RELEASED 3-30-78

REPORT BY THE

Comptroller General

OF THE UNITED STATES

Health Care Needs Of Veterans In Puerto Rico And The Virgin Islands Should Be Assessed

The Senate Committee on Veterans Affairs asked GAO to review two VA programs to provide medical care to veterans living in Puerto Rico and the Virgin Islands who have nonservice-connected disabilities.

A disproportionate share of VA resources is going to non-VA hospitals because of lack of alternative facilities and other reasons.

A decision on the future of the "contract hospital" and "fee-basis program" cannot be made without assessing the total health care needs of veterans in Puerto Rico and the Virgin Islands. GAO recommends that the Congress direct VA to make this assessment and also recommends several improvements to the program.

HRD-78-84
MARCH 30, 1978

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133044

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

Dear Mr. Chairman:

We are enclosing our report on the Veterans Administration's (VA's) programs on providing contract hospital care and fee-basis outpatient care to veterans in Puerto Rico and the Virgin Islands who have nonservice-connected disabilities.

As requested by your office, we did not obtain formal written comments from VA on the report. A draft of the report was furnished to program officials of VA's Department of Medicine and Surgery for informal review and their comments have been incorporated, where appropriate.

As agreed with your office, we are making no further distribution of this report. However, the report contains recommendations to the Administrator of Veterans Affairs. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We will be in touch with your office in a few days to arrange for release of the report so that the requirements of section 236 can be set in motion.

We also believe that the report would be of interest to other parties. We will arrange with your office to have copies provided to these parties.

Sincerely yours,

Elmer B. Staats

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE SENATE COMMITTEE ON VETERANS AFFAIRS

HEALTH CARE NEEDS OF VETERANS IN PUERTO RICO AND THE VIRGIN ISLANDS SHOULD BE ASSESSED

D I G E S T

Because the San Juan Veterans Administration Hospital is operating near capacity, the Veterans Administration (VA) has made extensive use of two programs to provide medical care to veterans in Puerto Rico and the Virgin Islands: a contract hospital program and a program to provide outpatient treatment on a fee-basis.

The San Juan VA hospital has one of the highest occupancy rates in the entire VA system; however, about 82 percent of the admissions in fiscal year 1977 were for nonservice-connected conditions. Consequently, many patients with service-connected disabilities are in contract hospitals with little monitoring by VA to insure the quality of care.

Expansion of VA programs in Puerto Rico has primarily benefited veterans with nonservice-connected disabilities and the expanded programs are now filled to capacity.

There are indications that Puerto Rico and the Virgin Islands are getting a disproportionate share of VA resources. There are a number of factors, however, which seem to contribute to this situation, including location, lack of alternative VA facilities, social and economic problems, and a high incidence of mental disorders among the veteran population.

If the programs are continued without limitation, it must be recognized that they will probably, as in the past, largely benefit veterans with nonservice-connected conditions. It can also be expected that if the San Juan outpatient clinic program is expanded as planned, its workload will probably be increased by treatment of veterans with

nonservice-connected conditions and may have little or no impact on the fee-basis program.

A decision on the future of the program cannot be made without assessing the total health care needs of veterans in Puerto Rico and the Virgin Islands. GAO recommends that the Congress direct VA to make such an assessment.

Since there is uncertainty as to whether a limitation on the use of contract hospitals is applicable to Puerto Rico and the Virgin Islands, GAO recommends that the Congress revise the law to clarify its position on whether and to what extent limitations should be imposed.

The Administrator of Veterans Affairs should (1) implement the conditions imposed by Public Law 94-581 on the type of veteran for which fee-basis care is authorized and (2) take certain actions to improve the programs' operations.

As the Committee requested, GAO did not obtain written comments from VA; however, the report was discussed with VA program officials and their comments have been incorporated, as appropriate, in the report.

C O N T E N T S

ABBREVIATIONS

VA	Veterans Administration
GAO	General Accounting Office
GM&S	General Medical and Surgery
GM&S/OPT	General Medical and Surgery/Outpatient
NP	Neuropsychiatric

CHAPTER 1

INTRODUCTION

In a letter dated October 7, 1977, the Chairman, Senate Committee on Veterans' Affairs, requested that we conduct a review of the Veterans Administration's (VA's) furnishing of hospital care and medical treatment for nonservice-connected disabilities under contracts with private facilities and arrangements with private physicians in Puerto Rico. Specifically, we were to determine

--the use made of VA's authority to provide medical treatment and hospital care for nonservice-connected disabilities under contractual arrangements with private facilities and physicians in Puerto Rico during the past 4 years--both prior to and following the enactment of Public Law 94-581,

--the justification which may exist for a special authority to provide such contract care and services in Puerto Rico, and

--the conditions which should be imposed on such authority in the interest of the equitable geographic allocation of VA resources.

In performing this review, we also included these programs in the Virgin Islands because they are under the auspices of the San Juan Puerto Rico VA hospital.

BACKGROUND OF CONTRACT HOSPITAL CARE AND FEE BASIS MEDICAL SERVICES

Chapter 17 of Title 38 of the U.S. Code authorizes treatment for veterans beneficiaries in Veterans Administration hospitals and outpatient facilities, and also authorizes non-VA medical services for certain beneficiaries. The authorization includes outpatient care, dental care, prescriptions and prosthetics, procured on a "fee-basis" at VA expense, hospitalization, and community nursing home care under contract with VA. In fiscal year 1977 the cost of fee-basis medical services and contract hospitalization exceeded $116 million.

Contract hospitalization

Section 202(10) of the World War Veterans' Act 1924, as amended by Public Law 628 of the 68th Congress, March 4, 1925, authorized hospitalization of veterans in other than Government hospitals in the possessions and territories of the United States.

Veterans' Regulation No. 10 (Mar. 31, 1933) included contract facilities in territories and possessions as part of the definition of VA facilities. Veterans' Regulation No. 10(b), issued on July 28, 1933, deleted a prior requirement that the treatment be for a service-connected condition and, thus, contract hospitalization for veterans in a possession or territory, with a nonservice-connected condition, was authorized.

The latest legislation affecting contract hospitalization was initiated in 1968 and was directed toward resolving problems arising as a result of Alaska and Hawaii becoming States. While Alaska and Hawaii were territories, they were covered by legislation authorizing VA to provide hospital care in private contract facilities in a commonwealth, territory, or possession for veterans with nonservice-connected conditions. This is an exception to the general statutory limitation that hospitalization for nonservice-connected disorders may only be furnished in a VA hospital or other Government facility to the extent that beds are available. When Alaska and Hawaii became States, their veteran population automatically became subject to the limitations governing the hospitalization of veterans in other States. Therefore, for several years, VA was without authority to furnish hospital care for the nonservice-connected conditions of veterans in Alaska or Hawaii, except in Federal facilities.

