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HEALTH CARE ACCESS

Opportunities to Target Programs and Improve Accountability

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Health Care Access: Opportunities to Target Programs and Improve Accountability

Mr Chairman and Members of the Subcommittee:

We are pleased to be here today to expand on our testimony regarding the Rural Health Clinic program that we presented to you last February. In that testimony, we said that the program did not focus on improving access to care in areas that most needed it. Today, we would like to discuss our findings in the broader context of our past reviews of federal efforts to improve access to primary health care. The federal government spends billions of dollars each year on programs like the Rural Health Clinic program that, in whole or part, are aimed at achieving this objective. I would like to (1) summarize the common problems we found and some recent initiatives to address them and (2) discuss how the type of management changes called for under the Government Performance and Results Act of 1993 (Results Act) can help the Rural Health Clinic and related programs improve accountability.

In brief, our work has identified many instances in which the Rural Health Clinic program and other federal programs have provided aid to communities without ensuring that this aid has been used to improve access to primary care. In some cases, programs have provided more than enough assistance to eliminate the defined shortage, while needs in other communities remain unaddressed. Our work has identified a pervasive cause for this problem: a reliance on flawed systems for measuring health care shortages. These systems often do not work effectively to identify which programs would work best in a given setting or how well a program is working to meet the needs of the underserved once it is in place. For several years, the Department of Health and Human Services (HHS) has tried unsuccessfully to revise these systems to address these problems. The goal-setting and performance measurement discipline available under the Results Act, however, appears to offer a suitable framework for ensuring that programs are held accountable for improving access to primary care.

Background

All communities contain populations that may have difficulty accessing primary health care services for reasons such as geographic isolation or, more often, inability to pay for care. Multiple federal agencies, often with state and local governments as partners, have long supported a broad range of programs to remedy these access problems. The largest and best known is Medicaid, which spent over $161 billion in fiscal year 1996 on health and long-term care for low-income Americans considered to be

unable to purchase services.[1] However, over 30 other programs exist. (See appendix for an overview of some of these programs.) These other programs, which collectively spent more than $1 billion a year as of 1996, use one of three strategies aimed to ensure that all populations have access to care.

- Providing incentives to health professionals practicing in underserved areas. Under the Rural Health Clinic and Medicare Incentive Payment programs, providers are given additional Medicare and/or Medicaid reimbursement to practice in underserved areas. In 1996, these reimbursements amounted to over $400 million. In addition, over $112 million was spent on the National Health Service Corps program, which supports scholarships and repays education loans for health care professionals who agree to practice in designated shortage areas. Under another program, called the J-1 Visa Waiver, U.S. trained foreign physicians are allowed to remain in the United States if they agree to practice in underserved areas.[2]
- Paying clinics and other providers caring for people who cannot afford to pay. More than $758 million funded programs that provide grants to help underwrite the cost of medical care at community health centers and other federally qualified health centers. These centers also receive higher Medicare and Medicaid payments. Similar providers also receive higher Medicare and Medicaid payments as "look-alikes" under the Federally Qualified Health Center program.
- Paying institutions to support the education and training of health professionals. Medical schools and other teaching institutions received over $238 million in 1996 to help increase the national supply, distribution, and minority representation of health professionals through various education and training programs under Titles VII and VIII of the Public Health Service Act.

[1]Medicaid is a joint federal-state program, which in fiscal year 1996 financed health care for about 37 million low-income, blind, disabled, and elderly people. The federal contribution to state Medicaid programs in that year amounted to $91.9 billion or about 57 percent of the $161.2 billion total. In 1995, more than 70 percent of Medicaid expenditures paid for care for the elderly, blind, and disabled and for payments to hospitals serving large numbers of Medicaid and low-income patients under the Disproportionate Share Hospital program.

[2]In 1995, 4 federal agencies and 23 states requested waivers to requirements that foreign physicians return to their home country after completing U.S. medical training under a J-1 visa.

