journal of Medicine, Vol. 334, No. 22 (1996), pp. 1441-47.

The longer-term effects of access points on VA's budget are less certain. Our work has shown that VA has not clearly delineated its goals and objectives nor has it developed a strategic plan that specifies the number of potential access points, time frames for beginning operations, and associated costs.

If access point clinics attract a significant number of new users—veterans who heretofore have not used VA for their health care needs—VA hospital specialty use and hospitalization rates may actually increase. The effect on VA's medical budget will depend largely on the number and willingness of these "new" veterans who are referred by clinics to receive specialized treatment at VA hospitals. For example, as of March 1996, 40 percent of the 5,000 veterans enrolled at VA's 12 new access points were new users.[10] If new users receive care only at the clinics and not at VA hospitals, the budget effect may be small. However, if a significant number of new users begin using VA hospitals for specialty and inpatient care, overall VA use could remain stable or even increase with a corresponding increase in VA's expenses. Therefore, the projected savings attributable to managed care could be offset by increased costs at VA hospitals.

Both Current and New Veteran Users Benefit

Overall, both veterans and veterans service officers indicated their satisfaction with the care that veterans have received at the new access points, but some concerns have been expressed about the ownership and operation of the clinics. One veterans service officer at a clinic we visited said that the access point was an improvement for veterans seeking care. Previously, veterans now using the clinic had to travel long distances to get to the nearest VA medical center. The representative said that he had not heard any veteran complaints and that the clinic is especially effective in providing preventive care. He added that the veterans were happy to have medical care available to them at the clinic. He also told us that now veterans are more likely to see a physician more frequently because it is much more convenient to seek care and not wait until the last minute.

A veterans service officer at another clinic was very supportive of the clinic, but said she would prefer that the clinic be VA-owned and operated. She was concerned because the clinic only had a part-time physician. If a veteran arrived at the clinic without an appointment, the veteran might have to be cared for by a physician assistant or nurse. She indicated that veterans want to be seen by a physician. She also said there had been

[10]VA officials estimate that up to 20 percent of the veterans who receive care at access points will be new to the VA health care system.

problems with medical files not being transferred to or available at the clinic. As a consequence, medical care was delayed. The same representative said that veterans' demand for care may overwhelm the clinic. She said that some of the veterans getting care at the clinic had not received medical care before because it took 3 hours to drive to the nearest VA facility. The veterans are now using the clinic because it is more accessible. About one-half of the veterans we interviewed said that as long as VA paid for the care, they were not bothered by the fact that the care they received was given at the access point rather than at a VA facility.

Access points may prove more attractive to veterans than VA hospitals in part because access points moderate barriers such as geographic inaccessibility. The financial benefits that will accrue to veterans using new access points will vary depending on whether veterans are currently using VA hospitals or are new users of VA services. Current users should realize savings related to travel expenses. New low-income users will save these costs in addition to any costs they previously incurred by receiving care at non-VA providers. Savings realized by new high-income users will be offset by VA copayments that will be required.

Current VA users will benefit primarily from reduced travel costs. VA reports that many veterans must travel several hours to get to a VA hospital. Because of the distances involved, many elderly patients are not able to travel to and from their homes and receive medical treatment all in one day. Often, veterans and those assisting them must stay in lodging the day before or after a scheduled appointment. Although VA may reimburse these veterans a set amount of money for each mile they travel, lodging and meals are not reimbursed. Clinics located closer to current users would save these veterans both time and money.

Veterans new to the VA system have the potential to experience significant cost savings. Besides the savings that current users would receive associated with travel, new users would realize additional savings at rates dependent on the amount that they were spending for health care before they used VA's access points. For example, an insured veteran could avoid a deductible of $250 or more by using VA. In addition, low-income veterans, who previously may have received minimal health care because they lacked the means to travel or pay for care, would no longer have to forgo care.