Public Law 90-612, approved October 21, 1968, was directed toward resolving this problem. This law expanded the definition of medical services to cover contract hospital care:

> "* * * for veterans of any war in a State, Territory, Commonwealth, or possession of the United States not contiguous to the forty-eight contiguous States, except that the annually

determined average hospital patient load per thousand veteran population hospitalized at Veterans' Administration expense in Government and private facilities in each such non-contiguous State may not exceed the average patient load per thousand veteran population hospitalized by the Veterans' Administration within the forty-eight contiguous States; but authority under this clause * * * shall expire on December 31, 1978." (38 U.S.C. 601(4)(C)(v))

Subsequent interpretations of this section by VA's General Counsel indicated that the mathematical limitation in this clause applied only to Alaska and Hawaii. However, the expiration date of December 31, 1978, includes territories, possessions, and the commonwealth.

Fee-basis medical services

Public Law 93-82, the Veterans Health Care Expansion Act of 1973, approved August 12, 1973, authorized for the first time outpatient care benefits for any veterans suffering from a nonservice-connected disability, if the treatment would "obviate the need" for hospitalization. This liberalization led to a surge in the number of nonservice-connected outpatient visits both to VA facilities and on a fee-basis.

Congressional concern over care in non-VA facilities

In recent years there has been a rapid growth in medical care in non-VA facilities, particularly in fee-basis care, because of expanded eligibility, increased workloads at VA facilities, and the increasing veteran population.

The Congress interest in the fee-basis program was initially sparked by the growth in expenditures for outpatient fee-basis care. Total expenditures for this care rose from $27.9 million in 1970 to $70.8 million in 1975.

In 1976 the Congress was concerned with the rapid growth in expenditures for outpatient fee-basis care and the growing proportion of fee-basis funds going for the treatment of nonservice-connected disabilities. There was particular concern that the liberalization of eligibility requirements

and the expanded capacity of the VA health care system in the past 7 years had primarily benefited veterans with nonservice-connected disabilities.

The Veterans Omnibus Health Care Act of 1976 (Public Law 94-581, approved Oct. 21, 1976) applied a new limitation to the Veterans Administration's contracting authority.

The act revoked the fee-basis care eligibility of those veterans being treated for a nonservice-connected condition who do not have a service-connected disability rated at 50 percent or more and who are not in a post-hospital care status but who are eligible for aid and attendance or household benefits.

The act also revoked the fee-basis care eligibility for those who were eligible to receive fee-basis care solely on the grounds that outpatient care for them would obviate the need for hospitalization.

This, therefore, limited fee-basis care for nonservice-connected treatment to only two circumstances--either for the nonservice-connected condition of a veteran with a 50-percent or more service-connected disability or for a veteran who requires post-hospital followup care on an outpatient basis.

In addition to these limitations on outpatient medical fee-basis services, the authority which permits contract hospitalization for veterans with nonservice-connected disabilities in Puerto Rico, Virgin Islands, other U.S. territories and possessions, and Alaska and Hawaii is due to expire on December 31, 1978. Expenditures for contract hospitalization and fee-basis care were about $117 million in fiscal year 1977. For fiscal year 1977 expenditures in Puerto Rico and the Virgin Islands totaled about $12 million, or about 10 percent of the total contract hospital and fee-basis expenditures.

Administration of VA programs

The San Juan VA Center, of which the hospital is a part, is responsible for administering all VA programs in Puerto Rico and the Virgin Islands. The VA hospital (see photograph on p. 6) was completed in 1969 and has 692 operating beds.

240 Psychiatric beds
239 Medical beds
173 Surgical beds
20 Rehabilitation medicine beds
20 Spinal cord injury beds

692

The hospital is affiliated with the University of Puerto Rico School of Medicine. The VA hospital has specialized medical programs such as cardiac catheterization, electron microscopy, renal transplantation, and open heart surgery. The hospital also has an ambulatory care area (outpatient clinic) which was built to accommodate about 70,000 visits per year.

VA plans a $6.8 million addition to its outpatient clinic in fiscal year 1979. The San Juan hospital's 5-year plan also proposed the addition of a 720-bed psychiatric wing to the existing VA hospital, but was not approved by VA central office.

An outpatient clinic was opened in Mayaguez in July, 1976, to serve the western part of Puerto Rico (see p. 9).

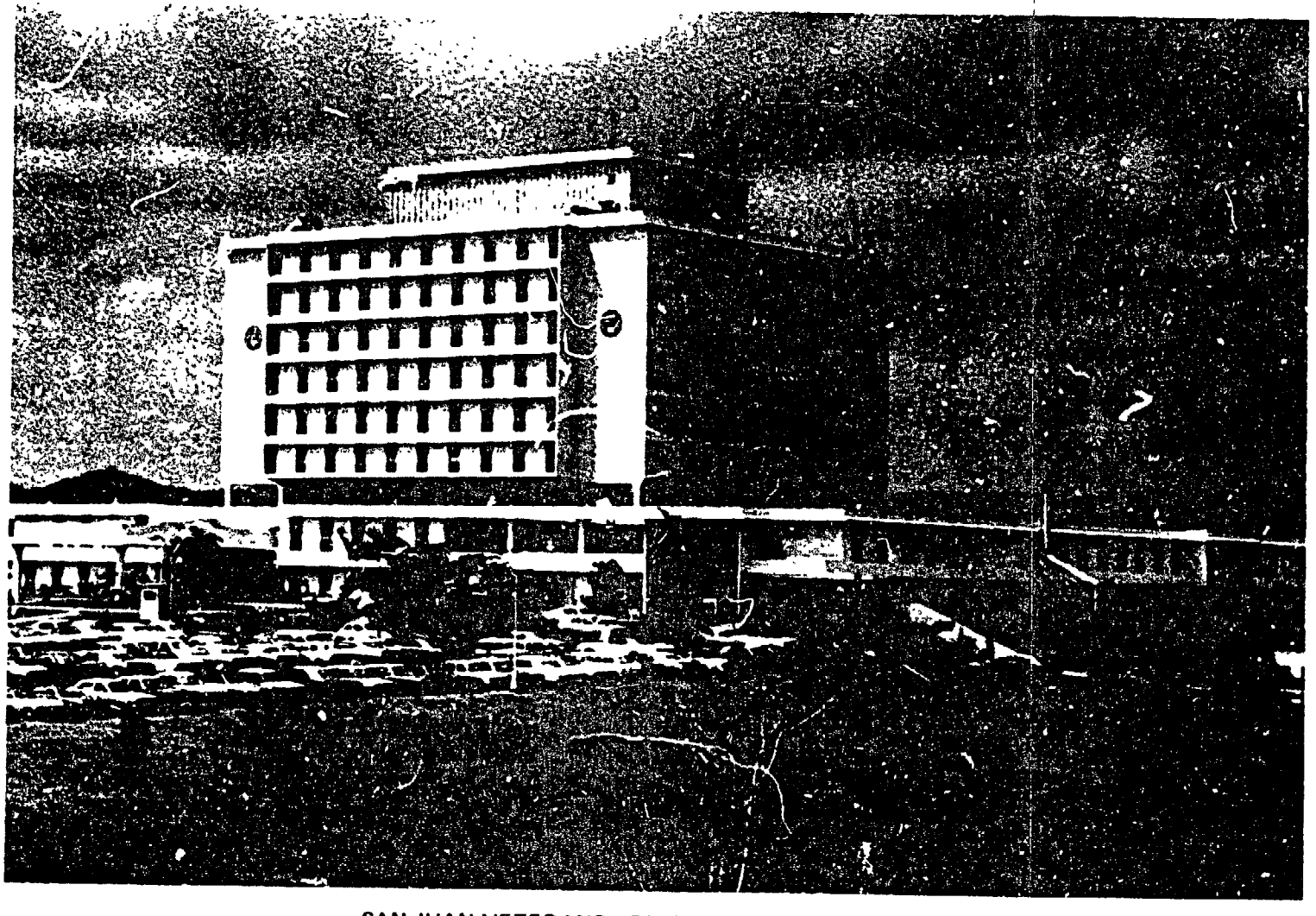
There are no VA medical care facilities in the Virgin Islands.

