

GAO

Report to the Ranking Minority Member,
Subcommittee on Compensation,
Pension, Insurance, and Memorial
Affairs, Committee on Veterans' Affairs,
House of Representatives

February 1996

VA HEALTH CARE

Exploring Options to Improve Veterans' Access to VA Facilities





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

**Health, Education, and
Human Services Division**

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The Honorable Lane Evans
Ranking Minority Member
Subcommittee on Compensation, Pension,
Insurance, and Memorial Affairs
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Evans:

The Department of Veterans Affairs (VA) runs one of the nation's largest health care systems. As a major health care provider, it competes with private health care providers to serve veterans. In fiscal year 1994, VA served about 2.4 million of the nation's 27 million veterans. The other 24.6 million veterans either received care from private providers or did not seek health care services.

When the VA health care system was established in 1930, public and private health insurance were virtually nonexistent. VA developed its system as a direct delivery system, with the government owning and operating its own health care facilities. Since then, the VA system has become one of the nation's largest networks of direct delivery health care providers, with 173 hospitals and 376 outpatient clinics nationwide. Because public and private health insurance programs have also grown, most veterans now have one or more alternatives to VA health care. Many veterans indicate that they use private providers because they live too far from a VA hospital or outpatient clinic. VA has recently encouraged its facilities to improve veterans' access to VA health care.

This report responds to your request for information on veterans' use of VA medical facilities. It discusses (1) characteristics of recent users of VA medical facilities; (2) the geographic accessibility of VA and private medical facilities that provide standard benefits; and (3) options that VA facilities might explore to improve accessibility of VA health care, such as where to locate new medical facilities and whether to establish new VA-operated facilities or contract with private providers.

We reviewed VA studies and previous GAO reports for information on users of VA medical facilities. To assess medical facilities' accessibility to veterans, we interviewed VA and private-sector officials, analyzed VA and private-sector provider documents, and compared sites of VA and private

facilities in four locations that represent the types of markets typically served by VA:

- Chicago, Illinois—an urban area with a VA medical center,
- Rockford, Illinois—an urban area with a freestanding VA outpatient clinic,
- Salem, Oregon—an urban area with no VA medical facility, and
- Dublin, Georgia—a rural area with a VA medical center.

To identify the options that VA facilities might consider to improve accessibility of VA health care, we reviewed VA policy directives and other guidance and interviewed VA headquarters and selected medical center officials (see app. I for a detailed discussion of our scope and methodology). We did our work between January 1994 and November 1995 in accordance with generally accepted government auditing standards.

Results in Brief

Veterans who used VA medical facilities during the early 1990s had lower incomes and were less likely to have private insurance than veterans who obtained their health care from non-VA facilities. Also, almost half the veterans who used VA facilities had conditions incurred during or aggravated by military service. Most veterans lived over 25 miles from VA medical facilities, but veterans who lived within 5 miles of such facilities made greater use of them.

VA hospitals and outpatient clinics that provide standard benefits are generally less geographically accessible to veterans than private medical facilities because they are outnumbered by private facilities and are located throughout the country. VA has 173 hospitals and about 14,000 physicians, compared with the nation's over 6,000 public and private hospitals and 550,000 private physicians. Consequently, veterans often travel longer distances or endure longer travel times to obtain care in VA medical facilities than they would if they used private providers. For example, while dozens of community hospitals and hundreds of private physicians are located in the 52-county area served by VA's Dublin, Georgia, medical center, some veterans in the area travel up to 150 miles to obtain services from the VA facility.

VA has recently begun taking steps to improve veterans' access to VA health care. In improving accessibility, VA faces two basic decisions: where to locate new facilities and how to deliver care. We found that in deciding where to locate facilities, VA could target areas that would improve

convenience for existing users, improve access for all veterans, or improve access for specific veteran groups or eligibility categories. For example, VA's Dublin, Georgia, medical center has targeted two relatively densely populated areas as possible locations for new outpatient clinics so it can improve access to new and current users. In deciding how to deliver care, VA could compare the costs and other factors involved in providing care in VA-operated facilities with those involved in contracting with private providers. For example, while VA-operated facilities typically are more expensive in the short run, such facilities would give VA more control over resources.

Background

In fiscal year 1994, VA medical care cost over \$15.6 billion. VA facilities served about 2.4 million veterans nationwide. VA services included 925,000 inpatient hospital stays and about 25 million outpatient visits.

The VA health care system was established primarily to treat war-related injuries and help rehabilitate veterans with disabilities incurred or aggravated as a result of military service; such service-connected disabilities include blindness, paralysis, and loss of limb. Subsequently, the Congress expanded the system so that hospital services could be provided, to the extent space and resources were available, to veterans who did not have service-connected disabilities and who lacked the resources to pay. Today, all veterans are eligible for treatment at VA medical facilities, but few are entitled to the full range of services under the existing complex eligibility requirements. For example, veterans with service-connected disabilities are eligible for cost-free hospital care, while high-income veterans without such disabilities are eligible for such care but may receive it only if space and resources are available. Such high-income veterans are also subject to co-payments and, if insured, their insurers must be billed for services provided by VA facilities.

When the VA health care system was established, there were no health insurance programs to help veterans pay for needed care. Private insurance began to emerge in the 1930s and expanded rapidly in the 1950s. In the 1960s, the Congress established the Medicare and Medicaid programs—public insurance programs that help the elderly and selected low-income individuals pay for health care. By 1990, 9 out of 10 veterans had one or more alternatives to VA health care for standard benefits (excluding such special services as psychiatric care and prescription drugs): about 81 percent had private health insurance, almost 26 percent were eligible for Medicare, and 1.6 percent had Medicaid coverage.

The VA health care system is fundamentally different from private or public health insurance programs. VA generally delivers health care to patients directly using salaried physicians, nurses, and other professionals in VA facilities. Insurance programs, on the other hand, provide services on a fee-for-service basis or through contracts with private providers. VA does not charge veterans for services provided to treat service-connected disabilities, although veterans may be required to make co-payments for nonservice-connected conditions if their income exceeds prescribed thresholds. Insurance programs typically charge premiums to, impose deductibles on, and require co-payments from all enrollees. In addition, VA provides some services that insurance programs typically do not provide. For example, VA covers outpatient prescription drugs and dental care that are not covered by Medicare. Similarly, while Medicare and most private insurance programs provide short-term nursing home care following hospitalization, VA may, in some instances, offer more extensive, longer-term nursing home and domiciliary care.¹

If cost and service differences between VA and insurance programs diminish, the importance of accessibility as a factor in veterans' decisions on where to obtain health care could increase. VA surveyed the status of veterans in 1987 and found that distance to VA facilities was one of the reasons most frequently cited by veterans for not using VA facilities.² VA's survey of the status of veterans in 1992 also showed that about one-third of the responding veterans who received inpatient care did not choose a VA hospital because they were too far from the VA location.³ Similarly, over one-fourth of the veteran respondents to VA's health care reform customer satisfaction survey said that, given a choice of health programs and assuming no difference in cost, they would choose private providers, in part, because the private providers were more accessible.⁴

In October 1995, VA began a major reorganization that will replace its four regional offices with 22 integrated service networks. Each network will include from 5 to 11 medical centers. The service networks will be the basic budgetary and planning units for delivering veterans' health care. VA officials envision greater emphasis on integrated delivery systems of care

¹According to VA officials, eligibility requirements for long-term care are very complex.