Programs Need to Improve Their Focus on Access Problems

Over the past several years, we have issued a number of reports examining most of these programs.[3] Our findings show that while the Rural Health Clinic program and other federal programs have provided resources to improve access to primary care, the programs historically have not been held accountable for showing that access has indeed improved. Here are some examples:

- The Rural Health Clinic program—which had an original purpose to subsidize health care in remote rural areas lacking physicians—now costs Medicare and Medicaid more than $295 million a year[4] to primarily subsidize care in cities and towns already having substantial health care resources. Our review of a sample of clinics showed that the availability of care did not change appreciably for at least 90 percent of Medicare and Medicaid beneficiaries using the clinics. Staff we interviewed at most clinics said they did not use the subsidies to expand access to underserved portions of the population or need the subsidies to remain financially viable.[5]
- The Medicare Incentive Payment program, created out of concern that physicians would not treat Medicare patients due to low Medicare reimbursement rates, pays all physicians in designated shortage areas a 10-percent bonus on Medicare billings. Physicians receive bonus payments now totaling over $100 million each year, even in shortage areas where Medicare patients are not underserved or where low Medicare reimbursement rates are not the cause of underservice.[6]
- Federal and state programs placing providers in underserved areas have oversupplied some communities and states with providers, while others received none. Considering the National Health Service Corps program alone, at least 22 percent of shortage areas receiving National Health Service Corps providers in 1993 received providers in excess of the

[3]We have not reviewed how health center grants or benefits provided to other federally qualified health centers improved access to care. However, we did review HHS budget documentation for programs directed at relieving underservice, including the health center programs.

[4]This is the estimated additional cost to the Medicare and Medicaid programs due to higher payment rates to rural health clinics.

[5]We reviewed the health care resources of a sample of communities where 144 rural health clinics were certified in 4 states: Alabama, Kansas, New Hampshire, and Washington. We analyzed past access to care for Medicare and Medicaid beneficiaries using 119 of these clinics, and subsequently interviewed staff at 76 of the clinics. See Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996) and related testimony (GAO/T-HEHS-97-65, Feb. 13, 1997).

[6]See Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995).

number needed to remove federal designation as a shortage area,[7] while 785 shortage areas requesting providers did not receive any providers at all. Of these latter locations, 143 had unsuccessfully requested a National Health Service Corps provider for 3 years or more.[8] Taking other provider placement programs into account shows an even greater problem in effectively distributing scarce provider resources. For example, HHS identified a need for 54 physicians in West Virginia in 1994, but more than twice that number—116 physicians—were placed there using the National Health Service Corps and J-1 Visa Waiver programs. We identified eight states where this occurred in 1995.[9]

- While almost $2 billion has been spent in the last decade on Title VII and VIII education and training programs, HHS has not gathered the information necessary to evaluate whether these programs had a significant effect on changes that occurred in the national supply, distribution, or minority representation of health professionals or their impact on access to care. Evaluations often did not address these issues, and those that did address them had difficulty establishing a cause-and-effect relationship between federal funding under the programs and any changes that occurred. Such a relationship is difficult to establish because the programs have other objectives besides improving supply, distribution, and minority representation and because no common goals or performance measures for improving access had been established.[10]

Limitations of Existing Approaches Used to Measure Need and Target Assistance

Our work has shown that these programs share a common problem: HHS does not have a way to effectively match the various programs with the specific kinds of access problems that exist. Its systems for identifying underservice are so general that they often are of little help in identifying who is underserved and why. Likewise, these systems are often of little use in measuring whether a program, once applied, is having any effect on

[7]In creating the federal health professional shortage area designation system, federal intervention was considered justified only if the number of health care providers was significantly less than adequate, indicating that the needs of these areas were not being met through free-market mechanisms or reimbursement programs.

[8]See National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement (GAO/HEHS-96-28, Nov. 24, 1995).

[9]For these eight states, the number of J-1 visa physicians for whom waivers were processed in 1994 and 1995, combined with the number of National Health Service Corps physicians in service at the end of 1995, exceeded the number of physicians to remove health professional shortage area designations in the state. See Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Shortage Areas (GAO/HEHS-97-26, Dec. 30, 1996).

[10]See Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care is Unclear (GAO/HEHS-94-164, July 8, 1994) and Health Professions Education: Clarifying the Role of Title VII and VIII Programs Could Improve Accountability (GAO/HEHS-97-117, Apr. 25, 1997).

the problem. Despite 3 decades of federal efforts, the number of areas HHS has classified as underserved using these systems has not decreased.

HHS uses two systems to identify and measure underservice: the Health Professional Shortage Area (HPSA) system and the Medically Underserved Area (MUA) system. First used in 1978 to place National Health Service Corps providers, the HPSA system is based primarily on provider-to-population ratios. In general, HPSAs are self-defined locations with fewer than one primary care physician for every 3,500 persons.[11] Developed at about the same time, the MUA system more broadly identifies areas and populations considered to have inadequate health services, using the additional factors of poverty and infant mortality rates and percentage of population aged 65 or over.