Contract and fee-basis care to eligible veterans in Puerto Rico and the Virgin Islands are provided by nine hospitals, four of which provide both inpatient and outpatient care, and by numerous private physicians. (See app. I.)

SCOPE

We conducted our review at the VA hospital and clinic in San Juan, Puerto Rico. We held discussions with hospital officials and physicians, gathered program statistics, and reviewed pertinent documentation.

In addition we visited the two contract outpatient clinics in Ponce, Puerto Rico where we reviewed a sample of patient files. We also reviewed a sample of case files at a contract hospital in Hato Rey, Puerto Rico and case files at the offices of two private physicians in St. Thomas, Virgin Islands.



SAN JUAN VETERANS ADMINISTRATION HOSPITAL

CHAPTER 2

VA'S USE OF CONTRACT HOSPITALS AND FEE-BASIS PROGRAMS

In Puerto Rico and the Virgin Islands, the Veterans Administration has made extensive use of the contract hospital program to provide inpatient care and the fee-basis program to provide outpatient care. Although Public Law 94-581 placed certain restrictions on VA to provide outpatient care on a fee basis, VA has continued to provide this care in Puerto Rico and the Virgin Islands as if the legislation had never been enacted. As a result many veterans have received ineligible care under the fee-basis program.

On the basis of the number of veterans served by VA and under VA auspices, there appears to be a need to continue both the contract hospital program and the fee-basis program at some level. However, before it can be determined at what level these programs should be operated, the fee-basis program must agree with the intent of Public Law 94-581, controls need to be strengthened over the programs, and certain policy questions need to be addressed.

The need to strengthen controls is discussed in chapter 3, the policy questions, in chapter 4.

VA CONTRACTED MEDICAL SERVICES

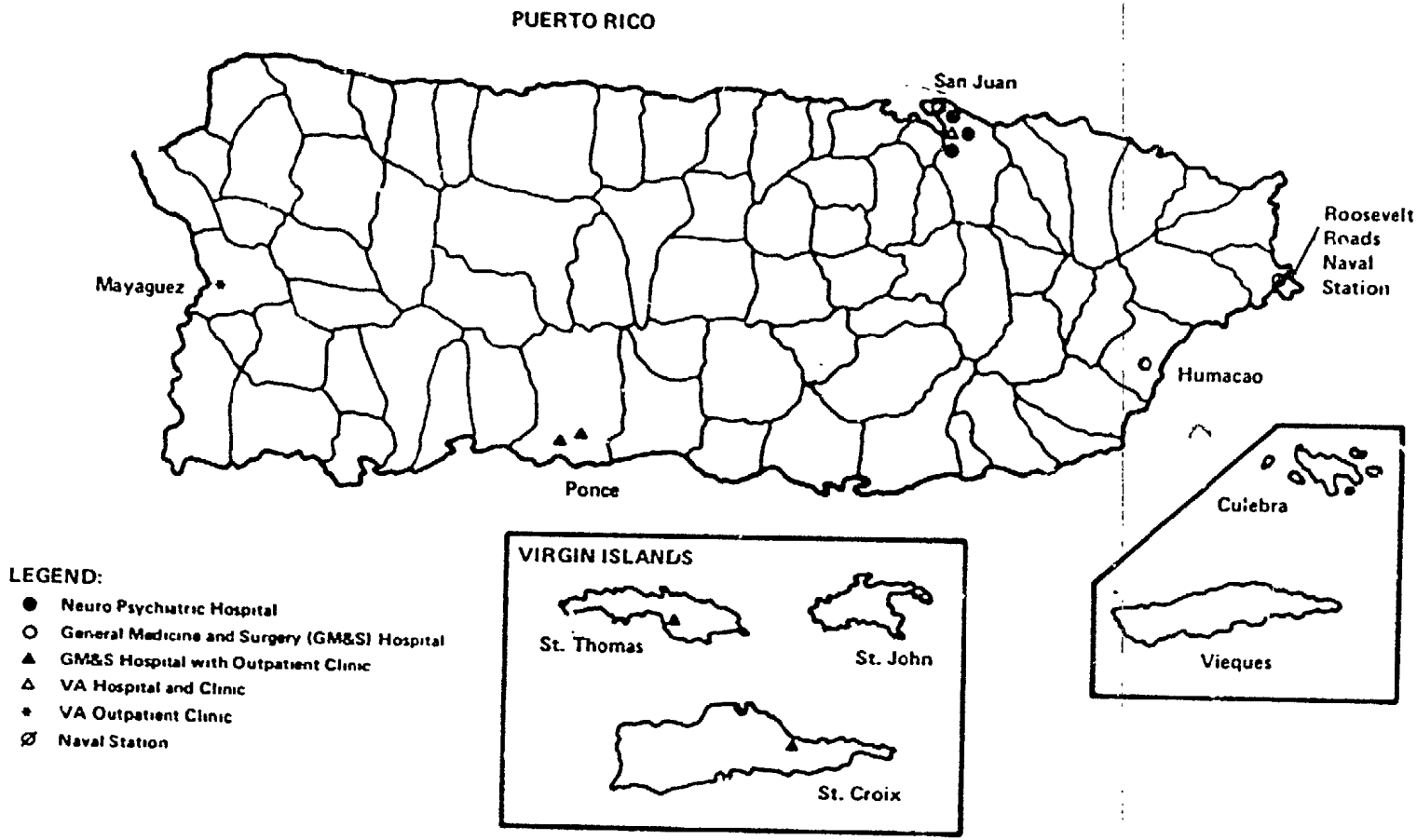
In order to supplement its staff and facilities, VA has entered into contracts with hospitals and clinics in Puerto Rico and on St. Thomas and St. Croix in the Virgin Islands. VA also uses the services of private physicians in both Puerto Rico and the Virgin Islands, and a few beds at the Naval hospital at Roosevelt Roads Naval Station in the eastern part of Puerto Rico (see map on p. 8).

The use of these facilities and physicians has steadily increased over the last 4 years, with psychiatric hospitalization accounting for the majority of contract beds and cost.

Contract hospitalization is increasing

VA has contracts with 3 neuropsychiatric hospitals and 4 general medicine and surgery hospitals in Puerto Rico.

