United States General Accounting Office

GAO

Report to the Chairman, Committee on Veterans' Affairs, U.S. Senate

September 1992

VA HEALTH CARE

Use of Private Providers Should Be Better Controlled

GAO/HRD-92-109

GAO

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

Human Resources Division

B-249947

September 28, 1992

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) faces a serious management challenge in dealing with rising medical costs. In fiscal year 1990, VA spent about $112 million for outpatient medical care purchased from private health care providers on a fee-for-service basis. You questioned whether VA could provide more of this care in its own facilities at less cost. Specifically, you asked us to determine whether VA had proper controls in place to ensure that its purchases of private medical care are appropriate.

To respond to your request, we (1) reviewed VA's policies and procedures for purchasing private outpatient medical care; (2) reviewed medical and administrative files for a sample of veterans at the Salem, Richmond, and Hampton, Virginia, medical centers to assess how these policies and procedures were implemented; (3) reviewed VA Inspector General reports to identify problems concerning private medical care purchases by other medical centers; and (4) visited the Lebanon, Pennsylvania, and San Francisco, California, medical centers to assess how they resolved problems that the Inspector General had identified. Appendix I discusses the scope and methodology of our work in more detail.

Results in Brief

VA is not adequately controlling medical centers' purchases of private outpatient medical care for veterans. Centers may use private providers only if the needed care is not available at the VA center or private providers can provide care more economically than VA, due to geography. However, VA has not issued clear guidance to medical centers on how this requirement is to be implemented. As a result, centers are not evaluating the cost-effectiveness of private care, as needed, when the centers have the capability to provide the needed services. They may be needlessly purchasing millions of dollars of medical care from private providers, when the care could be more economically provided in VA facilities.

Background

VA operates the nation's largest health care delivery system. Of its 171 hospitals and 240 outpatient clinics, most are organized into 159 medical centers. In fiscal year 1990, these centers spent over $11 billion providing

care to about 2.6 million veterans, including about 21 million visits to VA outpatient clinics. During that year, VA also paid about $112 million for over 1 million outpatient visits that about 223,000 veterans made to private providers. (App. II shows fiscal year 1990 expenditures for private medical outpatient care by VA clinic of jurisdiction.) These providers include physicians, clinics, group practices, nurses, and others who provide medical treatment, rehabilitation services, minor surgical procedures, medication, and medical supplies.

Private Care Eligibility Requirements

Veterans who seek care at VA expense are to obtain such care in VA facilities. However, VA may purchase care for certain veterans from private providers when needed care is unavailable in VA facilities or cannot be economically provided in VA facilities due to the veterans' geographic inaccessibility to a VA facility. Eligible veterans include those who need outpatient care for (1) a service-connected disability[1] or (2) a condition that was treated during a VA hospital stay. (App. III shows a complete listing of criteria for determining veterans' eligibility for receiving private care at VA expense.)

When determining a veteran's geographic inaccessibility, VA guidelines require clinics to consider such factors as the existence of severe medical conditions that make it necessary for the veteran to travel by ambulance to a VA facility or the veteran's accessibility to reasonable public and private transportation. VA guidelines state that the distance from a veteran's residence to a VA facility does not by itself constitute geographic inaccessibility. As such, clinics are instructed not to establish arbitrary mileage boundaries or routinely authorize private care for veterans based on the number of miles they live from VA facilities.

For veterans judged to be geographically inaccessible, VA policy requires a comparison of the combined costs of travel to and care in a VA facility with the cost to VA for private provider care. The policy states that this cost comparison is the basis for determining whether the required medical services can be more economically provided by a VA facility or private providers. VA guidelines do not explain how clinics are to compare VA and private care costs to determine the appropriateness of authorizing private care.

[1]Service-connected disability means disability incurred or aggravated in line of duty in the active military, naval, or air service.

Private Care Authorization Process

To receive private outpatient medical care at VA expense, veterans must apply for authorization at a VA administrative office. VA has designated 83 medical centers and five outpatient clinics to serve as administrative offices, which VA calls clinics of jurisdiction. Each clinic covers veterans living in specified geographical areas. For example, the Salem medical center serves as the clinic of jurisdiction for all veterans living in Virginia.

