STATEMENT OF
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U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
POTENTIAL BUDGETARY SAVINGS WITHIN VA: RECOMMENDATIONS FROM VETERANS SERVICE ORGANIZATIONS

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Mr. Chairman and Members of the Committee, thank you for this opportunity to testify on the potential for budgetary savings within the programs and operations of Department of Veterans Affairs (VA). We read the recommendations made by Veterans Service Organizations (VSOs) for budgetary savings within VA with great interest and can comment on VA's performance in several of these areas. My testimony today will highlight a broad range of programs and issues where we have identified possible cost savings, recoveries, better uses of funds, and opportunities for VA to achieve economies and efficiencies.

VA FEE CARE PROGRAM

Of the many issues raised by the VSOs, improved management and oversight of medical care provided outside of VA facilities, commonly known as fee care, offers the greatest opportunity for savings. Under the program, VA medical centers authorize veterans to receive treatment from non-VA health care providers when certain services are unavailable at VA facilities; cannot be economically provided in the veteran's geographic area; or in emergencies when delays may be hazardous to life or health. The cost for fee care has increased from $1.6 billion in fiscal year (FY) 2005 to $4.4 billion in FY 2010. This amount is expected to increase further in future years as both the demand and cost of health care rises. We have issued four audit reports related to fee care since August 2009.

In August 2009, we reported that the Veterans Health Administration (VHA) improperly paid 37 percent of outpatient fee claims, resulting in $225 million in overpayments and $52 million in underpayments in FY 2008 and an estimated $1.1 billion in overpayments and $260 million in underpayments over a 5-year period. Also, serious weaknesses in the processes for authorizing outpatient fee care resulted in 80 percent of payments lacking proper justification. Clinicians typically documented the diagnosis and treatment plan but no rationale for using fee care. Fee staff did not conduct required cost analyses to determine if lower cost alternatives, such as transporting patients to other VA facilities, were available. In August 2010, we reported that VHA improperly paid 28 percent of inpatient fee claims, resulting in net overpayments of $120 million in FY 2009 and an estimated $600 million in improper payments over a 5-year period. Between these two audits of inpatient and outpatient medical care, we estimated potential improper payments of $1.5 billion through FY 2015 could be avoided by more effective policies and procedures to oversee and manage fee care services. (*Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, August 3, 2009, and

Veterans Health Administration – Audit of Non-VA Inpatient Fee Care Program, August 18, 2010)

During the audit of inpatient claims, we found the Fee Program's inadequate payment processing system, Veterans Health Information Systems and Technology Architecture (VistA) Fee, contributed to the high rate of payment errors. VHA was aware of the shortcomings of VistA Fee and has fielded an integrated claims processing and management system. Further, the average cost per claim for the Fee Care Program was $9.96 compared to $2.55 for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), a difference of $7.41 per claim. In addition, sites that processed fee payments for a single VA medical center (VAMC) had an average cost per claim of $10.78. Consolidated sites, which processed claim payments for multiple VAMCs, had an average cost per claim of $6.85, or about one-third less. As a result, we conservatively estimated that current claims processing inefficiencies cost VHA $134 million through FY 2015 and recommended VA evaluate alternative organizational models and payment processing options, which they agreed to do.

Consolidation of processing activities is one solution to lowering the average cost per claim, but not the only alternative. Commercial claims processing organizations already process claims for Federal government agencies, such as Medicare and TRICARE. Since our first audit in 2009, VA has adopted Medicare payment methodologies for common services such as ambulatory surgery, anesthesia, dialysis, and the payment of professional services. With business changes, VA may be able to leverage competition for the claims processing services. In response to our recommendation, VA contracted with the National Academy of Public Administration to study organizational alternatives, including consolidation or contracting out for services.

We also evaluated VHA's controls to prevent and detect fraud and reported VHA had not identified fraud as a significant risk to the Fee Care Program. Health care industry experts have estimated that 3 to 10 percent of all claims involve fraud and we see VA facing similar risks. We estimated that VA could be paying between $114 million and $380 million annually for fraudulent claims and recommended VA establish a fraud management program with data analysis and high-risk payment reviews, system flags for suspicious payments, employee fraud awareness training, and fraud reporting. (*Veterans Health Administration – Review of Fraud Management for the Non-VA Fee Care Program*, June 8, 2010)

In the 2½ years since our 2009 report on the Fee Care Program, VHA has made many changes to the program. However, fundamental controls are still problematic, as illustrated by our recent report, *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* (November 8, 2011). We reported the medical facility mismanaged fee care funds and experienced a budget shortfall of $11.4 million, which was 20 percent of the health care system's FY 2010 fee care program funds. One cause of the shortfall was the lack of effective pre-authorization procedures, the same problem we reported in 2009. In fact, the facility processed about $56 million in fee claims without adequate review to ensure services were medically necessary.