LOCATION OF VA AND CONTRACT FACILITIES IN PUERTO RICO AND THE VIRGIN ISLANDS



MAYAGUEZ VETERANS ADMINISTRATION CLINIC

In addition VA contracts for 10 beds at the Roosevelt hospital.

The contracts on St. Thomas and St. Croix are with the Virgin Islands Department of Health for one general medicine and surgery hospital and one clinic on each island.

All of the hospitals under contract have been approved by the Joint Commission on Accreditation of Hospitals, except one. This facility is currently operating as a nursing home and is awaiting final approval from the Puerto Rico Department of Health to operate as a hospital. The facility is providing services to chronic psychiatric patients.

The table below shows the continuing increase in admissions and costs for contract hospitalization in Puerto Rico and the Virgin Islands from fiscal year 1974 to 1977.

	Fiscal year			
	1974	1975	1976	1977
Admissions	3,389	4,110	4,164	5,211
Patient days of care	109,366	157,469	179,592	221,742
Average daily census	300	431	491	608
Cost (million $)	$4.7	$6.8	$7.9	$9.6

This data is not available broken down by service-connected or nonservice-connected, but the Center Director told us that in fiscal year 1974 about 90 percent of the contract hospitalization was service-connected and in fiscal year 1977 about 40 percent of the cases were service-connected and 60 percent were nonservice-connected.

We selected a sample of 165 cases from one hospital for 1 month that showed that 43 percent of the cases were for service-connected conditions and 57 percent for non-service-connected conditions.

This data indicates that most, if not all, of the growth in contract hospitalization is nonservice-connected.

Majority of contract hospitalizations is for psychiatric beds

In fiscal year 1974 61.4 percent of contract hospitalizations was for psychiatric care. In 1976 and 1977 psychiatric beds accounted for 82.3 and 85.2 percent, respectively, of the contracted beds. The remainder were for surgery and general medicine. As of January 1978 psychiatric hospitalization accounted for 85.5 percent of the contracted beds.

In fiscal year 1977 hospitalization for psychiatric disorders accounted for $6.4 million of the $9.6 million contract hospital program.

Fee-basis outpatient visits increasing

In 1977 VA had contracts with two outpatient clinics in Ponce, Puerto Rico to provide fee-basis care. In addition under an identification card program--a program to provide outpatient treatment primarily to service-connected veterans on a continuing basis--private physicians provide services to veterans in Puerto Rico. Two contract hospitals and many private physicians provide fee-basis care to veterans in the Virgin Islands.

In fiscal year 1974 60,738 outpatient visits were made under the fee-basis program. The number of visits increased to over 76,000 in 1975, 80,000 in 1976, and to 94,196 in fiscal year 1977. The cost of this program rose from $1.4 million in fiscal year 1974 to $2.3 million in fiscal year 1977.

Visits were not being identified as service-connected or nonservice-connected until April 1976. In fiscal year 1977 the visits were classified as follows.

Service-connected	41,769
Nonservice-connected	40,725
Not specified	11,702
Total	94,196

We were told by the Center Director that even though the visits were not classified as service-connected or nonservice-connected before April 1976, we could get some idea of what type they were by breaking down the visits by location. The breakdown of these visits follows.

No. of Fee Basis Visits

	Fiscal year			
	1974	1975	1976	1977
Category				
Ponce clinics	19,856	30,860	43,601	48,057
ID card program	36,208	40,364	34,356	30,017
Virgin Islands (note a)	-	-	533	4,420
Not specified	4,674	5,602	2,006	11,702
Total	60,738	76,826	80,496	94,196

a/Fee-basis program did not begin until January 1, 1976.

VA officials told us that 70 to 80 percent of the patients treated at the Ponce clinics and 95 percent in the Virgin Islands were nonservice-connected and that all but a few of the patients in the ID card program were service-connected.

This data indicates that the increase in visits has been primarily in the nonservice-connected category.

INELIGIBLE PATIENTS ARE BEING TREATED

In fiscal year 1977 94,196 visits were made under the fee-basis program at a cost of about $2.3 million. Fifty-one percent, or 48,057, of these visits were made at the Ponce clinics and 4.6 percent, or 4,420, were made in the Virgin Islands.

Public Law 94-581 limited fee-basis care for nonservice-connected treatment to only two circumstances--for veterans with a 50 percent or more service-connected condition and for post-hospital, followup care. Outpatient fee-basis care solely to obviate the need for hospitalization and prebed care--both of which were authorized prior to Public law 94-581--became ineligible. This type of care, however, is still being given to a great extent at VA's

two contract clinics in Ponce (Damas and St. Luke's) and by private physicians in the Virgin Islands. 1/

Most of the visits sampled at Ponce clinics were ineligible

Our review of case files of 10[illegible] nonservice-connected patients who made 272 visits to the Ponce clinics during August, September, and October 1977, showed that for 185 visits, or 68 percent, ineligible treatment was received. The ineligible treatment consisted of 182 visits to obviate the need for hospitalization and 3 visits for prebed care.

Taken individually 63 percent of the visits to the Damas Clinic were ineligible and 88 percent of the visits to St. Luke's were ineligible. Ineligible visits included treatment for back pain, nausea, psoriasis, stomach pain, hemorrhoids and similar problems.

A VA physician reviewed 51 of the 100 case files we sampled and agreed with our findings.

Virgin Islands physicians are also treating many ineligible patients

Our review of 20 nonservice-connected patients treated by two physicians on St. Thomas, showed that all 20 cases were treated to obviate the need for hospitalization, and were, therefore, ineligible. Examples of the care provided included treatment of chest pains, headaches, flu, and back problems.

The Virgin Islands VA representative told us that most of the outpatient visits are made by nonservice-connected veterans and a few of these visits are as a followup to hospitalization.

How did this occur?

VA officials told us that the VA Center in San Juan has been providing nonservice-connected ambulatory care

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1/Although this care is not permitted by law, it should be noted that at least some portion of the patients provided ineligible outpatient care could have been treated in either the VA or a contract hospital.

in the Ponce clinics and in the Virgin Islands under the authority of Public Law 93-82.

The Center Director confirmed that he received VA Central Office Interim Issue 10-76-45, dated November 10, 1976, which advised field medical facilities of the enactment of Public Law 94-581 and provided instructions for implementing the law. However, he told us that he did not realize that it affected the treatment provided in Puerto Rico and the Virgin Islands to nonservice-connected veterans. He agreed that, as a result, these patients went on receiving care as if the act had never been enacted. He stated that the contracts with the Ponce clinics should not be renewed. Temporary extensions have been granted by VA's Central Office for the contract with St. Luke's Hospital which expired in December 1977, while VA's General Counsel considers its renewal. The contract with Damas does not expire until June 30, 1978.

The Director said that the curtailment of these contracted services would result in serious negative effects to VA in Puerto Rico and the Virgin Islands. It would adversely affect public relations in the community as well as service organizations. It would also put considerable strain on existing VA facilities in San Juan and Mayaguez, which are already overloaded.

He also stated that if the contracts for the clinics were canceled, the two hospitals which house the clinics would probably cancel their hospitalization contracts with VA.