A clinic may provide a veteran with a letter of authorization for short-term care (such as for a one-time treatment) or an identification card authorizing care for a period of up to 3 years. VA policy requires a reevaluation near the expiration of veterans' long-term authorizations to determine the need for continuing the private care. The authorization letters and cards are to contain the condition(s) authorized for treatment by the private provider and provide information for use by the provider in billing VA for services. The veteran may choose his or her own provider, who bills VA directly and agrees to accept VA's payment as full reimbursement for services provided.

Salem Made Inappropriate Authorizations for Private Outpatient Care

The Salem clinic of jurisdiction routinely authorized private care for veterans without determining whether the services could have been provided more economically in VA facilities. In fiscal year 1990, the Salem clinic paid $1.3 million for private outpatient care and had 5,218 Virginia veterans approved for private outpatient care as of September 30, 1990. We reviewed the administrative and medical files of 29 veterans who reside in those areas served by the Salem, Richmond, and Hampton medical centers.[2] Salem's lack of cost comparisons for its private care authorizations resulted in most of its expenditures for private care during fiscal year 1990 being inappropriate.

Inappropriate Criteria for Justifying Private Care

When authorizing private care for veterans, Salem staff used the clinic's local administrative procedures, which did not require cost comparisons. Salem staff based private care decisions solely on other factors, such as the veteran's medical condition and distance from the veteran's residence to the VA facility.

Salem staff had not analyzed whether it was less expensive to treat these veterans in VA facilities or at private providers. Cost comparisons were required because none of the 29 veterans was approved for private care

[2]In fiscal year 1990, the Salem clinic paid for private care for 2,065 veterans residing in areas served by these three medical centers.

based on the fact that the needed services were not available at VA facilities. Instead, the Salem clinic based its decisions solely on noneconomic factors. Of the 29 veterans' files we reviewed, 10 authorizations were approved based on a determination that the veterans were geographically inaccessible to VA facilities. Salem staff determined for some veterans that use of private providers was in the best interest of VA and the veteran. According to Salem staff, this reason was used for special circumstances, such as for psychiatric patients with behavioral problems. Patients with difficult behavioral problems do not, for this reason alone, meet VA's eligibility criteria for private physician care.

We found information in medical and administrative records suggesting that for Salem to have provided the services in VA facilities might have been more economical for 25 of the 29 veterans we sampled. The medical and administrative files for these 25 veterans did not indicate any medical conditions that would preclude them from traveling to the VA medical center. These veterans did not require specialized medical facilities or travel by ambulance to a VA facility. Rather, they received services that VA facilities routinely provide. Most had traveled to VA medical centers on several occasions for medical care, as the following examples show.

- A veteran living about 25 miles from the Richmond Medical Center was first issued a long-term authorization (3 years) in 1981, covering medical care for any condition that might need future treatment. Salem justified this authorization based on the distance from the veteran's residence to the VA center. Subsequently, Salem extended this authorization three times, for a total of 12 years. During fiscal year 1990, the veteran visited the Richmond Medical Center on two occasions and had appointments scheduled at two of the center's clinics in fiscal year 1991. Moreover, he traveled about the same distance to his private physician as he did to the Richmond center. In fiscal year 1990, VA paid a private physician about $488 for office visits, removal of a mole, and tests related to diabetes.
- A veteran living about 80 miles from the Salem Medical Center was issued a long-term authorization in 1989 for treatment of any medical condition by private physicians. The veteran's medical and administrative records had no evidence of medical conditions that would preclude the veteran from traveling to the Salem Medical Center. In fact, this veteran visited the Salem center four times to receive medical care during fiscal year 1990; he visited the center on at least four occasions during 1991. In fiscal year 1990, VA paid $159 to private physicians for X rays and office visits and treatment of a tick bite, strep throat, and an upper respiratory infection.

Inappropriate Use of Long-Term Authorizations

VA policy requires clinics to authorize private care for a specific condition that needs treatment. The number of authorized visits to private providers is to be based on a treatment plan prepared by a VA physician; VA policy limits treatment authorizations to no more than 36 months. As such, private care authorizations are to be based on the specific treatment needs of existing medical conditions and not broadly defined to treat any condition that may arise in the future.

