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STATEMENT OF

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COMPTROLLER GENERAL OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON SPECIAL INVESTIGATIONS

HOUSE COMMITTEE ON VETERANS AFFAIRS HSE03907

ON

FRAUD, ABUSE, WASTE AND MISMANAGEMENT

IN THE VETERANS ADMINISTRATION

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our work in the area of fraud, abuse, waste and mismanagement, particularly as it relates to the Veterans Administration (VA).

As you know, we issued a report 1/ in September 1978 on the efforts of Federal agencies to detect fraud in their programs. The basis for this report was our work aimed at ascertaining whether Federal agencies had instituted effective policies and procedures for combating the fraud that might exist in their programs. One of the agencies included in this report was VA.

1/"Federal Agencies Can And Should Do More To Combat Fraud In Government Programs" (GGD-78-62, Sept. 19, 1978).

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What we said was that, prior to 1978, VA lacked a solid commitment to deal with fraud and abuse in its programs. During our review we found that although VA has detected fraud and abuse over the years, its efforts were limited and sporadic and were never the result of any systematic approach for identifying fraud and abuse. Since program personnel are primarily responsible for duties other than the identification of fraud, VA could not separate that portion of employee time spent on this endeavor. Moreover, the agency as a whole did not have data which would have enabled it to estimate the amount or incidence of fraud in its programs, nor did it have established techniques to assist in generating valid data. Consequently, VA, like other agencies we visited, was hampered in taking affirmative actions aimed at anticipating, seeking out, and identifying fraudulent activity.

VA relied primarily upon program people and internal audit to detect fraud. There was no separate fraud group or unit which handled these matters. Fraud detected in the regions was referred through regional counsels directly to the Department of Justice. Fraud detected by headquarters was referred through General Counsel at Central Office to the Department of Justice. Regional counsels did not send copies of their referrals to Central Office. Since most cases were referred/handled at the regional level, VA had no way to monitor the agency-wide implications of fraud.

We were told by VA regional representatives that they considered service to the veteran as their top priority, and this effort precluded them from making sufficient efforts to detect fraud. Also, many VA regional officials that we contacted during June and August 1977 believed that fraud was not a problem. For example, five VA regional office directors visited during our review believed that, for the most part, fraud was not a significant problem. In addition, the majority of top management officials in each of these regions shared the same view.

Each year VA dispenses large sums of public funds in support of benefit and service programs for eligible recipients. For fiscal year 1980, VA's budget submission to the Congress exceeds $20 billion. Benefits programs total $12.3 billion and represent 64 percent of VA's budget. Medical programs total $5.5 billion or 29 percent of the budget. As such, these programs are inviting targets for abuse, waste and fraud.

EXAMPLES RESULTING FROM GAO REVIEWS

To illustrate VA's vulnerability, I would like to highlight the findings of a few issued GAO reports on areas where mismanagement permitted fraud, abuse, or waste.

Program abuses of VA benefits in the Philippines

We were asked by the Chairman, Subcommittee on HUD-Independent Agencies, Senate Committee on Appropriations, to

review the veterans' compensation, pension, and education benefits programs administered by VA in the Republic of the Philippines.

We reported 1/ that VA monetary benefits were so high relative to Philippine income levels that many abuses of the programs occur. These abuses include fraudulent claims by widows, adopting children and siring illegitimate children to increase benefits, prolonging illness to extend benefits, and attending school for income.

Our review showed that VA's administration of benefits in the Philippines under the same broad interpretations as in the United States provided an incentive for certain individuals to try every conceivable ploy to obtain VA benefits.

We recommended that VA take the necessary actions to insure that payments are being made only to eligible recipients.

Overpayments in predischarge education program (PREP)

We reviewed the financial controls exercised by VA over the PREP program and found that VA had made excess payments over cost, amounting to $9.9 million, at the nine schools included in our review.

1/"Veterans Administration Benefits Program In The Philippines Need Reassessment" (HRD-78-26, Jan. 18, 1978)

We reported 1/ that these surpluses occurred because VA did not have sufficient financial controls to assure that such payments approximated reasonable costs.

We recommended that VA should recover most of these surplus funds. VA started its audits in May 1978. Recently, VA finalized two of the audits and collection action has been initiated to collect $904,000 from these two schools. Audits of the remaining seven schools are all in progress and when completed will be subject to similar collection of any overpayments. VA has not made a decision on auditing other schools that were in the program.

