PAST AND PRESENT EFFORTS TO IDENTIFY AND ELIMINATE FRAUD, WASTE, ABUSE, AND MISMANAGEMENT IN PROGRAMS ADMINISTERED BY THE DEPARTMENT OF VETERANS AFFAIRS

HEARINGS

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHT CONGRESS

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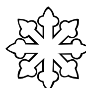

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PAST AND PRESENT EFFORTS TO IDENTIFY AND ELIMINATE FRAUD, WASTE, ABUSE, AND MISMANAGEMENT IN PROGRAMS ADMINISTERED BY THE DEPARTMENT OF VETERANS AFFAIRS

THURSDAY, MAY 8, 2003

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. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Bilirakis, Buyer, Stearns, Simmons, Brown, Miller, Boozman, Bradley, Beauprez, Brown-Waite, Renzi, Murphy, Evans, Snyder, Michaud, Hooley, Strickland, Berkley, Udall, Davis, and Ryan.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Good morning. Welcome to today's oversight hearing. Let me just say I apologize for being late. As every Member of the House knows, we all have conflicts with other committees. We had an International Relations Committee markup and the first two amendments were mine so I simply could not get here on time. So I do apologize to my colleagues and thank them for being here. As a matter of fact, Ms. Berkley is there as well. So she will probably be a little late as well.

And we gather today to examine the effectiveness of veterans' programs, it seems appropriate to reflect briefly on who veterans are and what they expect from their government. Living veterans and their dependents span more than a century of the American experience, from the few surviving veterans of the First World War to the millions of active-duty personnel who will inevitably become 21st Century veterans when their current military service ends.

In recent weeks, the world has seen the effects of ensuring that our military men and women have the right equipment and the best leadership. When the mission is clear and our service members are properly trained, no goal is unachievable. Each service member also learns that there is no substitute for personal integrity and commitment in achieving that goal. And, as we all know, the job was done exceeding well.

As the war in Iraq winds down, it is appropriate that Congress refocus attention on the benefits and services that our soldiers, sailors, airmen, and marines have earned through their service.

Our service men and women need to be assured that federal programs serving veterans are managed better than any other federal program, that they are supervised by employees who understand the meaning of personal integrity and commitment, and that the benefits and services are delivered in an efficient and timely fashion.

The Department of Veterans Affairs employs over 220,000 people, many of them veterans themselves, and is the second largest agency in the Federal Government. The VA has a budget that will exceed $63 billion in fiscal year 2004. VA programs touch millions of lives each year with benefits and services designed to rehabilitate veterans injured during their service, and to help all veterans transition into healthy and productive post-service careers.

Today is the first hearing in a series that the committee plans to hold to focus the Congress' attention on major issues confronting the VA. Our goal is to find out what Congress can do to curtail or eliminate waste, fraud, abuse, and mismanagement so that taxpayer dollars are spent only for useful purposes. When it comes to caring for those who have protected our freedoms, we don't have one dollar to waste. As we examine the results of authorized programs on veterans' lives, we sometimes learn that we need to change the law. In other cases, the law is fine but the execution is flawed. In those cases, we need to hold the appropriate executives accountable and insist that the law be swiftly and faithfully executed.

I want to note for some of the newer members of the committee that this committee has a well-regarded history of carefully examining the successes and failures of veterans' programs, and then crafting and implementing thoughtful proposals to make improvements. In areas such as improving third-party health insurance reimbursement, joint procurement of pharmaceuticals by the VA and DOD health care systems, reform of veterans' job training programs, and cracking down on fugitive felons receiving veterans' benefits, we have had some very notable successes as the result of our oversight and legislative efforts.

Part of the oversight function of Congress is to recognize and encourage reforms that improve federal programs. These hearings will also be an opportunity to learn abut many of the veterans programs that are working. VA today provides world-class health care, valuable compensation and readjustment benefits, and various other transition services to millions of former servicemen and women. There is much for all of us to be proud of within the VA, but there is also room for improvement.

For example, the GAO will testify today the VA has a massive and aged infrastructure, which is not well aligned to efficiently meet veterans' needs. VA owns about 4,700 buildings, over 40 percent of which have operated for more than 50 years, and almost 200 of which were built before 1900. Few of these old buildings serve their original purpose, some urgently need to be replaced, while others should be torn down or turned over to organizations that can re-use them.

This year, about 2.7 million veterans will receive disability compensation or pension payments from the VA through the Veterans Benefits Administration. However, the VA uses a disability deter-

mination process based on a 1945 economic conditions. It doesn't accurately reflect currently relationships between physical impairments and the skills and abilities needed to work in today's business environment. Some may see this issue as fraught with peril, but I would like to know if future veterans deserve more or less than the current system allows.

The VA inspector general will testify that a study it performed clearly show that part-time physicians were not working the hours established in their VA appointments. As a result, part-time physicians were not meeting their employment obligations to the VA, and millions of dollars are being wasted. More seriously, this abuse is a symptom of the Department's refusal to decide how many physicians are needed at each medical center it operates.

In 2001, the Congress considered and passed a measure designed to deny veterans' benefits, such as disability compensation to convicted felons and other persons who are fleeing prosecution for a felony offense. This extended an existing law which denied such benefits to most incarcerated veterans. The IG will testify that between 1 and 2 percent of all fugitive felony warrants submitted to the VA through agreements with federal and local law enforcement authorities will involve VA beneficiaries. Savings related to the identification of improper and erroneous payments are projected to exceed $209 million annually.

We have invited the GAO and the inspector general for the Department of Veterans Affairs to tell us what they have learned from their examinations of VA programs. A good bit of their testimony will focus on how programs can serve more veterans, or how resources could be better distributed. At future hearings, we will ask VA officials and others the same questions. As I have said, I am particularly interested in what additional steps we can take to ensure that waste, fraud and abuse are minimized because the resources we provide are not always sufficient, as we all know, to meet veterans' demands. Every dollar we save is one more dollar for a deserving veteran.

I would like to recognize my good friend and colleague, Lane Evans, the ranking Democrat on our committee.

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

Mr. EVANS. Thank you, Mr. Chairman. This is an important hearing today that you have brought before us. Today, when we ask these questions about the past and present behaviors, we should also frame expectations for the future. VA has a tremendous portfolio of programs, process, and objectives. It is not unreasonable that cobwebs may sometimes form around the corners and detract from the organization. These cobwebs have names, call them fraud, waste, and abuse. They slow effectiveness. They consume resources. They really are parasites on our system. When there are too many or they grow too unsightly, they may indicate mismanagement. For years, GAO, the IG and this committee have helped the VA to identify those cobwebs. Sometimes problems remain after we point them out. Why? Procurement, contracting and DOD/VA sharing have all been looked at. We will look at them

again today. Waiting times and benefits delivery also remain problematical.

VA has a 21st Century mission with a 1950's infrastructure. As we look at the past problems, let us not forget our responsibility and authority for impacting the future.

Mr. Chairman, I applaud your taking up this issue today, and I yield back the balance of my time.

[The prepared statement of Congressman Evans appears on p. 106.]

The CHAIRMAN. Thank you very much, Mr. Evans. I would like to welcome our distinguished witnesses to the witness table. And our first witness will be the Honorable Richard J. Griffin, the Inspector General of the Department of Veterans Affairs. As IG, 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 for Meritorious Executive.

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

Our second witness will be Ms. Cindy Bascetta, the director of the Veterans Health and Benefits Issues at the General Accounting Office. For the past 4 years, she has led reviews of VA's budget and planning process and evaluations of specific programs in the Veterans Health Administration and the Veterans Benefits Administration.

Before that, she directed GAO's work on the Social Security Administration's disability programs. Her work resulted in billions of dollars in savings and supported bipartisan legislation to improve the Disability Insurance and Supplemental Security Income Programs. She also directed numerous reviews of health financing and public health issues, including federal efforts to reduce the spread of HIV infection through research and public education. She joined GAO in 1983 after beginning her career at the U.S. Department of Labor's Occupational Safety and Health Administration where she prepared regulatory impact analyses of major workplace health standards.

Mr. Griffin, if you could begin.

STATEMENT OF HON. RICHARD J. GRIFFIN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL SLACHTA, JR., ASSISTANT INSPECTOR GENERAL FOR AUDITING, DEPARTMENT OF VETERANS AFFAIRS

Mr. GRIFFIN. Thank you, Mr. Chairman. As you know, I have submitted a lengthy written statement, which I would ask be included in the record.

The CHAIRMAN. Mr. Griffin, without objection, your full statement will be made a part of the record.

[The prepared statement of Mr. Griffin appears on p. 117.]

Mr. GRIFFIN. I am accompanied at the table by my assistant inspector general in charge of audit, Mr. Michael Slachta.

The CHAIRMAN. Thank you.

Mr. GRIFFIN. Mr. Chairman, Mr. Evans, and members of the committee, I am pleased to be here today to address our efforts to eliminate fraud, waste, abuse, and mismanagement at the Department of Veterans Affairs. We have focused on mission-critical activities and programs in health care delivery, benefits processing, financial management systems, procurement practices, and information management.

From fiscal year 1998 through March 31, 2003, we have issued 872 reports, process 2,008 hotline cases, performed 7,073 investigations, and made recommendations having the potential to save the Department approximately $7 billion.

Both the quality and cost of medical care has been foremost in our recent work in the Veterans Health Administration, $3.5 billion of our recommended monetary benefits relates to savings and efficiencies in VHA. Over the years, we have found many instances where VA physicians were not present during their scheduled tours of duty. Since fiscal year 2000, my staff has substantiated 15 hotline allegations of time and attendance violations by VA physicians. Additionally, since fiscal year 2000, we have examined physician time and attendance issues at 43 medical centers and identified deficiencies at 24 of the 43. Our audits have also found significant staffing disparities among VA medical centers. VHA was unable to evaluate or justify the staffing needed to accomplish medical center workload efficiently. This resulted because VHA had not established physician-staffing standards and was not effectively managing physician time and attendance.

At the request of the Secretary, we audited VHA's management of part-time physicians. We released this audit report on April 23. Our results showed that some part-time physicians were not working the hours established in their VA appointments and, as a result, were not meeting their employment obligations to VA. Some examples include:

A review of 382 part-time physicians at five medical centers showed that 223 had no patient workload on 33 percent of their scheduled days.

At one medical center, we identified 20 occasions when surgery was cancelled because the part-time physicians were not available.

Part-time surgeons at six medical centers were performing surgery at the affiliate during their scheduled VA tours or hours at VA.

And some attending physicians were not present to supervise the residents' treatment of veterans.

In addition, VA medical centers did not perform any disciplined analysis to determine how many physicians were needed to accomplish the medical center's workload nor did they evaluate hiring alternatives, such as part-time, full-time, intermittent, or fee basis.

In October of 2002, we issued the Combined Assessment Program Review of Medical Center, Lexington, KY. We concluded that there had been a breakdown in physician timekeeping controls in the medical center's medical and surgical services, contributing to low physician productivity. We found that neither timekeepers nor supervisors knew when physicians were on duty. A follow-up investigation at Lexington is ongoing.

Based on the tests we performed, we concluded that medical and surgical services were overstaffed by at least 7.3 FTE at a cost of $1.2 million in Lexington. At the time of the review, the medical center's primary care services needed approximately $1 million to eliminate the waiting time at Lexington. The medical center agreed to eliminate the unneeded physician positions and reallocate the resources to primary care services.

In January 2002, 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 is adequate to provide veterans appropriate, high-quality care and services. In complying with this law, VHA should take advantage of past physician staffing studies, as well as established staffing models in other government agencies. The Army, Navy, and Air Force have all recognized that manpower is one of their most significant medical care expenses and have developed models to determine their staffing requirements. These models, which incorporate graduate medical education programs, should be of use to the Department in developing their standards.

Let me move on to another area of concern. We have conducted significant criminal investigations involving drugs at a number of VA facilities.

During May 2001, two armed individuals entered the pharmacy of VA Medical Center in Boston and stole 3,000 tablets of Oxycontin and other narcotics valued at over $250,000. A joint investigation with the Federal Bureau of Investigation and VA police disclosed that a medical center employee aided the robbers by providing them details regarding the pharmacy. All three subjects involved in the robbery have been indicted and trial preparation is underway.

Based on information received from an employee of the Nashville VA Medical Center, a joint investigation was initiated with the Drug Enforcement Administration. The investigation disclosed that over 233,000 dosage units of controlled substances have been diverted from the pharmacy in Nashville, having an estimated street value of $3.5 million. A VA supervisory pharmacist diverted the drugs by filling prescriptions for random veterans for whom no legitimate prescriptions were written and who did not have follow-on appointments. She then passed the drugs to her uncle who fenced them on the street.

The government seized property and cash as proceeds of this crime. The employee's uncle has been sentenced to 70 months imprisonment and 3 years supervised release and ordered to pay restitution. Sentencing for the former employee is pending.

The VA spends approximately $2.4 billion dollars a year on pharmaceuticals. The Boston and Nashville pharmacy investigations highlight the critical need for rigorous controls at all VHA facilities. Vulnerabilities in this area have been repeatedly cited in our Combined Assessment Program review of VA medical centers.

Regarding the Veterans Benefits Administration, we have made recommendations over the last 5 years to VBA to address many potential improvements and identify potential monetary savings in excess of $1.5 billion. In addition, our investigations have led to the assessment of fines, receipt of restitution payments, and other recoveries through civil judgments, totaling about $150 million. The potential savings in erroneous payments derive from many aspects of VA programs, including the income verification match, the death match, incarcerated veterans, overseas beneficiaries, and recently the fugitive felon initiative.

In response to Public Law 107–103, we established the Fugitive Felon Program to identify VA benefit recipients and VA employees who are fugitives from justice. Once a veteran or employee is identified as a fugitive, we coordinate with the local law enforcement organization, which issued the warrant to assist in the apprehension. Fugitive information is then provided to VA to suspend benefits and initiate recovery action of any overpayments. Based on our pilot study and matches conducted to date, I anticipate that a significant number of all fugitive felony warrants reviewed will involve VA beneficiaries. Savings related to the identification of improper benefits and erroneous payments are projected to exceed $209 million.

We are still in the initial phases of setting up the program but our efforts have already identified more than 11,000 potential fugitives. Details of recent investigations demonstrate the violent nature of some of these individuals. Agents arrested a fugitive beneficiary on a payroll violation warrant for aggravated kidnaping. Photographs were circulated and a briefing was given to the VA regional office on the fugitive status of the veteran. Several months later, the fugitive attempted to enter the regional office to inquire about the status of his benefits checks. A member of the VARO recognized the fugitive from the pictures we had provided and immediately alerted my staff. OIG agents were able to take the fugitive into custody and subsequently turned him over to state investigative agents.

In another case, a fugitive sought by the FBI was arrested at his residence based on a federal arrest warrant issued for unlawful flight to avoid prosecution. The veteran was wanted on a state warrant for manslaughter, assault, and reckless driving, and had fled to avoid prosecution of the state case. Allegedly, the veteran killed a 10-year-old girl and her aunt because of his reckless driving. The Seattle VA regional office had previously suspended the veteran's benefits under provisions the Fugitive Felon Project. The successful execution of the Fugitive Felon Program contributes to homeland security and results in the apprehension of dangerous criminals.

Moving to the international front, during 2002, the OIG and the VA regional office in Manila worked together to identify and eliminate erroneous benefit payments to payees in the Philippines. As of May 2002, awards of 594 beneficiaries were identified for suspension or termination. The overpayment for these 594 beneficiaries totaled approximately $2.5 million with a projected 5-year cost avoidance of over $21 million. We also referred 94 beneficiaries to the VARO for review regarding a possible increase in benefits; appointment of a fiduciary; Prisoner of War medal status; and various other benefits changes. VA officials from the Manila regional office and VA's Financial Systems Quality Assurance Service were instrumental to the success of this review. Similar reviews are being planned to ensure the integrity of the $600 million a year that is distributed to veterans living outside the continental United States.

An OIG investigation at the Atlanta regional office uncovered $11.2 million that had been fraudulently paid to a 30-year VA employee and her 11 co-conspirators, representing the largest known embezzlement by a VA employee. The employee channeled funds to a retired career VA employee and a former VA employee. The Atlanta regional office employee violated her position of trust and used the VA computer system to resurrect the claims files of deceased veterans who had no known dependents. Once the files were reestablished, the employee generated large retroactive benefit payments and, in some cases, recurring monthly payments. After the payments were deposited in private bank accounts, the co-conspirators shared the bounty with the VA employee by giving her what amounted to approximately one-third of what they had received. The 12 co-conspirators pled guilty to various charges, including theft of government funds and conspiracy to commit money laundering. The VA employees guilty plea came after being indicted on 1,000 counts. During 2002, the 12 defendants were sentenced to a total of 39.5 years imprisonment, 35 years probation, and were ordered to make restitution totaling over $34 million.

As a result of the employee fraud, the Secretary of Veterans Affairs requested that we make a department-wide fraud review. We reviewed over 58,000 one-time payments greater than $25,000 and found one additional case of employee fraud. The rest appeared to be okay.

The Department spends about $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction and services. High-level management support and oversight are needed to ensure VA leverages its full buying power and maximizes competitive procurement to achieve most favored customer prices or better. Our contract review and evaluation work has returned $70 million to VA's supply fund over the past 3 years, primarily from contractors who over-charged the VA.

VA supply inventory practices must also ensure that adequate quantities of medical and other supplies are available to meet operating requirements while avoiding excess inventories that tie up funds and other resources that could be used to meet other VA needs. Since fiscal year 1999, we have issued six national audits of inventory management practices for various supply categories,

including medical, prosthetic, pharmaceutical, engineering, and miscellaneous supplies with cost savings of almost $388.5 million.

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

The CHAIRMAN. Mr. Griffin, thank you very much for your extraordinarily good work and your testimony before the committee today. During the course of your testimony, Tim Murphy sent a note back and said you really do deserve special commendation for the work you are doing. We have read over the years, I have been on this committee 23 years, and since you have taken the helm, the reports that you have tendered, they are very, very effective, thorough, and we thank you for the good work of the IG.

Mr. GRIFFIN. Thank you, Mr. Chairman. If I may, I have my senior staff behind me in the first row, I would like to recognize them as the people who did this work.

The CHAIRMAN. Thank you. And, Ms. Bascetta, if you could proceed.

STATEMENT OF CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE, VETERANS' HEALTH AND BENEFITS ISSUES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY PAUL REYNOLDS, ASSISTANT DIRECTOR, HEALTHCARE, U.S. GENERAL ACCOUNTING OFFICE; AND IRENE CHU, ASSISTANT DIRECTOR, EDUCATION, WORKFORCE AND INCOME SECURITY, U.S. GENERAL ACCOUNTING OFFICE

Ms. BASCETTA. Thank you, Mr. Chairman. Let me start by introducing my colleagues, Paul Reynolds, an assistant director for VA health care issues and Irene Chu, an assistant director for VA benefits issues.

Thank you for inviting me today to talk about two major programs at VA, their health care and disability benefits programs. Currently, these programs serve millions of veterans. Mr. Chairman, it goes without saying that the deployment of our troops to Iraq this year refocuses our hearts and minds on the sacrifices that veterans make for our country. As you know, VA spending on health care and disability benefits now totals about $50 billion annually. My statement today will highlight challenges that VA faces ensuring reasonable access to health care, using its health care resources efficiently, and managing its disability programs effectively.

In 1995, VA began a historic transformation of its health care system from a hospital-dominated model to one that emphasized outpatient and primary care services. This new model allows VA to provide a full continuum of care closer to where veterans live through community-based networks of VA and non-VA providers. As a result, the number of VA delivery locations has increased substantially and VA has been able to enhance veterans' access to health care, especially for those seeking primary care.

But travel times and waiting times are still unacceptable for too many veterans. And, in particular, those who need to consult with specialists or require hospitalization often travel long distances to receive care. Improving access to care is a key element of VA's CARES program, which the Secretary calls the "initiative of the decade." Mr. Chairman, the Capital Asset Realignment part of

CARES gets a lot of attention but it is the enhanced services part of the initiative that is really at the heart of the matter. In our view, the compelling reason for the Capital Asset Realignment is to free up resources so that they can be reinvested in service enhancements that benefit veterans.

So it was with this key objective in mind that we testified before this committee's Health Subcommittee in March 1999. At that time, we pointed out that VA's large and aged infrastructure, over 4,700 buildings and 18,000 acres of land, was not well-aligned to efficiently meet veterans' health care needs. Subsequently, we concluded that this infrastructure could be the biggest obstacle to a more convenient community-based outpatient model.

CARES had made significant progress over the past 4 years, and much of the credit goes to the persistence of this committee's Health and Oversight Subcommittees, as well as others in the Congress and the Executive Branch. During the 1999 hearing, the Health Subcommittee chairman urged VA to undertake the landmark task of realigning its infrastructure, as we had recommended. When CARES got off to a slow start, the Oversight Subcommittee held a hearing to hold VA accountable to make good on its promise to the Health Subcommittee.

So far, our review shows that CARES is in fact consistent with the approach that we outlined.

Specifically, VA is conducting systematic examinations of how well the geographic distribution of VA's health care resources matches veterans' needs now and in the future. It is also conducting comprehensive evaluations of alternative service delivery strategies to align resources to meet those needs more efficiently and effectively. To date, VA has completed several very important tasks. It has projected veterans' health care needs over the next 20 years, evaluated available capacity at existing delivery locations, targeted geographic areas where access improvements are needed, and identified areas where alternative delivery strategies could allow VA to operate more efficiently and effectively.

In targeting areas for access enhancements, VA used newly-established travel standards for acute in-patient, tertiary inpatient and primary care. These standards vary depending on whether veterans live in urban, rural, or highly rural counties. Using these standards, VA has identified almost 1,800,000 veterans, more than 25 percent of the enrolled population, who live outside VA's travel standards for acute inpatient care. They have also identified about 350,000 veterans, less than 5 percent of all enrollees, who live outside VA's travel standards for tertiary care. And over 1,700,000 veterans who live outside VA's travel standards for primary care.

While our review of CARES is still in its early stages, let me mention a concern that we have about VA's potential outcomes in enhancing access. VA identified 76 geographic areas in which enrollees' travel times exceed its access standards. In 25 of these areas, network directors are mandated to improve access because fewer than 65 percent of the total enrolled veterans reside within the standards. About 900,000 veterans will be effected in these areas. However, in the 51 other areas, improving access is not mandatory because 65 percent of the enrolled veterans do reside within the access standards. But if network directors in these areas

opt not to take action, 875,0000 veterans will be left behind by the CARES process, even though they are outside the access standards. In other words, CARES will not be of benefit to them.

Turning to asset realignment, a potential source of funds to pay for these access enhancements, VA identified four situations that could yield savings. They identified 30 geographic areas where two or more health care delivery locations are in close proximity to one another and provide duplicative acute care services; 38 areas were two or more tertiary care delivery locations are in close proximity, 28 areas where existing delivery locations have low acute medicine workloads and about 60 opportunities for partnering with the Department of Defense in order to better align the infrastructure of both agencies.

While accessing these efficiency opportunities that could best meet veterans' needs seems to involve a relatively straightforward analysis, choosing options that are closest to where veterans live can have significant ramifications for stakeholders. For example, providing contract care to large concentrations of veterans who are now driving beyond the access standards could drain workload from existing locations. And, in turn, the size of medical residency opportunities at those locations could be reduced. Also, efficient operation of existing facilities could become more difficult with declining workloads, potentially jeopardizing their continued financial viability.

Another challenge that concerns us is the need for sizing of capital investments, especially in locations where future workload may increase over the short term before steadily declining. In large part, such declines are attributable to the expected nationwide decrease in the overall veteran population. It may be in VA's best interest to partner with other public or private providers for services to meet veterans' demands in these locations rather than risk making a major capital investment that would be under-utilized in the latter stages of its useful life.

Waiting times—excessive waits for appointments—is another serious problem that I am sure you are all well aware of. We and others have reported on this problem for the last decade. A more recent version of this problem involves waiting times for initial primary care appointments for newly enrolled veterans. Currently, VA is trying to develop more reliable data about the magnitude and distribution of the waiting time problem across its locations so that it can get a better handle on the root causes of the problems and take corrective action. Of note, VA faces an impending challenge that is likely to exacerbate the current waiting times, namely, a projected surge, perhaps a doubling in veterans' demand for outpatient specialty care over the next 10 years. Unfortunately, CARES does not address these waiting time problems.

Another problem that CARES does not address is what to do about long-term care. Veterans' needs for long-term care are likely to increase as the veteran population ages. And, in particular, the population most in need of nursing home care, those aged 85 and older, is expected to grow from 640,000 to more than a million by 2012. In response, VA is developing a process separate from CARES to project long-term care needs. But a more fundamental problem is that current policy, which gives broad discretion to net-

works to determine which nursing home services to provide for most veterans, is apparently resulting in inequitable access. A systematic re-examination of this policy and its implementation in the field could help VA better project future needs for nursing home services and other long-term care services. But until this is accomplished, VA cannot provide reasonable assurance that its $2 billion nursing home program is providing equitable access to care or that it will do so in the future.

To end my remarks today, I will turn to the daunting challenges that face VA's disability programs. These involve both fundamental reform of the disability program and sustaining commitment to improving the quality and timeliness of claims processing. I would like to point out that VA shares these challenges with other federal disability programs, most notably the Social Security Administration.

Our bottom line is that significant program design and management challenges hinder VA's ability to provide meaningful and timely support to veterans with disabilities. Both the medical and economic underpinnings of VA's disability determination process are outdated. First, VA's paradigm equates certain medical impairments with the incapacity to work. But advances in medicine and technology have mitigated the consequences of some medical conditions, allowing veterans to live with greater independence and to function more effectively in the paid labor force.

Moreover, VA has not incorporated advances in assisted technologies, such as wheelchair design and voice recognition systems, which afford some veterans even greater capability to work. As a result, VA's rating schedule updates have been insufficient to provide the modern criteria VA needs to ensure meaningful and equitable decisions.

Second, and equally important for equitable decisions, are up-to-date economic criteria to apply in determining the average earnings loss from various impairments. But VA's criteria have not kept pace with changes in the labor market. In fact, the ratings still in use today are based on estimates made in 1945 about the effects of service-connected impairments on the average individual's ability to perform jobs requiring manual or physical labor. Clearly, the economy has moved away from manufacturing to service and knowledge-based employment. Therefore, VA's use of this outdated schedule raises questions about whether some veterans may be overcompensated while others may be under-compensated.

In January 1997, we suggested that the Congress consider directing VA to address the outmoded rating schedule. Our work demonstrated the availability of generally accepted and widely used approaches to statistically estimate the effect of impairments on potential earnings. These approaches could be used to set disability ratings in a revised schedule that would be appropriate in today's socio-economic environment.

Updating its disability criteria would be a substantial accomplishment, but VA would still face administrative challenges to ensure the production of accurate, consistent, and timely decisions. While VA has made important changes to improve accuracy, it has done little to ensure consistent decisions. In fact, VA does not know how consistently adjudicators evaluating the same evidence would

make those disability decisions. Last August, we recommended that VA establish a system to regularly assess consistency, for example, between regional offices and between different levels of adjudication.

On the other hand, VA has shown tremendous commitment to improving timeliness and reducing the backlog of claims. VA hired and trained hundreds of new staff, set monthly production goals, and incorporated these goals into regional office directors, performance standards. As a result, both inventory reduction and timeliness are headed in the right direction. However, we are concerned about VA's ability to sustain this performance over the long-run. For example, it will be difficult to cope with future workload increases due to factors beyond VA's control. These include future military conflicts, court decisions, legislative mandates, and potential changes in the filing behavior of veterans.

In addition, inherent in program design is that most of the workload involves repeat claims, that is claims from veterans currently receiving benefits who are seeking additional benefits because, for example, they believe that their conditions have worsened or they have a new service-connected disability. Most of these repeat claims are from veterans rated at 30 percent disabled or less. As long as this remains an essential program design feature, expecting more than incremental gains in timeliness and inventory reduction might not be realistic.

Mr. Chairman, this concludes my remarks, and we would be happy to answer your questions and those of the other committee members.

[The prepared statement of Ms. Bascetta appears on p. 150.]

The CHAIRMAN. Ms. Bascetta, thank you very much for your testimony, and I have read your full testimony, as I am sure many members of the committee have, and it is very detailed. And, as usual, we take these things very seriously and it gives us a blueprint for action. So thank you very much for that.

I have a number of questions. I will restrict my opening round in this first round to just two because we have such a large number of our members here today. I would like to ask, Mr. Griffin, first of all to you, you have spent some time on the whole issue of physician time and attendance or lack thereof. My understanding is there are about 5,000 part-time physicians. In your April 23 report on the subject, you said that either a statutory or an administrative response might be needed, and I wonder if you might comment about how much in dollars we are losing? Is this is a matter of maybe the doctors just not checking in properly but they are actually there or is this an abuse that needs to be eliminated?

And, Ms. Bascetta, I would like to ask you on the nursing home issue, you pointed out so rightly that the number of eligible veterans, especially those 85 or older, will skyrocket from 640,000 to one million by 2012, and will hold steady until the year 2023. So we have an expectation of a large number of veterans who will need nursing home services and yet I think the trend line has been going in the wrong direction. In 1998, we had a 33,603 average daily census, that now is 31,746. I have brought that issue up over and over again with Secretary Principi being deeply concerned that we are shifting so much, not only in raw numbers, average daily

census, but we are shifting a lot of it to the states. The states don't have the capability because of their coffers being lessened in this economic downturn, and my own state has had that very same thing happen. So bottom line, the veterans don't get served. And you might have some recommendations on that for us.

Mr. Griffin?

Mr. GRIFFIN. First of all, I would like to say that there are many, many extremely dedicated health care providers in the Department of Veterans Affairs that are doing the right thing. We have documented that in our cap reviews. However, we have also identified locations where they are not doing the right thing. The 5,000 part-time doctors that we allude to in our report actually represents about 2,600 FTEs because they are working about 20 hours a week, or at least that is what their contract calls for.

In our recent audit, we went looked for these part-time doctors during the hours they were being paid to work for VA, and we couldn't find 11 percent of them. Their supervisors couldn't find them. We couldn't find them. No one could find them. Now the cost for part-time doctors is about $400 million a year. So if you are losing 11 percent, you have $44 million right away. I think that it is not a question of them being there and us not knowing it. The protocols that we used in our audit allocated time not just for surgery or hands-on medical care. We also allocated time for administrative requirements that go with medical care, research and education. Some facilities, like the medical center in Boise, where they had a small number of part-time physicians, were exceeding productivity standards that you would expect to see. I say that, because the protocols we used in Boise, which allowed us to document doctors working more than 100 percent of the time they were being paid for, are the same protocols that we used in the facilities where we found that, in one instance, 70 of 150 part-time doctors had no medical care treatment during a four hour shift of duty for the period examined.

The CHAIRMAN. Ms. Bascetta.

Ms. BASCETTA. Yes, with regard to the nursing home situation, I would like to answer by saying first that we are concerned about VA's current policy and the fact that they don't seem to be as far along as we would like them to be given the projections in the aging of the population. In particular, it is not just the nursing home component that they need to be able to project but how they want to address the full continuum of care that veterans might need from institutional to non-institutional services. And in this regard, the federal advisory committee recommended in 1998 that they retain their current capacity for nursing home care but meet projected demand with non-institutional services. It is not clear to us that they have a strategy for doing that at this point. But, clearly, a decline in the nursing home demand is something that is puzzling and that we don't understand yet.

As far as what the committee can do, you have an opportunity to revisit with VA their long-term care policy to make it more explicit in terms of what should be provided and under what circumstances as the Millennium Act will be reauthorized. I believe that it expires this year.

The CHAIRMAN. Chairman Simmons will be holding a hearing on that very issue on May 22 to look further into the long-term care because we are deeply concerned about this trend line. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. Mr. Griffin, yesterday at a subcommittee hearing, Deputy Secretary Mackay defined VA core business functions. He determined that MCCF was such a core function. Why should organizations retain close internal control of core business functions. I would like your answer to this at this point?

Mr. GRIFFIN. I am sorry, Mr. Evans, could you repeat the question? I couldn't hear it.

Mr. EVANS. Sure. Secretary Mackay yesterday defined VA core business functions. He determined that MCCF was such a core function. Why should organizations retain close internal control of core business functions?

Why is that important?

Mr. GRIFFIN. Why is that important? Based on work that we and the GAO have performed in the recent past, there is a lot of money to be collected. I think they are projecting $2.1 billion in the coming year. We did an audit a few years ago, which we are currently bringing up to date to assess how they are doing. During that audit, we identified a billion dollars worth of unbilled medical care, which if billed out, with their normal collection rate of 36 percent, would represent $360 million. So if the deputy secretary is saying that they are going to put sharper focus on MCCF, I think that is great.

The CHAIRMAN. I would inform my colleagues we have 8 minutes pending on this vote. There are four votes. The last three are 5-minute votes. I would appreciate it if the witnesses could stay on, and we will reconvene and every member who has questions, will obviously be recognized them for that purpose.

Ms. HOOLEY. May I ask unanimous consent to turn in my opening statement?

The CHAIRMAN. Without objection, your statement and that of any other member who has an opening statement will be made a part of the record.

[The prepared statements of Ms. Hooley appears on p. 107.]

Ms. HOOLEY. Thank you.

The CHAIRMAN. And we will come back for questions.

Ms. DAVIS. May we also submit questions for the record if we are not able to return?

The CHAIRMAN. Yes.

Ms. DAVIS. Thank you.

The CHAIRMAN. Thank you. The hearing stands in recess.

[Recess.]

Mr. BUYER (presiding). The full committee Veterans' Affairs Committee will now come to order. We had a lot of members here right before we had to recess for votes. Since I chair Oversight Investigations, I don't want to get into a lot of questions at the moment because here at the full committee we have several issues that we are also addressing at the subcommittee level. Ms. Bascetta, I want to thank you for coming yesterday and for your contributions relative to the medical care cost recovery issues. Those aren't going to go away. We are going to see each other

again and again and again, as we really struggle to find a sensible solution here. And I think it is one of those things that the more we work on it, the more it begins to define itself. That is how I kind of feel about this one.

With regard to the issue on fugitive felons, Mr. Griffin, Mr. Slachta, I want to thank you for your work on this one. I think Congress did the right thing back when we did the welform reform initiatives and addressing SSI. And now we are addressing it with the VA. When I think about this, your working, you, i.e., the VA, working cooperatively with the U.S. Marshal Service when we have about 1.9 million outstanding warrants. You had another 2 million per year and then say, okay, how many of these fugitives are also receiving veterans' benefits? I know that you have done your hits but you also estimate that the number could be higher, is that correct?

Mr. GRIFFIN. Yes, but unfortunately, there is no national database that contains all the fugitive felon information in the country. So what we have to do is execute agreements with multiple states. We have got an agreement with the Marshal Service first, and then with NCIC, which is the FBI's database. We got one with the State of California, and the State of New York. There are so many states that don't send their warrants to the FBI, so to capture the whole universe, we are going to have to get signed agreements with all of them because of the requirements of the Computer Matching Act.

Mr. BUYER. But even though it is difficult, that is not going deter your efforts, right?

Mr. GRIFFIN. It is working. It is working. It is going to take some resources that I am going to have to find to do this. But so far the four databases that we have matched against contain over 700,000 felony fugitives. And we have already identified 11,000 matches with VA beneficiaries in just the four databases.

Mr. BUYER. All right, now once you identify them, then you have to vet them, correct?

Mr. GRIFFIN. That is correct.

Mr. BUYER. And then once you vet them and actually cut off the funds to those identified individuals, give me that number?

Mr. GRIFFIN. Some of the vetting is still going on. In California, we are matching against employees also.

Mr. BUYER. I know but how many fugitive felons out there have actually have cut the money off?

Mr. GRIFFIN. Well, as new is the program is, they are not immediately cut off because the arrangement that we have with VBA is that once we get the raw data and validate it, they will let the benefit run for another 60 days in order to allow law enforcement to try and apprehend the person while we still have a good address. Once that 60 days has run, VBA will terminate the benefit. I would like to give you an answer in writing for the record as to how many of those have happened to date.

Mr. BUYER. My gut is telling me based on the hesitation it is probably a pretty low number?

Mr. GRIFFIN. No, I just don't know. It is very new. The New York MOU was just signed about 2 months ago.

Mr. BUYER. All right, we are going to do follow-up at the subcommittee level on the Fugitive/Felon Program.

Mr. GRIFFIN. Great.

Mr. BUYER. Just to let you know that. Now, we have, the last 2 years, the full committee in the last 2 years and the Appropriations Committee, working cooperatively, have added 55 employees to the IG and 88. Can you tell us, are we getting our money's worth?

Mr. GRIFFIN. You are absolutely getting your money's worth. We did a review of our return on investment——

Mr. BUYER. That is a softball question.

Mr. GRIFFIN. Our return on investment for the past 5 years is $30 for every dollar in our appropriation. So my answer is, yes, you are getting your money's worth and you would get similar return on any future increases. (Laughter.)

Mr. BUYER. Wow. So you hit out of the park and then you took the ball and threw it further. Thank you. The chair now recognizes Mr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Mr. Griffin, you used—the title of this hearing today is a hearing on fraud, waste, abuse, and mismanagement, and you used the phrase "fraud, waste, and abuse" in your opening statement. and probably every member here has used the phrase "fraud, waste and abuse" in multiple speeches if not TV ads back home, is there a difference? I think I know what fraud is. I think I know what waste is. What is abuse? Is that different? Is that mild fraud or severe waste or is it just a phrase we all throw out there that really doesn't mean anything different?

Mr. GRIFFIN. That is a phrase that the framers of the IG Act put in the Act. We have done investigations of patient abuse and other examples. It has just become part of the cultural language, I guess a type of fraud having to do with exploitation.

Dr. SNYDER. I don't know but you are a lawyer.

Mr. GRIFFIN No sir, I am not.

Dr. SNYDER. So you are saying abuse could mean abuse, physical abuse of patients?

Mr. GRIFFIN. Right.

Dr. SNYDER. But that is not what you are looking at here today?

Mr. GRIFFIN. No.

Dr. SNYDER. Okay. I wanted to ask about this issue, because you spent a lot of time in both your written statement and your oral presentation on the part-time physicians. I think on page 5 of your written statement, you talk about, "We believe communication of expectations and responsibilities would significantly improve operations at the VA medical centers." What do you mean by that?

Mr. GRIFFIN. Well, when we conducted the audit, which resulted in the April 23 report, and found substantial under-achievement at those facilities by the part-time physicians, we asked the managers at those facilities what they told these doctors that the expectation was from the standpoint of what they were going to work on, what percent of their time was going to be patient care, what percent was going to be research, what was going to be education. And four out of the five didn't tell them anything. So they weren't told what they were being paid to do. And, as a result, they did what they wanted to do.

Dr. SNYDER. Okay, I want to be sure—and I guess this leads to my second question because I have trained at a couple of different VAs and have some familiarity I think with them. But when you are talking about part-time employees, are most of these full-time practicing physicians who have dual appointments with a medical center and a VA or private practice and the VA or what combination of that? Or are they true part-time people that just I am 57 years old and I am going to work——

Mr. GRIFFIN. Most of them are part time at VA and part time at the affiliate.

Dr. SNYDER. The affiliate being a medical school?

Mr. GRIFFIN. Right. And the problem is at the affiliate they have incentives for productivity. So if they can disappear and be working at the affiliate billing Medicare or billing private health insurance, there is an incentive to do that. And if there is no sound system in place for accountability at the VA medical center, they are going to take advantage of that and our work reflects that is what is happening.

Dr. SNYDER. Now I know at the Little Rock VA we actually several years ago, 8 or 9, 10 years ago, federal funds were spent to build a connecting, I don't know, something that goes across——

Mr. GRIFFIN. Bridge?

Dr. SNYDER. Bridge, there we go. Bridge.

Mr. GRIFFIN. Right.

Dr. SNYDER. Recognizing that there is just tremendous interplay back and forth, that VA patients end up going over to the medical school, that the students go back and forth, the residents go back and forth, the teaching goes back and forth, there are conferences on one side and then the other. Is your concern that not enough time is being spent on the VA site, not enough time is spent—that the guys are just not even showing up for work and they are out fishing somewhere or is it there is not adequate accountability for demonstrating that they are specifically doing VA-related work even though they may be at a conference?

Mr. GRIFFIN. I think that the number one mission for veterans' health care is to provide quality care for veterans. I am aware of their research mission. I am aware of their education mission. But quality care for our Nation's veterans has to be number one. And what we are finding is we are paying somebody, a part-time doctor who gets four-eighths, is supposed to work 20 hours a week for the VA. And we just have not found evidence at most of the locations that we have gone to that the VA is getting what they are paying for. The common theme seems to be where you have a large number of part-time doctors and you have an affiliate right next door, you have people that are conflicted because they are on two payrolls. Too often they are at the affiliate when they are being paid by the VA.

Dr. SNYDER. I appreciate what you are saying but now that you kind of hit a sore point with me there when you started demeaning research. We have a tremendous amount of money that goes toward research. We are in the process—there is already funding that has been allocated, I think the project is underway for expanding research space at the Little Rock VA. And currently they are having to lease space across the bridge at what you refer to as the

"affiliate" in order to complete the VA research. And they have a lot of shared responsibilities. So I don't think it is as simple as saying, well, people are going over to do research at the medical school. I think it is more complicated than that. I am just trying to get a sense of——

Mr. GRIFFIN. I agree that research is critically important to veterans, but I think that the doctors should be doing research that the VA has an interest in and not a pet project that they may have that may have no nexus to VA's mission.

Dr. SNYDER. Now, I didn't read your—I mean I read through your report, I didn't see anything in there though that you were specifically analyzing research versus medical affiliate research, VA research. Is that in there and I missed it?

Mr. GRIFFIN. Not the specific activities.

Dr. SNYDER. All right.

Mr. GRIFFIN. What we looked for was evidence of any work that benefitted VA, to include research and education and patient care.

Dr. SNYDER. Right.

Mr. GRIFFIN. And in collecting that information, we came up woefully short at a number of the facilities that we went to. I mentioned Boise, using the same protocols, exceeded what would be considered working 100 percent of the hours they were paid for. At these other facilities, for 70 out of 153, we could only find work for less than 25 percent of the time we paid for it.

Dr. SNYDER. Thank you, Mr. Chairman.

Mr. BUYER. Thank you, Mr. Snyder. I gave you latitude on that only because it is a pretty important issue and when Secretary Principi was sworn in, I think it was one of his initial requests and submitted the request for the audit for you and we are working now on the results of that. And I thank you, Dr. Snyder.

The chair now recognizes Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I am going to just very quickly hitchhike on the last point made by Dr. Snyder on the VA research, and I mentioned this to you, Mr. Griffin during the break. Yesterday, we introduced the Christopher Reeves Paralysis Act, which focuses on research and other quality of care issues and whatnot regarding the central nervous system and strokes basically and paralysis. And the newest treatment, which has borne an awful lot of fruit in terms of progress as far as Mr. Reeves is concerned and others I would say, is a result of VA research. And I had to leave yesterday because we had those five votes, after I introduced him, I had to run out. But he did tell me he was going to mention that and so I am very proud of that on behalf of this committee and the VA.

I have some mathematical questions here regarding the part-timers, Mr. Griffin and Ms. Bascetta. But first let me ask you, Mr. Griffin, how long have you been the IG?

Mr. GRIFFIN. I became the IG on Veterans' Day in 1997.

Mr. BILIRAKIS. 1997, so that is what, about——

Mr. GRIFFIN. About 5½ years.

Mr. BILIRAKIS. About 5½ years. And prior to that, you were with the ID's office?

Mr. GRIFFIN. Prior to that, I was the deputy director of the Secret Service.

Mr. BILIRAKIS. Oh, it is not secret anymore then.

Mr. GRIFFIN. No.

Mr. BILIRAKIS. Well, my question goes to you have made a number of recommendations. Over the period of time that you have been the IG, I would gather you have also made recommendations to the VA, right?

Mr. GRIFFIN. That is right.

Mr. BILIRAKIS. My concern is follow-up on these recommendations. Administrations change, which means that all the top level people in the VA change as a result of it, maybe not right away, some linger on until appointments are made or whatnot. So is that a problem in terms of the good things, the recommendations that are made by the IG and by others as far as the VA carrying them out? Is that why we have these problems where these things just don't seem to be taken care of, they just seem to linger on and on over a period of years? Comments?

Mr. GRIFFIN. I don't know that I would limit it to a change of administration.

Mr. BILIRAKIS. Okay. Is that a problem maybe to some degree at least?

Mr. GRIFFIN. That is certainly part of it.

Mr. BILIRAKIS. Okay, go ahead.

Mr. GRIFFIN. When we do audit reports or administrative investigations and make recommendations to the Department, we will keep our report open until we are satisfied to the extent that we can be that the recommendations have been addressed. We will send requests on a recurring basis if it has been 6 months and we haven't heard from them to see what the problem is. But if I can back up, before we issue a report, we get the concurrence of the Department in the report and we get their concurrence on the monetary value that is assigned to the problem.

Mr. BILIRAKIS. Well, you were asked specifically to run this report by the Secretary, were you not?

Mr. GRIFFIN. The Secretary asked us to do this audit. The Secretary is very concerned about the problem. There was tremendous anecdotal evidence that there was a problem, and we needed to do the audit to confirm that. We are also doing follow-up work in Lexington, KY where we are drilling much deeper and may perhaps be the subject of a future hearing as to the outcome of that activity.

But we do follow-up on our recommendations, and we will not close a report until we are satisfied that something has been done to fix the problem. It doesn't always happen as quickly as we would like. When it is delayed beyond a year, we report that in our semiannual report so the members of the committee will be reminded that this issue has been around for a year now or it has been around for 18 months or it has been around for 2 years and somebody can weigh in, and maybe together, we can make this thing happen.

Mr. BILIRAKIS. But you don't have—don't you feel that you have the clout to weigh in and to make sure that these things are at least seriously considered because they are only recommendations for the most part?

Mr. GRIFFIN. I am not bashful about discussing these matters with the Secretary or anybody else in the Department. The easy

problems go away quickly. The more difficult ones seem to take a while.

Mr. BILIRAKIS. Again, sir, the light is on and I did want to get into the mathematics of the part-timers but I guess I will wait on that. I wasn't here at the beginning and I didn't hear your remarks but someone said something as we were running to vote that the feeling that you had was that you did not need any legislative help? Do you? You don't need any help from the Congress regarding making sure that some of these things get done, if they are warranted of course?

Mr. GRIFFIN. I would be willing to entertain any action that would ensure that these recommendations get addressed. Otherwise, we are wasting your time and my time and everybody else's time.

Mr. BILIRAKIS. Okay.

Mr. GRIFFIN. Maybe we can discuss that later.

Mr. BILIRAKIS. Thank you, Mr. Griffin. Thanks, Mr. Chairman.

Mr. BUYER. Thank you, Mr. Bilirakis. Mr. Michaud, you are now recognized.

Mr. MICHAUD. Thank you very much, Mr. Buyer. A couple of questions. Are the escalating projections of savings indicative of better management practices, my first question?

Second question is how do you account for savings, specifically how can you analyze programs like A–76 programs when you don't have a good baseline?

And my third question is your accounting mechanisms, one of the things I found particularly work in chairing the appropriations committee for a number of years in Maine, actually you had mentioned you get more people, you can save more, what type of accounting mechanisms do you use and has that changed? I guess my big concern is you use what ever method, not you personally but the Executive Branch could use whatever method to meet a certain budgetary guideline. We have done it in Maine before, give us "X" amount of positions, we will raise this amount of revenue or save this amount of revenue and therefore we balance the budget. What type of mechanism do you use?

And my last question deals with prescription drugs. Have you analyzed what type of prescription drugs VA uses, i.e., generic drugs versus brand names and could you save more if you went with generic and do they currently do that?

Mr. GRIFFIN. Is your first question about the Department's claim of $985 million of management efficiencies?

Mr. MICHAUD. Yes.

Mr. GRIFFIN. Okay. I can't say where that number came from. I can tell you if you add up the dollars that are represented in the broad category of erroneous payments in our testimony today, it is about $1.5 billion. I think it is good that the Congress has made a requirement of reporting erroneous payments because in the past the Department wasn't all that interested in keeping score of things like that. Now there is a requirement to identify your erroneous payments with the budget submission. We have a Fugitive Felon Program that will be involved with erroneous payments, an income verification match process that involves erroneous payments, and you have incarcerated veterans that involves erroneous

payments. It is going to be a substantial amount of money. I don't believe that is necessarily where that $985 or $975 million figure came from though. I think you would have to ask the Secretary for a specific response.

In reference to A–76, we have not looked at any of the A–76 activity in the Department.

On prescription drugs, we haven't done any recent work on the formulary. I know my health care inspection team did some work on that a few years ago. We don't have any current work on that that I could cite for you. If there is something you would like for us to look at, we would be happy to do that.

Mr. MICHAUD. And my other question was on your accounting mechanism?

Mr. GRIFFIN. On the accounting within the IG?

Mr. MICHAUD. Yes.

Mr. GRIFFIN. Well, as I mentioned a moment ago, when we issue an audit report and we attach a dollar value to the findings, the draft report goes to the Department, and we ask them to concur or non-concur with our estimates of the monetary benefits. In the past 5 years, they have concurred with $5 billion worth of our findings. So as far as future projections, we did a strategic plan a few years ago. We listed in that strategic plan about 25 audits that we thought were very important for the Department's efficient management that we would do as part of our strategic plan. However, we haven't been able to do about 20 of them yet for lack of resources. So that is why I say I believe that a 30 to one return on investment, which has stood up for 5 years, is a number that I think is well established.