VA FACILITIES OPERATING NEAR FULL CAPACITY

Admissions to the San Juan VA hospital have increased from 13,233 in fiscal year 1974 to 17,222 in fiscal year 1977. The number of service-connected admissions remained relatively constant at about 3,200, while nonservice-connected admissions increased from 9,861 to 14,068.

The San Juan hospital occupancy rate is among the highest in the VA hospital system. The rate has ranged from 92.5 percent in fiscal year 1974 to 90.1 in fiscal year 1977. Psychiatric beds have had an occupancy rate of 99 percent for the last 4 years. The total operating cost of the San Juan VA hospital has increased from $16.7 million in fiscal year 1974 to $23.9 million in fiscal year 1977.

As shown below visits to the hospital's outpatient clinic over the past 4 years have also increased.

	1974	1975	1976 (note a)	1977
Service-connected	68,120	75,257		74,196
Nonservice-connected	26,967	24,564		71,918
Other (note b)	89,352	103,315		69,363
Total	184,439	203,136	216,236	215,477

a/1976 data recorded as number of veterans not visits, therefore only total visits are shown.

b/Includes visits to determine need for hospitalization, for compensation and pension matters, and for aid and attendance cases (pensioners who receive an extra monetary allowance because they need assistance of another person), all of which can be either nonservice-connected or service-connected but were not indicated.

VA estimates that the demand will exceed 400,000 visits by the early 1980s, although the clinic was designed for a capacity of 70,000 visits annually. A major construction project ($6.8 million) is planned for fiscal year 1979 to relieve congestion, improve patient flow, and provide additional space.

In 1976 VA established the Mayaguez outpatient clinic to better serve the veteran population on the west coast of Puerto Rico. In its justification for the clinic, VA estimated that the workload would be between 25,000 to 45,000 visits a year.

In fiscal year 1977, its first full year of operation, the Mayaguez outpatient clinic had 55,537 visits, exceeding the original anticipated workload.

VA officials had anticipated that the opening of the Mayaguez clinic would decrease the demand at the hospital's clinic. In fact, the number of visits stayed about the same. Although no documentation was available, hospital officials said that the anticipated decrease did not occur because veterans being treated at Mayaguez had not been served by VA prior to the opening of this clinic.

The cost of outpatient visits to VA clinics has increased from $3.9 million in fiscal year 1974 to over $8 million in fiscal year 1977.

REASONS FOR DEMAND FOR VA MEDICAL CARE

There are approximately 156,000 veterans in Puerto Rico and 5,000 veterans in the Virgin Islands. The high incidence of mental disorders, the high unemployment rate, and other economic factors have been mentioned as contributing to the great demand by veterans for medical care under VA auspices.

Many veterans in Puerto Rico are under the national poverty level. According to 1970 census data, the median income per veteran-headed family in Puerto Rico was $5,425 in 1969, $2,700 less than the lowest figure in any part of the United States. Slightly more than 8 percent of all veterans in Puerto Rico are receiving veterans' pensions based on need, as compared to 3.4 percent of all veterans. While there were no studies on the number of veteran families receiving food stamps, about 70 percent of the total population in Puerto Rico is eligible to receive them. The Island is also one of the most densely populated areas in the world and had an official unemployment rate of over 20 percent in 1976 (unofficial rates exceed 30 percent).

A limited survey in 1975 showed that only 3.7 percent of veterans admitted to the VA hospital had private insurance coverage.

The high unemployment rate, critical socioeconomic conditions, and low per capita income result in a great demand for free medical care. From October 1, 1976 to June 30, 1977, 38 percent of the veterans in Puerto Rico and the Virgin Islands applied for care, while VA-wide applications represented 5.9 percent of the total veteran population. Outpatient visits in Puerto Rico and the Virgin Islands during the period averaged 1.27 for each member of the veteran population, as compared to 0.37 for the total veteran population in the United States.

CHAPTER 3

PROGRAM CONTROLS NEED STRENGTHENING

The large contract hospital and fee-basis programs in Puerto Rico and the Virgin Islands require close monitoring and control to insure that veterans are receiving quality care and that the Veterans Administration pays for only services received. VA's control over these programs has been inadequate and as a result, VA has limited knowledge of the quality of care being received by veterans and of the services being rendered. In addition annual audits are not timely and substantial overpayments and underpayments to contract facilities have occurred.

VA MONITORING OF PATIENT CARE IS POOR

A VA inspection team visits each contract hospital annually and reviews a sample of patient records to determine if any problems have been encountered relating to the care being received.

The VA physicians responsible for monitoring the contract hospital program told us that the only reviews made of patient records at a contract hospital are made during these annual visits.

We accompanied VA officials on one annual inspection visit to a contract hospital. During this visit medical records of only eight patients were reviewed, even though almost 1,500 veterans were admitted to this hospital in the previous 1-year period. At another contract hospital we visited, we found a similar situation. During the annual visit, VA hospital officials reviewed about 65 patient records, even though 1,923 veterans were admitted to this hospital during the previous 1-year period. The physicians on the inspection team also reviewed interim and discharge summaries submitted to VA by the hospital's physicians.

We were told that the initial admission period of a psychiatric patient in a contract hospital is 30 days. At the end of this stay a discharge summary or a request for an extension is prepared. A psychiatrist at the second hospital we visited told us that he could not remember VA ever turning down a request for an extension, although it has at times reduced the length of the extension period requested.

The VA hospital's Chief of Psychiatry confirmed this and said that he would not disapprove a request for an extension because he would then be legally liable for any actions taken by the patient.

A VA physician responsible for monitoring activities at the Ponce clinics told us that he reviews new cases for medical eligibility and also specific cases brought to his attention by administrative personnel at the clinic to determine if ambulatory care should be continued. He said that he reviews all requests for consultations made by clinic physicians and conducts a physical examination at a patient's request. He estimated that he reviews 80 to 90 cases a week.

In a review of 100 cases treated at these two clinics in 1977, we found evidence of VA physician review in 49 cases. The physician responsible said that he does not always sign off on cases he reviews and at times administrative personnel fail to bring a case to his attention.

Fraudulent billings from fee-basis physicians

The VA Central Office in 1975 conducted an investigation of billings received from fee-basis doctors in Puerto Rico. The investigation stemmed from a psychiatrist billing VA for $9,785 for a 1-month period. The billing included services rendered on Sunday, September 8, 1974, for 33 fifty-minute interviews (a total of 27.5 hours for that day).

According to VA, results of the investigation showed that:

--One psychiatrist was not treating his veteran patients but billing VA as if services had been rendered.

--Six psychiatrists were seeing their patients for only a few minutes but billing VA for full (50-minute) sessions.

These cases have been referred to the U.S. Attorney in Puerto Rico for prosecution.

In addition the investigation uncovered seven VA-employed psychiatrists treating veterans on a fee-basis

while under full-time employment at the VA hospital. Full-time VA physicians are prohibited by VA regulations from engaging in outside employment.

The San Juan hospital's Chief of Medical Administration Services told us that the Center now regularly reviews fee-basis billings from any physician earning more than $15,000 per year from the program. The billings are examined for irregularities, such as, if a physician is working more than 8 to 10 hours a day. Such a situation would warrant a closer VA review.

