STATEMENT OF

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DEPARTMENT OF VETERANS AFFAIRS

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

MAY 8, 2003

INTRODUCTION

Mr. Chairman and Members of the Committee, I am pleased to be here today to address the Office of Inspector General's efforts to identify and eliminate fraud, waste, abuse, and mismanagement in programs administered by the Department of Veterans Affairs (VA). We provide oversight that addresses mission-critical activities and programs in health care delivery, benefits processing, financial management systems, procurement practices, and information management. Our work is accomplished consistent with our strategic goals and aligned with the strategic goals of the Department.

Today, I will present to you my observations, identify current efforts that are helping to raise fraud awareness in VA, and summarize some of our most significant work. I will also highlight management areas where I believe improvement can be made to prevent fraud, improve administration, and reduce waste in VA programs.

To provide continuing oversight of VA's operation, I established a Combined Assessment Program, (CAP), as part of my office's effort to ensure that high quality health care and timely benefits are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG Offices of Audit, Investigations, and Healthcare Inspections to provide collaborative assessments of VA medical facilities and regional offices on a cyclic basis. The CAP assessments provide management independent and objective evaluations of key facility programs, activities, and controls.

During CAPs, we conduct fraud and integrity awareness briefings to raise employee awareness of fraudulent activities that can occur in VA programs. CAPs continue to identify investigative leads, systemic weaknesses, and vulnerabilities in program areas and conditions that require management attention.

In March 1999, we issued our first CAP assessment and since that time we have completed almost 100 CAP reviews at VA healthcare systems, medical centers, and regional office facilities.

We also provide oversight by performing national program audits, preaward and postaward contract reviews, hotline reviews, healthcare inspections, and investigations. The results help identify where the Department needs to address major program challenges and improve the economy and effectiveness of its operations.

From fiscal year (FY) 1998 through March 31, 2003 we issued 872 reports, processed 2,008 hotline cases, performed 7,073 investigations and made recommendations having the potential to save the Department approximately $7 billion by preventing waste, fraud, and other abuses. My staff has detected major frauds impacting the delivery of benefits to veterans and their beneficiaries and investigated criminal activities perpetrated by employees and others that resulted in significant losses.

I will highlight the most significant of this work and address management areas where I believe further improvement is needed.

HEALTH CARE DELIVERY

Over the last 5 years we have made recommendations to address many conditions that have had the potential to save the Department $3.5 billion in monetary benefits and improve the delivery of health care. One of the most serious challenges facing VA is the need to maintain a highly effective health care quality management program and to provide quality care to our veterans. Although Veterans Health Administration (VHA) managers are addressing the Department's

quality management and patient safety procedures, health care system delivery issues remain. I see opportunities to enhance operations and improve health care delivery.

Over the years, evidence has come to our attention indicating that some VA physicians were not present during their scheduled tours of duty, were not providing VA the services owed under their employment agreement, or were "moonlighting" on VA time. Since FY 2000, my staff has substantiated 15 allegations of time and attendance violations by VA physicians received through our hotline. Additionally, since FY 2000 our CAP reviews have reviewed physician time and attendance issues at 43 medical centers and healthcare systems and identified deficiencies at 24 facilities.

In response to our concerns regarding physician time and attendance, VHA has often asserted that:

- Patient care is only one component of a VA physician's professional practice. VA physicians also have responsibility for education, research, and administrative duties that are not reflected in clinical documentation.

- Although physicians may not have been on duty during their scheduled tour, overall VA receives much more than it pays for because the physicians provide VA uncompensated on-call and weekend service.

Our audits have found significant staffing disparities among VA medical centers. These disparities were primarily attributed to historical-incremental budgeting and staffing practices, but we also found that VHA was unable to evaluate or justify the staffing needed to cost effectively manage medical center workload. This resulted because VHA had not established physician-staffing standards and were not effectively managing physician time and attendance.

The following describes results of our review of these issues.

Audit of Physician Time and Attendance Issues

At the request of the Secretary of Veterans Affairs, we audited the VHA's management of part-time physician time and attendance, physician productivity in meeting employment obligations, and physician-staffing requirements. The audit assessed if timekeeping and other management controls were effective in ensuring that part-time physicians worked the hours required by their VA appointments; and reviewed whether the administration used effective procedures to align physician staffing with workload requirements. As of December 31, 2001, VA employed 5,129 part-time physicians equating to 2,607 full time equivalent

employees (FTEEs) at a cost of $400 million. Our report, Audit of Veterans Health Administration's Part-Time Physician Time and Attendance, Report No. 02-01339-85, was issued April 23, 2003.

The audit disclosed that VHA medical center 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 medical center 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 apparent timekeeping violations. But, our results clearly showed that part-time physicians were not working the hours established in their VA appointments and as a result part-time physicians were not meeting their employment obligations to VA. Specifically, we found:

- There was no documented evidence of any patient care workload (patient encounters, operating room time, progress notes, physician orders, or network log on times) for 33 percent of the time in a 14-day review, where 223 part-time physicians were scheduled for at least 4 hours of duty.

- Part-time physicians did not complete a minimal amount of patient care time (at least 1 hour in surgery or at least 2 progress notes, doctors orders, or encounters per hour worked) on 53 percent of days the physicians were scheduled to work at least 4 hours. This includes the time part-time physicians spent on patient care on their days off and time without compensation (WOC) physicians spent providing direct patient care as substitute physicians.

- Surgeons spent 38 percent of their available time on patient care obligations – patient encounters and operating room time. Of the 153 surgeons reviewed, 70 spent less than 25 percent of their available time in direct patient care.

- Part-time surgeons at 6 VA medical centers reviewed were performing surgery at the affiliated medical schools during their scheduled VA tours of duty.

- Attending physicians[1] at 4 VA medical centers reviewed were not present to supervise the residents' treatment of patients in 6 of 29 clinics reviewed.

[1] An attending physician is a staff physician responsible for the patient care provided by resident physicians in training.

- One general surgeon had a 5/8^{ths} appointment representing 25 hours weekly. During a 10-week period, he was paid for 250 hours, reported no leave, and had no medical research projects. However, during this 10-week period he performed only one surgical procedure and had only one other documented patient encounter, totaling 3 hours.

- A neurosurgeon had a 3/8^{ths} appointment representing 15 hours weekly. During a 10-week period, he was on duty for 127.5 hours (150 paid hours less 22.5 hours of leave) and had no medical research projects. During this 10-week period, he performed only 5 surgical procedures and had 13 documented patient encounters. The time for these activities totaled 23 hours, representing just 18 percent of his 127.5 paid duty hours.

In addition, we found that VHA does not have effective procedures to align physician-staffing levels with workload requirements. VA medical centers did not perform any workload analysis to determine how many FTEE[2] were needed to accomplish the medical centers' workload or evaluate their hiring alternatives (such as part-time, full-time, intermittent, or fee basis). VA medical center managers responsible for staffing decisions did not fully consider the physicians' other responsibilities – such as medical research, teaching, and administration when they determined how many physicians the VA medical centers needed.

VHA officials told us the determination of the number of part-time physician FTEEs needed has more to do with the financial needs of the affiliate 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 VA medical centers we visited during our audit, had informed their part-time physicians of what was expected of them to meet their VA employment responsibilities. We believe communication of expectations and responsibilities would significantly improve operations at the VA medical centers.

To address these conditions we made a series of recommendations to the Under Secretary for Health for corrective actions. Some of these recommendations were:

- Require that Veterans Integrated Services Network (VISN) and medical center directors ensure part-time physicians meet their employment obligations and hold field managers accountable for compliance.

