



Testimony

Before the Subcommittee on Health,
Committee on Veterans' Affairs, House of
Representatives

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VA LONG-TERM CARE

Veterans' Access to
Noninstitutional Care Is
Limited by Service Gaps
and Facility Restrictions

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues



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Highlights

Highlights of [GAO-03-815T](#), a testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

With the aging of the veteran population, the Department of Veterans Affairs (VA) is likely to see a significant increase in long-term care need. VA uses noninstitutional long-term care services, such as home health care and adult day health care, and institutional care to meet this need. GAO identified limits in veterans' access to six noninstitutional long-term care services and factors that contribute to these limitations in its report *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care* ([GAO-03-487](#), May 9, 2003). The report is based, in part, on a survey of all 139 VA facilities. Today's testimony discusses conclusions and highlights recommendations GAO made in the report to improve access to VA noninstitutional long-term care services.

What GAO Recommends

In its report GAO recommended that VA:

- ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services, and
- refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services.

VA concurred with the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-03-815T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

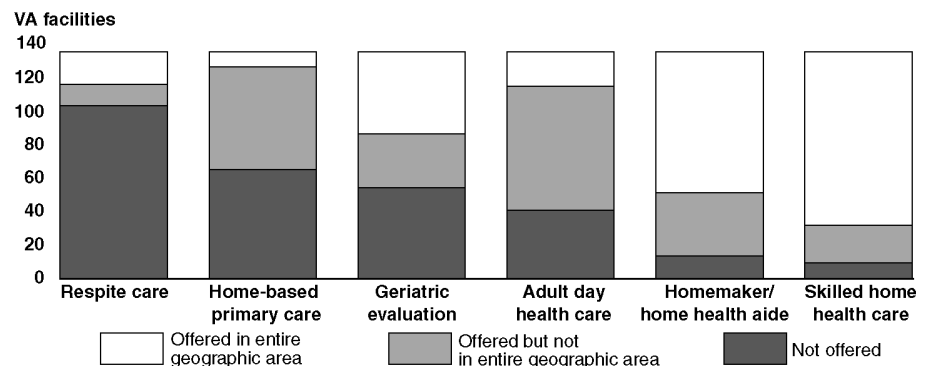
VA LONG-TERM CARE

Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions

What GAO Found

Veterans' access to the six noninstitutional services GAO reviewed is limited by service gaps and facility restrictions. Of VA's 139 facilities, 126 do not offer all six of these services—adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care. Veterans have the least access to respite care, which is not offered at 106 facilities. By contrast, skilled home health care is not offered at 7 facilities. Veterans' access is more limited than these numbers suggest, however, because even when facilities offer these services they often do so in only part of the geographic area they serve. In fact, for four of the six services the majority of facilities either do not offer the service or do not provide access to all veterans living in their geographic service area. Veterans' access may be further limited by restrictions that individual facilities set for use of services they offer. For example, at least 9 facilities limit veterans' eligibility to receive noninstitutional services based on their level of disability related to military service, which conflicts with VA's eligibility standards. Many facilities restrict the number of veterans who receive services resulting in veterans at 57 of VA's 139 facilities being placed on waiting lists for noninstitutional services.

Noninstitutional Long-Term Care Services Not Available to All Veterans, Based on Geographic Areas, at VA's 139 Facilities as of Fall 2002



Source: GAO.

VA's lack of emphasis on increasing access to noninstitutional long-term care services has contributed to service gaps and individual facility restrictions that limit access to care. Faced with competing priorities and little guidance from headquarters, field officials have chosen to use available resources to address other priorities. While VA has implemented a performance measure for fiscal year 2003 that encourages networks to increase veterans' use of five of the six noninstitutional services, it does not require networks to ensure that all facilities provide veterans access to noninstitutional services.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs (VA) noninstitutional long-term care services and how veterans' access to these services could be improved. Meeting the long-term care needs of veterans is growing in importance as the number of veterans most in need of these services—those 85 years old and older—is expected to increase from 640,000 to 1.3 million by 2012. To provide assistance to veterans with chronic illness or physical or mental disability, VA provides a continuum of noninstitutional and institutional services. Noninstitutional services are provided to veterans in their own homes or in community settings, and include specific services to meet the requirements of the Veterans Millennium Health Care and Benefits Act.¹

VA provides noninstitutional services directly through its own employees and by contracting for services. In fiscal year 2002, VA spent approximately \$283 million on noninstitutional long-term care services and served an average daily census of about 24,000 veterans. By contrast, VA spent nearly \$3 billion on institutional long-term care provided in nursing homes and other settings and had an average daily census of more than 43,000 veterans.

