FOLLOW-UP HEARING ON EFFORTS TO IDENTIFY AND ELIMINATE FRAUD, WASTE, ABUSE, AND MISMANAGEMENT IN PROGRAMS ADMINISTERED BY THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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THURSDAY, JUNE 17, 2004

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The committee met, pursuant to notice, at 10 a.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Evans, Bilirakis, Buyer, Snyder, Moran, Baker, Hooley, Simmons, Miller, Boozman, Udall, Davis, Beauprez, Brown-Waite, Renzi, Murphy, and Herseth.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Let me begin this hearing by referring to a statement that I made when I became Chairman of this Committee. In February of 2001, I said that holding VA officials accountable for carrying out the laws would be a constant in all of our Committee work. Although the vast majority of the Department's more than 200,000 employees are doing an excellent job, our Committee's oversight has found that many management improvements are needed, and some funds are being misspent. Despite the fact that Congress provided more than $62 billion in funds for the Department in this fiscal year, VA is unable to provide services to all the veterans who seek it. Caring for and assisting veterans is an essential function of the Federal Government, and we must constantly ask whether there are ways to use available funds more effectively.

I commend all of my fellow Committee members who have spent substantial time reviewing testimony and reports about how well the laws providing benefits to veterans are being executed. Even though the work of questioning witnesses and gathering accurate information about the effectiveness of programs serving veterans is a daunting task, it is an essential part of Congress' role as the maker of laws. Veterans deserve our best efforts.

Our witnesses today will address recent efforts to correct a variety of problems affecting programs providing important benefits to veterans. Not all of the changes needed have been made, but there is clearly some progress on important issues. We want to learn about what is preventing VA managers from achieving the success

they are striving for. This hearing also presents an opportunity to review VA's progress on implementation of the Government Performance and Results Act of 1993. This Act is potentially one of the most important oversight tools we have available. One of the purposes of the Act is to "improve congressional decision-making by providing more objective information on achieving statutory objectives and on the relative effectiveness and efficiency of the federal programs in spending." There is much that remains to be done, as my colleagues know, not only at the VA, but throughout the Federal Government, to achieve this goal, and we continue that work today.

Some fear that taking a hard look at the results of a program is a precursor of cutting funding or abolishing the program. I believe that we need to take a hard look so that we can know whether managers understand the law and have made wise choices to implement it. A hard look also helps us to learn whether funds are being well-spent, and what we might do to improve the results being achieved.

Recently, the Deputy Director of OMB for Management sent the Committee a letter on the performance assessments completed by the VA and five of its major programs. These five programs authorize disability compensation, medical care, educational assistance, burial benefits and research into diseases affecting veterans. Frankly, these are the programs that absorb the vast majority of funds that are appropriated for veterans benefits each year. The program assessments depict a wide range of performance and accountability, from programs that are achieving clear measurable objectives to programs that don't have any measurable results.

Although I disagree with one or two of the conclusions reached in these assessments, it is nevertheless important that an effort is being made to report objective findings so that Congress can better understand whether managers and programs are succeeding or failing. I hope that when we have the next hearing on this subject, the VA will be able to report that substantial steps have been taken to address some of these shortcomings.

In a report that was published in September of last year, this Committee documented a number of recent oversight findings. Among other matters, the Committee reported that health insurers are refusing to pay for care of insured veterans as required by law, leading to shortfalls in fundings for veterans care. The VA is losing millions of dollars each year because it has not adopted rigorous methods to insure that its bills for care are accurate and timely. VA and DOD have missed numerous opportunities to share health care resources, and have failed to emphasize sharing in the Department's planning for future medical facilities. VA has not taken sufficient corrective action to ensure that its capacity for providing long-term care meet legal requirements. VA was too lax in supervising physicians, particularly those who are employed part-time, leading to millions in questionable salary costs. Finally, VA overstated its success rate for its vocational rehabilitation program, revealing a program that is not serving disabled veterans in the manner that top VA leaders and Congress expect.

Although we may not cover all of these subjects in the hearing today, we will do so in the weeks and months ahead through public

oversight hearings such as this and through other meetings. It is the least we can do to honor those who have served our nation.

I would now like to recognize my good friend and colleague, the Ranking Democratic Member, Lane Evans, who will also, when she arrives, introduce our newest Member of the Committee. I recognize Lane for any time that he would like to consider.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Well, thank you, Mr. Chairman. We await Stephanie's arrival here; I appreciate your indulgence in interrupting our schedule.

Our efforts to greatly reduce or eliminate fraud, waste, and abuse in the VA will help the VA become more effective. In doing this, we serve our two most important stakeholders: veterans and taxpayers. This will become a recurring theme for future hearings. It is our duty to ask hard questions about uncomfortable topics, but we must toe the line for accountability.

Before we go on, I would like to thank you, Mr. Chairman, for your tireless work for veterans everywhere. Again, this is a very important hearing that you have arranged for and I look forward to working with you in the future.

[The prepared statement of Congressman Evans appears on p. 33.]

The CHAIRMAN. Mr. Evans, thank you very much, and it's a privilege to work with you, as well. We do have, I think, a very good partnership. Thank you for your kind comments.

Mr. EVANS. You're welcome.

The CHAIRMAN. The Vice-Chairman of the Committee, Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman, and I echo Mr. Evans' statements regarding your work for the veterans, you know that I do. And I commend you for scheduling today's follow-up hearing and you're awfully good at follow-ups, which is a big problem with us up here, quite often.

I, along with so many others, have participated in previous waste, fraud, and abuse hearings, so we're all anxious to hear what progress has been made to correct some of the problems that we have examined in the past. As members of this Committee, we all have a vested interest in making sure our nation's veterans receive the best possible services, and every dollar that is wasted is obviously a dollar that could be used to provide quality services, so we should be greatly concerned.

We also have an obligation to the taxpayer to ensure that the VA spends our tax dollars wisely to maximize the bang for the buck, so to speak. And this is especially true at a time when the VA is struggling to meet the high demand for health care services.

Mr. Chairman, I am particularly interested, and I know that you are, in receiving an update of the CoreFLS situation at Bay Pines in St. Petersburg. In May, the Department awarded a new contract, which I hate to pre-judge but it doesn't seem right. The De-

partment awarded a new contract to the same company under investigation for its work in the computer system project at Bay Pines. The company also received, as we now know, an incentive bonus on more than $200,000 for finishing CoreFLS project on time, even though there were warnings, as I understand it, that the system was not ready. And there are other bonuses given to veterans employed, to VA, VA employees for their work, et cetera, et cetera.

Given the amount of money that has been spent on that troubled system, I would think that we would question the wisdom of these decisions and I will probably explore these issues further during the hearing. So I am anxious to hear today's testimony from the GAO and Inspector General's offices on how the VA can reduce waste, increase efficiency and eliminate fraud, and I know we all look forward to our witnesses' suggestions. Thank you, Mr. Chairman.

[The prepared statement of Congressman Bilirakis appears on p. 34.]

The CHAIRMAN. Thank you very much. Would any other Members like to be heard? Mr. Buyer.

OPENING STATEMENT OF HON. STEVE BUYER, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. BUYER. I have an opening statement I would like to submit for the record, and also, Mr. Chairman, I want to thank you for holding this hearing along with Mr. Evans, and I want to thank the VA IG, Mr. Griffin. Please extend the compliments to your team. You're doing excellent work, and I'm sure it also pleases Secretary Principi, given his level of sincerity in wanting to do that which is right. I also want to compliment the GAO. Their outside eye on things is very important, and works in partnership with you, Mr. Griffin, and we appreciate that.

I have not had the opportunity to see the VA's rebuttal to the IG testimony. I have it in my hand, Mr. Mansfield, but when you get this stuff to us late, the night before the hearing, I wasn't aware of it, so I haven't been able to see it. I want you to know that I am pleased, because when I saw how thick and to go through the report from the IG, for their testimony, and then I looked at the VA's 6- or 7-page testimony, I gasped. And so I'm really pleased, though, that we've got this document, we can pour over it, and it will go far beyond today. So it sort of changes my opinion coming in to the hearing. I just wanted you to know honestly.

To give you another prime example, we can always talk about our sincerity, go after this waste, fraud and abuse. I sent a letter out to the VSOs 2 years ago, asking for their input in the area of waste, fraud, and abuse. Do you know only two of them responded? The American Legion and AMVETS were the only two that responded to me with recommendations on areas for which they want to help bring efficiencies to the system.[1] I thought that was very insightful.

So, Mr. Chairman, again, we thank you for the hearing.

[1] Correction for the record—Disabled American Veterans and Military Officers Association of America responded to Mr. Buyer's letter of January 31, 2003.

[The prepared statement of Congressman Buyer appears on p. 37.]

The CHAIRMAN. Thank you. Any other Member? Chairman Simmons.

OPENING STATEMENT OF HON. ROB SIMMONS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. SIMMONS. Yes, thank you, Mr. Chairman. When I joined the Committee 2 years ago, I was surprised to find how large the budget was for the IG, and I think I raised that question on the record. Of course, I was a freshman. Since then, I've become somewhat more educated to the nature of the beast. It's my understanding that the VA IG is one of the smallest relative to the size of the agency, and that for every dollar invested in the IG, we recover almost $30 in savings for cost avoidance, which results in about $180 million agency-wide. So that's very substantial, and I appreciate that.

I guess my own view with regard to waste is, let's eliminate it with abuse, let's correct it, but it comes to fraud, I stick by my original comments, Mr. Griffin, if we find that people within the system are engaging in fraudulent activities, I want to throw the book at them. I don't want to transfer them, I want to put them in jail, because people who are defrauding the system are defrauding veterans, and, quite frankly, that just irritates me. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Chairman Simmons. Are there any other Members that would like to be heard?

If not, I would like to introduce our distinguished witnesses, beginning with the Honorable Gordon H. Mansfield, who was nominated to serve as Deputy Secretary by President Bush on November 3, 2003, and confirmed by the Senate on January 22, 2004. He previously served as VA Assistant Secretary for Congressional and Legislative Affairs since August of 2001. Prior to his appointment, Mr. Mansfield served as the Legislative Advisor to the Secretary of Veterans Affairs, and was responsible for VA's Congressional relations and for representing VA programs, policies, investigations, and legislative agenda to the Congress. Secretary Mansfield previously served as the Executive Director of the Paralyzed Veterans of America, and in the Department of Housing and Urban Development during the previous Bush administration.

A graduate of Villanova University with a law degree from the University of Miami, Gordon enlisted in the Army in 1964, where he served two tours of duty in Vietnam. While serving as Company Commander with the 101st Airborne Division during his second tour, he was wounded during the Tet Offensive of 1968, sustaining a spinal cord injury. For his actions while his unit was under fire, he was decorated with the Distinguished Service Cross. He was medically retired by the U.S. Army at the grade of captain.

His other combat decorations include the Bronze Star, two Purple Hearts, the Combat Infantryman's Badge, and the Presidential Unit Citation. Secretary Mansfield, is also a recipient of the Presidential Distinguished Service Award.

Mr. McCoy Williams is the Director in the Financial Management and Assurance Team of the General Accounting Office. He

has worked in the Financial Management and Audit Issue area since 1980. He has broad responsibility at GAO on these issues. His work on numerous assignments over the past 23 years including GAO's first agency-wide audits of the General Services Administration and the Department of the Army. In addition, during 1990, he was detailed to the then-House Government Operations Committee and played a major role in the drafting of the Chief Financial Officers' Act of 1990.

Mr. Williams has a B.S. degree in business management from Virginia State College and an M.S. degree in accounting from Virginia Commonwealth University. In addition, he is a graduate of Harvard's John F. Kennedy School of Government, Senior Executive Fellows Program. He is a certified government financial manager and a certified public accountant, Maryland, of 1982.

We will then hear from the Honorable Richard J. Griffin, who is the Inspector General of the Department of Veterans Affairs. As the Inspector General, Mr. Griffin directs a nationwide staff of auditors, investigators, inspectors, and support personnel. His office conducts reviews to improve the economy, effectiveness and efficiency of VA programs, and to prevent and detect waste, fraud and abuse.

Mr. Griffin came to the VA from the U.S. Secret Service, where he was Deputy Director, responsible for planning and directing all investigative, protective, and administrative programs. He began his career with the Secret Service in 1971, as an agent in the Chicago office. Mr. Griffin received a number of special achievement awards during his career in the Secret Service. He also received in 1994, the Senior Executive Service Presidential Rank Award of Meritorious Executive.

In 1971, Mr. Griffin earned a bachelor's degree from Xavier University in Cincinnati, Ohio, and, in 1984, a master's degree in business administration from Marymount University in Arlington, Virginia. He is a 1983 graduate of the National War College.

Mr. Secretary, if you could begin your testimony.

STATEMENTS OF GORDON MANSFIELD, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY LAURA J. MILLER, DEPUTY UNDER SECRETARY FOR HEALTH; McCOY WILLIAMS, DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE TEAM, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY CARLA J. LEWIS, SENIOR AUDITOR; AND RICHARD J. GRIFFIN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JOHN D. DAIGH, JR., ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE INSPECTIONS

STATEMENT OF GORDON MANSFIELD

Mr. MANSFIELD. Thank you, Mr. Chairman. Good morning, Mr. Chairman and Mr. Evans and members of the Committee. I want to start out by stating that I and Secretary Principi fully appreciate and understand the purpose of this meeting and understand the Constitutional responsibilities involved here. You are the folks who authorize the laws that we carry out, you are the folks who appro-

priate the dollars that we spend, and you are the folks who are now exercising your oversight responsibility.

Today I will provide you with an update of VA's responses to findings included in reports issued last year by the Office of Inspector General and the General Accounting Office. I would ask that my full written statement be entered into the record as well as the paper we prepared that describes our efforts in detail with respect to each of the IG and GAO findings. And Mr. Chairman and Mr. Buyer, I would apologize for the lateness in delivery of that document, it's my fault, I was on travel status and did not communicate to the staff that they should get it down here in the time that they should have. So I apologize and will pay a little bit more attention to that in the future.

We take seriously our stewardship of America's programs of veterans' benefits and services. It remains incumbent on us to manage the considerable resources entrusted to us in the most effective manner so that we can best serve our nation's veterans as well as safeguard America's investment in these important programs.

I would like to comment first about an issue of concern to both the VA and the Congress that was brought to our attention in recent months. Mr. Bilirakis alluded to, discussed it, and that's the implementation of the CoreFLS system that is currently operational at Bay Pines. The Secretary will decide whether to continue CoreFLS after he reviews three reports, two of which are due this month, and the third in September. In the interim, the CoreFLS staff continues to work closely in support of Bay Pines.

Last year, the VA responded to a finding by the IG that some part-time physicians had not worked their scheduled hours and that others performed no work for the VA during the periods examined. Our response included placing physicians whose services are not needed on a regular basis on a more appropriate scheduling arrangement, requiring that every part-time physician be personally counseled about responsibilities, and that all VA network directors' performance reviews include compliance measures.

These measures have paid off. In unannounced follow-up visits, the IG found that a much lower number of the part-time physicians reviewed were not in compliance. Our goal is full system-wide compliance, which we will continue to pursue. That means that our goal is zero percent non-compliance.

In the area of purchase cards, we are pro-actively responding to vulnerabilities identified during the IG's reviews related to the purchase card. Specifically, the VA established new policies and procedures for employee responsibilities for proper use of purchase cards. The policy also provides for disciplinary action when an employee uses the card improperly. We recognize that our purchase card program is still vulnerable and we will continue to improve the program.

VA's federal supply schedule programs have enjoyed substantial growth in the last 4 years. Last year, sales topped $6 billion. GAO found that VA's aggressive efforts to ensure most favorable pricing in awarding contracts for medical products and services have saved taxpayers hundreds of millions of dollars per year. We still have improvements to make.

A GAO report noted that many of the VA's buildings remain under-utilized and its large and aged infrastructure is not well aligned to efficiently meet veterans' needs. To address this, the Secretary recently submitted the CARES package to Congress. Implementation of the CARES plan will reduce vacant space by 42.5 percent, resulting in a savings of $2.65 billion over the period from 2006 to 2022. Major construction requirements needed to implement CARES have been identified. VA will use currently-available funds and funds from the FY 2005 President's budget request to carry out the VA's highest priority projects in FY 2004 and FY 2005. VA's five-year asset plan will be submitted to Congress in the near future.

In response to the IG's report on VA purchasing practice, the Secretary chartered the VA Procurement Task Force. The task force has examined all aspects of VA procurement and contracting. One example of the task force's accomplishments is the post-award audit program. Audits are performed after they award a contract to ensure that they were made properly. If they were not, the VA can demand price reductions and refunds from the contractors and, through April 2004, refunds have totaled approximately $200 million.

That leads us to have two questions asked. Number one is, why $200 million to recover, and why weren't we doing it correctly the first time, but we also need to continue this program.

I am encouraged by the progress we have made in correcting shortcomings identified by the IG and GAO. I know that we have a long way to go. VA leadership, from the Secretary on down, is committed and prepared to address all of these issues. I thank you for this opportunity to provide the update, and I will be glad to respond to questions that you or any of member of the Committee may have.

[The prepared statement of Mr. Mansfield appears on p. 84.]

The CHAIRMAN. Mr. Secretary, thank you very much for your testimony.

I'd like to now ask Mr. Williams if he would present his testimony.

STATEMENT OF McCOY WILLIAMS

Mr. WILLIAMS. Mr. Chairman and members of the Committee, thank you for the opportunity to discuss our work on internal controls over the use of purchase cards at the Veterans Health Administration. As you know, the Department of Veterans Affairs, Office of Inspector General, has identified significant vulnerabilities in the Department's use of government purchase cards, including internal control weaknesses that resulted in instances of fraud, and numerous improper and questionable uses of purchase cards.

Given that VA is the second-largest user of the government-wide purchase card program, with reported purchases totaling about $1.5 billion for fiscal year 2002, and because of the program weaknesses reported by the OIG, we were asked to review the VA's purchase card program for fiscal year 2002, to determine if control problems still existed.

We were also asked to perform two separate reviews of VHA's operations. The first will address internal control activities over

third-party billings and collections at selected VHA medical centers. The second review will assess control activities at selected VHA medical centers over personal property, drugs returned for credit, and part-time physician time and attendance. We will issue two reports covering these issues in July.

In my testimony today, I will focus on the inadequacy of internal controls over VHA's purchase card program. Today, we are releasing a report that details the internal control weaknesses we found. I ask that the report and my entire written statement be included in the record.

The CHAIRMAN. Without objection, it will be included.

Mr. WILLIAMS. Mr. Chairman, before I continue, I want to make clear that GAO supports the concept of the purchase card program. The use of purchase cards lowers costs and lessens paperwork for both the government and the vendor community. At the same time, given the nature, scale and increase in use of purchase cards, it is important that agencies have adequate internal controls in place to help ensure proper use of purchase cards and thus to protect the government from waste, fraud and abuse.

We found that VHA locked adequate segregation of duties between those purchasing and receiving goods, payments for purchase card and convenience check transactions often did not have key supporting documents, timeliness standards for recording, reconciling and reviewing transactions were not met, and card holders did not consistently take advantage of vendor-offered purchase discounts.

Generally, we found that internal controls were not operating as intended, because cardholders and approving officials were not following operating guidance governing the program and, in the case of documentation and vendor-offered discounts, they lacked guidance.

We also noted that monitoring activities could be strengthened. For instance, we found accounts that remained active long after cardholders had left service at VA, credit limits on many accounts were significantly higher than actual usage, and human capital resources were insufficient to enable adequate monitoring of the purchase card program.

This lack of adequate internal controls resulted in numerous violations of applicable laws and regulations and VHA's purchase card policies. We found violations of applicable laws and regulations that included purchases for personal use such as food or clothing, purchases that were split into two or more transactions to circumvent single-purchase limits, purchases over the $2,500 micropurchase threshold that were either beyond the scope of the cardholder's authority or lacked evidence of competition, and purchases made from an improper source.

We also noted 250 questionable purchases totaling about $210,000 that lacked key purchase documentation from vendors that would more likely be selling unauthorized personal use items. Examples of these types of purchases included a purchase from Radio Shack totaling approximately $3,300, a purchaser from Gap Kids totaling approximately $800, and a purchase from Daddy's Junky Music for approximately $1,000.

Missing documentation prevented us from determining the reasonableness and validity of these purchases. While the total amount of improper purchases we identified is relatively small compared to the more than $1.4 billion in VHA's annual purchase card and convenience check transactions, we believe these results demonstrate vulnerabilities from weak controls that may have been exploited to a much greater extent.

In closing, Mr. Chairman, I want to emphasize that, without improvements in its internal controls to strengthen segregation of duties, documentation of purchase transactions, timely recording, review and reconciliation of transactions and program monitoring, VHA will continue to be at risk for non-compliance with applicable laws and regulations and its own policies, as well as vulnerable to improper, wasteful and questionable purchases.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.

[The prepared statement of Mr. Williams appears on p. 90.]

The CHAIRMAN. Mr. Williams, thank you very much for your testimony. We do have a number of questions, but I would like to yield to my friend, Mr. Evans, for the purposes of an introduction.

Mr. EVANS. Thank you, Mr. Chairman. I'd like to extend a welcome to South Dakota Congresswoman Stephanie Herseth, who joins us today as the newest member of our Subcommittee. Her record is quite impressive, including graduating summa cum laude from Georgetown University and graduating with honors from Georgetown University Law Center. And I'll say I'm a graduate of it, too, and didn't quite hear of the suffix on my degree as you've no doubt heard.

She has been very interested in continuing South Dakota's efforts as far as veterans are concerned, to Senator Johnson, Senator Daschle being the best representatives of that recently, but she is a supporter of veterans and has shown her commitment for caring for their needs.

I have no doubt that her addition to this Committee is a positive one and I look forward to working with her for some time to come. Mr. Chairman, I'd like to yield my remaining time to Stephanie, and she would like to say a few words.

Ms. HERSETH. Thank you, Congressman Evans, thank you, Mr. Chairman, and my colleagues on the Veterans' Affairs Committee, to those in attendance today, those testifying before the Committee today, it's certainly an honor for me to represent South Dakota as our lone member in the House of Representatives. As many of you know, we've had a vacancy for a number of months, and to be able to serve on this Committee, as well as the Resources and Agriculture Committee, serving important constituencies in South Dakota, where a very high number per capita, as many of you know, of veterans in South Dakota, including those currently serving in active duty as well as our National Guard and Reserve units. I look forward to working with them, as well as the veterans across South Dakota and across the country from past military conflicts. Thank you very much.

The CHAIRMAN. Thank you. And I'd like to welcome you, too, to the Committee, Congresswoman Herseth, and say that this is a

committee that, as you will quickly discover, if you don't already know, is a very bipartisan committee. We work very hard on behalf of veterans, and hopefully that will continue, and I have no doubt that it will continue. Welcome to the Committee.

[Applause.]

The CHAIRMAN. I'd like to now ask that our distinguished Inspector General, make his presentation.

STATEMENT OF RICHARD J. GRIFFIN

Mr. GRIFFIN. I am accompanied today by Dr. John David Daigh, who is my Assistant Inspector General for Health Care Inspections.

Mr. Chairman and members of the Committee, thank you for the opportunity to testify today. Since last year's hearing, we have issued 250 reports with actual or potential monetary benefits of over $2 billion. While much progress has been made, much work remains to be done. I will highlight some of the more significant management areas where continued improvement is needed.

The lack of staffing standards for physicians and nurses as required by Public Law 107–135, which was enacted in January of 2002, continues to impair VHA's ability to adequately manage personnel resources. Our current review of nurse staffing disclosed that the nursing shortage is affecting patient care, employee morale and costs at VHA facilities. Facility leaders might have been able to mitigate these consequences had VHA developed and implemented staffing standards.

Our follow-up to the 2003 physician time and attendance audit found that VHA's implementation of management controls continues to need improvement. We found that 8 percent who were scheduled for duty were not on duty, approved leave or authorized absence, and were potentially not meeting their VA employment obligations. Since I last addressed the Committee, my staff has conducted 42 CAP (Combined Assessment Program) reviews at veterans health care facilities. We continue to find systemic weaknesses relating to accountability for time and attendance for part-time physicians, and a need to align physicians' hours of work consistent with actual workload requirements.

In the past year, we completed 28 pre-award reviews of proposals for sole-source contracts to be awarded to VA-affiliated institutions, with recommended cost savings $9,496,000. For just four contracts awarded this year, negotiators sustained 98 percent of our recommended better use of funds for those proposals, or $1.2 million.

Our reviews provide recommendations to ensure that the contract meets the needs of the VA, is in the best interest of the government, and ensures that our veterans receive quality medical care in a timely manner.

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

One of our investigations disclosed that, between March 2001 and January 2003, two VA employees, a pharmacy technician and a purchasing agent, conspired to divert over 600,000 tablets of hydrocodone and alprazolam from the outpatient clinic in Oakland

Park, FL. The VA employees who stole these drugs sold them to a drug operation involving between 30 and 40 mid-level dealers. Both employees were indicted on multiple counts and pled guilty. Our special agent who worked this case recently received the National Commanders Law Enforcement Award from the Military Order of Purple Heart in recognition of his efforts in this investigation.

As I mentioned last year, the Fugitive Felon Project was established within the VA to comply with provisions of a new law. This program is a collaborative effort between my office, VBA, VHA and VA Police Services. To date, 8,299 fugitive felons identified have been referred to the department for benefit suspension, creating $54.5 million in overpayments and an estimated cost avoidance of over $100 million. The apprehension of felons creates a safer environment for VA facilities and for the rest of our communities.

We recently issued a follow-up draft report on VA's workers' compensation program. VA continues to be at risk for significant abuse, fraud and unnecessary costs because of inadequate case management and fraud detection. VA also continues to face major challenges in implementing a more efficient, effective and coordinated acquisition program. The Department spends about $6 billion annually for goods and services.

Our audit of procurement of medical, prosthetic and miscellaneous supplies found that purchases were not made from the best available sources, and more national-scope contracts are needed to take advantage of VA's buying power.

I'd like to thank the Chairman and the members of the Committee for the opportunity to testify today and I would be pleased to answer any questions that you might have.

[The prepared statement of Mr. Griffin appears on p. 112.]

The CHAIRMAN. Thank you very much for your tremendous work on behalf of the VA, and all taxpayers and our veterans. I do have a few opening questions, and then I will yield to my colleagues for any questions they might have.

First, Secretary Mansfield. I, too, got this report late last night, and have only been able to page through it and have not read it with the kind of focus I would like. On page 41, talking about long-term health care, an issue that we have raised repeatedly in terms of planning, the fact is that the emphasis has shifted to the state rather than the federal commitment to nursing home care. And I note that in the report, the statement is made that the Secretary is currently considering various policy options designed to adhere to the core principles. It also points out that, at this time, we are unable to say with certainty when the model will be finalized and released to the networks for their use.

We raised this issue by way of letter and in serious discussions and hearings, including a CARES hearing focused almost exclusively on it, that it was not part of the CARES process, and we thought it was a glaring omission to be doing long-term planning and re-alignment, and enhanced services, without looking at long-term care. Could you react to that? Are we looking to get out of long-term care, or are we looking to meet our obligations the way we ought to? And, when will you provide us the milestones to indi-

cate when the model will be completed, and when might we to expect those milestones.

And then, secondly, let me ask you, Mr. Griffin. Your $62 million budget and 442 FTE, is that enough? Have you made recommendations and requests for additional resources? Chairman Simmons, I think, made a very good point. For every person we put on the job, there is a return that is very significant, and, if you would, elaborate, on the physician and nursing standards. Are we talking about a loss of tens of millions, hundreds of millions? If you could try to quantify that.

And then, let me just ask Mr. Williams, you indicate, if I heard this correctly, that you're estimating maybe up to a third of VA purchase card transactions violated one rule or another, which is, I think, indicative of a very widespread problem. Has anyone been fired? What happens when people commit these, what someone might construe, to be crimes? Maybe Secretary Mansfield wants to comment on that as well. Secretary Mansfield.

Mr. MANSFIELD. First of all, sir, on the first question, about long-term care. As you indicated, it is under consideration by the Secretary right now. He's had a report from the group that he put together to work on it. Part of it is a follow-up to the CARES process. Whatever is decided on it will be rolled into the CARES process and become a part of that for the future. I can't tell you what the answer is, except I can tell you that we will comply with the law. And the Secretary has made that point very vividly to the folks, so that's the starting point, and I think right now we're moving towards that compliance. I think it's 13,361 or 91 is the target number for an average daily census. I think right now we're probably somewhere in the 12,600 or 300 range, but that is being worked on, and we will obviously communicate with you as soon as the Secretary makes the decision on which of the options he has accepted.

The second question then was the deal with the purchase card. Obviously, this is an area of concern. When I looked at the report from last year and the draft from the follow-up, I think I noted that, in comparison with other agencies, we're doing an all right job. But again, obviously, the goal is 100 percent in compliance with the law. You mentioned a point about anybody being fired. I do know that, as I mentioned in my statement, that the new handbook dealing with this provides for sanctions on employees as we go forward, but you have to keep in mind too that this, as in many other issues, deals with the federal employment rules and laws that we have to follow, and you have a process that you have to go through that's very lengthy and involved. Unless it's outright theft and you've got something like that, then I think we could probably say that we could move forward and would move forward as soon as we could, or at least that would be my intent and my direction.

The CHAIRMAN. Mr. Griffin.

Mr. GRIFFIN. On your first regarding budget. If there's no one in the room who would answer that, that they couldn't use more resources, I can answer it with a strong yes. I appreciate the support the Committee has given to our budget in the six and a half years that I've been the Inspector General. In three of those years there

been a supplement to the budget that came up here. I must say the Secretary has been supportive of my budget, but there have been initiatives that I have felt strongly about that didn't make it through the process.

One of those initiatives was the Fugitive Felon Initiative. We felt very strongly that that was a collaborative, good government initiative. At a time when the government is spending billions and billions on homeland security, that we would have fugitive felons coming and going in government facilities, and having their ability to come and go financed by taxpayers' dollars, was just not a good government. To support that initiative, I had requested 37 FTE a couple of years ago. I requested them again last year. To date we've been trying to make that program work from the piece that we own of it, with no staffing provided whatsoever.

Now, you can shift resources around, but we have a number of areas where we've got cases in the cue that we can't get to. We have several hundred cases in the death match area with potential recoveries of millions of dollars. Our workers' comp report which will soon be issued, once again, there's tremendous amount of dollars available, 42 million a year, that we identify in workers' comp work, that could stand further attention, but we don't have the resources to apply to it.

So, yes, we could very well utilize additional resources. This is a huge department. It's going to get bigger, perhaps, under the Capital Asset Realignment for Enhanced Service, or the CARES initiative. We're going to have more locations, it's going to be more spread out, we're going to have more veterans receiving care, and you need to invest some money in oversight in order to make sure you're getting what you pay for.

Regarding how much we are missing in the area of part-time physicians, T&A (time and attendance), in the unannounced work that we did, we looked at, we tried to track down 729 physicians that should have been working at the fifteen facilities that we went to. Of that number, 58 were not where they were supposed to be. Twenty-five claimed, "oh, I was on leave, I was supposed to be on leave. " Well, it wasn't recorded in any time and attendance record, the supervisor of that employee had no knowledge that he was going to be on leave. It's not like we're talking about painters, and if they don't paint the room today, they can paint it tomorrow. These physicians have veterans on a waiting list who are waiting to get care, and you don't just decide, unannounced, I'm not going in today.

So I think there has to be a zero tolerance for no-shows, and we're not there yet. Progress has been made, no question. But to have 8 percent not there on the day we did the unannounced audit, I think is not acceptable.

Mr. WILLIAMS. Mr. Chairman, to the best of my knowledge, I am not aware of anyone being fired as a result of the items that I discussed. During our review, we were informed that staff had been counseled on the proper policy, procedures or use of the credit cards. In addition, we were told that there had been some additional training to make staff aware of what they could and could not purchase under the Credit Card, Purchase Card Program.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Mr. Chairman, I think at this time, I would like to use my time for the members on the subcommittees.

Dr. SNYDER. Thank you all for being here, and we welcomed Congresswoman Herseth today, and she's been in the press a lot lately, but, Mr. Chairman, it's a pleasure to see you here, too, after reading about, some of the articles about you, Chairman Smith.

[Laughter.]

Dr. SNYDER. So thank you for being here, and all your work here. And, in fact, I thought of you when I, in the—Mr. Inspector General, you paged through the report, you specifically made mention of the fact that, since the increase in the number of veterans using the veterans' health care, by your numbers are 2.9 million use it in some way in 1995, then that went up to 4.5 million in 2003, and that's— in terms that Mr. Buyer has expressed in the past about it's easy for us in Congress to expand the numbers that can use the VA health care system, but then it's up to the VA folks to get the work done. And that's been a fairly dramatic increase that can, as you point out, and I think your exact words, this increase has significantly challenged the Department's capacity to treat veterans.

And I know Chairman Smith has been very zealous in his advocacy of being sure we have the right amount of resources to do the job. But then, once we have, what resources we have, that it be done efficiently.

I really just have one question, and it's with regard to this part-time physician issue. And that, this issue is a very prominent part of the discussion we had the last time we had met, and I know it's something that you all had focused on, but I'm confused then by why we seem to have, be working from different numbers about what kind of progress has been made. The, in Secretary Mansfield's report, you all did a spot check in August of 2003, follow-up visits to fifteen VA facilities, and, by your documentation of the 729 part-time physicians, only 2 percent were identified as not being in compliance, and that 98 percent of these had comprehensive written agreements.

But then, those numbers seem to be not consistent with what the Inspector General reports when you say that you had 8 percent that were supposed to be on duty that just weren't there, and you went through a list of other facilities. You've got seven of fifteen medical facilities did not make sure each part-time physician was provided a written agreement, and so, seven of fifteen, that seems to be a different percentage than 98 percent, talking about having comprehensive written agreements documented. So, why do we have this discrepancy?

Mr. MANSFIELD. Sir, part of that is my fault. The 2 percent and the 8 percent number is a discrepancy. When my folks took a look at the report, they failed to include, I think, 25—the number of 25 that were included that were not identified as being where they should have been. So the fault, the difference between the 2 percent number and the 8 percent number is my folks taking raw data and making a report on it.