[2] The FTEE needed to accomplish medical center workload is equal to the total number of hours worked by the physician (including hours used for patient care, non-patient care, and leave) divided by 2,087.

- Determine what reforms are needed to ensure VA physician timekeeping practices are effective in an academic medicine environment and ensure VA physicians are paid only for time and service actually provided. Also, recommend statutory or regulatory changes needed to implement the reforms and publish appropriate policy and guidance.

- Apprise all part-time physicians of their responsibilities regarding VA timekeeping requirements.

- Evaluate appropriate technological solutions to facilitate physician timekeeping.

- Publish policy and guidance that incorporates the use of workload analysis to determine the number of physicians needed to provide timely, cost effective, and quality service to veterans seeking care from VA.

- Publish guidance describing how VISN and medical center managers should determine, monitor, and communicate the allocation of physician time among patient care, administrative duties, academic training, and medical research.

- Require medical centers to review their staffing structures (such as part-time, full-time, intermittent, or fee basis) and determine if these appointments are appropriate to the needs of the medical center.

The Under Secretary for Health generally agreed with our findings and recommendations, except for a recommendation requiring the medical center directors to perform an annual staffing assessment and provide a certification of their staffing decision; and, the recommendation requiring national guidance on strategies to determine physician services. However, the Under Secretary provided an acceptable alternative implementation plan for the recommendation concerning the need for staffing assessments and certification of the medical center directors staffing decision. Since the Under Secretary indicated that staffing guidelines are under development, we will hold this recommendation open pending issuance of the staffing guidance.

Review of Physician Utilization at VAMC Lexington, KY

In October 2002, we issued our report on the CAP Review of VA Medical Center Lexington, KY. The CAP review included limited evaluations of physician timekeeping and productivity. We concluded that there had been a breakdown in physician timekeeping controls in the medical center's Medical and Surgical Services contributing to low physician productivity.

We found that neither timekeepers nor supervisors knew when physicians were on duty. As a result, medical center management did not know whether it received the physician services needed or paid for.

During the CAP we also tested physician productivity and found that, during March 2002, we could only verify that medical service part-time physicians were on duty 22 percent of the time they were paid and part-time surgeons were on duty 36 percent of the time they were paid. Due to the lack of record keeping and documentation at the medical center, we could not determine where the physicians were, or what they were doing, for the remainder of their paid time.

Based on the limited tests we were able to perform, we concluded that medical and surgical services were overstaffed by at least 7.3 FTEE physicians at a cost of $1.2 million. At the time of the CAP in June 2002, we found that the medial center's Primary Care Service needed approximately 4 FTEE in physicians and 10 FTEE in supporting nursing and clerical staff at a cost of about $1 million to eliminate the waiting list and meet increased workload expected by June 2003. We recommended and the medical center agreed to eliminate the unneeded physicians and reallocate the resources associated with those positions to Primary Care Service.

Follow-Up Review at VA Medical Center Lexington, KY

After our CAP report was issued, the Secretary of Veterans Affairs asked us to perform a more in-depth evaluation of physician staffing at VAMC Lexington, KY. We also received allegations that part-time attending physicians were giving resident physicians their passwords to the electronic medical record so that the residents could cosign their own entries into the medical record. This practice would violate requirements for attending supervision of residents, and potentially result in poor quality of care.

To evaluate physician time and attendance, productivity, and quality of care, we initiated a multi-stage evaluation protocol that includes a detailed, physician-by-physician review of clinical workload documents for two representative months – May and August 2002. We subpoenaed scheduling and other records from the University of Kentucky, where most part-time physicians held faculty appointments, and billing records from the Kentucky Medical Services Foundation, the clinical practice group representing University of Kentucky physicians. This data was merged with the VA clinical workload data to obtain a comprehensive picture of where VA part-time physicians worked during the period reviewed. We are expanding the scope of our review to evaluate expanded periods, for selected physicians.

While we have much more work left to do, the preliminary results are showing that some part-time VA physicians were not on duty for large segments of their schedules and were not engaged in the research or education activities that VHA has often put forth as explanation for the absence of significant patient care service.

Technological Solutions

There is new technology that provides effective systems for granting employees access and tracking locations of personnel working in facilities. Today, intelligent locator systems have the capability to track over a million badges. VA can acquire state-of-the-art technology systems to help accurately control labor costs in today's hectic workplace. Given our concerns and the issues identified, I support acquiring new technology to meet VA's needs more effectively.

Healthcare Resources Contracts

Our preaward reviews have also reported that some solicitations to acquire healthcare resources services do not consistently identify the physicians who are expected to provide the services, specify the number of hours to be worked by each physician in each pay period, or state the actual hours the physician is expected to work. Further, the solicitations often lack information to identify what portion of time will be spent providing patient care, or a method by which time and attendance can and will be monitored to ensure VA is only paying for services provided to or for veterans.

In addition, most solicitations do not include a requirement that VA will only pay for the hours worked at VA or that absences will be deducted from the scheduled contract payments. As a result, if the contract physicians are not working the hours VA is paying for, there may not be an appropriate mechanism to obtain recourse under the contract. In the contract reviews we have performed, contracts that utilized "per procedure" type of payment methodology seldom required the attending physician perform or be present during the procedure or treatment, or required a physician presence at the medical center for any specific tour of duty when procedures are to be performed at the VA. In addition, most of the proposals reviewed do not indicate a requirement for VA to credential and privilege the physicians.

Staffing Standards

In September 1995, we performed an audit to evaluate VHA's management of physician staffing and the equity of the distribution of physician resources among

VA medical centers (VAMCs). The audit found significant disparities among VAMCs with similar missions and levels of affiliation with medical schools, and among moderately affiliated, general, and psychiatric VAMC groups. These disparities were not explained by physician time allocated to patient care, education, or research; by the number of residents or physician extenders; or by differences in acuity and/or complexity of care.

At that time, we recommended VHA develop a benchmarking process for physician staffing and set goals to encourage VAMCs to move staffing levels closer to the levels of the most efficient medical centers. Establishing staffing standards could have permitted the better use of about 2,000 physician FTEE with associated costs of $180.6 million. VA did not concur with the recommendations or monetary estimate at the time of this audit. However, new VHA initiatives were expected to address the audit issues and produce a more equitable distribution of physician resources. The audit issues remain unresolved and VA still lacks staffing standards. Our recent audit covering physician time and attendance and numerous CAP reviews have demonstrated the continuing need for staffing standards.

In January 2002, Congress passed Public Law 107-135 which requires the Secretary of Veterans Affairs, in consultation with the Under Secretary for Health, to establish a policy on the staffing of medical facilities to ensure that staffing is adequate to provide veterans appropriate, high-quality care and services. In implementing this law, VHA should take advantage of past physician staffing studies as well as established staffing models in other government agencies. For instance, the Army, Navy, and Air Force have recognized that manpower is one of their most significant expenses and have developed models to determine their staffing requirements. Such models may be of use to the Department in developing their standards.

Review of Biological, Chemical, and Radiological Inventories

Some of our other recent work addressed heightened concerns in the wake of September 11, 2001 and the security of dangerous pathogens. The Secretary of Veterans Affairs requested the OIG conduct an inspection of the adequacy of security and inventory controls over selected biological, chemical, and radioactive agents owned by or controlled at VA. Our review found significant vulnerabilities in high-risk security areas in research, clinical laboratories, and pharmacies.