Our most recent national audit on VA's fee care program reported VHA missed opportunities to bill third-party insurers for 46 percent of billable fee care claims, reducing third-party revenue by $110.4 million annually or by as much as $552 million through FY 2016. VA bills third-party health insurers for nonservice-connected medical services provided by VA or non-VA care as part of the Medical Care Collection Fund (MCCF) Program, which supplements VA's medical care appropriations. In FY 2010, the MCCF Program collected approximately $1.9 billion in total third-party revenue, which was about 69 percent of the total $2.8 billion revenue. The potential for third-party revenue from the Fee Care Program is expected to increase in future years due to increased demand for care and increased health care costs. (*Audit of Veterans Health Administration's Medical Care Collection Fund Billing of Non-VA Care,* May 25, 2011)

CLAIMS BROKERING

The VSOs noted the potential inefficiencies of the Veterans Benefits Administration's (VBA) claims brokering process. We have testified several times on the many challenges that VBA faces to improve the accuracy and timeliness of disability claims decisions, managing an ever-increasing inventory of claims, and maintaining efficient VA Regional Office (VARO) operations. One of the steps VBA has taken to address these challenges is to establish 13 resource centers that process compensation claims brokered from other VAROs. VBA believes effectively shifting claims from one VARO to another allows VBA to better align workload with available staffing resources and reduce claims backlogs by expediting claims processing.

Our nationwide audit of the brokering process identified opportunities for VAROs to improve brokering effectiveness (*Audit of VBA's Compensation Claims Brokering*, September 27, 2011). We evaluated the overall effectiveness of claims brokering and reviewed available documentation on the costs of transporting hardcopy claims folders from one location to another. VBA and VAROs do not consistently track or report the costs of transporting brokered claims between VAROs. In fact, only one of seven audited VAROs was tracking the costs of transporting brokered claims. During one year, this VARO spent about $40,000, or approximately $2.00 per claim, for the one-way transportation of approximately 18,500 brokered claims folders. Based on the one VARO's cost information, we estimated that VBA could have spent almost $740,000 to transport brokered claims using express delivery services during FY 2009.

We also reported VBA can improve brokering effectiveness by addressing ineffective practices such as untimely brokering of claims by the original regional office, reducing excess inventories of unprocessed claims at resource centers, brokering to separate facilities for development and rating, and brokering claims to resource centers with lower claim processing accuracy rates than the original office. For nearly 171,000 brokered claims completed during FY 2009, we projected the average processing time of 201 days would have been 49 days less, or 152 days, if VBA had avoided the claims-processing delays identified during the audit. VBA agreed it can improve the overall effectiveness of brokering. We will monitor the implementation of the recommendations.

VBA could eliminate transportation costs associated with brokering claims and improve claims processing timeliness by digitizing claims folders. We caution that even digitized claims will require infrastructure and management controls to ensure VAROs consistently and accurately maintain documents to allow claims processing personnel complete and timely access to veterans' claims folders documents.

VA EMPLOYEE COMPENSATION ISSUES

The VSOs noted concerns with general administrative costs and overly generous employee bonus programs. We have issued several reports dealing with retention incentives that identified consistent themes regarding where VA falls short in its administration of this program.

Retention incentives are a valuable tool to retain quality and critical employees. VA uses retention incentives to retain employees in hard-to-fill positions and employees who possess high-level or unique qualifications that VA does not want to lose. Our review of retention incentives at the VA Medical Center in Providence, Rhode Island, concluded that for 17 (85 percent) of 20 cases, justification for retention incentive awards was not available or was inadequate, resulting in approximately $179,000 in questioned costs annually and over $895,000 over the next 5 years (*Review of Retention Incentive Payments at VA Medical Center, Providence, Rhode Island,* January 20, 2011). In response to our report recommendations, VHA outlined actions to accomplish a 100 percent review of Providence employees' retention incentives, establish controls to ensure incentives meet VA policy, develop standard operating procedures, and establish a system for maintaining this information.