The Salem clinic inappropriately authorized veterans to receive private care for treatment of any medical condition rather than basing decisions on treatment plans for existing conditions. Of the 29 veterans' files we reviewed, 28 had long-term authorizations, usually for 3-year periods, to use private physicians for treatment of any medical condition. As a result, these veterans visited private physicians whenever they desired. The Salem clinic learned of their use when the private physicians sent bills to VA. This practice, in effect, precluded the clinic from determining whether it was more economical for VA to treat the veterans' medical conditions.

Inappropriate Extension of Veterans' Private Care Authorizations

VA policy requires clinics to evaluate each veteran's authorization for private care on a continuing basis. The policy cautions that authorized use of private physicians will not be considered permanent for any veteran. Authorizations are to be cancelled and the veterans are to be requested to return to a VA facility for needed medical services when the veterans' condition or situation changes or if the VA facility enhances its service capability.

When a veteran's authorized time period for private care expires, the clinic is to determine whether treatment is complete; this evaluation should be done within 3 months of the expiration of a long-term (36 months) authorization. VA policy assumes that most authorizations will expire on schedule and the veteran's need for care will have been met. If the clinic staff decides that care is incomplete, they are to either cancel the authorization and schedule the veteran for care in a VA facility or extend the authorization. In making this decision, the clinic is required to review the veteran's medical record, consult with private providers about the need for continued care, and consider the relative total cost of each alternative.

The Salem clinic routinely extended long-term authorizations without evaluating veterans' continued eligibility for private care. As of September 30, 1990, 4,617 Virginia veterans with long-term authorizations still in

effect had been authorized private physician care for more than 12 years on average.[3] Of 27 veterans in our sample for whom long-term authorization was extended, we found that 22 were not reevaluated before extension of their private care authorization.

Salem administrative staff told us that they routinely authorized 3-year extensions without any evaluation for all veterans whose long-term authorizations expired since August 1989. They said that these extensions were necessary because clerical staff were not available to schedule the required reevaluations. In the absence of these reevaluations, Salem clinical staff were unable to determine whether veterans' medical conditions or their accessibility to VA facilities had changed or whether VA facilities now had needed services.

VA Guidance on Cost Comparisons

Without clear procedures for comparing costs, determining whether veterans meet VA's requirements for private care at VA expense is very difficult for Salem officials. A VA headquarters official told us that one of the most difficult aspects of doing cost comparisons is identifying costs for patient care in VA facilities in order to compare these costs to costs for such care by private providers.

VA headquarters officials also told us that they recognize the critical role of cost comparisons in clinics' decisions concerning private care authorizations. However, the officials said that they have not decided how clinics should develop cost comparisons. In March 1992, VA convened a working group to discuss the issue. VA officials plan to issue guidance to the clinics on how to develop the required cost comparisons.

VA Does Not Monitor Clinics' Compliance With Policies

Neither VA headquarters nor its regional offices monitor the clinics' private care authorization practices and procedures. VA headquarters officials told us that they rely on the Inspector General audits as their primary oversight mechanism. However, when the Inspector General identifies problems at specific medical centers, VA headquarters officials do not routinely follow up at the medical centers to identify whether the centers have adequately resolved the problems.

[3]Nationally, as of September 30, 1990, 116,556 veterans with long-term authorizations still in effect, had been authorized private provider care for about 8 years, on average.

Improper Authorizations Reported at 22 Medical Centers

Between 1986 and 1991, VA's Inspector General reported deficiencies in the private care authorization processes at 22 VA facilities.[4] The Inspector General questioned the appropriateness of the private provider payments—ranging from 16 to 100 percent of the veterans sampled at 19 locations.[5] He identified similar problems to those we found at the Salem clinic:

- VA personnel were not properly applying VA's criteria for authorizing private provider care for veterans; that is, they were using arbitrary mileage boundaries for authorizing private provider care, and authorizing some veterans to receive private care for any medical conditions which may arise rather than only conditions currently needing treatment.
- Clinical and administrative evaluations of the veterans' eligibility for private provider care were not done; that is, no cost comparisons of whether private care was more economical than VA care were done and private care was authorized without treatment plans prepared or approved by VA physicians.