We found that security measures to limit physical access to VA's research facilities, clinical laboratories, and other high risk or sensitive areas varied significantly. In addition, we found that VHA's inventories of sensitive materials were incomplete and inadequate. While most facilities had complied with

requirements for disaster planning, many had not updated their plans to include terrorist activities. Our review also emphasized the ongoing challenge of obtaining adequate and timely credentials and background checks for employees and contractors. Fifteen of the 16 recommendations were not implemented as of March 31, 2003.

VHA's Contract Community Nursing Home Program

We conducted an evaluation of the Community Nursing Home (CNH) program to follow up on VHA's efforts to strengthen its monitoring of CNH activities and to ensure that veterans receive good care in safe environments. We found that VHA had taken years to implement standardized inspection procedures for monitoring CNH activities and for approving homes for participation in the program. VHA policy has been under review since 1995. We believe this slow pace of revising policy led to variances in the way local managers and clinicians administer and monitor CNH activities. VHA recently published new CNH policy at the conclusion of this review in December 2002; however, it still warranted clarification and stronger controls are needed.

The veterans we visited were generally well cared for and mostly satisfied with CNH services and accommodations. However, we found 9 reported cases of abuse, neglect, and financial exploitation during our review of the records of 111 veterans residing in 25 CNHs. This represented an average 8 percent incident rate in the sample population. We also found veterans not in our sample and non-veterans residing in VHA-contracted CNHs who were subjected to serious adverse incidents. These conditions emphasize the need for VHA to strengthen its oversight controls.

We found similar program vulnerabilities identified in earlier General Accounting Office (GAO) and OIG reviews continue to exist. For example, we found that not all VHA CNH review teams analyzed Health and Human Services data. This was evidenced by the fact that 27 percent of the veterans at the medical facilities visited were placed in Medicaid and Medicare Services watch listed[3] homes. The medical facilities we visited had active contracts with 41 CNHs on the watch list. The 41 CNHs were cited 273 times for administrative and quality of care violations.

We found that CNH contract procedures and inspection practices varied among VA medical facilities. Contracts need to be standardized and VA medical record documentation needs improvement.

[3] Substantiated violations of nursing homes cited for placing residents in harms-way or in immediate jeopardy result in nursing homes being placed on a Department of Health and Human Services, Center for Medicaid and Medicare watch list that identifies the nursing homes and the offending issues or violations.

In addition, clinicians needed to routinely obtain performance indicators to better monitor occurrences at the CNH facilities and to coordinate performance improvement initiatives. We also found that VHA's CNH review teams do not meet annually with the Veteran Benefits Administration (VBA) fiduciary and field examination supervisors to discuss veterans of mutual concern, as required by VBA policy. The absence of this communication link impedes the Department's ability to adequately protect veterans from financial exploitation and protect VA-derived payments.

We made 10 recommendations to VHA, and the Under Secretary for Health agreed with all but one issue pertaining to monitoring patients who reside outside a 50-mile radius of VA facilities. We agreed that no immediate action was needed on this specific issue, but we encouraged VHA managers to closely monitor and ensure the adequacy of monitoring these veterans. The Under Secretary for Health provided acceptable implementation plans for the remaining recommendations. The Under Secretary for Benefits agreed with our recommendation to coordinate efforts with VHA in this area and establish proper procedures for exchanging information.

Healthcare Investigations

We have also conducted significant criminal investigations at certain VA medical facilities.

Jamaica Plains Armed Robbery

During May 2001, 2 armed individuals entered the pharmacy at VA Medical Center Boston under the ruse of delivering flowers and, after leading the VA pharmacy employees to a secure vault and tying them up, stole 3,000 tablets of Oxycontin and other narcotics valued at over $250,000. The subsequent joint investigation with the Federal Bureau of Investigation (FBI) and VA Police disclosed that a VA Medical Center employee aided the robbers by providing them details regarding the pharmacy layout and daily routine. All three subjects involved in the robbery have been indicted and trial preparation is underway.

Nashville Pharmacy

Based on information regarding drug diversion received from an employee of the Nashville VA Medical Center, a joint investigation was initiated with the Drug Enforcement Administration. The investigation disclosed that over 233,000 dosage units of schedule 2 and 3 narcotics had been diverted from the pharmacy, having an estimated street value of $3.5 million. A VA supervisory pharmacist

diverted the drugs by filling prescriptions for random veterans for whom no legitimate prescriptions were written and who did not have follow-on appointments. She then passed the drugs to her uncle who distributed them on the street.

Both the pharmacist and her uncle were indicted and convicted for their roles in the scheme. The Government seized property and cash as proceeds of the crime. The employee's uncle has been sentenced to 70 months imprisonment, 3 years supervised release, and ordered to pay $4,140 in restitution. Sentencing for the former employee is pending and other suspects have been identified. The investigation is continuing.

The Jamaica Plains and Nashville pharmacy investigation highlight the critical need for rigorous inventory controls at all VHA facilities, especially considering that in FY 2002 VA's pharmaceutical purchases totaled about $2.4 billion.

BENEFITS PROCESSING

I am pleased to note that the Department's efforts to reduce claims backlogs that once peaked at about 535,000 outstanding claims in FY 2001, have been reduced in the past 2 fiscal years largely due to the Secretary's efforts to charter a VA Claims Processing Task Force to address claims processing backlogs in order to expedite claims and deliver benefits to veterans more timely. Over the last 5 years, in VBA we have made recommendations to address many potential improvements and identified potential monetary savings in excess of $1.5 billion. In addition, investigations have led to the assessments of fines, recovering restitution payments, and other recoveries through civil judgments totaling about $150 million.

Overall, I appreciate the responsiveness the Secretary and Under Secretary have shown to ensure the Department addresses OIG concerns. However, while VBA is making progress, there are still many opportunities for improvements to ensure the timely delivery of benefits and services to veterans. As a result of our work, I can see improvements through their efforts to ensure benefits are terminated or reduced upon incarceration of veterans.

Incarcerated Veterans

In July 1986, our office reported that veterans who were imprisoned in state and Federal penitentiaries were improperly receiving disability compensation benefits or needs based pension. This occurred because controls were not adequate to ensure benefits were terminated or reduced upon incarceration, as required by Public Law 96-385. As a result of our audit, Department managers agreed to

implement certain measures to identify incarcerated veterans and reduce or terminate benefits as appropriate.

We conducted a follow-up evaluation in 1999 to determine if disability benefit payments to incarcerated veterans were appropriately adjusted, and other procedures agreed to in 1986 had been implemented. We found that Department officials had not implemented the agreed to control procedures and improper payments to prisoners had continued.

During the follow-up evaluation, we reviewed a sample of veterans incarcerated in state and Federal prisons and found that 72 percent of the cases were not adjusted as required. Based upon the number of beneficiaries that were incarcerated, we estimated that nationwide, about 13,700 incarcerated veterans had been, or would be overpaid by about $100 million. Additionally, overpayments to newly incarcerated veterans totaling about $70 million would occur over the next 4 years, if VBA did not establish appropriate controls.

Subsequently, VBA initiated positive actions to enter into agreements with the Federal Bureau of Prisons to identify claimants in Federal prisons and with the Social Security Administration (SSA) that allows VBA to use the State Verification and Exchange System to identify claimants incarcerated in state and local facilities. As a result of their actions, the Department is in a much better position today to reduce erroneous payments paid to incarcerated veterans and realize the projected savings.

OIG audits and investigations continue to find that improper benefit payments are a significant problem in the Department. Improper payments have been attributed to poor oversight, monitoring, and inadequate internal controls. Improper payments have also occurred because of payments to ineligible veteran beneficiaries, fraud, and other abuses. I feel the risk of improper payments is high considering the significant volume of transactions processed through VA systems, the complex criteria often used to compute veterans' benefits payments, and the numerous instances of improper and erroneous payments previously identified.

