STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
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HEARING ON ACQUISITION DEFICIENCIES IN VA

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Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to testify on the findings of the Office of Inspector General (OIG) relating to VA procurement processes. I am accompanied today by Belinda Finn, Assistant Inspector General for Audits and Evaluations.

BACKGROUND

Procurement is one of VA's major management challenges. Our oversight of VA's procurement activities is through audits, investigations, reviews, and inspections. In addition, the Office of Contract Review conducts pre- and post-award reviews of contracts awarded by VA's National Acquisition Center. These include Federal Supply Schedule (FSS) contracts for pharmaceuticals; medical and surgical supplies; health care services contracts; and national contracts for major medical equipment. The Office of Contract Review also conducts pre-award reviews of proposals for health care resources to be awarded to VA affiliated universities and medical centers on a sole-source basis. Our work provides us with a unique nationwide perspective on VA's procurement practices. A list of published reports from fiscal years 2004 through 2009 is attached to our testimony.

In the past 5 fiscal years, the OIG has published more than 35 reports relating to VA's procurement practices. These reports identified $112 million in better use of funds. Another 424 reports relating to pre and post-award reviews of FSS contracts awarded by VA's National Acquisition Center and pre-award reviews of health care resource contracts issued by VA medical facilities were issued directly to contracting officers during this time period and are not publically available because they contain proprietary information. The pre-award reviews identified $1.54 billion in potential cost savings if the contracting entity negotiated the recommended fair and reasonable prices. Of this amount, $166 million related to health care resource contracts awarded by VA medical facilities. The post-award reviews collected more than $115 million, which was deposited in VA's Supply Fund.

During this same time period, we conducted 254 criminal investigations relating to procurement that resulted in the arrest of 110 individuals.

In addition, an audit of payments made under Veterans Health Administration's (VHA) non-VA outpatient fee care program estimated about $1.126 billion in overpayments and $260 million in underpayments over a 5-year period due to poor oversight and administration of claims for payment. The audit found systemic program weaknesses similar to those we have identified in VA's procurement processes. We found that VA medical facilities were not properly justifying and authorizing fee services for 80 percent of outpatient care payments. In addition, VA improperly paid 37 percent of fee claims by making duplicate payments, paying incorrect rates, and through other payment errors such as paying for the wrong quantity of services.

Across the board, our audits, reviews, and investigations have identified systemic issues that caused or contributed to procurement failures, overpayments, and misuse of funds, including poor acquisition planning; poorly written contracts; inadequate competition; no price reasonableness determinations; and poor contract administration.

We believe the decentralized organizational structure for procurement activities in VA as well as inadequate oversight and accountability are primary factors contributing to these problems. As we have previously testified, VA procurement is so decentralized that on a system-wide basis, VA cannot identify what it bought, who it bought it from, whether the products or services were received, or whether prices were fair and reasonable.

Data systems such as VA's Electronic Contract Management System (eCMS) and the Federal Procurement Data System (FPDS), which should provide accurate information relating to procurements, contain inaccurate and incomplete data. Because of VA's lack of a system-wide inventory of contracts, we have had to develop techniques for identifying each universe of contracts for audits, investigations, and other reviews. For example, our audit of non-competitive clinical sharing agreements required that we contact each medical center selected for review to obtain their listing of agreements. Although we took steps to assess the information we received, we cannot be certain that we had a complete inventory of agreements for review. If an audit, investigation, or other review involves the purchase of items other than pharmaceuticals purchased through the pharmaceutical prime vendor program, we have to request VA sales data with line item visibility from the vendor as the information is not contained in any VA centralized database.

DEFICIENCIES IN THE PROCUREMENT PROCESS

The procurement process involves at least three critical steps and three groups of individuals who must work together for a successful procurement. The three steps include planning, solicitation/negotiation/award, and contract administration. The three groups of individuals involved in the process are the program office requiring the goods or services, the contracting entity, and the Office of General Counsel. Breakdown at any step in the process or by any of the three groups of individuals can result in the failure of the procurement. Through our oversight activities, we have identified breakdowns at all three steps in the procurement process and by each group of individuals involved in the process.