Mr. MICHAUD. And you have been going by the same accounting practices for some time? You haven't changed the methodology?

Mr. GRIFFIN. During the time that I have been IG, which is about 5½ years, we have done this same methodology of return on investment. I can tell you that for the fugitive felon initiative, there is a similar program in the Social Security Administration. It was mentioned earlier that 1996 legislation created that for Supplemental Security Income. The Social Security IG got 47 FTE to implement that program. I have about eight people at the present time that are trying to implement our program. There is a tremendous return on investment available, and we are going to make it happen because it is a safety issue but it takes resources to do it.

Mr. MICHAUD. Let me ask one follow-up. Does OMB agree with your analysis as far as if you had "X" amount of employees bring in "X" amount of dollars and in fact if that is the case, then some of the important legislation we are dealing with where veterans are inadequately taken care, we can actually zero out some of the programs under the Pay-go system if from what you are saying is correct?

Mr. GRIFFIN. Our budget process is not pretty. There aren't too many people that want to embrace their IG, I am sorry to report. But OMB does get a budget presentation from me only after I have made a budget presentation to the CFO and to the Secretary and then to OMB and depending on their perception of whether they want more reports from me or not, they decide how to fund my organization. Luckily, this committee has been very supportive. In

three of the past 5 years with the help of the committee, we have received an increase, and I am grateful for that.

Mr. BUYER. Mr. Michaud, on prescription drugs, the VA, we buy them at the best discounts. And they do utilize those generics and there have been some questions in the past on first fail policies. Generally, there isn't a written policy out there but sometimes different medical facilities put pressure on doctors to move toward generics and then the question is is that really the best drug on behalf of the patient as opposed to something else that is on the marketplace. So they get up into these quality assurance debates per facilities. So I just wanted to share that with you.

Mr. Simmons?

Mr. SIMMONS. Thank you, Mr. Chairman. I will have some questions for the record, if I could submit those, I would appreciate it.

Mr. BUYER. No objection.

[Mr. Simmons' questions were incorporated as part of Chairman Smith's question.]

Mr. SIMMONS. I additionally would like to thank GAO for their reports. For whatever reason, I am somebody who likes to read and I find that the GAO reports have been very helpful to me. On those late nights, when I don't have any letters to sign or listen to the special orders, I read GAO reports and I find them very informative. So I thank you.

Mr. BUYER. You know we can get you some help.

Mr. SIMMONS. Is there a psychiatrist in the house? I have three questions. I will ask them up-front so that I don't have to battle the red light. The first one deals with an issue that you discuss on page 16 of your testimony. You had a dozen defendants at the Atlanta VA regional office. They embezzled or stole $11 million. They were sentenced to 37 years imprisonment and 35 years probation total. That factors out to me about 3 years each if they have equal sentences, and I am sure they don't. But it occurs to me that 3 years each in prison is less time than John McCain spent in Walo Prison under far less congenial circumstances. I have to ask you if you are satisfied with the punishments that these people get given the fact that their activities are not only abusive but they are fraudulent? Because to mis-use your office is to abuse your office, and I believe it is important to punish people for the abuse of their office even if it doesn't reach the level of fraud, and I think that is what waste, fraud, and abuse is all about. Abuse is using your office wrongly or improperly, and I think that is something we have to continue to pursue. So point one, does that punishment fit the crime?

Point two, missed opportunities. On page 22, you refer to missed billing opportunities in the medical care collection fund. I have met with the head of VA collections. We will be doing a subcommittee hearing on the subject. He tells me that one of the problems he has is that the denominator of his collections fraction is inflated with Medicare dollars, that he has no chance of collecting. Now, clearly, some Members of Congress would love to see Medicare subvention so that you can collect against Medicare. But right now you can't. And, yet, his data reflects a denominator, which includes Medicare dollars which cannot be collected. Should that formula be changed so that we get a different percentage of collections out of that sys-

tem and have a more reasonable perception of how they are doing? And if that is part of the missed opportunities, should that not be set aside?

The third question goes to doctors and part time, and Dr. Snyder has raised that question. I would like to follow-on. I have talked to some of the part-time doctors and one of the things they tell me is that they are part time, they may be working or affiliated let's say with Yale, New Haven, and they head over to VA for a procedure. And the prep has not been done properly or there is something missing or there is a test that wasn't taken or there is a scheduling error or a surgical nurse doesn't show up. It occurs to me that part of the problem may not be fraud or abuse, maybe part of the problem is scheduling and ensuring that the system is working with maximum efficiency. I would be interested in your comments on all three of those questions.

Mr. GRIFFIN. Concerning the Atlanta fraud case, the ring leader, was the current employee at the time that that case occurred, was sentenced to 13 years in prison. At the time she was sentenced, I believe she was 60, 61 years old. So as the principal in the prosecution, she did get 13 years. Some of the people on the outside who she actually used as a vehicle to get this money out were given lesser sentences. I can tell you that we went after every asset that they had. They had made some strange purchases with this money. They bought a submarine. They bought RVs. They bought a mini-helicopter, a $40,000 Barbie doll collection. We took all of that. We seized everything that the law would allow us to seize that we could find.

In federal district court, there are sentencing guidelines. And the judge who is going to decide what the sentence is has to look at those guidelines and he has to say has this person ever been arrested before, what is the nature of the crime, et cetera, et cetera. And there are points that are associated with each of those elements. And you roll those things together and out comes the 13 year sentence for the ring leader.

I am with you. I would like to see them go away for a long time, a long time. That is $11 million that could have been used at the medical center in Atlanta to buy more treatment for veterans, to have more doctors available, to have the best of the best available. And instead it was squandered. I am with you.

Let me go to number three. Scheduling is a problem, no question. But part of that scheduling problem is that at some facilities, they allow the affiliate to schedule the part-time doctors. The VA had little or no input in that scheduling. So if they are being scheduled for hours where things aren't lined up, then it is a waste of resources. We were told by senior officials in VHA that the amount of money in the budget for part-time doctors had more to do with the salary needs of the affiliate than the needs of the VA medical center. That is backwards. That is wrong.

This map was made so we could point out that this is not an anecdotal situation. I think it is pervasive. I think 50 years ago when the affiliations were created that there was one set of circumstances that existed then. I think today VA is not getting their fair share of that relationship.

Mr. BILIRAKIS. Would the gentleman yield? Mr. Chairman?

Mr. SIMMONS. I have given up my time.

Mr. BILIRAKIS. Have you?

Mr. SIMMONS. He is just answering the questions, so the time belongs to the Chairman.

Mr. BILIRAKIS. Well, I was just concerned, you made the comment that the pay has more to do with the affiliate than the VA. Will you explain that and maybe give us an illustration?

Mr. GRIFFIN. The illustration is at the medical center where we are doing work right now. We were told by the chief of staff when we asked how do you decide how many part-time doctors you need, and what disciplines do you need in order to care for veterans here at your medical center, and he said it is more about the needs of the affiliate to meet their salary requirements than the needs of the VA medical center.

Mr. BILIRAKIS. In other words, if their salary at the affiliate is $150,000 a year, then their time at the VA is basically equivalent to that?

Mr. GRIFFIN. Based on a business practices I described earlier, if they can get, and this isn't a real number, but say they could get $10 million in salaries for part-time physicians that the VA would pay, that is $10 million that they can deflect from their medical staff expenses. All I am saying is if we are paying for $10 million worth of service at the VA, whether it is in education, research or hands-on medical care, we should get $10 million worth and our work suggests strongly that that is not the case.

The CHAIRMAN (presiding). The chair recognizes Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman.

Mr. SIMMONS. Mr. Chairman, excuse me, there was one final answer.

Mr. SLACHTA. I believe your question on the medical care cost recovery; you asked whether or not the data should reflect what we can collect, and of course it should. The data should reflect collections. I can understand why they would be booking Medicare bills that they cannot collect. It is a way of getting a handle on what possible future collections could be. Now, that data should be a management tool and it should not be figured into, at least I would not figure it into the cost of operations. It doesn't make sense to do that.

The CHAIRMAN. Thank you. The chair recognizes Mr. Udall.

Mr. BUYER. Mr. Chairman? Would you let Ms. Bascetta also answer? She has spent a lot of time on the issue and wanted to say something. Is that okay?

The CHAIRMAN. Ms. Bascetta.

Ms. BASCETTA. Yes, thank you. We testified about this very issue yesterday. The inclusion of the Medicare number in the denominator doesn't make sense. VA shouldn't be held responsible for dollars that they can't collect, as Mr. Slachta just said. But it is up to them to construct that number. They are the ones who put that number in there and actually in some of their later figures, they do adjust and take that number out and say they get a better cost to collect ratio than if the number is included.

But the point that I want to make is that we have been working with them very carefully to try to substantiate their cost to collect and we are not comfortable that they are able to do that in a reli-

able way at this point. Besides the problems with the denominator, there are problems in the numerator too. We are not sure that they are including the right salaries, the right people, training for coders, and other issues. And Dr. Mackay and Mr. Perrault yesterday in fact agreed to continue to work with us on this very issue because if we don't know what their cost to collect is and can't measure their progress against the potential collections they should be able to collect, we have no way of knowing how well they're augmenting or supplementing the medical care appropriations and that is the whole point of the collection process.

The CHAIRMAN. Thank you. The chair recognizes Mr. Udall and then Mr. Renzi.

OPENING STATEMENT OF HON. TOM UDALL

Mr. UDALL. Thank you very much, Mr. Chairman. My first question goes to the issue of indirect cost. NIH-funded research at VA facilities, and as you probably know, NIH pays indirect cost for research at other institutions but it doesn't—and even including foreign institutions but it doesn't do that for the Veterans' facilities. And current law requires NIH to pay on the same terms as other non-federal institutions in most circumstances. And this comes to about $100 million per year, which is obviously not an insubstantial sum. In my opinion, the veterans are suffering as a result of this. We are talking about $100 million taken away from VA health care every 4 days.

And so I guess my first question is what can we do about this? What can we do about moving this indirect cost issue forward? There are several letters out there. I would like to put those in the record, Mr. Chairman. There is a letter that the ranking member, I wrote a letter, the ranking member wrote a letter, Secretary Principi wrote to Secretary Thompson, wrote a very strong letter about this, saying that this was an important issue and should be resolved.

(The attachments appear on pp. 109 to 114.)

Mr. UDALL. And I am just wondering if either one of you have any perspective on that?

And my second question goes to the waiting list, which I think you both mention in your testimony. And we know that this administration has taken that as a top priority and been very aggressive with it. But I think each of you still note that the waiting times are too long and the veterans aren't getting the kind of quick care that they should. And I note in the GAO report specifically, I am wondering here, you talk about speciality care services over the next 10 years having been a huge demand and need and doubling by fiscal year 2012, and I am wondering what is the cause of that? Is it the aging veteran population or what it is. And so with that, I will let each of you comment as you see fit. Thank you.

Ms. BASCETTA. I have a brief response to your first comment about the indirect costs. We did some work last year on not-for-profit research corporations and in the course of that work the indirect cost issue came up. It was tangential to the main objectives of our work. But my recollection is that at the time NIH's position was that they didn't want to reimburse VA for indirect costs because VA already received an appropriation for the research func-

tion. But at the same time, they were willing to negotiate with them to come up with a way of providing some reimbursement. I am not current on what the status of that agreement is or if it is even still in play.

It also relates to another issue where I think there is broad consensus that not only VA but other government agencies that do scientific research could be more aggressive about sharing or collecting royalties when they have made significant advances that the government has had a heavy investment in.

Mr. GRIFFIN. We have not done any recent reviews in the NIH area. If there is something that you would like for us to look into, I would be happy to do that.

Regarding waiting times, we did an audit of waiting times several months ago when they first started to get a handle on what the true numbers were. The original number that came out of VHA was 300,000. And our audit revealed that due to duplicative counting and inaccurate entries of people who in fact were no longer waiting but had been seen, or had been scheduled for follow-up, that the true number even then was 200,000.

But it begs a question, Congress passed a law in January of 2002 mandating staffing standards. If you don't have staffing standards and you don't have accountability for performance, then how do you know how many doctors and nurses you need to address that waiting list of 200,000 or whatever the number is on a given day.

Ms. BASCETTA. Regarding your question about the potential surge in demand for speciality care, that number is the projection from the CARES process. VA has contracted with Milliman and Robertson to do projections in the near term, between now and 2012, and over the long term, between now and 2022, to project demand for care and the specialty care numbers are from that process. I don't know whether it is strictly related to the aging of the population or just new demand.

Mr. UDALL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Udall. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman. I want to thank the chairman for holding this hearing, one of the most important and timely. And the reason I focused on time is that there is a—or there was an argument, an argument that was afoot that said we should look at cutting VA benefits by a certain percent, which didn't happen, because we could find savings in waste, fraud, and abuse. So we could cut VA benefits because there was waste, fraud and abuse in the system, which puts a lot of pressure on the IG's office to show, and for us to make sure you got the right tools, that we can find recognizable achievements. And it is nice to hear your statistics of the millions of dollars that you saved over the last several months, the investigations that you have conducted, the hotline reports.

I want to go back to Mr. Bilirakis' line of questioning. Do you have all the tools you need so when this chairman in the wee hours of the morning has to fight for VA benefits, the logic that there is still billions out there or millions out there in your arena can be beaten back?

Mr. GRIFFIN. No, we don't have all of the resources that we could use.

Mr. RENZI. There you go. What do you need? What are the resources you need?

Mr. GRIFFIN. Let me tell you what I would do with additional resources, maybe that is a better way to describe what I think can happen. We started our combined assessment program review initiative about 3½, 4 years ago. In that program, we do cyclical reviews of VA medical centers and VA regional offices. Prior to the creation of that program, the only time we showed up at a medical center was when there was a three-alarm fire. This is a proactive initiative where we can go to each facility. We can share with them best practices that we have seen at the other facilities we visited. We can also share with them real breakdowns that we have witnessed in other facilities so they can make sure it doesn't happen in their facility and so on.

Mr. RENZI. I am with you.

Mr. GRIFFIN. We think a three year cycle for reviewing medical centers is a proper cycle.

Mr. RENZI. So rather than look at cutting benefits, you actually need more resources in order—so that we can find more waste, fraud and abuse?

Mr. GRIFFIN. We are also about efficiency and effectiveness.

Mr. RENZI. I am with you.

Mr. GRIFFIN. And we want to find best practices.

Mr. RENZI. I am with you. I am with you. I just want to expose the falsehood behind that logic.

Mr. GRIFFIN. Right, I am with you.

Mr. RENZI. Thank you. My good friend, Mr. Udall and I share and represent, have the privilege to represent the Navaho Nation. And I have got Native Americans who hitchhike the day before their appointment for 3½, 4 hours in order to get to the VA center down in Prescott, AZ. Now looking at the highly rural counties and the waiting times, I have had my guys hitchhike down there the day before, sleep overnight in who knows what kind of park bench, show up for the appointment, and then only to find out there were cancellations. I want to know is there any precedent for you teaming, ma'am, with IHS, Indian Health Services? The idea that we have got hospitals up on Navaho Nation, Tom, where they can get there and yet we have got no VA clinic in the hospital. And as we look to expand, we are not looking to expand on Navaho land, which I very much, I am going to ask my chairman to help me with. But is there anything that you are aware of from a statute standpoint that would preclude us from teaming with IHS, Indian Health Services, even though it is not on federal land? I know there is a sovereignty issue but we are able to get banks now out of California to lend money for homes on sovereign land. So, instinctively, from a freshmen Congressman who knows nothing, it tells me that we could be able to find ways to put a VA clinic on sovereign land so these people don't have to hitchhike 3½ hours and wait overnight?

Ms. BASCETTA. I think your instincts are exactly correct. We don't have work on VA partnering with IHS facilities but it is interesting to note that historically the VA hospital system that is in place now began as public health service hospitals, so did the Indian Health Services.

Part of CARES is a strong focus on the VA partnering with DOD for the very reason that you are pointing out, for the good of the government and the federal beneficiaries who are receiving direct care in federal facilities. If what makes the most sense is for them to partner to provide the best quality services at the best price, that is what needs to be done. And VA has focused quite a bit on partnering with DOD. They are not as far as long as we would like them to be in terms of results but the processes are in place for that hopefully to happen. I just don't know of any situations where that has occurred with IHS.

Mr. GRIFFIN. Mr. Renzi, if I may add briefly. We are presently doing an audit to review the several hundred outpatient clinics that have opened to determine that the level of activity is proper to support these clinics. Some are very busy and some aren't very busy at all.

Mr. UDALL. Mr. Chairman, if I might just have a moment. I want to join Mr. Renzi in his concern. And if there is any way we can work with these two agencies, the Veterans' Administration and the Indian Health Service, which is in another agency, and get them to partner, as the GAO witnesses testified, let's do it because I hear the same stories you do. And the thing that people don't realize is these are—I don't think it is as well know, very patriotic individuals, the Navaho code talkers helped in our victory in World War II and there are many other examples of their patriotic service.

Thank you for the courtesies, Mr. Chairman.

The CHAIRMAN. Are our witnesses finished responding? Mr. Renzi, thank you for your comments. We will follow up on that. And we will sit down with you and Mr. Udall and see what we can do. It is also something I think we should bring up with the CARES leadership because they will be releasing their recommendations some time in October and theirs is still a work in progress. And I think they need to be alerted to this so we will work with you on that as well.

Ms. Brown-Waite?

Ms. BROWN-WAITE. Thank you, Mr. Chairman. Actually, I believe most of these are—most of these questions are for the folks from GAO. There was an article in the St. Pete Times in 2000 about fraud and fraudulent claims. And I see that your report addresses that. And let me just briefly read from your report, I believe—I am sorry, from the inspector general. It says after learning of these thefts, the under secretary for benefits requested that you all go in and review and determine what vulnerabilities existed that might have facilitated these frauds. And that you provided a vulnerability assessment, reporting on 18 observed vulnerabilities in six general internal control categories. My question is were your recommendations adhered to? In other words, I know you made the recommendations. The question is did the St. Pete office follow them and are procedures in place so that I won't be having another headline like this facing me in the morning next week when I go home?

Mr. GRIFFIN. After we did that review at St. Pete, we did a national audit of other regional offices to see if the same 18 vulnerabilities that we found at St. Pete were system-wide. We found that they were. Twelve of the 18 vulnerabilities have been

addressed. One of the vulnerabilities that we have been concerned about, which also presented itself in the Atlanta fraud case, was the fact that there wasn't a trip wire in the benefits delivery network to prevent a fraudulent payment above $25,000 from even leaving the regional office. That was one of our principal recommendations, that they needed to secure the benefits delivery network. And the response we got was that that system was going to be replaced. It would be too expensive to try and fix the current system, so we are going to replace the whole thing.

Ms. BROWN-WAITE. Did they give you a time frame that they "were going to replace the whole thing?"

Mr. GRIFFIN. Not with any specificity.

Ms. BROWN-WAITE. Would you make sure that I get a copy of the 18 vulnerabilities that you highlighted. And, specifically, if you will, tell me which of the six have not been followed up on.

Mr. GRIFFIN. We will do that. We will give you the audit report that went with it too.

Ms. BROWN-WAITE. I would appreciate that. And I think that this next question is for the GAO and that is do you all have a list of the access deficiencies in Florida, the access to health care deficiencies actually in Florida? Do you have them geographically?

Ms. BASCETTA. We have what the CARES process has delineated as access gaps. That is where veterans are traveling in excess of their travel standards to the various types of care nationwide.

Ms. BROWN-WAITE. But you don't have them broken down by state?

Ms. BASCETTA. They are broken down by geographic area, by county.

Ms. BROWN-WAITE. Okay, if I could have them for the counties that I represent, I would appreciate it.

Ms. BASCETTA. We can get that to you.

Ms. BROWN-WAITE. The next question is has anybody ever looked at reviewing the "wait times?" I am very suspicious, I have a clinic that as of January had 600 people on a waiting list. As of February, it had 650. And as of March, because we were tracking them, had a zero waiting list. I think that from what I am hearing from veterans, waiting lists are being whittled away in a manner that gives false hope. In other words, if you whittle away your waiting list by getting somebody an appointment. In one case, I heard from a veteran, he has got an appointment 16 months from March. And it is in this county where they whittled it away to zero. An appointment 16 months out is not truly addressing the waiting list issue. And have you all done any studies on those waiting lists?

Mr. GRIFFIN. We are doing an audit right now of the demand at various outpatient clinics. We also have a separate audit that is looking at waiting times that is probably within 90 days of being issued.

Ms. BROWN-WAITE. I would ask please don't look at just what the waiting times are because sometimes, as I say, they say that there is not a waiting list because they schedule them 14 to 18 months out.

Mr. GRIFFIN. Sixteen months does not constitute being removed from waiting for health care.

Ms. BROWN-WAITE. Well, I am being told that is what is exactly what is happening in Florida.

The last question I have is arbitrariness in the CARES assessment process. I actually had some folks from VA tell me that a particular area in my district, because they sent me the plan, that a particular area in my district, oh, they were wealthy veterans and wouldn't need health care. Help me to understand is there a lot of arbitrariness in the decision-making process in the CARES recommendations?

Mr. GRIFFIN. Personally, I haven't heard that.

Ms. BASCETTA. Under certain circumstances there is a lot of discretion that is afforded to the network managers who are doing these assessments. I haven't heard what you just stated. It is too early for me to comment on whether that would be something that would be of concern to us or not, but we would certainly keep our ears open for that.

If I could just add to your comment about waiting times though. You are very right to be suspicious of waiting lists. We have been reporting on wait times data reliability problems since about 1998, I think. And, in fact, last year VA finally admitted that they agreed with us, that their system for measuring waiting times was totally unreliable. And they have gone to this electronic waiting list, which I believe is what the IG is looking into now. But, clearly, your concern is a valid one.

The CHAIRMAN. Thank you, Ms. Brown-Waite. Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you, Mr. Chairman. I am sorry I didn't get a chance to hear your testimony. I am anxious to hear it and I will be briefed on it and read the information that you have provided. I am in an International Relations Committee meeting simultaneously. So it is keeping me hopping.

First, I want to thank, Mr. Chairman, for holding this hearing. Eliminating waste, fraud and abuse at the Department of Veterans Affairs is important but it is essential to do so in a way that doesn't jeopardize the health and safety of our veterans.

Southern Nevada has one of the fastest growing veterans population in the country. The VA has projected that the number of enrolled veterans in Las Vegas will increase by 18 percent from 2001 to 2022. This growth is occurring in only one other area in the country and went unrecognized by the VA planners for far too long.

The veterans' health community is struggling to meet the needs of the population growth and that has been compounded in Las Vegas by the evacuation of the Addeliar D. Guy Ambulatory Care Clinic that is currently underway. The clinic, which was built in 1997, was closed because it is structurally unsound. For the next 3 years, my veterans, the veterans in my district, many of them in the 70's and their 80's, will suffer the inconvenience of shuttling between 10 different locations in the Nevada desert summer heat to have their health care needs met.

The VA has committed to building a new ambulatory care clinic in Las Vegas by 2006. As the VA determines whether the construction will be completed by the VA or contracted out on a lease-back option, the VA must, and I cannot encourage you more strongly, to

provide not only the fiscal oversight but on-site supervision of every step in the construction process. Only close supervision by the VA will prevent the wasteful situation that has occurred in Las Vegas, closing a 5-year-old building and spending millions of dollars to rent temporary health care service locations.

In addition, I am concerned that the VA is using the both the CARES and the Planning Initiatives data from the 1990 census to evaluate the elimination of waste and allocations of future resources. This does not adequately reflect the growth in areas, such as Las Vegas, where we had unprecedented growth. In the decade between 1990 and 2000, we have had an influx of population of 5,000 new people every month to the Las Vegas area. I don't believe that your evaluation is taking into account that extraordinary growth. I would ask the VA to ensure that the planning for the new ambulatory care clinic, the future inpatient needs served by the O'Callaghan Federal Hospital, and the long-term care needs of veterans in my district and all the VISNs are based on the 2000 census data and please report back to the committee on that.

Finally, based on the increase in enrolled veterans in Las Vegas, the CARES planning initiative proposed that the VA add 70 in-patient beds to the Michael O'Callaghan Federal Hospital, a VA/DOD joint venture site in Vegas. And, with all due respect, I disagree with your characterization of this as a panacea for our problems. My veterans have expressed strong dismay in going to the Michael O'Callaghan Hospital. They feel like they are second-class citizens and that preference is always paid to the Nellis Air Force Base people.

I am concerned that the space available at the hospital for this expansion is not enough to accommodate future Air Force and VA needs. I would like to ask the VA to determine the future in-patient needs of the Air Force at the Michael O'Callaghan Federal Hospital and report to this committee the number of beds needed by the Air Force through 2022 and how the facility will accommodate both the VA and Air Force needs. If it has been recommended that we need an additional 70 in-patient beds for the VA, and now Nellis and the DOD are saying they need an additional 70 beds, where are those beds going? Because I have been to the O'Callaghan center on many occasions, O'Callaghan Hospital, there isn't room for what they have got now. I still have 1,500 veterans a year from southern Nevada having to have their health care needs met in Long Beach because we don't have a full-service hospital that can accommodate those needs. So I will hope you will take that into account as well.

And, in conclusion, I came in late obviously but I see this map that is entitled, "VA Medical Facility Sites With Physician Time and Attendance Issues," and I see Las Vegas has a little star. If we have physician time and attendance issues, I would appreciate—I didn't see it in the testimony but I just perused it quickly, I would appreciate to know what those problems are. I spend a considerable amount of my time when I go home at my VA clinic until it closed because the plaster was falling down and the beams were going to collapse. And if there is a problem with our physicians, I would like to know about it so we can remedy it from that side as well.

And I thank you very much.

The CHAIRMAN. Ms. Berkley, thank you very much. Let me just ask a couple of questions, beginning a second round, and I do appreciate your patience and your willingness because this is a very important hearing, as my good friend mentioned earlier. Elliot Alvarez is heading up the CARES Commission, a very respected individual, a man in whom we all have a great deal of confidence. But, Ms. Bascetta, in your statement you talk about the 5 years that it took to consolidate the Chicago situation because of the affiliations with schools and the labor issues and the like. And it seems to me that if CARES is to work, if it truly is to really put assets where they are most needed and diminish those assets where they are not needed, it is going to be a heavy lift, if that was the foretaste and the harbinger of what is going to be happening when several facilities are listed for radical realignment. And the only thing that even comes close to it that I can think of is BRAC. And BRACs have been very painful in the past. Sometimes they were justified, sometimes there were data calls in the final products that were flawed but hopefully this will get it right. My question really is, since that comes out in October, how confident are you that we will be able to implement over a reasonable time, and what would you consider to be a reasonable time period, a matriculation from an inefficient system, where buildings and assets are under-utilized, to one where we get maximum utilization?

Ms. BASCETTA. That is exactly what we are trying to figure out, our confidence level. We are pretty early in the process. We have dedicated a lot of resources to evaluating this and we are anxiously awaiting the release of the market plans so that we can determine how well we think the process is going and whether or not it will achieve the kind of outcomes that we all know are needed to free up these scarce resources and to solve problems like the one in Nevada that we just heard about.

The CHAIRMAN. Let me ask you on nursing homes again, I had asked some earlier questions about that and it is something this committee is very deeply concerned about. You make the statement that, “Networks use of this discretion appears to result inequitable access to nursing home care.” And that is after you point out that there has been a diminution of daily census beds of about 1,800 since 1998. Has the GAO published or do you have the data per VISN, per network to tell us who is doing a good job, who is not? I always took the view, and hopefully our legislation we have produced in this committee reflects it, when we did the H.R. 811 legislation authorizing $550 million for enhancements to our infrastructure, not a dime of it went to New Jersey. It went to those seismically-challenged areas and infrastructure problems waiting to happen all over the country, much of it on the West Coast. A veteran is a veteran is a veteran, no matter where they are. And it seems to me if there is an inequitable treatment of an older veteran in need of long-term health care, a nursing home bed, that needs to be rectified. But we need the raw data. Do you have that? Is it being put together?

Ms. BASCETTA. What I am familiar with are the aggrevate data on the declines in the ADC in nursing homes beds. I would imagine there is backup that shows where those declines are.

The CHAIRMAN. Could we get the break out per VISN? If it means we need to formulate a letter to request a new study, we need to know that. I know there is discretion, the Millennium Health Care Act gave discretion, but it seems to me maybe if there needs to be a legislative fix, we should look at that. But at a time when we are seeing the number of age 85 or older veterans, as you pointed out in your testimony, peaking at 2012, remaining constant at that peak for another 12 or so years, seems to me that forewarned means that we have got to get ready and ready soon.

So, Ms. Berkley, before Ms. Bascetta answers.

Ms. BERKLEY. Thank you. Mr. Chairman, I think it is important to be a little more sophisticated than just providing data by VISN because VISN 22, where Las Vegas is, can have thousands and thousands of beds. In Long Beach, in southern California, I don't have a single bed. So if you do it by VISN, it may show ample nursing home space but let me assure you I have not a single bed.

The CHAIRMAN. Very good point. We need to break it down to a lower level and we will work on what should be able to get an accurate barometer so that we can make decisions. And I think it would help the VA itself. You indicated earlier, or in your testimony, that Under Secretary of Health Roswell is looking at July of this year to give at least some planning projections. But we need to know who is doing it well and who is not, because I think that is part of our oversight. We really want to take care of these veterans.

Mr. Griffin?

Mr. GRIFFIN. Mr. Chairman, we recently issued a health care inspection report, which addresses oversight of nursing homes by VHA to make sure that when veterans get out-placed in a nursing home, that the proper procedures are in place to ensure that they are not subject to some of the abuses that you hear about in the press, including elderly frail people not being given the proper level of attention. We are making sure that they are checking HHS databases, which include records about nursing homes that have been put on watch lists, and we find that veterans are being placed in those homes in spite of that fact. There were nine recommendations given to the under secretary. If you would like, I can provide extra copies of that report.

The CHAIRMAN. I was just going to say I would like to see it. Thank you.

(Subsequently, the Department of Veterans Affairs provided the following information:)

RECOMMENDATIONS AND COMMENTS

Recommendation 1:

The Under Secretary for Health needs to ensure that:

a. VHA medical facility managers devote the necessary resources to adequately administer the CNH program.

b. Critical aspects of the new VHA policy are discussed with senior managers, CNH review teams, and other applicable OM Program employees using education and training mediums.

c. VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials.

d. Clarify whether the new VHA policy intended the responsibilities of CNH oversight committees to be extended to CNH review teams or some other committee.

e. Consistently apply local and regional contracting requirements to preclude the potential for them to provide differing standards of care.

f. Survey requirements for LSC compliance are clarified between the recently issued CNH policy and instructions issued by VHA in April 2000.

g. Contracting officers strengthen the contracting process by requiring CNHs to produce current state licenses, CMS certifications, assurances of the clinical competency arid backgrounds of CNH clinical employees. CMS or State minimum standards for staffing levels to provide direct nursing care to veterans on a daily basis, and submissions of routine performance improvement data.

h. CNH review teams are reminded to critically evaluate and mitigate the risks associated with routinely transporting veterans between CNHs and VA medical facilities.

i. Clarify exceptions to visiting long-term placements and residents residing more than 50 miles away from the parent medical facilities at least quarterly, particularly in the cases of veterans who need to be seen more frequently because of their medical conditions or absence of family support systems.

j. Managers integrate CNH activities into medical facility QM programs and review performance data to monitor bedsores, medication errors, falls, and other treatment quality indicators that may warrant their attention.

Recommendation 2:

The Under Secretary for Health needs to coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits.

Under Secretary for Health Comments

The Under Secretary concurred with all the recommendations except 1i. See Appendix A for the Under Secretary's comments and corrective action plans.

Under Secretary for Benefits Comments

The Under Secretary agreed with the findings and the recommendation. The Under Secretary proposed that Central Office VHA senior managers and VBA Fiduciary staff meet to determine what information would be of value to share and the proper procedures for this exchange of information. See Appendix B for the Under Secretary's comments and corrective action plan.

Inspector General Comments:

The Undersecretary for Health concurred with our findings and all but one of our recommendations (1i), Upon further review and consideration of the Under Secretary's response to recommendation 1i, we agree that no immediate action is required but we encourage VHA managers to closely monitor this important issue, The Undersecretary provided acceptable detailed implementation plans on the remaining recommendations. The Under Secretary for Benefits concurred with our findings and recommendation and proposed a meeting between VHA and V8A Central Office managers to determine what and how information should be shared. We will follow-up on the planned actions until they are completed.

The CHAIRMAN. Let me ask, as there are two major commissions and maybe several others that are looking at specific issues like nursing issues and homeless issues, but the presidential task force is this close, maybe this week, perhaps next week, in issuing after 2 years of exhaustive study its findings as to what the VA ought to be doing in terms of making sure that the mismatch between resources and funding is bridged. I am wondering, Ms. Bascetta, have you seen that? Preliminary drafts have been floated. They make recommendations for guaranteed funding formulas, full funding, DOD/VA sharing. Has there been any GAO first look at that as to how well that may meet the needs of our veterans?

Ms. BASCETTA. We have attended their meetings but all that we have in hard copy, if you will, is their interim report. My understanding is that the final is pretty different and that it does address some issues that weren't as easy to glean from attending the meetings as it will be I think from reviewing the report, like guaranteed funding and the DOD sharing issues.

The CHAIRMAN. We will be asking you as soon as that is issued, which will probably be next week, for your insights and recommendations on that.

Let me just ask one final question, Mr. Griffin. You made a very strong statement with regards to Mr. Renzi's questions about the need for more IG personnel. You made the point way back in 2001 that the Office of Inspector General for the VA is among the lowest among all 29 statutory inspector generals in terms of what your caseload is and what you need to look at versus your available resources. This year you have asked for $442, up from $411 in the current year, an increase of $31 for your average employment, and an increase of $3.8 million. Is that enough?

Mr. GRIFFIN. No.

The CHAIRMAN. Please elaborate.

Mr. GRIFFIN. Our request this year included staffing for the Fugitive Felon Initiative. We have received zero funding for the initiative. There is a lot of talk about erroneous payments, as part of the President's management agenda it is something that we are all supposed to be going after. This is going to be a huge area of erroneous payments, and we think it is an excellent initiative. But so far I have only been able to divert eight criminal investigators from other duties to assign them to the Fugitive Felon initiative. We asked for 37 FTE for that program. We asked for a total of 92, which we believe would allow us to shrink the cycle for our cap reviews to 3 years. These reviews have been very well received by the Secretary and the senior staff. They have been very well received on the Hill. And it didn't happen.

The CHAIRMAN. When you say request, was that to OMB or to the Congress?

Mr. GRIFFIN. I am sorry?

The CHAIRMAN. Was your request made to the Office of Management and Budget or——

Mr. GRIFFIN. That was my request throughout the numerous times I got on bended knee and appealed.

The CHAIRMAN. Could I ask you, if you would, for our committee and we will then take it and do what we can to try to accommodate that request. As detailed as possible, please provide us with that

data and that information so that we can work with the appropriators, work with the House leadership so that you can do your job more effectively with the right personnel?

Mr. GRIFFIN. We will get that to you promptly.

The CHAIRMAN. And be as specific as you can. It would be very helpful to us.

Mr. GRIFFIN. Right, thank you.

(Subsequently, the Department of Veterans Affairs provided the following information:)

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
2004 FUNDING NEEDS

Current estimates indicate that the appropriation request of $62.45 million for the Office of Inspector General (OIG) supports a staffing level of 417 FTE. The OIG remains underfunded given the magnitude of its responsibilities in attempting to provide an appropriate level of oversight for the second largest department in the Federal government. An increase of $6.9 million, applied to the areas described below, will give the OIG needed resources to expand its presence and improve VA oversight.

Combined Assessment Program

In FY 2000, the OIG implemented the Combined Assessment Program (CAP). The CAP reviews represent a joint effort involving OIG Audit, Healthcare Inspections, and Investigations personnel in an evaluation of the quality, efficiency, and effectiveness of VA facilities through on-site visits on a cyclical basis. The focus of these reviews encompasses the following major activities at medical facilities and regional offices.

- access and quality of health care
- timeliness and accuracy of claims processing
- quality of financial management systems
- effectiveness and security of information technology
- efficiency of procurement processes

The success of the CAP created strong support and demand by the Secretary and Congress for a 3-year cycle, where the OIG would perform on-site reviews at 57 medical centers and 19 regional offices, annually. In 2003, the OIG is allocating an additional 12 FTE to CAP reviews, bringing the cycle to 4.5 years. To achieve the desired 3-year cycle for VHA and VBA facilities, the OIG needs an additional 20 FTE at a cost of $2.6 million.

Fugitive Felon Program

On December 27, 2001, Public Law 107-103 was enacted to prohibit veterans who are fugitive felons, or their dependents, from receiving specified veterans benefits. In addition, the law requires the Secretary to furnish law enforcement personnel, upon request, the most current address of a veteran identified as a fugitive felon.

OIG computer matches with the State of California, the United States Marshals Service, and the National Crime Information Center generated 11,278 matching records. These included 3,732 matches in compensation and pension programs, 7,296 matches in medical care programs, and 250 matches in other VA operations such as insurance, loan guaranty, education, and employee payroll. Using 2002 average benefit payments for these matches, OIG estimates an annual savings of $65.5 million. With an estimated 1.9 million fugitive warrants outstanding in the United States, potential savings reach $209.6 million. The OIG needs 37 FTE at a cost of $4.8 million to fully implement the Fugitive Felon Program.

The CHAIRMAN. I appreciate that. Yes, let me ask Ms. Bascetta do you need additional resources because we know you have been cut as well?

Ms. BASCETTA. GAO could always use additional resources, and I am sure that our return would be at least as good as the IG's.

The CHAIRMAN. If you could provide details for that as well because my understanding is you lost capacity as well.

Ms. BASCETTA. I am sorry?

The CHAIRMAN. If you could provide details on that for us as well.

Ms. BASCETTA. Okay.

The CHAIRMAN. Particularly as it relates to veterans' programs, obviously. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. I wanted to follow up on something that was mentioned earlier and that is this issue of the VA protecting its intellectual property rights. I believe you mentioned that. The VA has had major worldwide impact on health care. VA researchers over the years have collaborated on medical procedures, medical instrumentation, and medical devices. The heart stint and the nicotine patch are but two of many. And so the issue is some federal agencies have robust programs to patent their discoveries. For example, the Department of Energy routinely files for hundreds of patents per year. The VA is much less robust, sometimes 10 per year. And if you look at the patents actually received in a four year period, here in 1999, the VA is zero, the Department of Energy, 53. In 2000, VA, zero; Department of Energy, 57. In 2001, VA, 1; Department of Energy, 69. In 2002, two patents by the VA; 52 by the Department of Energy. So it is really my belief that the rights or partial rights to this property could result in both tangible and intangible benefits for the VA. And the question is what could the VA do to better secure its intellectual property rights and patents and reap the benefits of its inventiveness?

Ms. BASCETTA. I don't have any specifics to answer your question. That is really not my area of expertise and we haven't done any work in it. But certainly with the budgetary problems that the Department faces, it seems like an area that would be ripe for exploring.

Mr. UDALL. Would this be an area that you all would feel confident working in, looking at this?

Ms. BASCETTA. I am certain that we have staff in GAO who would be able to respond to that.

Mr. UDALL. Look at this kind of issue, yes. And the comparison between why an agency like the Department of Energy applies for so many and gets so many versus the VA applying for so few and obviously getting so few. I don't know if you have any comments, Mr. Griffin, or not on that issue?

Mr. GRIFFIN. I know that since Secretary Principi has been at the VA, he has highlighted this as something that they need to do a better job at but certainly the numbers that you just quoted would suggest that there is room for improvement. I think the Office of Research has been given the charge to make sure that happens in the future, but it is something we will be watching.

Mr. UDALL. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you. Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman. I just want to follow-up on the coattails of my chairman here on the question as it relates to the project, that proactive project you spoke about, the fugitive felony project. When you are looking at the details that you are going to provide back to the committee as it relates to staffing, can we also get a projection from you on—you mentioned 37 investigators, is that right?

Mr. GRIFFIN. Right.

Mr. RENZI. That you are looking at. And you only had eight. If you had 37, what kind of savings, what kind of potential savings does that equal? The idea of, hey, this is what we need but look at what we are going to be able to do. Because I tell you where we are going with this. We are able to take a negative, the idea that waste, fraud and abuse is where all the savings is, we are able to say, yes, but we are not funding it enough to provide you with enough inspectors. But if we do fund you enough, here is what we are going to get back. Please?

Mr. GRIFFIN. Based on the projected number of felony fugitives in the country, we need those 37 people—we have 22 offices around the country. We need to have at least one person in each office whose responsibility will be to manage this program in that part of the country. We currently have two program directors in our headquarters. This is going to entail finding people who know how to do data matching and extract data. Once you extract it, we want to be sure that we don't cut off benefits for a veteran who is appropriately entitled to receive those benefits. Not all departments put in all of the identifiers that you would like to see when you are doing data matching activity. Some will put in a date of birth, a social security number, and a full name and address. When we get a complete match against those, we feel very good. If there is just a date of birth and it is John Smith, well then you have to do additional investigative work to determine with certainty that you have the correct person. So there is a lot of leg work that has to happen after we get the raw data from the matches.

Mr. RENZI. I respect your expertise. I appreciate it. I am asking if you get the 37 investigators, what kind of savings can we expect for that cost?

Mr. GRIFFIN. We project $209 million worth of benefits is out there.

Mr. RENZI. So for 37 investigators, which is going to cost us a couple of hundred grand.

Mr. GRIFFIN. A little over a hundred grand each times 37.

Mr. RENZI. Okay, $3.7 million. Then we get back a projected $209 million?

Mr. GRIFFIN. Right.

Mr. RENZI. I think it is a worthy investment. Thank you.

Mr. GRIFFIN. Thank you.

The CHAIRMAN. Vice Chairman Bilirakis?

Mr. BILIRAKIS. Thank you, Mr. Chairman. I just have basically one generic question. Ms. Bascetta, let's see, looking at the first page of your written statement, "My comments today are based on numerous reports and testimony issued over the last seven years," et cetera, et cetera. Have you been working at the VA desk during that period of time?

Ms. BASCETTA. Yes, sir.

Mr. BILIRAKIS. You have, okay.

Ms. BASCETTA. Actually, not back 7 years but almost 5 years.

Mr. BILIRAKIS. Okay, all right. Well, I know we are dealing with human beings. The VA is not as big as the national health care system is, for instance, or as big as the Federal Government in general is but it is still pretty darn big. So we are dealing with bigness and we are dealing with human beings. And hiring practices, no matter how tough you may want to be, you are going to hire people who are going to do the right things sometimes. But I just wonder do we have to sort of accept that improvements are not being made? Ms. Bascetta, you know for 5 years now you have seen many of these same faults that you have testified here today and they haven't been corrected or any real efforts towards correcting them. Why should we—prefacing again, I preface my remarks by we are dealing with human beings and with bigness, and I appreciate all that. But why can't we solve some of these problems? Why can't we solve some of our claims problems? And the answer is not always more people, I like to think. Obviously, you need more people to some degree, I think. But why can't we solve some of those problems? Why can't we solve some of our waste, fraud, and abuse problems? Every bit of that takes money away from doing something good for a veteran, when it goes out the window that way. Any comments on that?

Ms. BASCETTA. Well, you are absolutely right that preventing these kinds of situations where you are needing to recoup is much less efficient than being able to have tight internal controls that prevent that kind of situation in the first place.

I guess with respect to your broader question about the Department's responsiveness to our recommendations, I would say that in some things they have been very responsive. Probably the most important recommendation we have made since I have been in this area has been to implement the CARES process and they are doing that. And although it doesn't deal with fraud, waste and abuse in the sense that you were just discussing, certainly tightening up those efficiencies would be a huge success. On the benefits side, they have done a lot to improve program integrity and their quality assurance program and that makes us feel much more comfortable that the information that we are getting from the Department is valid and reliable.

Mr. BILIRAKIS. And I am not throwing stones at the VA.

Ms. BASCETTA. Right.

Mr. BILIRAKIS. I think they are just terrific. But we talk about benefits, my gosh, we can go back to the 1980's. I have been on this committee now this is my 21st year. It has always been a problem.

Ms. BASCETTA. I think the biggest problem or the systemic concern that I have that seems to underlay the situations where they aren't responsive to our recommendations is that they are still very decentralized. And there is still a tremendous amount of discretion at the networks or even at the facility level on the health care side and in the regional offices on the benefits side. And so it is common for us to make a recommendation and VA will say they met the recommendation by issuing a directive. But if you then go and look at whether the recommendation was implemented, maybe it was,

maybe it wasn't. Maybe it was implemented differently in every location. And so maybe in some places, the VA employees are making a good faith effort to comply with the recommendation. In some situations, maybe they are not for a variety of reasons. Or maybe they haven't gotten good enough or specific enough guidance as to what they should be doing. So I would say that that is a problem that we have noticed in the administration of these programs.

Mr. BILIRAKIS. I think you are chomping at the bit, Mr. Griffin.

Mr. GRIFFIN. If I may, this hearkens back to your question about whether a change in administration can impact whether or not recommendations get addressed. In 1991, the Institute of Medicine was paid by the VA to produce a study that would give them staffing standards for physicians. They produced that study. It is two published volumes. There was a change of administration in 1992. In 1995, before I became the IG, but Mike Slachta was there doing audit work, we started an audit of physician time and attendance. The people at VHA at that time said, "Stop, don't waste your time. We agree. We are going to fix it." I implore you to make sure that it gets fixed this time because that is 12 years worth of abuse we are talking about. And I don't know how you can come forward with a request for 3,800 additional physicians or how you attack your waiting list problems if you don't have accountability for the performance of your doctors.

Mr. BILIRAKIS. Well, all right, but the current system is not solving that particular problem. So does it take something more from us up here. And then trouble with us even how we change. We change chairmen. We go out of office. We get defeated or we retire or whatever the case may be. You get new people coming in all the time. So I guess we sort of have the same sort of problem when it comes to follow up.

Mr. GRIFFIN. I understand that VHA has indicated that they will have primary care staffing standards in draft in June of this year. But they have had unofficial standards for primary care, which we have examined at a couple of facilities. It is roughly a panel of 1,200 veterans to be cared for by one doctor, two nurses, and one administrative support person. So when you talk about how much money you are going to spend on health care, you figure out how much it costs for a doctor, two nurses, and an administrative support person who can care for a panel of 1,200 veterans. This mirrors the staffing standard of the Army, the Navy, and the Air Force, which I alluded to earlier. That is a real standard and it works, but they haven't officially put it out there. It is out unofficially and those places that were aware of it were accomplishing it. I think in the speciality services, for which there are no VA standards right now, the Army, the Navy, and the Air Force, have very good standards. They are a great model and we need those standards in the VA.

Mr. BILIRAKIS. Well, my time has expired, Mr. Chairman. Thank you for your indulgence.

Well, I don't know, I was going to talk about the FTEs and 2,600 FTEs divided into $400 million comes out to a little better than $150,000, each FTE. And maybe try to get an explanation there. But I believe that is for another day, I guess. Thank you.

The CHAIRMAN. Thank you, Mr. Bilirakis. I would like to yield to Len Sistek, who is the oversight counsel for the Democrats, for any questions he might have.

Mr. SISTEK. Thank you very much, Mr. Chairman. Mr. Griffin, we have heard a lot about the physician time and attendance issue today. What about the root cause of that problem, is that more of a lack of oversight or is it more of a conflict of interest when we are talking with the affiliates? How would you weigh that out?

Mr. GRIFFIN. I think that it is in the culture. I think it has existed for so long that people have just come to accept that this is okay. As I mentioned earlier, we were told by senior officials that the number of part-time doctors and the amount of money invested in those part-time doctors was more of a function of the needs of the affiliate than it was of the VA. I think that speaks volumes about what needs to be done to get control of this thing again.

Mr. SISTEK. Would enhanced visibility of part-time physicians' work schedules so that folks in the working environment would know where these people should be at a particular time, would that help the system, greater clarity, visibility, sunlight on the system?

Mr. GRIFFIN. In so many locations, neither the T&A person nor the supervisor knew if or when those people were at the facility. There are automated systems available. If you run in a race, they will give you a chip and it will tell when you left the starting line and when you finished. There are fingerprint and other biometric systems that feed into T&A systems that will tell you who is there and who isn't there. There are proximity cards that will tell you who is in the hospital and who isn't.

Mr. SISTEK. So there are ways to solve the problem?

Mr. GRIFFIN. There are ways to address the problem.

Mr. SISTEK. Okay, on page 26 of your testimony, you talk about contracting for health care resources. Again, the bulk of your testimony seems focused on contracting with affiliates. Now in the problems you list on page 26, are those conflict of interest, lack of oversight, cultural problems, it is just the way we do business now? Which of those categories would it tend to fall into?

Mr. GRIFFIN. Let me turn to page 26 and I will speak to that.

Mr. SISTEK. Okay.

Mr. GRIFFIN. Concerning contracting, for contracting with the affiliate, the way the language of the law reads, it says the medical centers "may" go sole source for these contracts with the affiliates but it doesn't say they have to. And I think if you want to be competitive in costing your medical care, competition normally gets you the best price.