I would also appreciate the opportunity to address our current work and provide some examples of where our work has identified large numbers and amounts of improper payments and to address where we have identified fraud in the administration of VA benefit programs.

Fugitive Felon Program

In compliance with a recent law, I have established a fugitive felon program to identify VA benefits recipients and VA employees who are fugitives from justice.

The program consists of conducting computerized matches between fugitive felon files of law enforcement organizations and VA benefit and personnel records. Once a veteran or employee is identified as a fugitive, information on the individual is provided to the law enforcement organization responsible for serving the warrant to assist in apprehension. Fugitive information is then provided to VA so that benefits may be suspended and to initiate recovery action for any overpayments. Based on our pilot study and matches conducted to date, I anticipate that between 1 and 2 percent of all fugitive felony warrants submitted will involve VA beneficiaries. Savings related to the identification of improper and erroneous payments are projected to exceed $209 million.

To date, Memorandums of Understanding/Agreements have been completed with the U.S. Marshals Service, the States of California and New York, and most recently, the National Crime Information Center. While we are still in the initial phases of setting up the program, our data matching efforts have identified more than 11,000 potential fugitive beneficiaries and employees. Details of recent investigations of such fugitives follow.

- My agents along with state investigators arrested a fugitive beneficiary wanted on a parole violation warrant for aggravated kidnapping. Photographs were circulated and a briefing was given to the VA Regional Office (VARO) on the fugitive status of the veteran. We provided intelligence and assisted in field operations that resulted in terminating the fugitive's VA benefit. Several months later, the fugitive attempted to enter the VARO to inquire about the status of his benefits checks, however he was turned away by security due to the fact that he had a knife on his person. A member of the VARO recognized the fugitive from the pictures we had provided and immediately alerted my staff. OIG Agents were able to take the fugitive into custody and subsequently turned him over to the state investigative agents.

- In another case, a fugitive sought by the FBI was arrested at his residence based on a Federal arrest warrant issued for Unlawful Flight to Avoid Prosecution. The veteran was wanted on a state warrant for manslaughter, assault, and reckless driving and had fled to avoid prosecution of the state case. Allegedly, the veteran killed a ten-year-old girl and injured her aunt because of his reckless driving. The Seattle VA Regional Office had previously suspended the veteran's benefits under the provisions of the fugitive felon project.

- In yet another instance, following due process, VA benefit payments going to a veteran wanted for armed robbery of a bank in Red Wing, MN, were suspended and later terminated. This action resulted in a $44,448 cost

savings. In addition, during February 2003, the bank to which the veteran's funds were deposited was requested to return any available funds effective from the date the veteran became a fugitive felon. Accordingly, the veteran's bank sent VA a check for $8,975.90, the total amount of funds available in his account.

This program contributes to Homeland Security and results in the apprehension of dangerous criminals.

Death Match Project

In addition to the fugitive felon program, we are also conducting an ongoing proactive death match project. The OIG Death Match initiative is a continuous program that involves quarterly matching of the VA Compensation and Pension database with the SSA's records of death file. The purpose is to identify veterans who died, where VA is still erroneously paying benefits. Since we began this proactive initiative in FY 2000, our data matching efforts have identified 6,775 possible cases. To date, we have closed 2,803 cases due to VA previously terminating the benefits, 478 cases because the veteran was alive, and 440 cases resulted in a full investigation. Of the 440 completed investigations, $21.1 million has been, or is the process of being, recovered. Also, 70 individuals were arrested. Of the remaining 3,054 cases, there are currently 737 open investigations and 2,317 matches pending review. Based on results from completed cases, we project the remaining cases will produce an additional $70 million and 209 arrests.

Philippines Benefit Review

During 2002, the OIG and VA Regional Office Manila staff worked together on an international review to identify and eliminate erroneous benefit payments to payees supposedly residing in the Philippines. Over 1,100 interviews were conducted, approximately 2,600 files were reviewed, 9 criminal cases were initiated and 1 search warrant was obtained and executed. As of May 2002, awards of 594 beneficiaries were identified for suspension or termination. The overpayments for these 594 beneficiaries totaled approximately $2.5 million with a projected 5-year cost avoidance of over $21 million. Criminal investigations initiated during the Philippines review were turned over to the Philippines National Police. We also referred 94 beneficiaries to the VARO for review regarding a possible increase in benefits; appointment of a fiduciary; change of address; Prisoner of War Medal status; and various other benefits changes. From this review effort, several criminal investigations have been developed that will continue to be pursued during the next fiscal year. VA officials from the Manila Regional Office and VA's Financial Systems Quality Assurance Service were instrumental to the success of this review.

We are now looking at other areas outside the continental United States where large numbers of veterans or their dependents receive benefits. Presently, over 78,000 payees, outside the continental United States, receive approximately $49 million a month in benefit payments. For example, benefit payments of approximately $2.9 million are paid to approximately 5,100 veterans and their beneficiaries in Germany on a monthly basis. In addition, benefits valued at approximately $28 million are paid monthly to about 42,000 payees in Puerto Rico.

Atlanta VA Regional Office

An OIG investigation uncovered $11.2 million that had been fraudulently paid to a 30-year VA employee and her 11 co-conspirators representing the largest known embezzlement by a VA employee. The OIG team discovered that an employee of VA's Atlanta Regional Office devised a scheme whereby she used her position of trust and the VA computer system to resurrect the claims files of deceased veterans who had no known dependents. Once the files were reestablished, the employee generated large retroactive benefit payments and, in some cases, recurring monthly payments, to her co-conspirators. After the payments were deposited in private bank accounts, the co-conspirators shared their bounty with the VA employee by giving her what amounted to approximately one-third of what they had received.

The scheme started in July 1996, when the employee channeled funds to a retired career VA employee and a former VA employee. Between 1996 and August 2001, the trio stole over $6 million. As a result, the OIG team and the U.S. Attorney's Office decided to review all claims files touched by these individuals. We discovered a second conspiracy that showed the same VA employee embezzled approximately $5 million while working with close friends and eight co-conspirators. The scheme was devised whereby large lump sum payments and recurring monthly benefit payments were made to these individuals. Like the original scheme, the VA employee received a share of the benefits when the checks were cashed. Over 100 bank accounts were analyzed to determine the disposition of the stolen money. The investigation generated 73 seizure warrants and 30 forfeiture recoveries.

The 12 co-conspirators pled guilty to various charges including theft of Government funds, conspiracy, and conspiracy to commit money laundering. The VA employee's guilty plea came after being indicted on 1,000 counts from the two conspiracies. In addition to defrauding VA, three of the co-conspirators also pled guilty to defrauding the SSA. The 12 defendants were sentenced to a total of 37.5

years' imprisonment, 35 years' probation, and judicially ordered to make restitution totaling over $34 million.

Property with an appraised value of almost $2.8 million was seized or forfeited. This included houses, airplanes, and such oddities as a mini-submarine. In addition, numerous bank accounts, insurance policies, cash, jewelry, valuable collections (including a $40,000 Barbie doll collection), antiques, cars, boats, and motor homes were recovered from the individuals involved.

Houston VA Regional Office

We also investigated a matter involving a Houston VA Regional Office employee who was found to have created a false veteran payee within VA data systems and, with the assistance of another VA employee, caused benefit payments to be disbursed to an address they controlled. In total, during a 3-year period, they stole over $229,700 from VA. Both employees were prosecuted and received prison sentences, 3 years' probation and were directed to make restitution totaling $459,572.