In FY 2010, VA paid nearly $111 million in retention incentives to 16,487 employees. In a nationwide audit of VHA and VA Central Office (VACO) retention incentives that was recently issued, we questioned the appropriateness of 96 (80 percent) of 120 VHA incentives, and 30 (79 percent) of 38 VACO incentives, totaling approximately $1.06 million during FY 2010. (*Audit of Retention Incentives for Veterans Health Administration and VA Central Office Employees*, November 14, 2011)

As with the Providence review, we determined VHA and VACO approving officials did not adequately justify and document retention incentive awards. This occurred because VA lacked clear guidance, oversight, and training to effectively support the program. Also, VA did not effectively use the Personnel and Accounting Integrated Data system to generate timely incentive re-evaluation notices and did not always stop retention incentives at the end of set payment periods. VHA and VA officials agreed with our report recommendations and outlined corrective actions to address the issues identified.

VBA OVERTIME

The VSOs' letter raises concerns about VBA's use of overtime to meet claims production goals. In 2010, the OIG conducted a review to assess VBA's efforts to meet its hiring goals and the impact of VBA's increased workforce on Compensation and Pension (C P) claims workload. We found that VBA could not assess the impact of overtime on its capacity to complete claims and recommended that VBA collect data on the number of overtime hours worked to assess the capacity of its current workforce

and project future workforce needs. VA agreed and have reported to us that they have implemented a plan to address this issue. (*Review of New Hire Productivity and the American Recovery and Reinvestment Act Hiring Initiative*, February 18, 2010)

OTHER AREAS FOR POTENTIAL SAVINGS

In addition to the potential improvements identified by the VSOs, VA can reap substantial benefits by improving its processes in several areas: acquisition, delivery of health care and compensation benefits, information technology system development, and workers' compensation for employees injured on the job.

Acquisition Process

VA purchases goods and services in excess of $10 billion annually. In November 2009, the Secretary reported to the Office of Management and Budget that he had established a 2-year departmental goal of $958 million in acquisition savings by FY 2011. We have identified issues with processes at all levels and all phases of the procurement process—planning, solicitation, award, and administration.

Historically, problems in VA procurement have led to inadequate competition for many contracts and a general lack of assurance that VA has obtained fair and reasonable prices or the best value for goods and services. In the past, only about 50 percent of VA's contract awards were competitive. We strongly believe competition is a proven strategy to achieve better value for the Government. For example, VA originally planned to contract for approximately 940 non-recurring maintenance projects with its $1 billion in American Recovery and Reinvestment Act (ARRA) funds. VA reported that as they executed the ARRA program, it competed approximately 98 percent of these contracts, which resulted in cost savings that allowed VA to fund almost 1,125 projects, a 19 percent increase in projects to improve VA medical facilities. We validated the completion rate in our report, *ARRA Oversight Advisory Report Review of VHA's Efforts to Meet Competition Requirements and Monitor Recovery Act Awards*, (September 17, 2010).

VA can achieve savings by fully leveraging its buying power and improving the administration of contracts. The following examples highlight opportunities where VA can strengthen the integrity of its contracts and realize significant acquisition-related cost savings over 5 years:

- Savings of about $22 million by procuring aortic valves, coronary stents, and thoracic grafts through consolidating requirements using national contracts and blanket purchase agreements instead of making open market purchases. (*Audit of the Acquisition and Management of Selected Surgical Device Implants,* September 28, 2007)
- Savings of about $41 million through improved acquisition planning and oversight processes to increase the use of the Federal Supply Schedules for the purchase of medical equipment and supplies. (*Audit of Veterans Health Administration Open Market Medical Equipment and Supply Purchases,* July 21, 2009*)*

- Savings of about $60 million through improved clinical sharing agreement monitoring and negotiation practices when using noncompetitive clinical sharing agreements for professional medical personnel. (*Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*, September 29, 2008)
- Savings of about $38.5 million in health care staffing costs through increased competition, better price evaluations, and improved ordering practices. (*Review of Federal Supply Schedule 621I – Professional and Allied Healthcare Staffing Services*, June 7, 2010)
- Reduce unsupported costs and improper payments by about $16.8 million by strengthening contract administration practices in VHA's Home Respiratory Care Program. *(Audit of Veterans Health Administration's Home Respiratory Care Program*, November 28, 2007)
- Preventing $85.3 million in overpayments by effectively competing, awarding, and administering patient transportation contracts. (*Veterans Health Administration – Audit of Oversight of Patient Transportation Contracts,* May 17, 2010*)*

Management of Rural Health Initiatives

In addition to identifying potential savings, we also evaluate how funds are managed and used to meet a program's intended outcomes. In FYs 2009 and 2010, VA's Office of Rural Health (ORH) received $533 million in funds designated for improving access and quality of care for veterans residing in rural areas. We reported ORH lacked reasonable assurance that its use of $273 million of the $533 million improved access and quality of care for veterans residing in rural areas. For example, ORH provided $200 million of rural health funds to VISNs to cover fee expenditures for rural veterans through a project called the Rural Health Fee Usage Plan. ORH's goals for the use of these funds were to improve the percentage of fee care dollars spent on rural veterans and the percentage of rural patients utilizing VHA services. However, the health care facilities were unable to demonstrate that the use of these funds improved access to care for rural veterans. For example, one VAMC received $3.2 million of Fee Usage Plan funds. The VAMC transferred $3 million of these funds to their general account then used the funds without any restrictions. By the end of FY 2010, the VAMC's overall planned fee care expenditures increased only about $252,000.