²Department of Veterans Affairs, 1987 Survey of Veterans (Washington, D.C.: Department of Veterans Affairs, July 1989).

³National Center for Veterans Analysis and Statistics, Department of Veterans Affairs, National Survey of Veterans (Washington, D.C.: Department of Veterans Affairs, Apr. 1995).

⁴Department of Veterans Affairs, Veterans Health Administration Health Care Reform Customer Satisfaction Survey (Washington, D.C.: Department of Veterans Affairs: 1994).

and on outpatient and primary care services as a result of the reorganization.

Profile of VA Facility Users

While many veterans received medical care during the early 1990s, relatively few obtained their care from VA facilities. Veterans who used VA facilities generally had lower incomes and were less likely to have private insurance than veterans who used non-VA facilities. Also, almost half the veterans who used VA facilities had service-connected disabilities. Most veterans lived over 25 miles from VA facilities, but veterans who lived within 5 miles of such facilities made greater use of the facilities.

Most Veterans Used Non-VA Facilities

VA's survey of the status of veterans in 1992 showed that 54.8 percent of the 27 million veterans nationwide received medical care in 1992 but few received care in VA facilities. About 90 percent of the veterans who received either inpatient or outpatient care got it from non-VA sources, as did over 80 percent of the veterans who received both types of care. The survey also showed that of the 10 percent of veterans who received care in VA facilities, 5.6 percent received VA care exclusively and 4.4 percent received both VA and non-VA care. VA officials said that, while only 10 percent of all veterans used VA facilities in 1992, a larger percentage of veterans used VA facilities over a 3-year period; the reason for this is that many veterans do not require medical services every year. The officials also said that some veterans who received both VA and non-VA care needed resource-intensive care and had been transferred for that purpose to VA facilities.

VA Facility Users Generally Had Lower Incomes Than Users of Non-VA Facilities

Using VA patient treatment records and Internal Revenue Service information, we examined the incomes of the 2.2 million veterans who used VA medical facilities in 1991 and found that two-thirds had incomes under \$20,000, and about one-third of these had incomes under \$5,000.⁵ However, VA's survey of veterans in 1992 showed that only about 32 percent of all veterans had gross family incomes below \$20,000. This suggests that most VA facility users had lower incomes than non-VA facility users.

VA's survey also showed that veterans' use of VA facilities decreased as incomes increased. For example, over 44 percent of veterans with incomes

⁵VA Health Care: A Profile of Veterans Using VA Medical Centers in 1991 (GAO/HEHS-94-113FS, Mar. 29, 1994).

under \$10,000 received inpatient care from VA facilities, compared with 2.5 percent of those with incomes over \$50,000; and 32 percent of veterans with incomes under \$10,000 received outpatient care in VA facilities, compared with 1.7 percent with incomes over \$50,000. Moreover, cost was the reason most frequently cited by veterans who participated in VA's survey for choosing a VA hospital for inpatient care: over 19 percent cited cost as a reason for choosing a VA hospital, while less than 1 percent cited cost as a reason for choosing private or public hospitals.

VA Facility Users Were Less Likely to Have Insurance

Veterans who used VA facilities were also less likely than users of non-VA facilities to have insurance. VA's survey of veterans in 1992 showed that about 49 percent of all veterans had private insurance alone, 12 percent had public insurance alone,⁶ 29 percent had both, and 9 percent had no insurance.⁷ The survey also showed that the availability of insurance increased as income increased. For example, about 27 percent of veterans with income under \$10,000 had no insurance, compared with 1.3 percent with income over \$50,000. Conversely, about 14 percent of veterans with income under \$10,000 had private insurance, compared with over 76 percent with income over \$50,000.

Veterans With Service-Connected Disabilities Were More Likely to Use VA Facilities

Many veterans who used VA facilities had service-connected disabilities. In 1994, we reported that 1 million of the 2.2 million veterans who received care in VA facilities in 1991 had service-connected disabilities.⁸ In addition, VA's survey of veterans in 1992 showed that veterans with service-connected disabilities were more likely than those without them to use VA facilities. Almost 72 percent of the veterans who reported they had a service-connected disability used medical facilities, compared with 53 percent who did not have such disabilities. About 24 percent of veterans with service-connected disabilities received inpatient care exclusively in VA facilities, compared with less than 7 percent who did not have such disabilities. Similarly, about 16 percent of veterans with service-connected disabilities received outpatient care exclusively in VA, compared with slightly over 3 percent who did not have such disabilities.

⁶Public insurance includes Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

⁷Type of insurance was unknown for about 1 percent of the veterans.

⁸GAO/HEHS-94-113FS, Mar. 29, 1994.

VA Facility Users Often Traveled Long Distances

Veterans' use of VA facilities was influenced by the distances they had to travel to the facilities. Our analysis of 1990 census data showed that about 50 percent of all veterans lived over 25 miles from a VA hospital, including 6 percent who lived over 100 miles away, and 34 percent lived over 25 miles from a VA clinic.⁹ Many of those veterans traveled long distances to use VA facilities. For example, 44 percent of VA facility users lived over 25 miles from VA hospitals providing acute medical and surgical care, and 32 percent lived over 25 miles from outpatient clinics that provided such services.

Living closer to a VA facility significantly increases the likelihood that a veteran will use VA health care and VA officials told us that some veterans move to be closer to VA medical facilities. For example, about 11 percent of all veterans lived within 5 miles of a VA hospital, and they accounted for 22 percent of the facility users. Similarly, 17 percent of veterans lived within 5 miles of a VA outpatient clinic and accounted for 26 percent of the clinic users. The likelihood and frequency of VA use decline significantly among veterans living more than 5 miles away. Veterans with service-connected disabilities and low-income veterans, however, are less sensitive to distance.

VA Medical Facilities Are Less Accessible Than Private Facilities

VA medical facilities are located throughout the country and are outnumbered by private-sector facilities. Consequently, private-sector health care is usually more convenient to veterans than VA health care. In some urban areas, for example, VA operates one or two hospitals, while the private sector may have a dozen or more hospitals and hundreds of locations that provide primary and specialty care. While private-sector hospital and outpatient providers are less plentiful in rural areas than in urban areas, they still generally outnumber VA providers.