My remarks are based on a recent report and other issued work.² We surveyed each of VA's 139 medical facilities to obtain data on the availability of six noninstitutional long-term care services,³ and identified any limits in access and reasons for these limitations. These services included three VA provides to meet the requirements of the Millennium Act—adult day health care, noninstitutional geriatric evaluation, and noninstitutional respite care—in addition to home-based primary care,

¹In November 1999, the Congress passed the Veterans Millennium Health Care and Benefits Act, which required that VA provide veterans access to three services—adult day health care, geriatric evaluation, and respite care. VA chose to meet the Millennium Act requirements by issuing a directive in October 2001 requiring that facilities provide adult day health care, noninstitutional geriatric evaluation, and noninstitutional respite care to veterans in need of such services.

²U.S. General Accounting Office, *VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care*, [GAO-03-487](#) (Washington, D.C.: May 9, 2003). Also see Related GAO Products.

³Although VA has 172 medical centers, in some instances 2 or more medical centers have consolidated into health care systems. Counting health care systems and individual medical centers that are not part of a health care system as single facilities, VA has 139 facilities.

skilled home health care, and homemaker/home health aide. We also interviewed VA officials and examined documents related to these issues.

In summary, we found that veterans' access to the six noninstitutional services we reviewed is limited by the lack of service availability and restrictions on their use. Of VA's 139 facilities, 126 do not offer all six services. Veterans have the least access to noninstitutional respite care, which is not offered by 106 VA facilities. By contrast, skilled home health care is not offered by 7 facilities but is provided by the remaining 132. Veterans' access to care is more limited, however, because even when facilities offer these services they often do so in only parts of the geographic area they serve. More than half of VA facilities do not offer four of the six services—noninstitutional respite care, home-based primary care, adult day health care, and noninstitutional geriatric evaluation—at all, or only offer such services in parts of the geographic areas they serve. Veterans' access may be further limited by restrictions that individual facilities place on the services they offer. For example, we found that 9 facilities, in conflict with VA's eligibility standards, limited veterans' access to noninstitutional services based on their level of disability related to military service. In addition, restrictions placed by many facilities on the number of veterans who can receive these noninstitutional services have resulted in veterans at 57 of VA's 139 facilities being placed on waiting lists for noninstitutional services.

VA's lack of emphasis on increasing access to noninstitutional long-term care services and a lack of guidance on the provision of these services have contributed to service gaps and individual facility restrictions. VA headquarters has not emphasized increasing access to these services by establishing measurable performance goals as it has for other priorities such as maintaining workloads in VA nursing homes. Without such performance measures, field officials faced with competing priorities have chosen to use available resources to address other priorities. VA has implemented a performance measure for fiscal year 2003 that encourages networks to increase veterans' use of five of the six noninstitutional services, but it does not require networks to ensure that all network facilities provide veterans access to noninstitutional services. Moreover, VA has not provided facilities with adequate guidance on the provision of noninstitutional respite care, even though most have had little experience in providing the service. Some networks and facilities are confused about how to provide noninstitutional respite care and as a result some are not providing the service. VA has also not provided adequate guidance on which noninstitutional services are required. In particular, VA has not specified whether the home health services requirement includes one, all,

or some combination of home-based primary care, homemaker/home health aide, and skilled home health care. In the absence of VA headquarters guidance on what home health services are required, VA facilities vary in their interpretations of what services they must provide.