Dr. SNYDER. So the 2 percent number is wrong?

Mr. MANSFIELD. Yes, sir. And in my oral testimony, I changed that to a different number. I didn't, Mr. Griffin indicated earlier,

just before we started, that they were using the 8 percent number and I would agree with him.

Dr. SNYDER. All right, thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Doctor. The Chair recognizes the Vice-Chairman of the Committee, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I, too, want to welcome all of the panelists, Secretary Mansfield, and all the others. And it's great to see Mr. Griffin again. We were together at the Military Order of Purple Hearts meeting when your agent received that very much deserved award. It's good to see you here, sir.

Mr. Mansfield, I understand, getting to Bay Pines now, that CoreFLS project, I understand that there's about $18 million of CoreFLS funds unaccounted for, at Bay Pines? Is that true? And can anyone talk about this?

Mr. MANSFIELD. Mr. Bilirakis, I think the best thing I can do is ask Mr. McFarland, our assistant secretary for IT, to answer your question.

Mr. BILIRAKIS. Okay.

Mr. MANSFIELD. I think he can get you to the details quicker than I can.

Mr. MCFARLAND. Let me tell you what we've done in the last week and a half. The responsibility for the CoreFLS project has been transferred from the Office of Management to the CIO office, my office. We have put on the ground an experienced project director to take over the project. We are in what I would call stabilization mode. Right now, we are concentrating on trying to make sure that three installations—Bay Pines, St. Louis, and the cemetery in Florida—are able to get stabilized from a data input and a reporting process, so that, as we get near the end of the year, we are hoping to be able to close the books properly at those installations.

And that is the complete and 100 percent focus of what we are doing right now. That is at the direction of the Secretary. After receiving some input on stabilization and recommendations from the Carnegie Mellon University team that were put in place to look at the CoreFLS issue.

So, right now——

Mr. BILIRAKIS. Well, but, sir, is it true that there are $18 million of funds that are not accounted for?

Mr. MCFARLAND. Sir, I do not know of any instance where there are $18 million unaccounted for. We have had, my team has had about a week and a half on the ground. One of the things we are going to do is to look into the funds that we are using on that project, and I would have to defer to our finance department for any other comments on that issue.

Mr. MANSFIELD. Mr. Vice-Chairman, let me make the point. I am not aware of any $18 million, but let me make the point that we will go back, we'll check with you after this hearing, and we'll go back and double-check and then make a report to you and to the Committee as to that question.

Mr. BILIRAKIS. Yes, that's an awful lot of, obviously, it's a lot of money, but I can't, I can't imagine that there's an adequate accountability to——

Mr. MANSFIELD. Sir, there has been an awful lot of senior-level attention paid to this program since the problems were identified, and I think we would know if there were $18 million unaccounted for, but I will commit to you that we will go back. We'll check with you as to any details that you may have, and we will go back and we will——

Mr. BILIRAKIS. In any case, your response will be in terms of a complete accountability, right? I mean, it may eighteen, it may be zero, but still there will be complete accountability.

Mr. MANSFIELD. Yes, yes, sir.

Mr. BILIRAKIS. Well, let me ask this question then, it may be in the same vein. I mentioned this in my opening statements. The company under investigation for its work on that project at Bay Pines received an incentive bonus of more than $200,000 for finishing it on time, even though the rewarding system wasn't ready. And then, this company was awarded another contract. Subsequent to that, this same company was awarded another contract, probably at another location. Any explanation about that?

Mr. MCFARLAND. Sir, I am aware that this company was awarded a separate and different contract for another purpose——

Mr. BILIRAKIS. Subsequent to all this having taken place?

Mr. MCFARLAND. Yes, sir, it's been in the last, I believe, 60 to 90 days. I would have to defer to VHA, I believe that contract was awarded for the decision support system within VHA for some analysis. I did personally take a look at and ask the Office of Materials Management and Procurement to look at the contract. The contract itself was awarded under what appears to be very proper procedures, and I can't tell you that it has anything to do with the CoreFLS environment. It's a totally different——

Mr. BILIRAKIS. Yes, apparently that company was a low bidder. There are a couple of others—IBM was one, I think—and there was another company or whatever, there may have been more, but those are what, ones in the statements here. But I guess what I'm saying is, if you do it strictly on the lowest bid or whatever the case may be, proper procedures have been followed. But those procedures don't take into consideration the problem at Bay Pines, the CoreFLS problem at Bay Pines. I can't imagine.

Mr. MANSFIELD. Sir, I do know, and we may need to get the General Counsel in the discussion, but I do know that we have to be careful in these areas, because we do not, at this point in time, as I understand it, have the right to exclude anybody from contracting with the government, based on the——

Mr. BILIRAKIS. You don't have the legal right to do that?

Mr. MCCLAIN. Congressman, I'm Tim McClain, I'm the general counsel of the VA.

Mr. BILIRAKIS. Yes, thank you for being here, sir.

Mr. MCCLAIN. Thank you, sir. In answer to the question, the deputy secretary is correct in that, at this point, we don't have a debarment of any company under Bay Pines, and the contract that was let, once again, it was my understanding, it was done under the proper procedures. And so we don't have the right to exclude any one company at this point. But we are looking into it.

Mr. BILIRAKIS. Well, I should think in the process of looking into it, you should also be maybe coordinating with the Congress, if you

don't have the rights to at least take into consideration—and I'm not trying to be accusatory here of the particular company, all right, those are all details and what not.

But I know that they're under investigation. And I know that bad things happen. And I should think you'd be coordinating with the Congress here. If you don't have some sort of right, Gordon, that you feel you should have, you ought to be letting us know so that we can help you out in that regard. But I—it's just—well, my time is up, Mr. Chairman, but I just can't imagine, we're compounding the problem here, potentially, compounding the problem here.

Mr. MANSFIELD. Sir, if I may, I'd just make the point that the additional contract you refer to, has been reviewed in depth, and it is a firm, fixed-price contract with a specific deliverable and a specific time frame, areas we had problems with before and we will be paying strict attention to it.

Mr. BILIRAKIS. Yes, well, the problem previously was lack of quality, of course. It was not only a time—it wasn't a time frame, they received a $200,000 incentive bonus for coming in within that time.

Thanks, Mr. Chairman.

The CHAIRMAN. The Chair recognizes Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chair. I have a couple of questions, and I'm going to start with Mr. Mansfield. We've spent a lot of time on the Committee talking about some of the very good innovations and inventions that have occurred in the VA, and the Subcommittee hearings have tracked VA efforts to receive its financial due through patents or other intellectual property rights for its research efforts. Can you tell me what patents or intellectual property rights the VA has secured in the last year for its inventions? Do we know that?

Mr. MANSFIELD. I don't have that information currently at hand, but I would respond for the record, ma'am.

Ms. HOOLEY. Thank you, that would be great. I would appreciate it.

Mr. Griffith, thank you for all the good work you've done. I know year in and year out, the IG makes recommendations to the VA on ways to improve efficiency and effectiveness throughout the organization. This year, I know you forecast that you thought you would find $2 billion in savings. In the areas of laboratory security and information management, you had a total of thirty-two recommendations, and a formal set of sixty recommendations that date back to March of 2003.

Now I understand you've only been able to close on one of those recommendations, is that correct?

Mr. GRIFFIN. That's correct.

Ms. HOOLEY. So help me understand what the problem is and are we asking for unrealistic performance of the VA? What's going on?

Mr. GRIFFIN. I would not say that we are asking for unrealistic performance. I would say that, on each of those recommendations, progress has been made, but I can't close a recommendation out or close a report until we are totally satisfied that the recommended fixes have been put in place. Not 80 percent, not 90 percent there,

it has to be done, because, unfortunately, if we move on to something else, we may not get to the 100 percent mark.

And progress has been made on those recommendations. They have been around for a couple of years.

Ms. HOOLEY. Right.

Mr. GRIFFIN. Some of them have joint ownership. Some are issues for VHA and security and law enforcement with a little help from the general counsel's office. So when you have multiple entities needing to get together on the response, that will put a delay in.

My concern is that, too often, an excellent policy is promulgated, and it's sent out to the facilities, but then the implementation doesn't quite happen to the extent that it needs to happen.

As you recall, that particular report was done shortly after 9/11, and shortly after the anthrax attacks on the Hill and in other places in the country. It was something that needed to be reviewed timely, it was reviewed, and we need to get to closure on all sixteen of those recommendations.

Ms. HOOLEY. Because, I mean, with the $2 billion that you thought you would find in savings if you're off by 50 percent you're still talking about $1 billion. Do you think you're being ignored? That's probably an unfit question to ask you.

Mr. GRIFFIN. Well, I wouldn't say that. This is a huge department, it's decentralized, they've had a tremendous spike in demand for health care, which you would expect at a time——

Ms. HOOLEY. Right, we know that.

Mr. GRIFFIN (continuing). When the requirements were changed and private sector health care is going through the ceiling. So, naturally, there is tremendous demand there. But you need to have the right business processes in place to address the management side of the business in order to make it a system and not a hundred and fifty different individual hospitals.

And when you talk about CoreFLS and issues like that, you have to make sure that all of those medical centers out there are utilizing all of the legacy systems that have been prescribed by VA, so that when try and lay a CoreFLS over the top, that you've got accurate data in those systems, number one, and, secondly that every facility is using those systems in the same manner, so that when you go to the next facility to try and do CoreFLS there, that they are all using GIP (Generic Inventory Package) for their inventory package. If you're not using that and if CoreFLS assumes you are, the old saying of garbage in, garbage out would apply. And that was part of problem.

Ms. HOOLEY. Well, you just need to know that I personally think you're doing a terrific job, and this Committee is not ignoring you, and I'm anxious to hear a progress report as we go along. Thank you.

[The prepared statement of Congresswoman Hooley appears on p. 78.]

Mr. GRIFFIN. I'm pleased to say that I have most of my senior staff here because they are the ones who are really doing a fabulous job. And thank you for the compliment.

The CHAIRMAN. Chairman Simmons.

Mr. SIMMONS. Well, thank you, Mr. Chairman. Very briefly, Daddy's Junky Music, a thousand dollars, what were they buying at Daddy's Junky Music for a thousand dollars?

Mr. WILLIAMS. We're not for sure. That's one of those purchases that we couldn't find the supporting documentation, so that's why we classified it in that particular category. That's one of the problems, when you look at those items, it's difficult for us to explain or to be able to report what that particular purpose was for, that purchase was for, because the documentation was missing.

Mr. SIMMONS. Thank you. I would think they would have had enough common sense not to buy something at Daddy's Junky Music in the first place, but then—anyway, if you don't have enough common sense not to buy that kind of stuff, I guess you're going to use your card as well.

On a little more serious subject, Mr. Griffin, page 30 of your testimony. Two items—one is the pharmaceutical off-label drug promotion, which I assume is an initiative that did not just involve the VA, but it did involve a major pharmaceutical corporation, which pleaded guilty and paid more than $430 million to resolve its criminal and civil liabilities involving their activities that did involve the VA.

And the second is the New Orleans bribery scheme, where a VA employee and two other individuals apparently overcharged VA more than $75,000.

On the first case, is the VA continuing to do business with that major pharmaceutical corporation? If yes, why? And, on the second case, which involved a VA employee and two VA contractors, what is the status of the VA employee currently with the VA? Has that individual been fired? Two questions.

Mr. GRIFFIN. Right. As I sit here, I'm not sure what the employee's status is, I'll certainly check on that for you. Typically, when we bring criminal charges against an employee, the government personnel regs are pretty straightforward, that if a person has been charged with a felony for which they could they could be sentenced to prison time, they can be terminated in fairly short order, with limited notice. And that is the government reg, and the Department has been following that reg on criminal cases.

The question about the settlement on the off-label uses. The company that was involved in that activity was bought out by another company, so they are no longer a stand-alone company. And to what extent there may be contracts with the new parent, I'm hard-pressed to give you a number of contracts or what have you. But the original company is no longer in existence.

Mr. SIMMONS. Just briefly, Mr. Chairman. For the record, I'd like to know what the status of that VA employee is. According to your records, they've, he or she has been convicted with the contractors. They are awaiting sentencing. But, you know, this goes to my earlier point, that people within the VA who rip off the VA are low-life, and for us not to know the status of this individual, for us to say that, well, the rules and regulations are such that we can't be certain whether they're not still on the payroll subject to sentencing or incarceration, conveys a message that we don't really have a lot of concern about that or——

Mr. GRIFFIN. Mr. Simmons, if I may. We have over a thousand criminal investigations. I'm not saying that this person hasn't been fired. I'm saying that I can't testify here today as to the precise outcome of his case. My criminal squad has had 100 percent increase in their arrests and convictions in the last 2 years. No one in the Department has accused me of being a shrinking violet when it comes to going after these people, believe me. And I think maybe one of my people could leave the room now, and come back with that answer, before the hearing concludes.

Mr. SIMMONS. That would be terrific. And, with regard to the pharmaceutical company, I'm glad to hear they're not in business anymore. Thank you.

The CHAIRMAN. Thank you. I think the next time somebody accuses someone from the Secret Service of being a shrinking violet, it will be the first. Ms. Herseth?

Mr. SIMMONS. I used to work for the CIA, so I'm not a shrinking violet, either.

Mr. GRIFFIN. I can see that, sir.

Ms. HERSETH. Thank you, Mr. Chairman. Mr. Griffin, I want to acknowledge the efforts of you and your office and others to establish important measures like the Fugitive Felon Initiative to ensure the safety of our facilities, VA's facilities, across the country, and so we take your review of the VA's control of biological, chemical and radiological inventories very seriously.

On page 11 of your written statement, I note that your office is not going to close the recommendations until a number of actions are taken, including that the medical center directors certify implementation of directives and security requirements. Does any one of your sixteen open recommendations involve accountability statements by the directors, and what is the status of this and any reasons for delays?

Mr. GRIFFIN. Well, the accountability is that I have gone on record that we will not close that report until each director has certified that all of the security requirements in the report have been put in place at their facility. Not that a plan was sent to the facility that said, this is what needs to be done. When they certify that it has been done, then we will close the report.

Ms. HERSETH. Okay. And then, on page 31 of your written testimony, you state that the Department hasn't been able to effectively address its significant information security vulnerabilities and reverse the impact of its historical decentralized management approach. The VA's security remediation efforts continue to be ineffective with inadequate facility compliance with established security policies, procedures and guidelines.

It's my understanding that the Committees often express concerns about the lack of centralized authority in the CIO office. And, given that Mr. McFarland is here, perhaps he can respond to this as well. But is this a symptom suggesting that the problem hasn't been fixed, and how about the problems with the CoreFLS and patient financial services system? Did a lack of centralized control by the CIO office impact these programs?

Mr. GRIFFIN. Well, I think as the Deputy Secretary testified a short time ago, the control of the CoreFLS activity has apparently been moved to the CIO's office.

In our annual financial statement audit work for the last few years, we have identified IT security as a material weakness in the Department. Now, you can talk about accountability, you can talk about whether the CIO's office in Washington, DC has the clout to make somebody in a medical center 2,000 miles away accountable for doing certain things.

But my main concern would be that somebody accepts responsibility. Now, when those things are sent out to be implemented don't happen, the medical center director may not be fully aware when his information security officer receives traffic from the CIO's office or a patch is sent to be placed on the computers at a facility and it doesn't happen, as was the case in the Blaster report. But, if it's my facility, I'm responsible for what goes on there. And if it involves CIO activity or CFO activity or quality of health care, whatever it is, I'm in charge. The question of where the buck stops has to be with the person who is tasked with being the senior official at that facility, and they make it happen.

So, you know, it's more a question of, you can't just send stuff out there and have people decide whether or not they feel like implementing it. When someone doesn't, when it's an administrative thing, then administrative action needs to be taken.

If it's a criminal thing, then we will take action, and the appropriate disposition will happen from that also.

Ms. HERSETH. Okay, thank you.

The CHAIRMAN. Thank you. The Chair recognizes Chairman Buyer.

Mr. BUYER. Thank you. I'd like to do a little clean-up work from my opening statement. I went ahead and pulled all of the letters that the Subcommittee had sent to the veterans' service organizations. Now, the veterans' service organizations play an important role, and they request a lot of things from this Committee. They ask for a lot of money in support of veterans' causes.

So when the Subcommittee asked them for some help and assistance on how to streamline and improve the service to the nation's veterans, it doesn't feel very good when they ignore the Subcommittee. So what I'd like to do, Mr. Chairman, is place in the record all these letters that were sent.

[The letters appear on pp. 39 to 63.]

Mr. BUYER. Now, the American Legion was very responsive. But we sent a letter to the, not only the American Legion, these are dated January 31st of 2003. So if anybody would still like to respond to these, we're still waiting—to the Military Officers Association of America, we sent one to the NCOA, we sent one to the Military Officers Association of America, to the Military Order of World Wars, to the Paralyzed Veterans of America, to the VFW Washington Office, we sent one to the Vietnam Veterans of America, and we sent one to AMVETS, we sent one to TREA, and we sent one to Disabled American Veterans.

Then, when the only response we got was from the American Legion, we sent out a second, follow-up letter. So, from the second, follow-up letter, we received a response from AMVETS. So we're still awaiting response. So I'd like to submit those letters for the record.

Mr. Griffin, I want to compliment you, and, again, I actually did in my opening statements, but please extend it to your staff. I'd also like to compliment you on the Fugitive Felon Program. You've taken this on, and, to my understanding, it's just, you and—the VA and SAA, are you the only two in the Federal Government that have taken this on?

Mr. GRIFFIN. HUD is presently trying to put a copycat program together.

Mr. BUYER. That's great.

Mr. GRIFFIN. Yes.

Mr. BUYER. How many individuals have you had to take from other tasks to perfect the program?

Mr. GRIFFIN. Well, when we receive our hit list, if you will, we cannot possibly go after all those people ourselves. But as a member of the law enforcement community, we will try and assist any federal, state or local agency who is the owner of the warrant to the extent that we can. To date, there have been 400 fugitive felons arrested, and my people have participated directly in 240 of those arrests.

Mr. BUYER. I'm just trying to lay a base here. I believe that this Committee wants to help you, and do to so as quickly as we possibly can, so please lay a basis for me, on how many employees you have shifting away from other responsible tasks to perfect this program.

Mr. GRIFFIN. My people have a pool of potential work that is unquenchable. And, depending on the priority of the day, that's what they do. As I mentioned, we've got a number of cases in our death match queue, several hundred, which, when we have some time, we go do them.

When we came forward with this initiative, Social Security Administration was doing it with 46 FTE. We said, we can do better. We asked for 37. And there's a basis for each of those 37 positions. So what we've been able to do to date is, when we can find the time to do it, we go and do it.

But as you see in our testimony, these are not good people that we are arresting. These are murderers and rapists and kidnappers and drug dealers and so on, and we don't need them coming into VA facilities. I would stand by the 37 number to have a fully-implemented and well-managed program.

Mr. BUYER. How long does it take, after a felon warrant is put into the National Crime Information Center, until a fugitive felon's VA benefits are stopped?

Mr. GRIFFIN. Well, there are protocols for notification, even for fugitives, there's a 60-day delay, which is not a problem for us, because, when they create an overpayment—the overpayment goes back to the day the President signed the law, which was December 27, 2001. So if somebody gets a couple of payments along the way while we're trying to locate them, that's okay, because, after that 60 days, if that person was a fugitive on January 1 of 2002, the overpayment goes back to the entire time that they were a fugitive.

Mr. BUYER. Well, Mr. Chairman, this is a really good program. And I know it's one that you also like, and I wish to join you, any action you want to take to help make this a reality and give Mr.

Griffin the resources and authorizations he needs to perfect this program. So, I'll join you, Mr. Chairman.

Mr. GRIFFIN. Thank you, Mr. Buyer.

The CHAIRMAN. Thank you. Mr. Miller.

Mr. MILLER. Thank you very much, Mr. Chairman. I have a written statement that I'd like to add into the record, as well.

[The prepared statement of Congressman Miller appears on p.]

The CHAIRMAN. Without objection.

Mr. MILLER. Mr. Griffin, you talked about the death matches and the difficulty that you have in being able to fulfill the obligation necessary to recover the funds that are out there and, in addition to that, some other areas as well. Is there—and you talk about the additional FTEs that are necessary in order to do that work. Is there any way that in the short haul, that it can be contracted for by somebody that can go in and take a piece of what is out there? If we're losing the money anyway, whereby they can contract and receive a portion of what they bring back into VA? Is there any mechanism that allows you to do that?

Mr. GRIFFIN. There is not a mechanism to contract for federal law enforcement agents, because that is strictly, you know, a governmental function. We do contract for some of our audit work.

Perhaps a contract could be arranged by the Department to help them address the workers' comp backlog that exists, because, in workers' comp cases, it has to be worked from day one. And somebody has to manage that case, and somebody has to make sure that, if that employee can come back to work, that they're invited back to work, even if it's a different job than they had when they left.

And, due to the crush of all the other administrative and management issues that are out there, our recent audit report on workers' comp found that, for some workers' comp cases, there isn't even a case file created. Now, it's real easy to lose track of those cases, and then, over time, people forget about them, and you just continue making those payments, month after month, year after year, in some instances.

So there are business practices which could be contracted for, some of which are contracted for, in certain areas in the Department, where, once some of the initial legwork and the initial review is done, if there are fraud indicators, at that point, that case can be referred to my people, who have the training and the expertise to take it the last ten yards, and to make that criminal case.

But, right now, as you'll see, in our workers' comp report, case management there is an issue. Maybe it's an issue that could be addressed with contracting.

My people right now are the ones that do those post-award audits that the Deputy Secretary referred to with a couple hundred million dollars of recoveries. That's a contract job, where the Department pays us to have those 25 auditors do pre- and post-award audits. That's one of the most successful programs in the Federal Government. We're one of the few departments that even does it. GSA has a huge number of FFS contracts. They haven't been doing pre- and post-award audits. We do them, and I think the results speak for themselves. And that is a contractual situation, where we are reimbursed by the Department to do those.

Mr. MILLER. Well, let me ask you this, then. If in fact you are being contracted to do a portion of those audits, does the fact that you're doing those audits take away from the time that you could do, be doing something else?

Mr. GRIFFIN. I think those audits are worth every——

Mr. MILLER. I'm saying could the contracting for the audits be done outside instead of internally? Because if we're contracting agency to agency or internally and we're losing time because we're auditing for VA, could it be done by somebody outside the system?

Mr. GRIFFIN. They were previously done by an outside entity. It is a requirement that the Department has them done. But when the outside entity did them, they came through us on a pass-through, because we are where all the auditors are located. And we were finding that the previous group wasn't doing a very good job, frankly.

These staff salaries are being paid by this contract, rather than by appropriated funds. So if there were no contract, we would not have these employees to assign other work to.

And I think if you look at the return on investment, which I will provide for you for the record, over the last several years for that group, I think that group is paying for itself many, many times over. If anything, you might consider whether the thresholds which create those contracts that we look at are too high, and whether it might not be a wise investment to increase the size of that group and dig a little deeper in the review of certain contracts, scarce medical specialists, et cetera, to make sure that we're getting what we pay for.

The CHAIRMAN. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman. You know, people warned me when I got elected that this, it would be very frustrating dealing with how slow the Federal Government operates, and Mr. Griffin and Mr. Williams, you all have a very tough, probably thankless, job. And I think, you know, this is but one tip of the iceberg that you all look at, because your focus—these reports focus on the VA.

How do we, as members of Congress, see that your recommendations are enforced in a more timely manner, and actually be able to have some teeth to what you do? Is the problem the bureaucracy? Is it the head of the agency? Help me to understand what the problem is.

Mr. Griffin, do you want to go first?

Mr. GRIFFIN. Okay. The easy issues are quickly dealt with. If it's easy, it wouldn't be on the table. It's a combination of things, in my estimation. I think part of the problem, throughout the government, is turnover. I think the recent publication by the Volcker Commission talked about perhaps there are too many PAS positions, perhaps that's why it takes so long for someone to get confirmed for positions, perhaps that's why we see the turnover that we see in a lot of departments in very important jobs, like the CIO job.

When you've got the computer world changing at the pace that it's changing, it would seem that the more continuity you had in your top position, to stay the course, and have a vision, and see it through to the end, would serve the government well. Too often,

though, that's not the case. And look at Bay Pines. If you look at the turnover in the top three or four positions there, over the last 6 or 7 years, there's no continuity.

You need continuity. You need to have a vision, and then you need to take the time to take it from A to Z.

Ms. BROWN-WAITE. You know, we did away with indentured servitude, so, I, you know, we cannot restore that. So people are moving from job to job. Did you ever see the movie "The Enforcer"? How do we get an enforcer in this agency and every single other agency? Because, you know, you can't tell people back home that it's because of the fact that there is no continuity. People back home, every single taxpayer in America, wants their money spent wisely. And I'm not picking on you all, you just happen to be before this Committee. Believe me, I'd be saying the same thing before any other committee that came with us with results of fraud, waste and abuse. How do we get enforcement that translates into significant tax dollars? And then, Mr. Mansfield, I have a question for you.

Mr. GRIFFIN. Let me say that this Committee and this Department and my organization and the veterans' service organizations all have the same goal. Everyone wants to make sure that veterans get the care, support and recognition that they deserve.

Now, from our position, as you know, we have dual reporting requirements. Every report that I issue to the Department comes up here, to everybody on the Committee. Every report that I issue to the Department, my group does follow up on. And after 90 days, if we haven't heard from back from the Department, we send them a written letter asking what the status is of these recommendations.

Ms. BROWN-WAITE. And, excuse me. Do you also send a copy to the Committee so that we know that you're following up?

Mr. GRIFFIN. I'll be happy to send you a copy if you would like to have them. You'll need a fairly large file cabinet.

Ms. BROWN-WAITE. I'll personally buy the staff that file cabinet, sir.

Mr. GRIFFIN. But we do follow up on these, and some of them, as I said, are difficult and they take time. But, believe me, I'm with you. I'm making sure that the fixes happen. It does my people no good to do a lot of quality work and not have anything done in the way of making the right fixes to the system.

Ms. BROWN-WAITE. You all are kind of like the police officer who keeps arresting the criminal and the judge doesn't follow up or turns them loose. I mean, it's got to be the same frustration level.

Mr. Mansfield, I don't know if you're going to have time to answer this, but, of the recommendations that regularly come before us stating "management efficiencies," how do we quantify whether or not those management efficiencies really happened, and how much of a savings there is as a result of it?

Mr. MANSFIELD. I think the quick answer could be, for example, in the area of the productivity task force and the recommendations that were made there in my testimony, the testimony submitted for the record, and my statement, you'll see that there are some dollars associated, for example, with contracts for medical supplies, that we know we're saving more money this year, because we're doing

a better job on the contract. So that's one way that you can do it, and that, of course, follows out year after year.

Ms. BROWN-WAITE. Mr. Chairman, with your indulgence, I would ask Mr. Williams if—and I know you can't do it now because my time is up, but if you would also respond to the same questions that I asked Mr. Griffin. If you would just get back to me on that, please.

(See p. 181.)

Mr. WILLIAMS. Okay.

The CHAIRMAN. Dr. Murphy.

Dr. MURPHY. Thank you, Mr. Chairman, and good morning, everyone. I'd like to focus on some of the issues that I know we covered last year and that we're covering this follow-up and with physicians who are not putting in the time they're supposed to be doing, particularly part-time physicians, I believe.

Now, your testimony alludes to, I believe, that some of the VA facilities which are affiliated with the medical school, need to support the medical school at all costs. I'm wondering, first of all, if my conclusion is correct on that, and, secondly, if that is something that contributes to some of these breakdowns or that there might be some of the abuses coming through with regard to the part-time physicians and how much time they actually provide. Can anyone respond to that?

Mr. GRIFFIN. I think that, in some of the dealings with the affiliates, over the years, in the evolution of the system, that VA has become a source of cash for them, that they have, in some instances, gotten a little bit too careless about it, and—for example, in the question of sole-source contracts, which each medical center has the authority—it's actually written that they may grant a sole-source contract to the affiliate. They don't have to. And some of our experiences, when an initial proposal has been on the table, and the numbers from the affiliates seem to be excessively high, when challenged, there wasn't a whole lot of push-back on the amount. It was more of a, well, we'll do it for this amount. And I think it goes, as in anything else, if you have a little more competition, you get a better price.

Dr. MURPHY. Tell me a little bit more about that. What do you mean, when you get competition, you get better prices? As opposed to the monopoly?

Mr. GRIFFIN. I mean if the, if a medical center needs to contract for ear, nose and throat specialists. And if they simply go to the affiliate and say, this is what we think our workload is going to be, because that's been a difficult challenge also, to quantify that, and then to have a staffing standard that says, this amount of workload requires this number of doctors. But they may determine, using whatever tools they use locally, that we think we need four full-time ear, nose and throat doctors to take care of our veterans at the medical center this year.

If you're in a city that has a large number of ear, nose and throat doctors or practice groups, and if a contract was put out for a bid, as opposed to a sole-source contract to the affiliate, you would be able to get a more competitive cost for that service.

Dr. MURPHY. So does this contribute to having staffing standards because we have just this sole source? It's hard to get staffing

standards in when you don't have competition bidding on things and looking at other ways of reviewing and monitoring? Is that a contributory factor?

Mr. GRIFFIN. I think that, without staffing standards, I don't know how you would determine how many MD's and nurses you need.

Dr. MURPHY. So do we have adequate staffing standards now? know moves have been made to educate physicians or retrain them, as it were, in terms of their responsibilities whether they're part-time or full-time. Do we have adequate staffing standards now? Have we reached that point? What else do we need to do? Mr. Mansfield, you're responding.

Mr. MANSFIELD. We're still in the process of finalizing that. We've done it for primary care, but we still have do it for specialty care. I think the first group of three specialties is on target to be done sometime later on this summer, then we move on to the next group. But we're behind where we should be in that area.

And then the whole area of nursing standards is still out there, also.

Dr. MURPHY. Well, it will be extremely helpful, as I know you're moving towards having those standards to be able to review this some months from now and see how things have changed. I'm sure the situation will be that there are no more excuses for people to be abusing these issues, because the standards are clear.

So I thank you for doing that, I really appreciate your work, it's been a tremendous help. It's not only a cost savings, but it raises the bar of responsibility that we expect the VA to have, and I appreciate the work all of you are doing.

Mr. MANSFIELD. Just to make the point, sir, that we are following up on the IG's findings and attempting to make things right in the area of contracting for sole sourcing. There is now a directive that requires a review of the pricing in competition, if possible.

Dr. MURPHY. Thank you. And thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Dr. Murphy.

Mr. GRIFFIN. Mr. Chairman, I'd like to give Mr. Simmons the answer to his question that he asked earlier. The employee is currently on administrative leave without pay. He's to be fired when sentenced on July 7th of 2004.

Mr. SIMMONS. Thank you.

Mr. GRIFFIN. You're welcome.

The CHAIRMAN. Mr. Griffin, let me ask you a question, and I hope there is some press here. Very often when you hold an oversight hearing, you read the report the next day, and the only information that seems to be conveyed is negative. And, of course, you know, almost by definition, the IG is going to find some things that need to be rectified and remedied, and you did.

But what I think needs to be pointed out, and to the GAO as well, is that Deputy Secretary Mansfield and Secretary Principi and the VA itself move very quickly, and I think effectively, on the issue of the waiting lists, and I would hope that this could be amplified a bit. You point out, and properly so, Mr. Griffin, that waiting list data, to be accurate, is important for planning, budget priorities, measuring performance, and determining whether strategic goals are met. Inaccurate waiting lists compromise the ability to

assess and manage demand and the credibility of VA responses to internal and external stakeholder concerns.

You point out, so rightly and we thank you for this, that the number pursuant to your audit, was overstated as to that waiting list, by about 91,000 veterans, for a total of 309,186. It should have been reported at 218,000. And a whole series of reforms were indeed put into place by the VA. Perhaps Mr. Mansfield might want to speak to this. And the recommendations that you had made, Mr. Griffin, were followed. And those four recommendations were closed on June 3, 2004.

This is a good news story that comes out of this hearing. I hope, as well, that the waiting list has been driven down dramatically from even the number that was accurate when your audit was done. And, that's something that we care deeply about. If someone is waiting, and they get sicker, they are not being well-served, and it also is indicative of a poorly-constructed model for dealing with patients walking in the door or making appointments.

So if you, Secretary Mansfield, and perhaps Mr. Griffin, might want to comment on that, because, again, I hope that, in the interest of balance, because I am critical too of the VA, I'm critical of us, that we don't always do what we ought to do, given the opportunities we have. If perhaps you might want to touch on this.

Mr. MANSFIELD. Mr. Chairman, I thank you for making that point that we do try. We do try and do the right thing, and we are here to take care of veterans and that is the one issue that, I think, everybody agrees on.

In the waiting list area, we knew when we were getting these reports in originally, that there were probably overcounts, in many cases, because people were dually-registered, and you know, I know some people were registered at a hospital as well as one or more clinics.

But part of this also goes back to the issue—a pervading issue that Mr. Griffin mentioned earlier, and that is the point that we need to be able to say, from a centralized position, there are certain things that you will do and you don't have the option of deciding whether you'll do it or not. And in putting this waiting list, the new system in place, that's one of the points that was made. We do have a responsibility, at Central Office, that goes all the way down to the facility and we now have a system in place where we are getting a count on a periodic, regular basis, and we know what they are, and we're able to filter out the dual registrations and go forward.

So that is, in effect, a positive result of the findings that the IG, in one area that the IG brought forward.

Mr. GRIFFIN. If I may add, just briefly, I share your concern for the perception that all the reporting is negative. I purposely opened my written statement with several examples that occurred just in the last few months, of doctors, in the VA, who were out there, doing the right thing, providing superb care, some of whom have gotten international recognition, some of whom have been recognized with Presidential awards here in the United States. We've got a couple hundred thousand dedicated civil servants out there that are trying to make a difference.