Some Providers Benefit While Others May Not

The financial effect on non-VA providers will vary depending on whether they provide care to veterans under contract with VA or compete with VA

by providing the same care to veterans while being reimbursed by some other source. When VA enters a community as a payer of community providers, some local providers have the potential to benefit financially. Clinics that have excess capacity are in the best position to benefit from a VA primary care contract. For example, one official at a new access point clinic reported that the clinic's contract with the local VA hospital helped to offset its fixed costs without adding much to its variable costs. Because the general population was getting smaller, local primary care staffs were underutilized. In addition, the populations served by the clinics were disproportionately elderly, poor, and underinsured. Combined, these factors enabled the clinics to better utilize their existing staff and benefit financially by contracting with VA.

The veterans service officer at one location said that if it were not for the VA contract, the clinic would probably not have survived. Therefore, not only do the veterans benefit, but VA's presence has public health implications as well.

An additional benefit cited by one clinic physician for contracting with VA was the convenience for both veterans and their families to receive care at the same location. While VA pays only for a veteran's health care, a veteran's family can receive treatment at the same location.

After VA selects a health care provider to establish a new access point, those providers not selected will lose income to the extent that their veteran patients switch to the VA-sponsored clinic for their care. At one access point, a local physician complained to the clinic that one of his patients switched to the VA access point. The physician expressed concern about losing his other veteran patients. The likelihood that veterans will move from one provider to another depends on a variety of factors, including the number and types of providers available in the same geographic area.

VA believes that contracting with existing local health care providers will be less disruptive to the local health community overall. On the other hand, if VA established a VA-operated clinic in a community with sufficient capacity to treat the target veteran population, VA would most likely be viewed as a competitor duplicating existing medical resources.

Some Insurers Benefit While Others Are Unaffected

The financial effect on other health care financing organizations will vary depending on whether they are publicly or privately sponsored. Seventy percent of the veterans using access points that we interviewed had

Medicare coverage and 7 percent had Medicaid coverage. These public insurers may process fewer claims for these veterans because they are now using VA's access points.

Under current law, Medicare and Medicaid are not allowed to pay VA for eligible veterans treated at a VA facility. VA recently asked the Congress for authority to be reimbursed by Medicare for providing care to such veterans. Under the VA proposal, Medicare would reimburse VA for care at a rate no greater than 95 percent of the prevailing rate at which private Medicare providers are reimbursed.

Private insurers will likely realize little financial change. About one-half of the veterans that we interviewed reported that they had private insurance coverage. Typically, insurers would be billed by providers. Access points, however, are paid by VA. For veterans with private insurance coverage, VA bills the insurer to recover its costs.

Mission-Related Implications of Establishing Access Points

VA's new access points represent a proactive effort to transition from a hospital-based delivery system to an integrated network of VA-operated hospitals and non-VA primary care providers. The potential effect of access points on the future role of VA hospitals as health care providers for veterans depends to a large extent on hospitals' operational goals and objectives. To date, VA has not developed a strategic plan for its access points initiative, relying instead on VISN directors to develop their own goals and objectives. In effect, the access points may be considered pilot projects that provide useful information to assess the implications of different network integration goals and veterans' satisfaction with an integrated service delivery network.

The effect of the access points on demand for VA health care services is uncertain. Improved accessibility, however, could greatly affect future demand. Each of the three hospitals we studied has established access points to improve the convenience of primary care for their current users. At two of the hospitals, VA officials had decided that the veterans who would benefit most from access points would be those who lived the farthest from their respective medical center. Veterans who received care at these two hospitals had to travel 108 miles on average with some veterans having to travel as many as 300 miles from their homes.

While VA's goal is intended to benefit its current veteran population, all but two access points have attracted veterans who had not previously used VA

for their health care. The extent to which this occurs depends on a variety of factors, including the number of veterans living in areas served by access points. Despite the intent, access points should help VA improve service delivery for users, which in turn should improve user satisfaction with VA's health care system.