Mr. SISTEK. On that same note then, Mr. Griffin, in January of 2003, the VA reported a regulation change to Congress. It was titled, "VA Acquisition Regulation Simplified Acquisition Procedures for Health Care Resources." One of the things that this particular regulation seems to do regarding contracting with affiliates is it makes it blind. There is no advertising. There is no open system for that. Would you say that would be conducive to good contract rates or the fact that it wouldn't be advertised, would that tend to harm efficiency?

Mr. GRIFFIN. I haven't reviewed the regulations so I would like to take a read of it before I comment for the record.

Mr. SISTEK. We will do a follow-up question then, sir. One very, very quick one. You mention in lab vulnerabilities, the study that you performed in that area, that 15 of 16 of your recommendations were not yet implemented as of April 31—I am sorry, March 31 of this year?

Mr. GRIFFIN. Right.

Mr. SISTEK. Are you intending to do a follow-up on that?

Mr. GRIFFIN. We are continuing to follow-up on that. I think we had an example earlier from GAO about a policy directive going out that is supposed to address the problem, but these laboratories present great opportunities for mischief. And what we found in that lab review was that access control to the laboratories was almost non-existent. We found some dangerous substances at those laboratories that were totally unsecured. In a post-9/11 world, we need to know who is going in those laboratories. We need to know whether they are a VA employee or they are somebody from the university or exactly who they are, what business they have there, and what controls we have over certain pathogens.

Mr. SISTEK. Thank you, Mr. Griffin, Ms. Bascetta, your teams, thank you very much. Mr. Chairman, thank you.

The CHAIRMAN. Thank you very much. We have no further questions, although we do have some we will submit for the record.

(See p. 237.)

The CHAIRMAN. And I would just say generally any legislative fixes that you think are needed, you have made reference to, it could be done administratively or legislatively, and I know there is a protocol by which those things are done but the sooner we know about it, the better. Things being what they are, getting bills through the House and the Senate, as you know, we had several of our bills become law in the Congress but several others that had reform provisions in them got hung up over on the Senate side. So the sooner we know from you what we ought to be doing from your perspective, the better.

And I do thank you. This has been a very, very enlightening hearing. I thank you for your patience. You have been here for over 3 hours, and I apologize about the lateness for the start. But what you have conveyed to us will be used. We will follow-up, Mr. Griffin, on your request for additional employees because I think dollar for dollar, when we expend money to find waste, fraud, and abuse, as you indicated, the bang for the buck is very, very significant and it is money that is extremely well spent. So we will work on that as well and all the other ideas you have tendered to us.

Ms. Bascetta, thank you as well and your staff.

[Whereupon, the committee was adjourned.]

PAST AND PRESENT EFFORTS TO IDENTIFY AND ELIMINATE FRAUD, WASTE, ABUSE, AND MISMANAGEMENT IN PROGRAMS ADMINISTERED BY THE DEPARTMENT OF VETERANS AFFAIRS

TUESDAY, JUNE 10, 2003

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. Chris Smith (chairman of the committee) presiding.

Present: Representatives Smith, Evans, Bilirakis, Buyer, Snyder, Stearns, Rodriguez, Michaud, Hooley, Strickland, Miller, Boozman, Udall, Bradley, Davis, Beauprez, Ryan, Brown-Waite, Renzi, and Murphy.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. Good morning, and the hearing will come to order. And I want to thank our very distinguished witnesses for being here today, and I would like to make a brief opening remark, and then yield to my good friend and colleague, Mr. Evans, for any comments he might have.

Last month, this committee held a very important hearing, the beginning of a series of hearings on efforts to reduce and eliminate fraud, waste, abuse, and mismanagement in federal programs serving veterans.

At that 3-hour-plus hearing, the committee heard comprehensive—and sometimes disturbing—testimony about specific practices, potentially wasting hundreds of millions of dollars that could otherwise be spent providing benefits and services to veterans.

Both the VA's inspector general and the General Accounting Office furnished this committee with significant examples of current waste and inefficiency, as well as recommendations on what can be done to eliminate them.

Today we will continue this focus, and hear from the Department on their response to the IG and the GAO testimony, as well as their own activities to make better use of the precious resources entrusted to them.

Building upon these hearings, this committee will continue to use our oversight powers to spur the Department to root out fraud, waste, abuse, and mismanagement. We will also examine whether

or not there is a need for legislation to assist the VA in tackling these problems.

As all of my colleagues are aware, demand for veterans' services and benefits are at record levels, with more than 6 million veterans enrolled in the VA health CARES system, and over 2.3 million disabled veterans receiving monthly compensation payments. With a budget that will exceed $60 billion next year, the Department of Veterans Affairs is the second largest agency of the Federal Government, employing more than 220,000 dedicated men and women, a significant number of whom are veterans themselves.

Providing sufficient resources for such a large organization will always be a challenge, particularly in an economic environment where federal deficits are growing. The House and Senate, I am happy to say this year, agreed upon a record budget for veterans' programs for fiscal year 2004: $63.8 billion, a 10.7 percent increase totaling $6.2 billion. The actual increase being over $6 billion. Veterans' health CARES funding would increase by about $3 billion under this budget, a record 12.7 percent increase.

Of course, there is still an appropriation process ahead of us, and there are certain to be competing demands from federal programs. But no matter how high an appropriations level we reach, it remains absolutely essential that Congress and the administrative aggressively eliminate fraud, waste, abuse, and mismanagement wherever and whenever we find it.

When the Inspector General made his recommendations, he found that some part-time doctors were being paid, but not showing up for work. This not only hurts veterans, it also damages the reputation and morale of the vast majority of VA health care professionals, who are among the finest and the most dedicated in the world.

When fugitive felons or incarcerated veterans illegally obtain and receive VA benefits, this not only drains the system of much-needed resources, it also lowers the productivity of thousands of hardworking VBA employees, who should be spending their time processing legitimate claims for veterans' benefits.

Furthermore, when we continue to make our case for the fully justified higher levels of funding that were included in the budget, we are strengthened by documenting the ongoing efforts, both by Congress and the administration to cut waste and eliminate inefficiencies. And this committee has an excellent record of doing just that.

I would remind my colleagues that in 2001, we passed legislation to deny veterans' benefits, such as disability compensation, to convicted felons, and other persons fleeing prosecution for a felony offense. Using this tool, the IG went after such fraud, finding that savings related to the identification of improper and erroneous payments could exceed $200 million annually.

Recognizing the cost savings potential of combining VA and DOD purchasing power, Congress enacted several laws directing the VA and DOD to act to reduce pharmaceutical prices through joint contracting.

In 2001, VA and DOD joint procurement purchases resulted in $98 million in cost savings, $80 million of which was realized by the VA. In 2002, savings from joint procurement purchases for

pharmaceutical products totaled $369 million, with $279 million in cost avoidance realized by the VA.

In 1999, the Committee on Veterans' Affairs recommended a change in law that would allow VA to charge "reasonable and customary amounts" usually paid by insurance companies, instead of flat fees. This led to an increase in collections from third-party insurers, and between 2001 and 2002, it provided $442 million during this 2-year period for health care services that would otherwise have required additional appropriations. Five-years savings are estimated to be in excess of $1 billion.

I cite these as examples of specific congressional actions that have led to savings, money that is better directed at providing services and benefits to the millions of deserving men and women who have served our Nation.

There are other areas that we continue to pursue to make VA as efficient as possible, such as legislation to strengthen the VA's ability to collect reimbursements from third-party insurers, and I would cite the legislation recently passed by this committee that Mr. Beauprez sponsored as an example of trying to beef up our ability and your ability—our ability, collectively—to realize these additional monies.

Furthermore, we continue to seek long-term solutions to VA's health care funding problems. The President's task force recommendations, which we have all read and have already had our first hearing on that, makes a number of very significant and systemic recommendations for reform, so that we have a predictable and stable funding system for the VA.

Later on this week, I plan on introducing legislation to accomplish the enhanced appropriation process, as envisioned in recommendation 5.1. My good friend and colleague, Lane Evans, has also introduced legislation on the mandatory side. So we will proceed and move forward with a fix to what is a broken system, in terms of funding. VA health care isn't broken, but its funding mechanism, we believe, is.

Let me just finally say that I know the administration has an ambitions program for achieving management efficiencies, almost $1 billion in fiscal year 2004, and I do look forward to Secretary Mackay—hearing those details, which I am sure he is ready to outline for all of us this morning.

I yield to my good friend and colleague, Mr. Evans, for any opening comments he might have.

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

Mr. EVANS. Thank you, Mr. Chairman. Before I address the topic of this hearing, I would like to recognize the contributions of Dr. John Gauss, who has led the information technology reform of the VA. It is a reform process in the works that has received praise and accolades from numerous experts. John will be leaving the VA shortly, and his expertise and leadership will be missed.

Mr. Chairman, at our last hearing on this topic, we heard testimony from the IG and from GAO regarding past and present problems at the VA. What is the cause of these problems? Some problems have a systematic cause. Some problems spring from the lack

of accountability or oversight, other problems are caused by unreliable data and based on unjustified assumptions for taking management actions.

Fix these problems and the VA—or any other agency—will become more effective. The benefits fraud investigated by the IG in Atlanta may not have occurred if the management system restricted authorizations for benefits. The part-time physician and the attendance problems related by the IG would not occur if the managers were more proactive and helped people be accountable.

Competitive source and decisions and related savings estimates must be based on reliable data and valid assumptions. I question what is driving VA's competitive sourcing program when its outsourcing reports to Congress require revisions because outcomes and savings in this report are questionable.

We find no relief in OMB's May 14, 2003 reply to my request for information about savings estimates in the budget attributed to competitive sourcing. I asked if the $3 billion saving projection in the budget was an official estimate. I asked about the methodology of how these estimates were established in the assessment. I asked for all the details, but my questions were unanswered.

The OMB response identifies the $3 billion estimate as a "best-case scenario". It indicates a new estimate for competitive source savings that reduces the original estimate by about 57 percent, or $1.7 billion. Again, I asked, did the administration exaggerate its savings estimate to justify the needs for more reinforcement of this program? This $1.7 billion adjustment is significant. Yet, even if it is modified, its savings estimates are suspect. Details, analysis and justification are lacking.

The OMB response letter includes one sentence that I find unsettling. "As we gain more experience, our savings estimates will be continually refined." This sounds like someone is just guessing about the budget and its impact on our veterans. Mr. Chairman, I ask that my correspondence with the OMB be included in the record, and yield back the balance of my time.

The CHAIRMAN. Without objection, your comments—your correspondence—will be included in the record.

(The provided material follows:)

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

May 14, 2003

THE DIRECTOR

The Honorable Lane Evans
U.S. House of Representatives
Washington, DC 20515

Dear Representative Evans:

I appreciate your interest in the current competitive sourcing efforts by the Department of Veterans Affairs (VA). The Administration is committed to providing our nation's veterans with the highest quality health care in the most efficient manner.

As you know, VA employs approximately 190,000 employees in the Veterans Health Administration alone. Many of these employees are providing ancillary services that may be performed more efficiently in the private sector. VA will not subject its core health care functions to broad-scale competitive sourcing studies, but based on agreements with OMB, VA will use a streamlined, market-based analysis approach to study approximately 19 ancillary service functions that involve approximately 55,000 employees with annual salaries totaling over $1.9 billion. This approach will allow VA to meet the intent of the President's Management Agenda and ensure that VA appropriations are optimized for direct patient services.

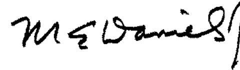
The focus of these studies will be on "non-core" ancillary functions and require establishment of effective partnerships and performance-based contract management. Where possible, individuals impacted by competitive sourcing studies will be reassigned and cross trained to core functions. Through these methods, VA will be able to ensure that long-term capacity or levels of performance are of high quality.

Based on calculations of annual salary for each of the 19 functions and a 5-year time frame for competitive sourcing studies of these functions, VA estimates over $1.3 billion in savings. This estimate assumes an average savings percentage of 17.5% from internal efficiency enhancements resulting from reengineering activities or from contracting out services to highly qualified contractors. This estimate also includes recurring annual net savings. As a clarification, the $3 billion projection stated earlier is based on a 30% savings rate, which is the best-case scenario. As we gain more experience, our savings estimates will be continually refined. The attached tables present the list of 19 functions to be studied, the projected savings, and the phasing of full time employee studies.

VA does not plan to contract with firms that hire foreign employees or perform work out of the country. For example, Ocwin, the company that VA has preliminarily selected to perform our property management function, has made a commitment to VA that all work will be performed in the United States.

I want to reiterate that our goal is not necessarily to move jobs into the private sector but to study the most efficient method of delivering these services while maintaining high quality care. I appreciate your continued efforts on behalf of our nation's veterans, and I hope this letter answers your concerns.

Sincerely,



Mitchell E. Daniels, Jr.
Director

Attachment

COMPETITIVE SOURCING PLAN ESTIMATED STUDY COMPLETIONS AND SAVINGS FOR FY 2003 - 2008

			Projected Savings Rate						
			Total 5-year	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
			17.5%	11.9%	41.5%	21.0%	13.4%	7.3%	4.8%
Title	Total FT&PT	Total Salaries[1]	Projected One-Time Savings Over 5 Years	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
DIAGNOSTIC RADIOLOGY	4,068	$184,936,453	$32,363,879	$3,863,292	$13,444,256	$6,799,394	$4,326,887	$2,373,607	$1,556,443
PATHOLOGY & LAB MED SVC	6,733	$300,484,773	$52,584,835	$6,277,077	$21,844,229	$11,047,656	$7,030,327	$3,856,636	$2,528,909
PHARMACY	8,216	$427,209,045	$74,761,583	$8,924,327	$31,056,657	$15,706,815	$9,995,246	$5,483,106	$3,595,433
MEDICAL LIBRARIES	357	$16,222,883	$2,839,005	$338,893	$1,179,349	$596,452	$379,561	$208,216	$136,533
PLANT OPERATIONS	1,318	$57,405,519	$10,045,966	$1,199,192	$4,173,188	$2,110,578	$1,343,095	$736,783	$483,130
GRNDS MAIN & OTH MISC OP	535	$18,000,341	$3,150,060	$376,024	$1,308,564	$661,803	$421,147	$231,029	$151,493
RECURING M&R/ST APRD PROJ	3,754	$156,241,867	$27,342,327	$3,263,867	$11,358,257	$5,744,406	$3,655,531	$2,005,320	$1,314,947
NONRECURRING M&R	196	$1,748,123	$305,922	$36,518	$127,083	$64,272	$40,900	$22,437	$14,712
OPERATING EQUIPMENT M & R	714	$29,865,546	$5,226,471	$623,886	$2,171,124	$1,098,040	$698,753	$383,316	$251,351
BIOMEDICAL ENGINEERING	985	$51,140,620	$8,949,609	$1,068,319	$3,717,751	$1,880,242	$1,196,517	$656,375	$430,404
ENVIRONMENTAL MGT SVC	378	$17,924,565	$3,136,799	$374,441	$1,303,055	$659,017	$419,374	$230,057	$150,855
GROUNDS MGMT OPERATIONS	63	$2,098,470	$367,232	$43,837	$152,552	$77,153	$49,097	$26,933	$17,661
SANITATION OPERATIONS	8,397	$208,810,298	$36,541,802	$4,362,013	$15,179,804	$7,677,142	$4,885,454	$2,680,021	$1,757,368
LAUNDRY & DRYCLEANING OP	1,002	$26,574,811	$4,650,592	$555,143	$1,931,899	$977,052	$621,761	$341,080	$223,656
LINEN & UNIFORM OPERATION	557	$15,171,865	$2,655,076	$316,938	$1,102,943	$557,810	$354,970	$194,727	$127,688
MCCF	2,295	$79,788,986	$13,963,073	$1,666,779	$5,800,390	$2,933,531	$1,866,792	$1,024,069	$671,512
MED INFO & RECORDS SECT	4,038	$124,472,569	$21,782,700	$2,600,211	$9,048,736	$4,576,372	$2,912,237	$1,597,570	$1,047,573
NUTRITION & FOOD SERVICE	8,752	$248,128,438	$43,422,477	$5,183,362	$18,038,101	$9,122,718	$5,805,366	$3,184,658	$2,088,273
TOTAL	52,358	$1,966,225,172	$344,089,405	$41,074,120	$142,937,938	$72,290,451	$46,003,015	$25,235,939	$16,547,942
Number of completed studies and commercial FT/PT reviewed:			52,358	6,250	21,750	11,000	7,000	3,840	2,518

Quarterly Savings Per FTE: $1,643

	Projected Cumulative Savings Over 5 Years					
	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1st Quarter	$0	$20,537,060	$50,931,909	$67,361,557	$77,219,346	$83,265,456
2nd Quarter	$0	$30,805,590	$55,860,803	$70,647,487	$78,862,311	$84,645,547
3rd Quarter	$0	$41,074,120	$60,789,698	$73,933,416	$80,505,275	$86,022,351
4th Quarter	$10,268,530	$46,003,015	$64,075,627	$75,576,381	$81,885,366	$86,022,351
Total	$10,268,530	$138,419,785	$231,658,038	$287,518,841	$318,472,298	$339,955,706
Cumulative Savings:	$10,268,530	$148,688,315	$380,346,352	$667,865,193	$986,337,491	$1,326,293,197

	Projected FTE Studied					
	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1st Quarter	0	6,250	3,000	2,000	1,000	840
2nd Quarter	0	6,250	3,000	2,000	1,000	840
3rd Quarter	0	6,250	3,000	2,000	1,000	838
4th Quarter	6,250	3,000	2,000	1,000	840	0
Total	6,250	21,750	11,000	7,000	3,840	2,518

	Cumulative FTE Used for Calculating Savings					
	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1st Quarter	0	12,500	31,000	41,000	47,000	50,680
2nd Quarter	0	18,750	34,000	43,000	48,000	51,520
3rd Quarter	0	25,000	37,000	45,000	49,000	52,358
4th Quarter	6,250	28,000	39,000	46,000	49,840	52,358

REPUBLICANS
CHRISTOPHER H. SMITH, NEW JERSEY, CHAIRMAN

DEMOCRATS
LANE EVANS, ILLINOIS, RANKING

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED EIGHTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

March 6, 2003

Honorable Mitch E. Daniels, Jr.
Director
Office of Management and Budget
Room 252, Old Executive Office Building
Washington, DC 20503

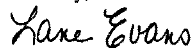
Dear Mr. Daniels:

On page 235 of the Performance and Management Assessments of the Budget of the United States of America, FY 2004, it is projected that competitive outsourcing of 52,000 Department of Veterans Affairs employee jobs may yield as much as $3 billion in savings over a five-year period. It is not noted if this $3 billion savings projection is an official estimate and there is no reference to the methodology used to establish this estimate.

If the Administration supports its assessment of the value of competitive sourcing at VA, please provide a copy of the detailed study that arrived at that estimate. In the alternative, if such study is not available, I request a detailed explanation that includes the cost of the competitive sourcing assessment, as well as the cost of increased contracting, management, and oversight functions to manage this program. Please also comment on its impact on organizational cohesion, reduced mission focus, human resources investment and loss of long-term capacities as outsourcing continues in out years. In addition, please provide the amount of the projected savings assumed to be derived from VA procuring goods and services from foreign countries with a prevailing wage that is lower than the U.S. minimum wage rather than from businesses based in the United States whose employees are residents of the United States.

As the $3 billion estimate appears in a public document, I assume the Administration can readily justify its claims. Please provide requested justification no later than March 24, 2003. Questions may be directed to Mr. Len Sistek of the Veterans Affairs Committee staff at 202-225-9756.

Sincerely,



LANE EVANS
Ranking Democratic Member

The CHAIRMAN. The chair recognizes the vice chairman of the committee, Mr. Bilirakis, from Florida.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I will be very brief, and I appreciate your holding this set of hearings, this being the second one on this particular issue.

You know, Dr. Mackay and gentlemen, no matter how pure we may want to be, no matter how hard we may want to work at work, I mean, there is just no perfection. And we can be 99 percent perfect, and then sure as hell, if somebody wants to attack us, they're going to find that other 1 percent and do it. And we all experience all of that, and that's no different, as far as the VA is concerned.

And I know that, in my opinion, the care that you give our veterans in general, you know, everything is relative of course, is pretty darn good. But there are these problems,

And we know that there are limited funds, and there are many who say there shouldn't be any limitation on funds, as far as veterans are concerned. I sort of go along with something like that, but again, our real world is that there are limited funds. And so you have so much to work with, and to do the best you can for our veterans.

And you know, I'm sort of disappointed, I guess, all the time that we have got to devote hearing time to issues such as this, and then find that there isn't really any great big amount of progress being made—at least we come away with that feeling.

So, I guess when we go into questions, we can go into details with some of the things that we heard in the last hearing from the Inspector General and GAO, a long list of problems, of wrongs, and things that are not corrected, that are really kind of disappointing.

Having said all that, I commend you for your work for much of your lifetimes for our veterans and for our country. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Any other members wish to be heard? [No response.]

The CHAIRMAN. If not, I would like to introduce our very distinguished witness and his panel, which is made up of very respected and dedicated leaders in the VA. Let me introduce Dr. Leo Mackay, Jr., the Deputy Secretary of Veterans Affairs, as the VA's second in command.

Dr. Mackay chairs the Department's governance process through the strategic management council, and drives its management through leadership of the business oversight board, and the capital investment board. He has co-chaired the VA/DOD joint executive council that is forging new ground in VA's cooperation and resource sharing efforts with the Department of Defense.

A 1983 graduate of the U.S. Naval Academy, Dr. Mackay completed pilot training in 1985, graduating at the top of his class. He was a member of the Fighter Squadron Eleven for 3 years, conducting operational deployments to the North Atlantic, Mediterranean, and Indian Ocean. His military decorations include the Defense Meritorious Service Medal, the Navy Achievement Medal, and the Armed Forces Expeditionary Medal.

From 1989 to 1993, Dr. Mackay was a Kennedy Fellow at Harvard University, earning a master's degree in public policy from the Kennedy School of Government, and a Ph.D. in political and economic analysis from the Graduate School of Arts and Sciences.

Following a brief stint as a teacher at the Naval Academy, Dr. Mackay served in the Office of the Secretary of Defense from 1993 to 1995, and military assistant to the Assistant Secretary of Defense for International Security Policy.

Leaving active duty military service in 1995, Dr. Mackay worked for Lockheed Martin and later, Bell Helicopter, until his nomination by President Bush in 2001. Dr. Mackay, welcome. And if you wouldn't mind introducing your distinguished panelists, and then proceed with your testimony.

Dr. MACKAY. Thank you, Mr. Chairman. It is—and members of the committee—it is a pleasure to be here this morning to discuss our efforts to ensure efficiency and integrity of VA operations.

With me today, to my right, is Dr. Bob Roswell, the Under Secretary for Health, Retired Admiral Dan Cooper, our Under Secretary for Benefits, to my left. And then to his left is William Campbell, our Assistant Secretary for Management and Chief Financial Officer.

STATEMENT OF LEO S. MACKAY, JR., DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; DANIEL L. COOPER, USN (RET.), UNDER SECRETARY FOR BENEFITS, DEPARTMENT OF VETERANS AFFAIRS; AND WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS

Dr. MACKAY. The President has dedicated his administration to ensuring that the resources entrusted to the Federal Government are well managed and wisely used.

Last month, Inspector General Griffin identified to you a number of opportunities for improved efficiencies and program integrity that his office has identified over recent years. I would ask that you would include in the record of these hearings a paper we have given committee staff, detailing our efforts in addressing each of the items covered by the Inspector General in his testimony before you.

The CHAIRMAN. Without objection, it will be made a part of the record.

(See 181.)

Dr. MACKAY. Thank you, Mr. Chairman. Our paper details, for example, the steps we have taken to improve oversight of the time and attendance of part-time physicians. The IG demonstrated a need for clearer expectations and understanding regarding tours of duty, and our Veterans Health Administration is moving decisively to resolve the problem.

There are also issues with staffing and productivity standards, and we have plans in place, that I am sure we will talk about, for that. There are also oversight and management issues. There are both questions of individual accountability, and also systemic per-

formance, and we are addressing both in our plans to rectify this issue.

Our paper also describes the controls our Veterans Benefits Administration now has in place to prevent the recurrence of isolated but serious instances of fraud on the part of VBA employees. These controls have satisfied an independent auditing firm that our payment authorization problem has been corrected, and we pledge to apply them strenuously.

The Inspector General's 2001 report on departmental procurement practices prompted the Secretary to establish a task force of acquisition experts across the VA to devise a more efficient, effective, and coordinated procurement policy.

The result was some 60 recommendations for reform, covering such important aspects as mandated purchases through nationally negotiated contracts, standardization of the most frequently purchased medical supplies and equipment, and enhanced procurement partnerships with DOD to better leverage our buying power.

Although roughly half of these are not yet fully implemented, over the past year the cost avoidance attributable to these recommendations has already been approximated at $220 million. Additionally, the chairman mentioned the $369 million in cost avoidances by joint procurement with the Department of Defense.

We realize that it is incumbent upon us to carry out our duties as efficiently as possible, in ways that protect the significant investment America has made in veterans programs. My prepared statement outlines the new governance structure that is enabling a more business-like approach to managing VA's assets and resources, and I ask that my entire statement be entered into the record, as well. We are striving for the best possible value for taxpayer dollars.

Finally, Mr. Chairman, you asked that we identify steps that Congress could take to help us save money. Our prepared testimony lists the cost saving and revenue-generating legislation proposed in the President's fiscal year 2004 budget.

I want to particularly urge the enactment of our proposal to legislatively override the court's decision in the *Allen* case, under which we are now required to pay additional compensation to certain veterans because they are abusers of alcohol and drugs. Paying veterans for their substance dependencies is an obvious disincentive to their sobriety, and in our view, a waste of taxpayer dollars.

We also ask your help in insuring that VA appropriations contain specific earmarks for studies to compare the cost of contracting for performing in-house certain commercial activities required by the Veterans Health Administration, among others.

Current law prohibits our using medical care funds or VHA personnel for purposes of these studies, absent specific appropriation. Specific funding was regularly enacted until fiscal year 2001, and its enactment must resume if we are to ensure best value for our health care dollars.

Mr. Chairman, that concludes my opening remarks. We would be pleased to entertain any questions that you or the committee may have. Thank you.

[The prepared statement of Dr. Mackay appears on p. 228.]

The CHAIRMAN. Thank you very much, Mr. Secretary, and thank you for bringing with you such distinguished panelists who are leading the VA each and every day, particularly in the health care and, of course, in the benefits area, as well.

I do have some questions—and we all have a number of questions. Last year, I offered an amendment to the DOD authorization bill to provide $30 million to try to implement, to provide incentives, for DOD/VA sharing. And frankly, I was amazed what a heavy lift it was to get that legislation enacted into law.

It was opposed at various stages by various interests. Many people thought that we were talking about one, seamless VA/DOD, but there are some fundamental differences between the two. We were looking for where it was possible to utilize the synergies that could be realized by that kind of sharing.

And it goes back, as we all know, to the legislation that I was a co-sponsor of, but it was offered by Ron Mottle, way back in the 97th Congress, 22 years ago. And the dream of DOD/VA sharing has yet to be realized. Has any of that $30 million been allocated yet?

Dr. MACKAY. Mr. Chairman, no, it has not. But concrete plans have been made for the Joint Incentives Fund. As you mentioned, it's $30 million, $15 million from DOD and $15 million from VA.

One of the significant milestones that has happened in the Joint Executive Council that you mentioned as well in your introductory remarks, is that we have agreed upon a joint strategic plan, a strategic plan that outlines the way forward, in terms of forging greater cooperation, particularly in areas of concern like sharing projects, and in capital planning, ways that we cannot conjoin our budget, as you mentioned, but ways that we can make decisions in light of each other's capabilities, and also in light of each other's needs.

The next meeting of the Joint Executive Council is to occur at the end of July 2003. By that time, detailed planning for the Joint Incentives Fund is to be delivered to Dr. Chu and myself, as cochairs of that. The financial management working group, which is part of the Joint Executive Committee structure has responsibility for that.

We anticipate that the first distributions of funds from the Joint Incentives Fund would be in the course of fiscal year 2004.

The CHAIRMAN. Okay, I appreciate that. Hopefully that will also be in concert with some of the very valid recommendations by the Presidential task force, which looked for the last 2 years at DOD/VA sharing, and came up with a number of very good recommendations that we have had our first hearing on, and we have a series on that planned, as well, to try to implement, see what needs to be done legislatively, and what could be done administratively.

But it seems to me that this is a blueprint for additional action, as well, and reform. So I hope that's taken very seriously by the Department.

Let me just ask you, the Inspector General Griffin testified recently, as you know, last May, and made a request upon my questioning, frankly, because he indicated that the amount of money that he has available to him for his OIG work is insufficient. He put it, "The OIG remains underfunded, given the magnitude of its

responsibilities," and he is asking for what seems like a modest amount, $7 million more. Will the administration back his increased appropriation request?

Dr. MACKAY. Mr. Chairman, we will certainly give every consideration to it. There have been some expansions in the IG staff in order to pursue the fugitive felons initiative, and also to reduce the CAP cycle. Both the Secretary and I are big fans of the Combined Assessment Program. And in order to shrink that cycle down to 2 to 3 years, so that all of our major facilities can get that kind of thorough look in that time frame, we have also had to devote resources to expand his staff.

Certainly, $7 million is not a large sum of money. As we begin our budget deliberations, I commit to you that every consideration will be given.

The CHAIRMAN. I would hope so, because on the two programs, CAP and fugitive felons, they are the two that would require additional money, according to his testimony and his follow-up submission.

Dr. MACKAY. Yes.

The CHAIRMAN. So, I know the committee would look very favorably on that, and we would help with the appropriations process as well, because that money, I think, would be exceedingly well spent, in terms of cost avoidance and money that could be saved from waste, fraud, and inefficiency.

In the GAO report and the testimony received from Cynthia Bascetta of GAO on May 8, she made the point that there may be an inequitable distribution of nursing home care. And part of it is systemic, it's based on resources that are improperly allocated, probably through no fault of any previous administration, but it's a fact we have to deal with.

The point is made that, because of the discretion that the networks have, that some opt not to have nursing home care, they opt for home health care. So it depends on where you live, as to whether or not you get the best and most prudent remedy for your individual situation.

The other disturbing part the report was that in 1998, there were 33,603 nursing home beds. That dropped to 31,746, and that's even with the addition of the state nursing homes.

What can be done to reverse that, and what is being done, especially in light of the fact which is that we will see a significant increase between now and the year 2012 of 85 or older veterans? As a matter of fact, the number will jump from 640,000 to over 1,000,000 by 2012, and will stay at 1,000,000 or above for the next 12 years thereafter.

So, we have got this bulge of need coming for nursing home beds, but not the response that I think is adequate. If you could respond to that?

Dr. MACKAY. Mr. Chairman, Dr. Roswell has recently testified on long-term care, and I will let him make extending remarks.

But certainly Cindy Bascetta is correct. Similarly situated veterans should get similar care. That's not an item of discretion, that's an item of the uniform benefit package, and unified policy within the Department. And so, we join—or agree, in that instance—with the GAO's recommendation.

As you know, long-term care is a very complex issue. There are issues of policy, issues in determining specifically what that demand is, and how it will be realized. We have to take into account, as well, the sweep of medical technology.

With telemedicine, with remote sensing, with all the other advances that are coming along in medical technology, pharmaceutical technology, things that used to be surgical procedure for us are now handled with drugs. We want to give veterans up-to-date care. And in so many instances with geriatric and long-term care, that is increasingly non-institutional care.

I am along with you, and the Secretary committed and pledged to watching the balance between institutional and non-institutional care. As good as non-institutional care is, and will get, there are groups of veterans that have dementia and Alzheimer's, and other concerns that cannot be handled in non-institutional care.

Bob, I will let you extend.

Dr. ROSWELL. Mr. Chairman, just to clarify for the committee the GAO report that looked at non-institutional services offered by the VA, and identified regional disparities in the delivery of those services, let me point out that all 21 of our VISNs have an extensive complement of nursing home beds available.

Let me also point out that while there has been a slight decline in VA staff nursing homes, and a small decline in contract community nursing homes, our overall nursing home bed capability has actually risen this past year, as a result of a significant increase in state veteran home bed availability, and we anticipate that that total combination of in-patient nursing home beds will continue to increase.

The GAO, in its report, looked at six types of non-institutional services, three of which actually were newer services, many of which are actually a duplication of existing programs.

For example, they looked at respite care in the home. Now, that was not available in all locations. But respite care in the hospital is in virtually all locations. They looked at a new program called Outpatient Geriatric Evaluation and Management, a comprehensive, interdisciplinary assessment of patients' geriatric needs, to optimize their long-term care planning.

Historically, that has been provided on an inpatient basis. The new program provides it on an outpatient basis, but it's not yet available at all locations. But the Geriatric Evaluation and Management program, either inpatient or outpatient, is virtually universally available.

So, a lot of these programs are new types of services that, while not fully implemented, were very much committed to meeting the geriatric needs in those non-institutional services.

The CHAIRMAN. I appreciate that. I see my time is up, but again, Dr. Roswell, the 2003 numbers, do they exceed at least what we had in 1998, in the aggregate, or is it still less, then?

Dr. ROSWELL. The 2003 numbers will not meet the VA staff nursing home, as required by the Millennium bill. In 1998, we had 13,391 veterans as an average daily census in VA staffed nursing homes. The Millennium Bill asked that we maintain that census. We have had a significant drop, to a low of about 11,700 last year. We have put additional management emphasis on that.

Today, we are over 12,000, and we expect to be at approximately 12,500 by the end of the year. But we won't fully reach the Millennium goal of 13,391 this year. It will probably be some time next year.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Dr. Mackay, your statement indicates that the VA hopes to gain a cost avoidance from full implementation of its procurement reform program between $250 million and $450 million over the next 5 years.

Yet, the VA budget submission to Congress for fiscal year 2004 estimates that VA will experience $250 million in management efficiencies through changes in that procurement practices program next year. How much do you really expect to save from procurement reform in the next fiscal year?

Dr. MACKAY. Congressman, as you notice by the figures that you read, $250 is the most conservative of the range of estimates that we have, $250 million to $450 million.

It is my practice, personally—it's a holdover from my business experience—to budget with conservative estimates. So, the budget reflects the most conservative end of that range, of $250 million to $450 million.

As we get closer, it is an inexact science. We have certain problems that come up. Certain things go better than we might expect. The response of our vendors and suppliers to certain actions that we have is another variable.

My best conservative estimate is that $250 million figure, but it could, indeed, go higher. Bill, if you have any insight or comment on that.

Mr. CAMPBELL. No, sir. The $250 million, we feel, is what we will get over the next year. I think that the experience that we have had to date shows that we can achieve that. But we still have not implemented over half of the recommendations from the PRTF, we have done 25 of the 60.

And although we concentrated on the ones that would be the most cost-effective, we still have a long way to go. But we feel that $250 million, which we put in our estimate for management efficiencies, is a pretty solid number.

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

The CHAIRMAN. The chair recognizes Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. We spent much of the last hearing, about a month ago, Mr. Secretary, on the part-time physicians, and the apparent lack of accountability. We are all very greatly concerned about that, and I would like to think and know that you must be, too.

The fact that many, apparently, were not fulfilling their obligations to the VA, and lack of accountability, maybe you can just take my time to get us up to date on that. I know it was just a little over a month ago, but hopefully some action has been taken towards that end.

Dr. MACKAY. Congressman, let me detail some of our actions in timekeeping and audit, policy actions that we will be taking, as well.

You are exactly correct. The IG's work, done at the request of the Secretary because a pattern had emerged in CAP reports that we

had seen, was disturbing. And it was disturbing because taxpayer dollars were not being fully utilized to take care of veterans, and that is their purpose. It was disturbing because there were individual instances of deception, and what—I don't want to prejudice any ongoing investigation—what may turn out to be criminal fraud.

There were also systemic problems, places where the Veterans Health Administration needs to improve. And while I will give an overview, I will ask Dr. Roswell to add his comments, as well.

In the matter of timekeeping, we have gone out and retrained, and given refresher training in time and attendance to all of our timekeepers and their supervisors. We will be, obviously, conducting periodic audits and this particular performance factor will be noted in quarterly network director performance reviews that happen with our Deputy Under Secretary for Operations and Management.

Mr. BILIRAKIS. Will you furnish copies of those quarterly reports and quarterly reviews to our committees, sir?

Dr. MACKAY. I would be happy to do that.

Mr. BILIRAKIS. Thank you. I'm sorry.

Dr. MACKAY. There will also be developed, in order to make this a more unified effort across the health administration, computer-based time and attendance training, so that there will be standardized delivery of standard training through our EES system. We anticipate that in the spring of 2004.

With respect to the audit and its administration, we have gone out and searched for best practices among the audit in our networks, a work group is due to report on that on July 31, 2003. There will obviously be a feeder into the training I talked about previously.

In addition, there will be an annual verification of staffing decisions required by each one of the network directors. As they make adjustments in their staffing, they will be required to justify those to the central office, so they will be evaluated and verified, as appropriate.

With regard to policy, the most significant change that we will have is a shift in the way that we document our hours, with respect to the employment of part-time physicians. We had a model that looked at core hours, hours that the part-time physician had to offer on a fixed basis, and then other hours were associated around that. And Dr. Roswell will be able to elaborate on that.

But the problem with that is that was not responsive to—was not dynamic enough—to handle health care in the first decade of this new millennium. Our new service level agreements will agree on an overall number of hours to be offered by a physician during the course of the year.

And then, on a biweekly basis, each medical center director will schedule that doctor, and so there will be more contemporaneous scheduling, more responsive and flexible scheduling, and we expect them to be there, to offer those hours, at the time that they are agreed to in that biweekly agreement. There are also the other routine adjustments that you would expect for leave, and for explained periods of absence.

Thus, we hope to have a final draft of this new service level agreement plan available by the end of July. We will be negotiating

with unions in August, and we hope to have field implementation rolled out in the first quarter of the new fiscal year, October to December 2003.

One of the principal innovations that we have is an electronic means to verify the location of physicians. One of the things that was most disturbing in the IG report was the prevalence of misidentifying, or just plain not knowing where physicians were during times when they were accountable to be seeing veterans in our hospitals.

We have a work group that is working on an electronic badge and swipe card system. We are in early discussions about how to make that work, and make it a system that responds to need and solves a problem, and does not become another issue with our part-time physicians. We anticipate having a pilot in the Miami VAMC, in the latter part of this calendar year.

And then finally, but in some sense almost most importantly, we have work that is beginning on staffing and productivity standards. One of the issues is that we have not had system-wide staffing and productivity standards, so that for a given workload, a medical center director has explicit guidance about what staffing with respect to physicians and other health care professionals is expected, and what work load each physician or health care professional is to handle in a given time period.

This, as you might imagine, is a very dynamic effort, it's a very complex effort, where we are looking at the unique factors that are in VA health care in our medical faculty, our doctors and nurses. We are starting with outpatient care and with outpatient speciality care in cardiology, in eye care, and urology, the places that are most heavily trafficked in our hospitals.

We are in final development of at least initial staffing standards. Hopefully, by the end of this month, we expect to have those in hand. This will require extensive work, however, that will extend through the balance of this calendar year. For those four areas that I talked about— primary care, cardiology, eye care, and urology— we hope to finish our work by October.

But there will be follow-on efforts that will expand to other areas of speciality care, and other outpatient treatment that will go on through the balance of 2003 and into 2004. So this is quite a lengthy effort, but it has to be done, and it is one of the cornerstones in rectifying this issue. Dr. Roswell?

Mr. BILIRAKIS. Well, the—my time is long up, Doctor.

Dr. MACKAY. Sorry.

The CHAIRMAN. Did you want to——

Mr. BILIRAKIS. Well, Dr. Roswell was apparently going to expand, but my time is well up. That is up to you, Mr. Chairman.

The CHAIRMAN. I think it is important.

Dr. ROSWELL. Just very briefly, Mr. Bilirakis, in addition to all of the actions Dr. Mackay has detailed, the Secretary and I recently met with the most senior leadership of the Association of American Medical Colleges, and a representative from the Council of Deans, who have pledged their full cooperation and utmost support to assure this mutual goal of making sure that part-time physicians are there.

Among the reasons we have to rely upon part-time physicians is that our salary rates aren't competitive in an academic practice setting. And later this month, we hope to have legislation submitted that will propose, for the first time since 1991, a revision and raise of the pay VA physicians receive.

That, coupled with the staffing guidelines that Dr. Mackay spoke of, should allow us to have substantially less reliance upon part-time physicians. But to be able to do that, we need the committee's support in seeking the pay reform necessary to allow us to acquire full-time staff to meet our veterans' needs. Thank you.

Mr. BILIRAKIS. Thank you. Thank you both.

The CHAIRMAN. Thank you. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman. I want to thank the panel for coming here today. I have several questions.

My first is does the VA have any data concerning the number of veterans who are currently being paid as a result of the *Allen* decision, and the amount of payment attributed to the *Allen* decision? That's my first question.

My other question, reading your testimony, and having served several years in the legislature on the Appropriation Committee, I would like, for every—to know your methodology, and if you would submit to the committee your supporting information, where you came up with these numbers for every one of the numbers that you had submitted.

The other thing, you had talked about the Inspector General's report, and you support it. And the—Chairman Smith had brought forward this report from the Presidential task force, which also has several recommendations in the report, and it also—one of them actually talks about the belief that even if the VA were to operate at maximum efficiency, it would be unable to meet its obligation to enrolled veterans at its current funding level.

My question is, have you read the report, and do you support the recommendations in the report? And if you haven't read the report, why not?

The other question I have is you talk about efficiencies, and how you want to save money. If it can be proven that if the VA is doing something currently, that it's not efficient, and would the VA reconsider its operation of contracting out?

And my last question is—not being familiar with the budget at the federal level—is does the VA submit a recommendation to the administration, and if so, how different is that recommendation, compared to what was finally put in the present budget? And if we can have a copy of the recommendation that was originally submitted to the administration.

Dr. MACKAY. There is a—and you're going to have to help me get through all the points that you raised, but you raised a number of good ones, Congressman, and I would like to answer them all—the internal deliberations—the administration has a budget. There is only one budget, and that's the President's budget.

There are, of course, a lot of deliberations that go back and forth. I don't think it's particularly wise or helpful to share what are proposals that did not enjoy the administration's support. The President's budget, as it is submitted to Congress, is the only budget

that matters. It is the final budget, and it is the President's budget, and we, of course, are very happy with it, and support it.

With respect to the President's task force, I have read the recommendations of the task force. It has now come back, and the recommendations are being evaluated. As the chairman alluded to, there will be a hearing on the 17th. We are digesting those recommendations. I saw many of them while they were being formulated during the regular briefings with Congressman Hammerschmidt and Dr. Wolinsky.

I think very many of those recommendations have much merit, but I would like to wait for a full and final statement of the administration reaction to the recommendations. It would be premature for me, at this time, to characterize any of the recommendations. But there are, suffice it to say, the vast majority of the recommendations will find nothing but approval within the administration.

And if you could help me to recall some of your other questions.

Mr. MICHAUD. One is the methodology in supporting information of all the numbers that you say you're going to be saving.

Dr. MACKAY. We will be very happy to make that available to the committee, and to your office, Congressman.

On the *Allen* case, the information I have is the estimate. I think we have an estimate, and we will be happy to share our methodology at arriving at the percent of compensation that's due to, you know, compensating veterans for their addictions to alcohol and drug use.

Mr. MICHAUD. But some of it, you must have the data, the number of veterans who are currently being paid as a result of the *Allen* decision, and the amount. That information you should have.

Mr. COOPER. We do not have specific information as to the number who have applied for benefits based on the *Allen* decision. Some have come in. As you know, the estimates that we did, as I discussed earlier do not agree with CBO. As a matter of fact, tomorrow, our people and CBO are sitting down to look at those.

I will be glad to give you all the assumptions and the estimates that we have, and we will submit that for the record.

Mr. MICHAUD. Okay.

(The provided material follows:)

Attachment A

Comparison of the Assumptions and Costs for Allen v. Principi Decision
Prepared by VA and the Congressional Budget Office (CBO)
Revised June 10, 2003

VA's and CBO's estimates for *Allen v. Principi* vary significantly. The assumptions that account for this significant difference are:

- VA considered all possible eventualities for an increase in the number of incoming claims by taking into consideration claims for increase to be filed by veterans already on the rolls and new claims for service connection to be filed by veterans not on the rolls. VA derived its claims for increase from the 2.3 million veterans on the roles. VA's number of new claims was derived from about 23 million veterans not on the rolls.
- CBO limited the impact of *Allen* to veterans who are already service connected for a mental condition, or 255,000, and 30,000 new claims for mental conditions (already considered in VA's base) based on a data extract from VA.
- CBO did not consider that substance abuse could be rated as a separate entity as a secondary service connected condition.
- VA considered the GOE impact of *Allen* while CBO did not.
- CBO considered the impact of *Allen* on survivors while VA did not.

The following chart captures all the major assumptions and compares VA's and CBO's numbers. To clearly show the significant difference in the populations used by VA and CBO, the assumptions specific to the population on the rolls are highlighted in yellow, while the assumptions specific to the population not on the rolls are highlighted in blue.

Assumption	VA estimate	CBO estimate	Explanation
Veteran Population	o 25.7million veterans o 2.3 million veterans on rolls		o VA assumed that any veteran, with or without service connected conditions, could apply for secondary substance abuse, not only veterans with psychiatric conditions. o CBO limited their population to only veterans with service connected mental conditions.
Population on the rolls (receiving compensation)	o 750,000 Vietnam Era veterans. o 1.55 million non-Vietnam Era veterans.	255,000 veterans service connected for psychiatric conditions	o VA assumed that many conditions, physical, organic, and psychiatric, can result in secondary substance abuse. o CBO assumed that alcohol and drug abuse arises primarily from mental conditions based on information provided by C&P's medical officer. They also excluded veterans who were already rated 100%.

Assumption	VA estimate	CBO estimate	Explanation
Population not on the rolls (not receiving compensation)	About 23 million veterans (total veteran population minus the number of veterans on the rolls)	About 30,000 accessions already part of VA's base	o VA assumed that veterans who are not currently service connected could now file claims for service connection for a primary condition (mental or non-mental) with secondary substance abuse. o CBO limited their population to the number of accessions for mental conditions for FY 2002 based on data extract from VBA's then called DMO.
Prevalence rates for substance abuse	o 45% for Vietnam era veterans o 33% for non-Vietnam Era veterans	About 36% for all veterans	o According to the National Vietnam Veterans Readjustment Survey Study, substance abuse among Vietnam Era veterans is significantly higher than the rest of the population. VA took this into account when calculating the potentially eligible population. o CBO's prevalence rate was based on co-morbidity rates for different mental conditions. Average percent based on peer reviewed research and interviews with medical professionals at National Center for PTSD and VA's Dr. Lehman.
Potential Eligible Population - Veterans with service connected conditions that could result in secondary substance abuse	o about 337,000 Vietnam Era veterans on rolls o plus 511,000 non-Vietnam Era veterans on rolls **TOTAL about 850,000.**	93,000	o VA multiplied 750,000 by 45% and added that to 1.55 million by 33%. o CBO multiplied their 255,000 by 36.5%.
Potential eligible population for veterans not on the rolls	About 8.4 million veterans	About 10,800 already in VA's base	o VA multiplied 23 million by 33% prevalence rate. We did not make a distinction between Vietnam and non-Vietnam since these veterans are not on the rolls. o CBO multiplied 30,000 times 36%.

Assumption	VA estimate	CBO estimate	Explanation
Claim rate for veterans already on the rolls	o 30%, or about 255,000 of potential eligible population who is on the rolls will apply in the first year. o 80%, or about 500,000 over a 10-year period	o about 8%, or 7,440 cases in the first year o about 40%, or 37,200 over a 10-year period	o VA assumed 30% claim rate for the first based on the past history of the prostate cancer and diabetes actual claim rates. We assumed 80% over a 10 year period because veterans on the rolls are more likely to come in for increases. In addition, VA assumed that veterans with service connected organic and physical conditions would be able to more readily prove secondary substance abuse since they would have available treatment records over the years. o CBO assumed that no more than 8% of veterans with service connected mental conditions will receive increases as a result of substance abuse. The 8% and 40% are based on judgment.- NA
Claim rate for the population not on the rolls	o .2, or about 16,691 in the first year o a total of 1%, or about 82,000 will file over 5 years	NA	o VA's claim rate was based on past cost estimates, particularly diabetes, showing that the claim rate veterans on the rolls and those not on the rolls are different. In addition, in this particular case, we assumed that the stigma of substance abuse as well as the possible deteriorated health of these veterans would not drive them to file claims at the same pace of those on the rolls. We also assumed that these new claims would most likely occur only over the first five years. o CBO - NA
Accessions for veterans already receiving compensation benefits	25%, or 63,750 will be granted increases for the first year.	10%, or starting with about 3,700	o VA assumed the close tie between mental disorders and substance abuse as well as the existence of substance abuse to ameliorate physical pain would result in this grant rate. o CBO obtained the 10% from C&P medical officer.