Abuses of VA programs in Puerto Rico and the Virgin Islands

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

We reported 2/ that our review of case files of 100 non-service-connected patients who made 272 visits to the Ponce clinics in Puerto Rico during August, September, and October 1977, showed that for 185 visits, or 68 percent, ineligible treatment was received. At the Damas Clinic, we found that taken individuallly 63 percent of the visits were

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1/ Letter report to the Administrator of VA (HRD-78-20, Dec. 8, 1977).

2/ "Health Care Needs of Veterans in Puerto Rico and the Virgin Islands Should Be Assessed" (HRD-78-84, Mar. 30, 1978).

ineligible and 88 percent of the visits to St. Luke's were ineligible.

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

We also reported that a 1975 VA Central Office investigation of billings received from fee-basis doctors in Puerto Rico showed that:

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

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

The investigation stemmed from a psychiatrist billing VA for $9,785 for a 1-month period. The billing included services rendered on a single day in September 1974, for 33 fifty-minute interviews or a total of 27.5 hours for that day.

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

In addition the investigation uncovered seven VA-employed psychiatrists treating veterans on a fee-basis while under full-time employment at the VA hospital. Full-time VA physicians are prohibited by VA regulations from engaging in outside employment.

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

Abuses in education loan program

We were asked by the Chairman of the House Committee on Veterans Affairs to determine if VA's education loan program was achieving its goal of providing an additional source of financial aid to students attending high-tuition schools who would otherwise be financially unable to do so.

We reported 1/ and testified before the House Veterans' Affairs Committee that the program was not accomplishing its intended goal. We found that most of the $33 million in loans made since inception of the program were made to veterans attending schools charging low tuition or no tuition at all. In many cases, loans were justified and approved on the basis of such questionable expenses as car payments, credit card installment payments or home improvement costs. We reported that forty-four percent of the loans which had come due were in default.

We recommended that Congress consider granting VA the authority to restrict loans to veterans in high-tuition

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1/ "Improvements Needed in VA's Education Loan Program" (HRD-78-112, May 11, 1978).

schools and shorten the required repayment period for small loans. We also recommended that VA take action to reduce the default rate and insure that loans are justified by a bona-fide education-related financial need. On the basis of these recommendations necessary legislation was enacted.

Abuse of medical benefits by ineligible persons

In May and September 1977 we reported 1/ to VA that we had received sixty-four indebtedness referrals from the Hines, Illinois, Houston, Texas, and Alexandria, Louisiana VA Hospitals, for medical treatment to persons who were subsequently found to not be eligible for VA medical benefits. The amounts of these claims totaled about $227,000.

Of the 64 cases, 32 cases were from the Houston VA Hospital; 2 cases from the Alexandria, VA Hospital; and 30 cases from the Hines VA Hospital. In 40 of these cases, the same patient had been admitted to the hospital more than once. In two cases, the same patient had been treated in excess of 100 times.

We recommended that VA review the admitting procedures at its hospitals and take action to preclude readmissions of persons previously determined to be ineligible for VA medical care. We also recommended that VA evaluate the ways

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1/ Letter report to the Director, Internal Audit (May 10, 1977)
Letter report to the Administrator of VA (HRD-77-149, September 19, 1977).

in which the period of time needed to determine eligibility can be reduced.

Illegal activities at Kansas City VA Medical Center DLG01426

In our report 1/ to the Chairman, House Committee on Veterans Affairs, we reported on an arrangement between the Midwest Organ Bank and the VA hospital in Kansas City, Missouri. The arrangement involved the diversion of VA personnel, supplies, mailing service and telephone service to the use of the organ bank--a private not-for-profit corporation which was headed by staff physicians at the VA hospital.

After the 3 years of continued operation, VA concluded that the organ bank's operation at the Kansas City hospital was illegal; ordered its removal. and sought to recover about $500,000 in costs incurred in support of the organ bank's activities.

The organ bank has declined to pay VA's bill and VA has turned the matter over to us for collection action.

Sharing of Federal medical resources needs improvement

Over the past several years we issued a series of reports concerning the opportunities for VA and other Federal agencies to more effectively use costly medical resources by mutual sharing. These reports covering

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1/ Letter report to Chairman, House Committee on Veterans Affairs (HRD-78-30, Jan. 17, 1978).

such specialized medical resources as computerized axial tomography (CAT) scanners, cardiac catheterization laboratories, and most recently, megavoltage radiation therapy equipment used for the treatment of cancer patients.

