



STATEMENT OF
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BEFORE
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS AFFAIRS
HEARING ON PAST AND PRESENT EFFORTS TO IDENTIFY AND
ELIMINATE FRAUD, WASTE, ABUSE, AND MISMANAGEMENT IN
PROGRAMS ADMINISTERED BY
THE DEPARTMENT OF VETERANS AFFAIRS
JUNE 17, 2004

INTRODUCTION

Mr. Chairman and Members of the Committee, thank you for the opportunity to provide the views of the Office of Inspector General (OIG) as I focus my Office's resources on identifying and eliminating fraud, waste, abuse, and mismanagement in programs administered by the Department of Veterans Affairs (VA). During the past year, I have worked closely with the Department to identify trends, programs, processes, and individuals who commit acts that are conducive to fraud, waste, and abuse.

Today, I will present to you my observations and summarize some of our most recent work. I will also highlight management areas where I believe further improvement is needed. But first, I would like to take this opportunity to acknowledge a few of the many VA employees who have been recognized for providing quality health care, timely service, creative research, or just plain caring for veterans.

Dr. George Cooper, the Cardiology Chief at VA Medical Center (VAMC) Charleston received the Carl J. Wiggers Award from the Heart and Vascular Section of the American Physiological Society for research on the causes of heart failure.

Dr. Gary Bryson, VAMC Connecticut and Dr. Richard Lin, VAMC Northport, received the Presidential Award for Early Career Scientists and Engineers. This is the highest honor bestowed by the federal government on outstanding scientists and engineers.

Dr. Merrill Benson, a staff physician at VAMC Roudebush in Indianapolis received the Pasteur-Weizman/Servier International Prize in Biomedical Research Award in Paris. This award is presented every three years to recognize a researcher who has achieved a major biomedical discovery that has led to a therapeutic application.

John F. Ciak, Social Worker at VA Pittsburgh Healthcare System, was recently awarded the Blinded American Veterans Foundation's (BAVF) George Alexander Memorial Volunteer Award during the 19th Annual BAVF Congressional Awards Reception.

Finally, in a ceremony at the Central Alabama Veterans Health Care System, Mr. Tommy Weldon presented the Acting Director with a check for \$86,515 from the estate of his brother Bennie Weldon. For the last 7 years of his life, veteran Bennie Weldon received compassionate care from the health care professionals at the Montgomery facility. Mr. Weldon's instructions were that his donation be used for patient activities and personal care items for hospitalized veterans. VA employees everywhere make a positive difference in the veterans' lives they touch. The OIG also works to make a positive difference in veterans' lives.

Since last year's hearing, we have issued 250 audit reports, contract reviews, administrative investigations, health care inspections, and Combined Assessment Program (CAP) reviews with actual or potential monetary benefits of over \$2 billion. We opened 1,053 criminal investigations, closed 1,062, arrested 617 individuals, and recovered \$43 million in fines and restitution. We continue to maintain an OIG presence

at VA facilities by conducting CAP reviews that include fraud and integrity briefings to raise employee awareness of fraudulent activities that can occur in VA programs.

I remain committed to ensuring our work is accomplished consistent with our strategic goals and aligned with the strategic goals of the Department. Our current work is addressing many of the challenges VA is facing, and we are identifying opportunities to maximize the economy and efficiency of VA's programs and activities.

HEALTH CARE DELIVERY

VA reports that the number of veterans using the Department's health care system has risen dramatically, increasing from 2.9 million in 1995 to nearly 4.5 million in 2003. This increase has significantly challenged the Department's capacity to treat veterans. We have identified several major issues impacting health care delivery that need to be addressed by the Department in order to provide safe, high quality medical care, reasonable waiting times, and accessibility to care.

I will highlight the most significant management areas where I believe further improvement is needed.

Staffing Standards and Time and Attendance

The lack of staffing standards for physicians and nurses as required by Public Law 107-135 continues to impair the Veterans Health Administration's (VHA) ability to adequately manage personnel resources. Congress passed Public Law 107-135 which requires the Secretary, in consultation with the Under Secretary for Health, to establish a policy on the staffing of medical facilities to ensure that staffing for physicians and nurses is adequate to provide veterans appropriate, high-quality care and services. These staffing standards were to be in place in January 2002. In our testimony of May 8, 2003, we stated that VHA must implement this requirement and advised that other government entities had physician staffing models that may be of use.

In their response to our testimony, VHA indicated that models for primary care physicians were being developed and that a model would be presented to the Deputy Under Secretary for Health by June 16, 2003. As of this date, VHA has yet to mandate that VHA facilities utilize a uniform model to establish primary care provider staffing standards. VHA is further behind in their process of establishing staffing models for subspecialty medical physicians.

The failure to utilize a standard model to determine requirements for physician and nurse staffing and performance impairs the organization's ability to effectively make resource allocation decisions. In our recent investigation of a VA medial center, we found that disputes over the number of physicians required to manage a given workload was central to a breakdown in trust between the facilities leadership and its physician staff. At a time when an aging veteran population has changing health care needs and veterans of current conflicts are becoming reliant upon the VA for services, VHA managers need an agreed

upon method to forecast personnel requirements at the clinic level to ensure that quality medical care can be provided.

At the request of the Secretary, we audited VHA's management of part-time physician time and attendance, physician productivity in meeting employment obligations, and physician staffing requirements. The audit objectives were to determine if: (i) timekeeping and other management controls were effective in ensuring that part-time physicians worked the hours required by their VA appointments; and (ii) VHA used effective procedures to align physician staffing with workload requirements. Our report, *Audit of Veterans Health Administration's Part-Time Physician Time and Attendance*, Report No. 02-01339-85, was issued April 23, 2003.

We reported that VAMC managers did not ensure that part-time physicians met employment obligations required by their VA appointments. Although VHA had established time and attendance policy and procedures to account for part-time physicians, neither VHA headquarters officials nor VAMC managers enforced the policy. VHA management at many levels told us they were generally satisfied with physician productivity and believed VA received more value than it paid for from the services provided by part-time physicians, despite timekeeping violations. However, our results showed that part-time physicians were not working the hours established in their VA appointments. As a result, we concluded part-time physicians were not meeting their employment obligations to VA.

VHA did not have effective procedures to align physician-staffing levels with workload requirements. VAMCs did not perform any workload analysis to determine how many full time employee equivalents were needed to accomplish the VAMCs' workload. In addition, VAMCs did not evaluate their hiring alternatives such as part-time, full-time, intermittent, or fee basis appointments. VAMC managers responsible for staffing decisions did not fully consider the physicians' other responsibilities - such as medical research, teaching, and administration - when they determined the number of physicians the VAMCs needed. VHA officials told us the determination of the number of part-time physician employee equivalents needed had more to do with the financial needs of the affiliated university in meeting physician pay packages, than the number of hours needed by VA to meet patient workload requirements. In addition, only one of the managers at the five VAMCs we visited told their part-time physicians what was expected of them to meet their VA employment responsibilities.

Nurse Staffing

In our current review of VHA Nurse Staffing, we found that the nursing shortage is affecting patient care, employee morale, and costs at VHA facilities. Facility leaders might have been able to mitigate these consequences had VHA developed and implemented procedures to ensure: (1) efficient management of nurse staffing resources through the use of consistent staffing methodologies, standards, and data systems; (2) monitoring of the potential impact of nurse staffing issues on patient care; (3) effective

use of recruitment and retention strategies; and (4) appropriate management response to issues that influence Registered Nurse job satisfaction.

VHA administrators in the field have sought help from military service manpower experts to use their models to assist in resource allocation decisions at the local level. Some senior managers at VA medical centers have created their own models as evidenced in the article by Dr. Coleman, Eileen Moran and others, entitled “*Measuring Physicians’ Productivity in a Veterans Affairs Medical Center*”.¹ This article suggests that there are benefits to having these standards beyond their use in resource allocation decisions to include:

- Identifying barriers to efficient clinical service.
- Identify clinicians who need assistance to become more productive.
- To equitably distribute workload.
- To improve documentation of clinical care and resident supervision.
- To promote quality care and other clinical goals.

Although we do not endorse this specific model, there are many possible models upon which to base productivity and staffing standards. Further delay by VHA in meeting the requirements of PL 107-135 only increase the likelihood that poor business decisions will be made.