When it comes to our reporting to try and make things better, too often it may appear that the sky is falling. Well, there are thousands of tremendous incidents of care that occur every day. And we shouldn't lose sight of that.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Thanks, Mr. Chairman. I had the same concern as Ms. Ginny Brown-Waite did. You had mentioned continuity, Mr. Griffin, lack of continuity, turnover. Also, let me ask you—also, in response to Mr. Simmons, you indicated when the person is adjudicated, this particular individual is adjudicated on July the 7th, or whatever that date is, that then he will be fired. Does that mean he can't be fired now? And I realize he's off-duty without pay, but can he not be fired now? I mean, is that one of our problems? That, I know civil servants and the protections of employees and that's important and all that, but is that one of our problems here, that——

Mr. GRIFFIN. You know, for criminal cases, the rules are different than when we're talking about an administrative action involving an administrative offense in the government. Obviously, in the criminal process, the person is presumed innocent until proven guilty. Having said that, once they're charged, as was the circumstance here, this person was suspended without pay. When I hear that, I'm, you know, I'm pleased. Maybe I'd like to see him fired immediately, but, suspended without pay, at least the person is no longer drawing a salary from the Department. What never happens is timely, as I would like to see.

Mr. BILIRAKIS. It does happen, it's timely. But is that—you're talking about criminal, I think there's an awful lot of cases of waste, fraud and abuse, and, I mean, these are pretty criminal things that we're talking about, purchasing, I realize that. But, in general, is the fact that you can't get rid of an employee—and I know there are employee rights and I'm just as supportive of them as anybody else is—but the fact that you can't, maybe, you know, get rid of an employee who is completely inefficient, not caring, you know, that sort of thing, is that some of the problem?

Mr. GRIFFIN. You can do it, but it takes work.

Mr. BILIRAKIS. Yes.

Mr. GRIFFIN. And as you know, if you wind up in a merit systems protection board hearing, there are Douglas factors, there are ten of them, and you have to justify the level of penalty that is being imposed based on these factors, which include things like previous offenses, and, you know, previous behavior and so on, how heinous was the offense committed, and so on. So there is a pretty elaborate due process system out there, and it can take time, but managers have to document the performance and create a record and then do what has to be done.

Mr. BILIRAKIS. Yes. Okay, thanks. I guess I got the response I expected.

The CHAIRMAN. Mr. Simmons.

Mr. SIMMONS. Briefly, Mr. Chairman, I have a question that Mr. Baker asked me if I would request. With regard to the New Orleans bribery scheme, which involves kickbacks of $75,000 and two plumbing contractors, what was the scope of that contract? What was the amount of the total contract? What was the source of dis-

covery? What he's getting at was, was this part of a larger contract, or was it simply plumbers? And who was the person that was involved in uncovering this scheme?

Mr. GRIFFIN. I would like to give you a full answer to that question for the record, unless my investigation's AIG has those answers with him.

Mr. SIMMONS. Mr. Baker shared with me that he is concerned that there may be a broader range of problems in that particular facility, and that is the thrust of his question. Thank you, Mr. Chairman. I guess I would request that for the record on behalf of Mr. Baker.

Mr. GRIFFIN. We will, you will have that within 24 hours.

The CHAIRMAN. Thank you very much. Chairman Buyer.

Mr. BUYER. Mr. Chairman, I have two issues very quickly. Number one, I would ask unanimous consent to have placed in the record the responses to the Subcommittee on O&I letters from the American Legion and AMVETS, to place that on the record.

The CHAIRMAN. Without objection, so ordered.

(See pp. 60 and 72.)

Mr. BUYER. I'd also ask the Committee, and I know under the rules, we keep the record open five days, but if we could even extend it to ten days, by unanimous consent, so that the other veterans' service organizations could respond to the Subcommittee's letter, or place extraneous material with regard to the comments at today's hearing, that is my request.

The CHAIRMAN. Sure. And, without objection, that request.

Mr. BUYER. Thank you. My other question deals with IT systems. Mr. Mansfield, there is a very large level of frustration here concerning the amount of money we have been spending annually on IT. And when the Secretary took his leadership position, I was pleased when he consolidated the IT—he made this huge effort about consolidations behind then-Admiral Gauss. At the time, I was more than willing to submit legislation, not only to make this consolidation a reality, but also to put funding power behind them.

There are many IT systems that are out there—strike that. There are many IT projects that are out there. It seems like every time the VA touches one, they never meet their timelines. With the PFSS right now in the Cleveland VISN, six months behind their timelines, it's hard for anybody to follow a contractor with this. I look more at leadership. And it's difficult for them to do their jobs, to get the information that's necessary to consolidate the clinical data so they can hit their milestones.

When I asked Mr. McFarland, who's in charge of PFSS, he immediately looked around, everybody looked around, he said, okay, I am. Then he finds out he really isn't, that it's the Business office. Mr. Mansfield, I just want you to know that I am right on the edge, and I think, I'd like for your response on whether we should take IT and put funding power behind him, and let's just cut the bureaucracies and let's stop wasting the money. What are your thoughts on that?

Mr. MANSFIELD. Sir, I share your concerns, and I think the Secretary does, too. We're right on the edge together. I would ask you that you let us go through the studies that we're doing and the reports that are coming in on CoreFLS as well as a few others that

we're doing based on the information developed, the CoreFLS leading us otherwise.

The one you referred to, the UNISYS contract, we have decided that there will be one person responsible, one person in charge. I agree with you that it's awful hard, when I asked the question, who's in charge and responsible for this, and don't get the answer that it's this or that person, it raises an issue.

So I think it's one that the Secretary intends to address in detail when we get all these reports in and have the back-up and further justification. I would ask you to bear with us and we would be more than happy to work with you.

Mr. BUYER. I look forward to engaging with you on it.

Mr. MANSFIELD. But I understand and agree with your concerns.

Mr. BUYER. All right. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. I want to thank our very distinguished panel for their insights, for their recommendations, their implementation of those recommendations, and say that we want to work with you and be partners. We will follow up, Mr. Griffin, as we did last year, on that request for the FTE for the project dealing with fugitive felons.

We tried very hard last year. I plan on initiating a letter. I hope I get multiple signers, and I'm sure I will. That money would be very well spent and would capture so much more money that can then be used wisely for the VA.

So again, I want to thank all of you. You're doing a tremendous job.

Mr. BUYER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Chairman.

[Whereupon, at 11:55 a.m., the committee was adjourned.]

APPENDIX

Statement of Honorable Lane Evans
Full Committee Hearing on June 17, 2004

Thank you, Mr. Chairman. Mr. Chairman, our overall efforts to greatly reduce or eliminate fraud, waste, abuse and mismanagement at VA help VA become more effective. In doing this, we serve our two most important stakeholders: veterans and taxpayers.

This topic should become a recurring theme for future hearings. It is our duty to ask hard questions about uncomfortable topics. We must hold the line for accountability. Before we proceed, I want to acknowledge all of the employees at the Department who work hard and diligently each and every workday. For their tireless service, we are grateful.

Today, we will look for progress on the issues addressed in the hearings on this topic last spring. At that time, we reviewed many core issues.

These were issues indicating problems with procurement, contracting, IT management, waiting times for health care and general accountability. Today we look to see what actions were taken by VA to address those problems. Inaction by VA should not be tolerated by the Committee.

Slow or incomplete action may reflect less than a full commitment to solving those problems. Mr. Chairman, last year we identified many problems at VA, some were based on a lack of oversight, a lack of action, or on unclear lines of accountability.

Hopefully today we will see results that prove most of these problems have been resolved. Then we can face a new portfolio of challenges for the future.

Thank you, I yield back the balance of my time.

The Honorable Michael Bilirakis
House Committee on Veterans' Affairs
June 17, 2004

Follow Up Hearing on Eliminating Waste, Fraud and Abuse in Veterans' Programs

Thank you Mr. Chairman.

First, let me commend you for scheduling today's follow up hearing on efforts to eliminate waste, fraud and abuse within the Department of Veterans Affairs (VA). I've participated in our previous waste, fraud and abuse hearings so I am anxious to hear what progress has been made to correct some of the problems that we have examined in the past.

As members of the Committee with oversight over the Department of Veterans Affairs, we all have a vested interest in making sure our Nation's veterans receive the best possible services. As members of

Congress, we have an obligation to the American taxpayer to ensure that the VA spends our tax dollars wisely to maximize the "bang for the buck" so to speak. This is especially true at a time when the VA is struggling to meet the high demand for health care services.

I am particularly interested to receive an update on the COREFLS situation at the Bay Pines VA Medical Center. In May, the Department of Veterans Affairs awarded a new contract to the same company under investigation for its work on the computer system project at Bay Pines. The company also received an "incentive bonus" of more than $200,000 for finishing the COREFLS project on time even though there were warnings that the system wasn't ready. Given the amount of money that has been spent on the troubled COREFLS system, I question the wisdom of these decisions and will probably explore these issues further during the hearing.

I am anxious to hear today's testimony from the General Accounting Office and the Inspector General of the Department of Veterans Affairs on how the VA can reduce waste, increase efficiency and eliminate fraud. I look forward to hearing our witnesses' suggestions on further steps we can take in this area. We should do everything we can to maximize the resources available to our nation's veterans, and I look forward to working with my colleagues on this matter.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF THE HONORABLE STEVE BUYER

Thank you, Mr. Chairman, for holding this timely hearing on efforts to curtail waste, fraud, abuse, and mismanagement within the Department of Veterans Affairs.

During last year's hearings we learned about several programs that were sorely in need of corrective action. What we hope to learn today is how the VA has addressed these issues and what has actually been done to correct these identified problems. As we all know, fraud, waste, abuse, and mismanagement ultimately ends up costing the American taxpayers and negatively impacts our veterans' access to care and benefits.

Several important programs were evaluated in our previous hearings. One of the programs discussed happens to be one of my top priorities. I am referring to the VA's Medical Care Collection Fund (MCCF) and its third party collections and the progress being made by the VA in improving all of its collections. In fact, on May 23, 2003, we asked the GAO to provide us with a report outlining its findings on the progress being made by the VA since the Oversight Subcommittee's May 7, 2003 hearing. Specifically, we asked the General Accounting Office to evaluate how the VA calculates its costs to collect third-party payments and compare and contrast VA's cost reporting practices with those of private sector health organizations.

As I have already indicated, several important issues will be examined today. Poor project management is clearly one such area. For example, it appears to be a dominant factor in the serious disruption in health care delivery that occurred when the Core Financial and Logistics System (CoreFLS) was undergoing operational testing at the Bay Pines medical center in St. Petersburg, Florida. This project has experienced numerous delays resulting in cost overruns in the millions. I hope the IG report and the Carnegie Mellon analysis, which was commissioned by the VA, will shed some light on why this happened. The Carnegie Mellon report has a $500,000 price tag. This is in addition to over $8 million already lost in delays experienced with the project.

Much terrain was covered at last year's hearings. What I hope to learn today is whether the VA and DOD have implemented any new sharing agreements and what net savings have resulted. With regard to physician time and attendance, today, both the IG and the VA will provide us with updates on efforts to make sure all VA health care providers are held more accountable. In reading the February 18, 2004, IG report (Follow-up of the Veterans Health Administration's Part-Time Physicians Time and Attendance Audit) it would appear that directives were sent from central office but were not, for the most part, implemented by individual facilities. Is the VA addressing this now?

I would like to compliment Mr. Griffin on the success of the Fugitive Felon program, which was established after passage of legislation initiated by the VA Committee, Public Law 107–103. To date, this program has resulted in $154.5 million in savings.

At last year's hearing the IG made the following comments about the Workers' Compensation Program (WCP), Inspector General Griffin said: "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." In its November 14, 2003, audit report the findings were almost identical in nature and it was reiterated that past recommendations made by the IG to correct the problems had not been fully implemented. The basic reasons for abuse, fraud, and unnecessary costs in the program are due to inadequate case management and fraud detection. The IG estimates that ineffective WCP case management and program fraud results in potential unnecessary costs to the Department totaling $42.7 million annually. Furthermore, an estimated $112.6 million in avoidable past compensation payments were made that are not recoverable because VA did not offer jobs to employees that were able to come back to work. How do we recover these lost funds? Hopefully, VA will address these problems to avoid future unnecessary costs.

In its Semiannual Report to Congress, dated March 31, 2004, the IG audit found that VA information security controls and security management have made insufficient progress in improving its information security position. More troubling is the fact that the disruptions caused by the Microsoft Blaster Worm virus security patch showed that VA computers were not patched in a timely and effective manner. The VA was virtually shutdown for three days. Again, how could this happen?

The last area I will address deals with the Veterans Health Administration's (VHA) Purchase Card Program. The General Accounting Office along with the VA Office of Inspector General have performed extensive reviews of the VHA's Purchase Card Program and found many vulnerabilities with its internal controls and compli-

ance. This issue is about good government and the need to ensure that VA employees' purchases made on these cards are legitimate. For instance, the GAO estimates that $312.8 million of the fiscal year 2002 purchase card transactions lacked vital supporting documentation. Were the $5,799 worth of purchases made by a cardholder for two restaurants, a movie theater, a country club and an airport café official business for the VA? There is no way of knowing because the cardholder did not provide documentation for these transactions. This is really more about the perception being perpetuated if this type of activity is allowed to continue, rather than the actual dollar amounts involved. Weak internal controls and lack of compliance set the stage for further abuse and fraudulent behavior. The VA must implement recommendations recommendations made by the GAO and the IG to rectify such wasteful practices. Thank you, Mr. Chairman, this concludes my statement.

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January 31, 2003

Mr. Robert Mix
Executive Director
NCOA
610 Madison Street
Alexandria, VA 22314

Dear Mr. Mix:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

Over the last several years the Department of Veterans Affairs (VA) has reformed the Department internally and is striving for high quality, prompt, and seamless delivery of benefits to veterans. In addition, the Department's employees continue to offer their dedication and commitment to help veterans get the benefits they have earned. Despite these efforts, and several significant budget increases by Congress, VA continues to have its challenges.

While there are many proposals on ways to improve VA services, the Subcommittee would like to focus on ideas that would bring about better business practices and a better allocation of resources and assets. I would like to focus on the VA's core missions to veterans. As a part of this process, I would like to encourage a dialogue concerning ways to reduce wasteful spending resulting from redundant program and a duplication of services. Several examples might be: law enforcement training; claims processing; facilities maintenance; housekeeping, food, and laundry services.

Again, the Subcommittee is requesting your recommendations on ways to improve VA's activities, programs, and services to America's veterans and their families. I look forward to working with you as we begin the 108th Congress. I would appreciate receiving your comments on or before February 28, 2003. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:akw

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January 31, 2003

BG Roger C. Bultman, USA, Ret.
Chief of Staff
Military Order of the World Wars
435 North Lee
Alexandria, VA 22314

Dear General Bultman:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

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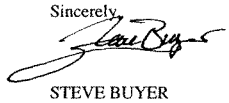

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

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January 31, 2003

Mr. Steve Robertson
Legislative Director
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Mr. Robertson:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

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Subcommittee on Oversight and Investigations

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January 31, 2003

Colonel Robert Norton
Deputy Director of Govt. Relations
Military Officers Association of America
201 N. Washington Street
Alexandria, VA 22314

Dear Col. Norton:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

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Sincerely,

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:akw

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January 31, 2003

Mr. Dennis Cullinan
Director for Legislative Affairs
VFW Washington Office
200 Maryland Avenue, NE
Washington, DC 20002

Dear Mr. Cullinan:

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Chairman
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January 31, 2003

Mr. Rick Weidman
Government Relations Director
Vietnam Veterans of America, Inc.
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear Mr. Weidman:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

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Chairman
Subcommittee on Oversight and Investigations

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January 31, 2003

Ms. Deirdre Parke Hollomen
National Legislative Director
TREA
909 N. Washington Street, Ste 301
Alexandria, VA 22314

Dear Ms. Parke Hollomen:

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Chairman
Subcommittee on Oversight and Investigations

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January 31, 2003

Mr. Richard Jones
National Legislative Director
AMVETS
4647 Forbes Boulevard
Landham, MD 20706

Dear Mr. Jones:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

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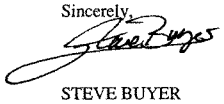

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January 31, 2003

Mr. David W. Gorman
Executive Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Mr. Gorman:

As Chairman of the House Veterans' Affairs Subcommittee on Oversight and Investigations, I am fully committed to assisting President Bush and the Secretary of Veterans Affairs in their goal to provide excellence in patient care, veterans' benefits, and customer satisfaction. As part of this process, the Subcommittee is requesting that your organization recommend ways to streamline and improve services to our Nation's veterans.

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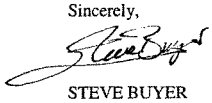

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Chairman
Subcommittee on Oversight and Investigations

SB:akw

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CHIEF COUNSEL AND STAFF DIRECTOR

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TOM UDALL, NEW MEXICO
SUSAN A. DAVIS, CALIFORNIA
TIM RYAN, OHIO

JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

BG Roger C. Bultman, USA, Ret.
Chief of Staff
Military Order of the World Wars
435 North Lee
Alexandria, VA 22314

Dear General Bultman:

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Although I had requested your response by February 28, 2003, I still look forward to receiving your recommendations and working with you as we begin the 108th Congress. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

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STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:jom

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TIM RYAN, OHIO

JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

Mr. Dennis Cullinan
Director for Legislative Affairs
VFW Washington Office
200 Maryland Avenue, NE
Washington, DC 20002

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STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:jom

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JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

Mr. Robert Mix
Executive Director
NCOA
610 Madison Street
Alexandria, VA 22314

Dear Mr. Mix:

In a January 31, 2003, letter to you, I asked your organization for input concerning ways to reduce wasteful spending at the Department of Veterans.

Although I had requested your response by February 28, 2003, I still look forward to receiving your recommendations and working with you as we begin the 108th Congress. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:jom

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JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

Mr. Rick Weidman
Government Relations Director
Vietnam Veterans of America, Inc.
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear Mr. Weidman:

In a January 31, 2003, letter to you, I asked your organization for input concerning ways to reduce wasteful spending at the Department of Veterans.

Although I had requested your response by February 28, 2003, I still look forward to receiving your recommendations and working with you as we begin the 108th Congress. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

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JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

Ms. Deirdre Parke Hollomen
National Legislative Director
TREA
909 N. Washington Street, Ste 301
Alexandria, VA 22314

Dear Ms. Parke Hollomen:

In a January 31, 2003, letter to you, I asked your organization for input concerning ways to reduce wasteful spending at the Department of Veterans.

Although I had requested your response by February 28, 2003, I still look forward to receiving your recommendations and working with you as we begin the 108th Congress. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

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Chairman
Subcommittee on Oversight and Investigations

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JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

Mr. Richard Fuller
National Legislative Director
Paralyzed Veterans of America
801 18th Street, NW
Washington, DC 20006

Dear Mr. Fuller:

In a January 31, 2003, letter to you, I asked your organization for input concerning ways to reduce wasteful spending at the Department of Veterans.

Although I had requested your response by February 28, 2003, I still look forward to receiving your recommendations and working with you as we begin the 108th Congress. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

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JAMES H. HOLLEY
STAFF DIRECTOR

March 11, 2003

Colonel Robert Norton
Deputy Director of Govt. Relations
Military Officers Association of America
201 N. Washington Street
Alexandria, VA 22314

Dear Col. Norton:

In a January 31, 2003, letter to you, I asked your organization for input concerning ways to reduce wasteful spending at the Department of Veterans.

Although I had requested your response by February 28, 2003, I still look forward to receiving your recommendations and working with you as we begin the 108th Congress. If you have any questions, please contact the Subcommittee Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:jom

March 13, 2003

The Honorable Steve Buyer
Chairman, Subcommittee on Oversight and Investigations
House Committee on Veterans Affairs
336 Cannon House Office Building
Washington, DC 20015

Dear Mr. Chairman:

I appreciate your invitation of January 31 to offer the views of the Military Officers Association of America (MOAA) on ideas that would improve business practices and the allocation of resources for services delivered to our nation's veterans by the Department of Veterans Affairs (VA).

MOAA remains firmly committed to a seamless transition from military service to veteran status. Government efficiency and the needs of veterans would be well served by a resolute commitment to the creation of a "seamless, transferable electronic medical record" for all servicemembers. A lifetime service medical record could help veterans to obtain early, accurate and fair VA disability ratings, facilitate timely access to care, enable collaborative medical research between the DoD and VA health care systems and, ultimately, reduce the substantial costs associated with the veterans' claims system. There have been many attempts to realize this "holy grail" of DoD-VA cooperation, but we believe the real problem is lack of true commitment in the two federal departments. MOAA urges your Subcommittee to re-double its efforts to oversee the accomplishment of a seamless, transferable medical record for our nation's servicemembers as soon as possible.

Supporting this goal is the need for the VA and DoD to collaborate on a cost-effective approach to implementing a single separation physical as a mandatory part of the separation process including for members of the National Guard and Reserve called to active duty for extended periods.

Another barrier that impedes better business practice is the antiquated paper DD214. The DD214 is a prerequisite for access to the VA health care system and other veterans' benefits. MOAA urges you to support transmission of the DD214 electronically as well as promote coordination of veteran information in the Defense Enrollment Eligibility Reporting

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p.2, Buyer

System (DEERS). When DoD and the VA can coordinate information between the DD214 and DEERS, information critical to benefits determination would be accomplished in a more expeditious manner.

MOAA appreciates the opportunity to comment on issues that we believe would save money, improve efficiency and provide better services to servicemembers and veterans.

Sincerely,

Robert F. Norton

Robert F. Norton
Colonel, USA-Ret.
Deputy Director for Government Relations

DISABLED AMERICAN VETERANS
Building Better Lives for America's Disabled Veterans

March 7, 2003

The Honorable Steve Buyer, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
United States House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Representative Buyer:

Thank you for your invitation to the Disabled American Veterans to recommend ways for streamlining and improving services to our Nation's veterans. Please accept our apology for the lateness of this response. In circulating this for staff review during a busy period, we unintentionally failed to respond by the date you requested.

Two core benefits for veterans are disability compensation and medical care. In recent years, the Department of Veterans Affairs has experienced its most serious problems in the administration of these two programs. That is not merely a coincidence. It is in large part because these two programs are funded by discretionary appropriations. That is where the President's budget historically shortchanges VA. Congress reacted appropriately to the crisis in compensation claims processing by giving VA more money for employees to process and decide claims. With more adequate resources, and reforms, VA seems to be making progress in attacking that problem, although we still see some counterproductive practices. VA's phenomenal improvements in medical care delivery are well recognized and highly commendable. However, inadequate funding still limits VA's effectiveness and diminishes some of its best efforts. Accordingly, we focus here on recommendations for these two programs.

Despite serious and meaningful reforms in disability claims processing, VA insists on employing shortsighted practices that are duplicative and inefficient. Congress designed a VA system in which Veterans Benefits Administration and Veterans Health Administration field offices in each of the 50 states gather evidence and make initial decisions on claims and other issues of eligibility and entitlement. A centralized Board of Veterans' Appeals has appellate jurisdiction to *review* those decisions and obtain independent medical expert opinions under very limited circumstances. The Board operates under its own limited authorizing statutes rather than the extensive general statutory authority of VA to administer programs. Congress gave the Board no authority to develop the record and make initial decisions on claims, or to perform the wide variety of administrative program functions performed by VBA and VHA field offices. The statutory scheme, on the whole, contemplates the Board operating as a board of review, with the offices of original jurisdiction routinely obtaining evidence; considering and making the initial decision on that evidence; informing the claimant of the reasons for the decision; and referring the case for a final decision by the Board only after the claimant has been fully informed of the reasons for the continued unfavorable decision.

For practical and economical reasons, it is not the function of an appellate tribunal to discover evidence and make the decision itself in the first instance. For an appellate tribunal to do so merely creates a duplicate and equal second decisionmaking process, itself subject to the same mistakes in judgment on issues of fact determined in the first instance. The goals, safeguards, and efficiencies of appellate "review" are lost when the appellate tribunal merely performs, a second time, record development and fact finding on the same level as the inferior tribunal. Moreover, under such circumstances, the role and value of appellate review as quality control function is lost. The goal of quality review is lost if the quality reviewer must itself correct the mistakes it finds. Where the Board must correct the mistakes of the offices of original jurisdiction, those offices have no incentive to improve performance. Without ever having to acknowledge and correct their own mistakes, these VA field offices are deprived of the means to learn from them.

Despite the law and these practical considerations, VA promulgated regulations in January 2002 that fundamentally changed the mission of the Board. Under the new rules, the Board is saddled with the responsibility of obtaining evidence to remedy failures by VA field offices to adequately develop the record. The Board then makes the first factual finding of VA based on an adequate record. Although the law affords claimants "one review on appeal" within the administrative process, the claimant has no administrative appeal to remedy errors of fact or law made in first instance by the Board. The only recourse is an appeal to the United States Court of Appeals for Veterans Claims.

Because of the large number of cases being referred to the Board without adequate record development, a logjam is developing at the Board with consequent delays at that level. We now hear of a push for higher production at the Board with a resulting decline in the quality of the Board's decisions. That will likely result in even more appeals to the Court. These problems may well be complicated further if the several veterans' organizations that have challenged the legality of these rules prevail. The Board may then be required to rework hundreds, if not thousands, of cases.

In addition to inadequately developed records, inadequate disability examinations have contributed substantially to VA's claims processing problems. A pilot project authorized by Public Law 104-275 has demonstrated that a private contractor can economically provide adequate and timely disability examinations to veterans at locations near their homes with a high level of veteran satisfaction. VA would like this authority expanded to enable it to obtain disability examinations from contractors at all its regional offices. The Subcommittee should assess the merits of allowing VA to rely more on contractors for disability examinations.

Our national security rests with the commitment of those willing to serve in our Armed Forces. Those who serve in uniform are called upon to do what few are willing and capable of doing. Military service always requires personal sacrifices that most citizens never have to make. We owe our very existence as a nation to the sacrifices of our veterans. Because of the extraordinary perils, rigors, and personal sacrifices of military service it represents the greatest contribution to citizenship. In turn, the American people have proudly honored the principle that any individual who devotes part of his or her life, usually as a young adult, to defend our country deserves benefits others do not. Thus, our citizens, acting through Congress, recognize a deep

moral obligation on the part of the nation to afford veterans special status and benefits. As noted, medical care is one of the most important of those benefits.

In 1996, Congress recognized the need for and enacted sweeping eligibility reform to make medical care available to more veterans, and to give VA the means to more efficiently and effectively treat greater numbers of veterans at a cost substantially less than in private sector or in other government health care programs. VA went from an outmoded system to an undisputed world leader in medical care delivery. It is one of our proudest accomplishments for veterans, and our citizens take great pride in providing this especially beneficial service to veterans as a way of repaying them for their special contributions. At a time when health care costs elsewhere are skyrocketing, VA continues to find ways to provide top quality health care at a lower cost per patient. Although VA medical care is indisputably a bargain, our government has not provided funding at levels necessary to meet demand. The consequent delay in providing, and necessary rationing of, medical care undermines VA's remarkable accomplishments in improving its system. In addition, because VA is held hostage to the capriciousness and uncertainties of the annual appropriations process, it cannot strategically plan for the long term to optimize its assets, achieve even greater efficiency, and realize long-term savings. Discretionary funding for VA medical care benefits neither VA nor taxpayers, and it certainly is now having a negative impact on veterans. For these reasons, the DAV and other veterans organizations consider mandatory funding one of the most pressing issues for consideration by Congress.

While eligibility reform allowed VA to modernize its mode of delivery of medical care, perhaps with the exception of long-term care, its infrastructure is still largely one that was designed for hospital-based care. The system needs to be reconfigured to correspond to the geographic locations of veteran populations and to the demographics of the VA patients. That is the purpose of VA's program for Capital Asset Realignment for Enhanced Services, or CARES. The CARES program holds great potential for improving medical care for veterans, but it also could be detrimental if misdirected. The Subcommittee should oversee this process closely.

While we have many meritorious government programs and while we all like to see taxes reduced, veterans' programs should always remain a higher priority. Their costs are a continuing cost of national defense and war. Veterans' programs have historically and rightfully enjoyed strong public support, and our citizens who do not serve should always be willing to bear the costs of providing special benefits to those who do. The gratitude we feel and the honor we bestow upon our veterans are part of what makes ours a great nation.

We appreciate your full commitment to VA and its efforts to provide excellence in patient care, veterans' benefits, and customer satisfaction.

Sincerely,

Joseph A. Violante
National Legislative Director

SERVING WITH PRIDE

AMVETS

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TELEPHONE: 301-459-9600
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E-MAIL: amvets@amvets.org

February 28, 2003

The Honorable Steve Buyer
Chairman, Subcommittee on Investigations
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Buyer:

Thank you for the opportunity to address the goal of providing excellence in patient care in the Veterans Health Administration operations. We appreciate your letter requesting our comments on the delivery of services to the nation's veterans.

Comments on the Department of Veterans Affairs Veterans Health Administration:

The mission of the Department of Veterans Affairs Veterans Health Administration is to serve the healthcare needs of America's veterans. The system provides specialized care, primary care, and related medical and social support services for eligible veterans.

In bringing about better business practices and better allocation of resources, it is important to recognize that the Veterans Health Administration is not composed of button-down business people. Business concepts have never really been core concepts for VHA.

Nevertheless, in these times of economic downturn and limited resources, American taxpayers, elected and appointed government officials and veterans, too, demand accountability for every dollar spent. Agencies like VHA – with a budget of nearly $26 billion -- must account every expense to ensure that services are in line with mission.

That's a tall order, given the fact that VHA operates the nation's largest integrated healthcare system providing care to over 4.5 million veterans who made more than 47 million outpatient visits last year.

Management of this system requires sober consideration. Our government has a responsibility to provide generous assistance to those who have special needs arising from service in the Armed Forces, particularly war service. In addition our nation shoulders an obligation to provide veterans who have so honorably served our nation timely access to quality health care, especially those who carry physical and mental scars of that service or who have no where else to turn for medical care.

Clearly if we are to find an affordable solution, VHA resources and processes need to be managed using best business practices within all its activities. To discover appropriate improvement remedies, the system as a whole must be broken down in detail. The costs of all activities, from simple tasks like taking phone messages to those as complex as psychiatric care, must be ascertained. These details provide the insight needed for sound business decisions comparison.

Operational expenses should be compared across the board from hospital to hospital and from clinic to clinic. If better organization and management is sought, detailed information is required throughout the system including utilities, emergency services, transportation costs, communication services, general accounting principles, environmental health services, in-house training, transportation of equipment and people, security, and maintenance.

Realizing high savings and ensuring value growth in mission requires a refined system that costs less to operate. In order to accomplish these results, business managers aware of activity-based accounting must be trained at each installation and healthcare-skill successes must be studied and tools used successfully communicated and fully integrated at each installation of VHA.

One of the most-clear areas of likely VHA improvement is in the field of medical care cost recovery from third parties who insure veterans. Veterans pay these insurers regular premiums, but VHA, authority to collect medical care payments, continues to fail in these collections. Private sector medial care facilities would fold into bankruptcy if their collection rates fell anywhere near the miserable rate of recovery found at VHA.

Last year, VHA reported that a mere 18 percent of priority groups 7 veterans reported health insurance coverage. This report compares to over 75 percent coverage of the general public. To maximize the appropriate recovery of funds due VHA for the provision of healthcare services to veterans and other using the system, priorities within the system must be in place.

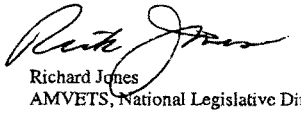
Currently there is no priority given to those who collect the payments regarding these collections. For example, clinics within a particular VHA system with high recovery rates have no certainty that the costs of service delivery will be restored to their operation. The recovery is provided the VISN, of course, but the operation that expensed the care does not automatically recover the third party payment. Reimbursement for care is a discretionary item for the VISN.

In addition, too many veterans who carry insurance are not having their insurers billed. Moreover, insurers who are billed are not paying. The question for activity-based best practices is how do some within the system do so well in recovery of costs and others fail so miserably. AMVETS does not believe we need to waste time in study of those who fail, we need only recognize the failure and seek out the successes. Improvement is obviously needed in insurance identification and receivable follow-up.

At this initial stage of focus on best practices, AMVETS believes it is important to focus on specific segments of VHA operations. While there may be no simple roadmap to developing VHA best practices, looking at cost comparisons and tightening emphasis on cost recovery may produce our best bang for the buck, which we trust is what we want to achieve. Taxpayers, elected officials and veterans all have a stake in seeing VHA on track within budget and fulfilling its mission accordingly.

Again, thank you for giving AMVETS the opportunity to comment on this important matter. While we recognize that our comments may not fully address the issues of improving VA's activities, we hope that in some small way we have contributed to the high goal you seek, namely a better, less costly, world-class health care system for those who honorably served our nation in the Armed Forces.

Sincerely,



Richard Jones
AMVETS, National Legislative Director

STATEMENT SUBMITTED BY
STEVE ROBERTSON, DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
CONCERNING
RECOMMENDATIONS TO STREAMLINE AND IMPROVE SERVICES TO THE NATIONS VETERANS

FEBRUARY 28, 2003

For several years, the Department of Veterans Affairs (VA) has instituted many reforms and myriad management efficiencies in order to stretch a discretionary budget that has continually been inadequate. The Fiscal Year (FY) 2004 budget request was no different. VA proposed even more management efficiencies to help them reach their clearly stated objective of continuing to focus on the health care needs of VA's core group of veterans - those with service-connected disabilities, the indigent, and those with special needs, while staying within budget constraints. The American Legion believes the level of funding proposed in the FY 2004 budget request may meet the President's goals, but will lead to over 1.2 million veterans leaving the system and many other veterans being denied enrollment. The American Legion also has reservations about the budgetary impact on other aspects of VA operations.

Sharing Agreements

The American Legion has worked closely with the Presidential Task Force (PTF) on several issues concerning VA and DoD sharing. We continue to support this issue and believe that some of the wasteful spending resulting from redundant programs and duplication of services can be reduced by an effective and efficient sharing agreement. Sharing of resources helps to improve access, satisfaction, and timeliness of services for VA and DoD beneficiaries while enhancing and expanding health care services, reducing overlaps and redundancies in support processes, and reducing costs.

Currently, VA and DoD sharing occurs among 165 VA Medical Centers (VAMC) with most military medical treatment facilities and 156 Reserve units around the country. VA and the military have agreed to share 6,602 services covering a broad range of hospital related activities. However, this represents a decrease of over 1000 services shared from two years ago. One of the possible problems cited is DoD's TRICARE managed care contract structure does not promote the use of government agency resource sharing.