Assumption	VA estimate	CBO estimate	Explanation
Accessions (new veterans service connected for condition that could have secondary substance abuse)	10%, or about 1,660 new claims will be granted each year.	10%, or about 1,080 accessions in VA's base will be granted increases.	o VA assumed that the grant rate for this population would be less than that of those on the rolls since they would have to provide extensive medical evidence to establish a primary condition with an associated substance abuse. o CBO multiplied 10,800 by 10%.
Total average monthly benefit for veterans	$338	$433	o VA assumed the average increase would be from 30 to 50% for a veteran with no dependents. o CBP used a weighted average from CP 127 and RCS 20-0227.
Total benefits obligation for all Allen v. Principi grants to veterans	o $127 million, first year. o $1.8 billion over five years. o $4.6 billion over ten years.	o $4 million, first year. o $52 million over five years. o $153 million over ten years.	
Total benefits obligation for all Allen v Principi grants to survivors (Death Indemnity Compensation)		o less than $500,000, first year o $6 million over five years o $27 million over ten years	o Although VA considered mortality in the living veterans numbers, due to time constraints to provide a cost estimate, the costs did not include death/burial claims. Shortly thereafter the numbers provided (without death/burial claims) were approved by the Secretary. o CBO assumed that Allen decision would increase DIC payment to eligible dependents of veterans who died from alcohol or drug related diseased caused by secondary substance abuse.
Total GOE obligation needed to work all veteran claims received as a result of Allen v. Principi	o $45 million, first year o $98 million over five years o $101 million over ten years		o VA assumed additional GOE costs due to the potentially large influx of veteran claims. o CBO's cost estimate does not show GOE costs for workload.

Dr. MACKAY. And then I know you had one other issue, and that was about competitive sourcing. And I would hasten to say that it is—what the administration is in favor of, and what I am in favor of, and what VA is engaged in is competitive sourcing.

And the history of competitive sourcing is—about 70 percent, is the information I have—are actually won by the groups of internal government employees. The issue is to get the best value, best value for the government, best value for taxpayers.

And so often, when you release a performance work statement, and you respond with the most efficient organization from the government workers that cover that performance work statement, that tends to be—or the 70 percent figure verifies—that tends to be the best value for the U.S. government.

And the historical data that I have seen shows that anywhere from about 15 to 25 percent or more of savings can be produced, simply by defining the work, and generating a most efficient organization, regardless of competition with outside contractors and suppliers.

So, we are interested not in contracting out, we are interested in competitive sourcing. Best value for the Department, best value and efficiency for taxpayers.

Mr. MICHAUD. Yes, Mr. Chairman, if I might follow up with a written question. That was not exactly what I asked. I said if there was outsource, and it's proven that it costs more and is inefficient, the question was whether or not you would reconsider that outsource. But I will submit that in writing.

And I do disagree with you, as far as what you put forward for a request. I know there is only one budget, but it does make a difference. If an agency submits a budget, and feels that this is what it needs to operate the agencies, and how we are going to take care of veterans, and the administration says, "Well, we can't do that, and therefore, you're going to only get this," I think it does make a big difference, as far as what you actually submit versus what you actually get back from the administration.

And I will also follow through on that, as well, at a later date. Thank you.

Dr. MACKAY. I would just point out, though, that the full demand model and the full projection, which is the way we baseline our budget, was accepted by OMB in the fiscal year 2004 generation of the budget. I will just point that out.

The CHAIRMAN. Mr. Beauprez, gentleman from Colorado.

Mr. BEAUPREZ. Thank you, Mr. Chairman. Doctor, good to see you again. I want to follow up just a little bit, a different angle, perhaps, but on the *Allen* case.

For me, at least—maybe every other member of the committee is fully aware of that case—but could you very briefly describe it, when it happened, the history of it, and then I really want to probe in the limited time we have, the procedure you follow, and maybe a follow-up question to that, as well.

Dr. MACKAY. Let me—I can give you the—not so much the history, but the result of the *Allen* case, as I understand it.

Essentially, the *Allen* case, the decision in the *Allen* case, means that the Department of Veterans Affairs would compensate veterans, not only for their disabilities, but in the event where a disabil-

ity was judged to have been, in some sense—where there are attendant—I would describe them as pathologies in terms of alcohol or drug use, that that would constitute an additional compensatory damage. And so, a veteran would, in some sense, get compensation for their drug and alcohol use.

We think that is destructive behavior, on the part of the government, paying, or subsidizing, if you will, behaviors that are injurious to the veteran in question. And so we are very strong proponents of legislation that would override the result of that *Allen* case legislation so that we would not, in effect, be paying veterans for drug and alcohol abuse.

Dr. ROSWELL. If I may, Congressman?

Mr. BEAUPREZ. Sure, go ahead.

Dr. ROSWELL. For example, a veteran from Vietnam suffers from post-traumatic stress disorder. That recognized compensable illness, in turn, leads to social maladjustment, and the veteran falls into a substance abuse problem.

The *Allen* case would allow us—or would require us, rather, to provide disability compensation for the PTSD, which is appropriate, and we support that. But it would also require us to provide additional disability compensation for substance abuse.

So, in essence, it would be subsidizing a substance abuse habit in the veteran. We believe that a preferable course of action would be to provide the disability compensation for the underlying pathology—in this case, the post-traumatic stress disorder—and engage the veteran in a rehabilitation and treatment program that terminates the dependency upon the substance abuse.

But if that detracts from the financial income to the veteran, obviously, it's a disincentive for participation.

Mr. BEAUPREZ. Okay, okay, you are going exactly where my follow-up question was going to go.

Surely, we—for whatever reason, someone finds himself in a substance abuse situation, you are not saying that the VA should not intervene and provide appropriate treatment?

Dr. MACKAY. Absolutely not.

Dr. ROSWELL. Absolutely not. But if treatment threatens the continued monthly disability compensation, then that creates a very significant disincentive to the veteran to engage in that treatment. And a psychiatrist will tell you that with substance abuse, patient acceptance of their dependency is the most critical first step.

So, you have to have an engaged patient, who is willing to enter into therapy. That's what we believe we need to do to deal with the substance abuse problems in our veterans—get them to recognize the problem, admit to the problem, and get involved in treatment. And we don't want any financial incentives staying in the way of that.

Mr. BEAUPREZ. Okay, I understand that. The numbers that you cite in your written testimony, Doctor, on page 6, are pretty staggering. I am having a little bit of difficulty, though, reconciling $125 million in the first year but $4.6 billion over 10. How do we get to that considerably larger number in the 10-year time frame?

Dr. MACKAY. I can only—well, no, it is obviously a phase-in of the savings estimate. I will commit to you to go back and to exam-

ine this, and to supply that to you for your further examination. But I would suspect that that is a phase-in of the savings.

Mr. BEAUPREZ. Yes, I would appreciate noting that. Especially for the purposes of this hearing, I see $4.6 billion in potential savings over a 10-year period, that is real money. And I would like to know exactly how we got to those numbers, and if, in fact—again, Doctor, based on the discussion you and I just had—if that estimate is inclusive of the cost for treatment that would still be required for substance abuse. Is that clear?

Mr. COOPER. Let me just mention that the estimate itself is based on the underlying assumptions, and those are what we will submit in response to Mr. Michaud's request.

It is a matter of estimating who would file claims for having an alcohol problem as the result of a service-connected condition: whether it would be just those with PTSD, or whether it would be the entire veteran population that has a service-connected condition of any type.

There are a lot of assumptions that we made based on facts that we knew some factors as we saw them, and also based on other studies that have been done.

CBO does not agree with us. We are at a fairly large variance with CBO. As I say, tomorrow we are sitting down with CBO to look at that. But we will submit the assumptions and show you how we got our figures. There are some things we included that CBO did not and there is one item that they included that we did not.

Mr. BEAUPREZ. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Dr. Snyder.

OPENING STATEMENT OF HON. VIC SNYDER

Dr. SNYDER. Thank you, Mr. Chairman, and Dr. Mackay, it's good to see you. In your relatively short tenure, I think you have made at least two trips to Arkansas that I am aware of, and maybe more than that, and we appreciate you having some good visits there.

I have several things I wanted to ask about, but I probably won't get to in this round. I see we may have another round, I think.

First, the issue of preferred provider and HMO reimbursements. On page 8 of your written statement, you say, "Establish VA as a preferred provider for members of health maintenance organizations and PPOs, so that VA may be reimbursed for non-service-connected care provided to members of these plans, as it is by other insurers."

My question is this, and this came up a few weeks ago, I think, during a mark-up we were doing on a bill. If I am a veteran, and I go out and buy insurance, which essentially, is I am negotiating a contract with another private entity—that's not what it seems like, you just send in your money, but that's what you are doing, you are getting a contractual obligation. I send you a certain amount of money as an insurer, and you will provide health care for me.

And in that contract it says if you go to this list of folks, you don't have to pay as much money—preferred provider. It seems to me that by this proposal that you're making, that you are putting

the government in the middle of a contract between two private entities, that you are asking the Congress to say, "Okay, Mr. Insurance Company, I know that's what you and your veterans agreed to do, but let me tell you what you're going to do. We're going to write in the name of any VA facility anywhere in the country as on your PPO list, and you're going to reimburse us for care, even though we were not part of that contractual arrangement."

That makes me a bit uncomfortable. I would think if I'm the insurance company, I'm going to have to respond, and do some kind of an analysis about impact on my insurance rates. How do you—am I off base on that, or not? Tell me what you think.

Dr. MACKAY. The train of logic, as you lay it out, is very straightforward. But from our perspective, we experience real costs when we provide care to veterans for non-service-connected illnesses or injuries. Those costs contribute to the great concern that we all have about the adequacy of the resources that our department has.

This step, or this legislation, would, as you say, insert us into those calculations, but it is also a way that we will be reimbursed for the real costs that are incurred. From our perspective, if this care—to invoke another economic principle—constitutes free ridership.

You know, the PPO or the HMO benefits, as it is currently constituted, from care that is given to their constituents, and or their subscribers to their policies in VAs to which they feel no penchant, no responsibility, and in track record and experience, in actuality, they have no payment rendered to us.

So, real costs that stress our budget are experienced by the Department of Veterans Affairs——

Dr. SNYDER. But you are no different than the private provider—I mean, you know, I practiced medicine for almost 20 years or so, and if someone shows up to my clinic, and I am not on the preferred provider list, and they say, "But that's okay, we want to see you," and it turns out I see them but they can't pay the bill, I mean, should I go and get legislation passed to insert me on that list? I don't think that's the way these contracts are going to work.

I think it's a problem. I understand what you are saying, but I think it's a problem. It would seem like—I don't know if VAs—ever tried to qualify to be on a PPO list, but I think we are basically asking—the government is going to just—you want us to pass legislation to put your name on a private contract, and I—maybe that is what we will do, but I think that creates some problems for those two contractors, both the veteran who is paying a certain rate to get service, and the insurer, who is making promises based on a certain amount of money. Dr. Roswell has something to say.

Dr. ROSWELL. Dr. Snyder, I totally agree with the premise you have established. But let me point out that we actually have anecdotes where a Fortune 500 Company recognized that its employees could be referred to VA at no cost, and it was essentially free out-of-network care.

All we are asking is for an opportunity to sit down and work with HMO and PPOs to negotiate compliance to be on that list, as opposed to being unilaterally excluded.

We recognize that there is a contractual obligation, that a managed care approach to patient care would be to reduce utilization

where possible, and we recognize that enabling legislation would only open the door to allow us to begin to negotiate and participate with HMO and PPO groups, so that reimbursement could be possible.

Dr. SNYDER. Well, negotiate and participate is not what your statement says here, and I do not think that's what the legislation has envisioned. I do not think anyone would have any problem with you negotiating with an insurance company to get on that list, subject to—given that you are a special entity—subject to the—whatever terms you all work out with your contractual arrangement.

Well, I did not get very far on my list of questions, Mr. Chairman. Thank you.

The CHAIRMAN. The chair recognizes Mr. Renzi.

Mr. RENZI. Thank you, Mr. Chairman. Doctor, it is good to see you again, and your team. I appreciate you coming over, and your testimony.

I guess I want to start with a philosophy that we have been hearing, and that I want to kick around with you, and I mentioned it to the IG when he was here, and that is that there were several people who thought that one of the ways to go after waste, fraud, and abuse was to cut veterans affairs across the board one percent, rather than going in and finding the federal program, or the different areas within the large organization that you help run—second largest in the Federal Government—rooting out those waste, fraud, and abuses, fining the programs, holding those managers accountable, and then going after specific areas, rather than just cutting across the board, and that's the philosophy that I also agree with, and the philosophy that I think our chairman had to fight for at 3:30 in the morning in order to get the kind of funding that we were able to come through with.

But given the fact that you are running a team that is the second largest in the Federal Government, and that the biggest team in the Federal Government is run by generals who are able to cut people when they don't perform—human performance—now, I know you have got the majority, the great majority, give their all in the VA, but I also see people in the sidelines sniping at you that you need to get your financial house in order, and different task force, and different people on the sidelines.

How do we provide you with the kind of tools that it takes to run the second largest organization in the Federal Government, as it relates to human performance? Does it still take an act of Congress to go after and get rid of people who are underperforming?

Dr. MACKAY. Well, Mr. Renzi, there is a very rich and full debate that was joined, I think, in the homeland security legislation last year. It is continuing in legislation that the Defense Department has put forward.

This is an area of some ferment, and I would also like to compliment Director James. She came over to meet with the Secretary and myself to talk to us about the human performance plans, and our use of flexibilities within VA. She has been very helpful in that effort.

I would also say that in the President's management agenda, one of the five big topics is workplace and human capital performance.

And we are in the midst, along with all the other agencies of government, of outlining strategic plans that focus on human capital performance.

You are correct in your assertion, at the philosophical level. It is harder, and managers don't have the flexibilities that they have in the private sector. I think many of the protections that are accorded to civil servants are fair, and they do proceed from a need, a need for our professional corps of civil servants to be free from political influence, and to have protections from those kinds of things.

In short answer, it is—there are more restrictions. A rich debate has been joined, and I would like to see real progress in areas like hiring flexibilities. It takes too long, in my estimation, to bring people on to our government jobs.

I would like to have more and greater flexibility in order to pay for performance, to reward people, to have more flexibility, in terms of assigning workers to various places within the department.

Mr. RENZI. What about——

Dr. MACKAY. Bill Campbell just served a stint as—yes?

Mr. RENZI. What about terminations?

Dr. MACKAY. Terminations, when they are justified, obviously, you want to have those flexibilities. But -

Mr. RENZI. Do you have that ability right now, or are you looking at different types of methodologies, procedures, that allow you to be able to move out the dead wood? Because that's where the efficiencies, I mean, that we are talking about.

Dr. MACKAY. That is an area, just like hiring, where, as a manger, I would like to have more flexibility than I currently——

Mr. RENZI. I can't imagine running the second largest agency in the Federal Government, and not having the ability to terminate those, justifiably, who need to be terminated.

Let me just finish by echoing the chair's comment that when the IG was here, he talked about adding more investigators, and the idea that if we spend a couple of million more dollars, then we would look at saving somewhere in the neighborhood of $200 million, is what we were told, so that an expenditure of under $7 million would gain us $200 million in the areas of more investigators being able to root out waste, fraud, and abuse.

And I would just echo the chair's position that hopefully, you will look favorably upon that.

Dr. MACKAY. Yes, sir. There are leverage points, like fugitive felons. But particularly in the CAP cycle, and keeping that at a 2 to 3-year—a very tight cycle, so that we don't get out of bounds at any one place, or any institution.

And so, there are leverage points where the investment of just a few million dollars can rebound, to the benefit of the Department, you know, many orders of magnitude more.

Mr. RENZI. Thank you.

The CHAIRMAN. Dr. Murphy.

Dr. MURPHY. Thank you, Mr. Chairman. And thank you for being here. And when we talk about the waste, fraud, and abuse, I guess a fourth category is really "other improvements," more on the posi-

tive side, rather than just rooting out the negative, and I appreciate you looking at some of those.

I wanted to ask about some of the comments made on the annual fees for category eight veterans, which of course, as you know, has developed some level of controversy associated with it.

Of course, that's for—that does not include people with service-connected disabilities, or POWs, or Purple Heart veterans, but with regard to some of these fees, what—the fee level, do you know what this is expected to generate in overall income for the VA?

Dr. ROSWELL. The $250 enrollment fee generally has about a $350 million to $360 million impact on our budget. We will verify those figures, but as I recall, that's approximately what the impact of those enrollment fees are.

Dr. MURPHY. And on a $60 billion-plus budget, that's some significant money, and that money then can go back to providing other improved health care and—for veterans.

How does that $250 a year fee compare with what it would cost someone to purchase health insurance, otherwise? Am I correct that it could be $3,000, $4,000, $5,000 a year for someone to purchase in a private market?

Dr. ROSWELL. The $250 was actually established because we believe it's a very modest amount. We looked at TRICARE, which is a DOD benefit for military retirees who have put in 20 years or more in military service. And the typical TRICARE copayment for an individual is a little over $250; for a family it's over $400 a year. So, we tried to set it at a reasonable rate in establishing that $250 proposal.

Dr. MURPHY. Okay. And of course, that is far less than if someone——

Dr. ROSWELL. Far less than the annual cost of any health care insurance that would be anywhere near comprehensive.

Dr. MURPHY. As part of the review, also, of pharmaceuticals, prescription drugs, has any discussion taken place between the VA and, for example, some of the proposals being discussed in the Senate and House, with regard to coverage of all retirees, all people over 65 with Medicare and prescription drugs?

Is there any sharing of information there? Because I suspect some of these proposals that will come out—may be some overlapping——

Dr. MACKAY. There is an ongoing dialogue, as Dr. Roswell reminded me, between us and the Department of Health and Human Services.

Obviously, a prescription drug benefit for seniors would have a programmatic impact on what happens at the Department of Veterans Affairs.

To tell you honestly, because the prescription drug benefit has not been outlined in detail, we don't even have an estimate. But obviously, common sense tells you that it would have some impact if Medicare would have a prescription drug benefit. It would be a more comprehensive package, it would be more competitive for our uniform benefit package, and it might be the case that veterans might opt to receive all their care within the Medicare framework.

Dr. MURPHY. Well, it does provide us with one mechanism of trying to speed things up and cut down on the waiting list, because

it still—it doesn't make sense to me sometimes that a person would have to wait 6 months, or a year or so, to see a VA doctor, when their own doctor is quite capable of making a decision and recommendation on prescription drugs. What we need to do is get them well quicker, and have those.

I also wanted to ask about the directive. I think it's 2003–001, which related to a number of actions on the part of medical center directors. And this relates to the Inspector General's report on physicians, and part-time physicians, and their schedules, or—and lack of patients thereof. This has already been communicated out to the VA hospitals?

Dr. ROSWELL. Yes, it has.

Dr. MACKAY. Yes, that has been, and I believe it bore Dr. Roswell's signature when it went out.

Dr. ROSWELL. We have actually had multiple communications going back to November of last year, and a new directive this year. Each medical center director and VISN director has certified not only timekeeper training, but also the fact that all part-time physicians have been fully apprised of their responsibilities, and that's been certified in writing.

So, there have been a number of communications, including the directive you alluded to.

Dr. MURPHY. I appreciate that, and I know I have been visiting my VA hospitals out in the Pittsburgh region, myself, and asking this very question, because we don't want the system and mismanagement of schedules to be part of the reason why someone isn't getting to see their doctor.

And I realize I'm almost finished with time, but I would appreciate perhaps talking with you later to talk about some of the procurement for medical supplies and prescription drugs, because I still want to make sure we're using novel and up-to-date mechanisms to purchase what we can at sizable discounts.

We also saw, in the Inspector General's report, that sometimes, even though discounts have been negotiated, they were still buying them on the local private market, which is not good.

But I think we can still come up with some other mechanisms, and always with the point of view that even though there are some out there criticizing we are cutting the VA budget, which we're not, any other things that you can find that helps put more money back to helping medical care within the Veterans Administration, we are grateful for, and I thank you for your time.

Dr. MACKAY. Actually, Congressman, I would welcome that, in either a subsequent round, or I would be happy to come up to the Hill to talk with you about that. I am very excited about some of the things that we are doing in our procurement practices, and there is really much more in prospect.

We have some systems issues, we have some data issues, and then I think we can really attack some of the other issues that we have in inventory management, and down the line. We are at the beginning of the kind of savings and efficiencies we can generate.

Dr. MURPHY. I would be grateful for that time, thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. I would like to follow up a little bit on a question Mr. Beauprez asked, as far as the *Allen* case.

You know, you talked about the result of the *Allen* case, but what were the facts in the *Allen* case? I assume the facts were something along the line that a person—as the example that Dr. Roswell used—went through a combat situation, you had a PTSD, or some other psychological category, and on top of that, it was concluded that the veteran had a disability as a result of drug or alcohol abuse. Is that the fact pattern, or do you know what the actual fact pattern was in that case, of why the court concluded that the government should be compensating for the disability?

Dr. MACKAY. Mr. Udall, I have not read the case itself. I am only familiar with the policy implications. But I want to make one differentiation as stark as I can, but that is very, very important in this.

There is a difference between the health care—you know, our attitude and conviction is that a person who has PTSD or other combat and pain-related issues, we need to get them into care. Our prescription for veterans in this situation is to get them into care.

And our objection to the *Allen* case is that by compensating someone for drug and alcohol abuse, there is a concrete disincentive to get them into that health care. And so, we oppose the compensation, but we are very arduous in our pursuit of getting those veterans into the health care, the kind of rehabilitation that's going to restore them. And that's the basis of our objection.

Mr. UDALL. Well, the—yes, I understand that. But the problem I am having is that if the veteran gets that money for the disability that they incurred as a result of a combat situation, and they want to take that money and get their treatment someplace else, and that treatment is going to be successful, aren't you, in fact, depriving them of a disability which they had, under the law, and preventing them from getting the kind of treatment they want?

I mean, I wonder whether—I mean, what kind of success rate are you having in your treatment programs for alcohol and drug abuse now, for these types of *Allen* veterans? And do you have specific proof that these veterans are not using that money to benefit themselves?

Dr. MACKAY. A——

Mr. UDALL. I mean, your testimony here seems to say that, you know, this is driving them further in to drug abuse, and those kinds of situations. I mean, what is the evidence that it is, in fact, doing that?

Dr. MACKAY. There——

Mr. UDALL. Is your medical staff willing to come forward here and talk about that?

Dr. MACKAY. There is actually literature—and I am familiar with at least one New England journal study—that correlates, you know, the delivery of the benefit checks with increased consumption of alcohol and drugs. Would that people were using this money to further their lives in being rehabilitated.

What tends to be, from all the literature that I have seen—and I will ask Dr. Roswell to comment—that the correlation between increased monies to people that are drug and alcohol dependent, is

that they will spend that money to increase their pathology to indulge their addiction. And that is a cycle that we are opposed to, and trying to break with this legislation that would, essentially, oppose this *Allen* decision. Dr. Roswell?

Dr. ROSWELL. Yes. I think the premise is are we offering the veteran free access to mental health providers. VA's mental health programs, including its substance abuse program, truly are world class, and we have a comprehensive system that actually looks at measuring our clinical outcomes as a part of our performance measurement system, and I——

Mr. UDALL. What's your success rate with these veterans, these kinds of veterans, in your treatment programs?

Dr. ROSWELL. It's hard to say, because recidivism is a problem with any substance abuse. If a veteran doesn't come back into our system, we are not able to determine recidivism rates with precision.

But let me point out that whether the veteran chose VA care, or non-VA care, disability compensation for substance abuse would terminate as soon as the underlying condition was treated and cured.

Therefore, the disincentive to seek and receive needed substance abuse treatment would be equal, either with the VA care system, or non-VA care system. Because, honestly, we care about the veteran.

Mr. UDALL. And I am totally supportive of the idea that we give them the treatment they need in order to get them well. My problem is with—is it working now, and what if, in fact, some of these veterans are using these dollars to better themselves?

And this was under the law at this point, it was a legitimate disability that they were awarded by a court. And with that, Mr. Chairman, I know my time has run out, but I think if we're going to consider this legislation, Mr. Chairman, we need to dig more in depth as to actually what is happening here. Thank you very much.

The CHAIRMAN. Thank you. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman and Dr. Mackay. We all have individual stories that we can talk about within our own communities of certain types of abuses of the system. We were made aware recently that there was a case of a woman in Florida who had been in vocational rehabilitation for some 17 years without ever receiving any type of certificate or degree before, finally, the benefit was terminated.

Can you tell me, what are you doing, and what can this congress do to stop that type of problem within the system?

Mr. COOPER. This lady's case was very unfortunate in that she had mental problems throughout this, and was in and out of the system. It is certainly a problem in that she was overall there for 17 years overall, but she was never able to complete the training. She was retained on the rolls and is now working on achieving an independent living condition.

However, we're doing a lot of things to improve the vocational rehabilitation program. The primary thing is the task force that the Secretary instituted about a month ago, headed by Ms. Dorcas Hardy, a former administrator for Social Security, to look at our total vocational rehabilitation program and ensure that we're doing

what Congress and the law have mandated we should do to help veterans.

Also, we have recently implemented a policy whereby the rehabilitation program that is determined for an individual veteran is reviewed and approved by appropriate level of management, according to cost. A program costing $25,000 and below can be authorized by the individual voc rehab counselor. At $25,000 to $75,000 the person in charge of the vocational rehabilitation program in the regional office would need to approve; for a program costing $75,000 to $100,000 the approval of Central Office management is necessary.

We have instituted quality reviews in the last year, not only at the stations themselves. We send random records back to headquarters, and every other week have a group come to headquarters to look at these various cases and give us an independent quality review.

We are trying to do a broad range of things within the vocational rehabilitation program, and we're looking forward to the results of the task force study to ensure we're doing it properly.

Mr. MILLER. Thank you, Admiral. And also, on the other side, I think all of us were shocked and dismayed at the amount of dollars that we had heard—individual cases, where there had been embezzlement by certain VA employees, and I am sure that it is a relatively small number within the overall system.

But can you talk to me—you did allude a little bit, I think, in your testimony, Dr. Mackay, about the stop-gaps, or the triggers that you are now putting in place because, you know, numbers of—in the hundreds of thousands of dollars that somebody could have a false claim set up by a VA employee, I think surprised a lot of us.

Can you talk to us a little bit about what is going on now to stop that?

Dr. MACKAY. I would be happy to. There are a number of individual measures that Admiral Cooper will be happy to elaborate on. But just as a matter of policy, it should surprise no one—and I think this committee would be after us if it was not the case—that we have no tolerance for this type of behavior, that we are perfectly and absolutely clear in our communications.

And as the Admiral will elucidate, we have several overlapping mechanisms now that provide protection of a higher order than was the case, even 5 to 7 years ago.

Mr. COOPER. Several of the things we have done have been in the area of information technology, to ensure that people cannot get into records that are sensitive.

The security policy we have for our Benefits Delivery Network, which is our payment system for VBA benefits, includes various passwords and codes that have been set up.

But one of the main things we have done is to review and hold the regional office directors responsible for any decision that would generate a one-time payment of more than $25,000. Each regional office director is responsible for reviewing those.

We have a new office that we set up in the last year called Program Analysis and Integrity, and that office will identify every record that is at includes a payment of $25,000 or more and notify

the regional office of those. The RO directors will then, if they haven't already done so, pull those records, and review them.

So it's that ongoing review and ongoing training, ethics training that we think will catch these fraudulent payments.

The people who were involved—there was one in St. Petersburg and several in Atlanta—I believe it was 2 years ago—all those people have gone to jail. The person in Atlanta who was the originator of it is in for about 13 years, I believe. As I recall, in St. Petersburg, the perpetrator received a sentence of about 3 years.

We have done a lot of things to ensure that we do not have these situations again, and if a person is trying to commit fraud, we can stop it fairly rapidly.

Dr. MACKAY. I would also point out that we were so concerned about Atlanta, in particular, where there was the potential for large-scale abuse, that we directed the IG, retroactively, to look at the last—I think it was—2 to 3 years of very large payments over $25,000.

And I was very pleased to find out, as he reported in his testimony, that 99.8 percent of those payments were dispensed correctly, and that there was no systematic, or large-scale defrauding of the VBA at the level of the large payment.

We still put in the three signature system, we still put in the overlapping IT methodologies, and the organization that the Under Secretary mentioned, PA&I, is a big point of an ongoing and continuous system of improvement, so that we, as smart as we are, you know, we're in a point-counterpoint battle, in some sense, with those that would sabotage us from the inside, the couple of malefactors that there may be. And we intend to stay ahead of them.

Mr. MILLER. Thank you, Dr. Mackay, and my time has expired. Mr. Chairman, I would like to submit the rest of my questions for the record.

The CHAIRMAN. Without objection, your questions will be tendered to our good friends from the VA. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman, and thank you very much, Mr. Secretary. And I think it's kind of difficult on a panel like this, when we talk about fraud and abuse. And unfortunately, we don't get the cameras when we are talking about the good stuff, and the good service you provide, so I want to thank you for being here today.

Let me just, I guess, question a little bit, and then ask you a question. I am a little concerned about the issue of substance abuse, as Congressman Udall had talked about, and I would be real concerned because a large number of them might have dual diagnosis.

And if that's the case, then I would be real cautious of us choosing not to provide service, or doing—especially with a dual diagnosis, because a lot of the self-medicating is a way of trying to self-cope with their situation. So I would ask you to be extremely cautious with that effort.

Secondly, I wanted to just kind of mention as we have the VA affiliates with other universities, and as they work that part time with physicians, and the problems there, as well as the possible

contracts with affiliate universities and oversight of that, one of the areas that I wanted to ask you to respond on is the issue of patents.

And I don't know if we have, you know, the appropriate contractual agreements with universities on patents or not, I don't know if we have appropriate monitoring or not. I was just, you know, told that, for example, between 1999 to 2000, that we didn't have any patents from the VA, and that 2001 we had one, 2002 we had two.

You know, I don't know, if we have a little history, I would like to get your feedback on that, in terms of trends and patents, and seeing that we are maybe leveraging as much as we can, from that perspective.

Dr. ROSWELL. Well, thank you. First, let me comment on the dual diagnosis. You are absolutely correct. Let me point out that the secondary diagnosis in a dual diagnosis patient is fully compensable, and that's where we would seek to provide disability compensation.

With regard to patents, we have made a major emphasis to recover and retain intellectual property rights within the Department of Veterans Affairs. Beginning several years ago, we hired additional general counsel staff to assert our right to intellectual property developed through VA funding, VA staff, VA research, VA laboratories, and retain those intellectual property rights.

We have a program called the Combined Technology Administration Agreement, or CTAA, that is an agreement with major affiliated medical schools that allows us to administer research and retain intellectual properties. I am pleased to report that a very large number of medical schools, including Harvard, Yale, and more recently Duke University, to name a few, have all signed the CTAAs, in which they basically agree to share intellectual property rights that are co-developed with VA, so that VA retains royalties after seeking a patent. It's an aggressive program, and our office of research and development monitors that, and we would be happy to provide more detail.

Mr. RODRIGUEZ. Yes, thank you. Just a little bit going back to that dual diagnosis. I think that—I used to work—I did about 3 years with heroine addicts and 2 years with substance abuse in adolescents and community mental health.

And initially, in the area of mental health, one of the things—at least the philosophy in the 1970s and early 1980s—was that we would try, with children, to do the least harmful diagnosis that we could, and so we would just, a lot of times, go with adjustment reaction.

Then, when the money was tied into it, when the money for reimbursement rates was tied in, then things, you know, things started to change a little bit, in terms of a little heavier diagnosis.

And so, your indication that they would continue to abuse, I would just give you an indication in terms of from a psychological, psychiatric, where we started to diagnose some of these kids with a lot more serious problems, that there might be some abuse, but the reality is that people that abuse alcohol, and abuse drugs, a lot of times, that they are dual diagnosis, and it's very difficult to determine, as to what came first, because usually the abuse is a way of trying to compensate for the problems that they are encountering. Thank you.

The CHAIRMAN. Chairman Buyer?

Mr. BUYER. First of all, Mr. Rodriguez, I want to thank you for bringing up the point about collaborative research. I appreciate that, because not only is it a problem that we have been finding in our research for years and years, and not getting anything out of it, the same applies to NIH. And we, as a government, really don't enforce it.

And so you have got universities—Dr. Roswell, you smoothed over it pretty quickly when you mentioned Duke, but Duke University pretty well thumbed their nose at us. They weren't going to work cooperatively with us, until they recently had an incident, didn't they, Dr. Roswell? They unilaterally went out there and marketed liquid nicotine, and it blew up in their face, and now they want to come back. Is that correct?

Dr. ROSWELL. Essentially, yes.

Mr. BUYER. So now Duke wants to work with us. So, I appreciate it. And if you want to continue to work with us on that issue, I invite you to. This is a good one.

Let me—also, Dr. Roswell, Brooklyn Hospital, I just had an opportunity to go up and do a tour there, along with committee staff, and I was pleased. I was pleased with the visit. The hospital director there has a very solid team. I spent a long time with the team, and you can tell.

I agree—again, forgive me, Mr. Rodriguez, you know, sometimes at these hearings, I'm not here to beat you up, I'm here also to tell you when you're out there and you recognize a solid team, and they exercise leadership, consolidated, did all the right things, trying to perform, doing more with less, and I was really impressed.

With regard to voc rehab, you know, that's an issue that I have not really gotten into, Admiral, on the oversight subcommittee of this committee. I did receive, from the Secretary, a break-out of the performance-based contracts. I was pretty stunned. You have got 100 million in here in performance-based contracts. And I was just going through—performance-based? I haven't a clue what these things are. Five million, and they just go on and on and on forever and ever and ever. And I haven't a clue what you're doing to measure them.

And you know, I almost—am I supposed to ask you, based on your testimony that you just had, that voc rehab is broken? I don't know. I mean, number one, do you think voc rehab is broken, and that—you all are pointing at each other.

Mr. COOPER. I am sorry but I honestly do not know what you are talking about. I don't know what paper you have there.

Mr. BUYER. Dr. Mackay, you indicated that you would like to meet. I look forward to doing that.

My only question was, with regard to all these performance-based contracts, you're not familiar with them now, Admiral, but now that you have had an opportunity to review the contracts—Mr. Cooper. I am sorry, sir?

Mr. BUYER. Are you not familiar with these?

Mr. COOPER. I, frankly, am not. I will get back to you for the record. I am not familiar with this report.

Mr. BUYER. That is $100 million in performance-based contracts broken down into $5 million increments to a lot of people, and I

haven't a clue who they are, what they are doing, and if you don't know——

Mr. COOPER. I am just not familiar with this. I will get back to you, and I am sorry, I just can't discuss it here today.

Mr. BUYER. Okay, thank you.

(The provided material follows:)

Attachment B

Summary of National Acquisition Strategy
Prepared: June 10, 2003

National Acquisition Strategy (NAS)

Currently, nearly all VR&E offices are making at least limited use of contracting. Contracting is being used for four basic reasons: (1) to provide timely rehabilitation services as workload demands have increased; (2) to provide higher quality services by reducing veteran to counselor ratios; (3) to provide specialized services when in-house staff do not possess the specialized expertise; and (4) to provide additional access points to disabled veterans who reside great distances from where VR&E staff are located. To develop a more cost-effective approach to providing services, the National Acquisition Strategy was developed to include a national acquisition contract. The statement of work (SOW) for the national contract was written as a performance-based SOW, so it focuses on the "end result" rather than the "how" the work is completed. The national contract will increase consistency among field offices, while still allowing local customization of contracting to accommodate specific regional needs with each regional office's jurisdiction.

Benefits

The Government's objective for this national contract is to both supplement and complement the services provided to veterans participating in the Chapter 31 program. This is a multiple award contract providing for multiple vendors in all regions. The NAS resulted in a list of qualified providers and prices for each service group for each VR&E office. Additionally, the NAS enables VR&E Officers to issue task/delivery orders against the NAS contracts in their particular geographical areas for the specific services which are needed. Each Regional Office issues its own task orders, to each awarded vendor, for a not-to-exceed amount, to cover the anticipated need for the services provided by that particular vendor.

The NAS contract standardizes the acquisition procedures used by VR&E staff to refer veterans being evaluated or who have been found eligible to receive rehabilitative counseling services. All contractors, with reference to each veteran referred, will be required to provide specific requested services through a series of interviews, educational and psychological testing, needs assessment, and other appropriate methodologies as described in the performance requirements of the NAS contract. Implementation of the NAS contract procedures also

puts VBA in full compliance with legal and regulatory standards for procurement. Additionally, implementation of the NAS corrects a deficiency in contracting procedures noted during VA's last review by the Inspector General.

Current Status

VBA implemented the National Acquisition Strategy contract to support vocational rehabilitation contract counseling services in our regional offices effective October 1, 2002. We contract for services such as Initial Evaluation/Assessment, Case Management/Rehabilitation Services, and Employment Services to support the rehabilitation and employment of disabled veterans.

The contracts approved under this national initiative were each assigned a high maximum limit ($5 million over the life of the contract) because of the potential for one or more of these contractors to receive work from all areas of the country. This was VR&E's first experience with the National Acquisition Strategy and contract expenditures are comparatively high at a couple of our largest regional offices with heavy VR&E workloads. The high limit ensured that the contract vehicle remains a viable source of support throughout the contract period. However, there is no guaranteed minimum to any of these contractors.

The amounts shown as the value of the vocational rehabilitation contracts on the report to Congressman Buyer represent the maximum limit for each contractor. However, VR&E contract expenditures total under $20 million annually, which projects to a $100 million 5-year spending estimate.

History

VR&E contractor expenditures for the past 3 years are shown:

2000	2001	2002
$29,326,409	$14,972,060	$13,844,844

2003 Field Allocation (Budgeted)

$12.4 Million

The CHAIRMAN. The chair recognizes Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. I have a question to Dr. Mackay regarding the legislative override of the *Allen* case.

Is it possible that if you are successful, a veteran who may have been free from the use of alcohol or drugs for many years would be denied compensation for, for example, Hepatitis C, which they may have contracted during their use days?

Dr. MACKAY. No, sir, our provisions about the legislation override strictly and only concern that part of the compensation that is due to alcohol and drug abuse. It would not affect any compensation for something like Hepatitis C, or any other underlying disability that is service-connected.

Mr. STRICKLAND. So if there was a condition that was the result of the alcohol and drug abuse, a liver condition, for example, that was the result of the alcohol and drug use, could the person continue to be compensated for that?

Dr. MACKAY. No, the—and I said, I believe, previously, that it's service-connected. If the Hepatitis C is service-connected, and then there was some other——

Mr. STRICKLAND. What if there is a determination that the alcohol and drug abuse is service-connected, and the Hepatitis C is the result of the use of the alcohol or drugs?

Dr. ROSWELL. That would generally be determined adjunct to a service-connected condition, and the veteran would be entitled to full access to care and treatment.

Mr. STRICKLAND. And——

Dr. MACKAY. Although I must say that I think that would be extraordinarily rare, to find that train that you described.

Mr. STRICKLAND. You know it might be, but for that individual who is affected, it is a big deal.

Dr. MACKAY. Yes.

Mr. STRICKLAND. In terms of co-occurring disorders, psychiatric disorders and drug and alcohol abuse, they are frequently co-occurring. And how would you tease out those two conditions and decide to provide compensation?

I mean, there are people who would be entitled to compensation because of a psychiatric disorder, would there not? And much of the time, I think more often than we frequently acknowledge, there is also the occurrence of a drug and alcohol problem. So what do you do with that individual, in terms of compensation?

Mr. COOPER. They would come in for an examination then they would be rated, depending upon the disability and in accordance with what our regulations. If they have a secondary effect of alcoholism then, under the new law, we would give them an increased amount of compensation, again, predicated on what our regulations stipulate.

Dr. MACKAY. But the—for administrative purposes—I acknowledge that, clinically, there are relationships between them—administratively, as the admiral laid out, they are separate determinations.

And so, the compensation portion that is attributed to that substance abuse is the part that we both——

Mr. STRICKLAND. But, you know, the problem that you identify with continuing to compensate individuals with drug and alcohol

problems would be there, because if they're being compensated for the psychiatric disorder, and they are also alcohol and drug abuse involved, then they are likely to use the compensation they get related to their mental disorder, and you know, to use those resources as you have described them using them, for purposes that perpetrate their dependency on alcohol or drugs.

Dr. MACKAY. That could be——

Mr. STRICKLAND. I am just trying to point out the difficulty which I think is going to be inherent in this policy, when you have got people who have these co-occurring disorders, and there are, you know, a vast majority of the individuals, I think, would fall into that category.

Dr. MACKAY. Again, I have to emphasize that the issue for us is compensation, and the phenomenon that the government would be, in our view, subsidizing alcohol and drug abuse. The issue is not care, the issue is not dealing with both, as a clinical matter, drug and alcohol abuse and the psychiatric condition. That is not the issue. It's compensation.

Mr. STRICKLAND. Okay. I just think it's a sticky area, and something that's got to be recognized.

One final question. On your list of legislative proposals to help the VA save money, I see the—you know, the annual enrollment fee, I see the increase in copayments for pharmaceuticals. Is that current administration policy?

Dr. MACKAY. It is part of the President's budget, as submitted.

Mr. STRICKLAND. And so, when my colleagues say that we're not going to pursue those proposals, that we're not going to try to increase the cost of prescription drugs, or impose an enrollment fee, what you're telling me is that the President and the administration is continuing to pursue these initiatives, and it's something that they hope to accomplish. Is that correct?

Dr. MACKAY. That is our submission. I would regret that if these are not enacted, that opportunities to more carefully match resources and demand would have been bypassed, I think.

Did you want to get in on this, Doctor?

Dr. ROSWELL. Well, I think the President's budget does articulate the financial impact, or the appropriations offset associated with those policies.

Mr. STRICKLAND. I can just say, sitting here, it's beyond belief to me that, rather than seeking additional funds to make those burdens unnecessary, that we're talking about the continued possibility of pursuing that. It just puzzles me. So I thank you for your time.

Dr. MACKAY. Thank you.

The CHAIRMAN. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman. Dr. Mackay, I have a question for you. How long do you think is an appropriate amount of time for a congressperson to wait for a response from VA to a very simple question?

Dr. MACKAY. Not very long.

Ms. BROWN-WAITE. Well, I would hate to be nagging since I asked the Citrus Clinic for information as to how they disposed of 600 people, almost 700 people in some months, on a waiting list, and then all the sudden in March, it got to 0.

My question—and it's a very simple question—and as a matter of fact, Secretary Principi, when he was down there 2 weeks ago, also got very angry about it. But to date, I still don't have an answer, and that is—now, Florida is known for sink holes. Did these 600 people fall into a sink hole?

I want to know what is the scheduled appointment times. You can get rid of a waiting list by giving somebody a scheduled appointment 14 months out. That's misleading. I am still waiting for the information. If the Secretary has it, I sure would appreciate it being sent to me. If not, on Friday, I am going up to that clinic myself and look at those records.

Dr. MACKAY. Congressman, we will get the information for you, and——

Ms. BROWN-WAITE. Do you understand the question?

Dr. MACKAY. Yes, I do.

Ms. BROWN-WAITE. The Secretary understood it, because he grilled the regional director, Dr. Headley, extensively about it. We still don't have that information. But I have a few other questions. If you would make sure that we would get that information.

Dr. MACKAY. I will.

Ms. BROWN-WAITE. Can you tell me why the VA feels the need to have a separate chaplain school?

Dr. MACKAY. What the chaplain program does in the chaplain school—and I would also rush to tell you that the whole program costs us about $400,000 in a single year—it provides us with the kind of orientation training for new chaplains, and some specialized programs that allow us to give the very best kind of pastoral counseling that we can in our VA hospitals and clinics.

I understand that it may appear to be duplicative, but we have worked very hard to keep those costs minimal, $408,000 in the current fiscal year, with just four staff assigned, and it gives us the opportunity to make sure that our chaplains are trained exactly to our specifications, and exactly to the requirements of our system.

Ms. BROWN-WAITE. Can you understand where it might appear to be duplicative of efforts in the various branches of service, Department of Defense, et cetera?

Dr. MACKAY. I do understand that, but I would also point out that our health care is different. Our population, because of who was inducted into World War II and Korea and Vietnam, overwhelmingly male, is still 91 percent male, overwhelmingly older, average age over 60.

So, our needs for counseling are different, our setting is different than DOD, which has a much more evenly balanced patient profile, in terms of gender. They also have a lot of pediatric care, and they provide their care in different settings, under different circumstances.

Ms. BROWN-WAITE. And the last question is—and again, we're looking at waste, fraud, and abuse, and one of the wasteful ways that sometimes government acts, different departments of government, is to duplicate other efforts.

Can you tell me why you have to have your own law enforcement training center, when you actually could use the federal law enforcement training center?

Dr. MACKAY. Well, the law enforcement training center is a franchise fund activity. The $2.9 million that goes through there is not appropriated money, and so, the biggest limiter on the size of our law enforcement training center is that they have to justify, and in that franchise fund get receipts for all the training that they provide.

Again, we have differences in the clinical setting. For instance, our law enforcement training people, even though they are armed, their training emphasizes the care of the clinical environment. If there is a perpetrator, an armed robbery or something on our property, their training is to defend our patients in the clinical environment first, to try to funnel that perpetrator off the property, and to make the apprehension in concert with other law officials, you know, state and local law officials, off the campus.

So it's a specialized form of law enforcement training that we need, because we have a very specialized form of law enforcement practice. And Dr. Roswell wanted to get in on this.

Dr. ROSWELL. Just to point out that to protect patients in a place of health care delivery, our police training is very, very much oriented towards what they would characterize as defensive police work. And that's not a curriculum that's associated with other federal police training facilities.

Dr. MACKAY. I think Bill has some observations about it.

Mr. CAMPBELL. As a franchise fund activity, the law enforcement training center only gets funded as they train. If the work were to disappear, then the size of the organization would either go down, or it would be eliminated.

We have looked in the past at other law enforcement training centers like the Federal Law Enforcement Training Center at Glencoe, GA. I did have this program when I was the chief financial officer of the Coast Guard, and we used FLETC. However, they are rather fully subscribed right now, and my understanding is that they have just opened another facility in Cheltenham, MD, so there is a real growth in the training requirements across the Federal Government.

We have been approached by other federal agencies to train their folks, and we cannot at this point, because we still have about 15 percent of our law enforcement officers who are not certified to carry firearms.

Dr. MACKAY. And as I understand it—and Bill, you correct me if I'm wrong—there is a differential between the rates that are charged at Glencoe and what we can train our own folks for down in Arkansas.

We get good value, we get customized training, and it's a franchise fund activity, so it's sort of self-limiting, there is a governor in there about how big it can be, and how much money it can spend. The rates are less expensive for us to do our own customized training for us and for others who come and purchase those services through the franchise fund.

Ms. BROWN-WAITE. It would be helpful if we could have a copy of that budget.

The CHAIRMAN. Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chairman, and thank you, members of the panel. I, too, want to thank you for the good work you

do. There are a lot of people all across the United States that depend on what you do, and so I appreciate what you're doing, and I also appreciate your attempts at looking at your costs, how do we reduce costs here, how do we save some money.

And I know that you had a report, a section 305 report, that was due March 18, that there were some problems with that, and you're coming back to us, along with the ranking Democrat, Mr. Evans—we sent a letter to Mr. Principi.

My question is, I mean, and I will just use the example that we used in the letter of the laundry facility, where you had said you were going to have four FTEs but there were actually only 3.37 FTEs there, but you rounded it up to 4. I mean, that makes a lot of difference, based on facility costs.

And as I go through this list, on your report you talk about a personnel—again, you rounded it up—which was going to cost $313,000, supplies $25,000, services $15,000, utilities $5,000. So you have got a total of $358,823 for that facility, for the laundry facility.

You then said, "Okay, we're going to contract out, and we're going to save some money." Good for you. Except that you have contracting out $302,000, and a saving of $58,000. The problem is your math, where you took $60,000 times 4, instead of times 3.37. I don't know, but from my math in school, if I do 4 times 6 is 24, or $240,000, not $313,000.

So, in fact, your contracting out costs you more money. What are you doing, and do you have—I guess I'm concerned, because I know—I worked for various groups where we contracted out, we did in-house—how do you—I mean, other than changing your math, how are you assured that when you contract out you are actually saving money, as opposed to doing it in-house?

I think the assumption many times is, well, if we contract out we're going to save money. And yet, if you look at that over a number of years, and that cost keeps going up, you would have been better off not contracting out in the first place. So, what are you doing to look at these kinds of errors in your program?

Dr. MACKAY. Well, Congresswoman, I acknowledge, as you have pointed out, the issues with the 305 report. We are correcting those and interfacing with staff to get at better figures.

With respect to our competitive sourcing program—and again, I emphasize that it's competitive sourcing, and I fully expect that in the course of events that we will have rates similar to those that have been experienced historically, and that about 7 out of 10 times, the government employees, when they are organized in a most efficient organization for a performance work statement, will actually provide best value to the government.

And "best value" is another term that requires some intellectual involvement with it, some work, that it's not simply, in all cases, an issue of cost. It's an issue of providing best value to the Department, to the veterans, and to the taxpayers.

With respect to laundry, you know, math errors aside, it is the case that laundry is an ancillary and support activity. It is easily available out on the—competitive market, by other contractors. Only in situations where we have small laundry facilities in isolated places where we cannot get the services, or in places where

we have just bought new—all new—equipment, and you look at the amortization of that, will it be the case, I think, when keeping that in house will be more efficient.

Because you know, laundry for surgical applications is no different when VA washes it as when somebody else does. I think when we have——

Ms. HOOLEY. Right. But you still want to save money. I mean, you do not want——

Dr. MACKAY. Yes.