The review system does not, however, have procedures (except where a physician's billing appears suspicious or irregular) for detecting those fee-basis physicians who either bill VA for services not rendered or who treat a veteran for a few minutes yet bill for a full session.

During our review, we noted an instance where a fee-basis psychiatrist billed VA for seven full session treatments on 1 day. In addition the physician serves as a full-time employee as Assistant Director and attending psychiatrist at a VA contracted hospital. VA officials were unaware of this arrangement and expressed need for a VA examination of this case for possible abuses.

In the Virgin Islands, VA has never performed any type review of fee-basis physicians.

The Center Director told us that he believes fee-basis doctors in Puerto Rico and the Virgin Islands are now "staying honest" because of the new review system and instructions from the VA Center.

CARE PROVIDED BY VIRGIN ISLANDS PHYSICIANS IS NOT MONITORED

There are no VA medical facilities in the Virgin Islands and veterans seeking treatment go to private physicians. During calendar year 1977 about 71 physicians billed VA for medical services to veterans.

We visited two of these physicians in St. Thomas and reviewed records of 20 veteran patients. We found no discrepancy between services authorized and corresponding treatment in the physician's records.

We did, however, note some examples of possible abuse. In one case a patient was authorized 20 different services over an 8-month period, and another was authorized 17 services in a 5-month period. One other patient was authorized six services in a period of 5 days. These services included an initial visit, a chest X-ray, EKG, urinalyses, and followup visits.

While we did not determine the need for the medical treatment, a VA physician agreed that the cases were questionable. He said, however, that abuse could not be determined without a physician's evaluation of the need for treatment and interpretation of test results. He said that the examples indicated a need for a review by VA.

Both of the two private physicians we visited said that they have never been visited by VA representatives. VA physicians confirmed this and said that they have never performed medical or administrative reviews at private physician offices in the Virgin Islands. They said that they have, however, met with Virgin Islands physicians in a group to discuss administrative procedures for the program, but medical records were not reviewed.

There is greater need for VA to monitor services of private physicians in the Virgin Islands because both the initial legal and medical eligibility of a veteran patient is determined by non-VA personnel.

VA hospital officials agreed that there should be a more indepth review of patient records at contract hospitals and private physicians in both Puerto Rico and the Virgin Islands.

AUDITS NEED TO BE MORE TIMELY

VA should make annual audits of contract facilities cost reports to verify cost data upon which yearly per diem rates are based. Past audits have not been timely, and substantial overpayments and underpayments have occurred.

Over the last 3 years, the VA hospital has completed 21 audits of the 6 hospitals and 2 outpatient clinics

under contract. Most of these audits covered periods through the end of fiscal year 1976. However, none of the facilities have been audited for the most recent 21-month period ended January 1978, and some have not been audited for over 32 months.

When VA enters into an agreement with a facility to provide contractual medical services, an interim per-diem rate is established. Subsequently an audit is supposed to be made -- usually annually -- and the per-diem rate adjusted. Since the interim per-diem rate is retained until adjusted by audit, it is important that the audits be timely.

The effects of untimely audits can be illustrated by the Hato Rey Psychiatric Hospital. As of January 1978 approximately 46 percent of all patients in contract hospitals were in this hospital.

An interim per-diem rate of $30.70 was paid to the hospital for the period July 1974 through June 1975. An audit for this period was conducted in August 1976, resulting in an adjusted per-diem rate of $27.73. However, since the audit was not made until August 1976, the $30.70 interim rate continued to be paid for the subsequent contract period of July 1975 through June 1976. When the July 1975 through June 1976 period was audited in January 1978, the adjusted per-diem rate was $27.72. The overpayment for the period from July 1975 through June 1976 was $246,950.

The Hato Rey hospital has been repeatedly overpaid. In December 1973 VA's Central Office conducted an audit which disclosed an overpayment of about $1.3 million. Of the 21 audits made by the VA hospital over the last 3 years, six have shown overpayments. Three of these six have been for Hato Rey.

The following table shows the overpayments to the Hato Rey Psychiatric Hospital through June 30, 1976.

Date of audit	Period	Overpayment	Balance due as of Jan., 1977
12/73	2/69-2/71	$1,283.693	$422,064
1/75	4/74-6/74	15,458	-
8/76	7/74-6/75	165,523	23,523
1/78	7/75-6/76	246,950	246,950
Total		$1,711,624	$692,537

Overpayments were due primarily to the computation of a per-diem rate based only on VA patients, not all patients, and the inclusion of unallowable expenses in cost reports.

Hato Rey hospital agreed in December 1973 to reimburse the Government for the overpayment identified in the December 1973 audit. The agreement provided for full payment of the claim. The hospital made an initial payment of $50,000 and agreed that VA would withhold 10 percent of all subsequent billings by the hospital until the balance was paid. However, in October 1977, the hospital successfully negotiated a repayment rate of 3 percent of subsequent billings.

The overpayment for the period April 1974 to June 1974 has been paid.

The overpayment for the period July 1974 through June 1975 was to be repaid by an initial payment of about $12,837 and 11 monthly payments of $14,000 each. Hato Rey hospital officials requested that the repayment schedule for the balance of this debt -- $28,000 -- be repaid at a rate of $4,000 per month. The VA Center's Chief of Finance approved this request after reviewing the hospital's current financial situation.

Arrangements have not yet been made for the overpayment for the period July 1975 through June 1976, and fiscal year 1977 has not yet been audited.

Officials at Hato Rey say that one of the reasons for the overpayments is that during a particular year, payments are made on the basis of the prior year's costs. If, as has happened in past years, the actual costs are lower than prior years' costs, overpayments result.

Underpayments to contract facilities have also occurred over the past 3 years. These underpayments have ranged from a low of about $19,000 for 1 year to a high of about $133,000 for 3 years.

In October 1976 a new system was instituted which, according to the Chief of Finance, centralized the entire audit function in the Finance Section. Prior to October

1976 several different offices within the VA hospital were responsible for per-diem rate adjustments.

Under the new system all information -- patient days, interim per-diem rates, over or underpayments -- which was previously obtained from various sources and sections is now compiled by the VA Center auditor and reflected in the auditor's report. VA officials expect this system to correct the deficiencies that we noted.

The Center Director indic .ed that the overpayment problem was due to the facilit_es conservative accounting methods. According to the Director, costs are kept relatively stable. However, as the number of patients increases, the actual per-diem rate decreases after the interim rate is set, causing overpayments.

CHAPTER 4

POLICY CONSIDERATIONS

There are indications that Puerto Rico and the Virgin Islands are getting a disproportionate share of Veterans Administration resources. However, there are several factors which seem to contribute to this situation, such as location and lack of alternative VA facilities, social and economic problems, and a high incidence of mental disorders among the veteran population. Also the applicability of a statutory limitation on the use of contract hospitals to Puerto Rico and the Virgin Islands is uncertain and has not been applied.