Nashville VA Regional Office

In another instance, a VA Regional Office employee, assigned to the Nashville Regional Office as a veteran services representative, was prosecuted because of a scheme he devised wherein he obtained the medical information of another veteran from VA's computerized Automated Medical Information Exchange. He then altered the patient information to show it was referring to his medical condition, and forwarded the fraudulent documents to the VA Regional Office in Cleveland for inclusion in his own claims folder.

This action caused the VARO managing his records to re-evaluate the claim and upgrade his rating to a 100 percent disability. During the investigation, it was also determined that compensation granted the employee in 1988, based on his claim for suffering a gunshot wound, was based on fictitious information. The employee later resigned and prior to his prosecution, made restitution to VA amounting to $42,976. After pleading guilty to a Criminal Information charging him with aiding and abetting and wire fraud, the employee was sentenced to 6 months' monitored home confinement and 24 months' probation.

In yet another case, a veteran was prosecuted on charges of wire fraud relating to falsified records submitted to VA. The records included his DD Form 214, Certificate of Release or Discharge from Active Duty. The veteran essentially misrepresented himself to VA as a wounded prisoner of war. He further fabricated his military service by claiming to have received the Distinguished Service Cross,

and Silver Star; and, a battlefield commission. During a major news network interview, the veteran claimed to be a surviving member of an Army group and claimed he was ordered to fire on Korean civilians at No Gun Ri during the Korean War.

Investigators proved he was not present and his account, therefore, was false. The veteran's false claims enabled him to wrongfully receive the Purple Heart and collect disability compensation and medical care benefits from VA for 16 years. The veteran was sentenced to 21 months' imprisonment, 36 months' supervised release and ordered to pay restitution to VA totaling $412,839.

In other benefit fraud cases, two VBA claims examination employees, at separate VBA Regional Offices, each embezzled over $600,000 in unrelated schemes.

New York VA Regional Office

In the first instance, a man was arrested in New Jersey on drug possession charges in April 1998. The arresting officers found a fictitious identification card on his person and records relating to a savings account in the name shown on the identification card. Our joint investigation led to the discovery that fraudulent VA disability compensation benefits were paid into the savings account monthly since August 1986. At the time the fraud was discovered, the payments were made at the rate of $5,011 monthly, the maximum VA compensation rate at that time.

The arrested man turned out to be a former VA employee who had worked as a disability rating specialist at VA's New York Regional Office from January 1986 to May 1987. The former employee was ultimately convicted of having fraudulently received VA compensation benefits to which he was not entitled. The scheme was perpetrated using another person's Social Security Number (SSN). The name and date of birth used were not those of the person whose SSN was used. The monthly fraudulent payments continued to be processed for 12 years, totaling over $620,000.

St. Petersburg VA Regional Office

In the second case, a supervisor at VA Regional Office St. Petersburg, FL, stole $615,451 by creating a fraudulent disability compensation award in the name of the employee's fiancé, a veteran who had served in the Persian Gulf War. The fraud began in March 1997 and continued until the employee's arrest in January 1999. The perpetrator used VBA's computer system on 10 occasions between March and October 1997, to retroactively increase the fraudulent payments she was sending to their bank account. These actions generated a series of one-time payments totaling about $520,000, and incrementally increased the recurring

benefit payments to $5,011 monthly. At the time of her arrest, the perpetrator was a Veterans Service Center Section Chief, a mid-level managerial position.

After learning of these thefts, the Under Secretary for Benefits requested that my office review internal controls in the compensation and pension (C&P) program to determine what vulnerabilities existed that might have facilitated these frauds. I provided a vulnerability assessment, reporting on 18 observed vulnerabilities in six general internal control categories. We also began our CAP review initiative to assess the scope and breadth of current vulnerabilities at VA's regional offices.

Department-Wide Review of One-Time Benefits Claims Initiated

In order to ensure the integrity of the benefits delivery system, the Secretary of Veterans Affairs requested the OIG conduct a department-wide review. We began a project examining all one-time payments of $25,000 or more made by the VBA, as well as a review of active awards that were considered vulnerable to fraud. One additional case of employee fraud was found in our review of 58,129 one-time payments. The OIG team was able to conclude that payments were valid for 99.8 percent of the cases reviewed, with the balance of cases being associated with the Atlanta Regional Office matter.

Although the benefits delivery system and claims processing in general were free of any similar one-time pay fraud situations, we did find unacceptably high rates of non-compliance with internal control requirements related to the processing of one-time payment claims. As a result, VBA began requiring that regional office management review all large one-time payments to ensure that they were appropriate and that required reviews were performed. In addition, we recommended that security deficiencies discovered in the claims processing system be corrected, and that regional office managers certify annually that their claims processing security is in compliance with required controls.

Income Verification Match

One of most significant and successful data matching initiatives was our November 2000 audit of VBA's Income Verification Match. We identified opportunities for VBA to:

- Significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered.

- Better ensure program integrity and identification of program fraud.

- Improve delivery of services to beneficiaries.

We found that VA's beneficiary income verification process with the Internal Revenue Service resulted in a large number of unresolved cases. We estimated the monetary impact of these potentially erroneous payments totaled $806 million. Of this amount, we estimated potential overpayments of $773 million were associated with benefit claims that contained fraud indicators such as fictitious Social Security numbers or other inaccurate key data elements. The remaining $33 million was related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. We also estimated that $300 million in beneficiary overpayments involving potential fraud had not been referred to the OIG for investigation. While VA addressed most of the recommendations in our report, the recommendation to complete necessary data validation of beneficiary identifier information contained in Compensation and Pension master records to reduce the number of unmatched records with the SSA remains unimplemented.

While the Department did not agree with our monetary impact, they did agree to report the Income Verification Match program as an internal high priority weakness. We did not accept the Department's rationale for reducing the monetary impact, since our estimate was based on a statistical sampling methodology that reflected a conservative estimate of the dollar impact of overpayments that have occurred.

Worker' Compensation Benefits

We also audited VA's Federal Employee Compensation Act program in July 1998 and concluded the program was not effectively managed and that by returning current claimants to work who are no longer disabled, VA could reduce future payments by $247 million. The audit found that the lack of effective case management practices placed the Department at risk for program abuse, fraud, and unnecessary costs.

In April 1999, in response to requests for assistance by the Department, we provided the Department with a handbook for VA Facility Workers Compensation Program Case Management and Fraud Detection. As a result by the end of FY 1999, Office of Workers Compensation Program costs had decreased by 1.6 percent to about $130 million. However, since that time costs have increased to approximately $151 million in 2002. We are currently performing a follow-up audit to our 1998 audit. Our preliminary results indicate VA continues to be at risk for program abuse, fraud, and unnecessary costs because prior IG program recommendations have not been fully implemented.

FINANCIAL MANAGEMENT SYSTEMS

Over the last 5 years, OIG has made recommendations addressing improvements needed in Financial Management activities and identified the potential for monetary savings totaling about $600 million. Since FY 1999, VA has achieved unqualified Consolidated Financial Statement (CFS) audit opinions. However, continuing material weaknesses, such as information technology security controls and noncompliance with Federal financial management system requirements have been identified. Corrective action needed to address noncompliance with financial system requirements is expected to take several years to complete.

The material weakness concerning the Department's financial management systems underscores the importance of acquiring and implementing a replacement integrated core financial management system. Achieving the success of an unqualified CFS opinion currently requires a number of manual compilations and extraneous processes that the financial management system should perform. These processes require extraordinary administrative efforts by the program, financial management, and audit staffs. As a result, the risk of materially misstating financial information is high. Efforts are needed to ensure adequate accountability, and reliable, useful, and timely information needs to be available to help Department officials make well-informed decisions and judgments.