In June 1978 we issued a comprehensive report 1/ on the obstacles which currently impede further interagency sharing of medical resources. In this report we stated that the Federal Government can make much better use of its health care delivery resources through interagency sharing. However, legislative and administrative obstacles prevent the effective use of these resources.

We believe that congressional action is needed for the development of an effective Federal medical resources sharing program. Further, a uniform executive branch policy regarding interagency sharing is needed.

Educational assistance overpayments

In March 1976 we reported 2/ to the Congress on the overpayment of educational assistance benefits by VA. During the 3-1/2 years ended December 31, 1975, overpayments totaled almost $1.3 billion, of which $446 million

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1/ "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency

2/ "Educational Assistance Overpayments, A Billion Dollar Problem--A Look at the Causes, Solutions, and Collection Efforts (MWD-76-109, Mar. 9, 1976).

was overpaid in fiscal year 1975 and $412 million in the first 6 months of fiscal year 1976. Of this, $298.2 million remained uncollected on December 31, 1975.

We told the Congress that the VA's overpayments were caused by (1) delays in reporting training changes, (2) the issuance of special payments, (3) poor VA processing practices, and (4) the prepayment and advance payment provision of the VA educational assistance law.

We recommended that VA take a number of actions to reduce delays by veterans and schools in reporting training status changes, reduce processing delays or errors, reduce special payments, improve normal processing time and improve collection actions on overpayments.

In February 1978 we reported 1/ to the Congress on the adequacy of VA's action to implement our prior recommendations. We said that, as of June 30, 1977, VA had identified $2.5 billion in educational assistance overpayments to veterans and dependents. Overpayments remaining uncollected as of June 30, 1977, amounted to more than $462 million, an increase of over $32 million since June 1976. VA estimates that as of December 1978, uncollected overpayments totalled over $380 million.

We recommended that VA take additional actions to reduce overpayments in the education assistance program and collect the amounts outstanding. VA agreed with our recommendations.

1/ "Further Actions Needed To Resolve VA's Educational Assistance Overpayment Problem" (HRD-78-45, Feb. 17, 1978).

Supplemental security income payment errors can be reduced

The Social Security Administration (SSA) has had many problems in administering the Supplemental Security Income (SSI) program. SSA estimates that over $1 billion was erroneously paid to recipients during the first 2 years.

We reported 1/ that a principal cause of erroneous payments is that SSA does not have accurate and complete information on compensation and pension income received by many SSI recipients from Federal agencies, including the VA. Such information is used in determining eligibility and benefit payment amounts.

If SSA had accurate VA and Railroad Retirement Board benefit information, SSI overpayments would be reduced by $60 million a year.

In response to our recommendations, the Department of Health, Education, and Welfare has taken steps to automatically obtain compensation and pension benefit data from VA, the Office of Personnel Management, and the Railroad Retirement Board. Consideration is also being given to obtaining benefit data from other Federal agencies.

Transfer of VA's St. Louis, Missouri record center to GSA DLG01427

In May 1977, we asked the General Services Administration (GSA) to study VA's Record Processing Center in St. Louis,

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1/ "Supplemental Security Income Payment Errors Can Be Reduced" (HRD-76-159, Nov. 16, 1976).

Missouri to determine whether VA's records could be stored more efficiently and economically in a GSA-operated record center.

Following its study, in October 1977 GSA advised VA of the potential 10-year savings of $8.5 to $12 million in space and equipment costs and $2 million in overhead if GSA assumed responsibility for storing and servicing the records at the VA center.

VA responded that it was necessary for VA to operate its own center. We analyzed the VA's decision 1/ and found that VA was not responsive to GSA's proposal. Subsequently, in November 1978, VA asked GSA to renew VA's authority to operate the center; restated its plans to proceed with the reorganization of the center; and asked that renovations planned by VA at a cost of $3.5 million be continued.

GSA refused VA's request and referred the matter to the Office of Management and Budget (OMB) for review. Recently, OMB determined that for programmatic reasons VA's claims files should remain in VA's records center. We do not agree with their decision.

Disability retirement processing can be improved

During the past 5 years, we have issued several reports on problems in VA and the Department of Defense (DOD)

1/ Letter report to the Administrator of Veterans Affairs (LCD-78-128-II, October 13, 1978).

administration of interrelated pay items. Our latest report 1/ on these problems disclosed that in more than half of the 88 cases where Air Force members received readjustment pay and were subsequently awarded VA disability compensation, offsets totaling $414,900 were not made or were made incorrectly. The accounts we reviewed have been corrected, and we were told that VA and the Defense Audit Service plan to complete a reconciliation of all other military service accounts during the second quarter of calendar year 1979. Reconciliation of uniformed services retired pay and VA compensation accounts disclosed about 95,000 mismatches, of which 29,000 were dollar mismatches.