We previously reported on the long-standing weaknesses in the HPSA and MUA systems in identifying the types of access problems in communities and in measuring how well programs focus services on the people who need them, including the following:

- The systems have relied on data that are old and inaccurate. About half of the U.S. counties designated as medically underserved areas since the 1970s would no longer qualify as such if updated using 1990 data.[12]
- Formulas used by the systems, such as physician-to-population ratios, do not count all primary care providers available in communities, overstating the need for additional physicians in shortage areas by 50 percent or more. The systems fail to count the availability of those providers historically used by the nation to improve access to care, such as National Health Service Corps physicians and U.S. trained foreign physicians, as well as nurse practitioners, physician assistants, and nurse midwives.

One result of such problems is the sheer number of HPSAs and MUAs that now exist, minimizing the usefulness of the systems in targeting assistance. Eighty-eight percent of all U.S. counties had HPSAs, MUAs, or both as of June 1995. Even when the systems accurately identify needy areas, they often do not provide the information needed to decide which programs are best suited to an area's particular need. Designations are generally made for broad geographic areas without considering the

[11]Under certain circumstances, the ratio used to designate a primary care HPSA may be 1 to 3,000. HHS has different criteria for dental and mental health HPSAs.

[12]MUAs are designated based on a relative ranking of all U.S. counties, minor civil divisions, and census tracts that occurred in 1975 and 1976. All areas that ranked below the county median combined score for the four criteria were designated as MUAs. MUAs have been added since then on the basis of newer data and the same cutoff score.

demand for services. As a result, the systems do not accurately identify whether access problems are common for everyone living in the area, or whether only specific subpopulations, such as the uninsured poor, have difficulty accessing primary care resources that are already there but underutilized. Without additional criteria to identify the type of access barriers existing in a community, programs may not benefit the specific subpopulation with insufficient access to care.

The Rural Health Clinic program, established to improve access in remote rural areas, illustrates this problem. Under the program, all providers located in rural HPSAs, MUAs, and HHS-approved state-designated shortage areas can request rural health clinic certification to receive greater Medicare and Medicaid reimbursement. However, if the underserved group is the uninsured poor, such reimbursement does little or nothing to address the access problem. Most of the 76 clinics we surveyed said the uninsured poor made up the majority of underserved people in their community, yet only 16 said they offered health services on a sliding-fee scale based on the individual's ability to pay for care. Even if rural health clinics do not treat the group that is actually underserved, they receive the higher Medicare and Medicaid reimbursement, without maximum payment limits if operated by a hospital or other qualifying facility. These payment benefits continue indefinitely, regardless of whether the clinic is no longer in an area that is rural and underserved.

Last February, we testified before this Subcommittee that improved cost controls and additional program criteria were needed for the Rural Health Clinic program. In August of this year, the Balanced Budget Act of 1997 made changes to the program that were consistent with our recommendations. Specifically, the act placed limits, beginning next January, on the amount of Medicare and Medicaid payments made to clinics owned by hospitals with more than 50 beds. The act also made changes to the program's eligibility criteria in the following three key areas:[13]

- In addition to being located in a rural HPSA, MUA, or HHS-approved state-designated shortage area, the clinic must also be in an area in which the HHS Secretary determines there is an insufficient number of health care practitioners.
- Clinics are allowed only in shortage areas designated within the past 3 years.

[13]The act also contains provisions related to quality assurance, staffing requirements, and payment for physician assistant services. In addition, the act allows states to begin limiting the higher Medicaid payments to rural health clinics starting in fiscal year 2000.

- Existing clinics that are no longer located in rural shortage areas can remain in the program only if they are essential for the delivery of primary care that would otherwise be unavailable in the area, according to criteria that the HHS Secretary must establish in regulations by 1999.

Limiting payments will help control program costs. But until, and depending on how, the Secretary defines the types of areas needing rural health clinics, HHS will continue to rely on flawed HPSA and MUA systems that assume providing services to anyone living in a designated shortage area will improve access to care.

HHS has been studying changes needed to improve the HPSA and MUA systems for most of this decade, but no formal proposals have been published. In the meantime, new legislation continues to require the use of these systems, thereby increasing the problem. For example, the newly enacted Balanced Budget Act authorizes Medicare to pay for telehealth services—consultative health services through telecommunications with a physician or qualifying provider—for beneficiaries living in rural HPSAs. However, since HPSA qualification standards do not distinguish rural communities that are located near a wide range of specialty providers and facilities from truly remote frontier areas, there is little assurance that the provision will benefit those rural residents most in need of telehealth services.