To help ensure that veterans have access to noninstitutional long-term care services and that such services are offered uniformly throughout VA, we are recommending that VA take actions to increase emphasis on provision of these services, provide adequate guidance on their provision, and ensure that VA's eligibility standards are used to determine eligibility. Specifically, we are recommending that VA (1) ensure that facilities follow VA's eligibility standards when determining veteran eligibility for noninstitutional long-term care services, (2) define and provide guidance on noninstitutional respite care, (3) specify in VA policy whether home-based primary care, homemaker/home health aide, and skilled home health care are to be available to all enrolled veterans, and (4) refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services. In commenting on a draft of our report, VA concurred with our recommendations, discussed preliminary actions it plans to take, and stated that it will provide a detailed action plan to implement our recommendations.

Background

Changes in VA's eligibility standards have resulted in an increase in the number of veterans who are eligible to receive VA health care, including noninstitutional long-term care services. The Veterans' Health Care Eligibility Reform Act of 1996⁴ authorized VA to provide health care services not previously available to veterans without service-connected disabilities or low incomes.⁵ As required by the act and due to an anticipated increase in demand for VA health care from these changes in eligibility, VA has eight priority categories for enrollment, with higher priority given to veterans with service-connected disabilities, lower incomes, or other recognized statuses such as former prisoners of war. If sufficient resources are not available to provide care that is timely and

⁴Pub. L. No. 104-262 §§ 101, 104, 110 Stat. 3178-79, 3182-83 (1996).

⁵A service-connected disability is an injury or disease that was incurred or aggravated while on active military duty. VA classifies veterans with service-connected disabilities according to the extent of their disability. These classifications are expressed in terms of percentages—for example, the most severely disabled such veteran would be classified as having a service-connected disability of 100 percent. Percentages are assigned in increments of 10 percent.

acceptable in quality for all priority groups, the act requires VA to limit enrollment nationally, consistent with the eight priority groups. If needed, enrollment restrictions would begin with the lowest priority category. On January 17, 2003, VA announced that it would no longer enroll priority 8 veterans, those in the lowest priority category, for the duration of the year.⁶

VA long-term care includes a continuum of services for the delivery of care to veterans needing assistance due to chronic illness or physical or mental disability. Assistance with veterans' needs takes many forms and is provided in varied settings, including institutional care in nursing homes or home and community-based noninstitutional care. Long-term care also includes respite care services that temporarily relieve a caregiver from the burden of caring for a chronically ill and disabled veteran in the home.

VA's long-term care infrastructure, including nursing homes it operates, was developed when the concentration of veteran population was distributed differently by region. When VA developed its long-term care infrastructure, it relied more on nursing home care and less on home and community-based services than current practice. To help update VA's long-term care policy, the Federal Advisory Committee on the Future of VA Long-Term Care recommended in 1998 that VA meet the growing demand for long-term care by greatly expanding home and community-based service capacity while maintaining its nursing home capacity at the level of that time.⁷

VA has delegated decision making regarding financing and service delivery for long-term care and other health care services to its 21 health care networks. VA allocates resources for health care to each of the 21 networks, including resources used for long-term care. In turn, VA's networks have budget and management responsibilities that include allocating resources received from headquarters to facilities within their networks—including resources used to provide long-term care services.

⁶Priority 8 veterans are primarily veterans with no service-connected disabilities who have incomes above established limits for geographic regions set by the U.S. Department of Housing and Urban Development to reflect regional costs of living. Priority 8 veterans enrolled prior to January 17, 2003, remain enrolled to receive VA health care benefits.

⁷*VA Long-Term Care At The Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care* (Washington, D.C.: June 1998).