Officials from the Inspector General's Office told us that their routine, periodic audits at individual VA facilities do not include an evaluation of private care authorizations unless they suspect problems. Moreover, Inspector General officials said that they are replacing these audits at VA facilities with systemwide program audits that focus on specific VA programs or systems rather than individual facilities. VA has not conducted a systemwide evaluation of private care authorizations nor is one currently in their plans.

Continuing Problems at Clinics With Previously Reported Problems

We visited the Lebanon, Pennsylvania, and San Francisco, California, medical centers to identify what steps they had taken to correct deficiencies that the Inspector General had identified. Although we found continuing problems at both centers, we observed that the Lebanon center had made considerable efforts to improve its private care authorization process.

Lebanon Medical Center

In December 1989, the Inspector General's Office reported that required reevaluations were not done for about 40 percent of the veterans it reviewed at the Lebanon medical center. The center subsequently reduced

[4]Appendix IV shows the VA facilities at which the Inspector General reported deficiencies.

[5]At three centers, the Inspector General reported problems with the private provider program, but did not quantify the extent to which these problems had resulted in inappropriate or questionable authorizations.

the number of long-term authorizations from 1,313 in February 1988 to 493 in August 1991. Its expenditures were reduced from about $1.1 million in fiscal year 1988 to about $594,000 in fiscal year 1991.

Lebanon officials told us that the center achieved these reductions through a collaborative effort on the part of the clinical and administrative staff. The Chief of Medical Administration stated that he reviews each case and if he has questions on the determinations made, he discusses and resolves the case with the clinical and administrative personnel. We were told that after a short period of time, the authorization process was operating much more efficiently, including significant reductions in staff.

To assess the Lebanon center's new authorization procedures, we reviewed medical and administrative records for 12 judgmentally selected veterans. We found that Lebanon staff had not done the required cost comparisons for any of these veterans. Lebanon officials said that they did not know how to perform the cost comparisons and that they had been lenient in applying the criteria to make sure that the veteran got any benefit of the doubt. We raised questions about the appropriateness of authorizations for eight veterans; four of these were regularly visiting the Lebanon center for outpatient care. After reviewing these cases, Lebanon officials canceled the authorizations for five veterans and requested that they receive care at VA facilities. As current private care authorizations for veterans expire, Lebanon officials expect that their reviews will result in further reductions in the number of veterans with long-term private care authorizations.

San Francisco Medical Center

In 1988, the Inspector General's Office reported weaknesses in the San Francisco center's procedures for authorizing veterans' private health care. It questioned 18 percent of the cases because VA staff were not properly applying program eligibility criteria and were not adequately considering the availability of other nearby VA facilities.

Over the last few years, private care expenditures increased from $980,000 in fiscal year 1986 to more than $1.3 million in fiscal year 1991. Between July 1990 and October 1991, the number of veterans authorized to use private physicians increased from 1,050 to more than 1,300.

San Francisco VA officials stated that they had taken corrective actions, including recently assigning a psychiatrist on a part-time basis, to assist in evaluating veterans' need for private psychiatric care. However, the

psychiatrist told us that he had not been trained in how to apply the program criteria.

In October 1991, center staff and GAO staff independently assessed the adequacy of the center's authorization procedures and individual veteran authorizations. The center staff found inadequate justification for 42 percent of the 38 veterans they reviewed. Our review of the medical and administrative files for 16 veterans found program eligibility criteria were not appropriately applied—no cost comparisons had been done for any of these veterans to determine whether private care was economical.

Conclusions

VA did not provide adequate guidance to medical centers on how to evaluate the cost-effectiveness of private care in deciding whether to authorize private care at VA expense, nor did it adequately monitor centers' use of private care authorizations. It is likely that many other centers, in addition to the 22 the Inspector General identified, are not complying with VA's authorization policies and, as a result, are using improper procedures. With more detailed guidance and systematic monitoring practices, VA could better ensure that centers' private care authorization processes are appropriate. Requiring authorizations for private care to be based on economic considerations is required by law and VA policy. Veterans should use private providers, at VA expense, only as a supplement to, rather than as a substitute for, VA facilities.