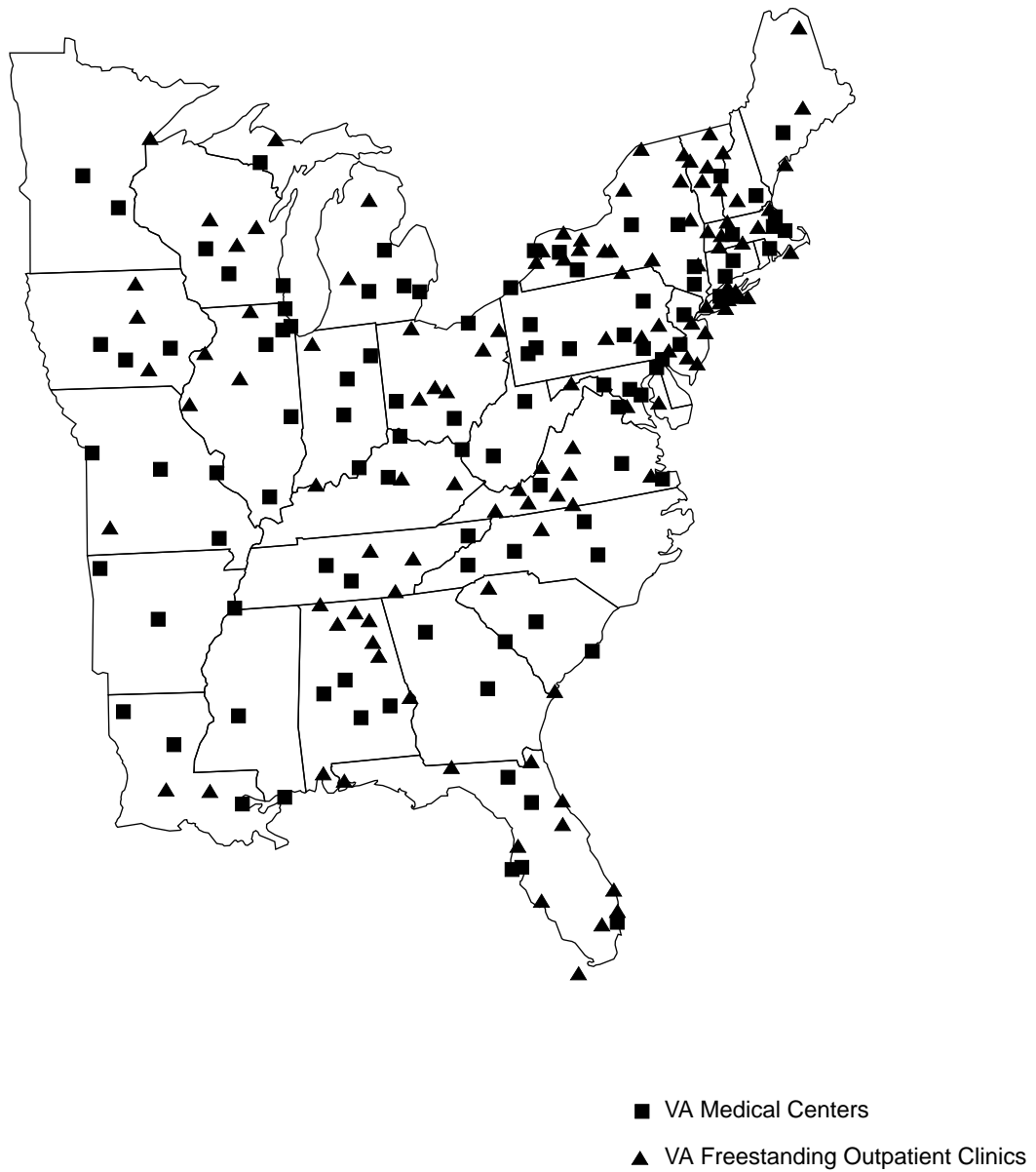
VA Health Care Facilities Are Scattered

VA hospital and outpatient clinics are often located hundreds of miles from each other, as shown in figure 1.

⁹VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

Figure 1: Locations of VA Medical Centers and Freestanding Outpatient Clinics





Some areas of the United States have more extensive VA medical coverage than others. Of VA's 158 medical centers,¹⁰ 124, or 78 percent, are located in urban areas and 33 are in rural areas.¹¹ Similarly, of VA's 187 freestanding outpatient clinics,¹² 123, or almost 66 percent, are located in urban areas and 58 are in rural areas.¹³ VA has no medical facilities in 147, or about 46 percent, of the country's 323 urban areas.

Private-sector medical facilities also significantly outnumber VA facilities. For example, in contrast to VA's 173 hospitals, there are over 6,000 public and private hospitals nationwide.

Moreover, private-sector health care programs generally target specific geographic markets and place a priority on developing extensive networks of providers. They typically strive to provide primary care within a few miles or minutes of their enrollees in urban markets and within a reasonable distance or time, albeit somewhat longer and farther, in rural areas.¹⁴ Further, while they realize that enrollees are willing to travel longer distances for specialty care, they also realize that such services must be "convenient" to attract enrollees and remain competitive with other private programs.

Comparison of Veterans' Access to VA and Private Facilities in Selected Markets

An Urban Area With a VA Medical Center

Veterans generally have less access to VA medical facilities than to private facilities, as the following market examples show. Nevertheless, VA officials said that veterans often have better access through VA facilities than through private facilities to such specialty services as mental health care, rehabilitation for the blind, and post-traumatic stress disorder care.

Veterans living in urban areas with one or more VA medical centers, such as Chicago, Illinois, may not have to travel long distances for care in VA facilities but may have to endure long travel times. Moreover, private facilities are generally more accessible.

¹⁰VA medical centers typically include one or more hospitals and a hospital-based outpatient clinic.

¹¹One VA medical center is located in Puerto Rico.

¹²Freestanding outpatient clinics are facilities that are physically separate from a VA medical center; that is, they are not located on the medical center property.

¹³VA also operates six freestanding outpatient clinics outside the United States: two in Puerto Rico, two in the Virgin Islands, one in Guam, and one in the Philippine Islands.

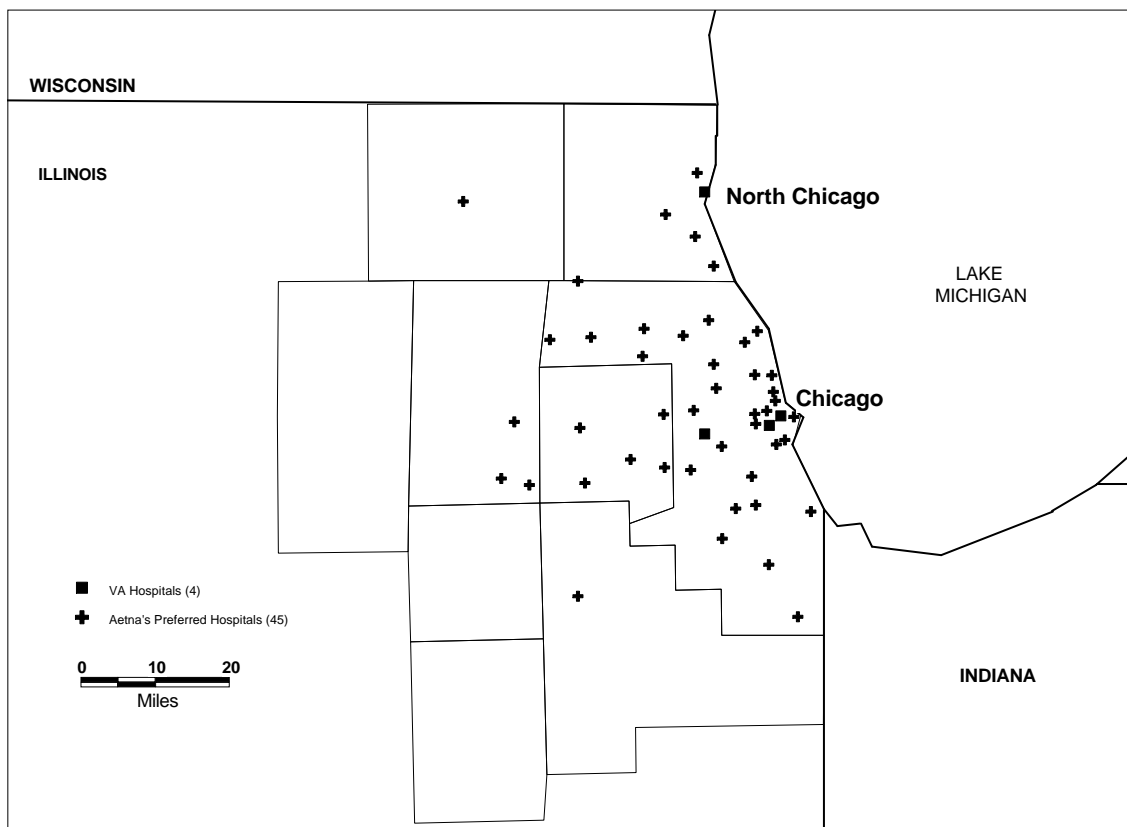
¹⁴Primary care is a point of entry into the health care system for nonemergency care.