I will now highlight some of my additional concerns focusing on debt management activities in the Department.

Debt Management Issues

As of December 2002, debts owed to VA totaled over $3 billion, of which active vendee loans comprise about 52 percent. Debts owed to VA result from the payment of home loan guaranties; direct home loans; life insurance loans; medical care cost fund receivables; and compensation, pension, and educational benefits overpayments. Over the last 4 years, my office has issued reports addressing many facets of the Department's debt management activities. We reported that the Department should: (i) be more aggressive in collecting debts; (ii) improve debt avoidance practices; (iii) streamline and enhance credit management and debt establishment procedures; and (iv) improve the quality and uniformity of debt waiver decisions. While VA has addressed many of the concerns we reported over the last few years, our most recent audits continue to identify areas where debt management activities could be improved and OIG report recommendations have not been adequately addressed.

Medical Care Collection Fund

During FY 2002, we conducted an audit of VA's Medical Care Collection Fund (MCCF) activities that resulted in identifying opportunities to maximize the

recovery of funds due VA for the provision of health care services. We reported there were potential opportunities for VA to enhance its collection efforts. Recovered funds are used to supplement the Department medical care budget and from FYs 1997 through 2001 MCCF collections have total $3 billion.

As of September 2001, VA reported a $1 billion backlog of unbilled care. We estimated that eliminating this backlog could result in additional collections of about $368 million.

Our audits continue to identify additional opportunities for improvements that can ensure the accuracy of medical record documentation and coding and more aggressively pursue accounts receivable collections. We also reported that insurance companies were not always billed in patient discharges sampled because the attending physician's participation was not documented in the patient medical record. Missed billing opportunities were estimated to total $13.1 million nationwide. Improvements can result in additional collections of about $4.6 million, based on projections that 35 percent of these billings are paid.

In our MCCF audit, we also noted that VA's average number of days to bill for these services took about 95 days. Private sector hospitals generally bill within 10 days of care. VA continues to be at risk of losing revenues by under-billing and not ensuring more timely billing efforts for services.

Our 2002 Healthcare Inspections review found incorrect Current Procedural Terminology codes in 50 percent of the outpatient records sampled. Thus, we are continuing to evaluate the accuracy of medical record documentation and coding during our CAP reviews with emphasis on reviewing the quality of documentation and aspects of residency supervision to ensure the proper coding of services performed.

I strongly support that additional opportunities exist to ensure aggressive follow-up of unpaid bills and appeal of denied insurance claims to increase future collection results in the Department. We have recommended that the Department continue to aggressively pursue improvements in these activities. Promoting results oriented accountability over the MCCF program will improve debt management in the Department.

PROCUREMENT PRACTICES

The Department spends about $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction and services. VA faces major challenges to implement a more efficient, effective, and coordinated acquisition program. High-level management support and oversight

are needed to ensure VA leverages its full buying power and maximizes the benefits of competitive procurements to achieve most favored customer prices or better. In addition, VA needs to improve buying practices.

This year along with other work, my staff has been conducting a national audit to evaluate the effectiveness of VA medical supply procurement practices. We are reviewing how 15 VA medical centers procured a selection of 50 commonly used medical, prosthetic, and other supply products in the 6-month period October 2001–March 2002. For most of these products, VA had negotiated numerous national-scope competitive contracts, multiple-vendor Federal Supply Service[4] (FSS) contracts, and blanket purchase agreements[5] (BPAs). We see that national contracts provided fair and reasonable prices that were generally lower than VA medical centers would otherwise have paid.

Our preliminary audit results are showing that VA medical center purchasers often paid higher prices than necessary for supply products because they did not make purchases from available VA national or FSS contracts or in some cases they established wasteful local contracts, as illustrated by the following examples:

- During the 6-month review period, 7 of 10 medical centers that purchased standard, powder-free surgical gloves used open market vendors instead of available FSS vendors. If the medical centers had purchased the gloves from FSS sources, they could have saved as much as $34,000, or about 28 percent of their expenditures for surgical gloves.

- Unaware that FSS contracts were available, one medical center established a local contract for Continuous Pressure Airway units used in the treatment of sleep disorders. The local contract cost per unit was $900. However, the medical center could have purchased the identical unit from an FSS

[4] The Federal Supply Service is directed and managed by the General Services Administration. The Service provides Federal agencies with a simplified process for obtaining commonly used commercial supplies and services at prices associated with volume buying. Using a schedules program, GSA enters into contracts with commercial firms to provide supplies and services at stated prices for given periods of time. The GSA schedule contracting office issues publications, entitled Federal Supply Schedules, containing the information necessary for placing delivery orders with schedule contractors.

[5] Blanket Purchase Agreements (BPAs) are a simplified method of filling anticipated repetitive needs for services and supplies. They are "charge accounts" established with GSA Schedule contractors by ordering agencies. Contractual terms and conditions are contained in a GSA Schedule contract, and do not need to be re-negotiated for use of Federal Supply Schedule BPAs. Therefore, as a purchasing option, BPAs eliminate contracting and open market costs such as: search for sources, processing solicitations, and synopsis requirements. BPAs are established directly with GSA Schedule contractors and negotiations with GSA Schedule contractors permit negotiation of price reductions based on the total estimated volume of the BPA, regardless of the size of individual orders.

contract for $322, or 64 percent less than the local contract price. By using the local contract, the medical center incurred unnecessary costs of about $19,600 for the 34 units purchased during the review period.

- VA negotiated national BPAs with two vendors for liquid body soap products. During the period, 6 of 14 medical centers that purchased liquid soap did not use the national BPA and instead made their purchases from other sources. If these medical centers had made their purchases from the BPA vendors, they would have saved $9,600, or about 41 percent of their actual expenditures for soap.

In addition, we found that existing VA national and FSS contracts did not cover some of the supply products, and VA paid a wide range of prices for these products. Most of the products have potential for greater standardization and national contracts that could result in significant cost savings, as illustrated by the following example:

- VA did not have national contracts for artificial intraocular lens used in cataract surgery. Eleven medical centers had purchased 1,670 intraocular lenses at open market prices, paying $238,000. The medical centers paid prices that ranged from a low of $125 to a high of $165 per lens, a variance of 32 percent, and the medical centers typically accepted the prices quoted by the vendors at the time of purchase.

We are still determining the monetary impact to the Department of not using national contracts. We believe VA could save substantially by making supply purchases from the best available contract sources, standardizing more products, and increasing national contacts.

FSS Pricing Reviews

Our contract review and evaluation work has returned $70.2 million to VA's supply fund over the past three FYs. We completed 84 post-award reviews of FSS contractors. Of the 84 reviews, 49 involved contractors voluntarily disclosing that they had reviewed their contracts and either owed the Government a refund for overcharges or that the contractors felt no refund was due VA. Voluntary disclosures made by VA contractors offered refunds that amounted to $16.6 million. However, our reviews of these voluntary disclosures resulted in recoveries of $50.5 million. Some examples of refund offers compared to recoveries follow.

- One FSS company's voluntary disclosure showed no refund due; after our review the Government recovered $15 million, of which $14.6 was refunded to the Department's Supply Fund.

- While the voluntary disclosure included in another refund offer was $93,000, we recovered $3.8 million after performing a detailed analysis of sales record.

- Another voluntary disclosure included a refund offer of $1.5 million; however, after our review VA recovered $10.5 million.