Implementation of the Government Performance and Results Act Provides an Opportunity to Address Identified Problems

To make the Rural Health Clinic program and other federal programs more accountable for improving access to primary care, HHS will have to devise a better management approach to measure need and evaluate individual program success in meeting this need. If effectively implemented, the management approach called for under the Results Act offers such an opportunity. Under the Results Act, HHS would ask some basic questions about its access programs: What are our goals and how can we achieve them? How can we measure our performance? How will we use that information to improve program management and accountability? These questions would be addressed in annual performance plans that define each year's goals, link these goals to agency programs, and contain indicators for measuring progress in achieving these goals. Using information on how well programs are working to improve access in communities, program managers can decide whether federal intervention has been successful and can be discontinued, or if other strategies for addressing access barriers that still exist in communities would provide a more effective solution.

Establishing Results-Oriented Performance Goals and Measures

The Results Act provides an opportunity for HHS to make sure its access programs are on track and to identify how efforts under each program will fit within the broader access goals. The Results Act requires that agencies complete multi-year strategic plans by September 30, 1997, that describe the agency's overall mission, long-term goals, and strategies for achieving these goals.[14] Once these strategic plans are in place, the Results Act requires that for each fiscal year, beginning fiscal year 1999, agencies prepare annual performance plans that expand on the strategic plans by establishing specific performance goals and measures for program activities set forth in the agencies' budgets. These goals are to be stated in a way that identifies the results—or outcomes—that are expected, and agencies are to measure these outcomes in evaluating program success. Establishing performance goals and measures such as the following could go far to improve accountability in HHS' primary access programs.

- The Rural Health Clinic program currently tracks the number of clinics established, while the Medicare Incentive Payment program tracks the number of physicians receiving bonuses and dollars spent. To focus on access outcomes, HHS will need to track how these programs have improved access to care for Medicare and Medicaid populations or other underserved populations.
- Success of the National Health Service Corps and health center programs has been based on the number of providers placed or how many people they served. To focus on access outcomes, HHS will need to gather the information necessary to report the number of people who received care from National Health Service Corps providers or at the health centers who were otherwise unable to access primary care services available in the community.

Establishing performance goals will also help clarify how each program "fits" into HHS' overall portfolio of programs to improve access to primary care. HHS has established national outcome-based goals and objectives for the year 2000 through its Healthy People 2000 initiative,[15] including the objective of increasing the proportion of Americans with a usual source of primary care from 84 percent in 1994 to 95 percent in the year 2000. HHS uses the results from its National Health Interview Survey, an existing

[14]The results of our review of HHS' draft strategic plan can be found in The Results Act: Observations on the Department of Health and Human Services' April 1997 Draft Strategic Plan (GAO/HEHS-97-173R, July 11, 1997).

[15]Healthy People 2000 is the U.S. Public Health Service's national public health initiative to improve the health of all Americans. In consultation with stakeholders, other government agencies, and the public health community, the Public Health Service developed a series of outcome-based public health goals and measures.

survey, to measure progress toward this goal by counting the number of people across the nation who do and do not have a usual source of primary care. For those people without a usual source of primary care, the survey categorizes the reasons for this problem that individual programs may need to address, such as people's inability to pay for services, their perception that they do not need a physician, or the lack of provider availability.

Although HHS officials have started to look at how individual programs fit under these national goals, they have not yet established links between the programs and national goals and measures. Such links are important so resources can be clearly focused and directed to achieve the national goals. For example, HHS' program description, as published in the Federal Register, states that the health center programs directly address the Healthy People 2000 objectives by improving access to preventive and primary care services for underserved populations. While HHS' fiscal year 1998 budget documents contain some access-related goals for health center programs, it also contains other goals, such as creating 3,500 jobs in medically underserved communities. Although creating jobs may be a desirable by-product of supporting health center operations, it is unclear how this employment goal ties to national objectives to ensure access to care. Under the Results Act, HHS has an opportunity to clarify the relationships between its various program goals and define their relative importance at the program and national levels.