We also noted concerns with the project review and selection process used to select projects for execution in FYs 2010 and 2011. In addition to improved organizational and management controls, we recommended that VA reassess ORH's FY 2012 budget requirements to align planned use of resources to their greatest rural health needs. As a result of our report, the Government Accountability Office recommended to the Appropriations Committees that ORH's budget resources for FY 2012 be restricted. VA has taken our recommendations seriously and strengthened its controls to provide increased oversight and transparency to ensure that future funds will be used as intended.

Temporary 100 Percent Disability Evaluations

Veterans' disability compensation payments are not usually an avenue for cost savings. We have, however, identified one area where a systemic problem leads to veterans receiving long-term payments to which they are not entitled. VBA grants veterans a temporary 100 percent disability evaluation for service-connected disabilities requiring surgery, convalescence, or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VA staff are required to review the veteran's medical condition to determine whether to continue the temporary evaluation. If a medical exam shows a change in the veteran's condition, and VARO staff determines that a reduced benefit is warranted, then VBA staff initiate action to reduce benefits. In January 2011, we issued a report detailing our concerns with VBA's processing of temporary 100 percent disability evaluations. We projected that regional office staff did not correctly process claims of about 27,500 (15 percent) veterans with temporary 100 percent evaluations and that since January 1993 VBA overpaid these veterans a net amount of about $943 million. Without timely corrective action, we conservatively projected that VBA will overpay veterans $1.1 billion over the next 5 years.

The primary message in our report is that VBA paid veterans a temporary 100 percent benefit without adequate medical evidence. Further, VBA rarely attempts to recover any monies paid to the veteran in error and once a temporary 100 percent rating has been in place for 20 years, VBA cannot reduce the rating unless the veteran committed fraud in obtaining the benefits. The then Acting Under Secretary for Benefits did not agree with the projected overpayment amounts, but agreed to implement the recommendations we made. We stand behind our statistical projection as a reasonable and conservative estimate of overpayments and potential future overpayments based on our review of compensation records available at the time of the audit. We monitor VBA's actions to correct this condition during the OIG's VARO Benefits Inspections program and we continue to find claims files without suspense dates for reexaminations. VBA has just recently started work to identify veterans who need reexamination, and to establish suspense dates to drive timely examinations.

Information Technology Issues

Information technology (IT) is critical to support VA in accomplishing its mission of providing benefits and services to veterans. For FY 2012, VA requested approximately $655 million for new product development out of a total budget of $3.2 billion for IT systems and support. If managed effectively, these IT capital investments can significantly enhance operations and increase efficiency in a range of VA programs, from medical care to compensation and pensions.

However, IT management at VA is a longstanding high-risk area. VA experienced significant challenges in managing its IT investments, including cost overruns, schedule slippages, performance problems, and in some cases, complete project failures. For example, VA spent over 14 years and $308 million developing the Veterans Services Network (VETSNET) to consolidate compensation and pension benefits processing into a single system. Although VETSNET has now achieved most of the planned functionality, VA has yet to identify a date for migrating all claims and decommissioning the legacy system, which costs about $7 million a year to maintain.

Also, VA has tried twice to develop an integrated financial management system. In 2004, after 6 years and spending more than $249 million, VA halted the Core Financial and Logistics System (CoreFLS) project due to significant project management weaknesses. In 2005, VA began work on the Financial and Logistics Integrated Technology Enterprise (FLITE) program, comprised of an accounting system, an asset management system, and a data warehouse component—all scheduled for deployment by FY 2014 at an estimated cost of approximately $609 million. In July 2010, VA cancelled two FLITE components, partly because of the same project management issues that had plagued CoreFLS. In October 2011, VA cancelled the remaining component after spending more than $127 million on the entire FLITE program.