Since FY 1993, when my office and VA's Office of Acquisition and Materiel Management entered into a Memorandum of Understanding for us to provide audit and advisory services supporting VA's FSS program, we have received 82 voluntary disclosures, 60 percent of which were received in the last 3 fiscal years. Prior to our audit presence in the FSS program, VA received almost no voluntary disclosures from industry. The increase of mergers and acquisitions in the pharmaceutical industry in the past 3 years has also contributed to a marked increase in the number of voluntary disclosures from pharmaceutical and medical/surgical vendors.

Additionally, our increased presence in the affiliated educational institution arena has caused a significant increase in the number of requests from VA's contracting officers for us to review proposals from our affiliates to provide VA with the services of scarce medical specialists. Requests from VHA to review these proposals almost doubled between FYs 2001 and 2002 with 10 and 18 requests respectively. These reviews have resulted in contracting officers negotiating contract savings of $7.4 million.

VA still has much work to do in order to leverage its purchasing power through prudent acquisition practices to obtain best prices considering the volume of items purchased. VA also needs to improve accountability over local purchasing.

Some of the Department's more significant challenges relating to aspects of procurement practices are contracting for health care resources and construction, and managing the national purchase card and inventory management programs. We are working with VA to improve procurement practices and we continue to perform contract audit and drug pricing reviews to detect defective and excessive pricing, and to provide improved assurance over the justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations.

Contracting for Health Care Resources

OIG audits and preaward reviews have identified a number of issues with the solicitations and proposals relating to contracting for health care resources. The issues we are identifying vary with each proposal and solicitation. We have identified numerous instances where conflicts of interest were identified in the request for or approval of a contract, preparation of solicitations, contract negotiations and contract administration efforts. For example,

- VA Contracting Officer Technical Representatives are often on staff at the affiliate, receive some benefit from the affiliate, or are supervised by someone who has a conflict of interest.

- VA staff associated with the affiliate are involved in the decision request or approve seeking a contract, the development of specifications and/or contract negotiations.

- Legal, technical, and pre-award cost reasonableness reviews are not always requested on all non-competitive contracts awarded. We see that some solicitations contain irrelevant clauses and do not contain terms and conditions that adequately protect the Government's interests.

- There is no evidence that VA assessed its actual needs, that the healthcare resources could not be hired directly, that the agreement was in the Government's best interests, or that the qualifications or experience level of the staff to be provided under the agreement are defined.

- When documentation is available, we have found that in some contract files solicitations have been issued after negotiations with the affiliate.

- Other available documentation suggests that in some cases the affiliate dictated the terms and conditions of the contract, including the services to be provided. For example, in one case the VA identified the need for 10 FTEE, but at the request of the affiliate, the number was increased to 13. In another case, documentation shows that the affiliate is developing its contract budget requests and requirements by working from a "required funding" position, i.e., the basis for the agreement is the funding needed by the affiliate, not related to the needs of the VA staffing requirements.

Contracting for Construction

In March 2002, VHA had 42 construction projects with a total estimated cost of $596.2 million in various stages of completion. In performing an FY 2002 audit, we reviewed contracts that were significantly behind schedule or completed late, had a significant number of contract change orders, and the change orders were a significant percentage of the total contract costs. Preliminary results of our audit are showing that VHA needs to strengthen the major construction contracting process to better assure that contract awards result in reasonable prices paid for work completed, are in the best interests of the Government, and are adequately controlled to prevent fraud. Although, our current audit is not complete, my auditors have identified improper and inadequate contract awards, along with poor administration and project management resulting in excessive prices paid by VA and instances of potential fraud. For example,

- VHA's Office of Facilities Management needs to establish a more effective construction contract administration and project management functions. These functions are not conducted independently and have resulted in delegation of contracting authority from Contracting Officers to project engineers who do not always have essential construction contract administration training needed to complete pricing decisions and ensure compliance with Federal Acquisition Regulations and VA Acquisition Regulations.

- We see that at times project engineers, managers, and contracting officers have been delegated dual responsibilities that are uniquely different and result in dual job functions that conflict with each other. In one case, an individual was serving as the Contracting Officer and the Project Manager and in other cases we found the Project Manager and the Resident Engineer were the same individual. Lack of appropriate separation of duties and independence can also result in increased risk for potential fraud, waste, abuse, and mismanagement.

- Facilities Management also needs to better control contract changes that add millions of dollars to major construction project costs and extend project completion schedules. Although this audit remains in progress, we have identified contract changes that were approved that were outside the scope of the original contract and should have been competitively bid or negotiated as a separate contract. As a result, there is little assurance that the work was reasonably priced.

Lastly, there is no Quality Assurance function to independently assess and report on contractor quality of work. Currently, quality assurance responsibilities rest with the Project Management staff. Permitting Project Management staff to perform quality assurance is a serious internal control weakness since Project Managers are involved in contract administration.

Purchase Card Activities

VA-wide use of the Government purchase card has grown from 170 cards and 2,400 transactions valued at $567,000 in FY 1994 to over 34,000 cards and approximately 2.5 million transactions valued in excess of $1.4 billion in FY 2001. During FY 2001, 287 VA facilities processed approximately 98 percent of all micro-purchases using the Government purchase card. Our CAP reviews have identified systemic management weaknesses in the oversight and use of purchase cards. Vulnerabilities persist in the management of purchase card activities in the department. We have identified instances of wasteful spending (buying without regard to need or price), purchases have exceeded cardholder's authority, and purchases have been split to inappropriately to avoid competition requirements. Some cardholders have avoided purchasing from existing contracts, which has resulted in paying higher prices for the same items and duplication of acquisition support effort. Some inappropriate purchases have been identified for purchases made by employees who have been reassigned or left VA employment.

Management controls over purchase card transactions need to be strengthened to provide better assurance that VA buying power is leveraged to maximum extent possible and quantity discounts are not lost. Efforts need to be made to increase visibility and oversight over purchases, ensure the price reasonableness and to ensure purchases are made to meet VA's needs effectively and economically.

Inventory Management

VA supply inventory practices must also ensure that adequate quantities of medical and other supplies are available to meet operating requirements while avoiding excess inventories that tie up funds and other resources that could be used to meet other VA needs. Since FY 1999, we have issued six national audits of inventory management practices for various supply categories including medical, prosthetic, pharmaceutical, engineering, and miscellaneous supplies with cost savings of almost $388.5 million. These audits showed VA had funds tied up unnecessarily because they were maintaining excess inventories. We identified potential savings in the management of following inventories.

- Medical Supply Inventories $75.6 million

• Prosthetic Supply Inventories	$31.4 million
• Pharmaceutical Inventories	$30.6 million
• Engineering Supply Inventories	$168.4 million
• Miscellaneous Supply Inventories	$53.7 million
• Consolidated Mail Outpatient Pharmacy Inventories	$28.8 million
Total	**$388.5 million**

In FY 2001, CMOP expenditures for pharmaceuticals totaled $1.44 billion and combined CMOP inventories totaled about $63.5 million. We reviewed CMOP operations and found that CMOPs could significantly reduce their pharmaceutical inventories. The CMOPs maintained supplies on hand that exceeded the applicable benchmarks for 11,553 of the 19,276, representing almost 60 percent of the items in their inventories. We estimated that of the $63.5 million in total inventory at the seven CMOPs, $28.8 million, or 45.4 percent, exceeded current operating needs.

INFORMATION MANAGEMENT

Information Security

VA faces significant challenges in addressing Federal information security program requirements and establishing a comprehensive integrated VA security program. We continue to report information security vulnerabilities as a Department material weakness under the Federal Managers' Financial Integrity Act (FMFIA). The security vulnerabilities identified represent an unacceptable level of risk to VA operations and VA's missions of providing health care and delivering benefits to veterans.