VA May Expand Its Market Share

Depending on the location of the access point and the number of veterans who live in the area, enrolling new users could significantly affect VA's mission and budget. VA officials at one hospital anticipate a 20-percent increase in the number of new users. To date, about 10 percent of its access point users have been veterans new to the VA health care system. There are 3,848 veterans in the area surrounding the access point clinic who are not currently using VA. In theory, this represents the potential customer base for the access point. VA officials anticipate the number of new users for this access point to be moderate because of the characteristics of the geographic area. Specifically, the access point service area consists of veterans whose homes are scattered throughout a rural area and many would still have to travel long distances to get to the access point. Consequently, a new access point would not be an attractive alternative to a veteran unless it was within a comparable travel distance to his or her current health care provider.

In more densely populated areas, however, VA's ability to attract new users is more significant. For example, one VA hospital has contracted with a clinic in a more urbanized area to provide primary care for up to 1,656 veterans. However, there are 4,048 veterans in the service area who currently use VA services and 24,856 veterans who live in the same area who can be considered potential patients. Because veterans who live close to a VA facility are more likely to use VA services,[11] there exists the potential for increasing VA's market share. Additionally, the potential for treating new veterans is much greater in urban areas than in the remote rural areas where the number of potential patients is far lower.

Equity Concerns Between Current and New Users Must Be Addressed

VA hospitals are contracting with access points to care for a limited number of veterans. VA hospital resources available to fund access points are finite and are limited to the extent that hospitals have a set of core activities and services that must be maintained and funded. Because demand for service at access points may outstrip VA hospitals' ability to

[11]See GAO/HEHS-96-31, Dec. 20, 1995.

fund the extra clients, VA hospitals have developed procedures to ration care provided at access points.

VA hospitals have the discretion to increase the number of veterans covered by contracts, but if demand for medical care at access points exceeds the VA hospitals' resources, the VA hospitals may need to limit care. VA hospitals have discretion on how to ration care. For example, veterans with high incomes and nonservice-connected disabilities might be refused care, but care might also be rationed by medical condition. While the VA hospital officials with whom we spoke did not anticipate having to ration care, they said that if it became necessary they would do so on a first-come, first-served basis rather than limiting care on the basis of VA eligibility criteria. This could result in a situation where veterans who have been using the VA system could be denied care at the access point if they sought care after an access point had enrolled its maximum number of veterans. Simultaneously, veterans who had never used VA health services before going to the access point would continue to use the clinic if they had been enrolled before the maximum number of enrollees had been reached.

Conclusions

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. The results of this action could range from improving access for a modest number of current or new users who live the greatest distances from VA facilities or in medically underserved areas to opening hundreds of access points and expanding VA's market share by attracting hundreds of thousands of new users. VA's growth potential is, in essence, limited 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 did not establish access points in conformance with applicable statutory authority. In addition, VA has not developed a plan to ensure that hospitals establish access points in an affordable manner. If developed, such a plan should 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 should 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 should also articulate clear goals for the target populations to be served. Hospitals should be directed to provide care at new access points following 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 should first serve veterans with service-connected disabilities; then other categories of veterans; and finally, higher-income veterans. This approach should provide for more equitable access to VA care than VA's current strategy of allowing local hospitals to establish access points that could result in veterans being served on a first-come, first-served basis and then having services rationed to them when resources run out.

VA proposed ways to address the legal concerns, and on October 9, 1996, the President signed legislation (P.L. 104-262) that provides VA hospitals with the authority to establish new access points. VA has also drafted guidance to address concerns about equity of access, convenience of access, and enrolling new users. However, the guidance has not been finalized and directors have great latitude in deciding how to use it. Consequently, 22 VISN directors must decide what is the fairest way to use their limited resources to establish new access points that could result in 22 different, potentially conflicting approaches.