Recommendations to the Secretary of Veterans Affairs

We recommend that the Secretary require the Chief Medical Director to:

- Clarify to medical centers that private care should only be purchased from private providers when the needed services are not available at VA facilities or the private providers can treat veterans considered geographically inaccessible more economically than VA facilities can treat them.
- Provide medical centers with procedures, including implementing guidance, on how to develop cost comparisons for use in authorizing private care.
- Ensure that all medical centers reevaluate the appropriateness of private care authorizations for all veterans currently authorized private care.
- Develop and implement a process for monitoring centers' compliance with VA's policies and procedures for use of private providers to treat veterans.

Agency Comments

The Secretary of Veterans Affairs commented on a draft of this report on August 5, 1992 (see app. V). He agreed that the Department could do more to control the costs of purchasing veterans' health care from private providers. He concurred with our recommendations and pointed out a number of actions that the Veterans Health Administration plans to take to ensure that veterans' use of private providers at VA expense is fully monitored and justified. These actions include directing all VA facilities to (1) compare costs of VA health care and private care before authorizing use of private providers and (2) authorize such use only when services are not available at VA facilities or the private providers can provide the care to veterans more economically than VA facilities can. VA facilities will also be directed to perform a cost analysis of all existing private care authorizations before extending them.

We are sending copies of this report to the Secretary of Veterans Affairs; the Director, Office of Management and Budget; and interested congressional parties. Copies will also be made available to others upon request. If you have any questions regarding this report, please contact me on (202) 512-7101. Major contributors to this report are listed in appendix VI.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

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Abbreviations

VA Department of Veterans Affairs

Scope and Methodology

We reviewed VA's policies and procedures for authorizing, monitoring, and paying for private medical care for veterans. We discussed with VA headquarters officials how clinics of jurisdiction (administrative offices) were expected to implement these policies and procedures. We obtained systemwide program data and discussed VA procedures for providing oversight of private care authorizations with headquarters and Western Region personnel. We also discussed the budgeting and funding processes for the program and the extent to which the Inspector General had evaluated the program.

We visited the Salem, Richmond, and Hampton, Virginia, Medical Centers, where we discussed with medical administration and other personnel how they authorized private care. In addition, at these medical centers, we reviewed a random sample of 29 cases that had private care payments during fiscal year 1990 to determine whether the veterans met VA's eligibility requirements. Our review found that VA staff had not done required cost comparisons for any of the veterans. Because of this high incidence of inadequate procedures, we decided not to review any additional cases.

At the Salem medical center, VA's administrative office for Virginia, we reviewed medical and administrative files for veterans we sampled and discussed the results of our review with center personnel. At the Hampton and Richmond facilities, we also reviewed medical and administrative records for those veterans in our sample who reside in their respective primary service areas and discussed each case with medical center personnel. In addition, at each of those facilities, we discussed budgeting and funding with administrative and fiscal personnel and obtained private care authorization and cost data.

We also reviewed VA Inspector General audit reports issued since October 1986 for all VA medical centers and identified 22 centers that issued private care authorizations without review. We contacted officials at 8 of the 22 medical centers to obtain preliminary indications on the nature and extent of corrective actions taken since the Inspector General's reports were issued. We analyzed the information obtained and selected two medical centers—Lebanon, Pennsylvania, and San Francisco, California—which we visited to obtain further information on the actions reported. At these two medical centers, we reviewed a small judgmental sample of cases to determine if the procedural weaknesses that the Inspector General identified had been corrected. At these medical centers, we obtained data, where available, on the number of veterans authorized private care and

the cost for this care. Our work, which was conducted between May 1991 and April 1992, was performed in accordance with generally accepted government auditing standards.