VA and DOD, in our opinion, have not aggressively addressed the need to improve management controls over this long standing problem. However, as a result of our recent report, VA and DOD established a joint Service/VA project team to determine the best way to correct this situation.

ONGOING WORK

This month we plan to begin a broad-scope effort to gather information concerning VA's procurement practices and determine whether this central procurement agency is experiencing problems similar to those at the GSA. VA is responsible for providing supplies and equipment, mostly of a medical nature, to its own hospitals and other Government agencies.

1/ Letter report to the Secretary of Defense (FPCD-78-75, Dec. 27, 1978).

VA's annual purchases total about $1.15 billion. The results of this effort will be used to determine the extent of detailed reviews of VA procurement activities.

As a follow-up to our earlier efforts regarding educational overpayments, we are currently reviewing VA actions in terminating collection action on overpayment debts. As of November 1978, VA has terminated collection action on 580 thousand overpayment cases amounting to $166 million. Our preliminary findings indicated that VA can do more than it is now doing to recover these overpayments.

At the request of the House and Senate Committees on Veterans Affairs, we are starting a management review of coordination between VA and SSA in the delivery of veterans' pension benefits, social security retirement and disability benefits, and supplemental security income benefits to elderly and disabled persons.

GAO TASK FORCE AND HOTLINE

Mr. Chairman, as a followup to our September 18, 1978, report, we established a Special Task Force for the prevention of fraud and have allocated substantial staff resources to assist the Task Force. The major responsibility of this group will be to:

--evaluate the adequacy of the management control systems in Federal agencies that are necessary for prevenion of fraud, and

--assess the adequacy of the followup and corrective actions taken on reports of auditors and investigators.

We believe that when systems have been properly developed and are functioning as planned, the possibility for fraud, theft, or error will diminish. Where the systems do not exist, or are not being used properly, the opportunities to defraud the Government and the possibilities of error increase dramatically.

The Task Force will analyze the reports of internal auditors in each agency it reviews, giving particular attention to indications of fraud or error the auditors have uncovered. Where these reports or our reviews show that controls are weak, we will search for potentially fraudulent situations, using our own computerized data retrieval and analysis packages where practicable. At the conclusion of our work at each agency, we will prepare a report to the Congress and the agency involved, with particular emphasis on any weaknesses in management controls that would permit fraud, theft, or error to occur.

In many instances concerned citizens nationwide have knowledge of specific examples of fraud or abuse which may or may not be known to agency administration. The details of these problems are invaluable in our examination of agency ability to combat fraud. In order to provide a means for utilizing this source of information, GAO established a "hotline" with a tollfree telephone number

on January 18, 1979. This allows any concerned citizen nationwide an opportunity to report instances of fraud to the Task Force for investigation and possible referral for prosecution.

In the first 6 weeks of operation we have received over 3,000 allegations of various types. Calls have been received from 48 States, the District of Columbia and overseas locations. Approximately 62 percent of the calls appear to have some substance for audit investigation.

About 82 of the 3,000 involve VA, and so far we have forwarded 20 of them to VA's Inspector General. Others will be forwarded to VA as we receive and screen more of these.

Following are a few examples of the type of allegations we are receiving:

Disability fraud

--Veteran receiving 100 percent disability payment operates heavy earth moving equipment. Also same veteran claimed 2 dependent children for 14 years but wife now alleges they have no children.

Theft of Government property

--VA motor pool employees working on and installing Government equipment in privately-owned vehicles.

--Employee taking items from VA Canteen without paying for them.

Wasteful practices

--VA hospital built a spinal cord unit but doors are too narrow to allow wheelchairs through. Also olympic size swimming pool was built but patients cannot get in to use it. Now pool is being torn up and patients are being sent to commercial pool for therapy.

--Equipment purchased for VA hospital left outside and ruined by weather.

--VA refused to pay totally disabled veteran transportation to and from local doctor's office ($3.00), but wanted to send cab to take veteran to VA hospital at a cost of about $100 round-trip.

--Hospital destroyed venetian blinds and replaced with shades. Blinds only needed cleaning.

Other abuses

We also received allegations of abuses of overtime, hiring practices and sole-source procurement, EEO complaints, etc.