Ms. HOOLEY. It seems to me that if you do not—the circumstances you just described—and let's go back to this, because it's a very simple thing. And I agree, that it's a job. But you still want to say if you're going to contract out, it seems to me you really want to save money.

Dr. MACKAY. Yes, we want to save money.

Ms. HOOLEY. And when it costs you more, then I would assume you don't want to contract out.

Dr. MACKAY. Well, Congressman, let me assure you that in a case where you have a commodity like laundry service—and we can supply it to ourselves more cheaply than you can outside—I have no interest, no interest, in paying more money and providing less value for taxpayers, our employees, and veterans, just to contract out.

I am not after contracting out, I am after competitive sourcing to make sure we are getting best value. And with commodities, that means that's a price competition. And if we can do it more cheaply inside, that should be the determining factor.

Ms. HOOLEY. And you will get back to us with a new 305 report?

Dr. MACKAY. And with correct math this time, I——

Ms. HOOLEY. Okay, thank you.

Dr. MACKAY. Yes, ma'am.

The CHAIRMAN. Mr. Ryan.

OPENING STATEMENT OF HON. TIM RYAN

Mr. RYAN. Thank you, Mr. Chairman, I appreciate the opportunity here. And I understand we're talking about waste, fraud, and abuse, and different issues. But I have to just tell you, being home over the Memorial Day break and spending a lot of time with veterans in my district, in the industrial Midwest and northeast Ohio, that they are extremely, extremely frustrated, and they are angry.

And you know, for someone like myself to have to go to event after event, as I am sure many members of this committee do, and face veterans that feel like they have been ignored in many ways, and to look at some of the legislative proposals here, it's heartbreaking.

An area that I represent, that I share with Congressman Strickland, Youngstown, OH, industrial Midwest, complete erosion of manufacturing jobs, our veterans are now trying to take advantage of the veterans health care system. And for them to say that their service is somehow being diminished because of the sacrifices they are asked to continue to make with increases in the copay, with issues of concurrent receipt, I mean, these are killing these people, emotionally, and they are frustrated.

And it's difficult for me to come to this committee—and I am not saying—public officials, we all take a lot of heat, but this is an issue that I hear about every single day, and there is not a place that I go when I'm back in my district on the weekends where these issues don't come up. And I felt that it's important for me to communicate that to you, that we're on the front lines, and we're hearing it, and it's heartbreaking.

And they're tired of the photo ops, they're tired of the PR games, they're tired of the, you know, fake left and go right, and they want these issues addressed, and all in the face of a tax cut where they are seeing a number of wealthy people getting $93,000 a year back, or $350 billion going back to the top—primarily the top 1 or 2 percent, and they're angry. And I wanted you to know that.

And I appreciate what you do, and I know you put in a lot of service and a lot of time, and probably not compensated nearly as much as you should be, but these are issues that are being heard in Youngstown and Akron, OH.

One of the questions I had was from the GOA office, from their testimony on May 8, they were saying that the VA's projections for the next 10 years—and the amount of demand is going to increase and double by 2012.

Can you just comment on that a little bit? Because what I see in our area is as we continue to lose manufacturing jobs, that people are going to continue to access this system, and I just want to know how sure you are about these numbers, because it would seem to me that they would be increasing even more.

Dr. MACKAY. Mr. Ryan, I have to ask you for a point of clarification. When you mentioned the doubling by 2012, I—Mr. RYAN. Acute health care.

Dr. MACKAY. Acute health care?

Mr. RYAN. Mm-hmm. We had the General Accounting Office, in their testimony, "VA's current projections show a surge in demand for acute health care services over the next 10 years, doubling by 2012." And my question is that with the erosion of these manufacturing jobs in the industrial Midwest, is that number accurate, or is it going to be even more severe?

Dr. ROSWELL. There is no question that the local economic situations in your home state have significantly increased even our projected demand this year in Ohio. Initially, we were surprised, and then later dismayed at the percentage growth in demand for VA care in your state, and actually began efforts months ago to try to ascertain the cause of that. We came to the very same conclusion that you have articulated, that it's local manufacturing job loss and economic conditions that have led to that.

It's clear that there will be an increasing demand, and the CARES process, the Capital Asset Realignment to Enhance Services process, has attempted to project that. But even that process is being looked at very carefully to try to adjust for situations like what you have described.

Mr. RYAN. I appreciate it. I guess I talked a little too long early on, but if you would like to comment.

Dr. MACKAY. It is important to realize, though, that—I go out there and I talk to the same veterans, and I understand the prob-

lems in your particular region, but we are moving people off of the waiting list and getting them scheduled for appointments.

From last summer, at over 310,000, we're now down below 150,000, if I remember correctly, those are the latest figures I have seen. And I can get you figures that show you what's going on in your particular region.

As it pertains to the budget, more resources are being directed to veterans and to veterans health care. From fiscal year 2001 to fiscal year 2004, 33 percent increase at the top line, from $48 billion to $64 billion. And with the help of the chairman and others, that may be even more money when the final appropriation comes down.

We are making headway, but I am with you, and I share your frustration. As long as there are veterans that are waiting to be scheduled for appointments, as long as there are dissatisfied veterans, then we have no right to be satisfied about the effort that we're putting out.

It's immaterial how much I am paid or not paid, that's our job, and we need to make sure that we are continually improving. We are improving, but particularly in regions and what we call VISN 10, in that part of Ohio, we have some real challenges. We know—Dr. Roswell just penned me—that we have about 1,500 veterans on the waiting list in Ohio, veterans that are not scheduled for an appointment. And it's our policy not to schedule more than 6 months out for an appointment. That's 1,500 veterans too many, and the waiting has to stop. We are getting better, but we are not good enough yet.

Mr. RYAN. Well, I appreciate that, and you know, Mr. Chairman, if I could just make one final comment, I don't know if you saw the cover of the *USA Today* today, but it was talking about how they are having a difficult time recruiting Reservists.

Dr. MACKAY. Yes, yes.

Mr. RYAN. And I think when we look at this system as the veterans do, they don't see it piecemeal, they look at the big picture. That's why I brought up the tax cut, is they see money going here, and they are not having the services that they feel like they need.

At the same time, it's, you know, how are we going to make these promises to veterans and break them, and then expect more people to want to get into the system?

Dr. MACKAY. Yes, I—it's going to sound like a bureaucrat's point, but it's important. With the enrollment fee, and the increases in copays, what we are doing is following through on the original agreement in the Millennium bill that says that non-service-connected veterans, those that did not have injury or illness by reason of service, could come to VA, but they are going to be expected to defray their cost, just like retirees, people that spend 20 to 35 years in the military, have to pay that $256, or $400-plus for family in TRICARE.

And so, that's part of our system, that was always part of the original understanding. So in that sense, it's not a broken promise. The law asks the Secretary every year to make a very difficult decision about who is eligible for care, to match resources with demand. And the adjustments that we have in copays and in that en-

rollment fee are part of that adjustment matching resources with demand.

With the increased resources that have happened in the last 3 years, the leadership of this President and this Secretary, we are making progress. We are not good enough, but I just wanted to get that on the record, about the full picture as to where we are with respect to funding, and what those adjustments in copays and enrollment fees, what they are pursuant to, and who exactly we are asking to make those contributions.

Mr. RYAN. Well, and I appreciate that, and it's—from my perspective, and our perspective in our area, it's these people now have lost jobs making $60,000 a year and now they are making $20,000 a year, and $15 and enrollment fees, and the cost of health care in general, I mean, it's just—it's becoming too much. And I'm sorry I took so much time, but I did want to make the point. I appreciate it, Mr. Chairman.

The CHAIRMAN. A very good discussion.

Mr. RYAN. I appreciate your indulgence.

The CHAIRMAN. Mr. Boozman.

Mr. BOOZMAN. No, thank you.

The CHAIRMAN. Let me just ask any members who might have additional questions during this second round, I hope you will stay.

Mr. Secretary, in talking about the CARES process, I have been very concerned that long-term health care planning appears not to be included in how we allocate our vast network of infrastructure and assets within the VA, and I know that Everett Alvarez, a good, honorable, and distinguished American is heading up that panel.

Has the guidance come yet, or is it at least being considered at the VA to include long-term health care? You know, in my earlier round—and I have raised this by way of letter and conversations for a number of years, now—this diminishing capacity in light of increasing demand. You know, we talk about mismatch in VA health care dollars versus need in general, when it comes to VA health care, and that is the gist of the report of the Presidential task force.

But in very subset of that, obviously, is long-term health care. And it seems like we're going to miss the forest in the trees. CARES will make its recommendations, and apparently, unless there is something you can shed today, some light, we're going to miss inclusion of all of these veterans increasingly are going to become in need of home health care, or long-term care in an institutional setting, and where are the assets going to be?

I mean, CARES is not included in their analysis. What do you think about that?

Dr. MACKAY. But CARES is—remember, we had a phase one to CARES, and now we're in a second part of CARES. It's very important that it's a progressive process, and when we need to we make adjustments.

I am sure you are aware that we have made schedule adjustments in order to address the work and issues and so that the plan, when it goes to the commission, can be more fully vetted and more well thought out.

At this point, you are correct. Long-term care is not included in this, in the studies that are contemplated with this CARES rec-

ommendation. That does not mean that long-term care will not be addressed in our strategic planning, it does not mean that we will not come forward with proposals about long-term care. It means that at this particular juncture in this progressive process, we are not going to be able to make recommendations, you know, coterminous with the other recommendations about acute care in this particular phase of care.

The CHAIRMAN. I am concerned, and I think other members of the committee on both sides of the aisle will be concerned that we may potentially mothballing facilities and downgrading facilities when we have a concurrent rise in demand for long-term health care.

And you know, to go back to that analysis in 2005, or 2006, or I mean, if we get it right now, we get it right, hopefully, for the intermediate and longer term.

Dr. ROSWELL. Mr. Chairman, if I may, you are absolutely right. Long-term care is critical to the needs of veterans, and it's something that we take very seriously, and we actually have established a group to look at our long-term care policy.

As you know, there is statutory guidance in the Millennium bill that is somewhat in conflict with the President's 2004 budget request, and we really feel that that needs careful and thoughtful resolution in this committee before those planning guidance, or those planning models, are applied to the CARES process.

But let me point out that the CARES process is about not only future demand, but our current capital infrastructure. We have learned repeatedly that taking 50-year-old infrastructure and converting that to provide long-term care is more costly than new construction. We fully anticipate that when we're able to properly define what our full long-term care institutional needs are, that there will very definitely be locations where additional long-term care infrastructure is required.

But we have ascertained that converting 50 and 55-year-old hospital buildings to provide the needs of institutional long-term care not only is more costly than new construction, it affords a less higher quality of life for the residents who receive their long-term care——

The CHAIRMAN. With all due respect, Doctor, why should that be part of the process now? I mean, not all of the buildings are 50 years or older, only some are. Some, obviously, would lend themselves to rehabilitation, and then perhaps utilization for this need.

But it seems like it ought to be part of the deliberation so that we don't miss a very vital component here. To go back and get it later, it seems to me, is going to make it that much more difficult.

Dr. ROSWELL. To make sure we don't miss an opportunity, I have given guidance to ask every VISN to preserve their current long-term care capacity, to make sure that we don't. We have not approved any downsizing or closures of long-term care beds since the enactment of the Millennium bill, and that is preserved through the CARES process.

But we really felt we needed to have better projection models to be able to fully articulate that. I am confident, though, that the long-term care institutional requirements can be added through a

strategic planning process to the current CARES recommendations in a way that will be synergistic to the overall care delivered.

The CHAIRMAN. Let me ask you a question with regards to legislative proposals, and as a matter of fact, we fought many a battle over the last 4 or 5 months on those legislative proposals, with regards to copayments for pharmaceuticals, the annual fees, the enrollment fees.

And the bottom line of what we worked out with the budget committee was that these proposals would not go forward, and yet they are being reiterated again today. I don't think that's going to happen in 2004, and I hope it doesn't happen any time thereafter.

With regards to the *Allen* decision, perhaps you can provide some reconciliation as to why this is the case. You know, as to having good, hard numbers as to what this decision actually costs, you suggested it would cost $4.6 billion over 10 years. CBO says it will be $180 million—million with an "M"—over 10 years. That is a wide gulf. How is it that two very reputable groups of people crunching those numbers have such a disparate outcome?

Mr. COOPER. Again, it's, frankly, based on the assumptions that were made, and one of the primary assumptions was that some percentage of people who have had disabilities will, in fact, eventually have an alcohol problem. CBO said the only people that might have that problem would be those who had PTSD or mental disabilities. Our population, therefore, included a lot more people.

We also said a larger percentage predicated on readings that are out there, studies that have been done, we said about 30 percent of those who had disabilities had the potential of coming in with this problem. CBO said 10 percent. That's just an example of the factors in which we differed, and the reason we're trying to get together here in the next couple of days to find out—and try to come to some kind of an agreement. I don't think we ever will come to a full agreement, but at least try to look at the assumptions.

Ours are predicated on assumptions that we thought were reasonable at the time, and that's just something that eventually plays out.

The CHAIRMAN. So it's likely we will get a new number from both, maybe——

Mr. COOPER. Yes, sir. I will ensure that you get the table and the assumptions that we use.

The CHAIRMAN. One of the legislative proposals that I certainly agree with, and the committee—most members, I think—strongly agree with is H.R. 1562, Mr. Beauprez's bill. We have an advance copy of the letter that Secretary Principi, I believe, will be signing shortly, and it makes the point that this bill, particularly section two of the bill, would be a significant enhancement to VA's collection authority, and suggests that there will be a $48 million 2004 savings. That is to say the insurance companies would be footing the bill, and not the taxpayer, and over 10 years, that's $483 million.

And CBO, again, comes up with a different number, but it's certainly a more positive number. It would be a savings of some $700 million. My hope is that we can move that bill—it's already been reported out of this committee—as soon as possible. Perhaps you might want to comment on that.

And just let me say, before you do, that we have touched on a lot of different items of savings during the course of this hearing. But one of the most underheralded success stories of the VA over the last couple of years has been in the area of third-party collections.

In 2001, $700 million was gleaned from that source. In 2002, there was a 71 percent increase, and that jumped to $1.2 billion. So I do want to congratulate and give strong credit where credit is due to the VA, and to you, Secretary Mackay, and your colleagues, for you know, rarely do we see a 71 percent 1-year increase. That is a success story that should not go underscored. It deserves neon lights, if you ask me. So I want to thank you for the good work you have done on that.

But again, if you would touch on an additional enhancement to the ability to garner that money.

Dr. MACKAY. Mr. Chairman, thank you very much for your kind words. We are on track to get over $1.5 billion—actually, closer to $1.6 billion this year—in collections. So that success story continues.

With respect to Congressman Beauprez's bill, it would significantly add to our flexibility. As Dr. Roswell said, it would give us authority to really open a negotiation with these HMOs and PPOs that currently are non-responsive to our billing.

When their insurees, their people that pay the premiums come to us, and taxpayers, foot the bill for that care, that is a real cost to VA. And from our standpoint, we are owed recompense. And Congressman Beauprez's bill, and your leadership, and the leadership of this committee, and in time, it is my hope, firmly, this congress, will give us that authority so that the monies that you have outlined could be restored to VA, and that the taxpayer could be relieved of that burden.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. Doctor, you indicate that the VA has established a new competitive sourcing office with a dedicated service director and a staff of five. In light of the limitations on funding outsourcing activities from the three health care funds of VHA, how will the VA fund this office? Who are these people, and what are they up to?

Dr. MACKAY. If you would like names, Mr. Congresswoman, we will certainly get those to you, but what they are up to is planning to be a central resource for our competitive sourcing efforts.

And as you are—as you mentioned, and it is correct, with section 8110—and as I mentioned in my remarks, we do need to have specific appropriations to utilize VHA personnel and those three medical care funds in order to conduct competitive sourcing studies and comparisons.

With respect to laundry, it is my understanding that there is one less legal interpretation that is being worked out. It involves the medical sharing provisions of sections 8111 and certain of the FAR requirements, and we have asked for clarification from our office of general counsel. And as soon as we get that, we, of course, will abide by that further clarification.

In the interim in the case of laundry outsourcing, we are continuing with those activities.

Mr. EVANS. We want to understand who is paying for it right now, and what activities that it is——

Dr. MACKAY. What we have right now is, pursuant to 8110, we understand that we cannot utilize VHA personnel, and we cannot use funds from those three medical care accounts.

Those five people are part of our PPP staff, policy—and they are part of the GO&E appropriation. They are on overhead right now. What that provision prevents is the use of VHA people and funds from those medical care accounts pursuant to comparison studies. And that we are not engaged in.

Mr. EVANS. All right. Thank you, Mr. Chairman, I appreciate the opportunity.

The CHAIRMAN. Dr. Murphy.

Dr. MURPHY. Thank you again, Mr. Chairman. Questions about—I want to go back to a question I had asked earlier about some of the proposal which seems to have been revived about charging a $250 fee for the category eight veterans.

Is there an assumption that a number of veterans will not be able to afford this, and will drop out of the VA health services?

Dr. MACKAY. There is an assumption that what they will do is they will make a judgement, based on the quality and the suitability of VA health care, and the costs that they confront, as it affects their situation. We anticipate that there will be some that may opt out of VA health care when confronted with those partial costs.

That in no way is the full freight for people that come to us, but they will be faced with those costs, and they will make an economic decision, and we anticipate that some priority eights will make a decision to seek their health care in other places.

Now, priority eight veterans, I would hasten to add, have higher incomes, and generally—not universally, but generally—have other places to seek health care, other providers, and other ways to provide for their health care.

Dr. MURPHY. Such as?

Dr. MACKAY. Some would be Medicare, some would be private insurance. At the income ranges we're talking about, they generally have employer-provided insurance programs.

Dr. MURPHY. I would be concerned that in some areas—for example, rural areas in Pennsylvania, sometimes people don't have another choice if they are trying to purchase Medicare part B or something, they don't have other choices to go through with this.

When you add that $250, and maybe add on to it some costs of prescription drugs, and the copayments with that, too, that can perhaps reach some of those levels. But I'm wondering what that data was based upon, what assumptions might that percentage be, that it cannot afford that? Was there some survey done on this, is that just a guess?

Dr. MACKAY. Go ahead.

Dr. ROSWELL. As Dr. Mackay pointed out, this is only applied to priority seven and eight veterans, who, in all cases, would have an individual income in excess of $24,000 a year, up to around $30,000 a year, depending upon the number of dependents. And in some cases, their income would exceed the HUD index, which is significantly above that.

So, we don't think that a $250 enrollment fee would represent a particularly onerous burden to this group of veterans. If their income fell below that, obviously, they would migrate to priority group five, which is not subject, nor is it proposed to be subject, to the enrollment fee.

Dr. MURPHY. I would hope as part of this, we could get some more detailed analysis to know, for sure, that the veterans do have other options. We don't want to leave them behind. And so we are well aware of—and there is resistance to going in that direction—but if that does occur, to make sure they have other options, because we want to make sure they do have that.

What are—another cost area—some of our options with regard to dealing with the expanded needs for nursing home care and at-home care for veterans, and what will the costs be, and how are we going to handle that for the future, too?

Will that be covered, any of those things going to be covered at all in some of the veterans' homes? Will there be cost savings that have been identified from there, which will allow us to provide more coverage for the increasing number of veterans?

Dr. ROSWELL. There are significant savings associated with providing care in the home setting. We have looked at a variety of levels of care. VA staff nursing home beds, the bed level that is required by the Millennium Bill, tend to be very highly staffed because of a significant rehabilitation mission that leads to over 70 percent of veterans receiving care in that setting discharged to home. It's really a rehabilitation type of skilled nursing home care. The average per diem cost is about $395.

When we contract for care in the community, we are able to acquire that skilled nursing home care in the community without the rehabilitation component that is available in the VA for, on average, about $200 per day.

When we place veterans in state veterans homes, our copay requirement is about $50 a day, but when we can keep a veteran in the home environment, using interactive technologies, home care services, contract health and homemaker services, we can reduce the cost per day, sometimes, to just a few dollars a day.

And that's why we're particularly focusing on that level of care, because we have found that we not only lower the cost per day of care provided, but we actually improve the quality of life and the functional independence of the veteran.

Moreover, when a veteran has been married for 50 or more years, as is often the case, it allows that marital bond to be preserved while the veteran receives care in the home.

Dr. MURPHY. And my understanding, in surveys with senior citizens, they would much prefer to remain in home care, given the choice of anything, even if all three were covered equally, that's what they prefer.

Dr. ROSWELL. Yes, yes.

Dr. MURPHY. And so I hope we can continue to support them to remain at home as long as they can.

Dr. ROSWELL. Yes, all the data and all the surveys that I have read or been familiar with reiterate that point.

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

The CHAIRMAN. Thank you. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Mr. Chairman, I wanted to ask you, every time we have another comment today about this *Allen* decision, the more confused I get. Have you made a decision yet about whether we're going to have a hearing this year on the *Allen* decision, or is that something that's being contemplated?

The CHAIRMAN. As of now, no. We have made no decision on—matter of fact, in terms of legislation, so far, pending information that I have not yet seen—and I have seen quite a bit—I see no reason why we would mark up anything relative to the *Allen* decision.

Dr. SNYDER. I understand. I'm like you, I think it's a fairly strong statement, and Dr. Mackay's statement today about the—talking about that.

A question was asked earlier about the law enforcement training center. And I know that when Secretary Principi visited Arkansas, that he toured through that facility because I went through with him. My recollection—I did not go in your tour. Did you tour through that facility?

Dr. MACKAY. Yes, I have been there twice. I toured it once, and I was there for a ground-breaking for the new firing range.

Dr. SNYDER. Right, I thought you were. My understanding, if for some reason this facility were to be closed by legislation, in order to get the kind of training you want for your personnel, you would end up going to another facility and paying tuition to go to that facility. Is that what you mean by a franchise operation?

Dr. MACKAY. Yes. Yes, Congressman. It would be a real hardship. Because we have a very specialized form of law enforcement that we engage in, we would have to purchase the basic training, the firing training, the other law enforcement training, at someplace else, at maybe the Glencoe facility, at a higher price, at least in the case of the Glencoe facility. I know that——

Dr. SNYDER. And then probably still have to come back and do——

Dr. MACKAY. And then we would still have to do——

Dr. SNYDER (continuing). Some kind of orientation towards what it means to be a VA person, yes.

Dr. MACKAY. Yes. We would still have to do specialized training someplace.

Dr. SNYDER. Right.

Dr. MACKAY. And it would have to be standardized in order to get the kind of consistency and uniform standards that we want across the system. It would be a significant hardship. And I dare say that we would have suboptimal outcomes in terms of the quality that we know experience.

Dr. SNYDER. This issue of the part-time physicians at the VA, that both you and Dr. Roswell have talked about, I mean, it's been an issue that has been sitting out there for 30 years or so.

And is the basic underlying issue that—or what brings about this challenge is that so many VAs are in proximity to medical schools, and when faculty are hired they divide a percentage—they say, "We're going to hire you 60 percent on the state and medical school and 40 percent on the VA," and in 30 years there has never been an accurate accounting on—I mean, they're on one campus or the other, someplace, perhaps more than a 40-hour week, but there has

never been a good accounting or accountability. Is that a fair overall assessment of what's going on, Dr. Roswell?

Dr. MACKAY. All right, let me——

Dr. SNYDER. Okay.

Dr. MACKAY. I agree with your assessment. And that's one of the more troubling aspects of this, is that it does appear to be, in some sense, a cultural issue that we're up against. And that's why it was important that the Secretary and Dr. Roswell met with AAMC, because this really is an issue that both we and medical colleges and universities have to confront together.

And over time, it is my impression, that a culture that you talked about has worked up—there has been, in some sense, not as business-like and formal relationship as there needs to be with respect to VA getting the work that it pays part-time physicians for.

Certainly—and I would join a chorus in saying—that we benefit from our relationship with affiliated medical colleges and universities. It's part and parcel of what we do. It's so important to research and education. But in this particular facet, that cultural milieu that you described has not redounded to the benefit of VA's patients, the veterans that come to us for care, and we're going to fix that. It needs to be altered.

Dr. SNYDER. Dr. Roswell, you wanted to make——

Dr. ROSWELL. I would just concur with you, Dr. Snyder, that this problem is virtually exclusively associated with affiliated medical schools. At the main Little Rock campus, as you may well know, the medical school and the VA hospital are literally side by side, and——

Dr. SNYDER. They are connected by a federally funded bridge.

Dr. ROSWELL. Correct.

Dr. SNYDER. Because there is such interchange between the two.

Dr. ROSWELL. And that predisposes to a full and interchange of activity and staff between those activities being driven by where the patient care demand is.

I think what we have learned is that when we put someone on a fixed schedule, then that's not consistent with the clinical practice patterns and an interfaced academic setting.

That's why this service level agreement that Dr. Mackay spoke about is so important, because basically that translates the part-time pay into an annual hour commitment, and then the part-time physicians draw against that hour commitment each and every time they provide services needed at the VA facility.

Dr. MACKAY. And the other thing, we talked about the productivity standards, and the staffing standards. That will give good guidance, and it has been—I know the IG has identified that in years previously, but we are going to act on it, and get the staffing out there so that there is good guidance to medical center directors about, for a given work load, what kind of staffing they should expect, and what kind of productivity they should get out of the physicians that work with them.

Dr. SNYDER. I talked to a department head the other day from a medical school back home, and I asked him, "Are you all in compliance? Do you feel good about your accountability?" And he said, "Painfully so," which I think was his way of saying that at some point, we may hear states complaining, "Wait a minute, these guys

are spending all the time at the VA, because they're afraid of Chairman Smith and his accountability"—I mean, this is a shared collaboration.

It has worked very well through the years for training —and I suspect Dr. Murphy has trained in VAs, also, but it's a kind of a swinging pendulum, I think, that you all are working on. Thank you.

The CHAIRMAN. Thank you very much. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. Dr. Mackay, I wanted to ask a question about indirect costs, and as they relate to research, and I appreciate that the VA is pursuing reimbursement for indirect costs, usually facility-related costs associated with the conduct of NIH, National Institute of Health funded research at VA facilities.

On May 2nd of this year, Secretary Principi wrote a strong letter to HHS Secretary Thompson to encourage quick action. And I wrote a similar letter in roughly the same period of time. NIH, apparently in violation of statute, is not pursuing—not reimbursing the VA under the same terms and conditions as it reimburses other non-governmental organizations, including foreign organizations.

What can you report to me on the status of this, and if this impasse is not resolved in the next 30 days, what action can the two executive agencies take to resolve this? I mean, should OMB be brought in to the process to resolve the dispute between the VA and HHS?

Dr. MACKAY. Congressman, you are—I agree with your assessment, 100 percent. There have been contacts—I know that Dr. Roswell has sent letters, and probably had meetings, I will let him comment later. I know that the Secretary has sent a letter to Secretary Thompson.

And we are at least at a sticking point in this relationship, as I understand it. The suggestion you make is to the point, that we need to involve OMB in this. It is an issue that perhaps affects other agencies beside VA, and that would be one way to get it government-wide resolution to the issue.

But we are of the opinion—and I know that this committee shares the opinion—that per statute, when we incur these research support costs, in conjunction with NIH-sponsored research in our hospitals and other facilities, that we are owed that recompense. And we have actually established a rate, which I believe is about 24 percent—Bob?

Dr. ROSWELL. By study we have shown.

Dr. MACKAY. But study. That would actually be much less expensive than the rate that is paid to other entities to whom NIH pays these fees, and costs right now. Would you like to add anything Dr. Roswell?

Dr. ROSWELL. The only thing I would add is that Dr. Wray, our Chief Research and Development Officer, recently met with Dr. Zahuni at the NIH, to discuss this issue. And while they didn't reach any specific resolution, I believe that the meeting was productive, and they have agreed to an ongoing, continuing dialogue.

We are optimistic that that will resolve the apparent impasse, but if not, then obviously, we will need to seek your support.

Mr. UDALL. Thank you. Let me follow up on Dr. Snyder's question, because you remarked in your testimony, Dr. Mackay, on April 2003—this is on page 2—"The OIG report demonstrated clearly that significant numbers of part-time physicians were not fully honoring the terms of their employment, and that VA was insufficiently vigilant in overseeing their compliance. We have required that all part-time physicians be counseled about time and attendance requirements."

I realize, from what he said, that there is this tug and pull between the medical school and between the VA. But where there are egregious examples of, in your words, part-time physicians not honoring their terms of their employment, have you all taken disciplinary action in order to resolve this?

Dr. MACKAY. With respect to the one case in the University of Kentucky, I cannot comment fully, because there are still ongoing investigations. But whether there is prosecution or not, will be left to the U.S. Attorney's office.

But where we find physicians that are defrauding—and there is really no other word for it—then we will terminate those physicians. And given the circumstances, if they require it, we will seek or request that the U.S. Attorney's office prosecute those folks. There is no excuse for this. When people defraud on Medicare, they, of course, are prosecuted. And we will do the same thing when the circumstances warrant it.

Mr. UDALL. Thank you very much, and let me thank the entire panel today for your service and your hard work on behalf of veterans.

And Mr. Chairman, let me also say to you that if we do decide to mark up something on *Allen*, if you could give us some kind of indication so that we can look into it. But I appreciate very much your comments, in terms of saying that you don't have any intention of marking it up. Thank you very much.

The CHAIRMAN. Thank you, Mr. Udall. Let me just thank you unless there is anything else you would like to add, Dr. Mackay, or any of your distinguished colleagues?

Dr. MACKAY. No, it's been expressed several times by members of the committee, and I would just like to reiterate, we get the cameras when we're going to talk about waste, fraud, and abuse, but the relationship between this committee and—both sides, I would hasten to add, both the Democrat side and the Republican side—is particularly close on issues of management efficiency, and there is no dissenting party to getting the best deal for the American taxpayer, and getting the most care to veterans.

And although sometimes it's a little painful, in a professional sense, I appreciate the oversight, the vigilant oversight, that this committee provides, and the very real help that your leadership, and the leadership of the ranking member and other members of the committee provide, the support to the Secretary and myself in our endeavors to make VA ever more efficient and a better provider of health care, and other benefits and services to veterans. So, thank you, sir.

The CHAIRMAN. Dr. Mackay, thank you for those kind remarks, and the committee does work in a bipartisan way. We are seeking after adequate, if not world class health care for our veterans. That

is the goal, at the best price for the taxpayer. And where there are inefficiencies, and where there is a need for legislation, we stand ready to provide that.

I would just note, for the record, that tomorrow we have two subcommittee hearings, benefits and the health care subcommittee, one in the morning and one in the afternoon, and we will be looking at the VA construction budget. We will also be holding a hearing on six separate bills.

But on June 17, we will be having, in this hearing room—and I do hope there will be cameras for that and the widest possible exposure—part two of our series of hearings on the Presidential task force. And Dr. Mackay, we are hoping that you will be able to testify, as well as Dr. Chu. We will have several members of the task force here to provide testimony, as well as at least seven of the VSOs and their leadership to provide their insights and counsel.

I think this Presidential task force document is a blueprint that everyone needs to take very seriously, and consider what our roles are, what should the legislative branch, and what should the administrative branch be doing to implement its very fine recommendations.

So, I again want to thank you for your leadership. It is extraordinary. And I look forward to working with you as we go forward. And to all of our distinguished panelists, thank you.

Dr. MACKAY. Thank you.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 12:40 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN CHRISTOPHER H. SMITH

May 8, 2003

As we gather today to examine the effectiveness of veterans programs, it seems appropriate to reflect very briefly on who veterans are, and what they expect from their government. Living veterans and their dependents span more than a century of the American experience, from the few surviving veterans of the First World War to the millions of active duty personnel who will inevitably become 21st century veterans when their current military service ends. In recent weeks, the world has seen the effects of insuring that our military men and women have the right equipment and the best leaders. When the mission is clear and our servicemembers are properly trained, no goal is unachievable. Each servicemember also learns that there is no substitute for personal integrity and commitment in achieving that goal.

As the war in Iraq winds down, it is appropriate that Congress refocus attention on the benefits and services that our soldiers, sailors, airmen and marines have earned through their service. Our servicemen and women need to be assured that federal programs serving veterans are managed better than any other Federal program, that they are supervised by employees who understand the meaning of personal integrity and commitment, and that the benefits and services are delivered in an efficient and timely manner.

The Department of Veterans Affairs employs over 220,000 people, many of them veterans themselves, and is the second largest agency in the federal government. VA has a budget that will exceed $63 billion in fiscal year 2004. VA programs touch millions of lives each year with benefits and services designed to rehabilitate veterans injured during their service, and help all veterans transition into healthy and productive post-service careers.

Today is the first hearing in a series that the Committee plans to hold to focus the Congress' attention on major issues confronting VA. Our goal is to find out what Congress can do to curtail or eliminate fraud, waste, abuse and mismanagement, so that taxpayer dollars are spent only for useful purposes. When it comes to caring for those who have protected our freedoms, we don't have one dollar to waste. As we examine the results of authorized programs on veterans' lives, we sometimes learn that we need to change the law. In other cases, the law is fine, but the execution is flawed. In those cases, we need to hold the appropriate executives accountable, and insist that the law be swiftly and faithfully executed.

I want to note for newer Members of the Committee that this Committee has a well-regarded history of carefully examining the successes and failures of veterans programs, and then crafting and implementing thoughtful proposals to make improvements. In areas such as improving third party health insurance reimbursement, joint procurement of pharmaceuticals by the VA and DOD health care systems, reform of veterans job training programs, and cracking down on fugitive felons receiving veterans' benefits, we have seen some very notable successes as the result of our oversight and legislative efforts.

Part of the oversight function of Congress is to recognize and encourage reforms that improve federal programs. These hearings will also be an opportunity to learn about many of the veterans programs that are working. VA today provides world-class health care, valuable compensation and readjustment benefits, and various other transition services to millions of former servicemen and women. There is much for VA to be proud of, but there is always room for improvement.

For instance, the General Accounting Office will testify that VA has a massive and aged infrastructure, which is not well aligned to efficiently meet veterans' needs. VA owns about 4,700 buildings, over 40 percent of which have operated for more than 50 years, and almost 200 of which were built before 1900. Few of these

old buildings serve their original purpose; some urgently need to be replaced, while others should be tom down or turned over to organizations that can re-use them.

This year, about 2.7 million veterans will receive disability compensation or pension payments from VA through the Veterans Benefits Administration. However, VA uses a disability determination process based on 1945 economic conditions. It doesn't accurately reflect current relationships between physical impairments and the skills and abilities needed to work in today's business environment. Some may see this issue as fraught with peril, but I'd like to know if future veterans deserve more or less than the current system allows.

The VA Inspector General will testify that a study it performed clearly showed that part-time physicians were not working the hours established in their VA appointments. As a result, part-time physicians were not meeting their employment obligations to VA, and millions of dollars are being wasted. More seriously, this abuse is a symptom of the Department's refusal to decide how many physicians are needed at each medical center it operates.

In 2001, the Congress considered and passed a measure designed to deny veterans benefits such as disability compensation to convicted felons and other persons who are fleeing prosecution for a felony offense. This extended an existing law which denied such benefits to most incarcerated veterans. The Inspector General will testify that between 1 and 2 percent of all fugitive felony warrants submitted to VA through agreements with Federal and local law enforcement authorities will involve VA beneficiaries. Savings related to the identification of improper and erroneous payments are projected to exceed $209 million annually.

We have invited the General Accounting Office and the Inspector General of the Department of Veterans Affairs to tell us what they have learned from examining VA programs. A good bit of their testimony will focus on how programs can serve more veterans, or how resources could be better distributed. At future hearings, we'll ask VA officials and others the same questions. As I said, I am particularly interested in what additional steps we can take to insure that waste and fraud are minimized, because the resources we provide are not always sufficient to meet veterans demands. Every dollar we save is one more dollar for a deserving veteran.

I now recognize my good friend from Illinois, the Committee Ranking Democratic Member, Lane Evans for his statement.

Prepared statement of Congressman Lane Evans

May 8, 2003

Thank you, Mr. Chairman. Through today's—first of a series—hearing on fraud, waste and abuse at the Department of Veterans Affairs, we seek a better understanding of the internal management of that large, geographically dispersed organization. When our series of full committee hearings on this topic is complete, we shall have a clearer picture of VA's performance and a better understanding of how to make that organization more efficient. When any organization harbors fraud, casts a blind eye to waste, and permits abuse of the system to any degree, the efficiency of that organization suffers. Management must eliminate these problems.

Mr. Chairman, we seek facts, not conjecture, not opinion. I strongly applaud your decision to explore this issue. The facts we elucidate will color our analysis and help us chart a course for VA's future. At the end of this series of hearings, we will understand what actions VA has taken or failed to take, and what actions, legislative and otherwise, are available for this committee and this Congress.

One only needs to review a listing of our Committee's and its Subcommittees nonlegislative hearings to ascertain many topics of interest. Some topics have oft recurring themes, such as waiting times for healthcare and the backlog of benefits. Issues including information technology management and DOD/VA sharing initiatives are also recent hearing topics.

Our witnesses, in their testimony, identify numerous areas for committee review. Some of their testimony indicates that previous valid recommendations by the Inspector General (IG) or the General Accounting Office are not always followed or adopted. For example, the IG observes that many access and accountability problems with VA control of biological, chemical, and radiological agents remain as of March 2003. This follows a full IG investigation, an Oversight and Investigations Subcommittee investigation, and two, "real world" "wake-up" calls.

The course for VA procurements and acquisition policy remains uncharted. Rule changes promulgated by VA seem not to be fully in concert with the recommendations of the Acquisition Task Force Report (May 2002), both the IG and the GAO have made general observations on procurement effectiveness. IG testimony singles

out anomalies with affiliate contracts—the rule change mentioned would mask many actions now critiqued by the IG. I seek a review of the full impact of this VA rule change through the Congressional Review Act.

Sometimes, VA seems to miss ready opportunities to enhance management effectiveness. For example, VA supports indirect costs for National Institutes of Health (NIH)-funded research conducted at VA facilities at an estimated cost of about $250,000 per day. NIH pays indirect costs for research with other institutions, including foreign institutions. Why are veterans who are seeking access to VA healthcare shouldering this burden?

Other easy opportunities for savings involve patents and intellectual property rights for VA discoveries. Imagine, Mr. Chairman, if VA had a 50 percent interest in every discovery springing from research at VA facilities with at least part-time VA researchers. The portfolio of discoveries is expansive! VA could be self-sufficient—it could even generate funds for the rest of the Federal government.

Sometimes VA is forbidden helpful management tools. Changes to permit Medicare claims by VA could create dramatic collection opportunities for the Medical Care Cost Fund. Another helpful management tool involves increased funding for the VA OIG. The VA OIG historically yields a 20 to one return on investment. This is very well documented. Two years ago, a $16.2 million request to increase IG staffing was rebuffed by our colleagues. At 20 to one, that would have yielded over $324 million in savings in one year. Fortunately, last year, the IG did receive additional funding, but an earlier opportunity was lost.

Mr. Chairman, clearly 100 percent efficiency is—like the challenge for Zeno's Arrow—unattainable. We must rely on our judgment and on the judgment of our expert witnesses to seek and define reasonable efficiency. Clearly that definition can not include fraud, waste and abuse.

Thank you, Mr. Chairman, I look forward to hearing from our witnesses this morning.

PREPARED STATEMENT OF CONGRESSMAN HENRY BROWN

May 8, 2003

Mr. Chairman, thank you for holding the hearing today on this very important issue to the VA, our veterans and all taxpaying Americans.

Eliminating fraud, waste, abuse and mismanagement are issues that are near and dear to my heart. As you know, we struggled in the Budget Committee to provide significant increases in the VA budget for fiscal year 2004. In future budgets, it may be ever more challenging to do so unless we can root out sources of fraud, waste and abuse in the VA system. In fact, this is an assumption that future budget projections rely upon. We need to truly focus our efforts on making a difference here—we owe this to the more than 84,000 veterans in my district and all veterans of this great nation.

With many uncertainties yet to be resolved in the global war on terrorism and operations in Iraq, a new generation of veterans continues to make us proud at home and abroad.I look forward to working with you, Mr. Chairman, along with Ranking Member Evans and the Administration, to ensure that we maintain our vigilance in this area.

Thank you.

PREPARED STATEMENT OF CONGRESSWOMAN DARLENE HOOLEY

May 8, 2003

Thank you Mr. Chairman,

I am pleased to be here today to address the need to identify and eliminate fraud, waste and abuse in the Department of Veterans Affairs.

Addressing these issues will assist the VA in providing better health care and better benefits for our nation's veterans instead of diverting critical funds that could be used to support the health care needs of our nation's veterans.

One issue that I am particularly concerned with today is funding for the Office of the Inspector General.

When front line managers fail to perform their accountability duties for the VA, the VA Office of the Inspector General is essentially the next accountability mechanism for the agency.

The testimony of the IG detailing efforts to curb fraud, waste and abuse lists their involvement in many situations that could have been avoided had managers and senior managers focused more on accountability.

The IG is a effective management tool that returns an estimated $20.00 to the agency for each dollar spent.

It is obviously a good investment.

Yet, on July 26, 2001, the former ranking member of the Oversight Subcommittee, Ms Carson of Indiana, introduced a floor amendment to increase funding for the OIG, noting that the VA Inspector General was staffed at one of the lowest levels among all 29 statutory Inspectors General.

Unfortunately, the real dollar value of the IG was lost on some members of the Appropriations Committee from the other side of the aisle—she was rebuffed.

Rising in opposition, a Member stated, "To hand over these funds to the Inspector General's Office, to me, just does not make sense.'

The VA DIG did not receive additional funding for staff that year.

One year later, aided by better understanding of the need for accountability and oversight in VA, and with support from both sides of the aisle on this Committee appropriators understood the value of the IG and appropriated additional needed funds.

PREPARED STATEMENT OF CONGRESSMAN TOM UDALL

May 8, 2003

Mr. Chairman,

The indirect costs associated with National Institutes of Health-funded research at VA facilities are costs now borne by the VA Healthcare system. NIH pays an "add-on" to its grants to cover indirect costs for research at other venues. Current law requires NIH to pay VA for some types of research under the same terms and conditions as apply to other non-federal institutions. The current law also stipulates that grants to federal institutions may be funded at 100 percent of the cost.

Prior to 1989, VA received a 15 percent add-on for research costs until that add-on was stopped by an agreement between VA and HHS. NIH now pays indirect costs to other organizations, including foreign institutions. Examples exist of NIH paying some institutions an add-on over 100 percent of the basic grant.

The Oversight and Investigation Subcommittee held two hearings last year to partly address the issue of indirect costs. The committee heard testimony from the Director of the NIH Extramural Grant Program in May, 2002 that she was willing to sit down with VA to determine an appropriate rate. At a September 2002 follow-up hearing, the Committee listened to testimony from VA's Undersecretary for Health and from an expert in indirect cost rates. The foffi1er indicated serious interest in receiving indirect costs, the latter deteffi1ined that a fair rate for indirect costs was 23.5 percent.

Meetings between NIH and VA did not produce results, even when hosted by the Office of Management and Budget. I wrote Secretary Thompson urging his personal involvement in resolving the problem, the response from HHS did not set a time table for action. Ranking Member Evans wrote Secretary Principi urging involvement. On May 2, 2003 the VA Secretary wrote a powerful letter to Secretary Thompson urging resolution. Some estimates place the value of indirect costs at nearly $100 million per year—all monies now supported by veterans health care. Today, we still have no results.

These indirect costs drain about $1 million from VA healthcare every 4 days.

Thank you Mr. Chairman.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 2, 2003

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

I am writing in response to your recent letter regarding the status of National Institutes of Health's (NIH) reimbursement to the Department of Veterans Affairs (VA) of facility indirect costs associated with conducting NIH-sponsored research at VA facilities.

In FY 2002, VA researchers received almost $400 million in NIH grants, a sum greater than VA's own Medical and Prosthetic Research budget. However, VA does not receive NIH reimbursement for indirect costs incurred in supporting that research. VA's inability to support all the indirect costs associated with the NIH-sponsored research threatens to limit artificially the amount of NIH research conducted at VA sites.

VA estimates that its incremental indirect costs for NIH-supported research equal 24 percent of the direct grant amounts, a rate that is lower than those negotiated with most universities and non-profit organizations. Those lower costs reflect the significant contribution that VA makes toward supporting NIH research conducted in its facilities.

The Department has strongly pursued this matter with NIH for more than two years. Although NIH officials have met with us about setting a level of compensation to VA for indirect research costs, we have not yet reached agreement on this issue. We are continuing to work within the Administration to resolve this matter. I have recently written the Secretary of Health and Human Services, Tommy Thompson, about the importance of VA being reimbursed for the indirect costs of conducting NIH-sponsored research, and I am awaiting his response.

I greatly appreciate your support and interest on NIH indirect costs, and I will keep you informed on the progress of my discussions with Secretary Thompson.

Sincerely yours,

Anthony J. Principi

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March 12, 2003

Honorable Anthony Principi
Secretary
Department of Veterans Affairs
Washington, DC 20420

Dear Secretary Principi:

Last year, during two different hearings, the Subcommittee on Oversight and Investigations heard testimony regarding the requirement for the National Institutes of Health (NIH) to reimburse the Department of Veterans Affairs (VA) for reasonable costs associated with NIH-funded research conducted at VA facilities. A 1989 agreement between VA and NIH discontinued the previous practice of NIH reimbursing VA for indirect costs. The discontinuation of NIH reimbursement to VA for indirect costs does not comply with the law requiring NIH to treat VA the same as it treats non-federal agencies with respect to some research grants. NIH clearly pays indirect costs associated with research to non-Federal institutions – including foreign institutions – but does not pay indirect costs to VA.

For the last 14 years, the VA healthcare system has borne the full burden of indirect costs for NIH funded research. As a result, funds appropriated for veterans' medical care have been diverted to pay indirect costs for NIH funded research. Most estimates place the indirect cost rate at 15-24 percent of NIH research grant awards. VA-wide, this could result in an additional $45-70 million annually available to provide VA healthcare if NIH accepts its responsibility regarding indirect costs. It is the right thing to do.

However, NIH appears reluctant to discuss the issue. Congressman Tom Udall wrote to HHS Secretary Thompson on November 19, 2002, asking him to become personally involved to break the gridlock on this issue. In his response to Mr. Udall (copy enclosed), Secretary Thompson discussed the need to examine the highly complex legal and administrative issues involved when one Federal agency

Honorable Anthony Principi
March 12, 2003
Page 2

requests indirect costs of another Federal agency. Yet, this type of reimbursement is the law today and it was the status quo in NIH-VA research prior to 1989. Little has changed since then.

Mr. Secretary, I believe VA has a duty to our veterans and should actively pursue reimbursement for these indirect research costs. Please advise me no later than April 15th, 2003, on the actions VA will take to re-secure reimbursement of indirect costs and the success of those actions. Mr. Len Sistek is the staff point of contact for this issue and may be reached at, 202-225-9756.

Sincerely,

LANE EVANS
Ranking Democratic Member

cc: Congressman Tom Udall

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 3 0 2003

The Honorable Tom Udall
House of Representatives
Washington, D.C. 20515

Dear Mr. Udall:

Thank you for your letter regarding the National Institutes of Health's (NIH) reimbursement of research conducted at Veterans Affairs (VA) facilities. I can assure you that this Department and the VA have been working to come to a resolution of the VA's request for reimbursement of indirect costs related to research supported by NIH.

The question of one Federal agency requesting indirect costs of another Federal agency requires us to examine a variety of highly complex legal and administrative issues. These issues are now being researched. An example of one of these complex issues involves determining the incremental indirect costs to the VA that are specifically due to the performance of NIH-supported research.

Dr. Elias A. Zerhouni, Director of the NIH, has asked his staff to keep him informed of the discussions between the NIH Office of Extramural Research and the VA, and you have my assurance that the Department will come to a conclusion as rapidly as possible. Please call me if you have any further thoughts or questions.

Sincerely,

Tommy G. Thompson

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C.M. DURISHIN
DEMOCRATIC STAFF DIRECTOR

November 19, 2002

Honorable Tommy Thompson, Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary:

The National Institutes of Health (NIH) does not reimburse the Department of Veterans Affairs (VA) for all reasonable costs associated with NIH funded research at VA facilities. Since 1989, it has been NIH policy not to reimburse VA for the indirect costs associated with its research conducted at VA facilities. The law requires NIH to treat VA the same as it treats non-federal agencies for some types of research grants. VA covers these indirect research costs using its own health care appropriations, often to the detriment of veterans seeking healthcare. Yet, NIH clearly pays indirect costs to non-Federal organizations – including foreign institutions.

Members of the House Committee on Veterans Affairs heard testimony on this issue in May and in September of this year. The two hearings covered fairness issues, legal issues, and the negative impact on veterans seeking healthcare. Witnesses included the Director of the NIH Extramural Grants Program, the Under Secretary of Health for VA, and other expert witnesses. Principals of VA and NIH who have met agree for the need of a reimbursement for indirect costs. Nonetheless, the final approval for the needed action is mired in a slow-moving decision process at NIH. I would appreciate your personal involvement to help break this gridlock.

Sincerely,

TOM UDALL
Member, Subcommittee on Oversight
and Investigations

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON
May 2, 2003

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

Historically, the National Institutes of Health (NIH) provided a 15 percent indirect cost recovery rate to VA facilities conducting research supported by NIH. Since 1989, NIH policy has prohibited reimbursement of these costs to VA facilities. VA believes that there is clear legal authority to reinstate the payment of some indirect costs to VA facilities conducting NIH research, and has urged NIH to reverse this policy. To date, we have been unsuccessful in achieving this goal.