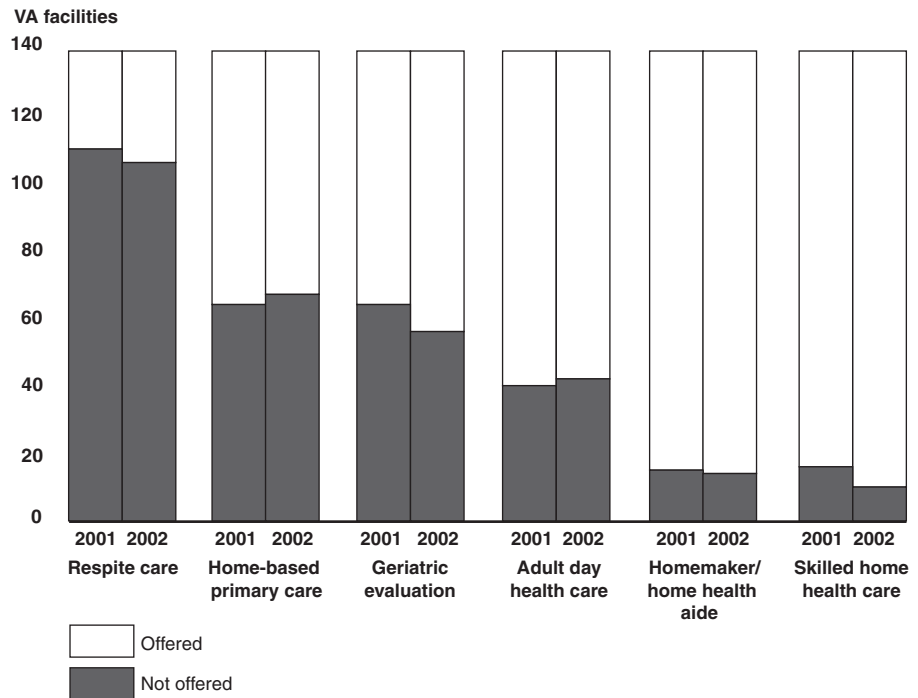
Veterans' Access Is Limited by Gaps in Service Availability and Facility Restrictions on Service Use

Veterans' access to the six noninstitutional services in our review—adult day health care, geriatric evaluation, respite care, home-based primary care, homemaker/home health aide, and skilled home health care—is limited due to gaps in availability and facility restrictions on use of the services. Of VA's 139 facilities, 126 do not offer all six noninstitutional services. Facilities that do offer a service do not always offer the service to veterans in the entire geographic area they serve. Further, veterans' access to the six noninstitutional services may be limited by restrictions that individual VA facilities place on service use. Some of these facility restrictions conflict with VA eligibility standards which state that most services are to be available to all enrolled veterans regardless of priority group.

Access to Care Is Limited by Service Gaps Across VA

Access to care is limited because many VA facilities do not offer the six noninstitutional services in our review. Of VA's 139 facilities, 126 did not offer all of the six noninstitutional services in fall 2002 with little progress made in expanding the availability of services from fall 2001. (See fig. 1.) The least commonly available service of the six we reviewed in 2001 and 2002 was noninstitutional respite care. This service was not available at 110 facilities in fall 2001, and as of fall 2002, noninstitutional respite care was not available at 106 facilities. In contrast, the most widely available service we reviewed was skilled home health care, which was offered at all but 7 facilities.

Figure 1: Noninstitutional Long-Term Care Services at VA's 139 Medical Facilities