VA operates four medical centers in the Chicago primary metropolitan statistical area, which encompasses nine counties with almost 700,000 veterans.¹⁵ Together, the four medical centers provide services ranging from primary care to highly specialized services, such as psychiatric inpatient care and treatment for spinal cord injuries. The centers provide 2,600 acute-, psychiatric-, and extended-care beds. In 1993, almost 17,000 veterans in the Chicago metropolitan area received VA inpatient services, and almost 70,000 received VA outpatient services. While over 77 percent of the veterans in the Chicago metropolitan area live within 20 miles of a medical center, traffic congestion makes these centers difficult and time-consuming to reach. When public transportation is used, travel times may exceed 1-1/2 hours.

Private facilities are often more convenient. Over 100 hospitals and thousands of primary care and specialist physicians are located in the Chicago primary metropolitan statistical area. In addition, insurance companies and managed care programs have formed networks of hospitals and physicians to offer enrollees a wide range of services located near their homes. Patients enrolled in one of Aetna's managed care plans, for example, have a choice of 45 hospitals and more than 450 sites where they can obtain primary care within the Chicago metropolitan area. (See fig. 2.) An executive from another major managed care plan serving the same area told us that the plan's goal is to provide two primary care physicians within 5 miles of every enrollee.

¹⁵The Office of Management and Budget designates areas of the country with a large population nucleus and surrounding communities that have a high degree of economic and social integration as metropolitan statistical areas.

Figure 2: Locations of Aetna Hospitals and VA Facilities in the Chicago Nine-County Primary Metropolitan Statistical Area



An Urban Area With a Freestanding VA Outpatient Clinic

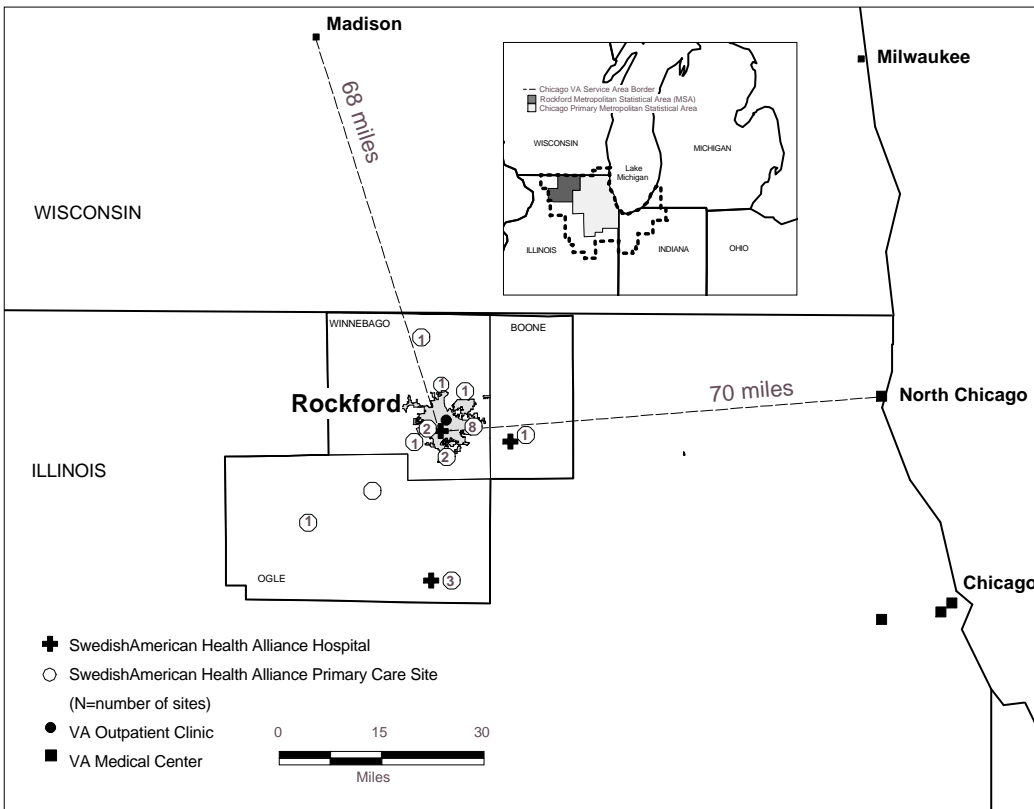
Veterans living in urban areas with only a freestanding VA outpatient clinic, such as Rockford, Illinois, often travel long distances to other VA facilities to obtain needed inpatient and specialty care. Such care is often available from nearby private providers.

VA operates one outpatient clinic in the Rockford metropolitan statistical area, which encompasses three counties with about 40,000 veterans. The VA clinic provides a broad range of primary care and some specialty services. In 1993, about 400 veterans in the Rockford metropolitan area received VA inpatient services, and about 2,200 received VA outpatient services. While almost 74 percent of these veterans lived within 10 miles of the clinic, they had to travel about 70 miles to obtain inpatient care or outpatient specialty services not available at the Rockford clinic. The

nearest VA medical centers are in Madison, Wisconsin, and North Chicago, Illinois.

According to local health care officials, private-sector care is generally available within minutes of most of the Rockford population. Rockford has three general medical and surgical hospitals that, together, have almost 1,000 hospital beds. Each has developed a network of providers. For example, the SwedishAmerican Health Alliance System includes 3 hospitals and 22 primary care sites in the Rockford metropolitan area and operates or is affiliated with many retail pharmacies, acute-care centers, and home-care and long-term care facilities in the Rockford area. (See fig. 3.)