The strength of VA's medical research program can be assessed not only by its discoveries and Nobel Prize winners but also by the successes of its investigators in winning research grants from NIH. In FY 2002, VA researchers received almost $400 million in NIH grants, a sum greater than VA's own Medical and Prosthetic Research appropriation.

However, failure of NIH to provide an add-on to defray the facility costs of supporting NIH-funded research has strained VA resources and infrastructure. VA recently commissioned an auditor with extensive prior NIH experience to estimate the facility costs of NIH grants conducted at 85 of our facilities. The national average of those facility costs for NIH grants was 24 percent, a rate far lower than the average university facility rate of 45 percent. The lower cost reflects the significant contribution that VA will continue to make toward supporting NIH-funded research conducted in VA facilities.

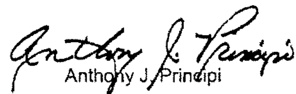
Discussion about re-instituting an add-on rate has been pursued vigorously in the last six months by the House Veteran's Affairs Subcommittee on Oversight and Investigations, as well as the Office of Management and Budget. However, prior discussions between my Office of Research and Development and the NIH have been unsuccessful in moving that forward.

Page 2

The Honorable Tommy G. Thompson

VA research is facing the challenge of a deteriorating infrastructure in need of maintenance coupled with spiraling compliance costs, all at a time when demand on the system likely will be the highest in years. I am increasingly reluctant to cover the NIH indirect costs with medical facility funding that is so desperately needed to provide patient care. VA and NIH have a long history as medical research partners, and the level has never been higher than the present. This issue is a high priority for the Department, and I would like to meet with you as soon as possible to dissolve any remaining barriers to a fair and just add-on rate of 24 percent for NIH research conducted at VA medical centers.

Sincerely yours,



Anthony J. Principi

PREPARED STATEMENT OF CONGRESSWOMAN SHELLEY BERKLEY

May 8, 2003

Thank you, Mr. Chairman, for holding this hearing today. Eliminating waste, fraud and abuse at the Department of Veterans Affairs is important, but it is essential that in doing so the VA does not jeopardize the health and safety of our veterans.

South Nevada has one of the fastest growing veterans population in the country. The VA has projected that the number of enrolled veterans in Las Vegas will increase by 18 percent from 2001–2022. This growth is occurring in only one other area in the country, and went unrecognized by the VA planners for far too long.

The veterans health community is struggling to meet the needs of the population growth, and this is compounded by the evacuation of the Addeliar D. Guy III Ambulatory Care Clinic that is currently underway. This clinic, which was built in 1997, was closed because it is structurally unsound. For the next three years, veterans in my district—many in their 70s and 80s—will suffer the inconvenience of shuttling between ten different locations, in the Nevada desert summer heat, to have their health care needs met.

The VA has committed to building a new ambulatory care clinic in Las Vegas by 2006. As the VA determines whether the construction will be completed by the VA or contracted out as a lease-back option, the VA must provide not only fiscal oversight, but on-site supervision of every step in the construction process. Only close supervision by the VA will prevent the wasteful situation that occurred in Las Vegas—closing a five year old building and spending millions of dollars to rent temporary health care service locations.

In addition, I am concerned that the VA is using both the CARES and the Planning Initiatives data from the 1990 census to evaluate the elimination of waste and allocation of future resources. This does not adequately reflect the growth in areas such as Las Vegas. I would ask the VA to ensure that the planning for the new ambulatory care clinic, the future inpatient needs served at Michael O'Callaghan Federal Hospital and the long term care needs of veterans in my district and all VISN s are based on 2000 census data and report back to this committee.

Finally, based on the increase in enrolled veterans in Las Vegas, the CARES planning initiative proposed that the VA add 70 inpatient beds to Michael O'Callaghan Federal Hospital, a VA/DOD joint venture site in Las Vegas. I am concerned that the space available at the hospital for this expansion is not enough to accommodate both. future Air Force and VA needs. I would like to ask the VA to determine the future inpatient needs of the Air Force at the Michael O'Callaghan Federal Hospital and report to this committee the number of beds needed by the Air Force through 2022, and how the facility will accommodate both VA and Air Force needs.

Thank you, Mr. Chairman.

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

MAY 8, 2003

INTRODUCTION

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

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

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

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

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

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

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

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

HEALTH CARE DELIVERY

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

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

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

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

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

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

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

The following describes results of our review of these issues.

<u>Audit of Physician Time and Attendance Issues</u>

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

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

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

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

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

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

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

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

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

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

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

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

VHA officials told us the determination of the number of part-time physician FTEEs needed has more to do with the financial needs of the affiliate university in meeting physician pay packages, than the number of hours needed by VA to meet patient workload requirements. In addition, only one of the managers at the five VA medical centers we visited during our audit, had informed their part-time physicians of what was expected of them to meet their VA employment responsibilities. We believe communication of expectations and responsibilities would significantly improve operations at the VA medical centers.

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

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

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

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

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

- Evaluate appropriate technological solutions to facilitate physician timekeeping.

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

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

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

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

Review of Physician Utilization at VAMC Lexington, KY

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

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

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

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

Follow-Up Review at VA Medical Center Lexington, KY

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

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

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

Technological Solutions

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

Healthcare Resources Contracts

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

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

Staffing Standards

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

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

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

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

Review of Biological, Chemical, and Radiological Inventories

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

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

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

VHA's Contract Community Nursing Home Program

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

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

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

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

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

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

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

Healthcare Investigations

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

Jamaica Plains Armed Robbery

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

Nashville Pharmacy

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

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

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

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

BENEFITS PROCESSING

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

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

Incarcerated Veterans

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

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

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

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

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

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

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

Fugitive Felon Program

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

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

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

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

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

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

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

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

Death Match Project

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

Philippines Benefit Review

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

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

Atlanta VA Regional Office

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

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

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

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

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

Houston VA Regional Office

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

Nashville VA Regional Office

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

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

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

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

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

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

New York VA Regional Office

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

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

St. Petersburg VA Regional Office

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

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

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

Department-Wide Review of One-Time Benefits Claims Initiated

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

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

Income Verification Match

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

- Significantly increase the efficiency, effectiveness, and amount of potential overpayments that are recovered.
- Better ensure program integrity and identification of program fraud.
- Improve delivery of services to beneficiaries.

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

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

Worker' Compensation Benefits

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

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

FINANCIAL MANAGEMENT SYSTEMS

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

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

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

Debt Management Issues

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

Medical Care Collection Fund

During FY 2002, we conducted an audit of VA's Medical Care Collection Fund (MCCF) activities that resulted in identifying opportunities to maximize the recovery of funds due VA for the provision of health care services. We reported there were potential opportunities for VA to enhance its collection efforts. Recovered funds are used to supplement the Department medical care budget and from FYs 1997 through 2001 MCCF collections have total $3 billion.

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

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

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

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

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

PROCUREMENT PRACTICES

The Department spends about $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction and services. VA faces major challenges to implement a more efficient, effective, and coordinated acquisition program. High-level management support and oversight are needed to ensure VA leverages its full buying power and maximizes the benefits of competitive procurements to achieve most favored customer prices or better. In addition, VA needs to improve buying practices.

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

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

- During the 6-month review period, 7 of 10 medical centers that purchased standard, powder-free surgical gloves used open market vendors instead of available FSS vendors. If the medical centers had purchased the gloves

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

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

from FSS sources, they could have saved as much as $34,000, or about 28 percent of their expenditures for surgical gloves.

- Unaware that FSS contracts were available, one medical center established a local contract for Continuous Pressure Airway units used in the treatment of sleep disorders. The local contract cost per unit was $900. However, the medical center could have purchased the identical unit from an FSS contract for $322, or 64 percent less than the local contract price. By using the local contract, the medical center incurred unnecessary costs of about $19,600 for the 34 units purchased during the review period.

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

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

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

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

FSS Pricing Reviews

Our contract review and evaluation work has returned $70.2 million to VA's supply fund over the past three FYs. We completed 84 post-award reviews of FSS contractors. Of the 84 reviews, 49 involved contractors voluntarily disclosing that they had reviewed their contracts and either owed the Government a refund for overcharges or that the contractors felt no refund was due VA. Voluntary

disclosures made by VA contractors offered refunds that amounted to $16.6 million. However, our reviews of these voluntary disclosures resulted in recoveries of $50.5 million. Some examples of refund offers compared to recoveries follow.

- One FSS company's voluntary disclosure showed no refund due; after our review the Government recovered $15 million, of which $14.6 was refunded to the Department's Supply Fund.
- While the voluntary disclosure included in another refund offer was $93,000, we recovered $3.8 million after performing a detailed analysis of sales record.
- Another voluntary disclosure included a refund offer of $1.5 million; however, after our review VA recovered $10.5 million.

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

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

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

Some of the Department's more significant challenges relating to aspects of procurement practices are contracting for health care resources and construction, and managing the national purchase card and inventory management programs. We are working with VA to improve procurement practices and we continue to perform contract audit and drug pricing reviews to detect defective and excessive

pricing, and to provide improved assurance over the justification, prioritization, accountability, and delivery of pharmaceuticals and other goods in VA's operations.

Contracting for Health Care Resources

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

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

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

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

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

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

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

Contracting for Construction

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

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

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

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

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

Purchase Card Activities

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

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

Inventory Management

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

• Medical Supply Inventories	$75.6 million
• Prosthetic Supply Inventories	$31.4 million
• Pharmaceutical Inventories	$30.6 million
• Engineering Supply Inventories	$168.4 million
• Miscellaneous Supply Inventories	$53.7 million
• Consolidated Mail Outpatient Pharmacy Inventories	$28.8 million
Total	**$388.5 million**

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

INFORMATION MANAGEMENT

Information Security

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

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

VA is also making progress in staffing Information Security Officer positions to provide the opportunity to strengthen oversight and implementation of necessary information security control measures at the facility level. However, VA has not effectively implemented a number of information security remediation efforts and has not ensured compliance with established policies, procedures, and guidelines. As a result, significant information security vulnerabilities continue to place the Department at risk of:

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

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

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

Information System Development

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

Our audit found that the estimated project completion date had slipped from FY 1999 to FY 2003 and revised budget and schedule estimates projected completion

in FY 2006 with an estimated cost of $469 million, while original project system development costs were estimated at about $37 million.

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

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

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

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

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

degree of adherence to the DSS structural model that is required of medical center systems.

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

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

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

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

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

Here are some changes I believe would be beneficial:

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

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

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

OTHER LEGISLATIVE REFORM OPPORTUNITIES

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

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

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

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DEPARTMENT OF VETERANS AFFAIRS

Key Management Challenges in Health and Disability Programs

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-03-756T

Highlights

Highlights of GAO-03-756T, a testimony before the Committee on Veterans' Affairs, House of Representatives

May 8, 2003

DEPARTMENT OF VETERANS AFFAIRS

Key Management Challenges in Health and Disability Programs

Why GAO Did This Study

In previous GAO reports and testimonies on the Department of Veterans Affairs (VA), and in its ongoing reviews, GAO identified major management challenges related to enhancing access to health care, improving the efficiency of health care delivery, and improving the effectiveness of disability programs. This testimony underscores the importance of continuing to make progress in addressing these challenges and ultimately overcoming them.

What Remains to Be Done

VA remains challenged to:

- ensure timely, convenient, and equitable access to health care, including hospital, specialty outpatient, and nursing home care;
- realign its health care delivery infrastructure and implement other management initiatives to increase the efficiency of the delivery of patient support services; and
- seek solutions to modernize its disability programs as well as improve the timeliness and quality of disability claims decisions.

www.gao.gov/cgi-bin/getrpt?GAO-03-756T.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

What GAO Found

VA has taken actions to address key challenges in its health care and disability programs. However, growing demand for health care and a potentially larger and more complex disability workload may make VA's challenges in these areas more complex.

- **Enhancing access to health care.** VA is challenged to deliver timely, convenient health care to its enrolled veteran population. Too many veterans continue to travel too far and wait too long for care. However, shifting care closer to where veterans live is complicated by stakeholder interests. In addition, VA's efforts to reduce waiting times may be complicated by an anticipated short-term surge in demand for specialty outpatient care. VA also faces difficult challenges in providing equitable access to nursing home care services to a growing elderly veteran population.

- **Improving the efficiency of health care delivery.** VA is challenged to find more efficient ways to meet veterans' demand for health care. VA operates a large portfolio of aged buildings that is not well aligned to efficiently meet veterans' needs. As a result, VA faces difficult realignment decisions involving capital investments, consolidations, closures, and contracting with local providers. VA also faces challenges in implementing management changes to improve the efficiency of patient support services, such as food and laundry services.

- **Improving the effectiveness of disability programs.** VA is challenged to find more effective ways to compensate veterans with disabilities. VA's outdated disability determination process does not reflect a current view of the relationship between impairments and work capacity. Advances in medicine and technology have allowed some individuals with disabilities to live more independently and work more effectively. VA also faces continuing challenges to improve the timeliness, quality and consistency of claims processing. Major improvements may require fundamental program changes.

GAO designated federal real property, including VA health care infrastructure, and federal disability programs, including VA disability benefits, as high-risk areas in January 2003. GAO did this to draw attention to the need for broad-based transformation in these areas, which is critical to improving the government's performance and ensuring accountability within expected resource limits.

Mr. Chairman and Members of the Committee:

Thank you for inviting me to discuss our past and current work on veterans' health care and disability benefits—two major program areas at the Department of Veterans Affairs (VA). As you know, VA's budget submission for fiscal year 2004 includes about $64 billion and 214,000 staff. In fiscal year 2002, VA spent about $23 billion to provide health care to over 4 million veterans and about $26 billion to provide cash disability benefits to over 3 million veterans, family members, and survivors.

It is especially fitting, with the recent deployment of our military forces to armed conflict, that we reaffirm our commitment to provide high quality services in a convenient and timely manner to those who serve our nation in its times of need. Meeting this commitment as efficiently and effectively as possible is also of paramount importance. In this regard, my statement focuses on challenges that VA faces to ensure reasonable access to health care, use its health care resources efficiently, and manage its disability programs effectively.

My comments today are based on numerous reports and testimonies issued over the last 7 years, including significant recommendations we have made and VA's progress in implementing them. (See Related GAO Products.) We did our work in over 100 VA health care delivery locations and conducted surveys of all 21 health care networks and reviews of disability management issues covering all 57 disability claims processing regional offices. We are also reporting preliminary results of ongoing health care work that started in November 2002. This involves visits to delivery locations, document reviews, and interviews with VA officials in headquarters and the networks. We did our work in accordance with generally accepted government auditing standards.

In summary, VA is challenged to meet the acute and nursing home care needs of veterans in a timely, convenient, and equitable manner. Despite VA's significant access enhancements over the past several years, too many veterans continue to travel too far and wait too long for appointments, especially when they require hospital admissions or consultations with specialists on an outpatient basis. When trying to reduce travel times, VA faces difficult decisions because shifting care closer to where veterans live can have significant ramifications for stakeholders, such as medical schools, as well as for the use of VA's existing resources. In addition, VA's efforts to reduce waiting times may be complicated by an anticipated surge in demand for VA specialty outpatient care over the next 10 years. Also, the population most in need of nursing

home care—veterans who are 85 years old or older—is growing. As a result, VA faces difficult decisions concerning the delivery and sizing of nursing home care services to equitably meet these needs.

VA is also challenged to find ways to use available health care resources more efficiently to meet veterans' demand for health care. For example, VA operates and maintains a large portfolio of aged health care assets, primarily buildings. This infrastructure is no longer effectively aligned with VA's new delivery model that emphasizes outpatient care. As a result, VA faces difficult realignment decisions involving capital investments, consolidations, closures, and contracting with local providers. These may have significant ramifications for stakeholders, such as medical schools and unions, primarily because realignments involve a shifting of workload among delivery locations or workforce reductions. VA also faces challenges in implementing management changes to improve the efficiency of patient support services, such as food and laundry services.

In addition, VA is challenged to find ways to compensate disabled veterans in a more meaningful and timely manner. For example, VA uses a disability determination process that is based on economic conditions in 1945 and, as such, does not accurately reflect current relationships between impairments and the skills and abilities needed to work in today's business environment. Moreover, the consequences of some medical conditions for many individuals have been reduced through advances in medicine and technology, which allow individuals to live with greater independence and function more effectively in work settings. Besides modernizing the economic and medical underpinnings of the program, VA remains in the midst of significant challenges to improve the quality, timeliness, and consistency of disability claims processing. Despite its recent efforts, too many disabled veterans wait too long for disability decisions. Significant and sustainable improvements may not be possible without fundamental program design changes, including those that require legislative actions to implement. VA and the Congress could face significant stakeholder resistance to such changes.

I would also like to point out that we designated federal real property and federal disability programs as high-risk areas in January 2003.[1] We did this

[1]U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-03-119 (Washington, D.C.: Jan. 1, 2003); U.S. General Accounting Office, *High-Risk Series: Federal Real Property*, GAO-03-122 (Washington, D.C.: Jan. 1 2003).

to draw attention to the need for broad-based transformation in these areas, which is critical to improving the government's performance and ensuring accountability within expected resource limits. If this transformation is well implemented, agencies will be better positioned to achieve mission effectiveness, reduce operating costs, improve facility conditions, and enhance security and safety.

Background

During World War I, Public Health Service hospitals treated returning veterans and, at the end of the war, several military hospitals were transferred to the Public Health Service to enable it to continue treating injured soldiers. In 1921, those hospitals were transferred to the newly established Veterans' Bureau. By the early 1990s, the veterans' health care system had grown into one of our nation's largest direct providers of health care, comprising more than 172 hospitals.

In October 1995, VA began to transform its health care system from a hospital-dominated model to one that provides a full range of health care services. A key feature of this transformation involves the development of community-based, integrated networks of VA and non-VA providers that could deliver health care closer to where veterans live. At that time, about half of all veterans lived more than 25 miles from a VA hospital; about 44 percent of those admitted to VA hospitals lived more than 25 miles away.[2] In making care more proximate to veterans' homes, VA also began shifting the delivery of health care from high-cost hospital settings to lower-cost outpatient settings.

To facilitate VA's transformation, the Congress passed the Veterans' Health Care Eligibility Reform Act of 1996, which furnishes tools that VA said were key to a successful transformation, including:

- new eligibility rules that allow VA to treat veterans in the most appropriate setting;
- a uniform benefits package to provide a continuum of services; and
- an expanded ability to purchase services from private providers.

[2]U.S. General Accounting Office, *VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services* GAO/HEHS-96-31 (Washington, D.C.: Dec. 20, 1995).

Today, VA operates over 800 delivery locations nationwide, including over 600 community-based outpatient clinics and 162 hospitals. VA's delivery locations are organized into 21 geographic areas, commonly referred to as networks. Each network includes a management office responsible for making basic budgetary, planning, and operating decisions concerning the delivery of health care to its veterans. Each office oversees between 5 and 11 hospitals, as well as many community-based outpatient clinics.

To promote more cost-effective use of resources, VA is authorized to share resources with other federal agencies to avoid unnecessary duplication and overlap of activities. VA and the Department of Defense (DOD) have entered into agreements to exchange inpatient, outpatient, and specialty care services as well as support services. Local facilities also have arranged to jointly purchase pharmaceuticals, laboratory services, medical supplies, and equipment.

Also, VA has been authorized to enter into agreements with medical schools and their teaching hospitals. Under these agreements, VA hospitals provide training for medical residents, and appoint medical school faculty as VA staff physicians to supervise resident education and patient care. Currently, about 120 medical schools and teaching hospitals have affiliation agreements with VA. About 28,000 medical residents receive some of their training in VA facilities every year.

Veterans' eligibility for health care also has evolved over time. Before 1924, VA health care was available only to veterans who had wounds or diseases incurred during military service. Eligibility for hospital care was gradually extended to war-time veterans with lower incomes and, in 1973, to peace time veterans with lower incomes. By 1986, all veterans were eligible for hospital and outpatient care for service-connected conditions as well as for conditions unrelated to military service.[3]

VA implemented an enrollment process in 1998 that was established primarily as a means of prioritizing care if sufficient resources were not available to serve all veterans seeking care. About 6.2 million veterans had enrolled by the end of fiscal year 2002. In contrast, the overall veteran population is estimated to be about 25 million. VA projects a decline in the

[3]U.S. General Accounting Office, *VA Health Care: Issues Affecting Eligibility Reform Efforts*, GAO/HEHS-96-160 (Washington, D.C.: Sept. 11, 1996).

total veteran population over the next 20 years while the enrolled population is expected to decline more slowly as shown in table 1.

Table 1: Veteran Population and Enrollment Projections between Fiscal Years 2007 and 2022 (in millions)

	2007	2012	2017	2022
Veteran population	22.8	20.6	18.6	16.9
Enrollment	6.3	6.3	6.1	5.7

Source: VA

In addition to health care, VA provides disability benefits to those veterans with service-connected conditions. Also, VA provides pension benefits to low-income wartime veterans with permanent and total disabilities unrelated to military service. Further, VA provides compensation to survivors of service members who died while on active duty.

Disabled veterans are entitled to cash benefits whether or not employed and regardless of the amount of income earned. The cash benefit level is based on the percentage evaluation, commonly called the "disability rating," that represents the average loss in earning capacity associated with the severity of physical and mental conditions. VA uses its Schedule for Rating Disabilities to determine which disability rating to assign to a veteran's particular condition. VA's ratings are in 10 percent increments, from 0 to 100 percent.

Although VA generally does not pay disability compensation for disabilities rated at 0 percent, such a rating would make veterans eligible for other benefits, including health care. About 65 percent of veterans receiving disability compensation have disabilities rated at 30 percent or lower; about 8 percent are 100 percent disabled. Basic monthly payments range from $104 for a 10 percent disability to $2,193 for a 100 percent disability.

To process claims for these benefits, VA operates 57 regional offices. These offices made almost 800,000 rating-related decisions[4] in fiscal year 2002. Regional office personnel develop claims, obtain the necessary

[4]Rating-related claims are primarily original claims for compensation and pension benefits and "reopened" claims; for example, when a veteran claims that a service-connected claim has worsened.

information to evaluate claims, and determine whether to grant benefits. In doing so, they consider veterans' military service records, medical examination and treatment records from VA health care facilities, and treatment records from private providers. Once claims are developed, the claimed disabilities are evaluated, and ratings are assigned based on degree of disability. Veterans with multiple disabilities receive a single, composite rating. For veterans claiming pension eligibility, the regional office also determines if the veteran served in a period of war, is permanently and totally disabled for reasons unrelated to military service, and meets the income thresholds for eligibility.

Access to Health Care Could Be Enhanced

Over the past several years, VA has done much to ensure that veterans have greater access to health care. Despite this, travel times and waiting times are still problems. Another problem faced by aging veterans is potentially inequitable access to nursing home care.

Many Veterans Travel Too Far for Hospital Admissions and Specialty Consultations

The substantial increase in VA health care delivery locations has enhanced access for enrolled veterans in need of primary care, although many still travel long distances for primary care.[5] In addition, many who need to consult with specialists or require hospitalization often travel long distances to receive care. Nationwide, for example, more than 25 percent of veterans enrolled in VA health care—over 1.7 million—live over 60 minutes driving time from a VA hospital. These veterans would have to travel a long distance if they require admissions or consultations with specialists, such as urologists or cardiologists, located at the closest VA hospitals.

In October 2000, VA established the Capital Asset Realignment for Enhanced Services (CARES) program, which has a goal of improving veterans' access to acute inpatient care, primary care, and specialty care. CARES is intended to identify how well the geographic distribution of VA health care resources matches projected needs and the shifts necessary to better align resources and needs. Toward that end, VA has divided, for analytical purposes, its 21 networks into 76 geographic areas—groups of counties—in order to determine the extent to which enrollees' travel times exceed VA's access standards.

[5]U.S. General Accounting Office, *VA Health Care: Community-Based Clinics Improve Primary Care Access*, GAO-01-678T (Washington, D.C.: May 2, 2001).

For example, as part of CARES, VA has mandated that the 21 network directors identify ways to ensure that at least 65 percent of the veterans in their areas are within VA's access standards for hospital care—60 minutes for veterans residing in urban counties, 90 minutes for those in rural counties, and 120 minutes for those in highly rural counties. VA has identified 25 areas that do not meet this 65 percent target. In these areas, over 900,000 enrolled veterans have travel times that exceed VA's access standards. In addition, as part of CARES, VA identified 51 other areas where access enhancements may be addressed at the discretion of network directors, given that at least 65 percent of all enrolled veterans in those areas have travel times that meet VA's standard. In these areas, about 875,000 enrolled veterans have travel times that exceed VA's standards.

By contrast, VA has not mandated that network directors enhance access for veterans who travel long distances to consult with specialists. Unlike hospital care, VA has not established standards for acceptable travel times for specialty care. Currently, nearly 2 million enrolled veterans live more than 60 minutes driving time from specialists located at the closest VA hospital.

When considering ways to enhance access for veterans, VA network directors may consider three basic options: construct a new VA-owned and operated delivery location; negotiate a sharing agreement with another federal entity, such as a DOD facility; or contract with nonfederal health care providers. Shifting the delivery of health care closer to where veterans live may have significant ramifications for other stakeholders, such as medical schools. For example, within the 76 areas, there are smaller geographic areas that contain large concentrations of enrollees outside VA's access standards—10,000 or more—who live closer to non-VA hospitals than they do to the nearest VA hospitals. Such enrolled veterans could account for significant portions of the hospital workload at the nearest VA delivery locations. Therefore, a shifting of this workload closer to veterans' residences could reduce the size of residency training opportunities at existing VA delivery locations.

Enhancing veterans' access can also have significant ramifications regarding the use of VA's existing resources. Currently, VA has most of its resources dedicated to costs associated with its existing hospitals and other infrastructure, including clinical and support staff, at its major health care delivery locations. Reducing veterans' travel times through contracting with providers in local communities or other options could reduce demand for services at VA's existing, more distant delivery

locations. Efficient operation of those locations could become more difficult given the smaller workloads in relation to the operating costs of existing hospitals.

Many Veterans Wait Too Long for Appointments

We also have found that excessive waiting times for VA outpatient care persist—a situation that we have reported on for the last decade. For example, in August 2001, we reported that veterans frequently wait longer than 30 days—VA's access standard—for appointments with specialists at VA delivery locations in Florida and other areas of the country.[6] More recently, a Presidential task force reported in its July 2002 interim report that veterans are finding it increasingly difficult to gain access to VA care in selected geographic regions.[7] For example, the task force found that the average waiting time for a first outpatient appointment in Florida, which has a large and growing veteran population, is over a year.

Although there is general consensus that waiting times are excessive, we reported, and VA agreed, that its data did not reliably measure the scope of the problem.[8] To improve its data, VA is in the process of developing an automated system to more systematically measure waiting times. VA has also taken several actions to mitigate the impact of long waiting times, including limiting enrollment of lower priority veterans and granting priority for appointments to certain veterans with service-connected disabilities.[9]

VA faces an impending challenge, however, reducing the length of times veterans wait for appointments. Specifically, VA's current projections of acute health care workload indicate a surge in demand for acute health

[6]U.S. General Accounting Office, *VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress*, GAO-01-953 (Washington, D.C.: Aug. 31, 2001).

[7]*President's Task Force to Improve Health Care Delivery for Our Nation's Veterans: Interim Report*, (Washington, D.C.: July 31, 2002).

[8]U.S. General Accounting Office, *Veterans' Health Care: VA Needs Better Data on Extent and Causes of Waiting Times*, GAO/HEHS-00-90 (Washington, D.C.: May 31, 2000).

[9]The Veterans' Health Care Eligibility Reform Act of 1996 required VA to establish priority categories for enrollment to manage access in relation to available resources. VA has 8 priority categories, with Priority 1 veterans—those with service-connected disabilities rated 50 percent or more—having the highest priority for enrollment. By contrast, Priority 8 veterans are primarily veterans with no service-connected disabilities and higher incomes.

care services over the next 10 years. For example, specialty outpatient demand nationwide is expected to almost double by fiscal year 2012.

Veterans' Access to Nursing Home Care May Be Inequitable

VA's long-term care infrastructure, including nursing homes it operates, was developed when the concentration of veteran population was distributed differently by region. Consequently, the location of VA's current infrastructure may not provide equitable access across the country. In addition, when VA developed its long-term care infrastructure, it relied more on nursing home care and less on home and community-based services than current practice. To help update VA's long-term care policy, the Federal Advisory Committee on the Future of VA Long-Term Care recommended in 1998 that VA maintain its nursing home capacity at the level of that time but meet the growing veteran demand for long term care by greatly expanding home and community-based service capacity.[10] The House Committee on Veterans' Affairs has expressed concern that VA needs to maintain its nursing home capacity workload at 1998 levels.

VA currently operates its own nursing home care units in 131 locations, according to VA headquarters officials. In addition, it pays for nursing home care under contract in community nursing homes. VA also pays part of the cost of care for veterans at state veterans' nursing homes and in addition pays a portion of the construction costs for some state veterans' nursing homes. In all these settings combined, VA's nursing home workload—average daily census—has declined by more than 1,800 since 1998. See table 2. The biggest decline has been in community nursing home care where the average daily census was 31 percent less in 2002 than in 1998. Average daily census in VA-operated nursing homes also declined by 11 percent during this period. A 9 percent increase in state veterans' nursing homes' average daily census offsets some of the decline in average daily census in community and VA-operated nursing homes.

[10] *VA Long-Term Care At The Crossroads: Report of the Federal Advisory Committee on the Future of VA Long-Term Care*, (Washington, D.C.: June, 1998).

Table 2: Nursing Home Average Daily Census Provided or Paid for by VA in Fiscal Years 1998-2002

Type of nursing home	1998	1999	2000	2001	2002
VA nursing homes	13,426	12,653	11,828	11,674	11,974
Community nursing homes	5,575	4,547	3,682	4,010	3,831
State veterans' nursing homes	14,602	15,051	15,286	15,593	15,941
Total	**33,603**	**32,251**	**30,796**	**31,277**	**31,746**

Source: VA

Note: The average daily census represents the total number of days of nursing home care divided by the number of days in the year.

VA headquarters officials told us that the decline in nursing home average daily census could be the result of a number of factors. These factors include providing more emphasis on shorter-term care for post-acute care rehabilitation, providing more home and community-based services to obviate the need for nursing home care, assisting veterans to obtain placement in community nursing homes where care is financed by other payers, such as Medicaid, when appropriate, and difficulty recruiting enough nursing staff to operate all beds in some VA-operated nursing homes.

VA policy provides networks broad discretion in deciding what nursing home care to offer those patients that VA is not required to provide nursing home care to under the provisions of the Veterans Millennium Health Care and Benefits Act of 1999.[11] Networks' use of this discretion appears to result in inequitable access to nursing home care. For example, some networks have policies to provide long-term nursing home care to these veterans who need such care if resources allow, while other networks do not have such policies. As a result, these veterans who need long-term nursing home care may have access to that care in some networks but not others. This is significant because about two-thirds of VA's current nursing home users are recipients of discretionary nursing home care.

[11]This act requires that VA provide nursing home care to veterans with service-connected disabilities of 70 percent or more and those who need such care because of a service-connected disability. This provision of the act expires on December 31, 2003.

VA intended to address veterans' access to nursing home care as part of its larger CARES initiative to project future health care needs and determine how to ensure equitable access. However, initial projections of nursing home need exceeded VA's current nursing home capacity. VA said that the projections did not reflect its long-term care policy and decided not to include nursing home care in its CARES initiative. Instead, VA officials told us that they have developed a separate process to provide projections for nursing home, and home and community-based services needs. These officials expect that new projections will be developed for consideration by the Under Secretary for Health by July 2003. VA officials also told us that VA will use this information in its strategic planning initiatives to address nursing home and other long-term care issues at the same time that VA implements its CARES initiatives.

Because VA has not systematically examined its nursing home policies and access to care, veterans have no assurance that VA's $2 billion nursing home program is providing equitable access to care to those who need it. This is particularly important given the aging of the veteran population. The veteran population most in need of nursing home care—veterans 85 years old or older—is expected to increase from almost 640,000 to over 1 million by 2012 and remain at about that level through 2023. Until VA develops a long-term care projection model consistent with its policy, VA will not be able to determine if its nursing home care units in 131 locations and other nursing home care services it pays for provide equitable access to veterans now or in the future.

Efficiency Could Be Improved through Health Care Asset Realignment and Other Management Actions

In recent years, VA has made an effort to realign its capital assets, primarily buildings, to better serve veterans' needs as well as institute other needed efficiencies. Despite this, many of VA's buildings remain underutilized and patient support services are not always provided efficiently. VA could make better use of its resources by taking steps to partner with other public and private providers, purchase care from such providers, replace obsolete assets with modern ones, consolidate duplicative care provided by multiple locations serving the same geographic areas where it would be cost effective to do so, and assess various management options to improve the efficiency of patient support services.

Capital Assets Not Well-Aligned to Meet Veterans' Needs

VA has a large and aged infrastructure, which is not well aligned to efficiently meet veterans' needs. In recent years, as a result of new technology and treatment methods, VA has shifted delivery from inpatient to outpatient settings in many instances and shortened lengths of stay when hospitalization was required. Consequently, VA has excess inpatient capacity at many locations.

For example, in August 1999, we reported that VA owned about 4,700 buildings, over 40 percent of which had operated for more than 50 years, and almost 200 of which were built before 1900. Many organizations in the facilities management environment consider 40 to 50 years to be the useful life of a building.[12] Moreover, VA used fewer than 1,200 of these buildings (about one-fourth of the total) to deliver health care services to veterans. The rest were used primarily to support health care activities, although many had tenants or were vacant.[13] In addition, most delivery locations had mission-critical buildings that VA considered functionally obsolete. These included, for example, inpatient rooms not up to industry standards concerning patient privacy; outpatient clinics with undersized examination rooms; and buildings with safety concerns, such as vulnerability to earthquakes.

As part of VA's transformation, begun in 1995, its networks implemented hundreds of management initiatives that significantly enhanced their overall efficiency and effectiveness.[14] The success of these strategies—shifting inpatient care to more appropriate settings, establishing primary care in community clinics, and consolidating services in order to achieve economies of scale—significantly reduced utilization at most of VA's inpatient delivery locations. For example, VA operated about 73,000 hospital beds in fiscal year 1995. In 1998, veterans used on average fewer than 40,000 hospital beds per day, and by 2001 usage had further declined to about 16,000 hospital beds per day.

[12]Price Waterhouse, *Independent Review of the Department of Veterans Affairs' Office of Facilities Management* (Washington, D.C.: June 17, 1998).

[13]Health care support buildings include warehouses, engineering shops, laundries, fire stations, day care centers and boiler plants.

[14]U.S. General Accounting Office, *Veterans' Affairs: Progress and Challenges in Transforming Health Care*, GAO/T-HEHS-99-109 (Washington, D.C.: April 15, 1999).

In 1999, we concluded that VA's existing infrastructure could be the biggest obstacle confronting VA's ongoing transformation efforts.[15] During a hearing in 1999 before this Committee's Subcommittee on Health, we pointed out that, although VA was addressing some realignment issues, it did not have a plan in place to identify buildings that are no longer needed to meet veterans' health care needs. We recommended that VA develop a market-based plan for restructuring its delivery of health care in order to reduce funds spent on underutilized or inefficient buildings. In turn those funds could be reinvested to better serve veterans' needs by placing health care resources closer to where they live.

To do so, we recommended that VA comply with guidance from the Office of Management and Budget. The guidance suggested that market-based assessments include (1) assessing a target population's needs, (2) evaluating the capacity of existing assets, (3) identifying any performance gaps (excesses or deficiencies), (4) estimating assets' life cycle costs, and (5) comparing such costs to other alternatives for meeting the target population's needs. Alternatives include (1) partnering with other public or private providers, (2) purchasing care from such providers, (3) replacing obsolete assets with modern ones, or (4) consolidating services duplicated at multiple locations serving the same market.

During the 1999 hearing, the subcommittee chairman urged VA to implement our recommendations and VA agreed to do so. In August 2002, VA announced the results of a pilot study in its Great Lakes network, which includes Chicago and other locations. VA selected three realignment strategies in this network – consolidation of services at existing locations, opening of new outpatient clinics, and closure of one inpatient location. Currently, VA is analyzing ways to realign health care delivery in its 20 remaining networks. VA expects to issue its plans by the end of 2003. To date, VA has projected veterans' demand for acute health care services through fiscal year 2022, evaluated available capacity at its existing delivery locations, and targeted geographic areas where alternative delivery strategies could allow VA to operate more efficiently and effectively while ensuring access consistent with its standards for travel time.

[15]U.S. General Accounting Office, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83 (Washington, D.C: Mar. 10, 1999).

For example, VA has the opportunity to achieve efficiencies through economies of scale in 30 geographic areas where two or more major health care delivery locations that are in close proximity provide duplicative inpatient and outpatient health care services. VA may also achieve similar efficiencies in 38 geographic areas where two or more tertiary care delivery locations are in close proximity. VA considers delivery locations to be in close proximity if they are within 60 miles of one another for acute care and within 120 miles for tertiary care. In addition, VA may achieve additional efficiencies in 28 geographic areas where existing delivery locations have low acute medicine workloads, which VA has defined as serving less than 40 hospital patients per day. VA also identified more than 60 opportunities for partnering with the DOD to better align the infrastructure of both agencies.[16]

VA faces difficult challenges when attempting to improve service delivery efficiencies. For example, service consolidations can have significant ramifications for stakeholders, such as medical schools and unions, primarily due to shifting of workload among locations and workforce reductions. Understandably, medical schools are reluctant to change long-standing business relationships involving, among other things, training of medical residents. For example, VA tried for 5 years to reach agreement on how to consolidate clinical services at two of Chicago's four major health care delivery locations before succeeding in August 2002. This is because such restructuring required two medical schools to use the same location to train residents, a situation that neither supported.

Unions, too, have been reluctant to support planning decisions that result in a restructuring of services. This is because operating efficiencies that result from the consolidation of clinical services into a single location could also result in staffing reductions for such support services as grounds maintenance, food preparation, and housekeeping. For example, as part of its ongoing transformation, VA proposed to consolidate food preparation services of 9 delivery locations into a single location in New York City in order to operate more efficiently. Two unions' objections,

[16]In May 2000, we reported that most VA/DOD sharing activity involved a relatively small number of sharing agreements and joint ventures. U.S. General Accounting Office, *VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies*, GAO/HEHS-00-52 (Washington, D.C.: May 17, 2000). The Congressional Commission on Servicemembers and Veterans Transition Assistance also reported that opportunities exist for greater sharing and partnering between VA and DOD. See *Report of the Congressional Commission on Servicemembers and Veterans Transition Assistance* (Washington, D.C.: Jan. 14, 1999).

however, slowed VA's restructuring, although VA and the unions subsequently agreed on a way to complete the restructuring.

VA also faces difficult decisions concerning the need for and sizing of capital investments, especially in locations where future workload may increase over the short term before steadily declining. In large part, such declines are attributable to the expected nationwide decrease in the overall veteran population by more than one-third by 2030; in some areas, veteran population declines are expected to be steeper. It may be in VA's best interests to partner with other public or private providers for services to meet veterans' demands rather than risk making a major capital investment that would be underutilized in the latter stages of its useful life.

In cases when VA's realignment results in buildings that are no longer needed to meet veterans' health care needs, VA faces other difficult decisions regarding whether to retain or dispose of these buildings. VA has several options, including leasing, demolition, or transferring buildings to the General Services Administration (GSA), which has the authority to dispose of excess or surplus federal property. When there is no leasing potential, VA faces potentially high demolition costs as well as uncertain site preparation costs associated with the transfer of buildings to GSA. Given that such costs involve the use of health care resources, ensuring that disposal decisions are based on systematic analyses of costs and benefits to veterans poses another realignment challenge.[17]

The challenge of dealing with a misaligned infrastructure is not unique to VA. In fact, we identified federal real property management as a high-risk area in January 2003. For the federal government overall and VA in particular, technological advancements, changing public needs, opportunities for resource sharing, and security concerns will call for a new way of thinking about real property needs. In VA's case, it has recognized the critical need to better manage its buildings and land and is in the process of implementing CARES to do so. VA has the opportunity to lead other federal agencies with similar real property challenges. However, VA and other agencies have in common persistent problems, including competing stakeholder interests in real property decisions. Resolving these problems will require high-level attention and effective leadership.

[17]U.S. General Accounting Office, *VA Health Care: Improved Planning Needed for Management of Excess Real Property*, GAO-03-326 (Washington, D.C.: Jan. 29, 2003).

Patient Support Services Could Be Provided More Efficiently

As VA continues to transform itself from an inpatient- to an outpatient-based health care system, it must find more efficient, systemwide ways of providing patient care support services, such as consolidation of services and the use of competitive sourcing. For example, VA's shift in emphasis from inpatient to outpatient health care delivery has significantly reduced the need for inpatient care support services, such as food and laundry services. To make better use of resources, some VA inpatient facilities have consolidated food production locations, used lower-cost Veterans Canteen Service (VCS) workers instead of higher-paid Nutrition and Food Service workers[18] to provide inpatient food services, or contracted out for the provision of these services. Some VA facilities have also consolidated two or more laundries into a single location, contracted for labor to operate VA laundries, or contracted out laundry services to commercial organizations.

VA needs to systematically explore the further use of such options across its health care system. In November 2000, we recommended that VA conduct studies at all of its food and laundry service locations to identify and implement the most cost-effective way to provide these services at each location.[19] At that time, we identified 63 food production locations that could be consolidated into 29, saving millions of dollars annually. We estimated that VA could potentially save millions of dollars by consolidating both food and laundry production locations.

VA may also be able to reduce its food and laundry service costs at some facilities through competitive sourcing—through which VA would determine whether it would be more cost-effective to contract out these services or provide them in-house. VA must ensure, however, that, if a decision to contract for services is made, contract terms on payments and service quality standards will continue to be met. For example, we found that weaknesses in the monitoring of VA's Albany, New York laundry

[18]The wage differences between the two result from differences in how wage rates for their respective pay schedules are determined.

[19]U.S. General Accounting Office, *VA Health Care: Expanding Food Service Initiatives Could Save Millions*, GAO-01-64 (Washington, D.C.: Nov. 30, 2000); U.S. General Accounting Office, *VA Laundry Service: Consolidations and Competitive Sourcing Could Save Millions*, GAO-01-61 (Washington, D.C.: Nov. 30, 2000).

contract appear to have resulted in overpayments, reducing potential savings.[20]

In August 2002, VA issued a directive establishing policy and responsibilities for its networks to follow in implementing a competitive sourcing analysis to compare the cost of contracting and the cost of in-house performance to determine who can do the work most cost effectively. VA has announced that, as part of the President's Management Agenda, it will complete studies of competitive sourcing of 55,000 positions by 2008. VA plans to complete studies of competitive sourcing for all its laundry positions by the end of calendar year 2003. Similar initiatives for food services and other support services are in the planning stages at VA. Overall, VA's plan for competitive sourcing shows promise. However, VA has not yet established a timeline for implementing an assessment of competitive sourcing and the other options we recommended for all its inpatient food service locations. Until VA completes these assessments and takes action to reduce costs, it may be paying more for inpatient food services than required and as a result have fewer resources available for the provision of health care to veterans.

We recognize that one of the options we recommended that VA assess, the competitive sourcing process set forth in the Office of Management and Budget (OMB) Circular A-76, historically has been difficult to implement. Specifically, there are concerns in both the public and private sectors regarding the fairness of the competitive sourcing process and the extent to which there is a "level playing field" for conducting public-private competitions. It was against this backdrop that the Congress in 2001, mandated that the Comptroller General establish a panel of experts to study the process used by the government to make sourcing decisions. The Commercial Activities Panel that the Comptroller convened conducted a yearlong study, and heard repeatedly about the importance of competition and its central role in fostering economy, efficiency, and continuous performance improvement. The panel made a number of recommendations for improving sourcing policies and processes.

As part of the administration's efforts to implement the recommendations of the Commercial Activities Panel, OMB published proposed changes to

[20]U.S. General Accounting Office, *Inadequate Oversight of Laundry Facility at the Department of Veterans Affairs Albany, New York, Medical Center*, GAO-01-207R (Washington, D.C.: Nov. 30, 2000).

Circular A-76 for public comment in November 2002. In our comments on the proposal to the Director of OMB this past January, we noted the absence of a link between sourcing policy and agency missions, unnecessarily complicated source selection procedures, certain unrealistic time frames, and insufficient guidance on calculating savings. The administration is now considering those and other comments as it finalizes the revisions to the Circular.

Fundamental Changes Could Improve Effectiveness of VA's Disability Programs

Significant program design and management challenges hinder VA's ability to provide meaningful and timely support to disabled veterans and their families. VA relies on outmoded medical and economic disability criteria. VA also has difficulty providing veterans with accurate, consistent, and timely benefit decisions, although recent actions have improved timeliness.

VA's Disability Criteria Are Outmoded

In assessing veterans' disabilities, VA remains mired in concepts from the past. VA's disability programs base eligibility assessments on the presence of medically determinable physical and mental impairments. However, these assessments do not always reflect recent medical and technological advances, and their impact on medical conditions that affect the ability to work. VA's disability programs remain grounded in an approach that equates certain medical impairments with the incapacity to work. Moreover, advances in medicine and technology have reduced the severity of some medical conditions and allowed individuals to live with greater independence and function more effectively in work settings. Also, VA's rating schedule updates have not incorporated advances in assistive technologies—such as advanced wheelchair design, a new generation of prosthetic devices, and voice recognition systems—that afford some disabled veterans greater capabilities to work.

VA has made some progress in updating its rating schedule to reflect medical advances. Revisions generally consist of (1) adding, deleting, and reorganizing medical conditions in the Schedule for Rating Disabilities, (2) revising the criteria for certain qualifying conditions, and (3) wording changes for clarification or reflection of current medical terminology. However, VA's effort to update its disability criteria within the context of current program design has been slow and is insufficient to provide the up-to-date criteria VA needs to ensure meaningful and equitable benefit

decisions. Completing an update of the schedule for one body system has generally taken 5 years or more; the schedule for the ear and other sense organs took 8 years. In August 2002,[21] we recommended that VA use its annual performance plan to delineate strategies for and progress in updating its disability rating schedule. VA did not concur with our recommendation because it believes that developing timetables for future updates to the rating schedule is inappropriate while the initial review is ongoing.

In addition, VA's disability criteria have not kept pace with changes in the labor market. The nature of work has changed in recent decades as the national economy has moved away from manufacturing-based jobs to service- and knowledge-based employment. These changes have affected the skills needed to perform work and the settings in which work occurs. For example, advancements in computers and automated equipment have reduced the need for physical labor. However, the percentage ratings used in VA's Schedule for Rating Disabilities are primarily based on physicians' and lawyers' estimates made in 1945 about the effects that service-connected impairments have on the average individual's ability to perform jobs requiring manual or physical labor. VA's use of a disability schedule that has not been modernized to account for labor market changes raises questions about the equity of VA's benefit entitlement decisions; VA could be overcompensating some veterans, while under-compensating or denying compensation entirely to others.

In January 1997, we suggested that the Congress consider directing VA to determine whether the ratings for conditions in the schedule correspond to veterans' average loss in earnings due to these conditions and adjust disability ratings accordingly. Our work demonstrated that there were generally accepted and widely used approaches to statistically estimate the effect of specific service-connected conditions on potential earnings. These estimates could be used to set disability ratings in the schedule that are appropriate in today's socio-economic environment.[22]

[21]U.S. General Accounting Office, *SSA and VA Disability Programs: Re-Examination of Disability Criteria Needed to Help Ensure Program Integrity*, GAO-02-597 (Washington, D.C.: Aug. 9, 2002).

[22]U.S. General Accounting Office, *VA Disability Compensation: Disability Ratings May Not Reflect Veterans' Economic Losses*, GAO/HEHS-97-9 (Washington, D.C.: Jan. 7, 1997).

In August 2002, we recommended that VA use its annual performance plan to delineate strategies for and progress in periodically updating labor market data used in its disability determination process. VA did not concur with our recommendation because it does not plan to perform an economic validation of its disability rating schedule, or to revise the schedule based on economic factors. According to VA, the schedule is medically based; represents a consensus among stakeholders in the Congress, VA, and the veteran community; and has been a valid basis for equitably compensating disabled veterans for many years.

Even if VA's schedule updates were completed more quickly, they would not be enough to overcome program design limitations in evaluating disabilities. Because of the limited role of treatment in VA disability programs' statutory and regulatory design, its efforts to update the rating schedule would not fully capture the benefits afforded by treatment advances and assistive technologies. Current program design limits VA's ability to assess veterans' disabilities under corrected conditions, such as the impact of medications on a veteran's ability to work despite a severe mental illness. In August 2002, we recommended that VA study and report to the Congress on the effects that a comprehensive consideration of medical treatment and assistive technologies would have on its disability programs' eligibility criteria and benefit package. This study would include estimates of the effects on the size, cost, and management of VA's disability programs and other relevant VA programs; and would identify any legislative actions needed to initiate and fund such changes. VA did not concur with our recommendation because it believes this would represent a radical change from the current programs, and it questioned whether stakeholders in the Congress and the veterans' community would accept such a change.