There has been sharing of clinical and administrative services, equipment, joint procurement of pharmaceuticals, supplies, employee education and training, and many other services and functions. However, the amount and degree of sharing is not well documented and the data is

incomplete. Unfortunately, the actual amount of sharing of health care resources between VA and DoD and the cost efficiencies and cost avoidance that have resulted can only be surmised.

The American Legion recommends the following:

- Coordinated purchasing -- A renewed focus on joint efforts between the two agencies to share services and purchases of medical/surgical and pharmaceutical supplies.

- Enhanced sharing agreements -- The American Legion would like to see maximum utilization of sharing agreements between all regional VA, DoD and TRICARE health care providers.

- Implemented Medicare reimbursement -- The American Legion cannot over emphasize the importance of the approval of Medicare reimbursement for all enrolled Priority Groups 7 & 8 Medicare-eligible veterans and TRICARE for Life veterans being treated for nonservice-connected conditions. This first step is essential in the process of improving health care delivery for this nation's veterans. The American Legion continues to advocate for the approval of Medicare reimbursement for VA.

- Improved billing and collection -- The American Legion recommends either providing enhanced information technology and training to improve VA's billing and collection capabilities or purchasing this service from the private sector. The American Legion is surprised VA is not authorized to hire certified coders. The Office of Personnel Management (OPM) should reevaluate this decision, not only for VA, but also in the Indian Health Services (IHS) as well.

- Shared patient medical records -- The use of technology, such as bridging, would help alleviate current problems of sharing vital information between agencies.

- Contracted TRICARE Services -- The American Legion strongly recommends that Congress allow VA to become a primary contractor for the DoD health care system. Legislation would be required to authorize VA to act as a primary contractor and be able to compete with the private sector for these contracts. Instead of VA being the subcontractor, it would become the contractor using VHA medical facilities to provide care to TRICARE beneficiaries. This level of cooperation would go a long way in reducing costs for all three Federal agencies -- DoD, VA and the Centers for Medicare and Medicaid Services (CMS) -- and would provide consistent, coordinated quality health care for the entire patient population. The American Legion believes this would be the ultimate "joint venture" that would better coordinate the delivery of quality health care among the Federal agencies without obfuscating their unique missions.

Improving Funding for VA Health Care

Mandatory Funding

When Congress opened access to the VA health care system, many veterans believed VA was their best health care option and voted with their feet. Since CMS, the nation's largest public health insurance program, does not offer its beneficiaries a substantive prescription program, many Medicare-eligible veterans chose to enroll in VHA specifically to receive quality health care and access to an affordable prescription program. Since the DoD's TRICARE and TRICARE for Life programs require military retirees to make copayments or pay premiums, but does not provide for specialized care (like long-term care), many military retirees also chose to enroll in VHA. Clearly, VA's reputation for providing quality health care and its outstanding patient safety record places VA at the top of the list in the health care industry in both the public and private sector.

Funding for VA health care currently falls under discretionary spending within the Federal budget. VA health care budget competes with other agencies and programs for Federal dollars each year. The funding requirements of health care for service disabled veterans are not guaranteed under discretionary spending. VA's ability to treat veterans with service-connected injuries is dependent upon discretionary funding approval from Congress each year.

Under mandatory spending, however, VA health care would be provided funding by law for all enrollees who meet the eligibility requirements, guaranteeing yearly appropriations for the earned health care entitlement of veterans. Medicare receives mandatory funding to assure their beneficiaries receive access to timely health care, why shouldn't service-connected disabled veterans receive the same assurance?

Medicare Reimbursement

By law, VA is providing health care to Medicare-eligible veterans, but VA is unable to seek reimbursement from Medicare for timely, quality health care provided to these veterans. Since nearly half of VA's enrolled patient population identify Medicare as their primary health insurance provider, VA is currently subsidizing Medicare, except from veterans' co-payments and reimbursements from Medicare supplemental insurance providers (Part B coverage).

The American Legion continues to strongly encourage Congress to allow VA to be reimbursed for providing treatment of nonservice-connected medical conditions to those Medicare-eligible veterans that chose to enroll in VA as their primary health care provider. Access to VA health care is based solely on military service – not Medicare-eligibility. Medicare is a Federally-mandated, public health insurance program. Most Medicare participants make monthly payments into the program for years before they are actually eligible to receive coverage, then they continue to pay for that coverage for the remainder of their lives. Benefits are paid to recognized health care providers for the delivery of timely, quality health care. VA should be recognized by CMS as an authorized Medicare provider.

VA has much to offer Medicare-eligible veterans – outstanding patient safety record; quality heath care; specialized services (long-term care, spinal cord injury, blind rehabilitation, etc.); and an affordable prescription program. Although a large number of Americans are Medicare-eligible, only a small percentage are eligible for quality health care within VA – the nation's largest integrated health care network.

Veterans Benefits Administration and Claims Processing

The American Legion remains very concerned by the issues of timeliness and quality decision making in the processing of veterans' claims for benefits and Veterans Benefits Administration (VBA) efforts to address these longstanding problems. The American Legion believes VBA's lack of sound business practices, or adherence thereto, contributes in large measure to their continued inability to overcome many core quality-related problems.

Claims must be fairly and properly decided - the first time. To do otherwise is not acceptable to The American Legion, to veterans, and the Congress. The speed of the adjudication process should be a secondary consideration. Claims that are properly developed and fairly decided are what veterans expect and deserve. Quality decisions, in the long run, help reduce wasted effort by VBA and the Board of Veterans Appeals (BVA). Until this becomes VBA's guiding management and budgeting principle, countless man-hours will continue to be wasted on improper or unnecessary development, useless and confusing Veterans Claims Assistance Act (VCAA) letters, premature denials, unnecessary appeals, and BVA remands. Court-directed rework of claims, such as those related to Agent Orange diseases, continues to add to current regional office workload. The current emphasis on production in order to achieve an arbitrary and artificial timeliness goal is hurting many veterans. Claims continue to churn through the system, due to the lack of full compliance with the VCAA's duty to notify and assist requirements, which is resulting in flawed decisions and unnecessary appeals, remands, and BVA development action.

The American Legion believes that one of the primary obstacles to improving regional office decision-making is VBA's current work measurement system. Even though it does not directly contribute to either the claims or appeals backlog, it is the background environment within which the adjudication process takes place. There is a specific End Product (EP) established at the time a claim is received and each EP has a different value (or work credit) based on the average number of hours required to complete all action on that type of claim. The use of EPs are a way to recognize that more work is required to develop and adjudicate a claim for service connection than to make a benefit adjustment in a pension case. However, the regional office can receive only so much 'work credit' per case, regardless of whether the claim is granted or denied, or whether it took one month or two years to decide the claim, or whether the original adjudication was correct or not, or that additional work credit may subsequently be taken when the regional office has to readjudicate or correct a prior erroneous decision.

Under this system, station performance is measured and evaluated by the number of EPs generated, average processing time, and how many employees were needed to produce this amount of completed cases. Thus, there are very strong incentives for station managers to report as many completed cases as possible in the shortest amount of time, since productivity and timeliness are two of the most important factors in their annual performance evaluations. The problem is that this goal may conflict with the managers' legal responsibility to ensure that the adjudication process functions fairly, timely, and in a manner consistent with the law and VA regulations and policies. Administrative and procedural requirements, such as placing claims under control, identifying all issues involved, providing proper notice, developing evidence as

required under the duty to assist, rendering a fair and proper decision with adequate reasons and bases, and reviews for quality assurance, all affect station managers' productivity and timeliness statistics.

Station management and individual adjudicators are currently under extreme pressure to report completed EPs, in order to reduce the backlog of pending claims and reach the Secretary's stated goal of 250,000 pending cases with an average processing time of 100 days by the end of FY 03. Regardless of what the law, VA regulations, manuals, and guidelines say, very often adjudicators will prematurely deny a claim, rather than continuing with development, in order to take the EP or work credit. In this way, they do not have to spend the additional amount of time (days, weeks, or months) on the case. The net effect of such arbitrary action is to cause cases to be churned through the system, sometimes for years, which generates additional, but otherwise, unnecessary EPs. Without adequate supervision and quality assurance procedures, expediency and self interest may well take precedence over a concern for propriety and the welfare of the veteran represented by each claims folder an adjudicator handles. Such churning also has the practical effect of rewarding some stations with additional staff and resources, because they appear to be more "productive." Stations whose numbers are low, but who are trying to provide fair and proper decisions in a timely manner do not always get the support they need.

The American Legion continues to believe that quality decision making should be VBA's highest priority. Collaterally, there must be greater accountability and a more effective quality assurance program. One way to help promote quality would be to remove the incentive to take inappropriate or premature action on a claim by amending the statute to require that work credit not be given until the decision on the claim becomes final. A final decision would be one in which either the claimant failed to file a timely appeal or where a final decision was rendered by the BVA, regardless of the amount of time involved. We recognize this would require a major overhaul of both the work measurement system and prevailing culture within the VA regional offices. Such change would more accurately reflect the amount of work actually being performed by a regional office and provide a more realistic and reliable basis to evaluate staffing and equipment needs.

What The American Legion cannot understand is, despite its longstanding and well known deficiencies, local and VBA management continue to rely on unreliable EP data in determining staffing needs at the station, region, and service levels and in the development of VBA's annual budget request for staff. Serious problems can arise if the data developed by the work measurement system is neither accurate nor reliable in reporting the actual amount of work accomplished. In our opinion, the current system produces a distorted view of the way the claims adjudication process is operating. It also does not indicate what the true staffing needs are to handle the number of pending claims and appeals, both locally and system-wide.

The American Legion believes the current work measurement system is seriously flawed and cannot provide VBA or Congress needed information on how long it actually takes to properly process and finally decide a claim or how many staff are required to perform this function in a timely manner. The work data produced is also prone to frequent manipulation and abuse, which makes its accuracy and reliability of questionable value to management in making budget decisions. These issues have also been the subject of several Government Accounting Office

(GAO) reports in 2002. The American Legion believes the development and implementation of a new work measurement system must become one of VBA's top priorities.

In the absence of action by VBA to implement needed revision to their work measurement system in the very near future, The American Legion is prepared to seek legislation to accomplish this. The American Legion proposes the establishment of a work measurement system that will only give work credit in a claim that has been finally decided, i.e., where either the claimant has not appealed within the one-year time limit or the BVA has rendered a final decision on the claim. The data produced under this type of system would more accurately reflect the total time it takes to actually 'complete' a claim. This would make it possible for management to better assess the resources needed to handle the amount of work to be done.

Closing

The American Legion appreciates the opportunity to submit this overview of recommendations to help reduce wasteful spending and eliminate redundancies within VA.

The American Legion is involved in addressing the future needs of ALL veterans through its involvement in the PTF and the CARES process. We have an active Field Service Unit that serves as the "eyes and ears" of the organization, as well as, a Quality Review Team that visits VA Regional Offices and evaluates management practices and claims processing. In addition, the "I Am Not A Number" campaign which was initiated to receive and record veterans' first-hand experiences in obtaining VA health care is running concurrently with National Commander Ron Conley's visits to VA Medical Centers across the United States.

Thank you again, Chairman Buyer and we look forward to working with this Subcommittee on seeking ways to improve services to the Nation's veterans.

Statement for the Record
Congresswoman Darlene Hooley
6/17/04 VA Hearing on Waste, Fraud and Abuse

Thank you Mr. Chair

Today, we have many recurring themes from last year's series of hearings on this topic. Procurement, contracting, accountability are once again on the agenda.

Last year, I asked Deputy Secretary MacKay a series of questions on contracting for services previously performed by VA employees. I questioned some of the results from the program and he acknowledged that the numbers did not add up. What appeared as a savings for the taxpayer, in some cases, cost more because of the procedures and mis-analysis.

This year, the VA Inspector General revisits in far greater detail the issue of Health Care Resources Contracts, especially regarding sole-source contracts with affiliated institutions. From his testimony, it appears that significant overpayments by VA are a recurring problem. These overpayments dilute the value of scarce health care dollars. VA leadership has long been aware of this problem as indicated by their comments in last year's hearing report. They note the long standing problem and further note that their actions, including training programs and policy memoranda have not yielded desired results over at least a 25-year period. Two and a half ***decades*** is long enough to wait for a policy memo to take affect and generate the desired result. Perhaps, in the interest of the taxpayer, a more involved oversight and enforcement approach would better solve this problem.

I thank Mr. Griffin for his careful review of this critical area. I note that under his leadership the Office of the Inspector General has identified potential monetary benefits of over $2 billion dollars and also note that

for every dollar the taxpayer has spent on the OIG, the IG has returned 57 dollars in potential savings. That, for me, is management efficiency!

One other area needing further scrutiny is the span of control of VA's Chief Information Officer (CIO). In previous hearings, we questioned the lack of line authority for the CIO and for the Chief of Cyber Security. The IG notes problems caused by this decentralized approach. I note that the management of major IT projects has suffered because of unclear lines of control. When the taxpayer invests over 100 million dollars for a single information technology project, someone should be fully in charge and fully accountable. Delayed, underperforming, and failed systems like HR Links$, early VETSNET, CoreFLS, and PFSS underscore this need. VA receives over one billion dollars a year for IT improvement – this area is ripe for improvement through clarification of authorities and vesting responsibility under one person.

I yield back.

Statement of Representative Jeff Miller
Committee on Veterans Affairs
Follow-up Hearing to May 8, 2003 and June 10, 2003 Hearings on
Eliminating Waste, Fraud, and Abuse in Veterans' Programs
June 17, 2004

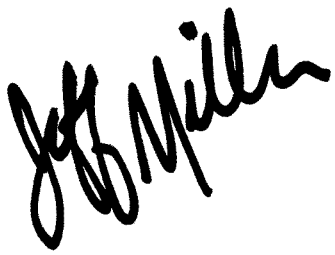
Thank you, Mr. Chairman. It's good to be here today.

Since I joined this Committee some two and half years ago, we have held several of these hearings and have done our part to oversee VA's efforts to streamline and improve efficiencies within its $63 billion operation. The fact that we are here today is indication enough that there is still much more work to be done. I want to thank all of you for being here today, for your willingness to look at these matters with a critical and discerning eye, and for your sustained efforts to work with this committee.

I look forward to today's testimony regarding existing vulnerabilities and the ongoing work to bring accountability for VA's property and its efforts at third party collections. But above all else, I am looking forward to hearing about progress with respect to VA's five-year plan for management of its capital assets, in particular via VA-DoD sharing.

Improving collaboration between VA and DoD is a priority of the President, the Congress and both Departments. Numerous reviews by GAO of VA/DoD sharing initiatives have supported the need for closer interagency planning to jointly address local health care needs to improve care delivery and control costs. And, as you know, Secretary Mansfield, we've got tremendous sharing going on in Northwest Florida that already bears several years of results, has saved thousands of dollars, and that is a model for cosharing endeavors across the nation that will eliminate waste and duplication.

Again, thank you all for being here. I look forward to your testimony today.



Opening Statement
HVAC Hearing 6-17-04
Full Committee Oversight Hearing on Waste, Fraud, and Abuse
Rep. Tom Udall

Thank you, Mr. Chairman.

I look forward to hearing the testimony of our panelists today. I always enjoy hearings on this topic because in the end the Committee, with the help of our panelists, is generally able to draw concrete conclusions about where we can all improve the operations of the VA. And this, in turn, benefits not only our nations veterans, but all taxpayers.

One issue with regard to tracking efficiencies in the VA that I have been following is the issue of indirect costs associated with NIH-funded research at VA facilities.

Some estimates show that the VA may lose up to $100 million per year in indirect costs to the NIH. I have brought up this issue at numerous hearings and I had been optimistic that high-ranking officials within the VA and HHS could come to an agreement. I know that the Secretary has been trying to solve this problem, and the staff of the Committee has worked diligently on it.

In his FY 2005 budget, the President deleted $50 million from research in the VA budget, I presume because it was calculated that indirect costs for research facility use would be paid to the VA by HHS. However, the Office of Management and Budget recently stated that the Administration does not support reimbursements from the NIH to the VA or any other Federal agency. This is bad news for the VA.

I know that the panelists today are familiar with this issue and look forward to hearing from them on this particular topic, as well as many other pressing issues such as VA-DoD sharing and the fugitive felon program.

Thank you again for being here today to discuss these important issues.

Thank you, Mr. Chairman.

Statement of the Honorable Gordon Mansfield
Deputy Secretary of Veterans Affairs
Before the Committee on Veterans' Affairs
United States House of Representatives
June 17, 2004
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Chairman Smith and Members of the Committee:

Thank you for inviting me to testify today. As my predecessor said last year, the Administration, and the Department, take very seriously our stewardship of America's programs of veterans benefits and services. It remains incumbent on us to manage the considerable resources entrusted to us in the most effective manner so that we can best serve our nation's veterans as well as safeguard America's investment in these important programs.

Today I will provide you with an update of VA's responses to findings included in reports issued last year by the Office of Inspector Generals (OIG) and the General Accounting Office (GAO). I respectfully request that you include in the record of today's hearing a paper that describes our efforts in detail with respect to each of the OIG and GAO findings. While I am glad to discuss any of the issues covered in the paper, my testimony will highlight important steps taken by the Department to respond to some of the major findings of the OIG and GAO. While more remains to be done, be assured the Department is committed to successfully resolving all outstanding matters. In addition, I would like to take this opportunity to mention great strides made by VA to generally maximize the Department's resources.

Initially, I would like to comment on an issue of concern to both VA and Congress that came to light in recent months: The implementation of the CoreFLS software system at the VAMC Bay Pines. The Secretary and I remain firmly committed to the development of a financial logistics information technology system that benefits VA patients and heath care providers. Towards that end, VA's management will oversee and ensure that all CoreFLS-specific concerns continue to be fully addressed. The Secretary will decide the appropriate future of CoreFLS based on the information gathered from the following on-going investigations and reports:

- VA Office of Inspector General (OIG) report - due June 2004
- House Committee on Appropriations Surveys and Investigations Staff - interim assessment due June 2004, final report due September 2004
- Carnegie Mellon's Software Engineering Institutes (SEI) Independent Technical Assessment (ITA) – report due June 30, 2004

In the interim, the CoreFLS staff continues to work closely with VAMC Bay Pines to support operations at the station.

On the positive side, the CoreFLS pilot programs located at the St. Louis Veterans Benefits Administration Regional Office and the Florida National Cemetery have, in sharp contrast, not experienced problems of the magnitude that VAMC Bay Pines has experienced with this system. This is generally due to the fact that both NCA's and VBA's processes are less complex than VHA's processes and both use a more limited version of the CoreFLS program. Both pilot sites expect their use of CoreFLS to be operational with only minor problems by the end of June.

Part-Time Physician Time and Attendance

Last year the Department responded to a finding by OIG that in a number of instances part-time physicians had not worked their scheduled hours. The OIG found that some part-time physicians had performed no work for VA during the periods examined.

Mr. Chairman, we have made substantial progress in addressing this important matter. First, physicians whose services are not needed on a regular, recurring basis have been or will be converted to a more appropriate scheduling arrangement, e.g., fee basis or intermittent.

Second, to ensure that part-time physicians and managers understand and comply with the rules, VHA has required that every part-time physician be personally counseled about time and attendance requirements and that all part-time physicians certify that they understand the rules. Refresher training has also been given to all timekeepers, and every facility was required to review and update, as necessary, local time and attendance policies. Those policies were subsequently submitted to Headquarters for review to ensure that they are complete.

Finally, VA Network Directors' quarterly performance reviews will include these measures, to ensure continued attention to compliance with these mandates.

We believe these measures have helped us to significantly correct this previously identified shortcoming. Indeed, on August 15, 2003, the OIG conducted unannounced follow-up visits at 15 VA medical facilities to reassess time and attendance practices of part-time physicians. Their report, issued February 18, 2004, indicated progress was being made in this area. Of the 729 part-time physicians reviewed, only 2 percent were identified as not being in compliance with applicable VA policy. In addition, OIG found that comprehensive written agreements were documented for 98 percent of these physicians. Our

goal is full system-wide compliance, but we are nonetheless encouraged that our efforts thus far have resulted in such a high level of compliance.

Purchase Cards

VA's Office of Finance continues to be very proactive in responding to systematic management weaknesses and vulnerabilities identified during OIG's audits and program office reviews related to the purchase card. Specifically, VA developed and published Directive and Handbook 4080, which established policy and procedures for obtaining a purchase card, the proper uses of a purchase card, and management and employee responsibilities for use of the card. An important aspect of this policy is that it provides for disciplinary action when an employee does not follow policy relating to proper use of these cards. The directive and handbook are currently being revised in response to the April 26, 2004, OIG report on VA purchase card practices. When completed we will provide a copy of these policies to the Committee.

The Office of Finance is also providing purchase card data to the Office of Business Oversight (OBO) so that OBO can conduct audits of any questionable transactions beginning in FY 2005. These focused audits will be in addition to the OBO's routine ongoing financial audits, which include review of purchase card internal controls and compliance with the Federal Acquisition Regulation (FAR) and VA policy. These efforts will enhance the overall effectiveness and oversight of the purchase card program within VA. They also respond directly to the OIG's April 26, 2004, purchase card recommendations.

While working to improve internal controls, VA also continues to identify additional ways these cards can be used to reduce operational costs and increase rebates. VA's recently re-competed purchase card contract (2003) resulted in substantially greater rebates to VA—rebates are double what they were prior to the re-competition, and anticipated rebates for FY 2004 and beyond are expected to exceed $33 million annually. VA is currently piloting use of the card with non-VA providers of medical services and supplies. Since inception of the pilot in mid-September 2003, VA has processed 8,644 transactions worth $1.6 million and earned $25,000 in additional rebates. Currently 66 providers are participating in the pilot.

Even though GAO and OIG reports have consistently found less fraud and misuse in VHA's purchase card program than in most large federal programs, we recognize that our purchase card program still has weaknesses that may leave it vulnerable to fraud and misuse. We will continue to improve the program to eliminate such vulnerability.

Federal Supply Schedule

In addition, VA's Federal Supply Schedule (FSS) programs have enjoyed substantial growth in the last four years. In FY 1999 VA's FSS sales were approximately $2 billion. This last fiscal year, sales topped $6 billion. The FSS for medical services, which was nonexistent in FY 1999, is expected to exceed $200 million this year. Most importantly, our schedules reflect very favorable pricing. GAO found that VA's aggressive efforts to ensure most favorable pricing in awarding FSS and national contracts for medical products and services have saved taxpayers hundreds of millions of dollars per year.

Capital Asset Management

GAO's May 8, 2003 report noted that many of VA's buildings remain underutilized and that its large and aged infrastructure is not always well aligned to efficiently meet veterans' needs. The Department, at the highest levels, has worked earnestly to address these problems. We recognize that we must update our facilities to reflect changes in the practice of medicine as well as the changing needs of our veterans.

To this end, the Secretary recently submitted the CARES package to Congress. Overall, the CARES plan identifies 100 major construction projects in 37 states, the District of Columbia and Puerto Rico and minor construction projects throughout our system. Investment in modernization, as well as costs avoided through vacating obsolete or redundant space, will pay off in resources committed to medical care rather than maintaining vacant or obsolete space.

Implementation of the CARES plan will also reduce vacant space in the Veterans Health Administration from 8.57 million square feet to 4.93 million square feet, a reduction of 42.5%. Further, the CARES plan will reduce the cost of maintaining vacant space over the period 2006 to 2022 by $2.65 billion and allow VA to direct those funds to patient care.

We next identified major construction capital requirements needed to implement CARES for fiscal years 2004 through 2010. These projects were identified through the CARES planning process to meet the challenges of providing veterans' health care in the 21st century and to implement the decisions identified in the Secretary's decision document released on May 7, 2004. VA will use available funds (FY 2004 and prior year appropriations) along with funds included in the FY 2005 President's budget request to carry out VA's highest priority projects in FY 2004 and FY 2005. VA's five-year asset plan will be submitted to the Congress in the near future.

Another tool we developed to improve management of VA's capital assets is the Capital Asset Management System (CAMS). This is an integrated, Department-wide system that enables VA to establish, analyze, monitor and manage its portfolio of diverse capital assets. The asset classes include: leases,

IT, equipment, agreements, buildings and land. CAMS extracts key information, including planned cost, actual cost and performance data from several existing data sources in order to provide a strategic view of existing assets, in-process investments and proposed assets across VA. CAMS implementation is innovative, and particularly impressive, because no tool previously existed that provided comprehensive portfolio management. VA is the first federal agency to consider all asset classes and to implement a tool to manage them collectively.

Procurement

In response to OIG's report on the subject of VA purchasing practices, the Secretary chartered the VA Procurement Task Force in 2001. Since its inception, the VA Procurement Reform Task Force has examined the extent to which VA obtained best available prices; complied with federal and VA acquisition regulations; used purchase cards appropriately; used adequate systems to track and document purchases; and ensured an adequate acquisition work force.

Some notable accomplishments of the task force include the following:

1). The establishment of a contract hierarchy which mandates VA use of national contracts and VA's FSS over open market purchases. This has dramatically changed the way VA does business. Companies that were previously reluctant to enter into national contracts or FSS Contracts are now aggressively seeking opportunities to refocus their participation in the new VA system. The National Acquisition Center in Hines, IL, received more than 100 new sources as a result of executing this new initiative.

2). The establishment of the High Tech/High Cost Equipment Consolidation Program, which has been in place since January 31, 2003. The program has resulted in the savings of approximately $11 million. New workgroups have been established to build on the successes of the Program. These clinically driven workgroups are charged with establishing national contracts for some specific high cost/high tech commodities.

3). Substantial savings under the National Standardization Program (NSP). In particular, over $8 million dollars was realized in cost avoidance for FY 03 for the Medical Surgical Standardization Program. An additional $12 million dollars in cost avoidance was realized for the Prosthetics and Sensory Aids (PSAS) Clinical Management Program. Currently, VHA is restructuring the NSP to incorporate the strengths, processes and guidelines of the very successful PSAS Clinical Management Program.

We are also taking other proactive measures to generally maximize Department resources. Two programs bear special mention.

First, VA's post-award audit program is an area of notable progress. Under this program, audits are performed after the award of FSS and other contracts to ensure that the contracts were properly awarded. When it is determined that they are not, VA is able to seek price reductions and refunds from the contractors. Through April 2004, refunds have totaled approximately $200 million; these refunds have been deposited in VA's Supply Fund.

Because contractors are aware of VA's audit activities, there has been a beneficial effect on their business practices. Since 1993, 94 companies have voluntarily disclosed situations where errors where made in their contracts and have made refund offers to VA. The OIG is currently reviewing 13 such disclosures, with refund offers amounting to $10.8 million. In certain cases, the OIG might make a referral of a company to VA's Debarment and Suspension Committee for its review.

Second, we are currently re-organizing VHA's business activities to strengthen and ensure compliance with finance, acquisition and capital asset policies and procedures. The following three positions will be created: Chief Financial Officer (CFO), Chief Asset Management Officer (CAM), and Chief Logistics Officer (CLO). Until now, oversight of these areas varied at each medical center, with no direct line of control and accountability. Each position will report to a VISN director and have authority over their respective areas of expertise across the VISN. Implementing these positions throughout VA will enforce corporate discipline, enabling greater accountability and uniformity in VA operations.

I am excited about the progress we have made thus far in correcting shortcomings identified by the OIG and GAO in the management of our programs. Thank you for this opportunity to share what VA has accomplished during the past year to ensure that the resources entrusted to us for the benefit of our nation's veterans are used in a wise and responsible manner.

I will be glad to respond to any questions that you or any member of the Committee may have.

United States General Accounting Office

GAO

Testimony

Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
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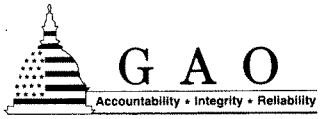
VETERANS HEALTH ADMINISTRATION

Inadequate Controls over the Purchase Card Program Resulted in Improper and Questionable Purchases

Statement of McCoy Williams
Director, Financial Management and Assurance



GAO-04-857T

June 17, 2004

GAO
Accountability · Integrity · Reliability

Highlights

Highlights of GAO-04-857T, a testimony before the Committee on Veterans' Affairs, House of Representatives

VETERANS HEALTH ADMINISTRATION

Inadequate Controls over the Purchase Card Program Resulted in Improper and Questionable Purchases

Why GAO Did This Study

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) has continued to identify significant vulnerabilities in the department's use of government purchase cards. Over the years, the OIG has identified internal control weaknesses that resulted in instances of fraud and numerous improper and questionable uses of purchase cards. The OIG has made a number of recommendations for corrective action.

Given that VA is the second largest user of the governmentwide purchase card program, with reported purchases totaling $1.5 billion for fiscal year 2002, and because of the program weaknesses reported by the OIG, GAO was asked to determine whether existing controls at the Veterans Health Administration (VHA) were designed to provide reasonable assurance that improper purchases would be prevented or detected in the normal course of business, purchase card and convenience check expenditures were made in compliance with applicable laws and regulations, and purchases were made for a reasonable cost and a valid government need.

GAO's report on this issue, released concurrently with this testimony, makes 36 recommendations to strengthen internal controls and compliance in VHA's purchase card program to reduce its vulnerability to improper, wasteful, and questionable purchases.

www.gao.gov/cgi-bin/getrpt?GAO-04-857T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact McCoy Williams at (202) 512-6906 or williamsm1@gao.gov.

What GAO Found

Weaknesses in VHA's controls over the use of purchase cards and convenience checks resulted in instances of improper, wasteful, and questionable purchases. These weaknesses included inadequate segregation of duties; lack of key supporting documents; lack of timeliness in recording, reconciling, and reviewing transactions; and insufficient program monitoring activities. Generally, GAO found that internal controls were not operating as intended because cardholders and approving officials were not following VA/VHA operating guidance governing the program and, in the case of documentation and vendor-offered discounts, lacked adequate guidance.

The lack of adequate internal controls resulted in numerous violations of applicable laws and regulations and VA/VHA purchase card policies that GAO identified as improper purchases. GAO found violations of applicable laws and regulations that included purchases for personal use such as food or clothing, purchases that were split into two or more transactions to circumvent single purchase limits, purchases over the $2,500 micro-purchase threshold that were either beyond the scope of the cardholder's authority or lacked evidence of competition, and purchases made from an improper source. While the total amount of improper purchases GAO identified is relatively small compared to the more than $1.4 billion in annual purchase card and convenience check transactions, they demonstrate vulnerabilities from weak controls that may have been exploited to a much greater extent.

The ineffectiveness of internal controls was also evident in the number of transactions classified as wasteful or questionable. GAO identified over $300,000 in wasteful or questionable purchases, including two purchases for 3,348 movie gift certificates totaling over $30,000 for employee awards for which award letters or justification for the awards could not be provided and a purchase for a digital camera totaling $999 when there were other less costly digital cameras widely available. Also, 250 questionable purchases totaling $209,496 from vendors that would more likely be selling unauthorized or personal use items lacked key purchase documentation. Examples of these types of purchases included a purchase from Radio Shack totaling $3,305, a purchase from Daddy's Junky Music totaling $1,041, a purchase from Gap Kids totaling $788, and a purchase from Harbor Cruises totaling $357. Missing documentation prevented determining the reasonableness and validity of these purchases. Because only a small portion of the transactions that appeared to have a higher risk of fraud, waste, or abuse were tested, there may be other improper, wasteful, and questionable purchases in the remaining untested transactions.

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss internal controls over the use of purchase cards at the Veterans Health Administration (VHA). At the outset, I want to make clear that GAO supports the concept of the purchase card program. The benefits of using purchase cards are lower costs and less bureaucracy for both the government and the vendor community. At the same time, given the nature, scale, and increasing use of purchase cards, it is important that agencies have adequate internal controls in place to help ensure proper use of purchase cards and thus to protect the government from waste, fraud, and abuse.

As you know, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) has continued to identify significant vulnerabilities in the department's use of government purchase cards.[1] In its most recent report, the OIG identified internal control weaknesses that resulted in instances of fraud and numerous improper and questionable uses of purchase cards. The OIG made a number of recommendations for corrective action.

Given that VA is the second largest user of the governmentwide purchase card program, with reported purchases totaling $1.5 billion for fiscal year 2002, and because of the program weaknesses reported by the OIG, you asked that we review VHA's purchase card program for fiscal year 2002 to determine if control problems still existed. Our report on this issue is being released today at this hearing.

You also asked that we review internal control activities (1) over third-party billings and collections at selected VHA medical centers to assess whether those controls were designed and implemented effectively and (2) in three areas of operation at selected VHA medical centers—accountability over personal property, drugs returned for credit, and part-time physician time and attendance. These two reports will be issued later this month.

In my testimony today, I will discuss the inadequacy of internal controls over VHA's purchase card program. The scope of our work, which was performed from April 2003 through April 2004 in accordance with generally

[1]U.S. Department of Veterans Affairs, Office of Inspector General, *Evaluation of the Department of Veterans Affairs Government Purchase Card Program*, Report Number 02-01481-135 (Washington, D.C.: Apr. 26, 2004).

accepted government auditing standards, is detailed in the report being released today.

Heads of agencies are required to establish systems of internal control consistent with our *Standards for Internal Control in the Federal Government*.[2] Effective internal controls are the first line of defense in safeguarding assets and in preventing and detecting fraud. In addition, they help to ensure that actions are taken to address risks and are an integral part of an entity's accountability for the stewardship of government resources.

As I will discuss in my testimony, we found that (1) existing controls at VHA were not designed to provide reasonable assurance that improper purchases would be prevented or detected in the normal course of business, (2) lack of compliance with applicable laws and regulations in VHA's purchase card and convenience check programs led to improper purchases, and (3) poor controls resulted in some wasteful and questionable purchases. We focused on the approximately $1.4 billion of disbursements that VHA made during fiscal year 2002, the most recent fiscal year for which complete data were available when we began our review.

I will first address the inadequacy of VHA's internal controls.