Figure 3: Locations of SwedishAmerican Health Alliance Hospitals and Primary Care Sites and VA Facilities in the Three-County Rockford, Illinois, Metropolitan Statistical Area



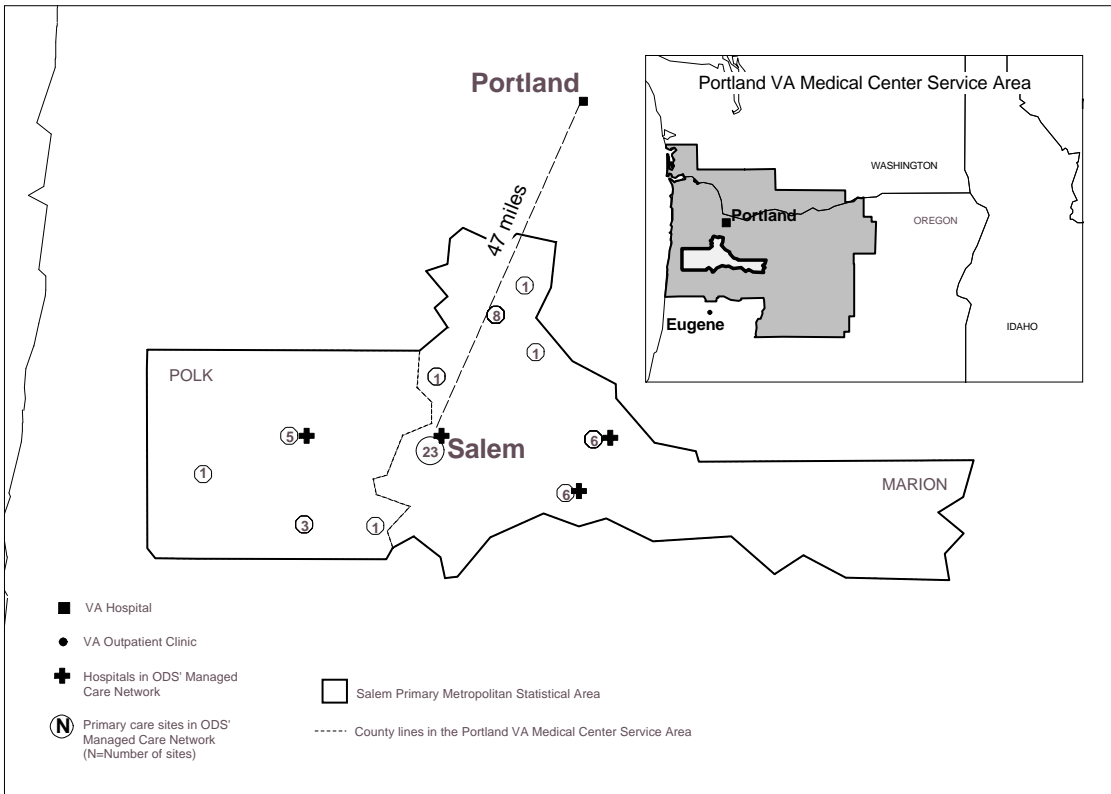
An Urban Area Without a VA Facility

Veterans living in urban areas with no VA medical facilities, such as Salem, Oregon, often travel long distances to obtain VA health care. Private providers are often nearby.

VA operates no hospital or outpatient clinic in the Salem primary metropolitan statistical area, which encompasses two counties with about 46,000 veterans. The Salem metropolitan area, situated in VA's Portland, Oregon, service area, covers 27 counties in northwest Oregon and southwest Washington. In 1993, about 600 veterans from the Salem metropolitan area received VA inpatient services, and about 2,700 received VA outpatient services. These veterans had to travel from 20 to over 70 miles to get to the Portland facility.

Many private medical facilities are located in the Salem metropolitan area, typically, according to officials of these facilities, within 20 minutes of Salem residents. One of Oregon's largest hospitals—a 454-bed facility that serves as a referral point for smaller hospitals in surrounding communities—is located within the Salem city limits, and there are three smaller hospitals in the metropolitan area as well. Physicians are widely distributed and within easy reach of most residents. In addition, the area has several private-sector managed care plans that have developed networks of providers to make care convenient for their enrollees. ODS Health Plans, for example, offers its enrollees a choice of 4 hospitals and 56 primary care sites in Salem. (See fig. 4.)

Figure 4: Locations of ODS Health Plan Hospitals and Primary Care Sites in the Salem, Oregon, Primary Metropolitan Statistical Area and the Nearest VA Facility



A Rural Area With a VA Medical Center

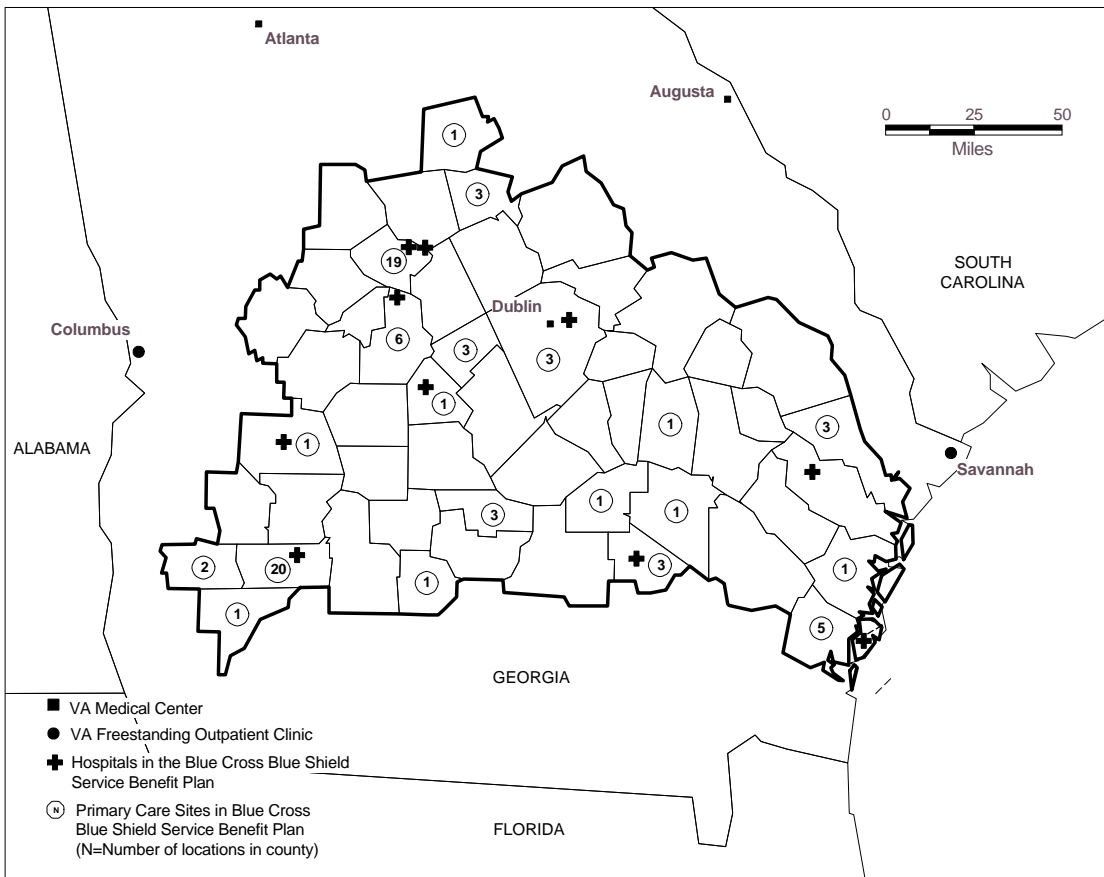
Veterans living in rural areas served by a single VA medical center, such as central Georgia, often travel long distances to obtain care in VA facilities because such facilities often serve large geographic areas. Private facilities scattered throughout the rural areas may be more convenient.