VA's disability program challenges are not unique. For example, the Social Security Administration's (SSA) disability programs[23] remain grounded in outmoded concepts of disability. Like VA, SSA has not updated its disability criteria to reflect the current state of science, medicine, technology and labor market conditions. Thus, SSA also needs to reexamine the medical and vocational criteria it uses to determine whether individuals are eligible for benefits.

[23]Disability Insurance (DI) provides benefits to workers with severe long-term disabilities who have enough work history to be insured for coverage under the program. Supplemental Security Income (SSI) provides benefits to disabled, blind, or aged individuals with low income and limited resources, regardless of their work histories.

VA Is Trying to Improve the Quality and Timeliness of Claims Processing

Even if VA brought its disability criteria up to date, it would continue to face challenges in ensuring quality and timely decisions, including ensuring that veterans get consistent decisions—that is, comparable decisions on benefit entitlement and rating percentage—regardless of the regional office making the decisions. VA has made some progress in improving disability program administration, but much remains to be done before VA has a system that can sustain production of accurate, consistent, and timely decisions.

VA is making changes that will allow it to better identify accuracy problems at the national, regional office, and individual employee levels. In turn, this will allow VA to identify underlying causes of inaccuracies and target corrective actions, such as additional training. In response to our March 1999 recommendation,[24] VA has centralized accuracy reviews under its Systematic Technical Accuracy Review (STAR) program to meet generally applicable government standards on segregation of duties and organizational independence. Also, the STAR program began reviewing more decisions in fiscal year 2002, with the intent of obtaining statistically valid accuracy data at the regional office level; regional office-level accuracy goals have been incorporated into regional directors' performance standards. Further, VA is developing a system to measure the accuracy of individual employees' work; this measurement is tied to employee performance evaluations.

While VA has made changes to improve accuracy, it continues to face challenges in ensuring consistent claims decisions. In August 2002, we recommended that VA establish a system to regularly assess and measure the degree of consistency across all levels of VA claims adjudication.[25] While VA agreed that consistency is an important goal, it did not fully respond to our recommendation regarding consistency because it did not describe how it would measure consistency and evaluate progress in reducing any inconsistencies it may find. Instead, VA said that consistency is best achieved through comprehensive training and communication among VA components involved in the adjudication process. We continue

[24]U.S. General Accounting Office, *Veterans' Benefits Claims: Further Improvements Needed in Claims-Processing Accuracy*, GAO/HEHS-99-35 (Washington, D.C.: Mar. 1, 1999).

[25]U.S. General Accounting Office, *Veterans' Benefits: Quality Assurance for Disability Claims and Appeals Processing Can Be Further Improved*, GAO-02-806 (Washington, D.C.: Aug. 16, 2002).

to believe that VA will be unable to determine the extent to which such efforts actually improve consistency of decision-making across all levels of VA adjudication now and over time.

VA's major focus over the past 2 years has been on producing more timely decisions for veterans, and it has made significant progress in improving timeliness and reducing the backlog of claims. The Secretary established the VA Claims Processing Task Force, which in October 2001 made specific recommendations to relieve the veterans' claims backlog and make claims processing more timely. The task force observed that the work management system in many regional offices contributed to inefficiency and an increased number of errors. The task force attributed these problems primarily to the broad scope of duties performed by regional office staff—in particular, veterans service representatives (VSR). For example, VSRs were responsible for both collecting evidence to support claims and answering claimants' inquiries. Based on the task force's recommendations, VA implemented its claims process improvement (CPI) initiative in fiscal year 2002. Under this initiative, regional office claims processing operations were reorganized around specialized teams to handle specific stages of the claims process. For example, regional offices have teams devoted specifically to claims development, that is, obtaining evidence needed to evaluate claims.

Also, VA focused on increasing production of rating-related decisions to help reduce inventory and, in turn, improve timeliness. In fiscal years 2001 and 2002, VA hired and trained hundreds of new claims processing staff. VA also set monthly production goals for fiscal year 2002 for each of its regional offices, incorporating these goals into regional office directors' performance standards. VA completed almost as many decisions in the first half of 2003 (404,000) than in all of fiscal year 2001 (481,000). This increase in production has contributed to a significant inventory reduction; on March 31, 2003, the rating-related inventory was about 301,000 claims, down from about 421,000 at the end of fiscal year 2001. Meanwhile, rating-related decisions timeliness has been improving recently; an average of 199 days for the first half of fiscal year 2003, down from an average of 223 days in fiscal year 2002.

While VA has made progress in getting its workload under control and improving timeliness, it will be challenged to sustain this performance. Moreover, it will be difficult to cope with future workload increases due to factors beyond its control, such as future military conflicts, court decisions, legislative mandates, and changes in the filing behavior of veterans. VA is not alone in facing these challenges; SSA is also challenged

to improve its ability to provide accurate, consistent, and timely disability decisions to program applicants. For example, after failing in its attempts since 1994 to redesign a more comprehensive quality assurance system, SSA has recently begun a new quality management initiative. Also, SSA has taken steps to provide training and enhance communication to improve the consistency of decisions, but variations in allowances rates continue and a significant number of denied claims are still awarded on appeal. SSA has recently implemented several short-term initiatives not requiring statutory or regulatory changes to reduce processing times but is still evaluating strategies for longer-term solutions.

More dramatic gains in timeliness and inventory reduction might require program design changes. For example, in 1996, the Veterans' Claims Adjudication Commission noted that most disability compensation claims are repeat claims—such as claims for increased disability percentage—and most repeat claims were from veterans with less severe disabilities. The Commission questioned whether concentrating processing resources on these claims, rather than on claims by more severely disabled veterans, was consistent with program intent. Another possible program design change might involve assigning priorities to the processing of claims. For example, claims from veterans with the most severe disabilities and combat-disabled veterans could receive the highest priority attention. Program design changes, including those to address the Commission's concerns, might require legislative actions.

In addition to program design changes, outside studies of VA's disability claims process identified potential advantages to restructuring VA's system of 57 regional offices. In its January 1999 report, the Congressional Commission on Servicemembers and Veterans Transition Assistance stated that some regional offices might be so small that their disproportionately large supervisory overhead unnecessarily consumes personnel resources. Similarly, in its 1997 report, the National Academy of Public Administration stated VA should be able to close a large number of regional offices and achieve significant savings in administrative overhead costs.

Apart from the issue of closing regional offices, the Commission highlighted a need to consolidate disability claims processing into fewer locations. VA has consolidated its education assistance and housing loan guaranty programs into fewer than 10 locations, and the Commission encouraged VA to take similar action in the disability programs. VA proposed such a consolidation in 1995 and in that proposal enumerated several potential benefits, such as allowing VA to assign the most

experienced and productive adjudication officers and directors to the consolidated offices; facilitating increased specialization and as-needed expert consultation in deciding complex cases; improving the completeness of claims development, the accuracy and consistency of rating decisions, and the clarity of decision explanations; improving overall adjudication quality by increasing the pool of experience and expertise in critical technical areas; and facilitating consistency in decisionmaking through fewer consolidated claims-processing centers. VA has already consolidated some of its pension workload (specifically, income and eligibility verifications) at three regional offices.[26] Also, VA has consolidated at its Philadelphia regional office dependency and indemnity compensation claims by survivors of servicemembers who died on active duty, including those who died during Operation Enduring Freedom and Operation Iraqi Freedom.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

Contact and Acknowledgments

For further information, please contact me at (202) 512-7101. Individuals making key contributions to this testimony include Paul R. Reynolds, James C. Musselwhite, Jr., Irene P. Chu, Pamela A. Dooley, Cherie' M. Starck, William R. Simerl, Richard J. Wade, Thomas A. Walke, Cheryl A. Brand, Kristin M. Wilson, Greg Whitney, and Daniel Montinez.

[26] These are the VA regional offices in St. Paul, Minnesota; Philadelphia, Pennsylvania; and Milwaukee, Wisconsin.

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VA's Comments on Items of Concern Identified in
Inspector General Griffin's Statement
May 8, 2003
before the
House 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

Physician Time and Attendance

VAIG Testimony, pages 3-9

The OIG has identified in its CAP reviews a number of instances where some part-time physicians did not work their scheduled hours. The OIG could not find evidence in workload reports or patient files that some part-time physicians had performed any work for VA during the periods examined.

The OIG has acknowledged that the current time and attendance policy requiring part-time physicians to work fixed hours is not responsive to the actual work requirements of patient care. Nonetheless, there were real problems with ensuring that part-time physicians worked all the hours they were paid for. It also became apparent that there were many misunderstandings of the time and attendance policy and requirements.

VHA has responded to these findings with a series of actions (see attached action plan). To address the difficulties posed by the inflexible time and attendance system, VHA has formed a series of workgroups to develop proposals. The result of those efforts – Service Level Agreements – will allow VA to schedule part-time physicians for a part of their overall time commitment, and provide the flexibility to VA to schedule these individuals only as needed for patient care. 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.

VHA is addressing the problem with recording and documenting time worked with a pilot program to test the efficacy of swipe cards that will record part-time physicians' arrivals and departures at VA facilities. This pilot and other possible technological solutions will be evaluated and recommendations made to the Secretary's Office by January 2004.

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 been given to all timekeepers. Every facility was required to review and update as necessary local time and attendance policies. Those policies have been submitted to and reviewed in VACO to ensure that they are complete. To ensure compliance with these mandates, each action item will be reviewed and discussed by the Deputy under Secretary for Health for Operations and Management with Network Directors in their quarterly performance reviews.

Action Plan

OIG Recommendations and VHA Actions

Recommendation 1. Suggested Actions to Improve the Accuracy of Part-Time Physician Timekeeping:

a. Require that VISN and medical center directors ensure part-time physicians meet their employment obligations and hold field managers accountable for compliance.

OVERALL STATUS: ●

Start Date	Action	Status/Target Date
Before October 2002	Timekeeper records subject to periodic audits by finance staff	Completed / Ongoing and re-emphasized
October 2002	DUSH-OM issued guidance in the form of a memo to the field on best practices used to effectively monitor time and attendance of part-time physicians	Completed
December 2002	Networks required to certify that all part-time physicians be trained in and certify that they understand VA policy on time and attendance	Completed
December 2002	Networks required to certify that refresher time and attendance training is provided to all timekeepers	Completed
January 2003	VHA Directive 2003-001 requires that medical center directors develop local policies to ensure compliance with time and attendance requirements	Completed
January 2003	VHA Directive 2003-001 mandates ongoing monitoring and compliance with the above requirements	Completed / Ongoing – discussed quarterly at performance reviews
January 2003	VHA Directive 2003-001 requires facility directors ensure that all supervisors and timekeepers receive time and attendance training	Completed / Initial certification completed in March 2003

January 2003	VHA Directive 2003-001 requires that medical center directors review the appointment types and tour schedules for all part-time physicians develop local policies to ensure compliance with time and attendance requirements	Completed / Initial review completed March 2003
January 2003	Requirement for facilities to conduct annual timekeeper training (EES and VSSC to develop new training tool for 2004)	March 2004
January 2003	Stations will also be required to document in writing their staffing review for all positions as they become vacant	Ongoing
April 2003	All station policies to be reviewed in VHACO	Completed / May 30, 2003

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

OVERALL STATUS:

Start Date	Action	Status/Target Date
October 2002	DUSH-OM issued guidance to the field on best practices used to effectively monitor time and attendance of part-time physicians	Completed
November 2002	Workgroup formed to explore more effective ways to document work hours and alternatives to the core hours approach	Completed December 2002
February 2003	Workgroup charged to evaluate current systems and recommend changes, including time banks, electronic badge readers, and automated aids.	Completed March 2003
April 2003	Policy development to include concept of **Service Level Agreements* – annually negotiated agreements with part-time physicians to provide VHA with agreed-upon amount of services	1) Proposal to 00 - May 14, 2003 - Completed 2) Final draft – July 31, 2003 3) Union negotiations – August 2003 4) Field implementation – October-December 2003

NOTE: Service Level Agreements: Negotiated annual employment agreements with part-time physicians based on VA work requirements. VA managers determine the amount of physicians' services needed on an annual basis. Physicians would receive regular prorated payments each pay period, but could vary their hours throughout the year based on patient care needs. Managers will be responsible for scheduling and monitoring the time and attendance of part-time physicians each pay period.

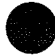
c. Establish performance monitors to measure VISN and medical center enforcement of physician time and attendance; ensure desk audits are conducted of timekeeping functions, provide continuing timekeeping education to supervisors, physicians, and timekeepers; require medical center managers to certify compliance with applicable policies and procedures to the Deputy Under Secretary for Operations and Management annually, and hold VHA managers accountable for successful implementation of time and attendance requirements.

OVERALL STATUS:

Start Date	Action	Status/Target Date
Before October 2002	Timekeeper records subject to periodic audits by finance staff	Completed / Ongoing emphasis and reminders
October 2002	DUSH-OM issued guidance in the form of a memo to the field on best practices used to effectively monitor time and attendance of part-time physicians	Completed
December 2002	Networks required to certify that all part-time physicians be trained in and certify that they understand VA policy on time and attendance	Completed
January 2003	VHA Directive 2003-001 requires that medical center directors develop local policies to ensure compliance with time and attendance requirements	Completed
January 2003	VHA Directive 2003-001 mandates ongoing monitoring and compliance with the above requirements	Completed / Discussed at performance reviews
January 2003	VHA Directive 2003-001 requires facility directors ensure that all supervisors and timekeepers receive time and attendance training	Initial certification completed in March 2003

January 2003	VHA Directive 2003-001 requires that medical center directors review the appointment types and tour schedules for all part-time physicians develop local policies to ensure compliance with time and attendance requirements	Initial review completed March 2003
January 2003	Requirement for facilities to conduct annual timekeeper training (EES and VSSC to develop new training tool for 2004)	March 2004
January 2003	Stations will also be required to document in writing their staffing review for all positions as they become vacant	Ongoing
April 2003	All station policies to be reviewed in VHACO	Completed / May 30, 2003
May 2003	Develop computer-based training for part-time physicians, supervisors, and timekeepers	1) Develop course content – Oct. 2003 2) On-line course developed – Feb 2004
November 2003	Monitor networks' and facilities' implementation of Service Level Agreements for part-time physicians	Oversight through Networks' Quarterly Performance Reviews

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

OVERALL STATUS: 

Start Date	Action	Status/Target Date
December 2002	Networks required to certify that all part-time physicians be trained in and certify that they understand VA policy on time and attendance	Completed

e. Evaluate appropriate technological solutions that will facilitate physician timekeeping.

OVERALL STATUS:

Start Date	Action	Status/Target Date
April 2003	Evaluate workgroups' recommendations concerning electronic badges, swipe cards, computerized sign-in sheets, electronic interface of VISTA/ETA	Early discussions / October 2003
April 2003	Preliminary discussions involving the Chief Academic Affiliations Officer, Chief of Staff at Miami VAMC and the Dean of the Medical School have begun. Issues requiring further development include costs, technology, HR and union issues. VHA HQ IT staff have also discussed a proposed pilot of card technology for recording physical access/security events with the VA CIO.	Early discussions / January 2004

f. Develop comprehensive guidance for medical centers to use when conducting desk audits.

OVERALL STATUS:

Start Date	Action	Status/Target Date
June 1, 2003	Charge workgroup to review the activities of those facilities noted in the report who conducted acceptable desk audits and prepare guidance for use by all facilities. VHA will collaborate with the Office of Financial Management to develop comprehensive guidance for timekeeper audits.	Workgroup's report due July 31, 2003

g. Establish appropriate training modules, making best use of technological solutions, for training VHA managers, VA physicians, and timekeepers in timekeeping requirements, responsibilities, and procedures.

OVERALL STATUS: ●

Start Date	Action	Status/Target Date
May 2003	Develop computer-based training for part-time physicians, supervisors, and timekeepers	Develop course content by October 31, 2003 On-line course developed Feb. 2004

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

OVERALL STATUS: ●

Start Date	Action	Status/Target Date
January 2003	VHA Directive 2003-001 requires that medical center directors review the appointment types and tour schedules for all part-time physicians develop local policies to ensure compliance with time and attendance requirements	Completed / Initial review completed March 31, 2003
January 2003	Stations will also be required to document in writing their staffing review for all positions as they become vacant	Ongoing

c. 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.

OVERALL STATUS: ●

Start Date	Action	Status/Target Date
May 2003	Require annual certifications for facility/VISN Directors	May 2004

d. Evaluate alternative methods to acquire physician services and publish national guidance to assist VISN and medical center directors in determining the best strategies for their regional, academic, and patient care circumstances.

OVERALL STATUS: ●

Start Date	Action	Status/Target Date
May 2003	VHA and OAMM (NAC) will work collaboratively to further establish uniform clinical services contracts for the Federal Supply Schedule	October 2003

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

OVERALL STATUS: ●

Start Date	Action	Status/Target Date
May 2003	*Service Level Agreements – annual negotiated agreements with part-time physicians to provide VHA with agreed-upon amount of services	1) Proposal to 00 - May 14, 2003 2) Final draft policy - June 30, 2003 3) Union negotiations - July 31, 2003 4) Field implementation - October 31, 2003

*NOTE: Service level agreements will take into account regular and recurring responsibilities associated with VA-related work, including administrative duties, research time (if funded), and other activities. VISN Directors will be responsible for assuring that facility managers negotiate these agreements, and progress will be monitored through quarterly performance reviews.

Physician Staffing Standards

VAIG Testimony, page 3-9

I. Primary Care

A. Description.

VHA is developing a productivity and staffing model of primary care (as defined by clinic stops 322 (Women's Clinic), 323 (Primary Care), and 350 (Geriatric Primary Care)) based on statistical analysis and expert panel review. The model will identify important patient, facility and provider characteristics that influence VA physician productivity, provide a framework to evaluate how resources become services, and serve as a tool to develop support staff and capital guidelines to achieve agency productivity goals.

B. Progress

1. VA internal data sets have been developed from automated systems including DSS and VISTA/NPCD systems that will serve as a foundation for productivity guidelines. Information is being collected on patients, facilities and providers.

2. Comprehensive survey information has been gathered from the field providing information on practice and clinic characteristics, the number of primary care providers, the number of primary care firms within VA hospitals, and the amount of support staff and capital devoted to primary care delivery. We anticipate that analysis of the survey information will be complete in mid June.

3. Non-VA data is being gathered under two contracts. The first contract has been awarded to Milliman who will provide VA with eleven primary care physician productivity measures by June 9. The Milliman data is based on the annual survey of physicians conducted by the American Medical Association.

   The second contract has been awarded to the Medical Group Management Association (MGMA) who in conjunction with the Management Science Group will develop private sector productivity standards for primary care and other areas of specialization. The MGMA data, based on their annual survey, was delivered to the VA on May 29.

4. Statistical models developing productivity and panel size given patient, provider and facility characteristics are under development and will be completed by June 16, 2003 for review by the Deputy Under Secretary for Health.

II. Specialty Clinics

A. Description

VHA is also developing productivity and staffing models in three specialty areas: cardiology, ophthalmology and urology. While originally conceived as strictly outpatient care models, VHA recently has decided to expand the focus of these models to include all areas of activity, inpatient, outpatient and long term care. This broadening of focus and short delivery timeframe will mandate an approach gathering productivity information that will differ from the methods used in primary care. Rather than gathering data universally, data will be gathered from a sample of VA hospitals and providers within each of the three areas. This will allow for fairly comprehensive workload review, using a model developed by David Coleman and Eileen Moran at the West Haven VAMC, forthcoming in Academic Medicine.

The Coleman paper develops an RVU-based model for comparing clinical productivity among and within VA facilities and with the private sector. CPT codes are determined for all inpatient and outpatient encounters. The model assigns CPT based relative value units for all physician activities in education, research, administration and patient care.

Using these CPT based relative value units, the models will identify important patient, facility and provider characteristics in these specialties, that influence VA physician productivity, provide a framework to evaluate how resources become services, and serve as a tool to develop support staff guidelines to achieve agency productivity goals. These models may be used as a template to expand to all remaining specialty areas.

B. Progress

A final paper will be developed by October 1, 2003 for review by the Deputy Under Secretary for Health.

Review of Biological, Chemical, and Radiological Inventories

VAIG Testimony, pages 9-10

At the request of the Secretary of Veterans Affairs, the Office of the Inspector General conducted a comprehensive review of research and clinical laboratory facilities in the VA following the September 11th and anthrax terrorist attacks. In his statement to the House of Representatives on May 8, 2003, the VA IG noted that: ".... Fifteen of the 16 recommendations were not implemented as of March 31, 2003."

Significant progress has been made on all of the OIG recommendations identified in Report Number 02-00266-76, dated March 14, 2002, although they have not been closed by the OIG. In early 2003, the OIG reconsidered the issues included in this March 2002 audit report and subsequently added new requirements. VHA is presently negotiating with the OIG's office regarding the best way to satisfy these additional requirements. The recommendations remain open largely as a result of the newly-added requirements.

The purpose of this summary is to highlight the progress that VHA has made on initiatives related to the OIG's recommendations. On October 30, 2001, VHA concluded its comprehensive inventory of all research laboratories. One site possessed a strain of anthrax that was not virulent in humans. Nonetheless, the site destroyed the culture because there was no continuing research need for the anthrax. All VA research labs that use or store live organisms on the Select Agent list currently possess the appropriate registration from the Centers for Disease Control and Prevention, except for one site for which the application for registration is now being processed. Research managers were directed to dispose or destroy Select Agents that were not in active use, in accordance with CDC guidelines.

In addition, CDC revised its Select Agent requirements in 2003, and now there are new threshold amounts for many toxins. Most of the VA research labs that previously reported the use or storage of these toxins in 2001 had amounts that were too low to require registration according to 2003 CDC guidelines.

On October 29, 2001, VHA completed an extensive inventory of all clinical laboratories and pharmacies for select biological and chemical agents identified for potential use in terrorist activities. No agents were identified from the Pharmacy Service. Some radiological agents were identified for radiology and nuclear medicine, but these were found to already be under very tight control as a result of existing regulatory requirements. Of 176 clinical laboratories that were inventoried within VHA, only 10 were found to have any agents of concern. All 10 of these laboratories were directed to destroy any of these agents that were not needed for routine clinical applications and were further directed to place under lock and key any that needed to be retained.

Since the clinical lab inventory was conducted, the CDC has defined new security and retention requirements for clinical labs that may isolate any of the Select Agents from patients. All such clinical isolates must be secured and those agents not destroyed within seven days must be registered with the CDC.

Publication of VHA Directive 2002-075, *Control of Hazardous Materials in VA Research Laboratories*, which was published in November 2002, directly addressed seven OIG recommendations, including improvements in physical security. The directive codified and clarified existing procedures and also complied with requirements mandated in the USA Patriot Act of 2001.

The Office of Research and Development (ORD) notified all research sites about the impact of the USA Patriot Act of 2001, and it served as the lead office in developing a memorandum on the *Physical Security of Hazardous Materials in Clinical and Research Laboratories*. The Deputy Undersecretary of Health for Operations and Management, the Chief Research and Development Officer, and the Deputy Assistant Secretary for Security and Law Enforcement jointly signed and distributed that memorandum.

ORD has been educating research laboratories about the additional personnel security issues needed to comply with the USA Patriot Act and with the CDC Select Agent guidelines. In 2003, ORD began to conduct unannounced inspections of sites with BSL-3 research laboratories to ensure compliance with safety and security guidelines. Any laboratories found to have major compliance issues will be given 30 days to correct the deficiencies or will be directed to discontinue operations.

ORD initiated a program to spend more than $2 million to upgrade laboratory security in February 2002, and ORD will systematically review all research sites over the next three years as part of its infrastructure program to identify and fund equipment needs, including security devices. 64 research sites have been identified that needed security upgrades. Fifty-five sites have received or been approved for funding. ORD will review the revised applications from the remaining 9 sites in FY 2003. However, the OIG will not close that recommendation until all 64 sites have completed their security upgrades.

The open OIG recommendations involve issues such as security training for research facilities. For example, OIG will not close the recommendation on lab security upgrades until all eligible VA facilities have received the equipment that was purchased with ORD grant funding. Similarly, OIG will not close the recommendation on training until ORD develops and implements a program of instruction for laboratory security. Such a training program is under development. In addition, in early 2003, the OIG mandated that VAMC Directors certify implementation of directives and security requirements before they will close the recommendations.

Community Nursing Home Oversight

VAIG Testimony, pages 10-11

VHA published a comprehensive policy document (VHA Handbook 1143.1) on oversight of Community Nursing Homes (CNH) in June 2002, implementing the long-standing OIG recommendations in this area. The policy established a national standard for annual reviews of CNHs and monthly visits by VA staff to patients in those homes. The new oversight system integrates the best information available from the Centers for Medicare and Medicaid (CMS), State Survey Agencies and VA's staff observations. At the national level, VHA has also implemented a certification process, to ensure that annual reviews are conducted on time and has initiated a monitor to determine timeliness of monthly visits.

In response to OIG's follow-up report on CNH (July 2002), VHA conducted an internal review of the program and outlined a 25-point plan to further refine VHA's oversight efforts, and to enhance related program areas. The Agency is scheduled complete its implementation of the plan by the end of the Fiscal Year.

VA staff education is a critical element in the Agency's upgraded oversight process. In August 2002, VHA introduced the new policy on CNH oversight with a 2-hour satellite broadcast. Currently, the Agency is developing web-based training modules on the oversight policies, to be reinforced with a series of small group web casts. VHA continues to provide weekly training to VA medical centers on the interpretation of CMS reports.

Specific actions related to CNH oversight also include:

- improved monitoring at local and national level;
- improved and expanded information sources for reference of VA facility staff with local oversight responsibilities;
- enhanced relationships between GEC staff and CMS and state survey agencies;
- weekly audio training conferences conducted by GEC staff with VA facility contacts;
- interactive web page with self-testing and case studies; and
- a revision of VHA Handbook 1143.1 (currently in progress, to be completed in FY 2003).

VHA published a comprehensive policy document (VHA Handbook 1143.1) on oversight of Community Nursing Homes (CNH) in June 2002, implementing the long-standing OIG recommendations in this area. The policy established a national standard for annual reviews of CNHs and monthly visits by VA staff to patients in those homes. The

new oversight system integrates the best information available from the Centers for Medicare and Medicaid (CMS), State Survey Agencies and VA's staff observations. At the national level, VHA has also implemented a certification process, to ensure that annual reviews are conducted on time and has initiated a monitor to determine timeliness of monthly visits.

In response to OIG's follow-up report on CNH (July 2002), VHA conducted an internal review of the program and outlined a 25-point plan to further refine VHA's oversight efforts, and to enhance related program areas. The Agency is scheduled complete its implementation of the plan by the end of the Fiscal Year.

VA staff education is a critical element in the Agency's upgraded oversight process. In August 2002, VHA introduced the new policy on CNH oversight with a 2-hour satellite broadcast. Currently, the Agency is developing web-based training modules on the oversight policies, to be reinforced with a series of small group web casts. VHA continues to provide weekly training to VA medical centers on the interpretation of CMS reports.

Specific actions related to CNH oversight also include:

- improved monitoring at local and national level;
- improved and expanded information sources for reference of VA facility staff with local oversight responsibilities;
- enhanced relationships between GEC staff and CMS and state survey agencies;
- weekly audio training conferences conducted by GEC staff with VA facility contacts;
- interactive web page with self-testing and case studies; and
- a revision of VHA Handbook 1143.1 (currently in progress, to be completed in FY 2003).

Criminal Investigations: Jamaica Plains and Nashville

VAIG Testimony, pages 11-12

In its testimony, the OIG emphasized the "critical need for rigorous inventory controls at all VHA facilities" in the area of pharmaceuticals. Controlled substances represent approximately five percent of all pharmaceuticals dispensed by VA medical facilities. VA already has the most stringent inventory controls and security of any pharmacies in the United States. There has been only one incident of an armed robbery in a VA pharmacy in over 30 years. Current security policy is designed to allow suspects to leave VA premises without causing injury to employees or patients. VA Police do not attempt to apprehend suspects on station. They secure the area, ensure the safety of the patient care environment, and notify the local authorities, who wait to apprehend suspects outside of VA buildings.

The incident at the Nashville VAMC raises particular concerns inasmuch as the pharmacy supervisor was able to utilize the records of either deceased patients or patients who had not been seen in the medical center for some time to fill prescriptions by creating false prescription entries without forging paper prescriptions. The supervisor either sent the drugs to a temporary address or passed them out to a third party.

Working with the Office of the Medical Inspector, VHA has developed some monitoring reports to determine if patients who have not been seen in over one year have received a prescription for a controlled substance. These reports will be available to pharmacy management not involved in the Controlled Substance dispensing and the Controlled Substance Coordinator for review. In addition, the inspection policy will include the mandatory auditing of paper prescriptions against the electronic entry in the VA information system.

VHA has been working on a longer-term project with the Drug Enforcement Administration (DEA) for the last three years to develop a prototype of an electronic order entry system of controlled substance prescriptions using a secure Public Key Infrastructure (PKI). A pilot is being successfully tested at the Hines VA Hospital. DEA intends to issue regulations for electronic order entry systems for all controlled substances based on this test. When this is done, there will be an electronic trail from the prescriber to the pharmacy dispensing systems. Paper prescriptions will be a rare and easier to audit for fraud and abuse.

VHA will release an update to its Drug Accountability software in June to provide a secure Internet connection to the VA Prime vendor. This replaces older technology that no longer meets the VA information security requirements. The updated software will allow the uploading of invoice information directly into the VA information system. This new process will improve the tracking of invoices and update the controlled substances inventory information automatically. The release of the software to address the vulnerability identified between the prime vendor and VA facilities is planned for June 16, 2003.

In addition, VHA has an external auditing program, conducted by disinterested parties, to audit the inventory of all controlled substances. Even with these strict controls, certain individuals are able to bypass certain systems. The OIG CAP reports show that narcotic inspections were not always performed on time, nor were all areas surveyed according to the current policy. Part of VHA's action plan to address this includes an annual process by the local Narcotic Inspection Coordinator to certify that this process is occurring in accordance with current policy. The Directors of the Medical Centers are responsible for the narcotic inspection team reviews and the VISNs will monitor the Narcotic Inspection Program. The VISNs will report findings to the Office of the Deputy Undersecretary for Operations and Management on a quarterly basis.

To prevent and potentially deter future diversion of controlled substances (a small, but highly visible class of drugs), VHA is revising the current Controlled Substance Storage policy (VHA Handbook 1108.1) and the Controlled Substance Inspection policy (VHA Handbook 1108.2). Pharmacy Benefits Management (PBM) and the Office of the Deputy Undersecretary for Health for Operations and Management conducted a task group meeting in March to develop new policies. The inspection policy is currently under review and will be finalized this summer.

A draft of VHA policy 1108.1 includes a requirement for new electronic security and installation of cameras in the vault and dispensing areas for controlled substances. These systems will be monitored for potential diversion of a few doses at a time and will be not visible to the staff. These changes will be incorporated into the security policies as well. The changes will not prevent armed robbery but are designed to deter diversion by VA personnel. They could be used by law enforcement to identify any robbery or burglary suspects.

In response to an earlier CAP summary concerning the Inspection Process, PBM began the development of a training film for Narcotic Coordinators, Directors, Pharmacy personnel, and Narcotic Inspectors on the importance of the procedures. PBM and Employee Education System have a web-based training and certification program planned for Narcotic Inspectors based on the new VHA Handbook 1108.2. VHA hopes to have this completed by September 2003.

Hold up of Jamaica Plans Pharmacy

Issue: In May 2001, two armed individuals entered the pharmacy at VA Medical Center Boston under the ruse of delivering flowers and, after leading the VA pharmacy employees to a secure vault and typing them up, stole narcotics valued at over $250,000.

Corrective Actions: The outpatient pharmacy had all the appropriate security at the time of the robbery. Access Control Doors, Motion Detectors, panic alarms, Police Patrolling the grounds and Bullet Resistant Glass. Unfortunately, all this security was bypassed by an employee in the pharmacy when she opened the door for a supposed flower delivery.

Therefore the 1st issue was training for the employees within the pharmacy. They were taught to ask for Identification of all who may just knock on the doors. Access to the pharmacy itself was strictly enforced as well. Other than official deliveries were curtailed to the employees of this secure area (i.e.; food or flower deliveries). Pharmacy management reinforces this training on a regular basis at staff meetings and periodically sends e-mails to all staff regarding this and other critical Pharmacy issues.

Camera Installations were then made with monitors inside the pharmacy so employees could see not only the face that might be in the door window but around corners and the general vicinity around the entrance/exit. These cameras can also be viewed from the Police Office. Access control alarms were installed and are monitored by the Police. These alarms activate when a door is open too long or as a duress alarm by staff.

Police Patrols to this area have increased during hours of operation.

Hours of operation have been reduced and the pharmacy is no longer open after business hours.

Police Officers have since been armed as a further deterrent.

DEPARTMENT OF VETERANS AFFAIRS (VA)
VA TENNESSEE VALLEY HEALTHCARE SYSTEM (TVHS)

Title: *Controlled Substance Diversion Prevention Measures at VA Tennessee Valley Healthcare System (TVHS)*

Issue: Measures taken to prevent loss of controlled substances at TVHS

Discussion: The purpose of this document is to outline preventative measures taken to prevent controlled substance diversion at TVHS. The discovery of the theft of controlled substances at the Nashville Campus by a supervisory pharmacist initially reported 11/27/2001 initiated an intense series of reviews and corrective actions designed to provide checks and reviews at all stages of the controlled substance handling and dispensing process. TVHS has had the opportunity to work closely with the Office of Inspector General, the Drug Enforcement Agency, the Office of the Medical Inspector and a VISN 9 appointed external review team in the development of policies and procedures that address the concerns of these review bodies. The TVHS policies are based on both VHA Handbooks 1108.1 and 1108.2, the Code of Federal Regulations, Part 21 to end, and other applicable regulations.

Central to the measures taken to prevent the loss of controlled substances is independent inspection of all controlled substances activity by narcotic inspectors with no day-to-day interest in pharmacy activities. Also of importance to the overall controlled substance process is limitation of access of pharmacy employees to controlled substance areas and to documentary processes involved in dispensing and accounting for controlled substance activity. No one person in pharmacy service has complete access to all of the procurement, dispensing, accounting, and destruction processes for controlled substances. For example, if a discrepancy is discovered in the count of on hand contents of a stock bottle, only a designated individual can make the balance adjustment, not the employee who discovered the discrepancy. Another important facet of the controlled substance process is detailed reporting of all discovered discrepancies no matter how insignificant. A broken tablet found in a stock bottle is reported through channels in accordance with VHA Handbook 1108.1. Independent controlled substance inspectors audit all of these processes on a monthly basis and provide a written report to the Director summarizing findings.

A new security system has also been installed for both Nashville Campus pharmacies and controlled substance storage vaults. The new security system uses biometric data (finger print) to allow entrance access only to a unique individual. Access to controlled substance vaults is strictly limited to only those individuals who have absolute need to be in the area. Police Service maintains the access control to pharmacy areas and vaults independently of pharmacy staff. Changes in vault access requirements must be requested in writing and concurrence obtained from the Chief, Pharmacist.

Incarcerated Veterans Benefits Adjustments

VAIG Testimony, pages 12-13

In the last year VA has increased its focus on identifying incarcerated beneficiaries and, when appropriate, adjusting their compensation and pension (C&P) benefits in accordance with applicable statutes (38 U.S.C. 5313 and 38 U.S.C. 1505). In June of 2002 VA started a computer match with the Social Security Administration (SSA) through which ¼ of the entire C&P file is run against SSA's prisoner database each month. The initial four monthly runs each produced in excess of 4,000 matches. Subsequent monthly matches have each produced around 800 matches. Since the start of the prison match, nearly 30,000 matches have been generated.

In addition to the computer match with SSA, which primarily identifies individuals in the custody of state and local authorities, VA has conducted a computer match with the Federal Bureau of Prisons (BOP) since 1998. The initial match with BOP in April of 1998 produced more than 800 matches. Subsequent runs produce 30-40 hits per month. VA has also done some special matches with BOP to identify long-term inmates.

VA is confident that it is identifying and adjusting the benefits of individuals identified on the BOP match. Although we have made a great deal of progress on the state and local cases, it has been difficult for many regional offices to keep up with the volume. However, it should be noted that fewer than half of the cases identified on the SSA Prison Match are actually subject to reduction by VA.

Many of the beneficiaries identified on the SSA Prison Match have either not yet been convicted of a crime or have been declared incompetent to stand trial and are confined in mental health facilities. If the beneficiary receives disability compensation or dependency and indemnity compensation, VA must establish that the beneficiary was convicted of a felony before reducing these benefits. Many individuals identified on the SSA Prison Match were convicted of misdemeanors, or the periods of incarceration occurred before the date the inmate became entitled to VA benefits. VA must also establish that the individual was incarcerated for 61 consecutive days after conviction. Many of the beneficiaries identified on the matches are released, sent to a halfway house, put on work release, or placed on parole before they have served 61 consecutive days. Although the SSA Prison Match shows the date an individual was incarcerated, it rarely shows a release date. Therefore, VA has to develop to determine whether the beneficiary was actually imprisoned for 61 consecutive days.

Overpayment to many incarcerated VA beneficiaries is unavoidable in almost all instances. Considerable time is required for VA to learn that a beneficiary has been incarcerated, to determine whether benefits are subject to reduction, and to give the beneficiary due process. In many cases, beneficiaries are out of prison before the processing of the benefit reduction is completed. Even inmates serving longer terms will have been overpaid for several months before processing is completed.

In spite of these problems, VA is working to properly adjust awards and establish overpayments for future collection and is making good progress on the caseload.

Death Match Project

VAIG Testimony, page 15

For more than 10 years VA has received a monthly file from the Social Security Administration (SSA) showing beneficiaries who may be deceased. Prior to 1999, the ROs received only writeouts for individuals identified as deceased. Since 1999 they have been provided with monthly control lists as well as individual case writeouts. The listings show new cases for the month as well as cases from prior months that do not appear to have been terminated or adjusted due to the beneficiary's or spouse's death.

Regional offices review the writeouts and listings and develop evidence to determine whether a beneficiary or spouse is deceased. In some instances, the VA beneficiary is not deceased but the SSN of the beneficiary or beneficiary's spouse in VA records is wrong and is matching with the actual SSN of an unrelated deceased person. If this is the case, the RO corrects the SSN in VA records.

This is a rather basic computer match but it produces significant benefits. For the first quarter of FY 2003 regional offices reported more than $1.5 million in overpayments and more than $7.6 million in cost avoidance due to the SSA Death Match.

VBA - Fraud Prevention

VAIG Testimony, pages 16-19

The IG's testimony cites several high profile cases of fraud and abuse in VBA in recent years. VBA has taken a number of specific actions to reduce or eliminate any potential problems and ensure appropriate controls are in place. The following highlights our efforts:

- The Statement of Written Assurance (SWA) now has mandatory specific internal controls that RO Directors must certify every year, including ensuring proper third signatures on all awards and proper physical and electronic security of files. (VBA Ltr 20-02-27)
- RO Directors' performance standards now have a critical element concerning Integrity. (OFO Ltr 201-66)
- The Large Payment Verification Process was instituted and requires that the RO Director or Assistant Director personally review all C&P payments above $25,000 and ensure proper third signatures on all awards. (VBA Ltr 20-01-50)
- The Network Support Centers review all regional offices every year to ensure that internal controls for benefits delivery systems and applications are followed.
- The VBA business lines and, our Office of Resource Management now conduct payment record reviews as part of their regional office site survey program.
- The Department's Financial Quality Assurance Service (FQAS) conducts analyses of improper payments as part of their financial quality assurance surveys at ROs.
- Trends and best practices from site surveys are communicated to ROs.
- An External Oversight Tracking System has been implemented incorporating all IG and GAO reports and recommendations.
- The Office of Performance Analysis and Integrity (PA&I) was established to properly reflect the level of commitment VBA places on ensuring program integrity. VBA is now able to more efficiently review data, utilizing data mining and other techniques to identify suspect data.
- Through our data mining efforts, VBA reviewed cases with characteristics similar to the Atlanta fraud cases. We looked at similar payment patterns, payment levels, and "resurrected" records.

- VBA developed an Erroneous Payments Plan for compliance with the FY 2002 Improper Payment Act.

- Deloitte & Touche considers the reportable condition "Authorization of Compensation Benefits Claims Payments" corrected (see independent auditors report 12/16/02).

- VBA received clean audit opinions on its Consolidated Financial Statements for FY 2001 & 2002.

- Significant progress has been made in implementing IG and GAO recommendations.

- Job descriptions for employees authorized adjudicative responsibilities were reviewed and separation of duties reinforced. (OFO Ltr 201-01-79)

- VBA increased employee awareness of fraud prevention and accountability through training initiatives and information dissemination.

- VBA is working closely with the OIG on the Fugitive Felon Program and are in the planning stages of a new proactive fraud initiative based on the IG's review of Philippine cases.

Large Payment Verification Review

VAIG Testimony, page 19

In response to the Atlanta fraud cases, VBA began a review of all C&P retroactive payments in excess of $25,000. Since October 2001, RO Directors or Assistant Directors are required to personally review and certify such payments.

Beginning in October 2001, the Office of Program Analysis and Integrity (PA&I) has sent twice-weekly listings of all C&P payments over $25,000 to every RO Director. The Director or Assistant Director is required to review the payments made at his or her station and certify the payment within 15 days to PA&I. To date, no fraud has been detected.

During FY 2002, RO directors reviewed 17,635 payments. Erroneous payments totaling $2,651,000 were reported and the ROs either recovered the amount in full or established an overpayment. Due to the requirement for timely reviews, less than $200,000 was written off due to administrative error.

Through May of FY 2003, RO Directors received notice of 15,675 payments and reported $2,604,000 in erroneous payments that were either recovered or for which an overpayment was established. While principally developed as a fraud detection system, the reviews have also been valuable for pointing out either system problems, policy confusion, or payment errors. For example, a computer-processing problem resulting in erroneous payments of more the $500,000 was identified through the Large Payment Verification Process.

Each RO must conduct an annual systematic analysis of operations (SAO) on the review process of these large payments. The stations have been directed to report the local findings, include analyses of the third signature process and the accuracy of payments, and outline a plan of action to address any inaccuracies or fraud.

Income Verification Match (IVM)

VAIG Testimony, pages 19-20

The one recommendation from the November 2000 audit of the IVM program that remains open concerns Social Security number (SSN) verification. The OIG testimony states that "the recommendation to complete necessary data validation of beneficiary information contained in C&P master records to reduce the number of unmatched records with the SSA remains unimplemented."

Problems with return files from the Social Security Administration (SSA) have prevented Compensation and Pension Service from conducting the semiannual SSN Verification project since the fall of 1998. During July of 2002 Hines Benefits Delivery Center (BDC) ran SSN Verification using a new process which sends an extract file into the Social Security Administration's State Verification and Exchange System (SVES) as part of the SSA Prison Match. The initial run under this new process resulted in more than 55,000 cases being written to the Unverified Social Security Numbers listing. This represented only terminal digits 00-24. C&P Service analyzed an extract of 86 hits from the July 2002 run and determined that most of the cases being written out did not require regional office action and that the process could be further refined to get the Unverified Social Security Numbers listing down to a more manageable size.

Project Initiation Requests (PIRs) modifying the Social Security Number Verification process and providing a sample of output were installed by the Hines BDC on March 28 and May 14, 2003. The results of the test are being analyzed in the Compensation and Pension Service. If it appears that the new Social Security number verification process is functioning correctly, Compensation and Pension Service will ask Hines BDC to start releasing monthly Social Security number verification lists to regional offices. If it is not functioning correctly, Compensation and Pension Service will attempt further modification of the processing.

Workers' Compensation Program Costs

VAIG Testimony, page 20

In 1998, IG completed an audit of the Department's Worker's Compensation Program (WCP) costs. The audit concluded with several recommendations:

a. Coordinate with individual Department elements to conduct a one-time review of all open/active WCP cases to prioritize and identify those cases where additional case management efforts could return employees back to work or otherwise remove them from the WCP rolls.

b. Include the case management best practices identified by our audit in VA's new directive on managing WCP cases.

c. Provide all VHA facilities with access to VA's WC-MIS (Workers Compensation Management Information System) and consider implementing the system modifications discussed in this report.

d. Issue policy and guidance on recording, tracking, and using "Continuation of Pay" information and cost as a management tool.

e. Establish a formal agreement between VHA and NCA on case management assistance that will be provided by VHA field facilities to NCA field facilities; and

f. Continue to monitor WCP as a management control Internal High Priority area.

VA addressed each recommendation and reported the results to the IG. In September 2001, the IG's office notified the Assistant Secretary for Human Resources and Administration that the audit recommendations were completed and closed.

The Department seeks opportunities to reduce VA's WCP claims and costs. VA accomplishes this through training, oversight, and procedure verification. One example is VA's emphasis on returning employees to light duty assignments. This effort helps reduce the number of active cases and in some instances costs. However, those employees who often remain on WCP rolls long term are those with severe injuries. The significant increases in health care costs are another contributing factor.

FINANCIAL MANAGEMENT SYSTEMS

VAIG Testimony, page 21

The Department continues to move ahead toward implementing an integrated financial and logistics system. CoreFLS deployment represents a major leap forward in VA's effort to implement a centralized system where policies, processes, procedures and data classification rules are consistently applied. The CoreFLS system will be the basis for a more comprehensive solution across all VA systems. While CoreFLS implementation alone may not remedy all OIG concerns, it will assist VA by addressing internal controls and financial reporting deficiencies in many significant ways. CoreFLS can provide the following features/capabilities to support the VA in obtaining an unqualified OIG audit opinion:

- CoreFLS will integrate many disparate systems into one single system to improve VA's ability to track, reconcile, and report VA-wide financial and logistics activities automatically.
- CoreFLS will allow VA to manage financial and logistical activities as "*One VA*" by streamlining operations, standardizing on best practices, and providing timely information for management decisions.
- CoreFLS will build a VistA AR staging table to drill down GL summarized data to the supporting detailed transactions in the subsidiary ledger and feeder system.
- Once fully deployed, CoreFLS will allow for a better alignment of resources to program activities, track program performance against full cost, improve automated reconciliation and improve ad hoc analytical tools.

By retiring a number of disparate systems and bringing their functionality under the CoreFLS umbrella, by servicing the entire VA community under one unified database, by standardizing processes and procedures for all of VA, and by implementing robust interfaces to feeder systems, CoreFLS will represent a significant leap forward to the implementation of a VA-wide integrated system.

CoreFLS will greatly simplify the process of generating VA's consolidated financial statements by combining the financial activities of all VA administrations and reporting them from a single system of record. CoreFLS will also provide the capability to reopen closed periods in a controlled manner (or perform multiple preliminary yearend closings) so that revised financial statements can be prepared. The capabilities of CoreFLS will reduce manual compilations, and streamline extraneous processes, thus reducing administrative burden.

CoreFLS will also develop a System Security Plan to improve the protection of Information Technology (IT) resources. The security plan will be consistent with FISCAM, NIST SP 800, OMB Circulars A-123, A-127 and A-130, and other relevant regulations and guidelines.

DEBT MANAGEMENT ISSUES

VAIG Testimony, page 21

Although improvements are still needed, much progress has been made toward addressing debt management issues identified in OIG reports, including the need to be more aggressive in collecting debts, improving debt avoidance practices, and streamlining and enhancing credit management and debt establishment procedures. We are working with VA Administrations to address recent OIG concerns in this area as well as with OIG staff to resolve audit findings and remove debt management as one of VA's Major Management Challenges.

VA met goals established by the Department of the Treasury for referral of delinquent debts to Treasury for administrative offset (Treasury Offset Program (TOP)) and cross-servicing. At the end of the second quarter of FY 2003, TOP compliance is 97 percent and cross servicing is 95 percent. VA has collected $101 million from TOP over the last three calendar years and another $23 million from cross-servicing referrals that began late in calendar year 2000. VHA increased medical care collections in FY 2002 to approximately $1.2 billion and are is on target to collect a record $1.6 billion in FY 2003. VHA has also incorporated the MCCF program into a business office and is continuing to address the OIG issues regarding old receivables, improving the processing of bills, and identifying missed billing opportunities.

VA's Debt Management Center continues to utilize all available collection tools to maximize recovery of outstanding debts. This includes collection of credit card payments by telephone and via the Internet, which has resulted in payments from debtors of $1.1 million in FY 2003 through April (a 16 percent increase over the same time period in FY 2002 and a 56 percent increase over FY 2001), and use of toll-free telephone and predictive dialing systems. Debtors can respond to a collection notice and establish payment arrangements via phone or provide information substantiating their objections to payment of the debt. DMC staff also use predictive dialing systems to reach debtors directly and arrange repayment. The DMC attributes millions of dollars in collections as a result of their ability to reach debtors personally. DMC has also assisted VHA with first- party delinquent medical billings. DMC began matching delinquent first-party medical debts against VA benefit payment files. Through an administrative offset process, done on a monthly basis, over $29 million has been collected. In addition, over $65 million in delinquent medical debts have been collected over the last three calendar years from referral of these medical debts to TOP.