Critical Internal Controls Were Ineffective

Our review found that VHA's internal controls were not designed to provide reasonable assurance that improper purchase card and convenience check purchases would not occur or would be detected in the normal course of business. We found that (1) VHA lacked adequate segregation of duties between those purchasing and receiving goods; (2) payments for purchase card and convenience check transactions often did not have key supporting documents; (3) timeliness standards for recording, reconciling, and reviewing transactions were not met; and (4) cardholders did not consistently take advantage of vendor-offered purchase discounts. Generally, we found that internal controls were not operating as intended because cardholders and approving officials were not following operating guidance governing the program, and in the case of documentation and vendor-offered discounts, they lacked guidance. We also noted that

[2]U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

monitoring activities could be strengthened, for example, as in instances where (1) accounts remained active long after the cardholder had left service at VA, (2) credit limits on accounts were significantly higher than actual usage, and (3) human capital resources were insufficient to enable adequate monitoring of the purchase card program.

Our *Standards for Internal Control in the Federal Government* requires that (1) key duties and responsibilities be divided or segregated among different people to reduce the risk of error or fraud; (2) all transactions and other significant events be clearly documented and readily available for examination, and other significant events be authorized and executed only by persons acting within the scope of their authority; (3) transactions be promptly recorded to maintain their relevance and value to management in controlling operations and decisions; and (4) internal control monitoring be performed to assess the quality of performance over time and ensure that audit findings are promptly resolved. Similarly, internal control activities help ensure that management's directives are carried out. They should be effective and efficient in accomplishing the agency's objectives and should occur at all levels and functions of the entity.

We found that VHA lacked adequate segregation of duties regarding independent receiving of goods and separation of responsibilities within the purchasing process. Independent receiving, which means someone other than the cardholder receives the goods or services, provides additional assurance that items are not acquired for personal use and that they come into the possession of the government. This reduces the risk of error or fraud. From our purchase card internal control testing, we estimate that $75 million[3] in transactions did not have evidence that independent receiving of goods had occurred. In addition, our data mining of the purchase card and convenience check activity identified 15 agency or organization program coordinators (A/OPC) who were also cardholders and collectively made 9,411 purchases totaling $5.5 million during fiscal year 2002. Because A/OPCs are responsible for monitoring cardholders' and approving officials' activities for indications of fraud, waste, and abuse, these A/OPCs were essentially monitoring their own activities.

We also found instances where purchase card and convenience check transactions lacked key supporting documentation. This would include

[3]We are 95 percent confident that the total dollar value of purchase card transactions that lacked independent receiving was between $37.4 million and $112.6 million.

internal written authorization for convenience check disbursements and vendor invoices that support the description, quantity, and price of what was purchased. VHA's purchase card guidance does not address the types of documentation that cardholders should maintain to support their purchases. It only addresses documentation requirements in its audit guide, which is an appendix to the purchase card guidance that provides instructions to internal reviewers for performing their monitoring functions. Furthermore, we noted that VA's operating guidance for convenience checks has no requirement that vendor documentation be provided before checks are issued. The guidance only provides that sufficient documentation, such as a VA-created purchase order, must be evident before checks are issued.

The invoice is a key document in purchase card internal control activities. Without an invoice, independent evidence of the description and quantity of what was purchased and the price charged is not available. In addition, the invoice is the basic document that should be forwarded to the approving official or supervisor so that he or she can perform an adequate review of the cardholder's purchases. Of the 283 purchase card sample transactions we tested, 74 transactions totaling $2.1 million lacked an invoice, credit card slip, or other adequate vendor documentation to support the purchase. Based on these results, we estimate that $312.8 million[4] of the fiscal year 2002 purchase card transactions lacked key supporting documentation. For the convenience check sample, we found 35 of 255 transactions totaling $43,669 lacked the same key documentation. Based on these results, we estimate that $3.8 million[5] of the fiscal year 2002 convenience check transactions lacked key supporting documentation.

We also noted that VA's operating guidance over convenience checks does not provide detailed procedures regarding appropriate written documentation or authorization that must be forwarded to the authorizing employee before funds are disbursed to a third party. VA's operating guidance only provides that the required documentation be the same as that for paying with cash, such as a purchase order. The guidance makes no mention of independent vendor documentation and that this type of

[4]We are 95 percent confident that the total dollar value of purchase card transactions that lacked key supporting documentation was between $243.2 million and $382.4 million.

[5]We are 95 percent confident that the total dollar value of convenience check transactions that lacked key supporting documentation was between $2.4 million and $5.3 million.

documentation be required prior to issuing checks to vendors. In addition, VA's guidance only requires that the authorizing employees issuing convenience checks retain copies for 1 year. This documentation requirement is inconsistent with the *Federal Acquisition Regulation* (FAR) and VHA's *Records, Control Schedule 10-1*, dated February 14, 2002, which requires that such records be retained for 6 years and 3 months after final payment for procurements exceeding the simplified acquisition threshold and for 3 years after final payment for procurements below the simplified acquisition threshold.[6]

We found that of 255 convenience check transactions, 17, totaling $8,890, lacked written authorization needed for issuance. Based on these results, we estimate that $1.7 million[7] of the fiscal year 2002 convenience check transactions lacked written authorization. In addition, we noted that 19 of the 255 convenience check transactions lacked a copy of the check or carbon copy. Based on these results, we estimate that $2.3 million[8] of the fiscal year 2002 convenience check transactions lacked this supporting documentation. Although VA only requires copies of convenience checks to be retained for 1 year, retaining the copies and the supporting documentation for the longer retention period mandated by the FAR and incorporated in VHA's *Records, Control Schedule 10-1*, would facilitate subsequent internal and external reviews in assessing whether a transaction was proper and in compliance with acquisition policies and procedures.

At the time of our work, VHA had also established several timeliness standards for cardholders and approving officials to ensure prompt recording, reconciliation, and review of purchases. Specifically, within 1 workday of making a purchase, cardholders are required to input or record the purchase information in VA's purchase card order system. Within 10 calendar days of electronically receiving the transaction charge information from Citibank,[9] the cardholder must reconcile 75 percent of

[6]48 C.F.R. § 4.805. See also General Records Schedule 3, Transmittal No. 8 (December 1998).

[7]We are 95 percent confident that the total dollar value of convenience check transactions that lacked written authorization was between $.8 million and $2.7 million.

[8]We are 95 percent confident that the total dollar value of convenience check transactions that lacked a copy of the check or carbon copy was between $1.2 million and $3.4 million.

[9]Citibank issues purchase cards to VA operating administrations, including VHA.

these Citibank charges to the purchase information in the system. Within 17 calendar days, 95 percent of the Citibank charges must be reconciled. As evidence of reconciliation, the purchase card order system assigns the date the cardholder reconciled the purchase in the system. For testing the timeliness of cardholder reconciliations, we used the 17 calendar day criteria. In addition, VHA requires that within 14 calendar days of electronically receiving the cardholder's reconciled purchases, the approving official, through an electronic signature, certify in the purchase card order system that all procurements are legal and proper and have been received.[10]

Our review found untimely recording, reconciliation, and approving official review. Table 1 summarizes the statistical results of VHA's timeliness standards that cardholders and approving officials must meet to ensure prompt recording, reconciliation, and review of purchases. Our work shows that the internal controls were not operating as intended to ensure prompt recording of transactions and events.

[10]VA revised its timeliness standards in the agencywide government purchase card procedures issued April 4, 2003. Specifically, cardholders are now required to reconcile all of their purchases within 5 working days instead of 10 calendar days. VA has removed the incremental reconciliation goals of 75 percent of the purchases within 10 calendar days and 95 percent within 17 calendar days. Also, VA converted the 14 calendar days formerly allotted to approving officials for review and certification to 10 working days.

Table 1: Summarization of VHA Timeliness Standards Exceptions

VHA timeliness tests of purchase card order system	Number of sample transactions in error	Estimated total number of transactions in error	Confidence interval at a 95 percent confidence level	Estimated dollar value of amount in error (in millions)	Confidence interval at a 95 percent confidence level (in millions)
Purchase card orders were entered within 1 day	36	289,352	164,100 – 458,414	$152.5	$99.9 – $205.1
Cardholder reconciliation within 17 days	53	351,256	216,683 – 522,909	$252.7	$184.4 – $321.0
Approving official certification within 14 days	44	308,448	181,930 – 475,207	$212.4	$149.2 – $275.7

Source: GAO.

Note: GAO's estimate of the audit results for 283 sampled transactions selected to test VHA timeliness standards for fiscal year 2002. The population total of transactions from which this stratified random sample was selected was 1,884,695.

The following examples illustrate the extent of untimely recording, reconciliation, and review of the purchase card transactions. For instance, one cardholder made a purchase on July 9, 2002, of $994, but did not record the information in VA's purchase card order system until August 29, 2002—51 days later and 50 days after VHA policy required that the information be entered. Another cardholder made a purchase of $100 on August 24, 2002. Citibank sent charge information for this purchase to VHA on October 8, 2002. According to VHA policy, the cardholder should have reconciled this charge within 17 days. Instead, we found that the account was not reconciled until September 8, 2003, or 335 days after receiving the charge information. In another instance, a cardholder reconciled a purchase card transaction totaling more than $3,000, which should have been reviewed and certified by an approving official within 14 calendar days. We found no evidence that the approving official reviewed this cardholder's reconciliation until 227 days later. It is critical that cardholders and approving officials promptly record, reconcile, and review purchase card transactions so that erroneous charges can be quickly disputed with the vendor and any fraudulent, improper, or wasteful purchases can be quickly detected and acted upon.

We also found instances where cardholders did not consistently take advantage of vendor-offered purchase discounts. Our review identified 69 invoices containing vendor-offered discounts totaling $15,785 that were not taken at the time of purchase or subsequently credited for the discount

amount. When purchases are made, vendors may offer purchase discounts if buyers make early payments of their invoices. Typically, the vendor specifies a period during which the discount is offered, but expects the full invoice amount for payments made after that period. When cardholders use the purchase card, payment to vendors, via Citibank, generally occurs at the time of purchase. In turn, Citibank bills VA for the purchases through a daily electronic file. Therefore, it is critical that cardholders ask about any vendor-offered discounts at the time of purchase and make efforts to obtain a credit upon receipt and review of the invoice. Our detailed testing indicated that VHA did not always take advantage of vendor-offered discounts and that it lacked purchase card guidance to ensure cardholders ask about vendor payment terms to determine whether discounts were being offered.

For example, one vendor offered VHA a discount of 2.9 percent, or $896, for an invoice amount of $30,888 if it was paid within 15 days. Citibank, on behalf of VA, made payment to the vendor within the 15-day time frame, yet the vendor charged the cardholder's account for the full invoice amount. We found no evidence that the cardholder attempted to obtain a credit for the available discount offered. In another example, we found that a cardholder had taken advantage of the vendor-offered discount.

A factor that may contribute to cardholder inconsistencies in taking advantage of vendor discounts is the lack of established policies and procedures that address this issue. We found that VHA's purchase card guidance did not include procedures to ensure that cardholders take advantage of available vendor discounts before making payments or require that approving officials identify instances when cardholders did not take advantage of vendor discounts in order to determine the frequency of these occurrences. Without such guidance, VHA will not be able to determine the frequency of these occurrences and actual dollars lost by the government.

While VHA's purchase card guidance includes prescribed monitoring procedures to help ensure purchases are legal and proper, we found no monitoring procedures to identify active accounts of cardholders who had separated from VA nor any provisions to assess cardholder credit limits. We also noted insufficient human capital resources at the A/OPC level for executing the prescribed monitoring activities. For instance, we identified 18 instances in which purchase card accounts remained active after the cardholders left VA and all related outstanding purchase orders had been reconciled. Of the 18 purchase card accounts that remained active after

the cardholders had left VA, we determined that 14 accounts remained active 6 or more days after the cardholders' outstanding purchase orders had been reconciled, which we deemed too long. The remaining 4 purchase cards had been promptly canceled after all outstanding purchase orders were reconciled.

Of the 14 accounts that were untimely cancelled, 11 accounts remained open between 6 and 150 days and 3 accounts remained open between 151 and 339 days. For example, one cardholder separated from VA on April 3, 2002, with five outstanding purchase card orders made prior to separation. The last purchase transaction was reconciled on May 21, 2002, but the account was not canceled until April 25, 2003, or 339 days after reconciliation. Requiring monitoring procedures to identify active accounts of departed cardholders and to ensure prompt closure once outstanding purchase orders have been reconciled would assist in reducing the risk of fraud, waste, and abuse that could occur when accounts remain open beyond the necessary time frame.

In addition to accounts left open, our analysis of purchases VHA cardholders made in 2002 showed that cumulatively they bought $112 million of goods and services per month on average, but they had credit limits of $1.2 billion, or about 11 times their actual spending. According to VHA's purchase card guidance, the approving official, in conjunction with the A/OPC, billing officer, and head of contracting activity, recommends cardholder single purchase and monthly credit limits. However, we found no guidance on what factors to consider when recommending the dollar amounts to be assigned to each cardholder. Further, we found no monitoring procedures that require the A/OPC or approving official to determine periodically whether cardholder limits should be changed based on existing and expected future use.

Periodic monitoring and analysis of cardholders' actual monthly and average charges, in conjunction with existing credit limits would help VHA management make reasonable determinations of cardholder spending limits. Without adequate monitoring, the financial exposure in VHA's purchase card program can become excessive when its management does not exercise judgment in determining single purchase and monthly credit limits. During our review, for instance, the difference between the monlthly cumulative credit limits of $1.2 billion and actual spending of $112 million represents a $1.1 billion financial exposure. Limiting credit available to cardholders is a key factor in managing the VHA purchase card

program, minimizing the government's financial exposure, and enhancing operational efficiency.

Furthermore, VHA has not provided sufficient human capital resources to enable monitoring of the purchase card program. One key position for monitoring purchases and overseeing the program is the A/OPC. While the A/OPC position is a specifically designated responsibility, we found in many instances that the A/OPC also functioned in another capacity or performed other assigned duties, for example, as a systems analyst, budget analyst, and contract specialist. Of the 90 A/OPCs who responded to a GAO question regarding other duties assigned, 55 A/OPCs, or 61 percent, reported that they spend 50 percent or less of their time performing A/OPC duties. For example, at the extreme low end of the scale, one A/OPC responded that he was also the budget analyst and that he spends 100 percent of his time on budget analyst duties, leaving no time for A/OPC duties on an ongoing basis. Given that VHA makes millions of purchase card and convenience check transactions annually, which in fiscal year 2002 exceeded $1.4 billion, it is essential that VHA management devote adequate attention to monitoring its purchase card program to ensure that it is properly managed to reduce the risk of fraud, waste, and abuse.

Noncompliance with Purchasing Requirements Resulted in Instances of Improper Purchases

The lack of adequate internal controls resulted in numerous violations of applicable laws and regulations and VA/VHA purchase card policies. We classified purchases made in violation of applicable laws and regulations or VA/VHA purchase card policies as improper purchases. We found violations that included purchases for personal use such as food or clothing, purchases that were split into two or more transactions to circumvent single purchase limits, purchases over the $2,500 micro-purchase threshold that were either beyond the scope of the cardholder's authority or lacked evidence of competition, and purchases made from an improper source. We also found violations of VA/VHA policy that included using convenience checks to pay for purchases even though the vendor accepted the government purchase card, convenience check payments that exceeded established limits, and purchases for which procurement procedures were not followed. While the total amount of improper purchases we identified, based on limited scale audit work, is relatively small compared to the more than $1.4 billion in annual purchase card and convenience check transactions, we believe our results demonstrate vulnerabilities from weak controls that could have been exploited to a much greater extent.

For instance, from the nonstatistical sample, we identified 17 purchases, totaling $14,054, for clothing, food, and other items that cardholders purchased for personal use. Items that are classified as personal expenses may not be purchased with appropriated funds without specific statutory authority. The FAR emphasizes that the governmentwide commercial purchase card may be used only for purchases that are otherwise authorized by law or regulation.[11]

We identified eight purchases totaling $7,510, in the nonstatistical sample that were subject to procurement from a mandatory source of supply but were obtained from other sources. Various federal laws and regulations, such as the Javits-Wagner-O'Day Act (JWOD), require government cardholders to acquire certain products from designated sources. The JWOD program generates jobs and training for Americans who are blind or have severe disabilities by requiring that federal agencies purchase supplies and services furnished by nonprofit agencies, such as the National Industries for the Blind and the National Institute for the Severely Handicapped.

We noted that cardholders did not consistently purchase items from JWOD suppliers when they should have. For example, a cardholder purchased day planner starter kits and refills for employees, totaling $1,591, from Franklin Covey, a high-end office supply store. These items provide essentially the same features as the JWOD items, which would have cost $1,126, or $465 less. During our data mining, we noted that VHA made 652 purchases totaling $76,350 from Franklin Covey during 2002. While we did not review all of the individual purchases, based on our detailed testing of similar transactions, it is likely that many of them should have been procured from a mandatory source at a much lower cost.

Using data mining techniques, we identified purchases that appeared to have been split into two or more transactions by cardholders to circumvent their single purchase limit. We requested documentation for a statistically determined sample of 280 potential split transactions totaling $4 million. Of these 280 transactions, we determined that 49 were actual splits. Based

[11] 48 C.F.R. § 13.301 (a).

on these results, we estimate that $17.1 million[12] of the total fiscal year 2002 purchase card transactions were split transactions.

For example, a cardholder with a single purchase limit of $2,500 purchased accommodations in 110 hotel rooms totaling $4,950. When performing follow-up, the cardholder stated that VA provides lodging accommodations for veterans receiving medical services such as radiation therapy, chemotherapy, and day surgery who live at least 150 miles from the medical facility. The cardholder created two separate purchase orders and had the vendor create two separate charges, one for $2,500 and the other for $2,450, so that the purchase could be made. On the documentation provided, the cardholder stated the "purchase was split per the direction of the previous purchase card program administrator." The cardholder also stated that currently, her purchase card at that facility is no longer used to pay hotel lodging for veterans. Hotel payments are now disbursed electronically via VA's Financial Service Center. The purpose of the single purchase limit is to require that purchases above established limits be subject to additional controls to ensure that they are properly reviewed and approved before the agency obligates funds. By allowing these limits to be circumvented, VA had less control over the obligation and expenditure of its resources.

The FAR provides that the purchase card may be used by contracting officers or individuals who have been delegated micro-purchase authority in accordance with agency procedures.[13] Only warranted contracting officers, who must promote competition to the maximum extent practical, may make purchases above the micro-purchase threshold using the purchase card. Contracting officers must consider solicitation of quotations from at least three sources,[14] and they must minimally document the use of competition or provide a written justification for the use of other than competitive procedures.[15] When cardholders circumvent these laws and regulations, VHA has no assurance that purchases comply with certain simplified acquisition procedures and that cardholders are

[12]We are 95 percent confident that the total dollar value for actual split purchase card transactions was between $12.4 million and $21.9 million.

[13]48 C.F.R. § 13.301 (a).

[14]48 C.F.R. § 13.104.

[15]48 C.F.R. § 13.106-3(b).

making contractual commitments on behalf of VHA within the limits of their delegated purchasing authority.

From the statistical sample of purchases over $2,500, we found that for 19 of the 76 transactions, cardholders lacked warrant authority needed to make these types of purchases. Based on these results, we estimate that cardholders with only micro-purchase authority, made $111.9 million[16] of the total fiscal year 2002 purchases that exceeded $2,500. In addition, we found that 12 of the 76 transactions lacked evidence of competition. Based on these results, we estimate that $60 million[17] of the total fiscal year 2002 purchases totaling more than $2,500 lacked evidence of competition.

We identified 23 purchase card transactions totaling $112,924 in the nonstatistical sample related to the rental of conference room facilities used for internal VA meetings, conferences, and training. For these purchases, the cardholders could not provide documentation to show that efforts had been made to secure free conference space. VA's acquisition regulations state that rental conference space may be paid for only in the event that free space is not available, and require that complete documentation of efforts to secure free conference space be maintained in the purchase order file.[18] For one purchase, VHA paid $31,610 for conference room facilities and related services for 3 days at the Flamingo Hilton Hotel in Las Vegas. The cardholder provided no evidence that attempts to secure free facilities had been made. In addition, of the 23 purchase card transactions cited, 12 purchases totaling $103,662 occurred at one VHA facility. This included one transaction totaling $12,000 for a 3-day training course on Prevention and Management of Disruptive Behavior at the MGM Grand Hotel in Las Vegas. Again, we were not provided evidence that efforts had been made to secure free conference space.

We identified improper use of convenience checks related to purchases that exceeded VA's established limits of $2,500 and $10,000 and payments to vendors who accept the purchase card payments. VA's convenience check

[16]We are 95 percent confident that the total dollar value for purchases over $2,500 made by nonwarranted cardholders was between $52.8 million and $170.9 million.

[17]We are 95 percent confident that the total dollar value for purchases over $2,500 that lacked evidence of competition was between $26.3 million and $93.7 million.

[18]We are 95 percent confident that the total dollar value for actual split convenience check transactions was between $13.6 million and $14.0 million.

guidance requires that a single draft transaction be limited to $2,500 or in some cases $10,000 unless a waiver has been obtained from the Department of the Treasury, restricting convenience check use to instances when vendors do not accept purchase cards. From the statistical testing of convenience check limits, we found that 91 of 105 convenience check purchases were paid using multiple checks because the total purchase amount exceeded the established convenience check limit. Based on these results, we estimate that $13.8 million[19] of the total fiscal year 2002 convenience check transactions were improperly used to pay for purchases exceeding the established limits. In April 2003, VA issued new purchase card guidance providing that for micro-purchases, convenience checks may be used in lieu of purchase cards only when it is advantageous to the government and it has been documented as the most cost-effective and practical procurement and disbursement method. However, we found no established criteria for determining the most cost-effective and practical procurement and disbursement method.

Poor Controls Resulted in Some Wasteful and Questionable Purchases

The ineffectiveness of internal controls was also evident in the number of transactions that we classified as (1) wasteful, that is, excessive in cost compared to other available alternatives or for questionable government need, or (2) questionable because there was insufficient documentation to determine what was purchased. Of the 982 nonstatistical sample transactions we reviewed, 250 transactions, totaling $209,496, lacked key purchase documentation. As a result, we could not determine what was actually purchased, how many items were purchased, the cost of each of the items purchased, and whether there was a legitimate government need for such items. Because we tested only a small portion of the transactions that appeared to have a higher risk of fraud, waste, or abuse, there may be other improper, wasteful, and questionable purchases in the remaining untested transactions.

We identified 20 purchases totaling $56,655 that we determined to be wasteful because they were excessive in cost relative to available alternatives or were of questionable government need. The limited number of wasteful purchases found in the nonstatistical sample demonstrates that cardholders are generally prudent in determining that prices of goods and services are reasonable before they make credit card purchases. We

[19]The Department of Veterans Affairs Acquisition Regulation, Part 870, subpart 113 (VAAR 870.113).

considered items wasteful if they were excessive in cost when compared to available alternatives, and questionable if they appeared to be items that were a matter of personal preference or convenience, were not reasonably required as part of the usual and necessary equipment for the work the employees were engaged in, or did not appear to be for the principal benefit of the government. We identified 18 purchases, totaling $55,156, for which we questioned the government need and 2 purchases, totaling $1,499, that we considered excessive in cost. A majority of the purchases were related to officewide and organizational awards.

Many award purchases were for gift certificates and gift cards. Although VA policy gives managers great latitude in determining the nature and extent of awards, we identified 10 purchases, totaling $51,117, for award gifts for which VHA was unable to provide information on either the recipients of the awards or the purposes for which the recipients were being recognized. Therefore, we categorized these purchases as of questionable government need. For example, we identified two transactions for 3,348 movie gift certificates, totaling over $30,000. For these purchases, the cardholders and A/OPCs could provide neither the award letters nor justification for the awards. Consequently, VHA could provide no evidence that these purchases were actually used for awards.

We also identified two purchases that we considered wasteful because of excessive cost. We identified a cardholder who purchased a $999 digital camera when there were other less costly digital cameras widely available. For example, during the same 6-month period from February 2002 through July 2002, two other cardholders purchased digital cameras for $526 and $550. No documentation was available to show why the more expensive model was necessary. In the second example, we identified a purchase for a 20-minute magic show, totaling $500, that was performed during a VA volunteer luncheon. Although VA policies allow for funds for volunteer events, this expenditure, at roughly $25 per minute, seemed excessive.

We also found questionable purchases. As I discussed earlier, we identified numerous transactions from the statistical samples that were missing adequate supporting documentation on what was actually purchased, how many items were purchased, and the cost of the items purchased. We requested supporting documentation for a nonstatistical sample of 982 transactions, totaling $1.2 million. Of these, we identified 315 transactions, totaling $246,596, that appeared to be improper or wasteful, for which VHA either provided insufficient or no documentation to support the propriety of the transactions.

We classified 250 of these 315 transactions, totaling $209,496, as missing invoices because the cardholders either provided VHA internal documentation but no vendor documentation to support the purchase or provided no documentation at all to support the purchase. VHA internal documentation includes purchase orders, reconciliation documents, and receiving reports. Vendor documentation includes invoices, sales receipts, and packing slips. For 184 of these transactions, totaling $155,429, internal documentation was available but no vendor documentation was available. No documentation at all was available for the remaining 66 transactions, totaling $54,068. These purchases were from vendors that would more likely be selling unauthorized or personal use items. Examples of these types of purchases included a purchase form Radio Shack totaling $3,305, a purchase from Daddy's Junky Music totaling $1,041, a purchase from Gap Kids totaling $788, and a purchase from Harbor Cruises totaling $357.

An example of a transaction with internal documentation but no vendor documentation included a purchase from Circuit City where the cardholder stated that the purchase was for three $650 television sets and three $100 television stands, totaling $2,300 (including $50 shipping), that were needed to replace the existing ones in the VA facility's waiting area. In another transaction, no vendor documentation was available for a transaction from Black & Gold Beer where the cardholder stated that the purchase of beer was for a patient. The purchase order shows that three cases were purchased at $12.50 each, totaling $37.50. The cardholder stated that the purchase was at the request of the pharmacy for a specific patient; however, no documentation was provided to support this claim. We believe that at least some of the items we identified may have been determined to be potentially fraudulent, improper, or wasteful had the documentation been provided or available. In addition, we noted that of the 66 transactions for which VHA cardholders provided no documentation to support the purchase, 32 transactions (49 percent) represented 2 or more transactions by the same cardholder. For example, one cardholder did not provide documentation for 5 transactions, totaling $5,799, from various types of merchants, including two restaurants, a movie theater, a country club, and an airport café.

For 65 transactions, totaling $37,100, that we characterized as questionable but appeared to be either improper or wasteful, the documentation we received either was not correct or was inadequate, and we were unable to determine the propriety of the transactions. For example, one transaction was for $1,350 to Hollywood Entertainment; however, the purchase order and invoice listed Hear, Inc., as the vendor for closed captioning services.

The cardholder stated that she believed Hollywood Entertainment is an associate company name for Hear, Inc.; however, the company could not provide any documentation to support this statement. Additionally, from our Internet searches of both Hollywood Entertainment and Hear, Inc. we found no information to indicate that these two companies were associated in any way.

We also identified 68 transactions, totaling $31,772, involving the purchase of tickets for sporting events, plays, movies, amusement or theme parks, and other recreation activities for veterans and VA volunteers. The documentation provided for these transactions was inadequate or missing vendor invoices; therefore, we could not determine whether these tickets were used in support of the volunteers or veterans. As a result, we categorized these purchases as questionable. Various programs under VHA, such as Recreation Therapy, Voluntary Services, and Blind Rehabilitation Service, sponsor assorted activities for veterans and VA volunteers. From our review of these types of purchases, we found that VHA does not have procedures in place to ensure that the purchased items were used by the intended recipients and accounted for properly. In most cases, there was inadequate or no documentation to account for how the tickets were distributed and who participated in the events. For example, we found a purchase of 46 tickets, totaling $812, for veterans to attend a Pittsburgh Pirates baseball game. However, we were provided no documentation that identified who received the tickets or who attended the baseball game. Proper accountability over the distribution and receipt of tickets for such events is needed to help ensure that tickets are not improperly used for personal use.

In closing, Mr. Chairman, I want to emphasize that without improvements in its internal controls to strengthen segregation of duties; documentation of purchase transactions; timely recording, review, and reconciliation of transactions; and program monitoring, VHA will continue to be at risk for noncompliance with applicable laws and regulations and its own policies and remain vulnerable to improper, wasteful, and questionable purchases. Our report, which is being released at this hearing, makes 36 recommendations to strengthen internal controls and compliance in VHA's purchase card program to reduce its vulnerability to improper, wasteful, and questionable purchases.

This concludes my statement. I would be happy to answer any questions you or other members of the committee may have.

Contact and Acknowledgments

For information about this statement, please contact McCoy Williams, Director, Financial Management and Assurance, at (202) 512-6906, or Alana Stanfield, Assistant Director, at (202) 512-3197. You may also reach them by e-mail at williamsm1@gao.gov or stanfielda@gao.gov. Individuals who made key contributions to this testimony include Lisa Crye, Carla Lewis, and Gloria Medina.

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STATEMENT OF

THE HONORABLE RICHARD J. GRIFFIN

INSPECTOR GENERAL

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

JUNE 17, 2004

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

HEALTH CARE DELIVERY

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

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

Staffing Standards and Time and Attendance

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

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

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

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

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

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

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

Nurse Staffing

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

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

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

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

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

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

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

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

[1] Coleman, David L. et al, "Measuring Physicians' Productivity in a Veterans Affairs Medical Center", Academic Medicine, Vol. 78, No. 7 pp 1-8.

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

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

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

Time and Attendance Hotlines

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

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

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

- Physicians treated non-VA patients at the affiliated University Medical Center during their scheduled VA time, in some cases working at the university while claiming sick leave or authorized absence from VA. The physicians were inappropriately paid for 75.5 hours ($5,393) when the physicians were at the university treating non-VA patients.

- The Surgery service timekeeper did not always use the subsidiary time and attendance report as the basis for paying the physicians. We identified a net total of 109.25 hours ($7,709) the physicians were paid in excess of the hours they claimed on their subsidiary time and attendance reports.

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

Combined Assessment Program Reviews

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

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

Access to Care and Patient Waiting Time

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

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

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

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

Combined Assessment Program Reviews

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

Health Care Resources Contracts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Review of Biological, Chemical, and Radiological Inventories

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

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

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

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

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

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

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

VHA's Contract Community Nursing Home Program

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

In 2002, we published another report on community nursing homes[3] in which we found that veterans were subjected to abuse in community nursing homes. VHA published a new CNH policy (VHA Handbook 1143.1) on June 24, 2002, and in July of 2002, in response to our CNH report, conducted an internal review of their policy and determined that changes were required. In VHA's response to our testimony last year, they indicated that they had a 25 point plan to further refine their CNH oversight efforts.

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

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

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

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

VHA's Home Health Aide Program

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

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

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

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

Health Care Investigations

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

Albany Oncology Research

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

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

Oakland Park Out-Patient Clinic

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

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

Combined Assessment Program Reviews

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

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

BENEFITS PROCESSING

The Veterans Benefits Administration (VBA) reported just under 520,000 total Compensation and Pension (C&P) claims pending, including about 325,000 requiring rating action as of May 1, 2004. However, the number of claims pending rating decisions continues to increase. The timeliness of C&P rating actions that previously averaged 195 days is currently averaging 175 days, demonstrating improvement in the timeliness of claims processing.
In FY 2004, the backlog of claims began to increase primarily because VBA was unable to make decisions on cases as a result of a court decision. This decision invalidated a provision that permitted VA to decide a claim prior to the expiration of the one-year notice in the Veterans Claims Assistance Act. In December 2003, correcting legislation was signed by the President that clarifies VA may make a decision on a claim before the expiration of the one-year notice period.

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

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

Incarcerated Veterans

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

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

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

Fugitive Felon Program

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

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

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

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

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

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

- The Tennessee Bureau of Investigation requested the assistance of my New Orleans office in locating one of their "10 Most Wanted." The veteran was wanted on a state murder charge and a Federal Unlawful Flight to Avoid Prosecution warrant. Investigation resulted in the subject being located and taken into custody in April 2003 without incident at a VA Medical Center.

- A subject who was featured on the television show "America's Most Wanted" was identified as a veteran receiving monthly VA compensation benefits. A federal warrant had been issued for the subject for violating conditions of his pre-trial release on a bank robbery charge. The subject also had abducted and fled with his three-year-old son. Special Agents from my Dallas Office offered their assistance to the FBI and using the new law had the subject's VA benefits terminated. The FBI and local law enforcement officers subsequently apprehended the subject in September 2003 in another state. The child was returned unharmed to his mother.

- A case containing limited information was referred to my Dallas Field Office for further investigation. Our investigators determined that the fugitive, who was wanted for a double homicide that had occurred in 1975, had used an innocent veteran's social security number. During the course of the investigation, we determined the location of the fugitive and forwarded this information to a U.S. Marshals Fugitive Felon Task Force. The information provided led directly to the subject's location, and in May 2003, the subject was taken into custody.

- Special Agents from my Newark Office and Deputy U.S. Marshals apprehended a veteran fugitive felon wanted on an outstanding arrest warrant for murder. The subject recently had been charged with intentionally causing the death of another by stabbing. The subject was apprehended in July 2003 at a VA outpatient clinic in Philadelphia.

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

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

Death Match Project

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

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

San Juan VA Regional Office Benefits Review

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

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

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

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

- On November 7, 2003, VA sent the first letter to all 45,200 beneficiaries whose benefits awards were being administered by the VARO in San Juan.

- On January 12, 2004, a second letter was mailed to approximately 12,600 beneficiaries who failed to return the first questionnaire or improperly completed the form.

- On April 16, 2004, the San Juan VARO sent a third letter, composed in its entirety in English and Spanish, to 3,751 beneficiaries who had not responded to the previous two letters. As of May 14, 2004, only 1,760 beneficiaries failed to respond to the any of the three letters.

- On May 18, 2004, the OIG sent letters to 3,330 beneficiaries scheduling interviews at the San Juan VARO between June 14, 2004, and July 23, 2004.

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

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

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

Income Verification Match

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

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

Workers' Compensation Program

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

VA continues to be at risk for significant Workers' Compensation Program (WCP) abuse, fraud, and unnecessary costs because of inadequate case management and fraud detection. Prior OIG audit[5] recommendations to enhance the Department's case management and fraud detection efforts, and avoid inappropriate dual benefit payments[6] were not fully implemented. Additionally, our most recent audit found that VA's WCP costs are being impacted because of employee injuries associated with violent patient incidents. VA is also at risk for unnecessary WCP costs due to lack of action/response on case inquiries to the Department of Labor (DOL), who administers the Federal Employees' Compensation Act (FECA).