Procurement Planning

Planning involves identifying requirements, identifying potential sources through market research, developing an Independent Government Cost Estimate, and developing a comprehensive statement of work that clearly defines the requirements, deliverables, and performance measures. Our reports on the failure of contracts for the development of the Core Financial and Logistics System (CoreFLS), the National Vietnam Veterans Longitudinal Study, the development of the Patient Financial Services System, the Centralized Incident Response Capability (CIRC), and the development of the Replacement Scheduling Application identified the inability of the responsible program offices to adequately identify and define their needs as a significant factor in the poor outcome. These failures resulted in losses to VA that exceeded $650 million. (Report Nos. 04-1371-177, 04-02330-212, 06-03285-73, 04-03100-90, 09-01446-203.) Other reports that address deficiencies in procurement planning include the evaluation of sole-source healthcare resource contracts, a national audit of open market medical equipment and supply purchases, a national audit of the acquisition and management of selected surgical device implants, and the contract with the University of Texas Southwest Medical Center for Gulf War illness research, (Report Nos. 05-01318-85, 08-01519-172, 06-03677-221, and 09-0175-164)

The national audit of VHA open market medical equipment and supply purchases reported that VHA medical facility staff needed to plan medical equipment and supply purchases more effectively to reduce purchases on the open market and increase purchases through the FSS. Medical facility staff lacked the knowledge, information, and proper tools to effectively use the FSS. We estimated that VHA could reduce its supply costs by about $41 million over 5 years if it improved its acquisition planning and oversight processes and increased the use of the FSS to purchase medical equipment and supplies. (Report No. 08-01519-172)

Issues identified in these and other OIG reviews include the failure to develop complete and comprehensive statements of work containing specific deliverables and performance measures, which made them difficult to administer and ensure compliance. Our review of the Interagency Agreement between VA and the Department of Navy, Space and Naval Warfare Systems (SPAWAR), found that VA lacked qualified and experienced program personnel to plan and manage IT enterprise development. As a result, VA personnel were unable to develop the required statements of work and essentially abdicated responsibility for IT development to SPAWAR and ultimately to SPAWAR contractors. (Report No. 09-01213-142)

Solicitation/Negotiation/Award

The solicitation, negotiation, and award process can involve the award of a new contract, a modification to a contract to add services or change terms and conditions, or the issuance of a task order or purchase order against an existing contract. One of the most frequent issues we have identified is the failure to comply with Federal laws and regulations requiring competition. As an example, our recent review of the contract awarded to develop the Replacement Scheduling Application showed that the contract was improperly modified at the direction of the program office to change the scope of

work when it was determined that there was no commercial off-the-shelf product available for the program. (Report No. 09-01926-207) An audit of the use of expired funds and related contracting practices at the Boston Healthcare System, the subsequent national audit addressing the same issues, and our review of the CIRC contract also identified that contracts were improperly modified at the direction of program officials to add services that were outside the scope of the original statement of work. These improper *cardinal* changes to the contracts allowed VA medical facilities to noncompetitively obtain goods and services. (Report Nos. 06-03677-221, 08-00244-213, and 04-03100-90)

In a report issued in February 2007, we found that VA conducted a procurement in the middle of the night on a weekend to obtain the services of forensic analysts to review electronic media relating to the theft of an employee's external hard drive containing information about 26 million veterans. This was done at the direction of the program office to avoid competition and steer the contract to the vendor preferred by the program office. A separate administrative investigation found that a contracting officer who expressed concern over the inappropriateness of the procurement was subject to retaliation by a former VA supervisor. Further, we found that the program office approved and authorized payment for additional work that was outside the scope of the task order without consulting with or notifying the contracting officer and authorized payment for travel expenses without verifying the charges. (Report No. 06-02238-84)

Two reviews conducted in response to complaints received through the OIG Hotline identified the failure at facilities in Veterans Integrated Systems Network 7 to comply with Federal Acquisition Regulations (FAR) when purchasing services. Two of the purchases were off General Services Agency (GSA) FSS contracts. We found that a contract was awarded to a retired VA employee on a sole source basis without the justification required by FAR Part 6. In two others awards, the competition requirements in FAR Part 8.4 were not followed because the program office, not the contracting entity, negotiated the procurement. In one, the program officials identified and contacted the contractor, asked the contractor to hire a retired VA employee to perform the work, negotiated the hourly rates, wrote the task orders, and then submitted it to the purchasing agent for signature. In addition, we found that the task order was for services outside the scope of those on the vendor's FSS contract and the services were inherently Governmental in nature. (Report Nos. 08-02110-02 and 08-01866-61)