Follow-up of the Veterans Health Administration’s Part-Time Physician Time and Attendance Audit – Report Number 03-02520-85, dated 2/18/04

Our follow-up to the 2003 audit found that VHA’s implementation of management controls continues to need improvement to ensure that part-time physicians meet their employment obligations. Specifically, we found that:

- 58 of 729 part-time physicians (8 percent) scheduled for duty were not on duty, approved leave, or authorized absence and potentially not meeting their VA employment obligations.
- 25 physicians claimed to be on non-emergency leave but there was no evidence that the leave was approved.
- 18 physicians stated they had changed their scheduled tour of duty but had not requested and received prior written approval for the schedule changes.
- 15 of the 58 were either located performing non-VA duties or could not be located at all on the day of our follow-up.
- 7 of 15 medical facilities did not make sure that each part-time physician was provided a written agreement, specific to the physician, acknowledging the physician’s understanding of VA’s employment expectations and employee responsibilities, and which described the amount of time allotted for clinical, administrative, research, and educational activities.

¹ Coleman, David L. et al, “Measuring Physicians’ Productivity in a Veterans Affairs Medical Center”, *Academic Medicine*, Vol. 78, No. 7 pp 1-8.

- 120 of 215 (56 percent) supervisory physicians reviewed received a copy of VHA Handbook 1660.3 on conflict of interest controls.

We recommended that VHA ensure that part-time physicians receive advance approval before taking non-emergency leave and have tour of duty changes approved in writing, ensure part-time physicians execute a written agreement acknowledging VA employment expectations and individual responsibilities, ensure periodic evaluations are conducted to determine whether physicians are appropriately utilized, and ensure that physician supervisors and managers receive a copy of VHA Handbook 1660.3. The Under Secretary for Health agreed with the findings and recommendations.

As of June 3, 2004, all recommendations remain open. VHA needs to: create and program software changes to the VA electronic time and attendance program related to part-time physicians; finalize VA Handbook 5011, Hours of Duty and Leave; confirm all Network Directors are reporting on levels of compliance with Directive 2003-001, Time and Attendance for Part-Time Physicians and Handbook 5011 as part of their quarterly performance reviews with the Deputy Under Secretary for Health for Operations and Management; and confirm the VISN quarterly performance reviews show that all facilities establish oversight monitoring processes, ensure all part-time physicians have a written agreement concerning VA's expectations and employee responsibilities, continue to periodically reassess whether employees are appropriately utilized, and confirm that each Chief of Staff, physician, and health supervisor receives a copy of VHA Handbook 1660.3, Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis, and Intergovernmental Personnel Act Requirements, and signs the acknowledgement form.

Time and Attendance Hotlines

From May 1, 2003, through June 8, 2004, we opened 62 Time and Attendance hotline cases. At this time, 41 of the cases have been closed. Of the 41 closed cases, 4 had appropriate action taken prior to our inquiry, and 9 resulted in founded allegations.

Evaluation of Hotline Complaint Concerning Time and Attendance of Two Part-Time Physicians at Kansas City VA Medical Center, Report No. 02-01198-103, dated 5/23/03

At the request of the Secretary, we reviewed an anonymous complaint sent to Congressman Ike Skelton alleging that two part-time physicians continue to abuse their time and attendance responsibilities by treating non-VA patients at the affiliated Kansas University Medical Center. OIG investigators substantiated a previous accusation of time and attendance irregularities on both physicians in October 2001. We also substantiated the new allegation that both physicians did not meet their time and attendance responsibilities. In total, we estimate the physicians were overpaid \$13,102. We also found that:

- Physicians treated non-VA patients at the affiliated University Medical Center during their scheduled VA time, in some cases working at the university while claiming sick leave or authorized absence from VA. The physicians were inappropriately paid for 75.5 hours (\$5,393) when the physicians were at the university treating non-VA patients.
- The Surgery service timekeeper did not always use the subsidiary time and attendance report as the basis for paying the physicians. We identified a net total of 109.25 hours (\$7,709) the physicians were paid in excess of the hours they claimed on their subsidiary time and attendance reports.

The Medical Center Director concurred with our findings and took immediate actions. A bill of collection was issued to both physicians on May 13, 2003, for the amounts shown in the report. In addition, the medical center conducted a 100 percent review of the surgery service timekeeping records. Directions were issued immediately to all timekeepers to re-emphasize the importance of accurate timekeeping. We considered the Director's implementation actions to be acceptable, and all three recommendations are closed.

Combined Assessment Program Reviews

Since I last addressed this Committee, my staff has conducted 42 CAP reviews at VHA health care facilities. Our CAP reviews continue to find systemic weaknesses relating to accountability for time and attendance of part-time physicians and a need to align physicians' hours of work consistent with actual workload requirements.

The need for physician and nurse staffing standards grows more pressing every day as veteran demographics continue to change and plans are implemented to realign capital assets supporting the delivery of health care services.

Access to Care and Patient Waiting Time

Audit of VHA's Reported Medical Care Waiting Lists, Report No. 02-02129-95, dated 5/14/03

This audit was conducted to verify the accuracy of the medical care waiting lists and determine the causes of any inaccuracies found. Our results showed that VHA's medical care waiting lists for new enrollees and established patients were overstated. Also, significant numbers of new enrollees were misclassified and should have been reported on the established patient waiting list. The inaccuracies occurred because appointment schedulers did not update the waiting lists as veterans received appointments or medical care, and they did not enter follow up appointments appropriately into the Veterans Health Information Systems and Technology Architecture (VistA) scheduling package. The total waiting list of 309,186 veterans should have reported about 218,000 veterans, or 91,000 veterans (29 percent) fewer than reported.

It is important that waiting list data be accurate because VHA uses the data in planning budget priorities, measuring performance, and determining whether strategic goals are met. Inaccurate waiting lists compromise the ability to assess and manage demand and credibility of VHA responses to internal and external stakeholder concerns. VHA managers recognized the need to improve the accuracy of tracking patients who were on waiting lists. In response, the Department began taking corrective action during our audit, with plans for a nationwide electronic waiting list. The Under Secretary for Health concurred with the audit findings and provided acceptable implementation plans.

As of June 3, 2004, all four recommendations were closed. VHA created an electronic waiting list that replaced local systems and allowed patient information to be rolled-up nationally for analysis; installed a patient appointment patch to the FileMan routine so that it does not include veterans appropriately scheduled, erroneous appointments, duplicate names, or cancelled appointments on the waiting lists; released a video; and provided training.

Combined Assessment Program Reviews

A review of patient waiting time and pharmacy waiting time was included in many of the FY 2004 CAP reviews and identified opportunities for the Department to improve in these areas. We reported that VA needed to reduce waiting time for prescriptions and ensure that patient waiting time is accurately reported. I plan to continue close monitoring and oversight of this issue in the future.

Health Care Resources Contracts

As I noted in my testimony last year, OIG audits and pre-award reviews of contract proposals have identified a number of issues with the solicitations and proposals relating to contracting for health care resources. These issues include violations of conflict of interest laws, inadequate assessment of VA's needs, contracting for resources without evidence that the positions could not be procured through direct hiring, failure to ensure that contracts were in the best interests of the Department, and failure to ensure price reasonableness and to follow established contracting procedures.

Unfortunately, the problems cited in my prior testimony continue to exist. We have concluded that the issues relating to these contracts stem generally from poor acquisition planning and the belief that VA must support the affiliates at all costs.

In the past year, we completed 28 pre-award reviews of proposals for sole-source contracts to be awarded to VA affiliated institutions pursuant to the provisions of 38 USC § 8153. These reviews recommended cost savings in the amount of \$9,496,482. For four contracts that were awarded during this time period, the medical centers sustained 98 percent of our recommended better use of funds for those proposals or \$1,263,617. Our reviews provided VA officials with recommendations for ensuring that, when awarded, the contract meets the needs of the VA, is in the best interests of the Government, and ensures that our veterans receive quality medical care in a timely manner.

During the past year, we have seen an increase in contracting for health care services. These services are provided at VA facilities, on a procedure basis, using Medicare rates as the basis for establishing contract pricing. Our reviews have consistently shown that VA is paying significantly more than the Government would have paid for the same services under Medicare. In addition, we continue to find that VA is overcharged for services provided under Full Time Equivalent (FTE) based contracts. I will describe the issues we have identified below:

- Contract prices are established at 100 percent or more of the Medicare Part B rates. These prices are too high because the Medicare rate includes an overhead component, averaging 30 percent of the rate. The overhead component is to compensate the physician for costs associated with maintaining and providing care in a private office setting. When the care is provided to the veterans at VA facilities, the Government, not the contractor, has already incurred these costs.