VA operates a medical center in Dublin, Georgia, a rural community about 135 miles southeast of Atlanta. The medical center is the only VA medical facility in a 52-county area with about 130,000 veterans. The facility provides primary and secondary medical, surgical, and psychiatric care, as well as extended-care services. In 1993, about 3,700 veterans in the Dublin service area received VA inpatient services, and about 14,000 received VA outpatient services. The veterans came from as far away as 70 miles to the north, 150 miles to the east, 100 miles to the south, and 140 miles to the west. Moreover, veterans needing highly specialized care are referred to

the VA medical center in Augusta, Georgia, about a 2-1/2-hour drive from Dublin.

Private medical facilities are also scattered throughout the Dublin VA medical center service area and are more accessible to veterans, with the exception of veterans living in Dublin, than is VA's medical center. In 1993, there were more than 40 medical and surgical hospitals and almost 1,400 physicians in the area. In addition, Blue Cross/Blue Shield of Georgia, which operates a preferred provider network throughout the state, offers its enrollees a choice of 10 hospitals and 79 primary care sites in the 52-county area. (See fig. 5.)

Figure 5: Locations of Blue Cross/Blue Shield Hospitals and Primary Care Sites and the VA Facility in the 52-County Dublin, Georgia, VA Medical Center Service Area



Options VA Might Explore for Improving Accessibility of VA Health Care

In February 1995, VA issued an interim policy that encouraged its field offices to employ all means at their disposal, consistent with funding availability and federal law, to improve veterans' access to VA health care. VA also authorized its offices to establish VA-operated clinics as well as VA-funded or VA-reimbursed private clinics, group practices, or individual practitioners. The directors of VA's newly created 22 networks are exploring ways to better integrate service delivery.

In developing plans for improving veterans' access to VA health care, the directors face two basic decisions: where to locate new facilities and how to operate them. Each decision involves the assessment of a variety of key factors.

Target Population Is Key Factor in Deciding Where to Locate New Facilities

A key factor that could influence VA's decisions about where to locate new medical facilities is the population to be targeted. VA has several options: (1) improve convenience for current users, (2) attract new users by improving access for all veterans, or (3) improve access for specific groups of veterans, such as those in selected eligibility categories or those residing in medically underserved areas.

Improving Access for Current Users

In improving convenience for existing users by making VA medical facilities more accessible, VA could decide, for example, to help veterans traveling great distances or times to receive care or to help the largest number of veterans, without regard to travel distances or times.

To improve convenience for current users with long travel distances or times, VA would have to establish criteria for determining reasonable travel distances or times and then assess the number of current users residing in areas beyond those distances or times. These criteria could vary depending on whether the area targeted is urban or rural. Facilities could be located so they could provide the maximum number of existing users with improved access, as illustrated in the following examples.

- In a densely populated urban area like Chicago, Illinois, one-quarter of a medical center's current users might live 10 to 20 miles from the facility. However, traffic congestion and transportation barriers might cause these veterans to travel an hour or more one way to obtain care, especially if they needed to use public transportation. A medical center could decide to make outpatient care available within 30 minutes' average travel time. That is, the center could establish facilities nearer to large numbers of current users who now have to travel significantly longer than 30 minutes.

- In a largely rural area, such as the one served by the VA medical center in Dublin, Georgia, many veterans must travel extensive distances to obtain VA care. In fiscal year 1994, over 23 percent of the outpatient visits at Dublin were by veterans living in or around Macon and Albany, Georgia, which are located approximately 50 and 100 miles away, or about 1 to 2 hours, respectively, from the medical center. A rural VA medical center like Dublin could significantly reduce the time veterans needed to travel for outpatient care by adding access points in key population centers, such as Macon or Albany.

To establish delivery sites that improve access for the largest number of current users, VA could identify large concentrations of veterans currently served. These concentrations would be likely to be within close proximity of existing medical centers. For example, a medical center in an urban area could elect to establish a nearby clinic because over one-third of its current users resided in that area. Providing a new facility in a nearby location could help alleviate overcrowding at the medical center.

Attracting New Users

Medical facilities could also be located to attract new users. VA could identify areas that have a large number of veterans who do not now receive VA care. The target population could be based on the total number of veterans in an area, as shown in the following examples.

- Officials from the Dublin, Georgia, VA medical center told us their goal was to improve the accessibility of VA health care services for new and current users. Consequently, Dublin targeted population centers in its service area, such as Macon and Albany, as possible locations for new outpatient clinics.
- Portland, Oregon, VA medical center officials told us their plans were designed to retain existing users and attract new veterans. As a result, Portland officials planned on adding access points in major urban areas of their service area, such as Salem, from which they would be likely to draw the most veterans.

VA also could target a population on the basis of a predetermined percentage of nonusers, regardless of how many veterans resided in the area. For example, a VA medical center could choose to establish a delivery site in a remote area where less than a prescribed percentage of veterans, such as 5 percent, obtained care at the medical center. By providing an access point closer to where the veterans lived, the medical center could encourage more veterans to use its health care services.

Improving Access for Selected Eligibility or Other Groups

VA's assessment of areas in which to locate new medical facilities could also consider differences in veterans' eligibility status and other factors. In general, veterans with service-connected disabilities, low-income veterans, and certain other "mandatory care" veterans, such as World War I veterans and veterans exposed to toxic substances, have the highest priority for receiving VA health care. High-income veterans without service-connected disabilities have the lowest priority.

VA could improve access for one or more of the high-priority groups. For example, a medical center could target veterans with service-connected disabilities. The center could establish medical facilities in areas with high concentrations of such veterans, providing more convenient access. Moreover, the size of the facility could be based on the estimated number of such veterans residing in the targeted area.

VA medical centers also could choose to provide better health care access for veterans living in areas where community providers are unavailable. For example, although many veterans have public or private health insurance, those that live in underserved areas may not be able to obtain care because of shortages of private providers. To improve access for such veterans, a VA medical center could identify veterans living in areas designated Health Professional Shortage Areas¹⁶ and establish a medical facility in the area.¹⁷

Resources, Market Conditions, and Private Provider Willingness to Contract With VA Are Key Factors in Deciding How to Deliver Care

VA has identified two alternative approaches for expanding access. First, it could establish VA-operated facilities, using either VA-owned or VA-leased space. Second, it could contract with non-VA providers to provide care.¹⁸ VA's decisions in this regard are likely to be primarily influenced by three factors—resources, market conditions, and the willingness of private providers to contract with VA.

¹⁶Health Professional Shortage Areas are geographic areas and population groups recognized by the federal government as having an acute shortage of health care personnel.

¹⁷In *VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs* (GAO/HEHS-95-39, Apr. 21, 1995), we discussed how well the VA health care system is meeting the health care needs of veterans and options available for reconfiguring the system to better meet veterans' needs.

¹⁸Currently, VA has authority to contract for health care services under prescribed conditions, for example, when specialized medical resources or routine treatment of certain veteran groups, such as those with service-connected conditions, is required. VA recently developed a legislative proposal to expand its contracting authority.