Another issue we have repeatedly identified is the failure to accurately assess price reasonableness. Our review of VA's contract with QTC Medical Services, Inc., to conduct disability rating examinations showed that VA failed to make a fair and reasonable price determination prior to award. We found indicators that VA may have paid more than fair and reasonable prices for the services provided. When an independent audit conducted at the request of the Veterans Benefits Administration and a subsequent review by the OIG Office of Contract Review identified overcharges, VA officials declined to recover $2.6 million of the $6 million in overcharges. (Report No. 07-02280-104)

Our national audit of VHA's Government purchase card practices examined more than 700 purchase card transactions. We found that for 17.4 percent of the transactions examined, the cardholders did not maintain the documentation needed to confirm price reasonableness or ensure the most efficient use of funds. The results supported the need for VHA to strengthen controls to ensure cardholders maintain adequate documentation of the receipt of goods and services to ensure purchases are made for valid medical facility needs at reasonable prices. (Report No. 07-02796-203)

Our review of the contract awarded to Dell for the lease of computers found that in addition to limiting competition, the price analysis was faulty and that it would have been more cost effective to purchase rather than lease the equipment. (Report No. 08-02213-138)

Our report on FSS contracts awarded to resellers found that contracts and contract modifications adding products and increasing prices were awarded without obtaining the information necessary to determine price reasonableness. For 63 percent of 11,576 products added to four contracts via 28 modifications, the contracting officer failed to document that an adequate price reasonableness determination had been made. (Report No. 05-01670-04)

Our 2005 report relating to our reviews of 72 proposals for sole-source contracts awarded to affiliated institutions to purchase health care services found that VA was overpaying for services provided at the VA medical facility on a per procedure basis because VA was paying 100 percent or more of the applicable Medicare Part B rate, which consists of four components – practice expense, physician expense, malpractice insurance, and a geographic adjustment. The rate should have been reduced because VA was already incurring the costs associated with the practice expense component. (Report No. 05-01318-85) VA subsequently issued policy requiring that the practice expense be excluded from the Medicare rate when negotiating prices. However, a 2008 audit of the administration of these contracts found the policy was not followed. The audit concluded that exclusion of the practice expense component could result in a savings of $2.5 million annually. (Report No. 08-00477-211)

Contract Administration

Once a contract has been awarded or a purchase or task order issued against an existing contract, it must be administered. This process includes ensuring that the right product or service is delivered in a timely manner, at the agreed upon price, and in accordance with the terms and conditions of the contract. Contract administration is the responsibility of the contracting officer and/or the contracting officer's technical representative. When the contractor fails to perform, action must be taken in a timely manner to ensure compliance or the termination of the contract. We have identified numerous systemic problems in contract administration.

A national audit of 58 contracts for health care resource clinical services awarded non-competitively to affiliated institutions showed that VA lacks reasonable assurance that it receives the services it paid for because of ineffective controls to monitor performance.

We identified problems in all contracts in the sample reviewed and found that for 52 percent of the contracts, the vendor was overpaid. We estimated that by strengthening controls, VA could save $9.2 million annually. (Report No. 08-00244-213)

During our recent reviews of contracts for primary medical services provided at VA Community Based Outpatient Clinics (CBOCs) we found that VA overpaid for the services because the Contracting Officer Technical Representatives (COTRs) were not properly administering the contracts. For example, we found that the COTRs were not disenrolling patients in a timely manner, reviewing invoices for accuracy and completeness before authorizing payment, and monitoring performance according to performance measurements in the contract. (Report Nos. 09-01446-233, 09-01446-226, and 09-1446-37)

A national audit of Consolidated Mail Outpatient Pharmacy (CMOP) contract management showed that poor monitoring controls during contract administration put VA at significant risk to overpay for services on contracts valued at $40.7 million. (Report No. 09-0026-143)