One affiliate proposed payment of 110 percent of the Medicare Part B rates for physician services to be provided at VA. Based on the anticipated numbers and types of procedures, the proposed cost for the first year of the contract was approximately \$1.25 million. Including the overhead component of the Medicare rate and a proposed 6.5 percent mark-up for each procedure, anticipated cost savings of \$420,749, or 34 percent of the proposed contract costs, could be realized.

- Regulations issued by the Centers for Medicare and Medicaid Services require that the examination or procedure be done by or in the presence of the attending physician to qualify for payment under Medicare Part B. We have not seen any evidence in our reviews that these regulations were applied, or even considered, by VA personnel in contracting for services on a per-procedure basis.

A post-award review of operating room records for a 9-month time period indicated the presence of the attending physician as the surgeon, first or second assistant in less than 47 percent of the 307 procedures used to determine contract pricing. Clinic records for a 7-month period of time that were used as the basis for determining payment for outpatient treatment showed attending involvement in less than 10 percent of the 2,328 patient encounters.

- Medicare Part B payments for procedures may be global in nature in that they cover care provided for a finite number of days both pre- and post-operatively. Our reviews indicate that VA medical centers have not established adequate mechanisms to monitor the patient encounters used to calculate payment to ensure that VA is not overcharged.

In one review, we identified surgical procedures that had a 90 day global rate. We then reviewed records reflecting outpatient visits that were used to determine contract pricing. We found examples where services rendered within the global time period were counted as separate billable events. In several instances, VA was charged two

or more times for the same clinic visit because the attending and the resident or two residents charged for the same encounter.

- In FTE based contracts, we have identified reluctance on the part of some VA medical centers and their affiliates to identify the key personnel who will be expected to provide services under the contract. This practice raises both quality of care and contract pricing concerns. From a quality of care standpoint, the failure to identify the personnel expected to provide care reduces VA's ability to provide continuity of care to veterans. We believe this could lead to delays and errors in diagnosis and treatment. With regard to pricing, an affiliate will identify its entire pool of physicians who are able to provide the services, in lieu of identifying key personnel. The proposed pricing is based on an average of the salaries and benefits of the physicians in the pool rather than the salaries and benefits of the physicians who will actually provide services under the contract. Because there is great disparity between the salaries of individual physicians, this can result in VA paying more than its pro-rata share of the costs.

A review disclosed that salaries and benefits for physicians at one facility ranged from \$158,000 to \$281,000 (\$123,000 difference). At another, they ranged from \$108,000 to \$233,000 (\$125,000 difference). A third ranged from \$168,000 to \$278,000 (\$110,000 difference).

One affiliate proposed an annual cost of \$418,700 for each of the three FTE required under the contract. Review showed that the salaries for the pool of seven physicians ranged from \$263,000 to \$441,000 or a weighted average of \$418,700. Our review of data from the prior agreement showed that only three of the seven physicians actually provided the services and their salaries ranged from \$386,000 to \$387,000. If VA accepted the proposed price of \$418,700, VA would have paid \$96,000 more per year than the affiliate would have paid in salaries and benefits to the physicians providing the services.

- Another area of concern is the "level of effort" used by VA and the affiliate in defining an FTE. For VA contract pricing purposes, both VA and the affiliates define an FTE "level of effort" using a standard 40 hour work week or 2080 hour work year. This is consistent with Title 38 which requires that a full-time physician work at least 80 hours every bi-weekly pay period. In addition, Title 38 does not contemplate that physicians will be compensated for working more than 40 hours a week. However, it is not unusual for the contractual agreement between the affiliate and the provider to define the work week as 50-60 hours or more. If VA pays the entire salary and benefits package for an FTE and the level of effort for the contract physician at VA is 40 hours, he is still expected to work the remaining 10-20 hours per week treating patients at the affiliate. The result is a windfall profit for the affiliate because the provider is generating revenue for the affiliate with no off-set for salary or benefits.

- Recently, we have seen a trend towards adding costs for call time in addition to the salary and benefits packages used to calculate prices for an FTE based contract. We have learned that the affiliates do not pay the providers any additional pay or benefits for call time. We also have been advised that the physicians are not on-call only for VA. Rather, they routinely provide call support at the affiliate and VA. This not only results in additional funding to the affiliate but it puts veterans at risk if an attending physician is providing care at the affiliate and not available to provide care at VA.

Review of Biological, Chemical, and Radiological Inventories

On March 19, 2002, my office issued 16 recommendations to the Department to improve overall security, inventory, and internal controls over biological, chemical, or radioactive agents at VHA facilities.² We performed this review at the request of the Secretary in October 2001 following the September 11, 2001, terrorist attacks and the anthrax distribution in the U.S. Postal System.

In the report, we identified that security and physical access controls were needed in research and clinical laboratories, and other areas in which high risk or sensitive materials may be used or stored, or where those materials were actually in use (e.g., biological agents [bioagents], chemicals, gases, and certain radioactive materials). We found inventories of these types of sensitive materials were often incomplete or inadequate. While most facilities we visited had complied with requirements for disaster planning and preparedness, many had not updated these plans to include considerations for terrorist threats or actions. We also found inadequacies in background screening and assurance procedures for employees and contractors allowed to access sensitive areas.

Most of the report's recommendations were made to the Under Secretary for Health; however, several recommendations required joint efforts on part of VHA, VA Human Resources, Security and Law Enforcement, Disaster Preparedness and Planning, and others in the Department. As of June 3, 2004, 15 of the 16 report recommendations remain open.

My office will not close these recommendations until laboratory security upgrades have been made, training is developed and provided to all applicable employees, personnel security issues are addressed, and VAMC Directors certify implementation of directives and security requirements. Before VA can achieve these measures, actions are needed to internally review the VA laboratories, and publish related research and clinical laboratory requirements. Directives also need to be issued on the use of facility identification cards, shipment, receipt, and possession of biological agents defined in 42 CFR Section 72.6, background checks, emergency response training, vulnerability assessments of department property, and physical security requirements.

² OIG Report Number 02-00266-76, "Review of Security and Inventory Controls Over Selected Biological, Chemical, and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities", dated 3/19/02.

VA comments to my testimony last year indicated that actions would be taken to internally review Bio-Safety Level (BSL)-3 research facilities to ensure they complied with the necessary security requirements. VA's comments also indicated that security upgrades and other recommended actions were in process or would be taken on all applicable laboratories and areas of risk.

The Office of Research Oversight reported that it completed inspections in February 2004 at all VHA medical facilities that house BSL-3 laboratories. Unfortunately, these inspections did not address all the issues raised in our report. New research laboratory security policies and procedures have recently been issued. Clinical laboratory and the security and law enforcement directives were recently issued in draft for Department comment. VHA has assured us that once these directives have been issued all actions would be taken to implement and certify completion of the recommendations.

VHA's Contract Community Nursing Home Program

My office identified the need for VHA to strengthen Community Nursing Home (CNH) oversight and control practices as far back as January 1994. We found at that time that VHA needed to perform annual reviews, routinely use quality-of-care information from state agencies in evaluating the quality and safety of CNHs, and conduct inspections and patient visitations to ensure veterans receive appropriate care. We also recommended that VHA develop standardized inspection procedures and criteria for approving homes for participation in the program to include quality oversight controls for monitoring the adequacy of care. In April 2002, I conveyed in my semi-annual report to the Congress concerns that VHA had still not responded to our recommendations to strengthen oversight of its CNH Program.

In 2002, we published another report on community nursing homes³ in which we found that veterans were subjected to abuse in community nursing homes. VHA published a new CNH policy (VHA Handbook 1143.1) on June 24, 2002, and in July of 2002, in response to our CNH report, conducted an internal review of their policy and determined that changes were required. In VHA's response to our testimony last year, they indicated that they had a 25 point plan to further refine their CNH oversight efforts.

On June 3, 2004, VHA finalized Handbook 1143.2 (VHA Community Nursing Home Oversight Procedures) and notified us that it was being issued. After the handbook is issued, the following actions are required to close all other recommendations: finalize new performance indicators; confirm all the scheduled training audio broadcasts have been completed; confirm that the website has been upgraded from the prototype to a finalized site; provide evidence to demonstrate that community health nurses and social workers are visiting veterans in CNHs at the recommended frequency and gathering the recommended information; complete additional guidance, appropriate website links, and special broadcast on new exclusionary criteria related to neglect and abuse; and finalize

³ OIG Report No. 02-00972-44, Healthcare Inspection "Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program", dated 12/31/02.

implementation plan/coordinated efforts on how VHA CNH and VBA Fiduciary and Field Examination employees can most effectively complement each other and share information.