VA Private Medical Outpatient Care Expenditures, Fiscal Year 1990

VA clinic of jurisdiction	Total private care expenditures
Albany, New York	$1,058,470
Albuquerque, New Mexico	898,074
Allen Park, Michigan	1,557,619
Altoona, Pennsylvania	681,208
Amarillo, Texas	941,578
American Lake, Washington	605,101
Anchorage, Alaska	10,303,418
Baltimore, Maryland	2,156,791
Bay Pines, Florida	4,634,236
Boise, Idaho	272,753
Boston, Massachusetts	2,223,299
Buffalo, New York	466,597
Butler, Pennsylvania	193,852
Cheyenne, Wyoming	241,162
Chicago, Illinois	3,650,923
Cincinnati, Ohio	871,371
Cleveland, Ohio	647,918
Coatsville, Pennsylvania	51,833
Columbus, Ohio[a]	3,287,119
Columbus, South Carolina	1,842,584
Dallas, Texas	911,351
Decatur, Georgia	3,008,653
Denver, Colorado	1,733,071
Des Moines, Iowa	910,119
East Orange, New Jersey	1,814,287
El Paso, Texas (OPC)	540,295
Erie, Pennsylvania	93,534
Fargo, North Dakota	946,741
Fort Harrison, Montana	753,638
Fresno, California	456,962
Honolulu, Hawaii	3,296,409
Houston, Texas	318,515
Huntington, West Virginia	1,047,874
Indianapolis, Indiana	1,456,057
Iron Mountain, Michigan	240,732
Jackson, Mississippi	891,706
Kansas City, Missouri	1,788,818
Las Vegas, Nevada[a]	295,354

(continued)

VA clinic of jurisdiction	Total private care expenditures
Leavenworth, Kansas	427,902
Lebanon, Pennsylvania	775,735
Lincoln, Nebraska	625,378
Little Rock, Arkansas	2,367,515
Los Angeles, California[a]	2,271,429
Louisville, Kentucky	722,423
Manchester, New Hampshire	466,980
Manila, Philippines	20,512
Martinez, California	1,065,609
Martinsburg, West Virginia	75,507
Milwaukee, Wisconsin	1,269,327
Minneapolis, Minnesota	4,021,425
Montgomery, Alabama	1,587,744
Muskogee, Oklahoma	2,173,416
Nashville, Tennessee	993,457
New Orleans, Louisiana	1,034,677
New York, New York	1,628,490
Newington, Connecticut	779,412
Palo Alto, California	1,114,436
Philadelphia, Pennsylvania	1,013,736
Phoenix, Arizona	1,354,179
Pittsburgh, Pennsylvania[b]	223,823
Pittsburgh, Pennsylvania[c]	1,626,338
Portland, Oregon	1,426,479
Providence, Rhode Island	1,037,938
Reno, Nevada	734,307
Roseburg, Oregon	627,675
Saint Cloud, Minnesota	215,157
Saint Louis, Missouri	667,490
Salem, Virginia	1,287,984
Salisbury, North Carolina	3,473,239
Salt Lake City, Utah	640,941
San Antonio, Texas	1,602,097
San Diego, California	830,495
San Francisco, California	1,428,758
San Juan, Puerto Rico	2,335,948
Seattle, Washington	1,130,131
Shreveport, Louisiana	760,094
Sioux Falls, South Dakota	462,142

(continued)

VA clinic of jurisdiction	Total private care expenditures
Spokane, Washington	367,182
Syracuse, New York	1,003,911
Togus, Maine	1,820,660
Topeka, Kansas	208,720
Waco, Texas	575,784
Walla Walla, Washington	294,471
Washington, District of Columbia	1,059,912
White River Junction, Vermont	893,374
Wichita, Kansas	944,043
Wilkes-Barre, Pennsylvania	938,128
Wilmington, Delaware	109,558
Total	**$111,552,020**

[a]Outpatient clinic

[b]Highland Drive location.

[c]University Drive location.

Veterans' Eligibility Requirements for VA-Financed Private Care

Veterans eligible to receive care at VA expense generally get such care in VA facilities. However, under section 1703, title 38 of the United States Code, when needed care is unavailable or cannot be economically provided in VA facilities because of geographic inaccessibility, VA may authorize care from private providers as follows:

- Hospital care or medical services for treatment of a service-connected disability or a disability for which the veteran was discharged or relieved from active service.
- Medical services for the treatment of any disability to a veteran who has a service-connected disability rated at 50 percent or more, and, to complete treatment incident to VA medical care, to any veteran (1) with a service-connected disability rated at 30 or 40 percent; (2) eligible for VA hospital care and an annual income below a certain amount; (3) who is a former prisoner of war; (4) of the Mexican border period or World War I; (5) receiving increased benefits based on need or by reason of being permanently housebound; and (6) if the veteran agrees to pay for it, eligible for hospital care.
- Hospital care or medical services for treatment of a medical emergency posing serious threat to life or health when receiving VA medical benefits in a VA facility or a nursing home.
- Hospital care for women veterans.
- Hospital care or medical services that will obviate the need for hospital admission, in a state not contiguous to the contiguous states, so long as the ratio between veterans treated directly by the VA and by private providers is the same in each such state as in the contiguous states.
- Diagnostic services necessary to determine eligibility for, or the proper course of treatment for, furnishing medical services at VA out-patient clinics to obviate the need for hospitalization.
- Outpatient dental services and treatment and related dental appliances for a former prisoner of war who was imprisoned for a period of not less than 90 days.
- Diagnostic services for observation or examination to determine eligibility for a VA benefit.