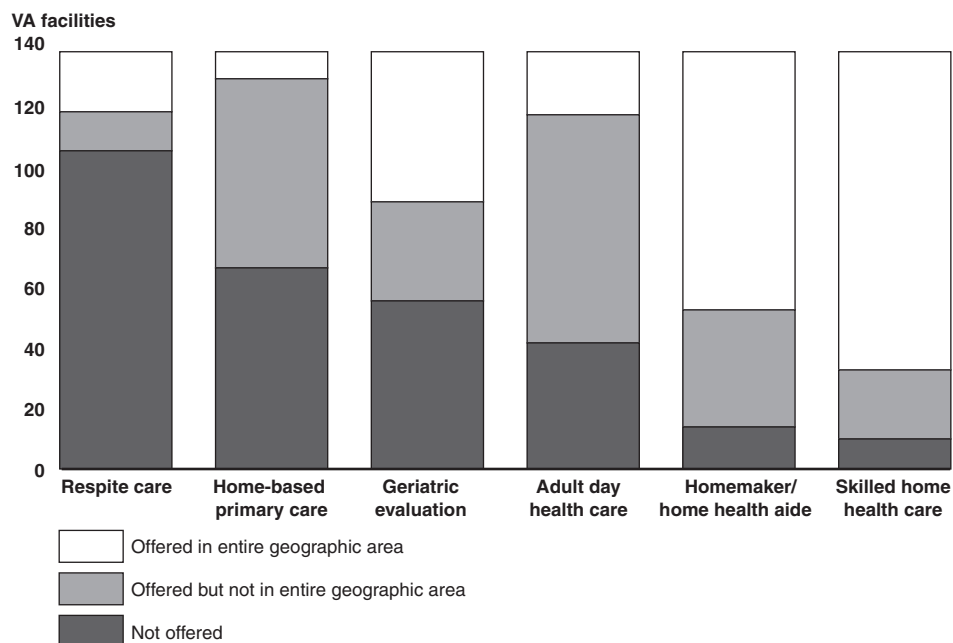


Source: GAO.

Note: Includes services provided directly by facilities or through contracts with other providers as of fall 2001 and fall 2002.

Veterans' access to these services is further limited because among facilities that offer services, many do so in only parts of the geographic area they serve. Our fall 2002 survey showed that for four of the six services—noninstitutional respite care, home-based primary care, adult day health care, and noninstitutional geriatric evaluation—the majority of the facilities either did not offer one or more of the services or did not offer them in the entire geographic area they serve. As shown in figure 2, 42 facilities did not offer adult day health care and an additional 76 facilities did not offer adult day health care in their entire geographic service area. As a result, where veterans live in a facility's geographic service area determined whether they had access to the services offered by the facility. The remaining 21 facilities reported that they offered adult day health care in all parts of their geographic service areas.

Figure 2: Noninstitutional Long-Term Care Services, Based on Geographic Areas, at VA's 139 Medical Facilities



Source: GAO.

Note: Includes services provided directly by facilities or through contracts with other providers as of fall 2002.

The Millennium Act and VA policy also allow facilities to make available to veterans the services required as a result of the Millennium Act—adult day health care, noninstitutional respite care, and noninstitutional geriatric evaluation—through other providers or payers while still overseeing the care delivered using a case management approach.⁸ In these cases, VA could arrange for these services from non-VA sources but would not pay for them. However, VA headquarters has neither issued guidance on the use of case management to meet this requirement under the Millennium Act nor has it monitored the extent to which facilities use this option. Further, the benefit of VA case management in assisting veterans to access these three services is limited to those veterans who have some other sources to pay for the care. That is, if veterans are not eligible for care

⁸Case management includes assessment of the veteran's care needs, care planning and implementation, referral coordination, monitoring, and periodic reassessment of the veteran's care needs.

covered by another payer, such as Medicaid, or cannot pay themselves, case management assistance is not likely to result in access to the three services.

Veterans' Access to Care Is Further Limited by Individual Facility Restrictions

Some facilities limit access to services based on veterans' service-connected disability levels. For example, we found that nine VA facilities imposed their own eligibility restrictions on access to noninstitutional services based on veterans' service-connected disabilities. Because we did not systematically ask in our survey if facilities had restrictions based on service-connected disabilities, it is possible that additional facilities may impose similar eligibility restrictions. Such restrictions conflict with VA eligibility standards and result in inequitable access for veterans enrolled at these facilities. VA's eligibility standards state that most services are to be available to all enrolled veterans, regardless of priority group.⁹

Many facilities also limit the number of veterans who may receive a service at a particular time. As a result, when more veterans need service than the established facility limit, these veterans have to wait for service until space or resources become available. In our survey, 57 of VA's 139 facilities reported that veterans are on waiting lists for one or more of the six noninstitutional services we reviewed as a result of restrictions placed on the number of veterans who may receive a service.