In recent years, the Congress has enacted legislation which has expanded the number of veterans who are authorized to receive VA medical care. In complying with this legislation, it has been a longstanding practice for VA to treat all eligible veterans who seek care.

It has been shown that as VA expands a medical program, the number of nonservice-connected veterans who are treated increases and the expanded program soon fills to capacity. It can be expected, therefore, that if VA is permitted to continuously expand its programs with no limitations, this situation will continue.

If limitations are imposed for veterans in Puerto Rico and the Virgin Islands, it would have the effect of VA treating these veterans differently than veterans in the contiguous 48 states. If limitations are placed on the contract hospital program, many veterans will no longer receive VA-sponsored care. Also, if the limitations of Public Law 94-581 are implemented, some portion of the veterans now receiving ineligible fee-basis outpatient care may receive this care as inpatients in either VA or contract hospitals.

Because of these factors, we do not believe that a decision on the future of the contract hospital and fee-basis programs can be made without an assessment of the total health care needs of veterans in Puerto Rico and the Virgin Islands. To date, such an assessment has not been made. We believe that VA is in the best position to make this assessment.

WHAT SHARE OF VA RESOURCES IS PUERTO RICO AND THE VIRGIN ISLANDS RECEIVING?

Puerto Rico and the Virgin Islands veteran population of 161,000 is about 0.54 percent of the total veteran population of 29,800,000. At the end of fiscal year 1977, the San Juan VA hospital's 692 operating beds were about 0.8 percent of the 91,754 beds in the VA system. During fiscal year 1977 VA had, in its own clinics, about 14.7 million outpatient visits. The San Juan VA hospital had about 215,000 visits--almost 1.5 percent of the total. An additional 2.4 million fee-basis visits were made VA wide. Of these, 94,000, or almost 4 percent, were in Puerto Rico and the Virgin Islands.

Other indicators of Puerto Rico's and the Virgin Islands share of VA resources for fiscal year 1977 are shown below.

Applications for medical care

--Total VA applications for care: 2,375,421, or about 8 percent of total veteran population. Total applications for care in Puerto Rico and the Virgin Islands: 81,151, or 50 percent of their veteran populations.

Fee-basis visits

--Total VA visits: 2.4 million, or about 8 percent of the veteran population. Total Puerto Rico and Virgin Islands visits: about 94,000, or about 58 percent of their veteran populations.

VA hospital beds

--Total VA hospital beds per veteran population: 91,754, or one VA bed per 325 veterans. Total Puerto Rico and Virgin Islands hospital beds per veteran population: 692, or one VA bed per 233 veterans.

Private hospital treatment per veteran population

--The proportion of veterans in non-VA hospitals to total veteran population was one per 22,406 veterans. The proportion of veterans in non-VA hospitals in Puerto Rico and Virgin Islands to veteran population was one per 248 veterans.

As shown below although Puerto Rico and the Virgin Islands have a larger percentage of VA beds per veteran population than the United States, they account for 48 percent of non-VA hospitalization in the entire VA system.

Non-VA Hospital Care at VA Expense

	ADC for (note a)	Total ADC for VA	Percent
Alaska	75	1,272	6
Hawaii	88	1,272	7
Puerto Rico and Virgin Islands	608	1,272	48
Remaining 48 States	501	1,272	39

a/Average daily census.

The reasons mentioned as contributing to Puerto Rico and the Virgin Islands receiving a disproportionate share of VA resources are discussed below.

Lack of alternative facilities

Although Puerto Rico and the Virgin Islands are getting a disproportionate share of VA resources in several instances, it must be kept in mind that except for the VA hospital and outpatient clinic in San Juan and the VA outpatient clinic at Mayaguez, veterans have no alternative VA medical care facilities at these locations.

This lack of alternatives is contrasted with the situation in the 48 contiguous states where various VA health care facilities, for example, hospitals, outpatient clinics, nursing homes and domiciliaries, are available. This appears to have contributed significantly to the reliance on the contract hospital and fee-basis programs in Puerto Rico and the Virgin Islands.

Social and economic problems

Economic and social problems may also affect the demand for VA-sponsored health care. Puerto Rico, in particular, is an economically depressed area, with an unemployment rate over 20 percent. It can be expected, therefore, that eligible veterans will avail themselves of "free" VA medical care particularly when they perceive this care as being superior to that available elsewhere.

Mental disorders

A study published in 1974 by the Commonwealth of Puerto Rico Planning Board estimated the incidence of mental illness on the Island at 10 percent. The problem is more seriously manifested in the Island's veteran population because 48 percent of the approximately 19,000 veterans with service-connected disabilities have received their rating for mental disorders. The high number of psychiatric cases among veterans has been a major cause for the need for contract hospitalization.

Many factors have been blamed as contributing to this problem. The socioeconomic status of the veteran is often cited. Another factor often cited is the cultural and language barriers experienced in the service as well as the breaking of close family ties.

Still another explanation which has been offered is the compensation program itself. A discharged veteran returning to an economically depressed environment and "outreached" by an inviting benefit program may "develop" a mental disorder in order to take advantage of a promising source of income.

VA's policy of compensating hospitalized service-connected veterans contributes to this problem. Once service-connected veterans are hospitalized for 21 days, they are deemed to be 100 percent disabled, regardless of their prehospitalization ratings, and receive compensation at the 100-percent level for the length of the hospital stay. This practice has been mentioned to act as an incentive for a service-connected veteran to seek hospitalization for a long period.

Because of problems found in the granting of service-connection for mental disorders and the treatment received by patients in Puerto Rico, certain questions are raised regarding the legitimacy of the problem as it relates to VA.

For example the results of the Commonwealth Planning Board's study led the San Juan VA Adjudication Division in 1974 to try to ascertain the propriety of disability ratings granted for service-connected mental disorders.

Results of the review indicated that from 1966 to 1969 rating boards were extremely liberal in the granting of service-connection for psychiatric conditions. Veterans' service records contained no indication of a nervous or a mental condition, but promptly after discharge, service-connected psychiatric conditions were claimed and awards were made.

The rating boards granted service-connections to many veterans for mild anxiety reaction. The rating boards justified this on the basis of the nature of Vietnam service and the fact that the condition was claimed within a short time after discharge.

VA's review also uncovered instances where service-connection was granted for a psychiatric disorder due directly to an organic condition. According to VA in these instances the rating board not only failed to obtain solid supporting expert opinions but at times even acted on the basis of opinions loosely expressed by rating board examiners.

As a result of VA's review, 396 of 413 cases considered suspicious had their service-connected status arbitrarily stopped in July 1975. Of these, 181 accepted the decision and 215 appealed. The disposition of the appeal cases was: 102 sustained, 73 reversed, 10 sent back for more information, and 30 still pending. At least 283 of the 396 cases have been permanently dropped.

Limitations on use of contract hospitals not applied to Puerto Rico

The limitation on the use of contract hospitalization imposed by Public Law 90-612 has not been applied to Puerto Rico or the Virgin Islands. If it had, the maximum number of contract hospital beds would have been 414 instead of the 608 beds contracted for in fiscal year 1977.

As discussed below VA's General Counsel has determined that the limitation is not applicable to Puerto Rico.