Inspector General Reports That Discuss Improper Private Care Authorizations (October 1986-December 1991)

VA facility reviewed	Date of report
Anchorage, Alaska	March 31, 1989
Butler, Pennsylvania	November 17, 1987
Cleveland, Ohio	September 29, 1989
Columbus, Ohio	November 20, 1990
Des Moines, Iowa	July 17, 1990
East Orange, New Jersey	January 13, 1987
Kansas City, Missouri	May 18, 1987
Las Vegas, Nevada	May 21, 1987
Lebanon, Pennsylvania	December 21, 1989
Los Angeles, California (OPC)	September 23, 1988
Martinez, California	October 15, 1991
Milwaukee, Wisconsin	October 15, 1991
Minneapolis, Minnesota	March 30, 1989
Muskogee, Oklahoma	March 31, 1989
Providence, Rhode Island	August 1, 1989
Saint Louis, Missouri	September 27, 1989
Salisbury, North Carolina	October 10, 1986
San Francisco, California	September 28, 1988
San Juan, Puerto Rico	July 14, 1988
Sioux Falls, South Dakota	November 30, 1989
Togus, Maine	January 25, 1991
Wichita, Kansas	November 6, 1987

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

AUG 5 1992

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
U. S. General Accounting Office
441 G Street, NW
Washington, VA 22209

Dear Mr. Baine:

I have reviewed GAO's draft report, **VA HEALTH CARE: Use of Private Providers Should Be Better Controlled** (GAO/HRD-92-109) and concur with your recommendations. I agree the Department of Veterans Affairs (VA) can do more to control the costs of providing veteran health care outside the Veterans Health Administration (VHA).

While it is essential that we make the best possible health care services available for veterans, I recognize there is a point when the workload does not justify the expense of providing these services within VHA. In these cases, we authorize certain eligible veterans to seek this care from private providers at VA expense. However, this places an added responsibility on VHA to assure that these expenses are fully monitored and justified.

The enclosure details actions we are taking and plan to take to implement the recommendations. Thank you for the opportunity to comment on the draft report.

Sincerely yours,

Edward J. Derwinski

Enclosure
EJD/vz

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT, **VA HEALTH CARE: Use of Private Providers Should Be Better Controlled**
(GAO/HRD-92-109)

GAO recommends that I require the Chief Medical Director to:

- **clarify to medical centers that private care should only be purchased from private providers when the needed services are not available at VA facilities or the private providers can treat veterans considered geographically inaccessible more economically than VA facilities can treat them.**

Concur - The VHA will issue a directive to all VA health care facilities clarifying that they shall only purchase private care from private providers when the needed services are not available at VA facilities or the private providers can treat veterans considered geographically inaccessible more economically than VA facilities can treat them.

- **Provide to medical centers procedures, including implementing guidance, on how to develop cost comparisons for use in authorizing private care.**

Concur - VHA is developing guidelines for field use prior to authorizing fee-basis care when the care is available at a VA facility. The guidelines will include guidance for developing cost comparisons.

- **Make sure all medical centers reevaluate the appropriateness of private care authorizations for all veterans currently authorized private care.**

Concur - VHA will issue a field directive advising of the need to reevaluate all fee authorizations based upon the revised guidelines. The directive will also advise field staff to do a cost analysis prior to extending fee authorizations.

- **Develop and implement a process for monitoring centers' compliance with VA's policies and procedures for use of private providers to treat veterans.**

Concur - VHA officials will undertake efforts to make certain medical center officials follow the policies and procedures governing the fee basis program.

Major Contributors to This Report

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