We are recommending that VA ensure that its facilities follow VA's eligibility standards when determining eligibility for noninstitutional long-term care services. The examples we found clearly point out the need for VA to take such action to ensure that facilities follow VA eligibility standards so that similarly situated veterans have access to similar care across the country. VA concurred with this recommendation and stated that the Veterans Health Administration will add eligibility sections in each new directive and handbook concerning Home and Community Based Care Programs. In addition, VA stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

⁹Although VA issued a regulation on September 17, 2002, granting priority for appointments to veterans with service-connected disabilities of at least 50 percent and veterans needing care for a service-connected disability, the regulation does not change other veterans' eligibility to receive services.

Lack of Emphasis and Inadequate Guidance Contribute to Limited Access

A lack of VA emphasis on increasing access to noninstitutional long-term care services and inadequate VA guidance on providing these services have contributed to limited access for veterans. Until fiscal year 2003 VA had not provided measurable standards for the provision of these services or oversight to monitor their provision as it had for high-priority services. VA guidance on the provision of noninstitutional long-term care services has left unclear to some facilities how noninstitutional respite care service is to be defined and provided and whether all of the home health services in our review are a part of what VA requires be made available to veterans who need them.

VA Has Not Emphasized Increased Access to Noninstitutional Long-Term Care Services

VA network and facility officials told us that VA headquarters has not emphasized increased access to noninstitutional long-term care services but emphasized other priorities. As a result, these officials said they use their resources for the priorities VA headquarters emphasizes rather than noninstitutional services. For example, officials in 9 of VA's 21 networks told us that VA headquarters' emphasis on the performance measure that requires networks to maintain workload in VA nursing homes has led them to devote resources to nursing home care that they might otherwise have used to provide noninstitutional services. One network director told us that the "pressure" from VA headquarters to maintain nursing home utilization is much greater than that to offer noninstitutional services. In another network, an official at a VA facility not offering three of the services in our study told us that these services were "victims of competition for resources." In other words, the facility had not funded these three noninstitutional services because facility officials had chosen to devote resources to other services. Another network director told us that, if forced to choose between funding different services, the network would allocate resources to services included in a performance measure.

One way VA emphasizes services is through performance measures, which VA establishes to monitor network officials' progress toward meeting certain VA strategic goals, such as increasing veterans' access to services. VA has demonstrated that requiring network officials to meet measurable performance standards can promote change. For example, since their inception in fiscal year 1996 VA has included a performance measure for providing immunizations to prevent pneumonia to veterans age 65 and older and those at high risk of the disease. VA increased the percentage of such veterans who received the immunization from 26 percent in fiscal year 1996 to 81 percent in fiscal year 2002.

In October 2002, VA introduced a performance measure for noninstitutional long-term care which requires all networks to provide noninstitutional services to a portion of their enrolled veterans needing such services.¹⁰ The fiscal year 2003 goal for this measure will require the majority of networks to increase utilization of their noninstitutional services. The performance measure includes five of the services in our review but does not include noninstitutional geriatric evaluation. However, the performance measure does not require networks to ensure that veterans have access to noninstitutional long-term care services at all network facilities. Instead, network performance targets can be achieved if networks increase utilization at facilities that already offer noninstitutional services.

We are recommending that VA refine current performance measures to help ensure that all VA facilities provide veterans with access to required noninstitutional services. Without refinements that include individual facility performance, existing measures will not hold networks accountable for providing required services at each facility. VA concurred with this recommendation and stated that the Veterans Health Administration will develop performance measures to underscore the importance VA places on its noninstitutional long-term care programs. In addition, VA stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

VA Has Provided Inadequate Guidance on the Provision of Noninstitutional Respite Care

VA headquarters has provided inadequate guidance to networks and facilities on the provision of noninstitutional respite care to address confusion in the field about what this service is and how it should be provided. This confusion exists, in part, because VA has limited experience with noninstitutional respite care and VA traditionally provided respite care in institutions such as nursing homes. Noninstitutional respite care, by contrast, is provided only in noninstitutional settings, such as a veteran's own home.