In our review of the contract between VA and QTC for rating examinations, we found that neither the contracting officer nor the COTR identified the applicable Medicare Current Procedural Terminology (CPT) codes for laboratory and other tests that QTC was allowed to charge for under the contract. As a result, the COTR approved invoices for payment that included procedural codes created by QTC. In addition, neither the contracting officer nor the COTR ever calculated the actual price that QTC could charge for each CPT code. Notwithstanding the absence of this key information, the COTR approved the invoices for payment. (Report No. 07-02280-104) Our review of the CIRC contract found that VA paid the invoice every month without verifying deliverables. We also found that under the contract VA purchased almost $35 million in equipment but did not know whether the VA ever obtained possession of the equipment and, if so, where the equipment was located. (Report No. 04-03100-90)

A national audit of VHA's Home Respiratory care program found that the program office, including the COTRs, lacked documentation to support purchases, and lacked invoices and delivery tickets to support certification for payment. We estimated that proper contract administration could reduce program costs by about $16.8 million over 5 years. (Report No. 06-00801-30)

We also have found that VA is reluctant to take appropriate and timely action when a contractor does not perform under the contract or does not comply with contract terms and conditions. For example, when Unisys consistently failed to submit deliverables for the Patient Financial Services System within the time frames established in the contract, it was almost 4 months before VA began any action to obtain compliance or terminate the contract for default. Despite the delay, the termination process was proceeding when the Office of General Counsel decided unilaterally that a termination for default was not feasible. Instead, VA terminated the contract for convenience, paid the contractor for the level of effort as of the date of termination, and took possession of the

work that had been completed. We were told that a termination for convenience was necessary because it was VA's intent to obtain the work completed to date and contract with another vendor to finish the project. Shortly thereafter, VHA cancelled the project, thus wasting the $30 million paid to Unisys. (Report No. 06-03285-73) Similarly, our review of the contract between VA and the University of Texas Southwest Medical Center for Gulf War illness research, showed that the contracting officer was precluded by internal and external forces from timely initiating the process to require compliance or terminate the contract for default when the contractor blatantly refused to comply with key terms and conditions of the contract. (Report No. 09-1075-164.)

CAUSATION

Deficiencies in VA's procurement program are caused by a variety of factors, including:

Decentralization of the acquisition function and lack of oversight

The vast majority of contracting officers and contract specialists work directly for the program office requesting the service. We have found that they experience undue pressure to comply with the desires of program office and/or facility management rather than complying with applicable laws and regulations. As a result, the interests of the Government are not protected.

In addition, there is inadequate oversight of procurement within VA. This is due to the decentralization of the process and the failure of VA entities with dedicated contract specialists to establish an oversight program. VA has expended resources to conduct pre-award and post-award reviews of FSS contracts and pre-award reviews of health care resource contracts awarded sole-source to affiliated institutions. VA has also vigorously campaigned against efforts to remove contract provisions that would prohibit oversight of FSS contracts through pre-award and post-award reviews. These reviews have not only resulted in significant dollar savings and recoveries as discussed above, but they have had a deterrent effect. Of the 164 post-award reviews conducted in the past 5 fiscal years, 97 (59 percent) were the result of voluntary disclosures.

Effective oversight is difficult because there is no central database that captures contracting and purchasing information. For example, in 2007, the Office of Acquisition, Logistics and Construction (OAL&C) began requiring contracting entities to use eCMS for procurements over $25,000 to gain better oversight of VA procurements and to ensure better contracting. However, our audit of the system found that it was far from a complete inventory of acquisitions. We estimated that only 17 percent of procurement actions that were required to be recorded were recorded in VA's eCMS system and 30 percent of VA procurement actions that were recorded in the FPDS were not recorded in eCMS records as required. We concluded that the reports generated by eCMS were unreliable and could not be used in making management decisions.

We also have found that some procurements are made invisible to oversight by having other Government agencies do the procurement. This problem was identified in our review of the Interagency Agreement between VA and SPAWAR and in our report on the Replacement Scheduling Application. In the latter report, we found that GSA is

awarding contracts on behalf of VA for IT related services. We found that these contracts did not appear in any VA system, that VA did not have a copy of the contract or task order, and the COTR was located at GSA even though the services were provided at a VA location.