We will continue to monitor VHA's actions to ensure full implementation of the handbook requirements and other recommendations.

VHA's Home Health Aide Program

We issued a summary evaluation of VHA's Home Health Aide Program.⁴ As part of the OIG's CAP reviews, we inspected the program at 17 VA medical facilities. Fourteen percent of the patients receiving program services in our sample did not meet clinical eligibility requirements. Initial assessments by clinicians were often no more than referrals to the program. The assessments rarely included documentation of actual evaluations by all required interdisciplinary team members, and did not thoroughly document patients' disabilities, dependencies, and needs for services. Some facilities had many patients on waiting lists and did not always consider clinical eligibility or patients' needs. Programs with scarce resources and wait-listed patients cannot afford to serve ineligible patients or patients not requiring these services.

To enhance controls, VHA managers need to issue policy for the provision and acquisition of program services to improve the quality of care and to maximize the use of resources. This policy should address assessment and monitoring of needs, including consideration of the patient's clinical eligibility and special monthly compensation or pension status. VHA managers also need to establish a method of benchmarking rates for the acquisition of program services. If VHA had established benchmark rates as recommended in a 1997 OIG report, the program could have, on average, redirected about \$10.7 million annually to treat additional patients.

We made two recommendations. The Under Secretary for Health concurred and provided responsive implementation plans. All recommendations remain open. VHA needs to: finalize a handbook on bench mark rates for home health and hospice care reimbursement that has been in draft since July 2000, finalize another handbook on general administration of purchased home health and hospice care, introduce a new referral form, and seek a General Counsel opinion as to whether a veteran's special monthly compensation or pension status can be considered when prioritizing need for services and determining frequency of authorized Home Health Aide visits.

⁴ OIG Report No. 02-00124-48, Healthcare Inspection, "Evaluation of VHA Homemaker and Home Health Aide Program", dated 12/18/03.

Health Care Investigations

I will highlight some of the more significant criminal investigations we have conducted at certain VA medical facilities.

Albany Oncology Research

As a result of an investigation, a Federal grand jury returned an indictment in October 2003 charging a former VA employee with criminally negligent homicide, involuntary manslaughter, wire fraud, mail fraud, and making false statements for his actions in a scheme to enroll ineligible veteran patients in lucrative drug studies being conducted at VAMC Albany. The indictment charges that the former employee falsified medical documentation so that veterans who did not meet the criteria to participate in the clinical studies could be enrolled and that his actions led to the death of one of these veterans.

Responding to allegations of improprieties regarding VA research programs is a priority in the Office of Inspector General. During the past year, we have opened eight investigations regarding allegations of wrongdoing in VA research programs.

Oakland Park Out-Patient Clinic

Our joint investigation with the Drug Enforcement Administration and local law enforcement disclosed that between March 2001 and January 2003, two VA employees, a pharmacy technician and a purchasing agent, conspired to divert over 600,000 tablets of hydrocodone and alprazolam from the VA outpatient clinic in Oakland Park, FL. The VA employees sold the drugs to a drug operation involving between 30-40 mid-level dealers in Florida. Both employees were indicted on multiple counts of conspiracy, possession with intent to distribute, and theft of property of a health care benefit program and both pled guilty. The first defendant was sentenced to 24 months' imprisonment to be followed by 36 months' supervised release and was ordered to make restitution. He also was ordered to forfeit \$600,000 to the U.S. Government. The second defendant was sentenced to three months' imprisonment to be followed by 36 months' supervised release and was ordered to make restitution. Our Special Agent who worked this case recently received the National Commander's Law Enforcement Award from the Military Order of the Purple Heart in recognition of his efforts regarding this investigation.

Maintaining strong inventory controls in VA pharmacies continues to be extremely important. During this past year, we have opened more than 80 investigations into theft of drugs. Of the 42 VHA CAPs completed during the past year, 31 disclosed controlled substance accountability issues.

Combined Assessment Program Reviews

A summary of recent CAP reviews is provided as an Attachment to my testimony. The most common areas needing VHA management attention are shown below:

- Contracting for Non-Clinical Services
- Environment of Care
- Government Purchase Cards
- Information Management Security
- Management of Supply Inventories
- Management of Violent Patients
- Patient Care and Quality Management
- Pharmaceutical Issue – Controlled Substance Accountability

BENEFITS PROCESSING

The Veterans Benefits Administration (VBA) reported just under 520,000 total Compensation and Pension (C&P) claims pending, including about 325,000 requiring rating action as of May 1, 2004. However, the number of claims pending rating decisions continues to increase. The timeliness of C&P rating actions that previously averaged 195 days is currently averaging 175 days, demonstrating improvement in the timeliness of claims processing.

In FY 2004, the backlog of claims began to increase primarily because VBA was unable to make decisions on cases as a result of a court decision. This decision invalidated a provision that permitted VA to decide a claim prior to the expiration of the one-year notice in the Veterans Claims Assistance Act. In December 2003, correcting legislation was signed by the President that clarifies VA may make a decision on a claim before the expiration of the one-year notice period.

The Department credits recent improvements in timeliness to the reforms recommended by the Secretary's Claims Processing Task Force, which was charged with identifying ways to expedite claims and deliver benefits to veterans more timely. The task force report defined some 70 actions to accomplish the 34 recommendations of the Task Force. VBA has implemented 55 of these 70 actions.

CAP reviews at VA regional offices continue to find that C&P claims processing is failing to achieve prescribed timeliness goals at most facilities where we tested these controls. In addition, we have found inaccurate actions on system error messages, inaccurate entry of data, and improper reduction of pension benefits of veterans hospitalized for extended periods at Government expense. VBA needs to address the continuing CAP findings and work toward full implementation of the Task Force recommendations.

Incarcerated Veterans

The total dollar value of incarcerated veteran overpayments is significant and additional incarcerated veterans are being identified at a rate of 600-700 monthly. Our 1999 report, *Evaluation of Benefits Payments to Incarcerated Veterans* (Report No. 9R3-B01-031), estimated that about 13,700 incarcerated veterans had been, or will be, overpaid about \$100 million. We closed the report on August 19, 2002, after VBA required their VAROs to establish and collect overpayments on state and local prison matches.

VBA reached an agreement with Social Security Administration (SSA) to use the State Verification and Exchange System to identify claimants incarcerated in state and local facilities. In addition, VBA is now matching C&P data with data managed by the Bureau of Prisons and SSA on a monthly basis to identify incarcerated veterans. At this time, VBA does not have procedures in place to track the disposition of these cases and quantify the results of the matching program, which VA is required to report annually along with other erroneous payments.

We will continue to monitor this important area during our CAP reviews at VBA Regional Offices.

Fugitive Felon Program

As I mentioned in my testimony last year, the Fugitive Felon program was established within the OIG in order to comply with the provisions of the new law. This program is a collaborative effort involving my office, VBA, VHA, and VA Police Services. The program consists of conducting computerized matches between fugitive felon files of law enforcement organizations and VA benefit files. Location information is provided to the law enforcement organization responsible for serving the warrant for those veterans identified as fugitive felons. Fugitive information is subsequently provided to VA so that benefits may be suspended and to initiate recovery action for any overpayments.

Memoranda of Understanding (MOU) have been completed with the U.S. Marshals Service, National Crime Information Center (NCIC), and the States of California, New York, and since my last testimony, Tennessee, Washington, and Pennsylvania. Agreements are pending with additional states that do not enter all of their felony warrants into NCIC.

To date, more than 2.2 million felony warrant files have been received from the participating agencies and states. These warrant files were matched to more than 11 million records contained in VA benefit system files, resulting in the identification of 32,346 matched records. The records match has resulted in 11,153 referrals to various law enforcement agencies throughout the country. The information provided to the agencies has led to the apprehension of 402 fugitive felons; 239 of these arrests were made with the direct assistance of my Special Agents and VA Police Officers. A number of the fugitives apprehended were sought on charges of murder, manslaughter, sexual assault, robbery, drug offenses, and other serious felonies.

In addition, 8,299 fugitive felons identified in these matches have been referred to the Department for benefit suspension resulting in the creation of \$54.5 million in overpayments and an estimated cost avoidance of over \$100 million. With an estimated 1.9 million felony warrants outstanding in the United States and an estimated 2 million new felony warrants added each year, should this program be fully funded, the estimated cost avoidance is projected to reach \$209.6 million.