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

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

Ineffective WCP case management and program fraud results in potential unnecessary/inappropriate costs to the Department totaling $42.7 million annually. These costs represent significant potential lifetime[7] compensation payments to claimants totaling $696.2 million. Additionally, an estimated $112.6 million in avoidable past compensation payments were made that are not recoverable because employees who were able to come back to work were not offered jobs by VA.

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

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

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

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

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

Additionally, VA has not implemented our prior audit recommendation to collect and use Continuation of Pay[8] (COP) data for monitoring potential WCP cost and employee health and safety issues. VA needs to collect information and monitor actions taken to controvert[9] COP and/or dispute questionable claims. Use of this data could provide for more effective WCP Department-wide oversight, management, and cost containment.

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

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

Benefits Investigations

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

Compensation Fraud at Bay Pines VA Regional Office

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

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

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

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

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

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

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

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

Tuition Assistance Top-Up Scheme

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

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

FINANCIAL MANAGEMENT SYSTEMS

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

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

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

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

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

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

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

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

Medical Care Collection Fund

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

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

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

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

PROCUREMENT PRACTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pre-award Reviews with Recommendations to Reduce Contract Costs

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

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

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

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

Post-Award Review Recovery

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

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

Purchase Card Activities

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

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

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

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

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

Contracting for Construction

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

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

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

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

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

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

Procurement Fraud Investigations

Pharmaceutical Off-Label Drug Promotion

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

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

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

New Orleans Bribery Scheme

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

INFORMATION MANAGEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Questions for the Record
Honorable Christopher H. Smith, Chairman
Committee on Veterans' Affairs
June 17, 2004

Follow-up Hearing on Efforts to Identify and Eliminate Fraud, Waste, Abuse and Mismanagement in Programs Administered by the Department of Veterans Affairs

Question 1: Mr. Mansfield, on pages 40 and 41 of a VA paper the Committee received on June 16, 2004, the Department reviewed the history of VHA's so-called "long term care model," originally intended to serve as a way to forecast future VA bed needs for long term care services, including nursing home beds. The paper indicates the following: *"However, at this time, we are unable to say with certainty when the model will be finalized and released to the Networks for their use."*

Mr. Mansfield, this model is now in its sixth year of development, having been initiated in 1998. The American Civil War and even World War II were completed in less time. The absence of a VA long-term care planning model represents a large gap in the CARES process. Yet the model that might accurately forecast needs for the current bed level, or for more beds as I believe are necessary, is incomplete.

- Do you foresee VA ever completing this model?
- Will you commit to this Committee a serious effort to get that model into place?
- Will you provide us milestones to indicate when the model will be completed? When might we expect to receive those milestones?

Response: The current long-term care model now provides us with the enrollee demand estimates for nursing home care and home and community-based care. Therefore, to a large extent it is complete and in place to provide estimates for network planning purposes. However, the process is iterative. This means that we will incorporate new data and methods into the model, either annually or as they become available. These data and methods will continuously improve its predictive capability.

The Secretary is currently considering long-term care demand policy options that are clinically sound, fair for veterans and can be modeled for network planning. We will notify the Committee upon resolution of that policy proposal. Current plans are to provide policy guidance and model projections (based on current model outputs adjusted for policy) to VISNs by October 1, 2004, in order for them to generate their strategic plans and identify their operational needs.

Question 2: Pursuant to Public Law 106-117, VA contracted with Logistics Management Institute (LMI) to conduct an assessment of the current and future burial needs of veterans. Volume 2, entitled "National Shrine Commitment", was a study on improvements to national cemeteries.

As you know, LMI examined the conditions of each cemetery and recommended a set of standards that NCA can use throughout its system. These standards of appearance fell into two categories — maintenance and burial operations — and identified standards for headstones, turf and other groundcover, horticulture, facilities, floral tributes, neatness, personnel and safety. LMI's overall assessment identified the need for 928 projects totaling more than $279 million.

The Committee is concerned that OMB determined, through its Program Assessment Rating Tool (which I cited in my opening statement), that while VA's burial benefits program is rated moderately effective, the Department quote lacks a way to define and measure national shrine commitment needs and performance.

From this finding, it appears the NCA is not using, in whole or in part, LMI's recommended standards for restoration and improvement projects, despite $25 million in funding to enhance the appearance of cemeteries.

Mr. Mansfield, would you please explain your efforts in this regard?

Response: VA is committed to ensuring that each of our 120 national cemeteries is maintained as shrines dedicated to honoring the service and sacrifice of veterans, preserving our nation's history, and nurturing patriotism. Funds appropriated by the Congress have been effectively used to serve this purpose. We have directed these resources to projects to enhance cemetery appearance, including the cleaning, raising and realigning of headstones and markers, and the renovation of turf.

The Program Assessment Rating Tool (PART) review of VA's burial programs was conducted in 2002. Since that time, the National Cemetery Administration (NCA) has implemented its plan to ensure the appearance of our national cemeteries meets the highest standards.

The LMI study recommended standards of maintenance and appearance commensurate with cemeteries considered "the finest in the world." Using the recommendations in the LMI study and building on previous efforts, VA has established standards and measures by which NCA can determine the effectiveness and efficiency of its operations. These standards and measures, which include performance expectations in key operational processes, including interments, grounds maintenance, headstones and markers, facilities maintenance, and equipment maintenance, were published and disseminated to all national cemeteries in January 2003.

NCA has also developed and implemented an Organizational Assessment and Improvement (OAI) Program to assess national cemetery performance in meeting operational standards and strengthen program accountability. This program is founded on the proven principles of organizational excellence found in the Malcolm Baldrige Award and VA's Robert W. Carey Award and incorporates, for national cemeteries, NCA's operational standards and measures. As part of the OAI program, assessment teams will continue to conduct site visits to all national cemeteries on a rotating basis to validate performance reporting.

In the fiscal year 2005 VA performance plan, NCA identified additional performance measures that will be used for assessing the cleanliness, height and alignment of headstones and markers and the ground condition of individual gravesites (sunken graves). NCA has developed a methodology and is currently collecting baseline data for these new performance measures. Having defined standards and a formal assessment process are proving to be valuable tools in assisting NCA in meeting its mission.

Question 3: Mr. Mansfield, we have been suggesting for many years that VA needs much more sophisticated measures to assess whether the Montgomery GI Bill is meeting its objectives. Specifically, we believe it is essential to know what percentage of eligible veterans are successful in achieving their stated educational objective. It's wholly misleading to simply look at how many veterans ever used the program. When will VA have these revised evaluative criteria in place?

Response: We have identified some possible education outcome measures and are currently working with our partners to test and validate them. These measures directly relate to achievement of educational objectives, as well as with overall customer satisfaction with veterans education training programs.

We anticipate that within the next 12 months we will have an education outcome measure(s) in place that will enable us to effectively assesses whether the Montgomery GI Bill is meeting its objectives.

Question 4: Mr. Mansfield, with respect to the Montgomery GI Bill and other VA educational assistance programs, VA's Fiscal Year 2002 Performance and Accountability Report noted that of 1,540 cases reviewed, 100 had payment errors and 340 had service errors.

What actions has the Department taken to reduce these kinds of errors?

Response: Significant improvements have been made in the quality of education benefit claims processing:

Quarterly Education Service quality reviews identified error trends and causes. This information is used by Regional Processing Offices in conducting refresher training. This training has been effective in reducing errors in all but the area of due process notification.

Education Service has recently completed development of standardized training materials for due process notification, which has been in use beginning in July 2004 to improve performance in this area.

As a consequence of these actions and a heightened emphasis on quality, we can report the following improvements in the data we collect.

- Of the 1,573 cases reviewed in FY 2003, there were 86 decisions with payment errors and 282 with service errors (some cases had more than one service error). The number and percentage of both payment and service errors was lower than in the previous fiscal year.

- From FY 2002 to FY 2003, payment accuracy improved from 92.6 percent to 93.5 percent, and service accuracy improved from 84.5 percent to 89.7 percent.

- Error rates for all types of service errors except due process notification were lower in FY 2003 than in the previous fiscal year. We anticipate that the error rate for due process notification will improve significantly following the introduction of the training materials mentioned above that are now being made available on-line to our employees.

Question 5: VA data show that customer satisfaction in the vocational rehabilitation program has remained essentially stagnant over the past five fiscal years. Nearly one of four customers is unhappy with this program. Why customers dissatisfied and what are are the Department's plans to make them satisfied customers?

Response: The data cited in this question is from the 2002 Customer Satisfaction Survey, the most recent survey completed for VR&E. In 2002, 76.7% of respondents were very or somewhat satisfied with the VR&E program as a whole, as compared to 76.4% in 2001. The statement is essentially correct for the customer satisfaction measure that is shown in the annual performance report--that is, the percent who are very or somewhat satisfied with the program as a whole--ranges from 76.4 (1999), 74.0 (2000), 76.4 (2001) to 76.7 (2002). However, it is not correct to say that the complement of this number is necessarily unhappy with the program. The remainder are either neutral (neither satisfied nor dissatisfied) or somewhat or very dissatisfied with the program.

Looking at the components of the 2002 survey: 82.4% of the respondents were very or somewhat satisfied with the evaluation process; 86.2% of the

respondents were very or somewhat satisfied with the rehabilitation process; 90.1% of the respondents reported that they were very or somewhat satisfied that VR&E counselors completely understood their feelings and concerns during the evaluation phase of the program; 94.6% of the respondents reported that they were very or somewhat satisfied that VR&E counselors were responsive to their needs during the rehabilitation phase of the program. However, in this same 2002 survey 92.1% of the respondents stated they would recommend this program to other disabled veterans.

VR&E will be implementing many of the recommendations from the recently completed VR&E Task Force. Redesigning the delivery of services to veterans by creating a 5-Track Employment Model is one of the major Task Force recommendations that VR&E is currently planning for and implementing. This model puts employment upfront and embraces access, customer choice, and service integration, which should enhance customer satisfaction with the VR&E program.

In addition to the typical VBA customer satisfaction survey, VR&E Service is working with the Office of Policy and Program Planning to develop another survey. This survey will focus on veterans who have exited the program prior to completion. The goal will be to determine the reasons for exiting and develop strategies to improve this drop out rate.

Question 6: The Veterans Benefits Administration as an entity is not designed for the work of personalized, face-to-face, long-term service delivery as necessary, for example, in rehabilitation medicine, psychological services, including post –traumatic stress disorder, vocational assessment, planning and rehabilitation, lifetime sustained employment, and independent living.

Many of the links vital to successful vocational rehabilitation and employment reside in the VHA, such as rehabilitation medicine, blind rehab services, prosthetics and sensory aids services, substance and alcohol abuse assistance, etc. Would the service delivery of the Vocational Rehabilitation and Employment Service function more efficiently as a part of an umbrella group within VHA?

Response: Vocational rehabilitation is a unique discipline that requires trained professionals to deliver services. VBA's rehabilitation professionals are required to meet strict qualification standards that ensure that they have sufficient academic and supervised work experience in the field of rehabilitation. The minimum qualification standards include a master's degree in vocational rehabilitation or a closely related field. As the main goal of the VR&E program is suitable employment and VHA primarily focuses on the treatment, healing, or curing of medical conditions, VHA may not be an ideal place to administer the VR&E program.

The recent VR&E Task Force, which included outside experts in rehabilitation, considered whether or not VR&E should be moved to VHA. They decided it was best placed under VBA. They determined that any weaknesses in the VR&E program would not be solved by transferring the program to VHA. In fact, transferring VR&E to VHA, which is a larger and perhaps more complex organization, might create additional problems for the VR&E program. Instead the Task Force recommended that the partnership between VR&E/VBA and VHA be strengthened. Specifically, VR&E is currently working on a memorandum of understanding (MOU) with VHA on priority services for veterans participating in the VR&E program; partnering with VHA's Compensated Work Therapy program (CWT) on providing appropriate services to Chapter 31 veterans and VR&E will be working closely with VHA to ensure that Independent Living services are properly coordinated.

VR&E partners with other business lines in VBA – namely Compensation & Pension (disability ratings and memo ratings); Loan Guaranty Service (Specially Adapted Housing Program for VR&E's Independent Living participants); and Education Service (common IT systems to gather educational information and award processing activities). VR&E is partnering with the greater disability community including: developing an MOU with the Council of State Administrators of Vocational Rehabilitation (CSAVR); offering training on rehabilitation for individuals with spinal cord injuries in partnership with Virginia Commonwealth University, one of the top 10 rehabilitation educational facilities in the country; and partnering with Department of Labor VETS Program to provide training on Uniformed Services Employment and Re-employment Rights Act (USERRA) – re-employment rights for returning guard and reservists, and training on Special Hiring Authorities.

Question 7: With respect to vocational rehabilitation, in 2002 VA program managers also conducted their own quality reviews on 3,200 vocational rehabilitation cases and found a 19 percent error rate in rehabilitation outcome decisions.

What actions has the Department taken to ensure that veterans in the vocational rehabilitation program are not classified as "rehabilitated" – when in fact they may not have been "rehabilitated"?

Response: The Quality Review Process was re-instituted for VR&E in FY 2002 both a local and national level. The national QA team reviews 65 cases from each Regional Office annually, and VR&E field managers review ten percent of their station's workload. When errors are discovered in the QA process, VR&E staff members are required to take corrective action to include any necessary data corrections. Also, accountability for VR&E outcome accuracy is now included in the performance standards for all Regional Office Directors.

Additionally, VR&E Officers are now required to review and concur in every decision to declare a veteran rehabilitated. Field site surveys have also been re-instituted – any "out of line" situations are validated and explored with the station and training is provided when necessary. A new tool, the Caseload Management Index (CMI), ensures that cases are correctly categorized and are included in the calculation of the rehabilitation rate for the appropriate fiscal year. Effective April 20, 2004, VR&E actions on all of the OIG recommendations contained in the above referenced OIG report have been successfully addressed.

Question 8: The report of the bipartisan Commission on Servicemembers and Veterans Transition Assistance concluded that "the many persistent [then] VA Vocational Rehabilitation and Counseling Service problems are related not to policy, but rather to a history of ineffective management and leadership support...aggressive leadership within VA and VBA could resolve the majority of VR&E's problems".

The Committee notes that 1984 was the last time VA placed a certified rehabilitation professional with requisite experience and management skills in managing the $665 million nationwide vocational rehabilitation and employment program. Most of the individuals running this program since 1984 came from VA's home loan program. Why?

Response: Program management of VR&E has completely changed since the Transition Commission Report of January 1999. VR&E Service has a new director, deputy director, assistant director, and 5 new supervisors. The new VR&E management has built and is continuing to strengthen an effective infrastructure for VR&E to include positions such as Independent Living Coordinator, Senior Policy Analyst, Contracting/Purchasing Specialist, Training and Outreach Coordinator, Employment Services Supervisor, Budget and Data Supervisor, Quality Assurance and Survey Supervisor and Rehabilitation Services Supervisor. The last Service Director with a Vocational Rehabilitation background, Dr. Dennis Wyant, served until 1994. After Dr. Wyant, Mr. Larry Woodard, a former Regional Office Director served as Director of the VR&E Service, and following Mr. Woodard, Mr. Julius Williams, was an Assistant Regional Office Director at the Washington Regional Office, before becoming Director of VR&E Service. The current Director, Ms. Judy Caden is most recently from the Education Service where she successfully served as Director for nearly two years. Ms. Caden is a seasoned manager, with an impressive and successful record and is considered one of VBA's top managers. Ms. Caden has as her Deputy, Dr. Jerry Braun, a Certified Rehabilitation Counselor, and former VR&E Officer with over 30 years of rehabilitation experience. Together Ms. Caden and Dr. Braun form a very strong management team for VR&E and are well received by VBA and VR&E staff, and the greater disability community.

Question 9: Mr. Mansfield, your written statement describes a rosy picture of current VA compliance with the part-time VA physician timekeeping matter that

so preoccupied us last year. But Inspector General Griffin's written statement, in its 2004 follow up on page 5, still shows potentially wide gaps in compliance. Can you explain these differences between your statement and Mr. Griffin's?

Response: The OIG reported that most part-time physicians were on duty as required. However, 58 of 729 part-time physicians (8 percent) who were scheduled for duty were not on duty, approved leave, or authorized absence. Specifically, OIG located 43 of the 58 who were not on duty. The OIG also found written agreements for 1,484 of the 1,519 part-time physicians (98 percent) at 15 VA medical centers visited. However, only 230 physicians (15 percent) had agreements that specified the amount of time allotted for clinical, administrative, research, and educational activities, as required for each part-time physician.

The Veterans Health Administration concurred with these findings. VHA has now incorporated part-time physician time and attendance into the performance reviews of VISN and facility Directors. Facility Directors are also required to audit the time and attendance of their part-time physicians (a random and statistically significant sample) and to submit the results of those audits and corrective actions taken to the Office of the Deputy Under Secretary for Operations and Management on a monthly basis.

A revised VA policy on part-time physician time and attendance has been developed and will be issued following development of required changes to VA's Electronic Time and Attendance (ETA) system. It is anticipated that those changes will be complete by May 2005. In the meantime, however, VHA will be conducting a pilot program to ensure a smooth transition to these new policies and procedures.

Question 10: Mr. Mansfield, in your testimony, you did not address the continuing lack of VHA staffing standards for VA physicians and nurses that Congress required in Public Law 107-135, although the IG testimony indicates VHA is finalizing a standard for one group – primary care physicians.

- What is the Administration doing to address this requirement, especially in light of its importance in several areas indicated in Mr. Griffin's statement?

Response: A draft directive on staffing guidelines for VHA health care providers has been developed and is currently under Departmental review. We hope to have the directive completed by October 2004.

On July 6, 2004, VHA Directive 2004-031 "Guidance on Primary Care Panel Size" was published and distributed to the field for implementation. This policy establishes the requirement that VHA primary care practices establish maximum panel sizes for all primary care providers.

VHA continues to work on a model for productivity for specialty care providers. Recent guidance employs a model that directly measures clinical work using standard Relative Value Units as the numerator and physician FTEE as the denominator. This methodology offers the possibility for VHA to benchmark to the private sector, and establish internal benchmarks to allow systematic performance monitoring.

Concurrently, VHA has also been looking at a population-based model, Automated Staffing Assessment Model (ASAM III), developed by the United States Army Medical Command (MEDCOM).

We expect to have a final analysis developed by late 2004 for review by the Undersecretary for Health.

Question 11: The IG has highlighted several areas that touch on employment of nurses. While providing no detail, his statement hints that VHA needs to make significant changes in recruitment and retention efforts related to nurses.

- ***Do you agree with Mr. Griffin that these improvements need to be made?***

Response: We concur with Mr. Griffin that nursing recruitment and retention must continue to be a priority for VHA. And, we believe these efforts must be continually reevaluated for their efficacy and redesigned when necessary.

- ***Can you give us a perspective on what you would propose to improve recruitment and retention of VA nurses? Please provide recommendations that respond to the VA's shortfalls in these areas.***

Response: Several recruitment and retention initiatives are underway:

1. The development of a new nurse-specific recruitment campaign through a national advertising contract to identify both the market conditions that impact nursing shortages and the key issues related to a successful nurse recruitment campaign.

2. The employment of diverse recruiting strategies including internet sites (e.g., VA Careers.com); newspaper ads, job fairs, and posting vacancy announcements at Schools of Nursing on the internet and through internal announcements.

3. The funding of recruitment and relocation bonuses. Example: In FY 2003, recruitment bonuses averaging $4,627 were paid to 966 new hires to attract RNs to work in the VA. In addition, 60 relocation bonuses averaging $5,111 each were granted to attract current Federal employees to accept positions as RNs with VA.

4. The funding of retention bonuses. Example: In FY 2003, retention allowances on the average $4300 were paid to 2,169 RNs (5.6 percent of all RNs in VA.)

5. The continued appropriation of education scholarship programs like the Employee Incentive Scholarship and Debt Reduction programs (approximately $10 million) and the VA Nursing Education Employment Program (approximately $16.9 million) that assist VA nurses to continue their professional education.

6. The Office of Nursing Services is directing several initiatives to standardize staffing policies, and improve quality of care and the work environment. Some of these are:

a. To develop and implement formal plans that link staffing levels and staff mix with patient outcomes
b. To establish reliable data collection for indicators that impact patient outcomes [the VA Nursing Outcomes Database (VANOD)]
c. To ensure that nurse work hours (including overtime hours) are monitored and issues appropriately addressed to evaluate their impact on retention, job satisfaction and recruitment.
d. To provide employees at the point of care with greater input into staffing decisions.

7. VA also has before Congress a legislative proposal allowing enhanced flexibility in scheduling tours of duty for registered nurses. The ability to offer compensation, employment benefits and working conditions comparable to those available in their community is critical to our ability to recruit and retain nurses, particularly in highly competitive labor markets and for hard-to-fill specialty assignments. We are pleased to note that H.R. 4231 contains our flexible scheduling proposals.

Question 12: In VA hospitals where VHA handbook 1600.3 is present, the issue of absentee doctors is less of a problem and they are fewer in number. Why is this Handbook not available at all VA hospitals?

- If it is available, why isn't it being utilized?
- How is VA tracking this to find out if the Handbook is being given to all facilities and that it is being used by those facilities?

Response: On July 15, 2004, the Deputy Under Secretary for Health sent a memorandum to the field again re-emphasizing the need to comply with VHA Handbook 1660.3. Along with the memorandum, an acknowledgement form

Management Efficiencies achieved by VISNs during FY 2003 amounted to $372 million. This was approximately $56 million above the FY 2003 budget goal of $316 million. These were achieved in the following areas:

Pharmacy Savings	$ 134.8 m
Equipment and Supplies	$ 66.3 m
Productivity	$ 42.7 m
Competitive Sourcing	$ 15.1 m
VA / DOD	$ 14.0 m
Administrative, Inventory and Other	$ 99.1 m
Total for FY 2003	$ 372.0 m

Anticipated Management Savings/Efficiencies for FY 04

National Contract / Procurement Efficiencies for Pharmacy, Prosthetics and Other Medical Supplies	$ 400 m
Procurement Efficiencies for equipment and other general supplies and materials	$ 80 m
Productivity Improvements	$ 50 m
Savings from Consolidations of Services, Administrative efficiencies, IT, Improved inventory practices and other	$ 30 m
Savings from local VA / DOD Sharing	$ 18 m
Plus recurring from FY 03	$ 372 m
Total for FY 2004	$ 950 m

The above combined with approximately $372 million in recurring efficiencies from FY 03 are expected to result in about $ 950 million in total management efficiencies for FY 04. As of the third quarter of FY 2004 the reported totals, including the recurring savings from FY 2003, come to some $752 million, which represents 79% of our budgeted goal of $950 million. Thus, we believe that we are well on the way to achieving our targeted savings. We will have a final report for FY 2004 sometime in late October.

Were each of the management savings made in FY 2003 and FY 2004 recurring changes that will continue in each succeeding year?

Response: Management savings achieved for 2003 and anticipated management savings during FY 2004 are considered to be recurring savings.

Exactly how will you achieve these additional savings in FY 2005?

Response: Per the FY 2005 President's budget submission, VA expects to achieve the net increase of $340 million through further improvements in standardization policies for the procurement of pharmaceuticals, supplies and materials, productivity improvements, and other operational efficiencies such as sharing agreements.

Question 21: In your FY 2004 budget submission made last March, VA endorsed the proposal that VA be made a preferred provider for all HMOs and PPOS so that VA could be reimbursed for services provided to their enrollees who use VA facilities. VA estimated that this could save VA $69M per year.

Secretary Principi again endorsed this proposal in a letter dated June 12, 2003, stating that "the Department strongly favors Section 2 of the bill" (HR 1562) ..."that would be a significant enhancement to VA's collection authority."

Does VA continue to support this proposal that could save VA $500 million or more over the next 10 years?

Response: Yes, VA continues to support the proposal.

Management Savings/Efficiencies Achieved for FY 03

Management Efficiencies achieved by VISNs during FY 2003 amounted to $372 million. This was approximately $56 million above the FY 2003 budget goal of $316 million. These were achieved in the following areas:

Pharmacy Savings	$ 134.8 m
Equipment and Supplies	$ 66.3 m
Productivity	$ 42.7 m
Competitive Sourcing	$ 15.1 m
VA / DOD	$ 14.0 m
Administrative, Inventory and Other	$ 99.1 m
Total for FY 2003	$ 372.0 m

Anticipated Management

Savings/Efficiencies for FY 04

National Contract / Procurement Efficiencies for Pharmacy, Prosthetics and Other Medical Supplies	$ 400 m
Procurement Efficiencies for equipment and other general supplies and materials	$ 80 m
Productivity Improvements	$ 50 m
Savings from Consolidations of Services, Administrative efficiencies, IT, Improved inventory practices and other	$ 30 m
Savings from local VA / DOD Sharing	$ 18 m
Plus recurring from FY 03	$ 372 m
Total for FY 2004	$ 950 m

The above combined with approximately $372 million in recurring efficiencies from FY 03 are expected to result in about $ 950 million in total management efficiencies for FY 04.

Were each of the management savings made in FY 2003 and FY 2004 recurring changes that will continue in each succeeding year?

Response: Management savings achieved for 2003 and anticipated management savings during FY 2004 are considered to be recurring savings.

Exactly how will you achieve these additional savings in FY 2005?

Response: Per the FY 2005 President's budget submission, VA expects to achieve the net increase of $340 million through further improvements in standardization policies for the procurement of pharmaceuticals, supplies and materials, productivity improvements, and other operational efficiencies such as sharing agreements.

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Does VA continue to support this proposal that could save VA $500 million or more over the next 10 years?

Response: Yes, VA continues to support the proposal.

stating agreement to abide by the guidance on conflicts of interest and scarce medical specialist service contracts was also sent to the field. Specifically, the policy required that facility directors ensure that each Chief of Staff and each physician, clinician or allied health supervisor, or manager, receives a copy of VHA Handbook 1660.3 and the acknowledgement form. A copy of the letter and the signed acknowledgement must be placed in the clinician's personnel folder. This requirement applies to all paid physician or allied health supervisors and managers.

In addition, a field has been added to the DUSH O&M monitors and we will require certification that facilities are in compliance with this policy requirement. This will be discussed with the Network Directors during their 3rd quarter performance reviews.

Question 13: When doctors fail to report for their assigned hours, how are they penalized? If not, why not?

Response: Part-time physicians have all been required to sign statements that they understand VA's policies and procedures related to time and attendance. Failure to comply with these policies and procedures has resulted in disciplinary actions up to and including removal.

Question 14: The IG's testimony indicates that the accountability of VA's part-time physicians continues to be a significant problem. Despite guidance from central office, Medical Center Directors have failed to implement or execute VHA's directive. What happens to these directors when they fail to follow VHA'S guidance? Please provide us with the specific personnel actions that have taken place?

Response: Facility Directors and part-time physicians are both accountable for compliance with these policies and procedures and subject to disciplinary action up to and including removal. There is no centrally maintained database for this information. We, therefore, surveyed our field activities concerning this issue. The results of that survey are included in the spreadsheet Attachment to Question 14.

Question 15: The CoreFLS project in Bay Pines has been in place since January 2004 and has cost over $400 million and still does not seem to work. What is VA's fall back plan to insure that there is no further disruption in delivering health care to veterans?

Response: On July 26, 2004, the Secretary decided to phase out a pilot program designed to test a new computerized financial management system (CoreFLS) from its current three test sites. Withdrawing CoreFLS will require the test sites to revert to the "Legacy Systems" previously in use. These include IFCAP for purchasing, AEMS/MERS for equipment maintenance and FMS for

financial records. All Legacy Systems were in use prior to cut-over onto CoreFLS, are known to work, and VA employees know how to use them. We are confident that with completion of the reversion process, there will be no further disruption of services to veterans. Completion of the reversion process is targeted for October 2004.

Question 16: When VA identifies egregious examples of purchase card abuses, what does VA do besides ask the individual to reimburse for the unauthorized purchases.

Response: If a VA employee misuses the purchase card, it may be immediately cancelled by the card coordinator and, depending on the nature of the use, disciplinary action taken. Disciplinary actions, as set forth in VA Standards of Conduct and purchase card policy are as follows:

- Admonishment
- Counseling
- Reprimand
- Demotion
- Reassignment
- Suspension
- Removal

In all but the first two instances, the action would be an adverse action and subject to applicable laws, regulations and policies. If it is determined the card was inappropriately used and the merchandise cannot be returned for a credit, the finance office may bill the employee the full cost of the procurement plus any administrative and debt collection fees. The agency may take all actions necessary to collect the debt, including salary garnishment and retirement withholding. The employee may also be subject to criminal prosecution.

VA approving officials and card coordinators consistently review transactions to ensure program integrity. In the past, when audits uncovered employee misuse, the Chief Financial Officer and the Inspector General (IG) have taken disciplinary action, as appropriate. Currently, VA's Office of Finance is working with the IG and Citibank to explore automated procedures to immediately identify and research potential employee misuse of the purchase card.

Question 17: Does VA require that purchase cards be turned in by employees when they leave VA?

Response: VA Handbook 4080, Government Purchase Card Procedures, dated 4/4/03, section 2.H.. Exit Procedures for a Cardholder provide that, as part of the exit clearance process, the government purchase card shall be surrendered to the program coordinator, cancelled and destroyed. The AO must certify that the cardholder has completed all order and payment reconciliations, or has provided

sufficient documentation so that a replacement cardholder can complete the reconciliations.

Question 18: On the issue of health care resources contracts, IG reviews have consistently shown that VA is paying significantly more than the Government would have paid for the same services under Medicare. Please explain how VA consistently allows this to happen.

Response. The Department's contracting efforts are designed to ensure access to necessary care for veterans. While Medicare rates provide a benchmark for comparison, they do not necessarily reflect the market rates that the VA must pay. The reasons for this include the following:

a. Because of the lack of non-VA providers, VA may be required to pay more than Medicare rates to ensure veterans have access to limited sources of care. This is especially true in Alaska and rural areas.

b. Many contracted services are for relatively small quantities of care. As a result, VA may not have sufficient buying power in a particular market to ensure it pays Medicare or lower rates.

c. The Medicare rates used do not include two additional adjustments for non-federal teaching hospitals, Direct Medical Education (DME) costs and Indirect Medical Education (IME) costs. Non-federal teaching hospitals receive DME costs associated with the salaries of teaching physicians, residents, supervisors, and administrators, as well as education-related expenses such as classrooms. They also receive Medicare's IME adjustment.

VA has recognized that a national contracting strategy for acquiring medical care has significant potential. Federal Procurement Data System reports indicate that the Federal Government spends approximately $5 billion annually for contract medical services. As a result, VA's National Acquisition Center, which has jurisdiction over Federal Supply Schedule (FSS) contracting for medically related supplies, equipment, and services, established an FSS for medical services in FY 2001. These FSS contracts incorporate quality-of-care requirements and ceiling prices, i.e. prices can be negotiated below the ceiling, e.g., for aggregated requirements. Since this FSS was first established in FY 2001, sales have increased from $98,000 in FY 2001 to $96,000,000 in FY 2003.

Additionally, as part of the Secretary's CARES decision, the Department is taking a comprehensive approach to contracting for health care resources called the National Clinical Contracting Strategy. This strategy is under development and will be presented for consideration by November 2004 to the CARES Implementation Board.

The Veterans Health Administration Clinic Logistics Office is establishing a contract template library that will be mandatory for all VHA contracting officers to use in the future. The Statement of Work templates will contain a list of questions that will require the contracting officer to consider during the acquisition process, thereby, improving the quality of the process and competitive pricing.

Question 19: The IG also found in its 2003 audit that VA's Workers' Compensation Program costs are affected employee injuries associated with violent patients. Furthermore, VA is at risk for unnecessary workers' compensation costs due to lack of action/response on case injuries to the Department of Labor, the agency responsible for administering the Federal Employees' Act.

Does VA agree with the IG's findings? If so, what steps has the VA taken to address these issues?

Response: 1. VA does recognize the implications of assaults for workplace safety and costs and has focused on this issue for the last several years.

Assaults represent an occupational hazard for health care workers. VHA established a program in 1980, known as Prevention and Management of Disruptive Behaviors, and has made modifications over the years. In 2001, because of concerns that policy and practice differed and might benefit from systematic review and coordination, VHA assembled a Task Force appointed by the Under Secretary for Health. Their report generated a series of recommendations, which are being implemented. VHA briefed VA's Deputy Secretary on this topic, with goals and plans to ensure VA leadership understood the strategy.

A first step was to examine data on assaults. Assaults represent slightly over five percent of injuries to VHA employees based on in-house data collected through a national injury reporting system. These injuries are among the most expensive within the system. In addition, reviews suggest that outside mental health practitioners are not following national guidelines and treatment recommendations.

A national survey identified rates of assaults by occupational groups, high- risk occupations, and areas. In response, VHA initiated a program focused on patient assaults first. Network Director Performance monitors have been in place for the last three years, and a follow-up is planned. Accomplishments of the program include:

- In FY 2002, VHA conducted a nation-wide awareness training with 91 percent participation, and a new or updated policy was developed in each facility.

- In FY 2003, each facility trained at least two trainers in self-defense, personal safety skills and de-escalation; formulated a training plan; and initiated the training.
- In FY 2004, each facility continued its training plan and implemented Patient Record Flags with a Disruptive Behavior Committee at each facility. VHA has trained over 50 percent of its high-risk employees over the last 1.5 years. Another monitor is planned for next year, process evaluations are under way, and VHA is planning a follow-up survey to measure intervention effectiveness in two years.

In addition, a detailed review of several high-visibility cases suggested the utility of two new program elements. First, a post-incident manual is under development by the National Center for Post Traumatic Stress Disorders. Second, a structured approach to active case management of "traumatic stress" claims is under way with development of a practice guideline, to be followed up by audits.

2. VA has been working with the department of Labor (DOL) to improve case management. Still, there remain opportunities for substantially improved collaborative work on case management. VHA has noted what it believes are discrepancies between DOL and VA priorities and has suggested to VA's OIG that joint work between DOL and VA programs and the OIG's of the two departments would be beneficial.