ACTIONS VA HAS TAKEN

With the establishment of the Office of Inspector General, VA has taken several steps which should help in this general area. For example, the IG has set-up vulnerability assessments, preinstallation reviews, special initiatives on fraud, waste and mismanagement; cyclical audits and reactive investigations.

The IG's office set-up in February 1979 a "hotline" to receive employee complaints of fraud, waste and mismanagement. According to VA, the employee hotline in its first three weeks of operation produced 100 complaints, of which over 20 percent appeared to have investigative or audit merit.

VA has also proposed several pieces of legislation which could help in preventing abuse and waste.

We have testified before that there was a need for stronger internal audit and inspection but that a strengthened criminal investigative capability is not sufficient to solve the problems. The internal auditors should also be very much involved. They have as one of their major tasks the evaluation of the adequacy of management's internal control systems necessary to the prevention of fraud. Theirs is a preventive role. In doing this they must work closely with the investigators in providing leads to the latter on potentially fraudulent situations and in return consider the investigator's findings as part of the internal control system assessment. Each has an important role to play but not to the exclusion of the other.

The establishment of the IG, bringing audits and investigations together, the increased staffing of that office and the actions mentioned above that the IG has taken, should permit VA to do a better job in planning and carrying

out audits and investigations and to actively seek out fraud and waste in VA. However, it is still too early to tell what impact this office and its actions has had on abuse and waste in the VA.

IS LEGISLATIVE ACTION NEEDED?

You asked if we believe that legislative action is needed. The Comptroller General's annual report cites numerous examples of financial savings and other benefits from our work, as well as open legislative recommendations which may be directed to making a program more efficient or effective and to improve its management. These legislative recommendations include those developed during the past fiscal year covered by the report as well as carry over recommendations which we still commend to the attention of the Congress. By letter dated February 1, 1979, we forwarded to the Committee Chairman two open recommendations on matters falling under the Committee's jurisdiction.

What we believe is needed is a more active, systematic approach to identifying fraud. As stated in our September 19, 1978, report, heads of Federal agencies should:

--Develop management information systems aimed at providing information on the most likely types and methods of fraud, including the development of techniques for estimating the magnitude of fraud in agency programs.

--Elevate fraud identification to a high agency priority.

--Take steps to make employees more aware of the potential for fraud and establish controls to see that irregulatities are promptly referred to appropriate personnel.

--Fix organizational responsibility for identifying fraud.

--Provide agency investigators with appropriate fraud training. In future hirings, concentrate on recruitment of personnel with backgrounds and education more suited to the financial complexities of fraud.

In addition, the Attorney General should establish a formal plan to assist Federal agencies in combating fraud, including such procedures as:

--Working with Federal agencies to develop information on the nature of potential fraud in their programs.

--Consulting with agencies to devise systems to identify and investigate fraud.

--Advising agencies of the types of cases which will receive priority for prosecution and working with agencies to devise alternative solutions for those which will not.

--Providing feedback to Federal agency officials on program and administrative weaknesses developed by Federal prosecutors during the course of various prosecutions.

We also believe that the Congress and its various committees can take action to eliminate waste, fraud, and abuse. We believe the committees should act with precision to the maximum extent possible. This can best be done on Congress' part by oversight and legislative action on (1) individual VA programs and (2) administrative functions, such as the recent creation of the Inspector General function, increased emphasis on collection of receivables, prosecution of

fraud cases, and implementation of the new personnel management functions.

At the individual program level, it can be determined when, and how much the funding level should be changed to correspond with actual reductions in waste, fraud, and abuse in the particular program. It is only at that level that Congress can assess the balance between administrative and program costs and address the underlying problems--poor management, poor program design, poor organizational arrangement, or actual fraud and abuse by individuals.

Across-the-board budget cuts--either in lump sum or as a percentage--get the message across that Congress wants the program costs lowered, but they give to the agency the control over the allocation decisions for individual programs. Thus, Congress cannot be sure that the reductions will be taken where and how they are needed to result in and correspond with actual reductions in waste, fraud, and abuse.

I do not believe it is realistic for the budget committees to lower the aggregate funding levels based on estimated "savings", unless it is done in cooperation with the authorizing and appropriating committees. These latter Committees can take the legislative actions needed at the program level to make the reduction happen, such as changing eligibility requirements where needed, strengthening administrative functions, etc.

Our laws must be periodically reviewed and modified to keep our programs and administrative functions up-to-date and responsive to current needs. We agree that the Congress cannot review programs every year, but it can and should make sure that they are looked at periodically.

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This concludes my statement. We would be happy to respond to any questions you or other members of the Subcommittee may have.