We also identified 69 VHA employees who had current outstanding felony warrants. To date, we have arrested 38 of these employees with the assistance of the VA Police. The other 31 employees were not arrested because they were non-extraditable. In those cases, we have notified VHA of the employee's fugitive felon status so that proper administrative action can be taken. The apprehension of felons creates a safer environment for VA facilities and our communities.

Some of the more significant VA OIG fugitive felon cases that resulted in apprehensions are highlighted below:

- The Tennessee Bureau of Investigation requested the assistance of my New Orleans office in locating one of their "10 Most Wanted." The veteran was wanted on a state murder charge and a Federal Unlawful Flight to Avoid Prosecution warrant. Investigation resulted in the subject being located and taken into custody in April 2003 without incident at a VA Medical Center.
- A subject who was featured on the television show "America's Most Wanted" was identified as a veteran receiving monthly VA compensation benefits. A federal warrant had been issued for the subject for violating conditions of his pre-trial release on a bank robbery charge. The subject also had abducted and fled with his three-year-old son. Special Agents from my Dallas Office offered their assistance to the FBI and using the new law had the subject's VA benefits terminated. The FBI and local law enforcement officers subsequently apprehended the subject in September 2003 in another state. The child was returned unharmed to his mother.
- A case containing limited information was referred to my Dallas Field Office for further investigation. Our investigators determined that the fugitive, who was wanted for a double homicide that had occurred in 1975, had used an innocent veteran's social security number. During the course of the investigation, we determined the location of the fugitive and forwarded this information to a U.S. Marshals Fugitive Felon Task Force. The information provided led directly to the subject's location, and in May 2003, the subject was taken into custody.
- Special Agents from my Newark Office and Deputy U.S. Marshals apprehended a veteran fugitive felon wanted on an outstanding arrest warrant for murder. The subject recently had been charged with intentionally causing the death of another by stabbing. The subject was apprehended in July 2003 at a VA outpatient clinic in Philadelphia.

- A VAMC employee was identified as a fugitive felon wanted on a kidnapping charge. The subject allegedly used a handgun in kidnapping a woman off the street, and drove her to another location where the victim was robbed and subsequently released. The employee was apprehended at the VAMC by VA OIG agents, VA Police and the local police department.

Our fugitive felon program will continue to assist other law enforcement agencies in locating and apprehending dangerous felons who have evaded justice and represent a significant safety risk to the American public and VA facilities.

Death Match Project

My office is also conducting a proactive death match project. This project is a continuous program that involves annual matching of the VA C&P database with the SSA's records of death file. It is conducted in concert with VBA and VA's Debt Management Center. The purpose is to identify veterans who died, where VA is still erroneously paying benefits. During the last year, our Special Agents recovered \$2.9 million in benefits paid to deceased payees and made 24 arrests of individuals involved in the theft of these payments.

Since we began this proactive project in FY 2000, 713 investigations have been opened. Of the 569 completed investigations, \$10.5 million has been recovered, and another \$7.5 million has been identified for recovery. Based on our efforts to date and pending and open cases, we project recoveries and savings of \$153 million. We have also arrested 94 individuals as a result of this initiative.

San Juan VA Regional Office Benefits Review

In FY 2004, my Office and VBA implemented a benefits review of the VARO in San Juan, PR. This project is modeled after the successful benefits review of the VARO in Manila, PI, resulting in the creation of overpayments amounting to \$2.5 million and identified projected cost avoidance to the Department of over \$21 million. Nineteen criminal investigations were initiated and turned over to the Philippine National Police for resolution. We also referred 94 beneficiaries to the VARO for possible modifications of their benefit payments, including increased benefits; appointments of fiduciaries; changes of address; and gaining Prisoner of War status.

The number of beneficiaries being serviced by the San Juan VARO is much larger, with 45,200 beneficiaries receiving about \$29 million a month in benefits. To accomplish this initiative:

- In October 2003, my staff visited Puerto Rico to brief the VARO senior staff, veteran service organization (VSO) officials and a representative of the Governor's office regarding the initiative and to address any concerns. We wanted to ensure that VA, VSOs, and Government officials were aware of our initiative and that this review is

just one in a series of reviews that have taken place or are being planned in and outside the continental U.S. in the coming years.

- On November 7, 2003, VA sent the first letter to all 45,200 beneficiaries whose benefits awards were being administered by the VARO in San Juan.
- On January 12, 2004, a second letter was mailed to approximately 12,600 beneficiaries who failed to return the first questionnaire or improperly completed the form.
- On April 16, 2004, the San Juan VARO sent a third letter, composed in its entirety in English and Spanish, to 3,751 beneficiaries who had not responded to the previous two letters. As of May 14, 2004, only 1,760 beneficiaries failed to respond to the any of the three letters.
- On May 18, 2004, the OIG sent letters to 3,330 beneficiaries scheduling interviews at the San Juan VARO between June 14, 2004, and July 23, 2004.

The following is the proposed schedule for future benefit reviews for locations outside the continental United States:

- FY 2005 Europe/Middle East
- FY 2006 Canada/Mexico/Latin America
- FY 2007 Guam and other Pacific Islands

The work that the OIG staff and VBA conduct during these benefit reviews will assist VA in insuring the right beneficiaries are being paid the right amount of money and reduce erroneous VA payments. Based on our experience on the Manila, PI project and the total benefits paid to locations outside the continental United States, we project combined overpayments and cost avoidance of \$105 million. It will also allow VA to update its beneficiary files.

Income Verification Match

On December 8, 2003, our recommendation that the Under Secretary should complete necessary data validation of beneficiary identifier information contained in C&P master records to reduce the number of matched records with the SSA was closed. As I last reported to the Committee, this match was one our most successful data matching initiatives based on our November 2000 audit of VBA's Income Verification Match.

With aggressive efforts, the Department could potentially recover overpayments associated with benefit claims that contain fraud indicators such as fictitious Social Security numbers or other inaccurate key data elements. Although the Department did not agree with our monetary impact, our past estimate of \$806 million reflects a conservative estimate of the dollar impact of overpayments we maintain remains at risk.

Workers' Compensation Program

Draft Report: Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program Cost

VA continues to be at risk for significant Workers' Compensation Program (WCP) abuse, fraud, and unnecessary costs because of inadequate case management and fraud detection. Prior OIG audit⁵ recommendations to enhance the Department's case management and fraud detection efforts, and avoid inappropriate dual benefit payments⁶ were not fully implemented. Additionally, our most recent audit found that VA's WCP costs are being impacted because of employee injuries associated with violent patient incidents. VA is also at risk for unnecessary WCP costs due to lack of action/response on case inquiries to the Department of Labor (DOL), who administers the Federal Employees' Compensation Act (FECA).

Reducing the risk to WCP abuse, fraud, and unnecessary costs is critical. Since 1998, Department WCP costs totaled \$876 million. In 2003, WCP costs totaled \$157.3 million. While the Department's annual WCP compensation costs have decreased since 1998, our audit findings show that the level of Department WCP compensation costs could be significantly lower, if the prior OIG audit recommended case management improvements were fully implemented. Case management improvements that still need to be completed include:

- Establishing and maintaining a VA case file on all open/active claims.
- Providing timely follow up actions on all open/active claims.
- Ensuring that if a claimant has work capacity, a job offer is made.
- Providing consistent resources to the program to complete necessary case management actions.

Ineffective WCP case management and program fraud results in potential unnecessary/inappropriate costs to the Department totaling \$42.7 million annually. These costs represent significant potential lifetime⁷ compensation payments to claimants totaling \$696.2 million. Additionally, an estimated \$112.6 million in avoidable past compensation payments were made that are not recoverable because employees who were able to come back to work were not offered jobs by VA.

The Department's WCP costs are also being impacted because of employee injuries due to violent patient incidents. Annually, we estimate WCP related costs total \$7.2 million,

⁵ Report No. 8D2-G01-67, "Audit of VA's Worker's Compensation Program Costs", dated 7/1/98 and Report No. 99-00046-16, "Audit of High Risk Areas in VHA Workers' Compensation Program", dated 12/21/98.

⁶ WCP and VA regulations prohibit concurrent payments of VA Compensation and Pension (C&P) and WCP compensation for the same injury or disability.

⁷ Lifetime estimates were calculated using the Veterans Benefits Administration (VBA) life expectancy table for net worth determinations contained in VBA Manual M21-1, Part IV, Chapter 16, Addendum B. The annual dollar impact was multiplied by the number years of life expectancy. The estimates did not include future increases in WCP benefits.

with lifetime compensation payments to claimants totaling \$148.7 million will be paid due to violent patient incidents. VA's WCP costs are further impacted by the fact that in 11 percent of the cases we reviewed, there was a lack of action/response from DOL on case inquiries from VA WCP case managers.