Question 20: Mr. Mansfield, VA's FY 2003 budget called for $316 million in management savings; VA's FY 2004 budget called for $950 million in management savings; and VA's FY 2005 budget called for $1.29 billion in management savings.

Did you meet your target of $316 million in FY 2003 and are you on target to achieve $950 million of management savings in FY 2004?

Response: VA exceeded its target for management savings for FY 2003 (see below), and anticipates achieving its target for FY 2004.

Can you please provide a detailed breakdown of all management savings achieved in FY 2003 and 2004?

Response: A breakout of management savings achieved during FY 2003 and of management savings anticipated during FY 2004 is given in the tables below. Total management savings for FY 2004 will not be known until after close of fiscal year on September 30, 2004.

Management Savings/Efficiencies Achieved for FY 03

Questions for the Record
Honorable Lane Evans, Ranking Democratic Member
Committee on Veterans' Affairs
June 17, 2004

Hearing on Efforts to Eliminate Fraud, Waste, Abuse and Mismanagement in VA Programs

Question 1: Level 3 Laboratory Security
All 15 of the 16 recommendations by the VA OIG regarding laboratory security that were open in March 2003 remained open on the day of the June 17, 2004 hearing.

Please explain why each open item remains open, the actions and resources needed to fulfill the IG recommendations on the open item and a timeline for full compliance.

Response: Significant progress has been made on all of the OIG recommendations identified in Report Number 02-00266-76, dated March 14, 2002, and the OIG initially closed most of the recommendations. However, in early 2003, the OIG reconsidered the issues included in this March 2002 audit report and subsequently added new requirements for closing the 15 outstanding recommendations.

In May 2004, VA published VHA Handbook 1106.2, *Pathology and Laboratory Medicine Service Biosecurity and Biosafety Procedures.* In June 2004, VA issued VHA Handbook 1200.6, *Control of Hazardous Agents in VA Research Laboratories.* With the publication of these two Handbooks, we have addressed all VHA-focused recommendations. With the anticipated publication of guidance from VA's Office of Security and Law Enforcement, we will have addressed the remaining recommendations. VHA will then implement and certify that all corrective actions have been addressed at each VA medical center. The OIG recommendations will remain open until these certifications are completed.

a) Provide copies of accountability statements for each VA BSL Level 3 laboratory.

Response: VHA plans to obtain certifications on the BSL-3 laboratories as part of the certification to be provided to OIG once all actions are implemented. We expect to have this completed by the end of the calendar year.

The VA response indicates a series of unannounced visits to BSL Level 3 Laboratories beginning in 2003.

b) Provide a list containing the laboratories visited, the lead inspector for the visit and contact information, the dates of visit and also note by laboratory

the number of outstanding deficiencies.

Response: On October 8, 2003, VA's Office of Research Oversight (ORO) conducted BSL-3 physical security inspections at VA medical facilities. The ORO Regional Office Director where each BSL-3 laboratory was located chaired the individual inspection teams. Physical security inspections were completed for all VA BSL-3 research laboratories as of December 3, 2003. All of the inspections were conducted as announced visits. Sites found to have deficiencies during the inspections were required to provide ORO with action plans on how corrections would be made. The current status of each of the laboratories is listed below. Three laboratories in two facilities have deficiencies that need to be resolved. The deficiencies and the plans for their correction are listed.

The table below summarizes the visits made and the deficiencies remaining based on use of a Physical Security Checklist developed by VHA.

ORO's SITE VISIT INSPECTIONS BSL-3 CY2003

INSPECTION DATE 2003	FACILITY LOCATION	INSPECTION TEAM LEADER	OUTSTANDING DEFICIENCIES July 23, 2004	COMMENT on PLANS FOR CORRECTION
October 30-31	Mid-Atlantic Region	Dr. Min-Fu Tsan	None	
November 4-5	Southern	Dr. David Miller	None	
November 6-7	Northeastern Region	Mr. Richard D'Augusta	None	
November 7	Western Region	Dr. Paul Hammond	None	
November 10	Western Region	Dr. Paul Hammond	None	
November 13	Western Region	Dr. Paul Hammond	1. Lexan window in lab on 6th floor does not meet VA Handbook 0730, App. B specifications 2. Voice-activated speaker phones not in lab 3. Permanent records of egress from 6th floor research area not maintained	*Waivers requested for: 1. Lexan window 2. Computerized telephone system that does not allow voice activated telephone 3.Electronic system that only records time of entrance

November 14	Northeastern Region	Mr. Richard D'Augusta	1.Voice activated telephones not in lab 2. Windows are located in two BSL-3 labs that do not meet VA Handbook 0730, App. B specifications	**1.New telephones on order; conventional phones used in the interim *2. Waiver requested.
November 19	Southern Region	Dr. David Miller	None	
November 18	Mid-Atlantic Region	Dr. Min-Fu Tsan	None	
November 19	Western Region	Dr. Paul Hammond	None	
November 20-21	Western Region	Dr. Paul Hammond	None	
November 24-25	Mid-Atlantic Region	Dr. Min-Fu Tsan	None	
December 2-3	Midwestern Region	Dr. Karen Smith	None	

***Waiver requests are to be reviewed by ORO, ORD, and the Safety and Technical Services staff. If waivers are not appropriate, proposals for alternate solutions to respond to the deficiencies are targeted for August 15, 2004.**
**** The delayed telephone order is being closely monitored to assure prompt resolution of the deficiency identified.**

Question 2: NIH Indirect Costs
In a July 31, 1989 memorandum, VA agreed to a National Institutes of Health (MB) draft policy proposal regarding NIH Grants and Contracts, and in the process ceded rights accorded VA by prior agreement and otherwise authorized by title 42, United States Code for reimbursement by NIH the for the indirect costs associated with research conducted by third parties at VA facilities. At the time, the reimbursement rate was 15 percent of the research grant and did not include administration costs associated with the grant. As a matter of record, VA covers indirect costs for research using resources dedicated for the support of veterans' health care. This places an encumbrance on veterans' health care with an estimated cost of $50-$100 million annually.

Also as a matter of record, NIH now reimburses non-governmental agencies — including foreign research entities — for indirect costs associated with research. As noted in the VA comments to the IG testimony for the June 17, 2004, hearing, Title 42, U.S.C. Chapter 6A, Subsection I, Section 238d requires NIH to ensure that the same terms and conditions as apply to non-Federal institutions, also apply for grants for the same purpose to VA and several other Federal entities.

The statute in effect in 1989, as well as current law, use the term "shall." NIH in 1989, as well as today, pays indirect costs to non-Federal entities.

Please provide the legal authority and rationale which you believe authorize VA to enter into third party arrangements funded by NIH using VA facilities without requiring payment for VA's indirect costs. Such costs are included in similar NIH contracts with non-Federal entities.

Response: Section 7303 of title 38 U.S.C. authorizes the Secretary to carry out a program of medical research to carry more effectively the primary function of VHA to provide complete a medical and hospital service for the medical care and treatment of veterans. If VA determines that a project furthers that purpose, costs associated with the project may be paid from funds appropriated to VA by Congress. If research is funded in full or in part by NIH grants, it is still VA research, and VA may make the determination that it is in the interests of the VA research program to fund any portion of the projects not paid for by NIH. Moreover subsection 7320(a)(4) directs the Secretary to "act in cooperation with" entities including schools of medicine, medical centers, hospitals and "such other public ...agencies... as the Secretary considers appropriate" in carrying out VA's research program. Thus, the Secretary may determine that it is in the best interests of the program to enter into arrangements with NIH without receiving reimbursement for all VA's indirect costs.

What is the Office of Management and Budget (0MB) official position on this issue?

Response: The Office of Management and Budget does not support reimbursements from the NIH to VA.

What effects will this estimated $50-100 million loss of veterans' health care resources have on VA research activity and medical services? Please provide a list detailing where the cuts will occur or planned activities will be curtailed.

Response: Based on a documented facility costs rate of 23.5%, VA would receive approximately $60 million in indirect costs from NIH. VA has not reduced or curtailed specific programs and services to support these costs but has opted to decrement various facility support activities.

The VA comments to the IG testimony for the June 17, 2004 hearing refer to an initiative in the President's Budget to assess pharmaceutical companies for indirect administrative costs with clinical drug trials.

Please provide an estimate of the indirect costs that will be recouped by that initiative and express the result in a whole dollar amount and as a

percentage of the total value of indirect costs at the 23.5 percent rate for third-party research covered by veterans' health care resources.

Response: Pharmaceutical companies often fund clinical drug trials that VA investigators conduct at VA Medical Centers (VAMCs). The university affiliates or the VA-affiliated non-profit corporations (NPC's) typically administer these funds. Each individual university or NPC negotiates indirect administrative cost rates with the pharmaceutical companies. The university affiliates typically charge an indirect rate of approximately 26% for industry-funded trials. NPC's charge variable indirect rates from 15 to 25% of the direct study cost. These funds are intended to cover administrative costs only. Facility costs are not included in this rate because facility costs are not typically incurred with privately funded studies. The 23.5% rate referenced is based on a VHA sponsored study assessing facility costs, not administrative costs. Therefore, that rate does not apply to privately funded trials since facility costs are not typically incurred.

VHA Directive 2003-031, issued June 13, 2003, requires that all industry-sponsored studies with human subjects be assessed an additional fee of 10% of the direct study cost, or a flat fee of $1200, whichever is greater. These fees help cover compliance costs associated with human subjects research (less Institutional Review Board [IRB] costs, since there is a separate fee for IRB review]. The NPC or affiliated university collects the fee on behalf of the VAMC.

Based on FY 2003 data, in which there were 4,765 ongoing industry-sponsored studies with human subjects, with $61 million expended, VA expects the NPC's and university affiliates to collect approximately $6.1 million in FY 2004 to help cover costs associated with compliance related activities. Since many of these compliance costs are borne by the VAMCs and assumed to be part of the Veterans' Equitable Resource Allocation (i.e. medical care dollars in support of research) the reimbursements go to the VAMCs and supplement the medical care appropriation and not the VA research appropriation.

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Also as a matter of record, NIH now reimburses non-governmental agencies — including foreign research entities — for indirect costs associated with research.

As noted in the VA comments to the IG testimony for the June 17, 2004, hearing, Title 42, U.S.C. Chapter 6A, Subsection I, Section 238d requires NIH to ensure that the same terms and conditions as apply to non-Federal institutions, also apply for grants for the same purpose to VA and several other Federal entities. The statute in effect in 1989, as well as current law, use the term "shall." NIH in 1989, as well as today, pays indirect costs to non-Federal entities.

a) Please provide the legal authority and rationale which you believe authorize VA to enter into third party arrangements funded by NIH using VA facilities without requiring payment for VA's indirect costs. Such costs are included in similar NIH contracts with non-Federal entities.

Response: Section 7303 of title 38 U.S.C. authorizes the Secretary to carry out a program of medical research to carry more effectively the primary function of VHA to provide complete a medical and hospital service for the medical care and treatment of veterans. If VA determines that a project furthers that purpose, costs associated with the project may be paid from funds appropriated to VA by Congress. If research is funded in full or in part by NIH grants, it is still VA research, and VA may make the determination that it is in the interests of the VA research program to fund any portion of the projects not paid for by NIH. Moreover subsection 7320(a)(4) directs the Secretary to "act in cooperation with" entities including schools of medicine, medical centers, hospitals and "such other public ...agencies... as the Secretary considers appropriate" in carrying out VA's research program. Thus, the Secretary may determine that it is in the best interests of the program to enter into arrangements with NIH without receiving reimbursement for all VA's indirect costs.

b) What is the Office of Management and Budget (0MB) official position on this issue?

Response: The Office of Management and Budget does not support reimbursements from the NIH to VA.

c) What effects will this estimated $50-100 million loss of veterans' health care resources have on VA research activity and medical services? Please provide a list detailing where the cuts will occur or planned activities will be curtailed.

Response: Based on a documented facility costs rate of 23.5%, VA would receive approximately $60 million in indirect costs from NIH. VA has not reduced or curtailed specific programs and services to support these costs but has opted to decrement various facility support activities.

The VA comments to the IG testimony for the June 17, 2004 hearing refer to an initiative in the President's Budget to assess pharmaceutical companies for indirect administrative costs with clinical drug trials.

d) Please provide an estimate of the indirect costs that will be recouped by that initiative and express the result in a whole dollar amount and as a percentage of the total value of indirect costs at the 23.5 percent rate for third-party research covered by veterans' health care resources.

Response: Pharmaceutical companies often fund clinical drug trials that VA investigators conduct at VA Medical Centers (VAMCs). The university affiliates or the VA-affiliated non-profit corporations (NPC's) typically administer these funds. Each individual university or NPC negotiates indirect administrative cost rates with the pharmaceutical companies. The university affiliates typically charge an indirect rate of approximately 26% for industry-funded trials. NPC's charge variable indirect rates from 15 to 25% of the direct study cost. These funds are intended to cover administrative costs only. Facility costs are not included in this rate because facility costs are not typically incurred with privately funded studies. The 23.5% rate referenced is based on a VHA sponsored study assessing facility costs, not administrative costs. Therefore, that rate does not apply to privately funded trials since facility costs are not typically incurred.

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Question 3: Part-time Physician Time and Attendance

On page one of the VA Response to the OIG testimony, VA states:

> "VHA is addressing the problem with recording and documenting time worked [by part-time physicians] with a pilot program to test the efficacy of swipe ... The pilot was completed successfully and is currently on hold until revised VA policies regarding time and attendance are implemented."

Please describe the particulars of this swipe card pilot program:

a) Where and when did the pilot take place?

Response: The Swipe Card Pilot is currently being conducted at the Miami VA Medical Center. The pilot began August 10, 2003, to test one specific technical solution in an effort to collect data on physician acceptance of an automated timekeeping system. Currently more than 60 physicians are still using swipe cards to record their hours at the Miami VA Medical Center.

b) What outcome measures were used to judge "success"?

Response:
1. Improved physician accountability (qualitative measure):

- 100% of physicians in the pilot received guidance on activities appropriate to count as workload toward VA payroll.
- Several physicians reduced or changed times for activities at the VA and/or the affiliate.
- Timeliness of physical presence improved for several participants as evidenced by review of MAS data versus previous reports/episodes of tardiness.
- Several physicians elected to change their tours and/or status due to increased scrutiny of physical presence (2 resigned; 2 retired; 1 converted to intermittent).
- Service Chiefs increased scrutiny of subsidiary time cards and verification of workload.

2. Physician compliance with use of the Millennium Access Management System (MAS):

- Compliance during the most active phase of the pilot (Fall 2003):
    a. Service Chief Group: 95 Percent Compliance (Average)
    b. Part Time Physician Group: 92 Percent Compliance (Average)

- Compliance during a time period of less frequent reminders to "swipe" (May 2004):
    a. Service Chief Group: 83 Percent Compliance (Average)
    b. Part Time Physician Group: 81 Percent Compliance (Average)

3. Improve data collection for PT MD Time & Attendance:

- MAS data added the element of physical presence to validate hours claimed on the subsidiary time card. (The ability to apply this technology was equal in proportion to physician compliance with use of the MAS system.)

4. Physician feedback on use of technology tools to record physical presence related to time and attendance (qualitative measure):

- Four surgical subspecialty physicians expressed great dissatisfaction with the system and at one point discussed resignation from their VA appointment.
- Several physicians verbalized (at focus groups and Medical Staff Meeting) that the pilot project was micromanagement of physician time and led to loss of autonomy.
- Several physicians verbalized (at focus groups and Medical Staff Meeting) that the MAS system of physical presence verification does not capture VA business off site.
- Several physicians expressed concern that VA/affiliate relationships were strained due to the pilot project and lack of service level agreements.
- Several physicians verbalized that technology solutions such as the pilot project would be an improvement over the paper subsidiary format.

c) What was the scope of the pilot?

Response: The pilot project was designed to validate the use of technology and not to provide an overall measure of time worked. The pilot and technology used do not capture time spent outside of the physical confines of the medical center. All physicians in the pilot project have time and attendance tracked through traditional systems as well. The system being tested is the Millennium Access Management System (MAS). This system has features similar to swipe card technology that can record facility access by person, area, date and time. Through the pilot, we obtained feedback from physicians on the use of the technology that will help us determine the most appropriate and useful guidance to provide to physicians on timekeeping processes.

d) When and how will the revised VA policies regarding time and attendance be implemented? Who will be accountable for complete implementation? What actions will be taken if implementation is not successful? Who will review and monitor all written documentation listed in the action plan?

Response: VA policies and procedures concerning part-time physician time and attendance have been revised and will be fully implemented in May 2005. All part-time physicians will be required to enter into a "Memorandum of Service Level Expectations" which specifically outlines their annual commitment to VA over the following year. During this period, employees will receive the same level of basic and special pay each pay period. However, each part-time physician will continue to be scheduled based on VA work requirements, and their progress toward meeting service level expectations will be monitored on a pay period by

period basis through VHA's Enhanced Time and Attendance System (ETA). This allows VA to schedule physicians in a manner that more closely parallels patient care requirements and physician practice patterns. Physicians who fail to meet service level expectations would be subject to appropriate disciplinary action and liable for any overpayments. VHA is also conducting pilot studies at several facilities to ensure these policies and procedures are clearly understood by managers and employees and that the policies and procedures are implemented on a nationwide basis in an effective manner.

VISN and facility Directors will be held responsible for implementation of these policies and procedures within their organizations. The Deputy Under Secretary will also review the performance of VISN Directors on a quarterly basis for Operations and Management.

Question 4: Information Technology

Considering the history of delays or substandard performance of major IT initiatives at VA in recent years, (VETSNET, HR Link$, CoreFLS, and PFSS), what institutional safeguards to assure centralized control and accountability have been implemented to ameliorate this problem? Is the CIO the person ultimately in charge? Does control for information security extend with direct line authority from the Office of the CIO to line information security officers at the medical centers?

Please provide an update on VETSNET including any problems encountered with respect to implementation of the Lincoln trial, actions which have been taken by Hines, St. Petersburg or Lincoln staff to address problems identified and problems involving coordination between VETSNET and the BDN, such as 1800-year errors.

Centralized Control and Accountability. In 2003, the Secretary of VA centralized the Department's information technology functions. As a result, VA's CIO now has formal authority to exercise oversight responsibilities for the Department's information technology systems through the Deputy CIO for Health, Deputy CIO for Benefits, and Deputy CIO for Memorial Affairs. The centralization helps to ensure that appropriate control and accountability of IT projects. Consistent with that authority, a unified approach to oversight of IT projects has been implemented via VA's Enterprise Information Board (EIB). The greatest benefits to the Department from these steps are yet to be realized, and we expect to see the most significant impact on IT projects currently under development.

Through the EIB process, the CIO has laid the groundwork for Departmental oversight of such projects by initiating a rigorous IT management process. The CIO, as Chairman of the EIB, has initiated and implemented a disciplined project management methodology. It is one that aggressively manages the

Department's IT portfolio to ensure that efficiencies are captured and problems are identified early in the process.

More specifically, the CIO can now leverage the EIB and the project management process to ensure that there are well-defined linkages among the: 1) Department's Enterprise Architecture; 2) IT portfolio; 3) identified resources; and 4) anticipated benefits from IT projects in development. By doing so, the CIO, in conjunction with the EIB, will provide systematic monitoring of all IT projects. In that vein, project management offices are required to work closely with the CIO on the annual VA Exhibit 300 submissions for IT initiatives. During the process of preparing those submissions, recommendations are made to improve a project's schedule, cost, performance and to mitigate security risks. All initiatives are evaluated to ensure that they support the Department's mission and are subsequently monitored.

Information Security. Regarding information security, direct line authority extends to the Veterans Integrated Service Network (VISN) information security officers (ISO's). The VISN ISO's are responsible for the management of security activities for the medical centers and other VA facilities in their respective regions. Informal authority extends from the CIO, through the Department Security Officer and the VISN ISO's, to the local facility ISO's to provide policy, procedures, tools, training, guidance, and support. The VA medical center ISO's report directly to their respective facility directors.

VETSNET Update. Parallel testing of VETSNET was conducted on schedule in Lincoln during March 2004. All defects that were identified were corrected prior to the beginning of live field testing on May 10, 2004. All defects that were identified during live field testing have been corrected and additional functionality will be included in this live field test beginning in September 2004.

Coordination between BDN and VETSNET includes considerable time and effort by Hines and St. Petersburg staffs to build safeguards to prevent duplicate payments and to ensure that BDN and VETSNET payments are timely and accurate.

Bridging BDN and VETSNET requires new processing and modifications to the BDN. The Record Locator Index is an example of a bridge program developed to track the creation of new payment records in BDN and in VETSNET. The Index was installed on May 10, 2004, at the beginning of the live field testing of VETSNET in Lincoln.

This installation resulted in a programming error that corrupted birth data in minimal records. No erroneous payments occurred. This error was identified by standard operation process in place and corrected by the coordinated efforts of the Hines and St. Petersburg staffs. A master record correction of the corrupted birth data will also be made.

Question 5: DoD/VA Sharing
When will the Joint Strategic Plan between DoD and VA be finalized and how will it be disseminated to all levels of interface between the agencies?

Response:
The first strategic goal in the current draft of the VA Joint Strategic Plan includes an objective to "enhance internal and external communications." Specific strategies regarding distribution of the plan to internal and external stakeholders will be included in this objective. Internal stakeholders will include those organizational entities in both departments whose operations may be impacted by the strategies and initiatives identified in the plan.

We will share the specific metrics related to this objective with Congressional and OMB staffs following its approval by the co-chairs of the VA/DoD Joint Executive Council (JEC). The plan will be presented for review and approval at the next meeting of the JEC, which is expected to be scheduled in late November or early December. As a result we expect the new strategic plan to be available by January 31, 2005.

Question 6: Physician Staffing Standards

Provide a listing of all current (as of June 17, 2004) Directives listed under the section "Physician Staffing Standards," i.e., those implementing national business rules for counting "Active Patients" in Primary Care. Who is accountable for Directive implementation and monitoring national staffing standards databases?

Response: Following is a list of the directives:

1. Guidance on Primary Care Panel Size, VHA Directive 2004-031, July 6, 2004

Facility director has responsibility for implementing this directive

2. Primary Care Direct Patient Care Time, VHA Directive 2004-027, June 15, 2004

Facility Director and Network Director are responsible for implementing this Directive

3. Active Patients in PCMM, VHA Directive 2003-063, dated October 23, 2003

Network Director, VISN and facility CIO and service chief are responsible for implementing this directive.

VA's Veterans Support Service Center (VSSC) will monitor the standards database and provide regular reports.

Question 7: Contract Nursing Home Oversight

Who is accountable for CNH Oversight policy implementation and monitoring? How will accountability success/failure be measured?

Response: VISN Directors are accountable for the implementation of CNH oversight policies, found in VHA Handbook 1143.2, dated 4 June 2004. Presently, VHA monitors the timeliness of the Annual Review process. The Office of Geriatrics and Extended Care (G&EC) analyzes the CNH Certification Reports submitted by each VAMC and reports its findings on timeliness to the Deputy Under Secretary for Health (DUSH) for Operations and Management for review and any corrective action. With the introduction of the CNH Website in September 2004, VHA will monitor the overall quality of homes under VA contract. As with the current system, G&EC will analyze the information and submit its findings to the DUSH for Operations and Management.

Question 8: Controlled Substances and Pharmacy Security

What systemic remedies were developed and promulgated throughout the national VA pharmacy system based on the corrective actions performed at the Jamaica Plains and VA TVHS facilities?

Response: The Department of Veterans Affairs (VA) has the most stringent accountability for Controlled substances in the United States. We require strict security of our perimeters with electronic access. Vault and wall construction are listed in VA Handbook 0730, Security and Law Enforcement, Appendix B. The VA's Office of Security and Law Enforcement is currently updating the electronic security measures for all VA pharmacies. The use of cameras in pharmacy vaults will be recommended.

In the case of the Jamaica Plains robbery, cameras and electronic access would not have prevented the robbery. The employees did not follow existing procedures for access to the pharmacy. The adherence to the security policies has been shared with all Chief's of Pharmacy on national conference calls.

In addition, VA has a disinterested third-party inspection process. This is outlined in VHA Handbook 1108.2, Inspection of Controlled Substances. This was revised in August 2003 in response to prior Combined Assessment Program (CAP) surveys and the related incidents from prior testimony. VA has reviewed the basic controlled substance storage policy, VHA Handbook 1108.1, as well.

The Office of the Medical Inspector (OMI) has developed a matching program to survey the PBM database and the VBA date of death files to determine if patients

who are allegedly dead are receiving controlled substances from a VA pharmacy. This information is shared on a semi-annual basis with VA pharmacies to determine if the date of death data is accurate or if there is a potential for diversion.

VHA has developed an Internet based system to update its inventories from the Prime Vendor. This will provide up to date information on the inventory receipts for controlled substances and other drugs procured by VA pharmacies.

To aid the Directors and Controlled Substance Inspection Coordinators, the VA Employee Education Service (EES) and Pharmacy Benefits Management Strategic Healthcare Group (PBM) developed and released a web-based training program and training video in December 2003. The web-based training has been announced on the VA Friday Operations conference calls and the monthly VA pharmacy managers calls.

VHA PBM has held numerous conference calls discussing the findings of OIG CAP surveys. The PBM discussed the most recent finds of the CAP surveys at a meeting of VA pharmacists in Memphis, TN, on May 21, 2004.

Beginning in 1999, the VA Pharmacy Benefits Management (PBM) group developed a patient specific prescription database. This database allows the PBM to monitor prescribing patterns by a number of different measures including drug, drug class, location, and individual physician. In August 2001, the PBM began a semiannual review of controlled substance prescribing especially for OxyContin. These reviews identify cases of abnormal prescribing patterns including duplicate (early or redundant) fills for narcotics from more than one facility or VISN. These reports are shared with the VISN Formulary Leaders who work with the individual medical centers. The reports are used to identify patients who are "shopping" for prescriptions as well as physician prescribing that may out of the ordinary. In many cases, these reviews indicate that local medical centers have identified the same behavior and have taken action prior to the reviews. These reviews will continue on a semi-annual basis.

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United States Government Accountability Office
Washington, DC 20548

July 28, 2004

The Honorable Christopher H. Smith
Chairman
Committee on Veterans' Affairs
House of Representatives

Subject: *VHA Purchase Cards: Committee Questions Concerning Efforts to Identify and Eliminate Fraud, Waste, Abuse, and Mismanagement in Programs*

Dear Mr. Chairman:

This letter responds to your June 30, 2004, request that we provide answers to questions relating to our June 17, 2004, testimony.[1] At that hearing, we discussed our recently reported findings on the Veterans Health Administration's (VHA) purchase card program for fiscal year 2002.[2] Your questions, along with our responses, follow.

1. *Mr. Williams, your testimony contains a number of estimates of questionable transactions by VA employees.*

    - *$312 million of the 2002 purchase card transactions lacked key supporting documentation.*
    - *$1.7 million of 2002 convenience check transactions lacked written authorization, while an estimated $14 million in checks were used to pay for goods or services in excess of the $2,500 limit on such purchases.*
    - *VA's credit limit on purchase cards exposes it to more than $1 billion in unnecessary charges each month.*
    - *An estimated $17.1 million in 2002 represented prohibited "split" purchase card transactions.*
    - *An estimated $112 million in 2002 purchase card transactions, all of which were in excess of the $2,500 micro purchase limit.*
    - *An estimated $60 million in purchases were made without meeting competition requirements.*

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[1]U.S. General Accounting Office, *Veterans Health Administration: Inadequate Controls over the Purchase Card Program Resulted in Improper and Questionable* Purchases, GAO-04-857T (Washington, D.C.: June 17, 2004).

[2]U.S. General Accounting Office, *VHA Purchase Cards: Internal Controls Over the Purchase Card Program Need Improvement*, GAO-04-737 (Washington, D.C.: June 7, 2004).

Would it be fair to add up all these estimates and say that more than a third of VA purchase card transactions violated one rule or another, and were thus improper?

No. The samples used to test purchase card and convenience check transactions were designed to address specific testing objectives and not to develop one estimate that covered all improper purchases identified in our report. As such, our reported estimates cannot be combined to determine a total number or dollar value of transactions that violated one rule or another, and were thus improper.

2. *This appears to be a widespread problem. Has anyone ever been fired for repeated violations? What would you recommend VA do to correct this problem?*

During our review of VHA's purchase card program, we found that none of cardholders were fired for the violations we identified. However, in some instances we were told that cardholders were counseled, retrained on applicable purchase card policies and procedures, or both. Also, in response to this question, we asked the Veterans Affairs (VA) national program coordinator if any cardholders, who had been identified as repeat offenders of policy violations, had been fired. According to the VA program coordinator, from fiscal year 2002 to July 2004, six cardholders were fired during this time frame as a result of investigations conducted by VA's Office of Inspector General (VA OIG).

To correct repeated occurrences of purchase card violations, VHA at a minimum, should implement our recommendations to strengthen internal controls and compliance in its purchase card program and continue its cardholder retraining requirements of every 2 years. One of our recommendations provides that VHA consider revoking or suspending purchasing authority of cardholders found to be frequently or flagrantly noncompliant with policies and procedures. We believe enforcement of this or other disciplinary action helps prevent or deter future violations of federal and agency purchasing requirements and assists in holding cardholders accountable for carrying out their responsibilities.

3. *VA has stated that the $435,900 of fraudulent activity identified by the VA OIG represents less than 1/100th of a percent of VHA's purchase card activity. What is GAO's response?*

Although the $435,000 of fraudulent activity identified by the VA OIG as well as the total amount of improper purchases we identified, was relatively small compared to VHA's annual purchase card and convenience check transactions of more than $1.4 billion, these results demonstrate vulnerabilities from weak controls that could be exploited to a much greater extent. Furthermore, neither the VA OIG nor GAO designed its work to identify all fraudulent or otherwise improper purchases made by VHA. Because we tested only a small portion of the transactions that appeared to have a higher risk of fraud, waste, or abuse, there may be other improper, wasteful, and questionable purchases in the remaining untested transactions. For example,

from our data mining[3] of VHA's purchase card and convenience check activity, we identified tens of thousands of transactions that appeared to have a higher risk of fraud, waste, or abuse, including (1) purchases from certain vendors that would more likely be selling unauthorized or personal use items, and (2) purchases made on the weekends, during holidays, or at fiscal year-end. The VA OIG also reported similar transactions in its evaluation of VA's departmentwide purchase card program.[4] As a result of this work, the VA OIG recommended, at the department level, that in addition to required monthly audits of randomly selected small samples of facility purchase card transactions, focused audits of questionable transactions that can be identified through data mining analyses should be periodically conducted. We support this type of recommendation and believe, if properly implemented, will assist VA's efforts to identify and review purchase card activity that appear to have a higher risk of fraud, waste, and abuse. The VA OIG reported that VA's Assistant Secretary for Management agreed with this recommendation and has developed improvement plans to address this and other recommendations included in the VA OIG's report.

In addition to our data mining results, during our audit, we also identified 66 purchases totaling $54,068 for which VHA provided no documentation at all regarding the purchases. Missing invoice documentation could indicate potential fraud. As a result, we recommended that VHA management follow up with these purchases to determine whether the items purchased were for a legitimate government need. VHA agreed to assess the purchases to determine their legitimacy.

4. *GAO's VHA purchase card report includes 36 recommendations to strengthen the agency's internal controls and compliance in VHA's purchase card program. However, these recommendations stem from audit findings related to fiscal year 2002 purchase card and convenience check activity. Are these recommendations relevant to current program operations?*

Yes. Our recommendations, if properly implemented, will assist VA and VHA in strengthening their current operations. Generally, our recommendations focus on establishing additional policies and procedures or expanding existing purchase card guidance that were in effect during fiscal year 2002, our period of review, and are currently in effect over VHA's purchase card program. Although VHA issued a new directive regarding its purchase card program in May 2003, no significant changes were made that addressed our recommendations. Also, VHA continues to operate under its purchase card handbook dated June 2000, which was the focus of most of our recommendations.

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[3]Data mining applies a search process to a data set, analyzing for trends, relationships, and interesting associations. For instance, it can be used to efficiently query transaction data for characteristics that may indicate potentially improper activity.

[4]Department of Veterans Affairs Office of Inspector General: *Evaluation of the Department of Veterans Affairs Government Purchase Card Program*, Report Number 02-01481-135 (Washington, D.C.: April 26, 2004).

In responding to these questions, we relied on our recent work related to our review of VHA's purchase card program for fiscal year 2002 and contacted VHA to determine whether any cardholders had been fired for repeated violations. We conducted our work in accordance with generally accepted government auditing standards during July 2004.

Should you or your staff have any questions on matters discussed in this letter, please contact me at (202) 512-6906 or williamsm1@gao.gov or Alana Stanfield, Assistant Director, at (202) 512-3197 or stanfielda@gao.gov. Major contributors to this letter include Sharon Byrd and Carla Lewis.

Sincerely yours,

McCoy Williams

McCoy Williams
Director, Financial Management and Assurance

(195048)

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United States Government Accountability Office
Washington, DC 20548

July 28, 2004

The Honorable Virginia Brown-Waite
House of Representatives

Subject: *VHA Purchase Cards: Hearing Questions Concerning Enforcement of Recommendations*

Dear Ms. Brown-Waite:

This letter responds to questions you asked related to our testimony[1] of June 17, 2004. During that testimony, we discussed our recently reported findings on the Veterans Health Administration's (VHA) purchase card program for fiscal year 2002.[2] Your questions, along with our responses, follow.

1. *How do we, as Members of Congress, see that your recommendations are enforced in a more timely manner, and actually be able to have some teeth to what you do? How do we get an enforcer in this agency and every other single agency? How do we get enforcement that translates into significant tax dollars?*

When we make recommendations to the head of an agency in a report, the agency head is required under 31 U.S.C. §720 to submit a written statement of the actions taken by the agency on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Reform not later than 60 days after the date of the report. The agency head must also submit the statement to the Committees on Appropriations of both houses of Congress in the agency's first request for appropriations submitted more than 60 days after the date of the report. These statements provide the Congress with information directly from the agency and assist the Congress in determining whether the agency could benefit from additional congressional oversight, such as through legislative action.