Resources

The availability of resources is a key factor affecting VA's decisions whether to operate new VA medical facilities or contract for care. In general, VA could assess the cost implications on a short- and long-term basis, taking into account start-up and operating costs. VA could also consider the potential for fraud, waste, and abuse.

VA-operated facilities typically require a substantial capital investment, which increases VA's costs over the short term. For example, VA would have to build, purchase, or lease a facility. It would also have to staff and equip the facility.

VA-operated medical facilities could be more costly to operate than contracting for care. Although performing valid cost comparisons is complicated, one VA medical center concluded that certain types of health care could be more expensive when delivered in a VA medical center. The medical center contracted with a community provider to furnish certain health care services to veterans at a capitation rate of \$178. A medical center official estimated that the cost to provide the same services in the VA facility would be substantially more.

Similarly, in their Fiscal Year 1995 Independent Budget for the Department of Veterans Affairs,¹⁹ veterans' service organizations estimated that adding 132 VA-operated leased clinics to VA's direct delivery system over a 4-year period could cost \$346 million—\$137 million more than the \$209 million the veterans' service organizations estimated it would cost to provide comparable services through contracts with the private sector.

VA-operated medical facilities would also be likely to result in less accessibility for veterans than could be achieved through contracting, because of high start-up and operating costs. VA could operate its own facility in an area or, for the same dollar expenditures, could contract for care at multiple locations, significantly enhancing the geographic accessibility of services to veterans living in the area. Managed care plans in the areas we visited typically contracted for care with geographically dispersed networks of physicians rather than operating their own facilities at only a few locations. In Salem, for example, most managed care plans contracted with an independent practice association that represented virtually all physicians practicing in the area. Thus, the plans were able to offer their enrollees numerous locations where they could obtain care.

¹⁹Annually, four congressionally chartered veterans' service organizations—American Veterans of World War II, Korea, and Vietnam; Disabled American Veterans; Paralyzed Veterans of America; and the Veterans of Foreign Wars of the United States—prepare and submit to the Congress an independent budget proposal for VA.

On the positive side, VA-operated facilities could give VA more control over resources, potentially lessening the risk of fraud, waste, and abuse. VA has had problems in administering contracts and sharing agreements. For example, in a 1987 audit of scarce medical specialist contracts, VA's Inspector General reported that VA medical centers had paid for services they had not received and had not established controls to ensure that contractor performance and billing complied with contract terms.²⁰ Our July 1992 follow-up to the Inspector General's report found that VA lacked assurance that these problems were identified and corrected.²¹

In addition, contracting has sometimes led to less VA control over the utilization of health care services to veterans because VA has had difficulty controlling practice patterns of private physicians. Chicago VA officials told us this was a major factor in their decision to replace a contract clinic that was reimbursed on a fee-for-service basis with a VA-operated clinic in Rockford, Illinois, in 1994. According to VA officials, reviews of the contract clinic's medical records indicated that many veterans continued to receive treatment at the clinic after their conditions had stabilized. Moreover, attempts to convince contractor physicians to discharge stable patients were unsuccessful, they said, because VA lacked direct administrative control over the physicians. While this problem could be avoided if VA contracted on a capitation basis, VA officials said that capitation contracts could lead to other problems, such as diminished services.

Market Conditions

The stability of market conditions and the competitive environment in which VA operates could affect its health care delivery decisions. In general, VA would need to ensure that its decisions included sufficient flexibility, since market conditions vary over time. Also, VA would need to ensure that its decisions considered the availability of existing providers in a particular market.

Operating its own facilities could limit VA's ability to expand or relocate operations promptly in response to changing market conditions. Expanding or relocating services could be more time consuming and difficult than modifying or renegotiating a contractual arrangement with a

²⁰Office of the Inspector General, Department of Veterans Affairs, Audits of Selected Aspects of VA's Program for Sharing Scarce Medical Resources, Report No: 7AM-A99-089 (Washington, D.C.: Department of Veterans Affairs, July 15, 1987).

²¹VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts (GAO/HRD-92-114, July 29, 1992).

private provider because clinics would need to be constructed or leased, equipped, and staffed.

Moreover, VA may be at a disadvantage in recruiting primary care physicians to operate its facilities. Only about 20 percent of VA's physicians are primary care physicians, while about 60 percent of managed care plans' physicians are typically primary care physicians. Private-sector officials we spoke with believed that VA would have difficulty increasing the number of primary care physicians to staff its facilities because of the shortage of such physicians and because VA currently is unable to match the salaries and benefits offered by managed care plans.

Further, VA-operated facilities might duplicate private-sector services in areas where the private sector has sufficient capacity, requiring VA to compete for existing patients. Several private-sector officials we spoke with questioned the need to open new VA outpatient facilities, especially in urban areas where the private sector already provides sufficient access. In these cases, contracting with existing providers might be a more viable option for improving access.

Conversely, VA-operated facilities might be a more viable option in areas that are underserved by the private sector. Some rural and inner-city areas, for example, suffer from a shortage of physicians. In other areas, physicians may have full practices and, as a result, be unlikely to take on additional patients. Thus, if VA wanted to improve access for veterans in such areas it might be able to do so only by establishing its own facility.

Willingness of Private Providers to Contract With VA

Finally, even if VA chose to do so, it could have difficulty contracting for veterans' health care. Several private-sector officials indicated that providers would be cautious about entering into capitation arrangements with VA because the risk of financial loss would be too high. They said that the VA patient population is perceived as being sicker and, therefore, more expensive to care for than the general population. At the same time, they questioned the willingness of VA to provide an adequate level of reimbursement, particularly under a capitation arrangement.

A medical center in Chicago recently encountered such an obstacle. The VA medical center proposed establishing a VA-operated outpatient clinic in its service area after failing to interest three local health maintenance organizations (HMO) in providing services on a capitation basis. The HMOs were not interested because they believed the medical histories of the medical center's patients represented too high an underwriting risk. The

HMOS, according to medical center officials, were unwilling to develop a rate for patients outside their normal risk definition.

In addition, officials at two managed care plans expressed concern about contracting with VA because doing so could adversely affect veteran patients' care. Non-VA physicians who lacked admitting rights in VA hospitals would be required to relinquish control of patients needing inpatient care to VA physicians. Officials at one managed care plan said that their physicians would not be likely to be receptive to such an arrangement because they would lose the ability to ensure continuity of care for their patients. Similarly, officials from another plan said that contracting only for primary care would result in veterans' seeing physicians from two different care systems—their plan and VA. This, they said, would make tracking their patients difficult.

Finally, some private-sector officials believed that many providers would be reluctant to contract with VA because of their unwillingness to deal with excessive government contracting requirements and regulations.

Conclusions

Veterans' access to VA health care could improve significantly if medical centers employed all means at their disposal to expand access, as VA's February 1995 interim policy encourages centers to do. While medical centers have numerous options in locating new facilities, selecting a target population, such as current or new users, poses a difficult policy choice. Also, medical centers' decisions on how to operate new facilities—directly or by contracting—require the evaluation of several key factors on a facility-specific basis to ensure care is delivered in the most appropriate manner. Overall, medical centers will be likely to use a variety of options tailored specifically to the variabilities of local conditions.