Additionally, VA has not implemented our prior audit recommendation to collect and use Continuation of Pay⁸ (COP) data for monitoring potential WCP cost and employee health and safety issues. VA needs to collect information and monitor actions taken to controvert⁹ COP and/or dispute questionable claims. Use of this data could provide for more effective WCP Department-wide oversight, management, and cost containment.

The Department's decentralized approach to WCP administration is not effective. There is a lack of effective case management and fraud detection Department-wide including VHA, VBA, National Cemetery Administration (NCA) and at VA Central Office. The Department needs to establish a more coordinated approach to WCP administration and implement necessary case management improvements.

Given the significance of the audit findings and the continued risk of program abuse, fraud, and unnecessary costs, the Assistant Secretary for Management should retain the WCP as an Internal High Priority Area. This should include preparation of an action plan and timeline to correct this program weakness. The Department faces a significant liability for future WCP compensation payments that is estimated at \$1.9 billion.¹⁰

Benefits Investigations

OIG investigators are aggressively pursuing criminals who are perpetrating crimes against VA programs. During this past year, we opened 332 new benefits fraud cases, closed 340, and currently have 295 pending. The closed cases resulted in 167 arrests. Under benefits fraud, we include pension, compensation, education, loan guaranty, equity skimming, and others. Two recent cases are described below.

Compensation Fraud at Bay Pines VA Regional Office

This investigation was initiated pursuant to an allegation received from a VA staff member that a veteran was collecting disability compensation for loss of use of both feet, back strain, impairment of sphincter control, and bladder paralysis. The staff member indicated the veteran was not impaired and that he had been observed walking with no

⁸ FECA provides eligible Federal workers who suffer traumatic injuries with salary COP benefits for a period not to exceed 45 days. After the 45th day, there is a 3-day waiting period before a wage-loss benefit begins.

⁹ The employing agency has no authority for approval or denial of claims filed under FECA. However, the employing agency may challenge paying Continuation of Pay (COP). This process is known as controversion of claim. There is an appeal process for injured employees if the claim is denied by DOL. However, once wage loss compensation has been approved by the DOL Office of Workers' Compensation Programs, the employing agency cannot controvert the decision.

¹⁰ Report of Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2003 and 2002, Report No. 03-01237-21, dated November 14, 2003.

apparent disability in recreational settings. The veteran was rated 100% disabled. The veteran was collecting \$3,107 a month in VA entitlements when the allegations surfaced and had already received over \$400,000. The investigation determined through witness interviews, records reviews, and surveillances that the veteran was not disabled as he claimed.

Our video surveillance showed the veteran pretending to be wheelchair bound when attending appointments at VA facilities. Other video showed the subject walking into a post office and picking up a twenty-pound box of pretzels that he believed he had won as a prize, a pretext arranged by my Special Agents.

The veteran was charged by a Federal grand jury with theft of public money, false statements, and wire fraud and was arrested by Special Agents from my St. Petersburg office. The veteran was found guilty in U. S. District Court and was sentenced to more than three years in prison. The veteran also was ordered to make restitution in the amount of \$384,934.

The Special Agent who worked this case recently received the National Commander's Award from the Military Order of the Purple Heart in recognition of his efforts regarding this investigation.

Tuition Assistance Top-Up Scheme

This case was initiated based on information from my staff at the VA Austin Automation Center after they noticed several anomalies concerning checks paid to active duty Navy personnel receiving VA Education Assistance under the Tuition Assistance Top-Up (TATU) program.

Investigation revealed that several active duty members of the Navy had conspired to perpetrate thefts of Government funds by making false claims to the TATU program for reimbursement for classes never attended. The ring leader, a Navy personnel clerk, submitted program documentation to VA reflecting that the bogus program participants were in compliance with the terms of the program and entitled to TATU reimbursements. He did this on behalf of 27 Navy personnel, only 9 of whom were aware of the fraud. The remaining 18 individuals were the victims of identity theft and had no idea their names were being used. The ring leader and the co-conspirators divided the proceeds from their fraudulent scheme. The monetary loss to VA is approximately \$375,000. To date, seven individuals have been indicted as co-conspirators in the scheme. Four individuals have been convicted.

FINANCIAL MANAGEMENT SYSTEMS

My office has made recommendations addressing improvements needed in financial management activities and identified potential for monetary savings totaling more than \$600 million.

I am pleased to report that since 1999, VA has achieved unqualified Consolidated Financial Statement (CFS) audit opinions. In recent years, the Department has made improvements in this area and is striving to fulfill the President's management agenda related to financial performance.

The Department needs to modernize and automate its financial systems. VA program, financial management, and audit staffs continue to perform manual compilations and labor-intensive processes in order to attain auditable Consolidated Financial statements. There is a need to automate these processes, because the risk of materially misstating financial information is high.

Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2003 and 2002, Report No. 03-01237-21, dated November 14, 2003

Since my last testimony, we issued our audit of VA's consolidated financial statements for FY 2003 and 2002, which provided an unqualified opinion and our report on the Department's internal control structure and compliance with laws and regulations.

The report on internal control identifies four reportable conditions, of which two are material weaknesses. The two material weaknesses are (i) information technology security controls and (ii) integrated financial management system. The two reportable conditions are (i) operational oversight, and (ii) medical malpractice claims data. Three of the four findings were reported last year; the medical malpractice claims data is the new reportable condition for FY 2003.

During FY 2003, VA management took corrective action to eliminate two reportable conditions reported in the FY 2002 audit report: (i) loan guaranty business process, and (ii) application program and operating system change controls.

Overall, the FY 2003 report concluded that VA is not in substantial compliance with the financial management system requirements of the Federal Financial Management Improvement Act (FFMIA) of 1996. The internal control issues concerning an integrated financial system and information technology security controls indicate noncompliance with the requirements of Office of Management and Budget (OMB) Circular A-127, "Financial Management Systems," which incorporates by reference OMB Circulars A-123, "Management Accountability and Control," and A-130, "Management of Federal Information Resources." The Assistant Secretary for Management concurred with the reported findings and recommendations. We will follow up and evaluate the implementation actions during our audit of VA's FY 2004 Consolidated Financial Statements.

Medical Care Collection Fund

VA has made efforts to improve debt management practices in the Department. Most notable are the positive results the Department is now achieving through more aggressive collection efforts in the Medical Care Collection Fund (MCCF) Program. The results clearly demonstrate that where our past work identified the potential for enhancing monetary program recoveries through aggressive collection efforts, those opportunities were attainable. In fact, our reports were right on target regarding the Department's ability to enhance its collections.

In February 2002, we issued an audit report on the Department's MCCF activities (Report Number 01-00046-65, dated February 29, 2002). The report concluded that VHA could increase FY 2000 collections \$135.2 million after remaining relatively stagnant for a three year period FY 1998 to FY 2000. Additionally, my auditors found that clearing the backlog of unissued bills totaling over \$1 billion would result in additional collections of \$368.4 million, totaling \$503.6 in additional MCCF collections.

We made several recommendations in this report that were designed to increase collections and revenue for the VA. Since our review, VHA has been aggressively pursuing and working to improve their collection procedures. As demonstrated in FY 2003, VHA met our reported projections and collected over \$1 billion.

Since implementing most of our recommendations, VHA has increased collections every year. As of June 3, 2004, one recommendation remains open. VHA needs to program software changes on their website to improve MCCF operations.

PROCUREMENT PRACTICES

VA continues to face major challenges in implementing a more efficient, effective, and coordinated acquisition program. The Department spends about \$6 billion annually for goods and services. High-level management support and oversight are needed to ensure VA leverages its full buying power, maximizes the benefits of competition, and improves contract administration. Based on my observations and recent review results, VA is making positive efforts to implement the recommendations of the Secretary's Procurement Reform Task Force (PRTF). The report included 65 recommendations and the Secretary ordered all to be put in place. VA has stated that 43 recommendations are completed and the remaining 22 will be completed by September 30, 2004.

Our reviews continue to identify problems with Federal Supply Schedule (FSS) contracts and blanket purchase agreements (BPA), along with procurements for health care items, and construction. I described scarce medical services procurement issues earlier in my testimony. My staff also continues to identify weaknesses in the management of purchase cards and problems with inventory management. I would like to highlight the results of one of our most significant audits and some examples of other acquisition weaknesses noted in other reviews we completed since my last testimony.