The limitation in 38 United States Code 601(4)(C)(v) states:

"* * * (T)he annually determined average hospital patient load per thousand veteran population

hospitalized at Veterans' Administration expense in Government and private facilities in each such noncontiguous State may not exceed the average patient load per thousand veteran population hospitalized by the Veterans' Administration within the forty-eight contiguous States * * *." (Underlining added.)

The VA General Counsel's opinion that the statutory limitation is not applicable to Puerto Rico is based primarily on the fact that the language in question was changed following the achievement of Statehood by Alaska and Hawaii, to continue the authority for contract care to veterans in those new States. Prior authority for contract care in territories and possessions did not contain the quoted restriction, and the VA General Counsel cites legislative history to the effect that the Congress intended the restriction to apply to Alaska and Hawaii so that veterans in those States would receive equal treatment with those in the 48 contiguous States with respect to hospitalization at VA expense. This assumes that the Congress never intended to change the prior treatment accorded to veterans in U.S. territories and possessions, including the Commonwealth of Puerto Rico.

In view of the circumstances cited by VA's General Counsel, we cannot state that the VA opinion is erroneous. We believe, however, that the statute relating to limitations on use of contract hospitals is ambiguous and should be corrected. Contract hospital care is authorized in a "noncontiguous State, territory, commonwealth, or possession," but only the word "State" is used in the limitation language. The ambiguity arises because the word "State," as used in title 38, is defined in 38 United States Code 101(20) to include territories, possessions, and the Commonwealth of Puerto Rico.

EXPANDED VA PROGRAMS UTILIZED BY NONSERVICE-CONNECTED VETERANS

It has been shown that as VA expands its medical care programs, the number of nonservice-connected veterans who are treated increases and the expanded program soon fills to capacity. For example Public Law 93-82 authorized outpatient care for veterans with nonservice-connected illnesses. From the time the expanded outpatient program was authorized in 1973, there was a rapid growth in fee-

basis care and a growing proportion of such funds being used to treat veterans for nonservice-connected conditions. Outpatient visits to the San Juan clinic have likewise increased from over 184,000 in 1974 to over 215,000 in 1977, and VA estimates the demand will exceed 400,000 visits by 1980. The workload for nonservice-connected conditions increased by 167 percent during this period--from 26,967 visits in 1974 to 71,918 visits in 1977. In 1979 the hospital plans to improve its outpatient program at an estimated cost of $6.8 million.

Another example is the opening of the Mayaguez outpatient clinic in 1976. The clinic was justified on the basis that it would reduce the cost of the fee-basis program for the large veteran population in that area. VA also believed that the demands on the outpatient clinic in San Juan would decrease.

The anticipated decrease in costs and reduced workload of the San Juan clinic did not materialize. For 1977, the first complete year of the Mayaguez clinic's operation, VA experienced an increase in costs over the fee-basis programs and the demand on the San Juan clinic did not substantially decrease. The opening of the clinic in Mayaguez actually "drew out" many veterans who were not previously receiving VA care in the Mayaguez area -- most of whom were nonservice-connected. More than two-thirds of the 41,000 visits in 1977 were for treatment of nonservice-connected illnesses.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Because the San Juan Veterans Administration hospital is operating at near capacity, VA has made extensive use of the contract hospital program to provide inpatient care and has used the fee-basis program to provide outpatient care. On the basis of the number of veterans served by VA and under VA auspices, there appears to be a need to continue both programs at some level. However, ineligible care is being provided under the fee-basis program as a result of not complying with the restrictions imposed on such care by Public Law 94-581. It is also not clear whether the statutory limitation imposed on the use of contract hospitals by Public Law 90-612 is applicable to Puerto Rico and the Virgin Islands.

VA needs to monitor more closely the programs so that it is aware of the quality of care being received by veterans. It also needs to perform more timely audits to provide better controls over program costs.

In considering the future of the programs, the Congress must recognize that the delivery of health care to veterans in Puerto Rico and the Virgin Islands is unique in that there are no alternative VA facilities available. This lack of alternative facilities, their locations, and the socio-economic conditions existing in Puerto Rico must be considered in deciding the future of the contract hospital and fee-basis programs.

If the programs are continued without limitations, it must be recognized that they will probably, as in the past, benefit largely veterans with nonservice-connected conditions. It can also be expected that if the San Juan outpatient clinic program is expanded, as planned, its workload will probably be increased by treatment of veterans with nonservice-connected conditions and may have little or no impact on the fee-basis program.

We believe that a comprehensive assessment is needed of the health care needs of veterans in Puerto Rico and

the Virgin Islands. We believe that such an assessment should also address the issue of the high rate of service-connected mental disorders in Puerto Rico as well as the management weaknesses we found in the contract hospital and fee-basis programs.

RECOMMENDATIONS

We recommend that the Administrator of Veterans Affairs:

--Implement the conditions imposed by Public Law 94-581 on the fee-basis outpatient program by not accepting any new patients who are ineligible for this care and terminating care as soon as possible for those patients who are now receiving ineligible care.

--More closely monitor the fee-basis and contract hospital program, such as more indepth reviews of patient records, to insure that veterans are receiving quality care and that VA pays only for services received.

--Perform audits of contract hospitals' cost reports within 90 days after the close of each period unless it can be demonstrated to VA hospital management that more time is needed.

--Require any proposal from the San Juan VA hospital for additional beds to clearly demonstrate what impact such an addition would have on the contract hospital program.

In order to provide time for VA to make a complete assessment of the total health care needs of veterans in Puerto Rico and the Virgin Islands, we recommend that a 1-year extension--to December 31, 1979--be granted for the contract hospital program. We also recommend that the Congress direct VA to make such an assessment and to provide a report, with appropriate legislative recommendations, to the Congress no later than April 1, 1979.

Since there is uncertainty as to whether the limitation imposed by Public law 90-612 on the use of contract hospitals is applicable to Puerto Rico and the Virgin Islands, we also recommend that the Congress revise the law to clarify its position as to what type and to what extent limitations should be imposed.

CONTRACT FACILITIES IN PUERTO RICO AND VIRGIN ISLANDS

Name	Type of facility	Location
Hato Rey Psychiatric	NP (note a)	Hato Rey, P.R.
Fernandez Garcia	NP	Hato Rey, P.R.
Nuestra Senora de los Angeles	NP	Rio Piedras, P.R.
Mimiya Hospital	GM&S (note b)	Santurce, P.R.
Ryder Memorial Hospital	GM&S	Humacao, P.R.
Damas Hospital	GM&S/OPT (note c)	Ponce, P.R.
St. Luke's Hospital	GM&S/OPT	Ponce, P.R.
Charles Harwood Memorial Hospital	GM&S/OPT	St. Croix, V.I.
Knud Hansen Memorial Hospital	GM&S/OPT	St. Thomas, V.I.

a/NP = Neuropsychiatric.

b/GM&S = General Medicine and Surgery.

c/GM&S/OPT = General Medical and Surgery/Outpatient. These hospitals provide both GM&S hospital care and outpatient clinic care.

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