Agency Comments and Our Evaluation

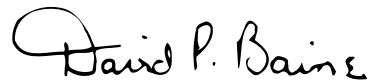
We obtained comments on a draft of this report from VA officials, including the Deputy Secretary for Health. The officials agreed with the basic concepts in our report. They cautioned, however, that evaluating veterans' access to health care and improving access may be more complex, in reality, than the report appears to suggest. For example, they said that the availability of a large number of private-sector medical facilities does not ensure that veterans can receive needed care from such facilities, noting that veterans often need such special services as psychiatric care and rehabilitation for blindness. We revised the report to show that we focused on veterans' access to standard health care benefits. VA officials also

suggested some technical changes, primarily for clarification. We incorporated the suggestions as appropriate.

Copies of this letter are being sent to the Chairmen and Ranking Minority Members of the House and Senate Committees on Veterans' Affairs and the Secretary of Veterans Affairs. Copies will be made available to others upon request.

Please call me at (202) 512-7101 if you have any questions or need additional assistance. Other GAO contacts and contributors to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink that reads "David P. Baine". The signature is written in a cursive style with a large initial "D".

David P. Baine
Director, Federal Health Care
Delivery and Quality Issues

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
HMO	health maintenance organization
VA	Department of Veterans Affairs

Scope and Methodology

To obtain information on users of VA medical facilities, we reviewed VA's studies of the status of veterans in 1987 and 1992²² and previous GAO VA health care reports.²³

To compare the accessibility of VA and private-sector facilities, we categorized VA's existing facilities into four general markets: urban and rural areas with medical centers and urban and rural areas with freestanding outpatient clinics. We also identified urban areas where VA operates no medical facilities. We visited the following locations:

- Chicago, Illinois—an urban area where VA operates a medical center,
- Rockford, Illinois—an urban area where VA operates a freestanding outpatient clinic,
- Salem, Oregon—an urban area where VA has no medical facilities, and
- Dublin, Georgia—a rural area where VA operates a medical center.

For purposes of this report, we considered metropolitan statistical areas and primary metropolitan statistical areas as urban areas. The Office of Management and Budget defines a metropolitan statistical area as either (1) an area that includes at least one city with a population of at least 50,000 or (2) a Census Bureau-defined urbanized area of at least 50,000 inhabitants and a total metropolitan population of 100,000 (75,000 in New England). Metropolitan statistical areas with populations of 1 million or more are called consolidated metropolitan statistical areas if separate component areas, or primary metropolitan statistical areas, can be identified in the areas.²⁴ We used the primary metropolitan statistical area rather than the consolidated metropolitan statistical area to determine whether VA had medical facilities in urban areas. For example, both Portland and Salem, Oregon, are part of the same consolidated metropolitan statistical area but are separate primary metropolitan statistical areas. VA has a medical center located in Portland, and we classified the Portland primary metropolitan statistical area as an urban area with a VA medical center. The Salem primary metropolitan statistical area has no VA facility, and we classified it as an urban area with no VA medical facilities.

²²1987 Survey of Veterans (July 1989) and National Survey of Veterans (Apr. 1995).

²³We made extensive use of two reports: GAO/HEHS-94-113FS, Mar. 29, 1994, and GAO/HEHS-96-31, Dec. 20, 1995.

²⁴As of June 1993, there were 250 metropolitan statistical areas and 18 consolidated metropolitan statistical areas consisting of 73 primary metropolitan statistical areas in the United States.

The four study locations were selected as a nonrandom judgmental sample representing VA's typical market categories and a diversity of geographic areas. In Chicago and Dublin, we met with local VA officials to discuss the accessibility of VA's health care facilities and options for improving access. For Rockford, we met with local and North Chicago VA Medical Center (the parent facility) officials. For Salem, we met with officials from the VA medical center in Portland, Oregon, the closest VA medical facility.

In each location, we also met with private-sector hospital and managed care plan officials to obtain information about the local health care market and the accessibility of their health care services. In each market area, we used the provider directory of one managed care plan to determine the number of primary care sites and hospitals available to the plan's enrollees. A provider directory is a listing of the hospitals, physicians, and other health care providers affiliated with the managed care plan. We graphically depicted these facilities and VA's facilities on maps of the four locations. The list of organizations contacted follows.

Chicago, Illinois

-
- | | |
|----|--|
| VA | <ul style="list-style-type: none">• Lakeside VA Medical Center• North Chicago VA Medical Center• Crown Point Outpatient Clinic |
|----|--|

-
- | | |
|----------------|--|
| Private Sector | <ul style="list-style-type: none">• Blue Cross/Blue Shield of Illinois• Chicago HMO• Aetna Health Plans• Northwestern HealthCare Network• HealthNetwork• Highland Park Hospital |
|----------------|--|

Rockford, Illinois

-
- | | |
|----|--|
| VA | <ul style="list-style-type: none">• Rockford Outpatient Clinic |
|----|--|

-
- | | |
|----------------|--|
| Private Sector | <ul style="list-style-type: none">• SwedishAmerican Health Alliance System |
|----------------|--|

-
- Rockford Health System

Salem, Oregon

-
- VA
- Portland VA Medical Center

-
- Private Sector
- HMO Oregon (Blue Cross/Blue Shield of Oregon)
 - Kaiser Permanente
 - ODS Health Plans
 - PacifiCare Health Systems
 - SelectCare Health Plans
 - Salem Hospital

Dublin, Georgia

-
- VA
- Carl Vinson VA Medical Center

-
- Private Sector
- Fairview Park Hospital
 - Blue Cross/Blue Shield of Georgia (Macon, Georgia)

To determine how far veterans in our study areas lived from a VA medical facility, we computed the distance from zip codes where the veterans lived to the closest VA medical facility in the area (that is, the Chicago primary metropolitan statistical area; the Rockford metropolitan statistical area; the Salem primary metropolitan statistical area; and Dublin service areas, as defined by VA). If VA had no facilities in the area, we computed the distance to the nearest VA facility. For example, in the Chicago, Illinois, primary metropolitan statistical area, we computed the distance from the zip codes where veterans lived to the closest of VA's four medical facilities in the area; in the Salem, Oregon, area, which had no VA facility, we computed the distance from where the veterans lived to the VA facility in Portland, Oregon, the VA facility closest to Salem.

We also used these zip codes to determine the number of veterans living and receiving services in the study areas. We applied 1990 U.S. census data to these zip codes to determine the number of veterans living in each study area. We applied data from VA's fiscal year 1993 Outpatient and Patient

Treatment databases²⁵ to these zip codes to determine the number of veterans who received VA outpatient and inpatient services in each study area.

To identify the factors VA considers in deciding where to locate new medical facilities and whether to add new VA-operated facilities or contract with private providers, we reviewed VA policy directives and other guidance and interviewed VA central office and selected medical center officials. We also reviewed prior GAO reports and other studies. In addition, we met with VA Office of General Counsel officials to discuss VA's contracting authority. We also discussed contracting and expanding VA's direct delivery system with officials from the private-sector organizations we visited.

²⁵VA's Outpatient File lists all veterans who received VA outpatient services each year. VA's Patient Treatment File lists all veterans discharged from a VA Medical Center each year. Both databases track veterans' zip codes.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Abigail Ohl provided assistance with data gathering and analysis, and Ann McDermott, Angela Pun, and Joan Vogel prepared the graphics.

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