Given limited resources, our work suggests that VA should first focus on improving the convenience of access for current users, with a goal of equalizing access systemwide. Once this is accomplished, VA could then evaluate the costs and availability of resources to decide whether to pursue seeking new users. This approach seems fair for two reasons. First, veterans will not encounter situations where VA hospitals in certain parts of the country may provide convenient access for new users while veterans who have used VA hospitals in other parts of the country for from 5 to 20 years will be required to travel long distances for care. Second, VA hospitals' efforts to add new users will exacerbate the potential resource shortfalls, resulting in hospitals running out of money sooner than they otherwise would. Ensuring equity of access for current users before adding new users will also provide VA hospitals with additional time to assess the financial implications of the access points and better plan outreach strategies for new users.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to establish a travel time or distance standard to be

followed by VA hospitals as they plan for additional access points in their service areas.

We also recommend that the Secretary direct the Under Secretary to require VA hospitals to establish their access points in a manner that focuses on (1) the equalization of access for current users of the VA health care system on the basis of the designated time or distance standard and (2) the enrollment of any new users of the system in accordance with statutory priorities for VA care.

Finally, we recommend that the Secretary direct the Under Secretary to provide the Congress a report that presents VA's overall plan and time schedule for the systemwide establishment of access points to assist the Congress in determining the affordability of VA's plan.

Agency Comments and Our Evaluation

In commenting on our draft report, VA agreed, in principle, with all but one of our recommendations. For example, VA stated that its ongoing network planning will include activities that should achieve our overall objectives of improving, in an equitable manner, veterans' access to care. Each VISN director is expected to consistently work to achieve specific desirable outcomes and goals and to consider desirable characteristics including travel time or distance criteria when making decisions about new access points for hospitals in his or her network. VA cautioned, however, that applying a single national standard as we recommended may be difficult given the diverse nature of the veteran population and VA's current health system that involves both urban and rural locations. For these reasons, VA believes that it is critical that the 22 VISN directors have considerable discretion in the placement of access points given veterans' travel times or driving distances.

In the draft report provided to VA for its comment, we recommended that VA comply with the then-existing statutes regarding both veterans' eligibility for health care services and contracting for those services. In response to that recommendation, VA said that its general counsel is reviewing each new request for access points. In VA's opinion, the recently passed reform bill will help resolve disagreements over its interpretation and implementation of existing statutes. In view of the recent congressional action, we have deleted our recommendation from this final report.

VA did not agree that it is necessary to provide the Congress with a report solely on VA's overall plans for systemwide establishment of access points. VA believes that the 22 networks' efforts to develop 1-year tactical and 2- or 3-year strategic plans will serve the same purpose. These 22 network plans will be consolidated into a national business plan that will include planned activities relating to the establishment of access points. While we agree that VA's national plan could provide a means to achieve the intent of our recommendation, it is not known at this time whether the plan will ultimately provide sufficient detail to afford the Congress enough information to determine the overall extent and cost of establishing access points.

Copies of this letter are being sent to the Ranking Minority Members of the House Committee on Veterans' Affairs and the Senate Subcommittee on VA, HUD and Independent Agencies, Committee on Appropriations and the Secretary of Veterans Affairs. Copies also will be sent to other interested congressional committees and made available to others upon request.

Please call me at (202) 512-7101 if you have any questions or need additional assistance. Other major contributors to this report include Paul Reynolds, Assistant Director; Michael O'Dell, Senior Social Science Analyst; Patrick Gallagher and Abigail Ohl, Senior Evaluators; Robert Crystal, Assistant General Counsel; Sylvia Shanks, Senior Attorney; Linda Diggs and Larry Moore, Evaluators; and Joan Vogel, Evaluator (Computer Science).

David P. Baine
Director, Veterans' Affairs and
Military Health Care Issues

Related GAO Products

VA Health Care: Efforts to Improve Veterans' Access to Primary Care Services (GAO/T-HEHS-96-134, Apr. 24, 1996).

VA Health Care: Exploring Options to Improve Veterans' Access to VA Facilities (GAO/HEHS-96-52, Feb. 6, 1996).

VA Health Care: How Distance from VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

VA Clinic Funding (GAO/HEHS-95-273R, Sept. 19, 1995).

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Official Business
Penalty for Private Use $300

Address Correction Requested

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100