Audit Of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies, Report No. 02-01481-118, dated March 31, 2004

This audit was conducted to determine if VAMCs effectively purchased medical, prosthetic, and miscellaneous operating supplies using the best available sources, such as VA national contracts. VHA facilities are required to follow a purchasing hierarchy under which VA national contracts, BPAs, and FSS contracts are the most preferred sources. Open market is the least preferred source.

We evaluated purchases of 50 representative supply products at 15 VAMCs. Large portions of supply purchases were not made from the best sources. Of the \$23.4 million spent on products available from contracts and BPAs, only \$14.2 million were made from the best contract/BPA sources. The remaining \$9.2 million was spent on purchases from the open market or from higher priced contracts. The audit also found that VA needed to award more national-scope contracts taking advantage of VA's buying power. Eleven of the 50 products reviewed were available only on the open market and were not covered by contracts or BPAs. In addition, 34 products were covered by FSS contracts but were not covered by VA national contracts or BPAs.

We estimated a VHA-wide purchasing savings rate of 8.8 percent and a contracting savings rate of 5.5 percent. Extrapolated to total VHA supply purchases, these rates equate to cost reductions of about \$213.5 million a year. Over the next 5 years, taking into account inflation and increased supply usage, the savings would be about \$1.4 billion.

We recommended that the Under Secretary for Health: (i) direct VAMCs to fully implement the purchasing hierarchy; (ii) implement performance monitors to ensure that VAMCs appropriately use each hierarchy source; and (iii) require National Acquisition Center approval of local supply contracts. We also recommended that the Under Secretary for Health and the Assistant Secretary for Management work together to: (i) ensure that purchasing staff are trained, and (ii) increase efforts to award new national contracts and BPAs for supply products. The Under Secretary for Health and the Assistant Secretary for Management agreed with the recommendations and provided generally acceptable implementation plans. As of June 3, 2004, all recommendations remain open.

The Secretary's PRTF report includes recommendations which address the issues we found in our audit. Although the Department has implemented some PRTF recommendations, we continue to find similar problems. Two recent CAP reports are described below.

Combined Assessment Program Review of the Coatesville VA Medical Center, Report Number 03-02278-08, dated October 29, 2003

As part of the CAP at the Coatesville VAMC, we reviewed the Government purchase card program and found that purchases needed to be made competitively. We found that cardholders needed to seek competition for purchases over \$2,500 made on the open market. Four cardholders did not seek competition for 28 of 50 sampled transactions totaling \$133,594.

The 28 purchases in question included 22 stair lifts and 6 orders of immune globulin. The stair lifts and immune globulin were available from FSS vendors. We obtained information from the National Acquisition Center (NAC) database that showed that the medical center could have received lower prices for the stair lifts and the immune globulin. Prices offered by FSS vendors indicated the medical center could have paid \$14,375 less for the stair lifts and \$37,627 less for the immune globulin. FSS contract purchasing would have resulted in total savings of \$52,002.

Combined Assessment Program Review of the Togus VA Medical Center, Report Number 03-03207-120, dated April 2, 2004

As part of the CAP at the Togus VAMC, we reviewed purchase cardholder procurements of high cost medical/surgical supplies to determine whether the supplies were purchased in compliance with the FAR and VA procurement policy. We also employed data mining analyses of all purchase card transactions made during the period October 2001 through June 30, 2003, to identify open market purchases made from the same vendors on a recurring basis. We found the following conditions requiring management attention.

During the period April 2, 2002, to July 17, 2003, the medical center made 159 purchases of hip and knee implants and accompanying components valued at \$712,409 (knee implants totaled \$569,928 and hip implants totaled \$142,482). These purchases were made by one cardholder from one vendor and certified by one approving official. We reviewed a sample of 30 of the high cost items valued at \$341,898 and determined that the cardholder, who was also a contracting officer, did not obtain competitive prices for the hip and knee implants or artificial limbs, as required by the FAR and VA procurement policy. In addition, the cardholder did not maintain receipts for the 30 purchases to enable reconciliation and certification of purchase card transactions, as required.

The cardholder did not consider preferred purchasing sources, such as FSS vendors that offered hip and knee implants, prior to procuring these items on the open market. The FAR and VA procurement policy require purchase cardholders to consider FSS vendors before making open market purchases. Both the cardholder and approving official were unaware of the existence of FSS contracts for hip and knee implants. We obtained information from the NAC that showed that FSS vendors offered comparable items at lower prices, 41 percent less for knee implants and 31 percent less for hip implants. We estimated savings of \$233,670 (41 percent x \$569,928) for knee implants and \$44,169

(31 percent x \$142,482) for hip implants. Based on these estimates, the medical center could have potentially saved \$277,839 by purchasing these supplies from an FSS vendor.

In addition, the cardholder's approving official did not effectively carry out her responsibilities. The approving official did not ensure that cardholder purchases greater than \$2,500 were competitive, or that the cardholder maintained receipt documentation and complied with the FAR and VA procurement policy.

In response to recommendations by the PRTF, in 2003, the NAC developed an electronic database listing all FSS contract items, prices, and vendors. According to VA officials, the database, which was partially implemented in July 2003, is expected to provide nationwide access by October 2004. My staff has used the system and found it to be user-friendly and very informative.

We also identified additional recurring open market purchases. Another cardholder made 48 open market purchases from one vendor for printer cartridges totaling \$72,180. We determined that the same cartridges were on GSA schedules. By using the GSA Advantage website, we identified 133 vendors who had the cartridges on GSA awarded FSS contracts. Forty-one of the 133 vendors sold the same or comparable printer cartridges for less than VA was paying open market. Three of the vendors sold the cartridges at prices 50 percent less than VA was paying open market.

Medical center management needed to strengthen controls to ensure Government purchase cardholders procure from preferred purchasing sources such as FSS vendors rather than more costly open market sources. Cardholders needed to maintain receipt documentation and approving officials needed acquisition training. Additionally, Acquisition and Logistics Section management needed to establish contracts for recurring procurements.

Pre-award Reviews with Recommendations to Reduce Contract Costs

During the past year, pre-award reviews of 75 FSS and direct delivery offers made recommendations for potential better use of \$590.8 million. Recommendations to negotiate lower contract prices were made because the manufacturers were not offering the most favored customer prices to FSS customers when those same prices were extended to commercial customers purchasing under similar terms and conditions as the FSS. Here are two examples:

- A pre-award review of a pharmaceutical manufacturer found that they could offer significantly better prices to FSS. While the disclosed discounts were substantially accurate, we found that there was insufficient justification for not offering the FSS most favored customer discounts. The most significant issue was that the manufacturer used unrestricted formulary status as the reason for not offering the most favored customer pricing to FSS. We found that the products were on VA formulary on an unrestricted basis. If the VA contracting officer negotiates discounts

equal to or better than our recommended discounts, the cost savings to FSS would be about \$262 million over the 5-year term of the contract.

- A pre-award review of a second pharmaceutical manufacturer found that they could offer significantly better prices to FSS. The contractor eliminated whole classes of trade from consideration when determining their offered prices. We found that eliminating those classes of trade was not warranted. If the VA contracting officer negotiates discounts equal to or better than our recommended discounts, the cost savings to FSS would be \$20.1 million over the 5-year term of the contract.

Post-Award Review Recovery

Since last year's testimony, we completed 30 reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts. The reviews resulted in recoveries amounting to \$24 million and potential better use of \$531,000. Here is one example:

- A biotechnology company submitted a voluntary disclosure and refund offer of about \$3.9 million to VA to account for overcharges on its FSS contract. The company used outside legal counsel and accounting consultants who developed exclusionary protocols and judgmental thresholds in the conduct of their review. These practices significantly underreported the amounts due. Based on our review of defective pricing and price reduction violations on the FSS contract, the company reimbursed the Government \$14.7 million, of which VA's supply fund will receive approximately \$14.3 million.

Purchase Card Activities

Evaluation of the VA Government Purchase Card Program, Report Number 02-01481-135, dated 4/27/04

We evaluated the VA Government purchase card program to determine the effectiveness of internal controls to prevent and detect fraudulent, improper, or questionable purchases. The evaluation was conducted utilizing the results of investigations, hotlines, and CAP reviews performed at VAMCs and VAROs. The evaluation also included separate data mining analyses of purchase card transactions at five VA facilities.