Agencies have a responsibility to monitor and maintain accurate records on the status of recommendations. These requirements are detailed in Office of Management and Budget (OMB) Circulars A-50 and A-123. OMB Circular A-50 provides the policies and procedures for use by executive branch agencies when

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[1]U.S. General Accounting Office, *Veterans Health Administration: Inadequate Controls over the Purchase Card Program Resulted in Improper and Questionable Purchases*, GAO-04-857T (Washington, D.C.: June 17, 2004).

[2]U.S. General Accounting Office, *VHA Purchase Cards: Internal Controls Over the Purchase Card Program Need Improvement*, GAO-04-737 (Washington, D.C.: June 7, 2004).

considering audit reports that require follow-up, including reports issued by GAO and inspectors general, other executive branch audit organizations, and nonfederal auditors. OMB Circular A-123[3] addresses internal management control systems. Among the requirements included are that the agency (1) appoint a top-level audit follow-up official, (2) maintain accurate records on the status of recommendations, and (3) assign a high priority to following up on audit recommendations.

Additionally, as a means of enforcing recommendations, we periodically monitor agencies' progress in implementing our recommendations, document the agencies' progress in a tracking system, and report annually to Congress on their status. Further, when conducting our work, we incorporate follow-up of significant findings and recommendations from prior reports that may affect the planning or implementation of the current audit.

As an investigative arm of Congress, our mission is to support Congress in meeting its constitutional responsibilities and to help improve performance and ensure accountability of the federal government for the benefit of the American people. As such, many of the benefits produced by our work can be quantified as dollar savings for the federal government. We produce financial benefits when our work contributes to action taken by Congress or the executive branch to (1) reduce annual operating costs of federal programs or activities, (2) lessen the costs of multiyear projects or entitlements, or (3) increase revenues from debt collection, asset sales, changes in tax laws, or user fees. For example, in fiscal year 2003, our work generated $35.4 billion in financial benefits, a $78 return for each $1 appropriated to our agency. The funds made available in response to our work may be used to reduce government expenditures or be reallocated by Congress to other priority areas.

2. *Do you send the Committee information on VA's progress to implement your recommendations so that we know that you are following up?*

We report annually to Congress on recommendations that have not been implemented and maintain a database of open recommendations that provides the status of agencies' progress in implementing these recommendations. The open recommendations database is available to the public on our Web site at www.gao.gov. Specific recommendations are easy to identify because the database is searchable by agency, congressional committee, and key words. Congressional oversight and authorization committees, as well as appropriations committees, can use this database to prepare for hearings and budget deliberations.

In responding to these questions, we relied on our recent work related to our review of VHA's purchase card program for fiscal year 2002, our *Policy Manual,*[4]

[3]The Federal Managers' Financial Integrity Act of 1982 directed OMB to establish guidelines for executive agencies to use in evaluating internal accounting and administrative control systems 31 U.S.C. 3512(d)(1).

[4]U.S. General Accounting Office, *Policy Manual* (Washington, D.C.: Jan. 1, 2004).

Performance and Accountability Highlights Fiscal 2003,[5] and *Agency Protocols.*[6] We conducted this work in accordance with generally accepted government auditing standards during July 2004.

Should you or your staff have any questions on matters discussed in this letter, please contact me at (202) 512-6906 or williamsm1@gao.gov; or Alana Stanfield, Assistant Director, at (202) 512-3197 or stanfielda@gao.gov. A major contributor to this letter was Carla Lewis.

Sincerely yours,

McCoy Williams

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Director, Financial Management and Assurance

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[5]U.S. General Accounting Office, *Performance and Accountability Highlights, Fiscal 2003*, GAO-04-264SP (Washington, D.C.: January 2004).

[6]U.S. General Accounting Office, *GAO's Agency Protocols*, GAO-03-232SP (Washington, D.C.: December 2002).

Questions for the Record
Honorable Christopher H. Smith, Chairman
Committee on Veterans' Affairs
June 17, 2004

Follow-up Hearing on Efforts to Identify and Eliminate Fraud, Waste, Abuse and Mismanagement in Programs Administered by the Department of Veterans Affairs

1. *Mr. Griffin, VA is a big agency and your office is very busy.*

   - *How do you decide the best way to allocate your resources?*
   - *If you had an additional $10 million in funding next fiscal year, what would you accomplish with it? How much would you need to fully staff your fugitive felon audits?*

a. The Office of Inspector General (OIG) mandate focuses our efforts on promoting economy and efficiency in the administration of, and preventing and detecting criminal activity, waste, abuse, and mismanagement in Department of Veterans Affairs (VA) programs and operations. We clearly recognize that the scope of VA operations, both in size and location, require us to carefully allocate investigative, audit, and healthcare inspection oversight resources. In determining that allocation, we take into consideration a variety of factors.

The OIG Strategic Plan for 2001-2006, provides the structure, goals, and strategies for fulfilling our oversight mandate and keeps the focus on the key issues facing VA in order to maximize our impact. Strategic goals at the forefront of this plan concern the quality and timeliness of VA health care, benefits processing, financial management, procurement, and information technology. We also consider the President's Management Agenda; the Major Management Challenges VA faces; requests from Congress, the Secretary, and other senior VA officials; projects evolving from our Combined Assessment Program (CAP) work; our proactive data-matching initiatives; and the 15,000+ Hotline contacts we receive each year. We also factor in and must address mandated workload such as the annual Consolidated Financial Statement audit.

We commit to ensuring that our resources are spent in a cost-efficient manner. We regularly use performance measures to determine the impact of our oversight work. For example, during the past 5 years our cost-benefit ratio has averaged $30 in monetary benefits for every $1 expended. For the semi-annual reporting period ending March 31, 2004, OIG reported $57 in monetary benefits for every $1 expended. We use performance and financial data to make decisions about allocating FTE, opening new offices, shifting resources, awards, and contracting for services. We also use it when deciding whether to address a Hotline case in-house or refer it to VA, and which proactive initiatives to implement. As unanticipated requests come in from Congress or the Secretary, we are constantly making decisions on how best to accomplish these requests and which office(s) should do the work. For example, when we conducted an

audit of the security and safety of all VHA research laboratories, and, more recently, a review of the Bay Pines Medical Center, we had to make decisions on which projects to cancel or postpone and the impact this would have on costs and overall performance. We constantly use financial and performance data; mandatory, proactive, and reactive workload information; expertise needed; and similar considerations in decisions on how we prioritize, assign, and carry out our mission.

It is important to note, however, that some very important work does not result in a quantifiable monetary benefit. For example, how do you put a dollar value on investigating the untimely death of a veteran, the cost for putting a serial killer behind bars, or removing a drug dealer or dangerous fugitive felon employee from one of our hospitals? In addition, much of our mandated work, such as the Consolidated Financial Statement audit or the Federal Information Security Management Act testing of the security of information systems, does not yield direct monetary benefits.

In every decision to commit OIG resources, we strive to improve VA programs and operations, provide objective and independent information for better decision-making, eliminate criminal activity, highlight accountability, and keep both the Secretary and Congress fully informed of our findings and recommendations. We also strive to have the greatest impact possible, achieve our strategic goals, and maximize overall performance.

b. If we received an additional $10 million in funding for OIG oversight in FY 2005, we would deploy resources to address two significant needs: (i) full implementation of the Fugitive Felon Program and (ii) expanded oversight coverage of VA medical care delivery by staffing two additional Office of Healthcare Inspection (OHI) regions. With this level of added funding, we would hire 37 FTE for the Fugitive Felon Program and an additional 12 FTE devoted to improving the delivery of VA health care.

We estimate full implementation of the Fugitive Felon Program in FY 2005 would cost $7.6 million. In partially implementing the program to date, we received more than 2.2 million felony warrant files from participating agencies and states. We are continuing to enter into agreements with additional states. We have compared warrant files to over 11 million records contained in VA benefit and health care system files, resulting in the identification of 32,346 matched records. As a result, we referred 11,153 cases to various law enforcement agencies throughout the country. The information we provided to the agencies has led to the apprehension of 402 fugitive felons; VA OIG Special Agents and VA Police Officers directly participated in 239 of these arrests. A number of the fugitives apprehended were sought on charges of murder, manslaughter, sexual assault, robbery, drug offenses, and other serious felonies. The apprehension of these felons creates a safer environment in VA facilities and our communities. We have referred 8,299 fugitive felons identified to VA for benefit suspension, resulting in the creation of $11.2 million in overpayments and an estimated cost avoidance of over $100 million.

Additional FTE would also provide us with the capacity to investigate and resolve partial matches between VA and fugitive felon records. Computer matching returns either exact or partial matching results. All exact matches are immediately forwarded by the OIG to the law enforcement agency holding the warrant. However, before a partial match can be converted to an exact match, OIG must further investigate to determine if the subject in the warrant is indeed the same subject in VA files. To validate a match, law enforcement personnel must gather additional information, generally from databases and information available for law enforcement use only. While time consuming, we anticipate significant benefits would result from resolving the partial matches. This additional work would identify more fugitive felons and further reduce erroneous payments. There are currently 460 partial matches pending review.

The United States currently has an estimated 1.9 million felony warrants outstanding, and an estimated 2 million new felony warrants will get added each year. The expected outcomes, if fully funded at a cost of $7.6 million, include an estimated cost avoidance reaching $209.6 million per year. This would remove thousands of fugitive felons from access to VA facilities, resources, and staff.

We would use the remaining $2.4 million to augment the FTE level of the OIG OHI, which is responsible for implementing Public Law 100-322 by conducting inspections of patient care and quality assurance issues; conducting Veterans Health Administration (VHA) health care program reviews; conducting evaluations of individual VA medical center operations; and overseeing the effectiveness of VHA Office of the Medical Inspector, Office of Quality and Performance, and the National Center for Patient Safety.

The expansion of OHI regions is necessary if the OIG is going to be able to provide an acceptable level of oversight of the current and future level of care and services provided by the Department. OHI has 36 operational FTE located in six OIG regional offices in Atlanta, GA; Dallas, TX; Bedford, MA; Chicago, IL; Los Angeles, CA; and Washington, DC. We would use additional funding to establish two new OIG Healthcare Inspection offices to provide enhanced coverage of VA facilities.

OHI currently operates with a ratio of one Healthcare Inspector for every 40 VA health care facilities. In other terms, this is one Inspector to review every 1.3 million patient encounters. In addition, presently OHI investigates less than 10 percent of the health care service and malpractice complaints received, leaving over 90 percent of the health care complaints for VHA's internal review.

The addition of 12 FTE would allow OHI to expand its efforts on strengthening VHA's quality management infrastructure, and address a variety of significant health care issues. In addition to continuing CAP reviews, OHI could expand nationwide evaluations of VHA health care programs; provide independent, objective oversight of a greater number of individual episodes of care in response to patients' complaints, Congressional inquiries, or stakeholder requests; increase clinical consultations on

criminal investigations; and expand OHI work on VHA's internal quality management programs.

2. *Your reports on VHA physician and nursing staffing standards are disheartening. Who is responsible for ensuring that your recommendations are not ignored? Should the Committee be considering legislation in this regard?*

The recommendations were made to the Under Secretary for Health, who is responsible for ensuring they are implemented. Public Law 107-135 requires the Secretary, in consultation with the Under Secretary for Health, to establish a policy on the staffing of medical facilities to ensure that staffing for physicians and nurses is adequate to provide veterans appropriate, high-quality care and services. In our view, no further legislation is necessary – only compliance with Public Law 107-135.

3. *Mr. Griffin, your testimony alludes to the belief that at some VA facilities VA must support the affiliated medical school at all costs. This leads to poor or unethical decisions concerning contracts for physician and other services. Could this belief also be a factor in VHA's failure to implement physician staffing standards?*

The OIG believes physician staffing and performance standards are important and necessary management tools that are required to determine personnel requirements, measure performance, and formulate reliable budget needs. We have reviewed contracts and proposals which generally reflect inadequate acquisition planning and justification for contracting out for services. We have also seen examples of vague requirements, duties and responsibilities not clearly defined, a lack of key personnel clauses, unsupported overhead rates, a lack of direct-hire effort, and contracts where VA is paying more than fair and reasonable pricing. The results frequently appear to benefit the affiliated medical school more than VA. VHA informed us that they have developed a directive on staffing standards; however, it has not yet been implemented. We were informed by VHA that they anticipate issuing it the end of August 2004.

4. *Mr. Griffin, in your opinion, what has caused the inordinate delay in the issuance of nursing staffing standards?*

VHA senior managers need to provide better guidance and oversight to facility managers by developing and implementing a staffing policy as prescribed by Public Law 107-135. The methodology has to be flexible enough to be implemented at all facilities and responsive to the dynamic changes in workload and the availability of nursing and support personnel. Facilities will have to begin collecting and inputting a standard set of data in order to apply the national methodology consistently and monitor staffing across all patient areas. Finally, issuing national nurse staffing standards goes against the tradition within VHA that staffing decisions are fully decentralized, with only generalized guidance from headquarters to address patient safety.

5. *Mr. Griffin, how much do you estimate VHA could save each year if it had the right physician and nursing standards and purchased health care resources at economical rates?*

OIG has not developed any cost estimates of savings resulting from implementing physician staffing standards or purchasing health care resources at economical rates. However, our current work on nurse staffing indicates that implementation of nurse staffing standards would reduce supplemental nursing resources by 10 percent, reduce absenteeism by 1 percent, and reduce RN turnover, yielding $38 million a year.

6. *Mr. Griffin, your written testimony talks about employee injuries due to violent patient incidents. The cost of these injuries is estimated to exceed $7 million in a single year, and $149 million in lifetime costs. Can you give us examples of typical injuries that are caused by such encounters, and how VA might reduce its future liabilities?*

The National Institute for Occupational Safety and Health, a research agency for the Centers for Disease Control and Prevention, defines workplace violence as "... violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." VA employees have experienced violence from patients that has resulted in mental and physical disabilities, injuries, and deaths. Examples of violent behaviors include verbal and physical assaults; use of weapons, including guns and knives, rapes; blunt injuries; choking; biting; spitting and throwing body fluids; and kidnapping.

Our *Draft Report: Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program Cost*, which we discussed during the June 2004 hearing, identified 17 violent patient incidents in our national random sample. These were generally attacks or assaults by patients that result in sprains and contusion to the employee. Specific examples follow.

- A 51 year old nursing assistant was attacked by a patient, who inflicted a karate-chop to the employee's neck, resulting in contusion to the neck and back. The employee is unable to work and is currently receiving $1,832 in workers' compensation every 28 days.
- A 49 year old nurse was assaulted by a patient. It took the intervention of another nurse to aid in the employee's escape from the patient. As a result of this assault, the nurse ended up with thoracic, neck, and lumbar sprains. Additionally, the nurse now has anxiety attacks. The employee is unable to work and receives $1,775 in workers' compensation every 28 days.

With regard to how VA could reduce future liabilities, our report, *Management of Violent Patients*, 02-01747-139, issued May 3, 2004, made recommendations to the Under Secretary for Health to reduce the incidence of patient-perpetrated violent acts. The Under Secretary for Health agreed with and provided acceptable implementation plans with target completion dates for the following recommendations.

- Guidelines be implemented for the appropriate use of automated warning flags, and that flags be used consistently by all VHA facilities to alert employees dealing directly with patients when there are histories of violence. (This recommendation remained unimplemented since publication of the earlier OIG report, *Evaluating VHA Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients*, Report Number 6HI-A28-038, dated March 28, 1996.)
- Interdisciplinary response teams be established in each facility and team members be trained in violence management; and that the teams appropriately respond to all emergency calls.
- A consistent method of identifying and reporting violent incidents be developed, and complete information be available to an interdisciplinary committee responsible for reviewing, analyzing, and trending this data, and recommending corrective strategies.

7. *The Committee understands that in some parts of the country, VA has made extensive use of case managers to control worker compensation costs. Why isn't this a standard practice throughout the VA?*

It is our understanding that staffing shortages limit some VA facilities' ability to control and reduce Workers' Compensation Program (WCP) cost. All facilities have someone designated to process workers' compensation claims. Generally, it is staff of the Human Resource Service; however, the caseload at some facilities does not warrant a full-time position. In those facilities, the staff designated to work cases have other duties and responsibilities. The key to successful management of any WCP is the commitment of the facility management to provide the resources needed to ensure that the facility effectively manages its cases in an effective and timely manner. In our *Draft Report: Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program Cost*, we pointed out that case management improvements still need to be completed. This would include maintaining a VA case file on all open/active claims; providing timely follow-up actions on these claims; ensuring that if a claimant has work capacity, a job is offered; and establishing a good working relationship with the Department of Labor's District Office of Workers' Compensation that handles the facility's WCP claims.

8. *The IG stated that VHA planned to have a developed model for primary care physicians by June 2003. Public Law 107-135 mandated that staffing standards for physicians and nurses be in place by January 2002. VHA has yet to mandate a uniform model to establish primary care provider staffing standards. When did the IG offer the DOD staffing models to VHA?*

We provided VHA information on the Department of Defense's staffing standards in November 2002.

9. *The IG stated that 7 of 15 medical facilities did not make sure that each part-time physician was provided a written agreement, specific to the physician, acknowledging the physicians understanding of VA's employment expectations and employee responsibilities and which describe the amount of time allotted for clinical, administrative, research, and educational activities. When was this audit done? Please identify the deficient facilities?*

The February 18, 2004 report, *Follow-up of the Veterans Health Administration's Part-Time Physician Time and Attendance Audit,* number 03-02520-85, was performed on August 12, 2003. The seven deficient facilities were the VA Medical Centers (VAMCs) in Ann Arbor, Baltimore, Durham, Milwaukee, Philadelphia, San Antonio, and West Haven.

10. *Only 120 of 215 (56 percent) supervisory physicians reviewed received a copy of VHA's Handbook 1660.3 on conflict of interest controls. Please elaborate.*

Past OIG and Government Accountability Office (GAO) reports on VHA practices in the area of scarce medical specialist services contracting disclosed that some physician supervisors and managers did not know about the applicable conflict of interest rules. OIG and GAO investigators found violations of these rules. On July 24, 2002, VHA issued Handbook 1660.3 to provide procedures for avoiding conflict of interest problems associated with scarce medical specialist services contracting.

The Handbook specified that Facility Directors must ensure that each Chief of Staff and each physician, clinician, and allied health supervisor or manager receive a copy of the Handbook. During our February 2004 *Follow-up of the Veterans Health Administration's Part-Time Physician Time and Attendance Audit,* we found that none of the supervisory physicians or managers tested at VAMCs in Ann Arbor, Cleveland, Philadelphia, San Antonio, Tampa, or West Haven had received a copy of VHA Handbook 1660.3.

11. *In 1998 and then again in 2003, the IG made several recommendations to improve the Workers' Compensation Program. According to the IG, there are at least four areas that need to be addressed to improve the program's case management. When will VA complete its implementation of the changes recommended by the IG?*

Department program officials are in the process of developing a plan, including milestone dates, to implement recommendations included in the draft OIG follow-up report that was recently issued. In the Department's response to the OIG draft report, it was noted that completion of much of the implementation plan would be contingent upon availability of administrative and funding support. We are in the process of preparing the final report.

12. The IG also recommended that the Assistant Secretary for Management make the Workers' Compensation Program an Internal High Priority Area. Does the VA have a plan of action with timelines to correct the identified weaknesses in the program?

The comments provided by the VA Assistant Secretary for Management noted that the Office of Human Resources and Administration (HRA) is working with appropriate VA elements to develop and implement a corrective action plan with milestones to correct this program weakness. The action plan will address the 10 actions identified in recommendation 2 of the OIG draft report and provide specific corrective actions with targeted milestone dates. Additionally, the Assistant Secretary recommended that this internal high priority area become an item for discussion at the monthly performance review meetings with the Deputy Secretary. However, as stated in response to question 11, implementation of many of the actions required is contingent upon available funding.

Question for the Honorable Richard Griffin
Inspector General of the Department of Veterans Affairs
From the Honorable Lane Evans
Ranking Democratic Member, House Committee on Veterans Affairs
Before the Full Committee Hearing on June 17, 2004

Comment on the key area of agreement or disagreement with the 81 pages of rebuttal, explanatory, or prospective action comments submitted by VA in response to the testimony of the IG, Richard Griffin for the June 17, 2004, hearing.

PHYSICIAN TIME AND ATTENDANCE (Pages 1 – 9)

The Department of Veterans Affairs' (VA's) comments discuss two recently-issued Office of Inspector General (OIG) time and attendance reports. The comments do not fully describe the status of the two OIG reports discussed below.

Audit of the Veterans Health Administration's Part-Time Physician Time and Attendance, Report 02-01339-85, issued April 23, 2003

Veterans Health Administration (VHA) comments on five of the ten recommendations indicated that either headquarters actions are completed or all actions are completed. However, our follow-up status shows that we are waiting for the following:

- Finalized copies of four directives/handbooks.
- Recommended statutory or regulatory changes needed to implement the reforms and publish the appropriate policy and guidance.
- Copy of the formal establishment of the two monitors (electronic and physical verifications) that measures enforcement of physician time and attendance.
- Documentation showing part-time physician time and attendance requirements is included in the VISN Directors' quarterly performance reviews.
- Documentation showing the established formal process that requires facility directors to certify compliance with applicable policies and procedures to the VISN directors, and in-turn the VISN directors will report the facility compliance to the Deputy Under Secretary for Operations and Management annually.
- Completed evaluation of appropriate technological solutions that will facilitate physician timekeeping and plans to pursue finalization.

Follow-up of the Veterans Health Administration's Part-Time Physician Time and Attendance Audit, Report 03-02520-85, issued February 18, 2004

VHA's comments stated that only 2 percent of the part-time physicians reviewed were not in compliance with VA policy. The OIG report detailed that 8 percent of the part-

time physicians scheduled for duty were not on duty, approved leave, or authorized absence and potentially not meeting their VA employment obligations.

Following is an explanation for the difference between VHA's 2 percent figure and OIG's 8 percent.

- On August 12, 2003, OIG conducted an unannounced follow-up at 15 VA medical centers (VAMCs). We reported that most part-time physicians were on duty as required. However, 58 of 729 part-time physicians (8 percent) who were scheduled for duty were not on duty, approved leave, or authorized absence.
- Specifically, OIG located 43 of the 58 who were not on duty. Of these, 25 claimed to be on non-emergency leave, but there was no evidence that leave was approved; and 18 stated they had changed their scheduled tour of duty but had not requested and received prior written approval for the schedule changes.
- There were 15 of the 58 who were either located performing non-VA duties or could not be located at all. These 15 are the 2 percent of the 729 part-time physicians reviewed to which VHA was referring.
- By using the 2 percent figure, VHA was not considering the 43 physicians who were not present at the VAMC during their duty hours and did not have approved leave, authorized absence, or approval for changed hours.

The statement that OIG found comprehensive written agreements were documented for 98 percent of physicians surveyed during this same audit is misleading. OIG staff did find written agreements for 1,484 of the 1,519 part-time physicians (98 percent) at the 15 medical centers. However, only 230 physicians (15 percent) had agreements that specified the amount of time allotted for clinical, administrative, research, and educational activities, as required for each part-time physician. This occurred because the VAMCs were either waiting for further guidance from their VISN or believed the requirement only applied to researchers. Generally, the 230 agreements that contained specific allocations of time were separate memoranda of understanding required when a physician receives Federal research funds.

The VHA comments did not explicitly state that all three multi-part recommendations remain open on this report. To close the report, we must receive evidence that VHA has taken the following actions:

- Ensure part-time physicians request and receive written approval before taking leave.
- Ensure part-time physicians receive approval in writing before changing their tours of duty schedules.
- Implement oversight procedures detailed in VHA Directive 2003-001 to ensure part-time physicians fulfill their employment obligations to VA.
- Ensure all part-time physicians have a written agreement concerning VA's expectations and employee responsibilities that is specific to the physician and

describes the amount of time allotted for clinical, administrative, research, and educational activities.
- Continue to periodically reassess whether employees are appropriately utilized.

We also recommended that the Under Secretary for Health require that Veterans Integrated Service Network (VISN) and medical facility directors ensure that each Chief of Staff and each supervisory physician, clinician or allied health supervisor, or manager receives a copy of the VHA Handbook 1660.3 and signs the required acknowledgement form.

PHYSICIAN STAFFING STANDARDS (VHA Pages 10-12)

Primary Care Panel Size standards (VHA Directive 2004-031) were issued on July 6, 2004. The proposed standard for a primary care panel is about 1,200 patients, adjusted for "support staff per provider," "examining rooms per provider," and the "primary care intensity factor." This directive applies to physicians, non-physician credentialed primary care providers, and providers who require supervision. This directive sets September 30, 2004, as the deadline for all primary care providers to identify their panel size in the Primary Care Management Module software package.

The OIG supports the actions taken by VHA in this directive. Importantly, this directive focuses upon the delivery of health care and does not attempt to quantify efforts that providers make to the many other missions that the VA assumes when determining panel size. Despite this simplification, the OIG is concerned that the complexity of the calculations required to determine panel size under this method add an administrative burden to the process of making the primary care panel size estimate. However, the OIG recognizes that this approach represents a well-reasoned effort to improve VHA's business metrics. As VHA considers the many medical and surgical specialties represented at a typical hospital, the OIG encourages VHA to consider a workload standard based upon data that are obtainable by current VHA data systems, for instance the coding and billing systems or patient scheduling systems. VHA should publish a timeline for the implementation of the remaining physician productivity standards.

Nurse staffing standards are equally important and are not mentioned in VHA's response to the OIG testimony. A plan leading to the adoption of nurse staffing standards should be identified by VHA.

In addition, the comments did not identify the following two open recommendations on physician staffing standards:

- 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.

- Require that VISN and medical center directors reassess staffing requirements annually and certify their staffing decisions to VHA's Deputy Under Secretary for Operations and Management.

REVIEW OF BIOLOGICAL, CHEMICAL, AND RADIOLOGICAL INVENTORIES (Pages 13 – 15)

In addition to the VHA actions listed, the Office of Security and Law Enforcement (OSLE) needs to finalize two security publications that were recently issued in draft for Department comment. After the OSLE guidance is issued, VHA must issue additional guidance, conduct training, and provide facility certifications that all corrective actions have been implemented before OIG will close the remaining 15 recommendations. These recommendations are detailed in the *OIG Semiannual Report to Congress (SAR) October 1, 2003-March 31, 2004,* in Appendix B-Status of OIG Reports Unimplemented for Over 1 Year, on pages 88-89. They have been listed in each SAR since March 2003.

COMMUNITY NURSING HOME OVERSIGHT (Page 16)

The comments did not address the following open recommendations in the December 2002 OIG report, *Healthcare Inspection, Evaluation of VHA's Contract Community Nursing Home (CNH) Program*:

- Finalize new performance indicators.
- Confirm all the scheduled training audio broadcasts have been completed.
- Provide evidence to demonstrate that community health nurses and social workers are visiting veterans in CNHs at the recommended frequency and gathering the recommended information.
- Complete additional guidance, appropriate website links, and special broadcast on new exclusionary criteria related to neglect and abuse.
- Finalize implementation plan/coordinated efforts on how VHA and Veterans Benefits Administration (VBA) employees can most effectively complement each other and share information.

WORKERS' COMPENSATION PROGRAM ISSUES (Pages 21-25; 63-64; 76-77)

We do agree with the VHA comment that improved case management is the primary needed activity. As a follow-up to our July 1998 report, *Audit of VA's Workers' Compensation Program (WCP) Cost, Report 8D2-G01-67,* we recently issued *Draft Report: Follow-up Audit of Department of Veterans Affairs Workers' Compensation Program Cost,* which found the following:

- In 17 of the 246 (6.9 percent) cases, there was not a case file maintained.
- In 43 of the 246 (17.5 percent) cases, the lack of follow up or other actions put the Department at significant risk for abuse or fraud.
- In 43 of the 246 (17.5 percent) cases, medical evidence in the case file showed that the claimant had work capacity, but no job offer was made by the facility. In 7 of these 43 cases, there was evidence that the facility refused to make a job offer.

A central concern that VHA has with our recommendation is they disagree with centralizing program management and oversight under the Office of Human Resources and Administration (HRA). This recommendation stems from the fact that individual Department elements have historically had difficulty in ensuring timely and thorough case management of OWCP cases. A centralized, Department-wide program management approach provides the opportunity for development of a comprehensive plan for effectively managing WCP throughout the Department. HRA's response to this issue is that implementation of our recommendation would be contingent upon available resources.

VHA's comments also stated that the majority of the current WCP costs are the result of old cases. They go on to state that in Department of Labor's (DOL) view, efforts by VHA on these older cases are misdirected and should be placed on new cases. We agree that the majority of costs can be attributed to older cases; but, due to lack of case management, the number of older cases continues to grow. A case example discussed in the draft report concerns a VHA employee who was injured on June 28, 2001. Medical evidence showed the injured employee could return to work with restrictions; however, in a letter dated June 26, 2002 (within a year from injury date), the facility informed the injured worker that no limited or restricted position was available. There was no evidence that the facility pursued any other actions. This case is now three years old and, according to VHA's comments, DOL is of the view that VHA should not be performing any additional case management. As a result of not providing a job to the injured employee to return to the work force in June 2002, the facility missed the opportunity to avoid over $567,000 in future WCP compensation cost. The Department is responsible for WCP cost, so they should be performing case management action on all cases regardless of age or until medical evidence suggests that the WCP recipient will never be able to return to work in any capacity.

The VHA comments also noted that the implementation of VISN level WCP Coordinators or Program Managers appears to have no impact on VISN WCP cost. Our assist efforts and audit results show that it does improve case management efforts, which in the long run will result in lower WCP cost. Admittedly, if facilities do not provide the support to the VISN level WCP Coordinator, then there would be no impact on the VISN's WCP cost. For example, a case discussed in the draft report is on a VHA employee who filed a notice of occupational disease in January 1992. There was no evidence of any significant case management by the facility. The VISN appointed a WCP Coordinator who reviewed the case in 2001. The VISN WCP Coordinator recommended on October 25, 2001, that the facility make a job offer to the employee.

When we reviewed the case file in 2003, there was no evidence that any action had been taken on that recommendation. Over $638,000 in future VISN WCP cost could have been avoided had the facility implemented the recommendation by making a job offer.

VHA's comments state that the majority of VHA's true cost lies in Continuation of Pay (COP) days and that COP data had been poorly measured in the current administrative system. Although FECA regulations require collection of COP information, our 1998 report recommended collection of this information, and our prior assist efforts to VHA in 1999 recommended collection of this information, VHA still does not to collect it. Therefore, no one knows the cost of COP days. It is not included in the annual WCP cost, because it is not a line item in the budget or consolidated financial statements. Collection of COP data is also a repeat recommendation made in the current draft report on our follow-up audit of VA's WCP cost.

CONTRACTING FOR HEALTH CARE RESOURCES (Pages 27 – 28)

VA's comments did not address the recommendations which remain open from the March 2004, *Audit of VA Medical Center Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies, Report 02-01481-118.* The actions require VHA to: (i) direct the full implementation of the purchasing hierarchy; (ii) develop performance monitors to ensure VISNs and VAMCs successfully make the transition to using the purchasing hierarchy; (iii) issue guidance requiring National Acquisition Center review and approval of proposed local contracts; (iv) provide training on the requirements of the hierarchy approach and on the use of available sources of information for contracts, products, vendors, and prices; and (v) increase efforts to award more national-scope contracts.

VETERANS BENEFITS ADMINISTRATION – LARGE PAYMENT VERIFICATION REVIEWS (Pages 70 – 71)

VA's comments did not address the four recommendations that remain open from the July 2000, Audit of the Compensation and Pension C&P Program's Internal Controls at VA Regional Office (VARO) St. Petersburg, Report 99-00169-97. The recommendations and current status are:

- Establish a positive control Benefits Delivery Network (BDN) system edit keyed to employee identification number that ensures employee claims are adjudicated only at the assigned regional office of jurisdiction and prevents employees from adjudicating matters involving fellow employees and veterans service officers at their home office. Current Status: As the Modern Award Processing system is designed, this control will be incorporated. Beta testing of the system began in March 2004. This control will be implemented in the final stages of deployment that is scheduled for completion in December 2005.

- Establish a BDN system field for third-person authorization and a control to prevent release of payments greater than $15,000 without the third-person authorization. Current Status: As the Modern Award Processing system is designed, this control will be incorporated. Beta testing of the system began in March 2004. This control will be implemented in the final stages of deployment that is scheduled for completion in December 2005.
- Determine the feasibility of direct input and storage of rating decisions in BDN. Current Status: A new version of the Rating Board Automation 2000 application was deployed to all VAROs. In March 2004, VAROs were notified that they had 60 days to review the new installation and validate that all outstanding defects that impeded the 100 percent utilization of the new application have been eliminated. Upon conclusion of this period of validation, VBA will determine the feasibility and schedule for the retirement of the old application.
- Take steps necessary to make use of Social Security Numbers (SSNs) as employee identification numbers, and tie BDN access to SSNs. Current Status: VBA implemented a change to the BDN security screen to include SSNs and the BDN user's full name, but the new system that replaces BDN will not have this control. VBA is developing a plan to fix this problem.

INFORMATION TECHNOLOGY SECURITY (Pages 73 – 75)

The comments did not state that all three OIG recommendations remain open from the December 2003 *Audit of the Department of Veterans Affairs Information Security Program, Report 02-03210-43.* These recommendations require VA to implement a centralized IT security program, complete security remediation efforts in 11 areas, and ensure that information security vulnerabilities identified by the audit are corrected.

PURCHASE CARD ACTIVITIES (Pages 78 – 79) and SUMMARY OF VHA PURCHASE CARD PROGRAM (Page 80)

The comments did not address the recommendations that remain open in the April 2004 OIG report, *Evaluation of the Department of Veterans Affairs Government Purchase Card Program, Report 02-01481-135.* VHA, VBA, and the Office of Management must: (i) direct managers to conduct quarterly focused reviews of the Programs to provide assurance that controls are implemented, staff are trained, and the span of control for approving officials is monitored; (ii) develop procedures for approving officials to use in monitoring cardholders' uses of purchase cards; (iii) update VA directive to include span of control criteria for approving officials; and (iv) periodically conduct focused audits of questionable transactions that can be identified through data mining analyses.

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