This lack of oversight within VA has been the common denominator in the criminal investigations involving procurement fraud we have conducted during the last 5 years. For example, until we arrested the third CMOP Director, VHA oversight of local CMOP contracts for supplies and services was non-existent. The former Director of the Dallas CMOP steered a $55 million services contract to a company and was arrested after he attempted to extort an ownership share of this company. The former Director and Associate Director of the Murfreesboro CMOP were arrested after we developed evidence that the pair had received $350,000 in kickbacks from supplies and services purchases without competition, including the purchase of 115,000 rolls of inferior quality red tape meant to secure controlled substance packages. The former Director of the Hines CMOP was arrested after we were notified by a supervisory contracting officer at the Great Lakes Acquisition Center of suspected collusion between this Director and a favored contractor who had been awarded $10 million in service and supply contracts non-competitively in the previous 10 years. Our investigation revealed that the Director had not only accepted gratuities in exchange for this favoritism but also knowingly allowed his Associate Director to operate a fraudulent 8A firm that received at least $7 million in sub-contracts for services from another company doing business with VA.

We noted in our national audit of CMOP contract management that in response to criminal investigations involving the CMOP program, the National CMOP Office began centralizing all CMOP procurement at the CMOP in Leavenworth, Kansas. In addition, the authority over CMOP contracting officers transferred from the National CMOP Office to VA's National Acquisition Center. (Report No. 09-00026-143) We believe this centralization of the two functions in different offices will result in better procurements and decrease the potential for similar criminal activity.

<u>Noncompliance with VA policies and regulations</u>

In addition to statutes and regulations, VA has established internal procurement policies. Our reviews have consistently found non-compliance. For example, after a report on VHA's purchasing practices that we issued in 2002, VA convened the Procurement Reform Task Force to address the issues raised in the report. One result was a purchasing hierarchy that required VHA to purchase medical/surgical supplies and equipment and pharmaceuticals from VA-awarded national contracts, including FSS contracts, before entering into a local contract or purchasing products open market. In 2004, 2007, and again in 2009, we issued audit reports showing that VA facilities were not complying with the purchasing hierarchy yet could save significant amounts of money if they used national contracts and blanket purchase agreements instead of purchasing health care products on the open market. (Report Nos. 02-01481-118, 06-03677-21, 08-01519-172)

Similarly, in response to our 2005 report on sole-source contracts with medical schools and other affiliated institutions, VA Directive 1663 established specific requirements for contracts awarded for health care services pursuant to 38 U.S.C. §8153. Our subsequent pre-award reviews of proposals for these contracts have found little compliance with the provisions of the policy. To gain better oversight of VA procurements and to ensure better contracting, in 2007, OAL&C issued policy requiring contracting entities to use eCMS for certain procurements. A recent audit found that the system was ineffective, in part, because VA personnel were not using the system as mandated. As a result, the reports generated by the system were unreliable and could not be used in making management decisions.

Lack of Training and Expertise

In the last couple of years, VA has made a significant effort to recruit and train a strong acquisition workforce. However, we still find that contracting personnel lack training and expertise in the types of procurements they are asked to process. Contracting officers who do not understand the nature of the goods or services being procured and their relationship to the needs of the program office are unable to assist program officials in the planning, awarding, and administration of the contract. IT procurement is one example. As noted in our 2009 report on the failure of the contract for the Replacement Scheduling Application, the contracting officer had no experience or expertise in the award and administration of contracts for IT system development. To help resolve this problem relating to IT procurements, VA is in the process of consolidating IT procurements under OAL&C at a facility in Fort Monmouth, New Jersey. We have identified the same problem at VHA facilities with respect to the award and administration of contracts for health care resources. Our pre-award reviews and our audit of the administration of the sole-source contracts to affiliated institutions have identified that the contracting officers and COTRs lack training regarding the use of Medicare rates even though prices are based on Medicare rates.

We also have found that program officials often do not have the training and expertise needed to define requirements, develop statements of work, or monitor contract performance. This results in poor contract development and administration. This problem was highlighted in our review of the Interagency Agreement with SPAWAR. We found that VA's Office of Enterprise Development had relinquished its authority and responsibility for IT program development to SPAWAR and SPAWAR contractors.

Mr. Chairman, this concludes our statement and we would be pleased to answer any questions that you or other Members of the Subcommittee may have on these issues.