We issued an earlier audit report on VA's Government purchase card program on February 12, 1999, (Report Number 9R3-E99-037). The audit showed that management controls were not effectively implemented to ensure the integrity of the Government purchase card program and maximum benefits were not being realized. Since that audit, the OIG issued 83 reports during the period March 31, 1999, through September 30, 2003, which have continued to identify internal control weaknesses in the Government purchase card program. Purchase card usage has grown from 20,000 transactions valued at \$4.5 million in FY 1995 to 3.2 million transactions valued in excess of \$1.7 billion in FY 2003. Over the years, the OIG reported numerous instances of improper and

questionable uses of purchase cards, including some instances of fraudulent activity. We identified internal controls that need to be fully implemented to provide management greater assurance that purchase cards are used properly.

Areas needing improvement included: (i) closer supervision and better training of cardholders and approving officials; (ii) timely reconciliation of purchase card transactions by cardholders; (iii) timely and thorough certifications of transactions by approving officials to ensure competitive prices are obtained and preferred purchasing sources are used; (iv) preventing improper purchases; and (v) avoiding split purchases. In addition, facility managers needed to focus audits on segregation of duties, training, approving official span of control, and identifying and validating questionable transactions. The Under Secretary for Health, the Under Secretary for Benefits, and the Assistant Secretary for Management provided acceptable improvement plans. However, as of June 3, 2004, all recommendations remain open.

Contracting for Construction

Draft Report: Audit of Veterans Health Administration Major Construction Contract Award and Administration Process

The audit found that contract awards, administration, and project management needed to be enhanced to ensure that the VA does not pay excessive prices for construction work. The audit identified a risk for excessive prices paid by VA involving major construction projects valued at \$133.1 million. The audit also identified the potential for fraud involving certain contract award actions that was referred to my Office of Investigations. VHA needs to improve the major construction contract process to ensure that contract awards:

- Result in reasonable prices paid for work completed.
- Are in the best interests of the Government.
- Are adequately controlled to prevent fraud, waste, abuse, and mismanagement.

The VHA Office of Facilities Management (FM) is responsible for the management of all major construction projects. At the time of the audit, FM was administering 31 major construction contracts valued at \$594.6 million where construction had been completed within 24 months of the start of our review or construction work was in process. The audit reviewed each of these contracts and identified contract award and administration problems with 24 contracts.

We made a series of recommendations to the Under Secretary for Health to improve the major construction contract process. The Under Secretary generally concurred with the majority of the audit recommendations. However, the Under Secretary concurred with qualification on 4 recommendations and provided alternative wording that we found acceptable and met the intent of our original recommendations. The Under Secretary's comments provide details on implementation actions that either already are in place or

planned that meet the intent of the recommendations. We will follow up on the planned actions until they are completed.

Procurement Fraud Investigations

Pharmaceutical Off-Label Drug Promotion

Recently, a major pharmaceutical corporation agreed to plead guilty and pay more than \$430 million to resolve both criminal and civil liabilities regarding a subsidiary's illegal and fraudulent promotion of Neurontin for off-label, i.e., non-FDA approved, uses. The global settlement was the result of a multi-agency investigation, including VA OIG, FBI, Health & Human Services OIG, Food & Drug Administration Office of Criminal Investigations, and the U.S. Department of Justice.

The case originally came to my office as a qui tam. We issued subpoenas that resulted in the initial collection of 62 boxes of source documents examined in this investigation. VA OIG Special Agents were involved in numerous meetings and strategy sessions with the Assistant United States Attorney and the interviews of many witnesses in the case. The investigation revealed that VA was affected by the scheme because the subsidiary directly promoted off-label uses of Neurontin to VA physicians and pharmacists on a nationwide basis in violation of FDA laws.

Of the \$430 million total settlement, \$240 million was a criminal fine, the second highest criminal fine ever paid in a health care fraud case. The criminal plea agreement provides that the violations of the FDA Act are felonies and that the criminal conduct caused \$150 million in losses.

New Orleans Bribery Scheme

In another investigation, we disclosed that a supervisory VA employee and two VA contractors engaged in a bribery scheme to inflate and falsify purchase orders for both emergency and routine plumbing repairs at the medical center. For approximately three years, the three co-conspirators overcharged VA more than \$75,000. The VA employee is believed to have received at least this amount in kickbacks demanded by him from the two contractors as payment for selecting and recommending their companies for the purchases of goods and services by the medical center. All three subjects involved in the scheme have been convicted and await sentencing.

INFORMATION MANAGEMENT

VA faces significant challenges addressing Federal information security program requirements and needs to establish a comprehensive, integrated VA security program. Information security is critical to the confidentiality, integrity, and availability of VA data, and to protect the assets required to support health care and benefits delivery. Additional efforts are needed to ensure management oversight contributes to the efficient practices in electronic information and adequate physical security. I plan to continue to

focus resources on identifying Department-wide vulnerabilities to ensure the protection of critical Department operations. I will highlight some of our most recent work in this highly vulnerable area. However, I cannot emphasize enough that more efforts are needed to secure the Department's systems and information and to protect its interests from security threats.

Audit of the Department of Veterans Affairs Information Security Program, Report No. 02-03210-43, dated 12/9/03

This audit evaluated VA information security controls and security management. Based on the results of the FY 2003 information security audit, we concluded that VA has made insufficient progress in improving its information security posture. VA is not in compliance with the requirements of Federal Information Security Management Act. VA's information security vulnerabilities have not been adequately addressed because the Department did not complete necessary corrective actions in response to our audit findings. Serious security vulnerabilities have continued to exist over a multi-year period that place VA systems, data, and delivery of services to the Nation's veterans at risk. This risk was demonstrated by the virus/worm incursions that disrupted vulnerable Department automated systems (see Microsoft Blaster Patch report below).

The Department has not been able to effectively address its significant information security vulnerabilities and reverse the impact of its historically decentralized management approach. VA's security remediation efforts continue to be ineffective with inadequate facility compliance with established security policies, procedures, and guidelines. As a result, significant information security vulnerabilities continue to place the Department at risk of:

- Denial of service attacks on mission critical systems.
- Disruption of mission critical systems.
- Unauthorized access to and improper disclosure of data subject to Privacy Act protection and sensitive financial data.
- Fraudulent payments of benefits.
- Fraudulent receipt of health care benefits.

Based on the audit results, VA information security should continue to be identified as a Department material weakness area under the Federal Managers' Financial Integrity Act.

We recommended a number of operational changes that will help improve VA's information security posture, ensure effective control over sensitive information, ensure continuity of operations, and support the Department's missions of providing health care and delivering benefits to the Nation's veterans. The Acting Assistant Secretary for Information and Technology agreed with the findings and recommendations, and provided acceptable implementation plans.

As of June 3, 2004, all 16 recommended actions remain open with the Associate Deputy Assistant Secretary for Cyber and Information Security. We will follow up on the planned actions until they are completed.

Evaluation of the Department of Veterans Affairs Installation of the Microsoft Blaster Patch, Report No. 03-02970-55, dated 1/09/04

We found that Microsoft's Blaster Worm security patch was not effectively installed leaving VA systems vulnerable to a denial of service attack. VA systems were not protected because VA had not established a Patch Management Program meeting guidance established by the National Institute of Standards and Technology, and the responsibility and accountability for VA-wide Patch Management is not specifically assigned.

The Associate Deputy Assistant Secretary for Cyber and Information Security is responsible for issuing guidance on installation of security patches through VA's Central Incident Response Capability Service (VA CIRC). However, VA CIRC does not have direct line authority to ensure the implementation of the patches by facility level Information Technology (IT) officials. Until such time as full consolidation of IT security functions can be completed, it is the responsibility of the Facility Directors to ensure that personnel under their supervision install security patches in accordance with VA-CIRC guidance and accurately report remediation actions to the VA CIRC.

The Acting Assistant Secretary for Information and Technology has presented a plan to implement a Patch Management Program that follows guidance described in National Institute of Standards and Technology, and identifies authorities and responsibilities for implementation. As of June 3, 2004, this plan is not fully implemented.

CONCLUSION

In conclusion, I would like to thank the Chairman and the members of this Committee for the opportunity to present this testimony today. My Office continues to enjoy a high level of success relative to important issues affecting the Department. Whether funds are lost to fraud, waste or other abuses the result is the same –fewer resources are available for meeting the needs of our Nation's veterans and their beneficiaries.

To be successful in areas such as health care, benefits administration, acquisition reform, financial management, and information management, the Department needs to hold managers accountable to ensure the benefits and outcomes expected are achieved in an efficient, economic manner. I would be pleased to answer any questions the Committee may have.