Although noninstitutional respite care has been required by VA for over a year, VA has not issued adequate guidance on the provision of noninstitutional respite care and VA staff told us they were unsure how to

¹⁰ According to VA, when it plans for noninstitutional services it assumes that the vast majority of veterans will choose to use their Medicare benefits for home health care.

develop a noninstitutional respite care service. VA issued a directive in October 2001 that requires all facilities to provide noninstitutional respite care to veterans in need of the service yet it inadequately defines noninstitutional respite care and does not provide facilities with information regarding how to provide the service. For example, the directive states that noninstitutional respite care may be provided in a home or other noninstitutional settings. However, it does not specify which noninstitutional settings may be used for the purpose of respite care. In fact, officials in 6 of the 21 networks indicated that there was confusion in their networks about how to establish noninstitutional respite care programs and 1 of these networks reported this was the reason facilities in the network were not providing the service. Further, in our survey, six facilities reported that they offer noninstitutional respite care in community nursing homes, which are institutional settings, thus not meeting the requirement for noninstitutional respite care. VA headquarters officials said they are developing a handbook that will define and provide guidance on the provision of noninstitutional respite care.

We are recommending that VA define and provide guidance on noninstitutional respite care so that facilities can be clear on what noninstitutional respite care is and how and where it is to be provided. VA concurred with this recommendation and stated that it will provide a detailed action plan to implement this and other recommendations we made on VA's noninstitutional long-term care services.

VA Guidance Does Not Specify Which Home Health Services Are Required

VA requires that facilities offer a home health services benefit as part of its medical benefits package.¹¹ VA headquarters officials told us that the home services benefit includes home-based primary care, homemaker/home health aide, and skilled home health care. However, VA policy does not specify whether one, some combination, or all three home health services are required under the home health services benefit. Currently 138 out of VA's 139 facilities offer at least one of these three home health services, 59 facilities offer two of the three services, and 66 facilities offer all three. Without clear guidance to facilities on what services they must make available in order to fulfill the home health services benefit, facilities vary in their interpretation of what is included in the benefit and headquarters cannot ensure that veterans have access to the services to which they are entitled.

¹¹The medical benefits package is the set of services to be available to all enrolled veterans.

Because facilities and networks vary in their interpretation of what is included in the home health services benefit, facilities do not uniformly offer the same home health services. For example, at one facility we visited, an official told us that the facility interpreted the home health services benefit to mean that veterans must have access to skilled home health care—which the facility made available to all veterans. The facility restricted veterans’ access to its homemaker/home health aide and home-based primary care services because facility officials did not believe these services were required under VA’s home health benefit. Similarly, in another network an official told us that the network interpreted the home health services benefit to include all three home care services—home-based primary care, homemaker/home health aide, and skilled home health care. As a result, access to these three services varies according to facility interpretation of what is required.

We are recommending that VA specify in VA policy whether home-based primary care, homemaker/home health aide, and skilled home health care are to be available to all enrolled veterans. VA concurred with this recommendation and VA stated that it will provide a detailed action plan to implement this and other recommendations we made on VA’s noninstitutional long-term care services.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgements

For further information regarding this testimony, please contact me at (202) 512-7101. James C. Musselwhite also contributed to this testimony.

Related GAO Products

VA Long-Term Care: Service Gaps and Facility Restrictions Limit Veterans' Access to Noninstitutional Care. [GAO-03-487](#). Washington, D.C.: May 9, 2003.

Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs. [GAO-03-756T](#). Washington, D.C.: May 8, 2003.

Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably. [GAO-02-1121](#). Washington, D.C.: September 26, 2002.

VA Long-Term Care: The Availability of Noninstitutional Services Is Uneven. [GAO-02-652T](#). Washington, D.C.: April 25, 2002.

VA Long-Term Care: Implementation of Certain Millennium Act Provisions Is Incomplete, and Availability of Noninstitutional Services Is Uneven. [GAO-02-510R](#). Washington, D.C.: March 29, 2002.

Veterans' Affairs: Observations on Selected Features of the Proposed Veterans' Millennium Health Care Act. [GAO/T-HEHS-99-125](#). Washington, D.C.: May 19, 1999.

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