Developing Better Information on the Cost-Effectiveness of Its Programs

Viewing program performance in light of program costs—such as establishing a unit cost per output or outcome achieved—can help HHS and the Congress make informed decisions on the comparative advantage of continuing current programs.[16] For example, HHS and the Congress could better determine whether the effects gained through the program were worth their costs—financial and otherwise—and whether the current program was superior to alternative strategies for achieving the same goals. Unfortunately, in the past, information needed to answer these questions has been lacking or incomplete, making it difficult to determine how to get the "biggest bang for the buck."

This is not just a theoretical point. Our work has shown the value of analyzing and comparing costs. For example, our review of the National Health Service Corps program showed the benefits of using comparative

[16]We previously reported on the type of information needed to oversee and evaluate federal programs; see Program Evaluation: Improving the Flow of Information to the Congress (GAO/PEMD-95-1, Jan. 30, 1995).

cost information to allocate resources between its scholarship and loan repayment programs. While both of these programs pay education expenses for health professionals who agree to work in underserved areas, by law, at least 40 percent of amounts appropriated each year must fund the scholarship program and the rest may be allocated at the HHS Secretary's discretion. However, our analysis found that the loan repayment program costs the federal government at least one-fourth less than the scholarship program for a year of promised service and was more successful in retaining providers in these communities. Changing the law to allow greater use of the loan repayment program would provide greater opportunity to stretch program dollars and improve provider retention. Comparisons between different types of programs may also indicate areas of greater opportunity to improve access to care. However, the per-person cost of improving access to care under each program is unknown. Collecting and reporting reliable information on the cost-effectiveness of HHS programs is critical for HHS and the Congress to decide how to best spend scarce federal resources.

Conclusion

Although the Rural Health Clinic program and other federal programs help to provide health care services to many people, the magnitude of federal investment creates a need to hold these programs accountable for improving access to primary care. The current HPSA and MUA systems are not a valid substitute for developing the program criteria necessary to manage program performance along these lines. The management discipline provided under the Results Act offers direction in improving individual program accountability. Once it finalizes its strategic plan, HHS can develop in its annual performance plans individual program goals for the Rural Health Clinic program and other programs that are consistent with the agency's overall access goals, as well as outcome measures that can be used to track each program's progress in addressing access barriers.

This program performance information can assist HHS' operating divisions, such as the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA), in better managing its programs toward a common goal. In addition, this information can assist in determining whether strategies such as providing higher Medicare and Medicaid reimbursement rates under the Rural Health Clinic program are still needed to improve access to care, or whether directing federal dollars to other strategies, such as those addressing the inability to pay for

services, would have greater effect in achieving HHS' national primary care access goals.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or members of the Subcommittee may have.

Selected Federal Programs Addressing Medical Underservice

Total FY96 federal funding (in millions)	Overall strategy to address cause of underservice	Program (amount of federal funding)	Program strategy used to address cause of underservice	Agency administering program
$514	Providing incentives to health professionals in underserved areas	Rural Health Clinic ($295)[a]	Pay higher Medicare and Medicaid rates to physicians and nonphysicians in underserved areas	HCFA
		Medicare Incentive Pay ($107)	Provide 10% bonus on Medicare payments to all physicians in shortage areas	HCFA
		National Health Service Corps ($112)	Pay education costs of providers agreeing to locate in shortage areas	HRSA and states
		J-1 Visa Waiver ($0)	Allow foreign physicians (exchange-visitors) to remain in the U.S. if they practice in shortage areas	Multiple federal agencies and states
$758+	Paying clinics and providers caring for people unable to pay	Health Centers Grants[b] ($758)	Subsidize certain providers willing to see patients regardless of their ability to pay	HRSA
		Federally Qualified Health Center[c]	Higher Medicare and Medicaid payments to certain providers willing to see patients regardless of their ability to pay	HCFA
$238	Paying institutions to support education and training of health professionals	Title VII/VIII Health Education and Training Programs[d] ($238)	Pay health professions schools to support training of health professionals	HRSA

[a]Estimated additional cost to Medicare and Medicaid programs due to higher payment rates to rural health clinics.

[b]Includes four health center programs: Community, Migrant, Homeless, and Residents of Public Housing. Prior to the Health Center Consolidation Act of 1996 (P.L. 104-299, Oct. 11, 1996), these programs were authorized under sections 329, 330, 340, and 340A of the Public Health Service Act.

[c]Includes health center grantees, as well as health centers that qualify for a federal grant but do not receive one. Medicare and Medicaid costs associated with this program are unknown.

[d]Includes 30 programs for increasing the supply, distribution, and minority representation of health professionals.

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