The Department has established a VA-wide security plan, and the required policies, procedures, and guidelines. A key accomplishment in improving information technology (IT) security made during FY 2002 was the Department-wide implementation of anti-virus protection. The implementation of anti-virus protection allows VA to detect, contain, and eliminate a significant number of viruses before any damage to system operations can occur.

VA is also making progress in staffing Information Security Officer positions to provide the opportunity to strengthen oversight and implementation of necessary

information security control measures at the facility level. However, VA has not effectively implemented a number of information security remediation efforts and has not ensured compliance with established 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.

Our reviews of security support that VA has continued to have problems with separation of duties, application change and update controls, and use of "super-user" IDs. For application system controls, all of the general system control weaknesses are present, along with inappropriate access privileges, and excessive assignment of override privileges. In addition, our internal penetration tests verified that VA's automated systems could be exploited to gain access to sensitive veterans' benefit and healthcare information.

CAP reviews also continue to support security vulnerabilities exist at local facilities and the lack of management oversight at all levels has contributed to inefficient practices and to weaknesses in safeguarding electronic information and physical security of assets.

Information System Development

Poor project management in the past has led to a failure in the *HRLink$* major system development effort. The *HRLinks$* development project was not effectively managed and prior OIG audit recommendations were not implemented. At the request of the Acting Assistant Secretary for Management, we initiated an audit in FY 2002 to evaluate the appropriateness of continuing with the *HRLink$* project as the best means of achieving an effective payroll and human resources system in a cost efficient manner. The *HRLink$* project was intended to replace VA's antiquated payroll system and to automate VA's personnel functions.

Our audit found that the estimated project completion date had slipped from FY 1999 to FY 2003 and revised budget and schedule estimates projected completion in FY 2006 with an estimated cost of $469 million, while original project system development costs were estimated at about $37 million.

During this audit, we identified a number of issues and areas of concern that needed improvement and warranted increased oversight by VA officials. Project documentation of plans and goals was insufficient. There was a lack of supervisory control over contractor performance. Managers did not ensure that VA received value for money spent. Stakeholders were not adequately involved in project planning. The project did not comply with the Information Technology Management Reform Act of 1996 (the Clinger/Cohen Act). Project managers did not properly carry out administrative functions.

To address these issues, we recommended no further resources be expended on the project until a determination was made that continuing with the *HRLink$* project would meet the Department's and stakeholders needs and result in a cost effective system for VA, or whether alternatives should be sought.

The Secretary approved the shutdown of the *HRLink$* project and all development and software license contracts were terminated by January 2002. VA reported that total *HRLink$* project costs at the end of the FY 2002 would be approximately $240 million and that VA avoided the potential additional $229 million of cost to complete the *HRLink$* project by terminating the project.

In 1999, we also audited VHA's implementation of a new Decision Support System (DSS) management cost accounting system intended to aid clinicians, managers, and executives in making decisions affecting the delivery of health care. The audit was to determine if implementation of DSS at medical centers was sufficiently standardized to ensure the usefulness of DSS data at local, Veterans Integrated Service Network, and VHA Headquarters levels. We found that the potential usefulness of DSS and its data was being compromised because some medical center staff had diverged from the system's basic structural standard. If such divergence had been detected, it would have prevented data from these medical centers being accurately aggregated along with data from other facilities that did adhere to the standard. We were also concerned that data divergences that had not been detected may have resulted in inaccurate data being aggregated into roll-up reports. Facilities that had diverged from the DSS structural standard also lost the opportunity to perform a variety of analyses that adhering to the structural standard provides.

For DSS to achieve its full potential, we recommended that all staff and managers involved with DSS be required to input data into the local DSS systems in adherence with the standard DSS structure and VA periodically determine the degree of adherence to the DSS structural model that is required of medical center systems.

ADDITIONAL BENEFITS OF COMPUTER MATCHING EFFORTS CAN BE ACHIEVED WITH LEGISLATIVE REFORM

Data sharing has been an important and successful tool for identifying improper payments, as well as fraud, waste and abuse. Verifying that the right person is getting the right benefit at the right time is a priority management objective. Computer data matching gives us the ability to verify program participant information and thereby detect improper payments sooner or perhaps even prevent them before they start. We find computer-matching initiatives cost-effective because this type of work saves a significant amount of labor.

Unfortunately, under current regulations, we are not realizing the timesaving features that computers offer. There is a huge untapped potential for saving the Federal government a significant amount of erroneous and improper payments in a timely manner through data matching. However, current regulations are overly cumbersome and time-consuming.

Currently, under the Privacy Act, initial computer matching agreement between two agencies may remain in effect for 18 months. Extensions must be negotiated for an additional 12 months. After this 12-month extension, agencies must then renegotiate a whole new agreement. Renegotiations are time-consuming and unnecessarily increase workload demands on the agency. Furthermore, renegotiations do not always add any additional value to data sharing between agencies. For example, VA matches with the Social Security Administration wage data is an integral part of our efforts to review veterans eligibility for pension benefits. This match should be accomplished annually.

There are other restrictions that keep us from realizing the full benefits of computer matching to identify fraud, waste, and abuse. For example, the cumbersome and time-consuming process under the Computer Matching and Privacy Protection Act of 1988 (P. L. 100-503), does not apply when matching records from the Department's system of records. However, P.L. 100-503 prevents the matching of Federal personnel records when there is the possibility that the match results will subject the Federal employee to adverse financial, personnel, disciplinary or other adverse actions. In other words, the law prevents us from timely stopping Federal employees from defrauding the Federal government.

Here are some changes I believe would be beneficial:

- Lengthen the time periods that computer-matching agreements can remain in effect.

- Amend the Computer Matching and Privacy Protection Act of 1988's exclusionary clause to include Federal personnel record when making internal matches using only records from the Department's system of records.

- Develop a process to streamline the development and implementation of a computer matching program. Actions can include consolidating notice requirements. Currently, we must provide record subjects with prior notice by direct notice, constructive notice, and a periodic notice and reevaluating the need to submit approved matches to Congress as well as OMB.

OTHER LEGISLATIVE REFORM OPPORTUNITIES

Acquiring routine access to Social Security wage and employment data is also critical to ensuring effective oversight and administration of VA benefits such as eligibility for monthly compensation and pension payments, verification of income for home loan guarantees, eligibility for medical care (without co-payment) and matching efforts to VA's payroll files for protection against employee fraud. We need to initiate actions that will improve VA's ability to review applicants' eligibility for benefits and enhance our efforts to detect and prevent fraud.

For example, gaining timely access to Social Security wage data would be indispensable to efficient oversight of the Workers' Compensation program. Investigation of workers compensation cases is very timely and resource intensive, frequently requiring lengthy surveillance to develop a fraud case. Access to the employment and earnings information held by IRS would also improve the effectiveness of our audits and investigations and ultimately free up audit and investigative resources for other high priority matters.

Many overpayments are caused by the inability of VA Regional Offices to act on information provided by VA employees or other Government entities. All entities other than the beneficiary or fiduciary are considered third party for purposes of verified information. As a result, while it is important to protect the interests of beneficiaries, the designation of benefit delivering Government entities as third parties creates backlogs in VA's claims processing activities and benefit overpayments. VA policy should be revised to include all VA entities in the definition of first party. This would expedite the due process notification requirement; and reduce overpayments and other unnecessary claims processing work.

This completes my written testimony; I would be pleased to answer any questions the committee may have.