VA recently began planning for a new financial system. Reviewing and applying the lessons learned from the previous failed attempts will be crucial to any future success. In September 2009, we reported VA needed to better manage its major IT development projects, valued at that time at over $3.4 billion, in a more disciplined and consistent manner (*Audit of VA's System Development Life Cycle Process*, September 30, 2009). In general, we found that VA's processes were adequate, but VA's Office of Information Technology (OI T) did not communicate, comply with, or enforce its mandatory requirements.

In June 2009, OI T implemented the Program Management Accountability System (PMAS) to proactively manage VA's IT projects to complete system development efforts on time and within budget. PMAS was designed as a performance-based management discipline that provides incremental delivery of IT system functionality—tested and accepted by customers—within established schedule and cost criteria. In September 2011, we reported OI T had not established key management controls to ensure PMAS data reliability, verify project compliance, and track project costs. Until these issues are addressed, VA will risk cost overruns, schedule slippages, and poor performance in future efforts to deliver the systems essential to accomplishing the Department's missions and programs.

Workers' Compensation Program Case Management

Ineffective workers' compensation program (WCP) case management leads to potential program fraud, as well as increased costs to VA. Over the past two decades, VA's WCP costs have increased 57 percent to approximately $182 million; VHA comprises 93 percent of these total costs.

We recently reported that VHA could reduce WCP costs by an estimated $264 million over the next 5 years through improved program case management oversight. (*Audit of VHA's Workers' Compensation Case Management*, September 30, 2011) While VHA submitted employee compensation forms timely, it often lacked the medical evidence necessary to support the employee's continued disabilities. VHA also missed opportunities to return able employees to work. Overall, we attributed these issues to a lack of oversight to ensure compliance with WCP statutory requirements.

We recommended that VHA provide oversight and assign dedicated resources to control costs and reduce the potential for future waste and abuse. The Assistant Secretary for Human Resources and Administration and the Under Secretary for Health agreed with our findings and recommendations and plan to complete all corrective actions by December 31, 2011. We will assess and monitor the implementation of corrective actions.

We also recommended that VA support legislation currently pending to convert claimants 65 years of age or older to more appropriate benefit programs. VA responded that they will contact the Department of Labor in support of its proposed change in legislation.

WORK IN PROGRESS

The VSOs expressed concerns about the size and growth of Veterans Integrated Service Networks (VISN) in VHA. We have ongoing audit work to examine VISN management structures and fiscal operations. Although our work is not yet complete, we believe the VSOs have raised valid concerns. When VHA created the VISNs in 1995, VHA specifically decentralized budgetary, planning, and decision-making functions to the Networks to promote accountability and improve oversight of the daily operations of its medical facilities. VHA estimated the overall size of the original 22 VISNs would range between 154–220 FTE with total operating costs of about $26.7 million annually. Today, we estimate the existing 21 VISNs employ at least 1,098 staff at an annual cost of over $165 million.

We also have concerns about the existence of national and regional fiscal controls and data that would allow VHA to effectively evaluate and compare the reasonableness of VISN staffing levels and costs. Strong financial management and fiscal controls would provide VHA the opportunity to identify inefficiencies in VISN operations and possibly reallocate funds back to direct patient care.

While not referenced in the VSOs' letter, we also have ongoing projects in several areas that could potentially result in cost savings. We are currently examining the extent to which the MCCF program effectively bills third-party health insurers for VA provided medical care. VHA is currently centralizing MCCF billings and collections processes nationwide, however medical centers are continuing to perform some MCCF functions. Although our work is ongoing, VHA continues to miss opportunities to increase MCCF revenue by not billing third-party insurers for billable fee care services provided. We expect to issue a final report by the spring of 2012.

We are also evaluating the effectiveness of VHA's acquisition and management practices used to purchase prosthetic limbs. Our preliminary results show that VA is paying more for prosthetic limbs than the agreed upon prices in the contracts in place. VA can reduce its risks for paying excessive prices by strengthening its oversight and controls with actions to ensure the review of vendor quotes, purchase orders, and to verify the costs of items billed on invoices match agreed upon prices in the associated contracts. We expect to issue a final report on this early in 2012.

CONCLUSION

As an agency whose primary mission is to deliver benefits and services, it is a challenge to achieve meaningful cost savings but it is not insurmountable. The suggestions from the VSOs are a good starting point for the discussion but we believe the Committee and VA should consider other areas, including those we have raised. The VA OIG is committed to continue reviewing VA programs and operations to ensure that that they function economically, efficiently, and effectively. We will continue to put forth recommendations that not only produce savings but more importantly provide better services to our Nation's veterans.

Mr. Chairman and Members of the Committee, this concludes my statement today. I will be pleased to answer any questions you may have.