Audit recovery efforts have also expanded over the past 2 years and have resulted in substantial recoveries. VA's Financial Services Center in Austin, TX, reviews VA vendor payments daily to systematically identify, prevent, and recover improper payments made to commercial vendors. Current payment files are matched to identify and prevent duplicates prior to payment. Also, payments from prior fiscal years are matched to identify potential duplicate payments for further analysis, assessment and, as appropriate, collection. In FY 2002, the FSC recovered more than $2.2 million, a 44 percent increase over FY 2001 recoveries of $1.6 million. FY 2003's year-to-date performance is 84 percent above FY 2002 levels and recoveries should reach $3 million. At the same time, improved oversight and process improvements throughout VA have reduced the number of duplicate payments. In FY 2002, duplicate payments fell to $1.8 million, a 42 percent improvement over FY 2001 levels of $3.0 million. FY 2003's performance is also running 84 percent ahead of FY 2002 levels and, at the current pace, FY 2003 duplicate payments should fall to $1.2 million. The General Accounting Office recognized the FSC's efforts to recover excess expenditures as a good example of effective government financial management.

Additionally, the VA has fully centralized its permanent change of station (PCS) travel payment processing at the FSC. This initiative consolidates all aspects of PCS travel payments, including travel authority and voucher preparation, bills of collection processing and relocation and move management services. Benefits expected include increased efficiency, a reduction in improper payments and improved internal controls and accountability over VA travel funds.

Procurement Practices
VAIG Testimony, page 22-29

The Office of Acquisition and Materiel Management (OA&MM) is working with the Chief Information Officer's (CIO) office to stand up an online searchable database that will allow all procurement offices to view and search every item that the National Acquisition Center (NAC) has on contract. This will assist Veterans Health Administration (VHA) procurement activities identify items on Federal Supply Schedules (FSS), National Contract, or Blanket Purchase Agreements. (BPA). This was a Procurement Reform Task Force (PRTF) recommendation.

VHA is working through the standardization program to establish a national pricing structure for its medical supply products. In an effort to meet the recommendations of the National Procurement Reform Task Force (PRTF) as it pertains to the establishment of a larger number of more narrowly focused groups, the Clinical Standardization Program has established 10 Clinical Product Lines which will subsequently assign items to 39 user groups for evaluation and subsequent standardization. Included among the assigned items are the top 50 items used. The product lines were formed in February 2003 and are standardizing medical supplies and equipment from VHA's Top Fifty List. These 50 items constitute annual procurement costs of approximately $200,000,000. The Standardization Program is clinically driven with quality being the major factor. Clinical User Group members were selected from all major health care services to participate on the following product-line sub-groups:

- Wound Care
- VA/DOD
- Laboratory
- Imaging
- Anesthesia
- Surgery
- Medicine
- Medical /Surgical General
- EMS
- Office Supplies

Chief Medical Officers have been assigned to each major product line in order to provide a wider perspective, ensure compliance, and to provide clinical and administrative oversight. The chartered user groups for each product line are charged to review procurement history of assigned supplies and products currently purchased throughout the VHA health care system. In addition, they establish product evaluation criteria, review, investigate, and recommend action on all Waivers and Quality Improvement Reports (QIRs) within 30 days. The groups maintain relationships with the Prosthetics and Pharmacy Standardization programs in order to avoid duplication of efforts and identify products that may cross clinical functionalities.

To date, the National Standardization Program has produced an anticipated $19,100,000 in cost savings. However, actual cost avoidance data cannot be calculated until an award has been finalized. VHA's efforts to leverage its buying power within the Department, as well as in collaboration with other Federal agencies, are well underway. The National Standardization Program within the Office of Clinical Logistics will provide leadership and direction for the established user groups, monitor progress, remove barriers/obstacles, and resolve issues. The work plan of each product line will be rolled up into a national plan for standardization.

FSS Pricing Reviews

During Fiscal Year (FY) 1993, the Department of Veterans Affairs (VA) established two programs designed to reduce VA's vulnerability to contract overcharges and procurement fraud and to provide oversight of companies conducting business with VA.

In FY 1993, the Office of Acquisition and Materiel Management (OA&MM) entered into a Memorandum of Understanding (MOU) with the Office of Inspector General (OIG) specifically to have the OIG's Contract Review and Evaluation Division recruit and retain auditors to provide audit and advisory services related to Federal Supply Schedule (FSS) contracts awarded by contracting officers at the VA National Acquisition Center and other contracts awarded by contracting officers in OA&MM's Acquisition Operations Service. Pursuant to the MOU, the VA Supply Fund would reimburse the OIG for all expenses related to the contract audits. The VA previously had paid the Defense Contract Audit Agency to perform these audits. With the establishment of the audit group, dollar recoveries resulting from post-award audits of FSS and other contracts increased dramatically. Through April 2003, post-award audits have returned approximately $184 million to the VA Supply Fund. The group quickly established a knowledgeable and professional presence in the pharmaceutical and medical/surgical supply industry, and as a result, many companies elected to perform their own internal reviews and submit their findings to the OIG. Since 1993, VA has received 65 voluntary disclosures and refund offers from FSS contractors. Prior to 1993, VA received almost no voluntary disclosures. The OIG currently is reviewing 33 voluntary disclosures with refund offers amounting to $20 million. When appropriate, the OIG also makes referrals to VA's Debarment and Suspension Committee for any action it deems appropriate. Many cases result in contractors developing and implementing a corporate responsibility plan, which is part of a multi-year settlement agreement that assists in ensuring compliance with acquisition regulations and statutes.

In FY 1993, VA also established a Procurement Working Group which consists of the OIG Counselor, auditors, investigators, Office of General Counsel attorneys, and OA&MM acquisition managers. The establishment of the Group is part of the Department's effort to improve the management of the Federal Government and eliminate fraud, waste, and abuse. The Group meets regularly to discuss issues impacting procurement of health care supplies and services and develops action plans to improve the procurement process.

Contracting for Health Care Resources

The Office of the Inspector General (OIG) findings regarding conflict of interest, marketing, performance monitoring, or that the affiliate had a strong role in the negotiations are not new issues. If we go back to OIG audits in the early 1980s, we would find some of the same, if not all, issues. Despite our training efforts and policy guidance, these issues still exist. Veterans Health Administration (VHA) is in the process of rewriting its procurement policy under Section 8153. This is a collaborative effort with the Office of Acquisition and Materiel Management (OA&MM). Through this collaborative effort, controls will be in place to: (a) mitigate conflicts of interest during pre-award and post-award periods of contract; (b) promote competition; and (c) ensure actions are in accordance with Federal Acquisition Regulation and VA Regulation. The draft policy should be finalized this fall, will repeat the existing policy, including conflict of interest. The main thrust of the new policy, however, is to involve the Association of American Medical Colleges and the Council of Teaching Hospitals.

The VHA Clinical Logistics Office will remind the Network Chief Logistics Officers (CLO) that it is essential to ensure that Contracting Officer's Technical Representatives (COTR) are completing required training prior to appointment and that refresher training is taken. VHA will work with OA&MM to stress to the VHA contracting and logistics communities the importance of determining and documenting the reasonableness cost or price prior to award. Additionally, VHA will work with OA&MM to develop self-evaluation tools to be used in conducting local reviews of specifically identified areas of weakness, i.e. completion of required COTR training, invoice reviews, negotiation documentation for non-competitive awards, and detection of inappropriate splitting of requirements. As a result of these initiative, VHA will provide targeted training in areas that have been identified as weaknesses. VHA will review quarterly Summary Reports of CAP Findings along with all other available current audits and review findings.

Purchase Card Activities

The Office of Finance has been very proactive in responding to systemic management weaknesses and vulnerabilities that have been identified during the course of Office of Inspector General (OIG) audits and program office reviews related to the purchase card. Specifically, VA has developed and published VA Directive and Handbook 4080 that establish policy 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 the policy is the provision for disciplinary actions when policy relating to proper use of the card is not followed. The Directive and Handbook also directly respond to recommendations from the VA's Procurement Reform Task Force related to strengthening the criteria for obtaining and using the card and for expanding the use of the card as a payment mechanism.

While these formal steps are important in documenting VA policy and procedures, we have also implemented (1) expanded training for card users and approvers, (2) continued networking and communication with field station and VACO card coordinators,
(3) automated controls to better control where a card can be used (Merchant Category Code) and the amounts authorized for single purchases and monthly limits, and (4) requirements for reconciling purchases. Greater emphasis on all of these have had, and will have, more positive results in addressing the OIG weaknesses and vulnerabilites. Other controls have also been put in place to improve employee clearance procedures and matching controls between card holders and the VA employee file to ensure that cards are not held by or issued to personnel who no longer work for VA or who are transferring to another VA site.

While not a preventative measure, the Office of Finance and the OIG have partnered in establishing an automated audit program based on data mining and fraud analysis techniques as another monitoring control to help uncover misuse or improper use of the card and to ultimatley provide information to further improve preventative controls. While improving internal controls and procedures, we are also continuing to identify additional uses of the card that would reduce operational costs and result in increased rebates to VA.

Inventory Management

As a result of the Office of Inspector General audits and from general program management, VA has enacted a number of measures to address inventory management problems. Below is a summary of some of the more significant actions.

Inventory management performance criteria, including turnover rate, inactive stock, and long supply stock, were established and are being tracked by Headquarters. Facilities are assigned color-coded ratings, and those not meeting acceptable standards receive follow-up action.

Directive and Handbook 1761.2, VHA Inventory Management, was issued 2 years ago and later updated to include Consolidated Mail Out Pharmacy (CMOP)s and Pharmacy. This document provides policy and guidance relating specifically to inventory management.

The Office of Chief Logistics was created in VHA that reports directly to the Deputy Under Secretary for Health to address logistics issues including inventory management.

A Materiel Management Subcommittee of the VHA Acquisition Board was recently established. The subcommittee has already issued a memorandum from the Under Secretary for Health mandating that all supply inventories be automated. Some projects the subcommittee will undertake are:

1. Develop and conduct a training program for VA automated inventory management.
2. Study and establish proper inventory turnover rates.
3. Examine the use of Supply Fund (a revolving fund) to finance inventories.

A materiel management email group was established to provide a mechanism for VA facilities to advertise excess stock within VA. The email group is very active, and nearly all items advertised are re utilized in the department.

The Office of Management has proposed a reorganization to create stronger, more centralized control of VHA logistics operations. In the reorganization proposal is a recommendation to establish more unified and consistent logistics organizations at VA medical centers. This should provide more discipline and better oversight to inventory management. The reorganization proposal is in the final stages of negotiation.

A business review program was established to have a team of experts periodically visit VA facilities. The team examines logistics operations and prepares a report of findings and recommendation. The VHA Chief Logistics Office conducts follow-up actions with facilities that have major deficiencies.

Information Security Issues

VAIG Testimony, pages 29-30

The Department has made significant progress in correcting the deficiencies identified by our Office of Inspector General (OIG) and the General Accounting Office (GAO). Over the past year, the Department fielded one of the largest anti-virus capabilities in the world which protects the over 140,000 desktops connected to VA's Intranet from malicious attack. To date, over two million viruses have been successfully detected and eradicated. In July 2002, a multi-year contract to significantly upgrade the capabilities of our VA-Central Incident Response Capability (VA-CIRC) was awarded. This enhanced VA-CIRC capability provides such global services as firewall and Intrusion Detection System (IDS) management, vulnerability assessment, and penetration testing. A subordinate activity to the VA-CIRC is the Security Operations Center (SOC). The SOC became operational in March 2003 and provides 7x24x365 monitoring of the security health of the department.

In addition to the anti-virus and VA-CIRC/SOC efforts, the Department is continuing to deploy other specifically focused initiatives developed during the past year to correct IT security weaknesses identified in our annual Federal Information Security Management Act (FISMA) self-assessment survey process. These programs include our Enterprise Cyber Security Infrastructure Project (ECSIP), the Information Security Technology Certification and Accreditation Program (ITSCAP), and our newly established Cyber Security Professionalization and Compliance Programs.

The ECSIP program has implemented the first of four centrally managed (by the SOC) Department-wide intrusion detection and firewall capabilities that will lead to a concurrent significant reduction in external network gateways. As part of the project, we plan to systematically collapse the over 200 existing external network gateways in VA into a more manageable number and efficient structure. Concurrent with this effort, Department-wide IDS capability is being incrementally deployed to provide significantly increased security protections for these gateways and other key elements of the infrastructure. Design and implementation efforts for this standardized architecture and configuration are underway and we anticipate completing the deployment of the remaining three gateways by the end of calendar year 2003.

The Department's newly established Cyber Security Professionalization Program (CSPP) is providing training, qualification and certification of VA cyber security practitioners. The Department will periodically evaluate the proficiency of current credential holders to ensure that established standards are maintained.

A Compliance Program is being implemented to provide independent verification of adherence to Department security policies and procedures through continual assessment of documentation archived in the Department's FISMA database, with subsequent periodic site visits to verify and test related IT security control implementation.

A recent reorganization within the Department centralized the management of the Cyber Security Program. This reorganization establishes a clear, unambiguous reporting chain for the Department's cyber security efforts. We have developed an organizational structure that combines the cyber security staff elements of the Administrations with the Central Office's Cyber Security staff, thereby creating a single integrated cyber security program office for the Department. Further, field Information Security Officers (ISOs) at the VHA VISN level and at the VBA Network Service Center (NSC) level have now become direct reports to the Office of Cyber Security. Within each hospital, regional office and at each cemetery, the ISOs will report directly to their respective facility director rather than the inconsistent manner of reporting in the past. The VISN and VBA NSC ISOs will provide functional cyber security direction to the facility ISOs, and conduct periodic inspections of the Cyber Security activities at each facility under their purview. The facility ISOs will be required to submit weekly reports as to each facility's cyber security health and welfare.

In summary of our cyber security efforts, we are building a strong foundation for our IT program, but much remains to be done in order to remove the material weakness in Information Technology.

Information-systems development

VAIG Testimony, pages 30-31

With respect to Information Technology (IT) Systems development, the Department recognized the need to establish a comprehensive Project Management oversight process in the summer of 2001. This oversight process reviews IT projects at critical milestones throughout its lifecycle.

VA's formal Project Management Oversight process has five major Milestone decision points. These milestones provide the ideal setting for senior management to ensure successful project execution in a project's evolution:

Milestone 0: Project Initiation Approval,
Milestone 1: Prototype Development Approval,
Milestone 2: System Development Approval,
Milestone 3: System Deployment Approval, and
Milestone 4: Post Implementation Review.

At each of these project milestone decision points, progressively more detailed information is available within the project and therefore available to support assessing that the project is being executed in consonance with sound Project Management disciplines. Furthermore, throughout the System Development Life Cycle of each project, the PM is required to notify the senior management oversight authority if the project will breech its established baseline in terms of cost, schedule, or performance. This will ultimately lead to successful delivery of requirements, on time and within budget.

Since implementing this oversight process, several projects that were in difficulty have been rebaselined and are now being successfully executed. Had this process been in place during the development of HRLINKS, the troubles that were encountered would have been identified very early in the development process and the project would have been terminated or put on a successful course.

Opening Statement of Christopher H. Smith, Chairman
Fraud, Waste, Abuse, and Mismanagement in Veterans' Programs
June 10, 2003

Last month, this Committee held its first in a series of full committee hearings on efforts to reduce and eliminate fraud, waste, abuse, and mismanagement in federal programs serving veterans.

At that hearing, the Committee heard comprehensive -- and ***sometimes disturbing*** -- testimony about specific practices potentially wasting hundreds of millions of dollars that could otherwise be spent providing benefits and services to veterans.

Both VA's Inspector General and the General Accounting Office furnished this Committee significant examples of current waste and inefficiency, as well as recommendations on what can be done to eliminate them.

Today, we will continue this focus and hear from the Department on their response to the IG and GAO testimony, as well as their own activities to make better use of the precious resources entrusted to them.

Building upon these hearings, this Committee will continue to use our oversight powers to spur the Department to root out fraud, waste, abuse, and mismanagement.

We will also examine whether there is a need for legislation to assist VA in tackling these problems.

As all of my colleagues are aware, demand for veterans' benefits and services is at record levels, with more than 6 million veterans enrolled in the VA health care system and over 2.3 million disabled veterans receiving monthly compensation payments.

With a budget that will exceed $60 billion next year, the Department of Veterans Affairs is the second largest agency of the federal government, employing more than 220,000 dedicated men and women, a significant number of whom are veterans themselves.

Providing sufficient resources for such a large organization will always be a challenge, particularly in an economic environment where federal deficits are growing.

The House and Senate this year agreed upon a record budget for veterans programs for FY 2004 -- $63.8 billion – a 10.7% increase totaling $6.2 billion.

Veterans' health care funding would increase by about $3 billion under this budget, a record 12.7% increase.

Of course, there is still an appropriations process ahead of us, and there are certain to be competing demands from federal programs. But no matter how high an appropriations level we reach, it remains absolutely essential that Congress and the Administration aggressively eliminate fraud, waste, abuse, and mismanagement wherever and whenever we find it.

When the Inspector General finds some part-time doctors being paid, but not showing up for work, this not only hurts veterans, it also damages the reputation and morale of the vast majority of VA health care professionals, who are among the finest and most dedicated in the world.

When fugitive felons or incarcerated prisoners illegally obtain and receive VA benefits, this not only drains the system of much needed resources, it also lowers the productivity of thousands of hard working VBA employees, who should be spending their time processing legitimate claims for veterans benefits.

Furthermore, when we continue to make our case for the **fully justified** higher levels of funding that were included in the budget, we are strengthened by documenting the ongoing efforts, both by Congress and the Administration, to cut waste and eliminate inefficiencies.

And this Committee has an excellent record in doing just that.

In 2001, we passed legislation to deny veterans benefits, such as disability compensation, to convicted felons and other persons fleeing prosecution for a felony offense.

Using this tool the Inspector General went after such fraud, finding that savings related to the identification of improper and erroneous payments could exceed $200 million annually.

Recognizing the cost savings potential of combining VA and DOD purchasing power, Congress enacted several laws directing VA and DOD to act to reduce pharmaceutical prices through joint contracting.

In 2001, VA/DOD joint procurement purchases resulted in $98 million in cost savings, $80 million of which was realized by VA. In FY 2002, savings from joint procurement purchases for pharmaceutical products totaled $369 million, with $279 million in cost avoidance realized by VA.

In 1999, the Committee on Veterans' Affairs recommended a change in the law that would allow VA to charge "reasonable and customary" amounts usually paid by insurance companies instead of flat fees.

This led to increases in collections from third party insurers of 35% in 2001 and 32% in 2002, providing $442 million during this two-year period for health care services that would otherwise have required additional appropriations.

Five-year savings are estimated to be in excess of $1 billion.

I cite these as examples of specific congressional actions that have led to savings, money that is better directed at providing services and benefits to the millions of deserving men and women who have served our nation.

There are other areas that we continue to pursue to make VA as efficient as possible, such as legislation to strengthen VA's ability to collect reimbursements from third party insurers.

Furthermore, we continue to seek a long term solution to VA health care funding problems. The President's Task Force on veterans health care last week told this Committee that *until a stable and predictable funding system is established*, VA will be unable to achieve further efficiencies through greater collaboration and resource sharing with DOD.

I know the Administration has an ambitious program for achieving management efficiencies – almost $1 billion in FY 2004.

I look forward to hearing from Deputy Secretary Mackay the details of how those savings will be achieved, as well as the details of recent management savings achieved by the Department.

When it comes to providing benefits and services to the men and women who served our nation in the armed forces, we don't have a dollar to waste.

Today's hearing is another step towards ensuring our nation meets its obligations to military veterans in the same manner these former soldiers, sailors, airmen, and marines met their obligations to our nation.

Statement of Congressman Lane Evans
Ranking Democratic Member, Committee on Veterans Affairs
Full Committee hearing on June 10, 2003

Mr. Chairman, this is the second of a series of hearings on fraud, waste, abuse and mismanagement at the Department of Veterans Affairs (VA). During the first hearing, the Committee accepted testimony from the VA Office of the Inspector General and the General Accounting Office (GAO) regarding their past and current investigations.

Based on investigations by those two agencies and by this Committee, we enhance our understanding of internal management effectiveness at VA. If the first hearing was about awareness of past problems – this hearing should chronicle VA progress in mitigating those problems and in establishing an accountable management team and a general system of management that eliminates fraud, waste, abuse and mismanagement. We expect meaningful progress in this regard.

Last month, the VA Inspector General testified about issues involving part-time physician attendance problems. Taxpayer dollars are paying for part-time physicians, but VA cannot account for time and services benefiting VA. Often, the part-time physician is also employed by an affiliated hospital creating the appearance of conflict of interest. What actions are being taken to address this problem and what is the timeliness of those actions?

Yesterday, the Committee received comments from VA regarding items identified by the IG at the May 8, 2003, hearing on Fraud, Waste, Abuse and Mismanagement at VA, as items of concern. VA's comments on June 9, 2003, proclaim, "VHA has responded to these (IG) findings with a series of actions."

But, why did it take an IG investigation with formal findings to generate action in VHA? Physician time and attendance is not a new issue – one can find references to this issue and even sample tracking forms in Committee Reports dating to the 91st Congress, circa 1969-70. Good managers should not require an IG's findings to know when to be proactive and take action.

The IG also addressed concerns with Contracting for Health Care Resources, finding that the affiliate had too strong of a role in the negotiations with potential conflict of interest or problems with marketing or performance monitoring. VHA notes that these are not new issues and that problems continue to exist despite

VA's training efforts and policy guidance. What happened to accountability – what happened to oversight – what happened to leadership?

If you know a problem exists, and you know it exists despite your training sessions and policy guidance, you should not just give up and accept the status quo. If an action officer is ignoring VA Central Office policy, it is incumbent on VA to willfully enforce that policy. If the message is clear and the policy is still ignored – VA Central Office needs to send a more powerful message about who is in charge. They should not wait for an IG finding before they take action. If the procurement process is inefficient or is compromised by conflict of interest and affiliate involvement -- veterans' health care suffers.

There is a third issue that may be rooted in close relationship to VA enjoyed by some affiliates. All too often VA misses opportunities to acquire intellectual property rights. VA has a very low rate of receiving patents for its intellectual property and discoveries. Revenues and royalties from these sources could offset costs. In 1999 and 2000 VA had zero patents, one in 2001 and 2 in 2002. By contrast, the Department of Energy averaged about 57 patents per year. VA should do more to secure its intellectual property rights and patents and reap the benefits of its inventiveness. It is not clear why VA performance in this area is so poor. More information is needed.

In his statement, Dr. Mackay states that it is incumbent upon us to carry out our duties as efficiently as possible, in ways that protect the significant investment a grateful nation has made in these programs. I fully agree.

He also praises the tone set by the President with his comprehensive Management Agenda for maximizing the value of Federal Programs. I think that agenda leaves too many questions unanswered. Is the threshold for results too low in matters regarding America's veterans?

On March 6, 2003, I wrote Office of Management and Budget Director Mitch Daniels regarding specifics in the Budget buttressing estimated savings attributable to the President's Management Agenda as it relates to competitive sourcing savings at VA. The Performance and Management Assessment projected that competitive sourcing of 52,000 VA employee jobs may yield as much as $3 billion in savings over a five-year period. I wanted to know how the Administration arrived at that estimate – what was the basis? The OMB response provided neither a basis nor analytical study nor detailed explanation.

Director Daniels' May 14th response referred to the $3 billion savings estimate as a "best-case scenario." The response failed to affirm the $3 billion savings as an official projection, but rather cited a lesser VA estimate of $1.3 billion in savings from competitive sourcing. Is it appropriate to build a $1.7 billion error into the Budget – a 57% error? If efficiency and accuracy is the goal, why exaggerate the projections? The exaggerated estimate of savings attributed to the President's Management Agenda cheats veterans when those savings fail to materialize.

I had asked OMB about the aggregate costs of sourcing assessments, increased contracting, management and oversight workload, as well as the impact of competitive sourcing on organizational cohesion, mission focus, HR investment, and the loss of long-term capacity. OMB did not address any of these issues. Should the public now conclude that these things were not considered in savings calculations and that they could produce a "worst-case scenario" beyond the 57 percent savings estimate error?

The letter seems to indicate a low confidence in the Administration's own Budget projections when it states, "As we gain more experience, our savings estimates will be continually refined." The competitive sourcing process comes at a cost – in the end these costs may off-set any short-term savings. The engine of government must function efficiently over the long-haul.

The OMB response also identified the need to study 19 non-core functions – among those 19 functions is the Medical Care Cost Fund (MCCF). However, this fund was referred to as a core business function by the Deputy Secretary at a hearing in May. As a core business function, the MCCF should not be outsourced – it is a vital part of VA's health care funding process – yet OMB includes this function in its savings calculations.

Mr. Chairman, we must examine savings estimates and projections carefully. The FY 2002 VA budget forecasted a savings of $299 million through management efficiencies. This savings would help VA meet healthcare expenses. What a great tool – by the FY 2004 VA budget, the savings projected by uncovering management efficiencies at VA increased to $1.1 billion. This too would supposedly help to balance the VA budget. What proof do we have that magnitude of savings was realized? Why, in one two-year period did VA's management create a landscape generating the need or ability for a 367 percent increase in additional management efficiency? We must answer these questions to understand the value of management efficiency savings.

Statement of the Honorable Leo S. Mackay Jr., PhD
Deputy Secretary of Veterans Affairs
Before the Committee on Veterans' Affairs
United States House of Representatives
June 10, 2003
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Chairman Smith and Members of the Committee:

Thank you for inviting my testimony today. This Administration, and my Department, take very seriously our stewardship of America's programs of veterans benefits and services. We realize it is incumbent upon us to carry out our duties as efficiently as possible, in ways that protect the significant investment a grateful nation has made in these programs. President Bush set the proper tone with his comprehensive Management Agenda for maximizing the value of Federal programs.

Comments On The Inspector General's Testimony

Last month, VA's Inspector General appeared before you to discuss a number of matters that have been the focus of his office in recent years. Although some of the concerns he identified arose some time ago and have since been appropriately addressed, all merited action. I commend him for his testimony and the valuable service his office provides.

I respectfully request that you include in the record of today's hearing a paper we have provided to Committee staff that highlights the Department's actions in addressing each of the major areas covered by the Inspector General in his testimony before this Committee on May 8. While I would welcome discussion of any of the points covered in our paper, I want to specifically mention three areas in which serious shortcomings have been identified and addressed.

We have taken what I believe to be strong, effective steps in response to the OIG's findings of insufficient oversight of the time and attendance of part-time VA physicians. As surging demand for VA health care strains our capacity to provide sufficient access to care, it becomes even more imperative that we get the full measure of value from the salaries we pay our health-care professionals. The April 2003 OIG report demonstrated clearly that significant numbers of part-time physicians were not fully honoring the terms of their employment, and that VA was insufficiently vigilant in overseeing their compliance. We have required that all part-time physicians be counseled about time and attendance requirements and certify to their understanding of the rules. Refresher training has been given to all timekeepers, and all local time-and-attendance policies have been reviewed by VHA headquarters to ensure their validity and national consistency. A pilot program will test the efficacy of swipe cards to record part-time physicians' arrivals and departures at their VA duty sites. I can assure you we will follow through to ensure that tours of duty are clearly understood and appropriately enforced.

We were of course deeply disturbed by the discoveries in recent years that a handful of VBA staff had been able to embezzle benefit funds. We now have in place a number of controls that greatly reduce the likelihood of recurrence of any such fraud. In fact, in December 2002 the auditing firm Deloitte and Touche reported that VBA's payment-authorization problem had been corrected. Among the safeguards now in place:

- All awards of VA benefits that are retroactive for periods exceeding two years require signatures attesting to the approval of three Regional Office employees, including the Service Center Manager or supervisory designee.
- Regional Office Directors or Assistant Directors must personally review all proposed compensation or pension payments in excess of $25,000, and ensure proper third signatures on awards.

- Network Support Centers annually review all regional offices' compliance with internal controls for benefit delivery systems and applications.
- Payment reviews are conducted as part of regional-office site surveys by VBA's business lines and its Office of Resource Management.
- The Department's Financial Quality Assurance Service conducts analyses of improper payments as part of its financial quality assurance surveys.

The inspector General also identified a number of challenges VA faces in attaining "a more efficient, effective, and coordinated acquisition program." Because VA annually procures some $6 billion worth of pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction and services, it goes without saying that we must strive for best-possible value.

In 2001, the Secretary chartered a VA Procurement Reform Task Force to review a major OIG report issued that year on the subject of VA purchasing practices. Comprised of acquisition experts from across the Department, the task force issued a report containing 60 recommendations covering a wide range of issues including purchase-card controls, mandated health-care-supply purchases through a prescribed hierarchy of nationally negotiated contracts, and enhanced procurement partnerships with the Department of Defense. The Secretary promptly approved the task force recommendations, and good progress is being made toward their accomplishment.

To date, 25 of the 60 task force recommendations have been implemented. Among these is the highest-priority proposal, which was implemented in December of last year. VA policy now requires the use of

national committed-use contracts and Federal Supply Schedule contracts for the most frequently used health-care items. Our National Acquisition Center has received 208 offers from potential suppliers, including 122 who are new to VA. This increased vendor participation will result in optimum pricing and expanded purchasing power for VA and other Government agencies. In April of this year, all administrations and staff offices were issued a handbook mandating new procedures for ensuring the integrity of our purchase-card program.

Over time, the Task Force recommendations will result in organizational efficiencies that will free resources to help sustain high-quality VA health care for veterans. Improvements will come in avoiding costs -- getting more for existing dollars. It is anticipated that a cost avoidance of approximately $250 million to $450 million for medical/surgical and prosthetic items alone will be realized over the next five years. (These benefits will be in addition to cost avoidances VA has already realized through pharmaceutical national contracting.) In addition, yet undefined savings will result from the procurement system and procedural improvements after the entire 60-plus recommendations are implemented. The VA's PRTF cost avoidance from May 2002 through May 2003 has been approximately $220 million.

Additional recommendations from the Task Force are on track as scheduled.

Standardization Groups. VA's efforts to leverage its buying power within the Department as well as in collaboration with other Federal agencies is also well underway. In February 2003, the Clinical Standardization Program established 10 Clinical Product Lines with 39 user groups. The 39 user groups have been given the assignment to evaluate and subsequently standardize medical supplies and equipment from the Veterans Health Administration (VHA) Top Fifty List. These fifty items constitute annual procurement costs of more

than $200,000,000. To date, the National Standardization Program has produced in excess of $19,100,000 in savings/cost avoidance.

National Item File. The National Item File (NIF) is a key to improving inventory management. The information contained within the NIF is being expanded beyond current VA capabilities. These expansions include the addition of the Universal Product Number, known as the UPN, and the United Nations Standard Products and Services Code (UNSPSC). The development of the expanded NIF will be far reaching. The expected results of the NIF will allow standardization of the existing item files across VA, provide a clean and complete NIF for coreFLS, and identify product availability across the Nation. The NIF will bring together information from the Department of Defense, health care support organizations, and international organizations. Development of the NIF has been a very ambitious undertaking. We expect rollout to begin in FY 2004.

VA/DOD Sharing. VA and DoD continue to benefit from joint cost avoidance of the consolidated pharmaceutical procurement program. Projected savings of $480 million are expected in FY 2003, an increase over the savings from last year of $369 million. To further expand our savings, we are actively working with DoD in the consolidation of medical/surgical commodities. Since the beginning of the year we have begun partnering with DoD for joint procurements of vital-sign monitors, medical/surgical instruments and cochlear implants. The joint project (Vital Signs Monitors) is in the final stages of the procurement process and is estimated to yield a substantial cost avoidance of $750,000 annually. We are also in the process of developing a data base tool which will accelerate our price comparisons with DoD and thereby accelerate our joint procurements for medical/surgical products.

Legislative Proposals

In inviting us to appear today, you asked that we identify steps Congress could take "to help VA save money." The following cost-saving or revenue-generating proposals were identified in the President's FY '04 budget request:

- Require annual fees for certain category 7 veterans, and all category 8 veterans, enrolling in VA's health-care system;
- Increase the pharmacy co-payments to $15 for each 30-day supply of medications obtained by certain veterans;
- Legislatively override the *Allen* decision, under which VA is now required to compensate service-disabled veterans for additional disability due to their abuse of alcohol or drugs; and
- Establish VA as a preferred provider for members of health-maintenance organizations (HMOs) and preferred-provider organizations (PPOs) so that VA may be reimbursed for non-service-connected care provided to members of these plans, as it is by other insurers.

Our *Allen*-case legislation, forwarded to the Congress in April, would itself result in mandatory savings estimated by the Administration to be $127 million the first year and $4.6 billion over ten years. Moreover, its enactment would put an end to a state of the law we consider unconscionable and an affront to most veterans. The same program that so fittingly compensates veterans for their combat-related disabilities should not be a source of payments to veterans *because* they are substance abusers. Congress established the appropriate policy when it provided in 1990 that "no compensation shall be paid if [a] disability is a result of [a] veteran's own . . . abuse of alcohol or drugs." VA is a recognized leader in the treatment of substance disorders, and that is an altogether appropriate role for the Government to assume. But paying veterans for the disabling effects of their own alcohol or drug abuse obviously can be a disincentive to their treatment and recovery. As currently interpreted by the

courts, the law in this regard reflects a public policy bordering on absurdity. We urge your prompt enactment of our legislation.

We also request your help to ensure that VA-appropriation acts for FY '04 and beyond contain funding specifically earmarked for studies to compare the costs of contracting for or performing in-house certain commercial activities required by the Veterans Health Administration. Current law, 38 U.S.C. §8110(a)(5), prohibits us from using medical-care funds or VHA personnel to perform these studies absent specific appropriations for the purpose. Specific appropriations were regularly enacted until FY 2001, and their enactment must resume if we are to achieve needed efficiencies and obtain best value for our health-care dollars.

Management-Oversight Structures

Secretary Principi has established a governance structure that ensures management's close and careful oversight of the Department's business planning and performance. Among the major components of this structure:

Strategic Management Council & VA Executive Board. All major Department initiatives are vetted through the Strategic Management Council, chaired by me, and comprised of top officials of the three administrations (deputy-undersecretary level) and staff offices (assistant-secretary level). The SMC meets twice monthly to critically analyze proposed and ongoing initiatives having significant resource implications. Its mission is to review, discuss, and to provide recommendations to the Secretary on Department-wide policies, strategic direction, resource allocation, and performance in key areas. It makes recommendations for

actions and decisions to the VA Executive Board, the Department's senior management forum, which is chaired by the Secretary and comprised of myself, the three Under Secretaries, the Chief of Staff and General Counsel. The VAEB convenes as needed to receive and review the recommendations of the SMC.

VA Business Oversight Board. The mission of the Business Oversight Board is to review and oversee the performance, efficiency, and effectiveness of the Department's business processes, to include procurement, collections, capital-portfolio management, and business revolving funds. The Secretary serves as chairperson and I as vice-chair. Membership includes the three Under Secretaries, the Assistant Secretaries for Management and Information and Technology, and the General Counsel. The Board meets at least quarterly.

Capital Investment Board. The VA Capital Investment Board is the Department's primary review-and-recommendation mechanism for all significant capital investments. The Board ensures that investment decisions are based on sound economic practices and are linked to the Department's strategic goals. The Board also makes certain that each of the Department's highest priority recommendations gets equal consideration in the development of an overall capital plan.

Asset Management. VA is developing a capital-asset-management system (CAMS) with business processes and decision frameworks covering long-term management of VA's assets. This system will improve financial and analytical capability by allowing VA to track actual against planned performance, enabling commercial benchmarking, and improving service delivery. VA is striving to move beyond asset management to

portfolio management, which involves leveraging an investment (or combination of investments) in order to minimize risk and maximize cost effectiveness and performance of assets.

These structures and processes are fostering a more business-like approach to our important work. As the President has said, "This Administration is dedicated to ensuring that the resources entrusted to the federal government are well managed and wisely used." We at VA owe that to all Americans, but especially to the veterans among them.

I would be pleased to respond to whatever questions you may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SMITH TO DEPARTMENT OF VETERANS AFFAIRS

Office of Inspector General Responses to
Questions for the Record
Honorable Christopher Smith, Chairman
Committee on Veterans' Affairs
May 8, 2003

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

1. *The latest IG Combined Assessment Program (CAP) report on medical facilities found 10 of 11 medical facilities reviewed lacked appropriate accountability for controlled substances. Given the pervasiveness of deficiencies, what actions are being considered by Central Office to address the apparent system wide problems and are these sufficient?*

   Medical facility directors have provided acceptable implementation plans to address the deficiencies identified during CAP reviews related to improving accountability over controlled substances. VHA has set goals to develop a comprehensive training and educational program for controlled substance inspectors, VA medical center managers, and VISN leaders. In addition, goals have been established to enhance security for narcotic storage and handling, establish a system for monitoring and assessing changes made in the narcotic inspection program, and monitor CAP review findings to assess the effectiveness of corrective actions. We plan to continue reviewing controlled substance accountability to assess the adequacy of the corrective actions.

2. *You mentioned in your written statement that the lack of VHA physician-staffing standards has led to understaffed medical facilities. Based on the various CAP reports and investigations you have conducted at VA medical facilities, what recommendations would you present to VA to resolve this problem?*

   Our studies have shown broad physician staffing disparities between VA medical centers. We have evidence that some specialties in some medical centers may be overstaffed, while other areas in the same medical centers may be understaffed to accommodate their respective workloads. We have found no medical centers significantly understaffed in physician manpower. We would recommend that VHA establish sound physician staffing standards similar to those that have been used by the military services for the past several years, and that VHA managers continually evaluate these staffing standards for efficacy in relation to the constantly changing needs presented by veteran demographics and morbidity patterns as the veteran population ages. The use of staffing standards is considered the norm in operating and maintaining complex health care organizations as exemplified by the VHA. Standards are essential to making rational budgeting and resource allocation decisions, as well as health manpower projections.

   VHA needs to establish staffing standards to help determine the clinical resources needed to provide timely care. VHA is in the process of developing such standards and we will review the standards and their implementation.

3. *After your 2002 CAP review of the VAMC in Lexington, KY, the medical center agreed to eliminate unnecessary physicians and to reallocate any resources associated with those positions to the Primary Care Service which was short-staffed. This was done to help clear the waiting list and eliminate the patient workload at this facility. Is it possible that situations like this are occurring at other facilities; and could the remedy in Lexington be applied to other facilities to help decrease waiting times?*

   Yes, it is possible that this situation is occurring in other locations and, in certain situations, could help to decrease waiting times. Results from our CAP reviews, ongoing evaluations, and anecdotal information coming to our atten-

tion, indicates that access to VA care varies by region, and in some areas, there may be significant waiting time for lower priority veterans.

Our recent *Audit of the Veterans Health Administration's Reported Medical Care Waiting Lists* (OIG Report No. 02–02129–95, dated May 14, 2003) found that VHA needed to improve the accuracy of their reported waiting lists. This audit reviewed the accuracy of waiting lists at two VISNs and concluded the patient waiting lists for the two networks were overstated. 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.

Based on our sample results in the two VISNs, we estimated that the nationwide established patient waiting list was overstated by about 44 percent. We also found that some veterans who were enrolled for care but were on the "established veteran waiting list," were erroneously reported on the new enrollee waiting lists, further impacting the accuracy of VHA's waiting list.

In response to this audit, VHA managers established plans to develop a nationwide electronic waiting list. The initial step in this process was the December 2002 introduction of new software that allows schedulers to enter patients into a facility electronic waiting list through VISTA. VHA plans to rollup the facility level waiting lists into the National Patient Care Database.

It is important that the waiting list be accurate because VHA uses this data in planning, evaluating 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 VHA responses to internal and external stakeholder concerns. We plan to continue reviewing waiting list management and patient scheduling practices on our future CAP reviews.

Notwithstanding the overstatement of the waiting list described above, the findings at VAMC Lexington showed overstaffing in specialty positions and that reallocation of the unneeded positions to primary care could improve patient access care. Our national *Audit of the Veterans Health Administration's Part-Time Physician Time and Attendance*, Report No. 02–01339–85, dated April 23, 2003, shows that there is a nationwide potential to achieve greater productivity by ensuring physicians work the hours for which they are paid under their VA appointment, or by reallocating unneeded positions to more productive purposes. We are currently developing findings showing disparate access to care (waiting lists) among VA medical centers and Community Based Outpatient Clinics that may also be remedied by reallocation of staff.

4. *On page 15 of your testimony you mention that your fugitive felon program contributes to homeland security. What is the relationship between your program and the Department of Homeland Security?*

   The program contributes to homeland security by apprehending fugitive felons, including some who are wanted for violent offenses in their communities. We are currently matching VA benefit and personnel records with fugitive felon files of the law enforcement agencies that make up the Department of Homeland Security.

   The program assists in reducing domestic terrorism. Veterans or individuals with prior military experience have committed a number of the most recent domestic terrorism incidents. The VA OIG was requested by other Federal law enforcement agencies to provide investigative assistance during the recent Washington, DC sniper incident. One of the suspects in this case was a veteran currently entitled to VA benefits.

5. *Despite timekeeping violations, VHA management has stated that they get more than they pay for with part-time physicians. One of the reasons given by the VA is that these physicians are some of the most respected specialists in their fields and they could never recruit such physicians with the salary structure and tools available at VA. In your opinion, could VA recruit and retain such a high caliber of physicians otherwise?*

We recognize that many of the part-time physicians in the VA health care system are some of the most respected physicians and academics in the nation. We also recognize that many of the part-time physicians can command salaries far in excess of government salary scales. However, our ongoing work at the VA Medical Center Lexington shows that these physicians are not actually providing patient care services to our veterans with the frequency VHA believes. In fact, in some cases we are finding a very low incidence of either direct patient care or supervision of care provided by residents by these highly respected physicians.

The UnderSecretary for Health testified on January 29, 2003 that VA faces a critical situation because the rules and pay scale for compensation of physicians and dentists are unresponsive to the demands of the current market. The UnderSecretary noted that VHA's special pay authorities have not been revised since 1991 and that the current statutory compensation structure does not offer a way for VA to link physician and dentist compensation to quantitative and qualitative outcomes. Noncompetitive pay and benefits has resulted in dramatic increases in VA scarce-medical-specialty and fee-basis contractual expenditures. Also, we are finding that many of these clinical services contracts are not properly structured or administered to ensure VA receives reasonably priced clinical services.

6. *You reviewed a series of programs in health care and benefits across a broad spectrum of VA activities. Were we to total up all the savings and cost avoidances outlined in your statement, the total would be in the billions of dollars. This raises a question about the accuracy of your estimates and what defines the concept of "savings." What is the degree of your own confidence that your recommendations are sound as to dollar "savings" or cost avoidance?*

Under the concept of savings, the OIG community includes three elements: "Funds Put to Better Use", "Dollar Recoveries", and "Fines, Penalties, Restitutions, and Civil Judgments". "Funds Put to Better Use" represents a quantification of funds that could be used more efficiently if management took actions to complete recommendations pertaining to deobligation of funds, costs not incurred by implementing recommended improvements, and other savings identified in reports. The second and third elements of "savings" are self-explanatory.

Every savings calculation is subjected to supervisory and senior-level review before a report is published. Draft reports are provided to the Department prior to issuance of final reports in part, to gain concurrence on identified savings. In nearly all cases, the Department concurs with projected savings.

I am confident that the savings reported in my formal statement are available to the Department if, and when, appropriate management actions are taken.

7. *Mr. Griffin, on page 14 of your written statement you state that "savings related to the identification of improper and erroneous payments [to fugitive felons] are projected to exceed $209 million." The $209 million reflects what time period, please?*

You note that you have completed Memorandums of Understanding/Agreements with law enforcement organizations in the states of California and New York, so as to share VA beneficiary data. Is there a need to establish agreements with other states, as well?

The $209 million reflects projected savings once the program is fully implemented. Full implementation includes adequate resources to staff this effort and implementation of all required matching agreements. The initial matches from the program have recently been forwarded to the Department to initiate benefit adjustments.

The OIG plans on initiating Agreements with those states that do not submit all of their felony warrants to NCIC. The identification of additional fugitive felons will contribute to their timely apprehension, reducing the safety risks to other veterans, VA employees and the general public, and contribute to reducing erroneous payments to veteran fugitive felons.

8. *On page 15 of your written statement you speak to the Joint Manila Regional Office and VAIG, "international review to identify and eliminate erroneous benefits payments to payees supposedly residing in the Philippines." You note that "as of May 2002, awards of 594 beneficiaries were identified for suspension or termination . . . the overpayments for these 594 beneficiaries totaled approximately $2.5 million with a projected 5-year cost avoidance of over $25 million."*

   Were the 594 overpayments identified from the 1,100 interviews you conducted, the 2,600 files VAIG reviewed, or some other means? (594 overpayments is a pretty significant percentage of both 1,100 and 2,600).

   The 594 beneficiaries identified for suspension or termination was derived from the whole population of VA beneficiaries in the Philippines (over 18,929 beneficiaries). Therefore, in terms of percentages, the 594 beneficiaries (overpayments) are a percentage of the whole population of 18,929 beneficiaries.

   The 594 beneficiaries identified for suspension or termination included: 1) beneficiaries who did not return the Payee Identification Sheets from April or July mailings and were not reconciled; 2) beneficiaries who did not respond when invited to be interviewed; 3) beneficiaries reported and confirmed dead after receiving the Pay Identification Sheet; 4) beneficiaries invited to the interview process and who were confirmed dead as a result of paperwork brought in by relatives; and 5) criminal and administrative cases created as a result of the Philippines Benefit Review.

9. *Mr. Griffin, on page 21 of your statement you noted that "as of December 2002, debts owed to VA totaled over $3 billion, of which active vendee loans comprise about 52 percent." VAIG issued reports over 4 years recommending that VA, for example, improve debt avoidance practices.*

   Could you tell the Committee a little more about debt avoidance? That is how and under what circumstances is debt avoidance most effectively used?

   OIG has reviewed the management of debt as part of its continuing oversight of VA programs and operations for the past several years. One significant recurring theme in our reports is that the Department should improve debt avoidance practices, streamline credit management and debt establishment procedures, and improve collection procedures.

   For example, the Department could avoid the creation of new debt caused by benefit overpayments as highlighted in our *Audit of Veterans Benefits Administration Income Verification Match Results* (Report No. 99–00054–1, dated 11/8/00). We reported that opportunities exist for VBA to significantly increase the recovery of potential overpayments; better ensure program integrity and identification of program fraud, and improve delivery of services to beneficiaries. We specifically recommended that the Under Secretary for Benefits complete necessary data validation of beneficiary identifier information contained in the Compensation and Pension master records in order to reduce the number of unmatched records with the Social Security Administration. This recommendation remains open as of June 2003, although we highlighted associated monetary benefits of $773.6 million in potential savings and better use of funds. (Additional details are provided in our response to Question No. 10 below)

   Of the approximate $1.5 billion in debt that is not vendee loans, what percentage would you expect VA to be able to collect?

   We do not have a basis to make a reasonable estimate of the percentage of debt VA can collect associated with the $1.5 billion in debt. However, our reports over the last few years consistently reported VA needs to be more aggressive in collecting debts and that through improved collection practices, the Department can increase receipts from delinquent debt. As an example, our review of the Medical Care Collection Fund disclosed a collection rate of about 36 percent.

10. *Also, on page 21, you state with respect to debt management issues, "our most recent audits continue to identify areas where debt management activities could*

be improved and OIG report recommendations have not been adequately addressed." What are these areas?

OIG has issued many reports addressing debt avoidance issues and practices. Recurring issues in our reports were that VA needed to be more effective and timely in managing its Compensation and Pension program and to better communicate program policies and responsibilities to customers to avoid debt creation.

- In September 2002, we issued an audit report titled *Audit of VBA Benefit Payments Involving Unreimbursed Medical Expense Claims* (Report No. 00–0061–169 dated September 30, 2002) reporting that some beneficiaries were submitting unsupported or fraudulent UME claims that inappropriately increased the level of their benefit payments and beneficiary overpayments of $124.7 million. Underpayments totaling $19.9 million annually were also identified. These improper payments occurred because VAROs were not effectively managing the processing of UME claims. VBA needs to enhance verification of UME claims and ensure that claims greater than $15,000 are verified. VBA reports it has implemented five of the seven report recommendations. The two remaining unimplemented recommendations are:

  - Notify all beneficiaries in the Improved Pension (IP) and Parents Dependency Indemnity Compensation Program that they may only claim UMEs in Medicare (Part B) premiums if they are not reimbursed by the State or other third-party.

  - Recover UME related beneficiary overpayments and make payments to beneficiaries for benefits that they are entitled to receive.

- Our Evaluation of Veterans Benefits Administration's Income Verification Match (IVM) Results in 2000 identified opportunities for VBA to increase the effectiveness, efficiency, and amount of potential overpayments that can be recovered and to better ensure program integrity and identification of program fraud. The IVM is an annual computer match with the Internal Revenue Service and the Social Security Administration (SSA) to assess the impact of unmatched records on the Department's ability to verify income reported by beneficiaries and identify potential fraud. As of June 2003 one report recommendation remains unresolved.

  We estimated that VA could achieve a better use of funds valued at $773.6 million by implementing actions to complete the necessary data validation of beneficiary identifier information and reduce the number of unmatched records with SSA. We also identified other potential opportunities to save about $32.7 million related to inappropriate waiver decisions, failure to establish accounts receivable, and other process inefficiencies. VA did not agree with the monetary impact in this report, however they did agree to report the IVM program as an internal high priority weakness. We did not accept VA's rationale, since our estimate was based on a statistical sampling methodology that reflected a conservative estimate of the dollar impact of overpayments that have occurred.

- Our evaluation of the Effectiveness of Veterans Benefits Administration's Controls to Detect and Prevent Compensation and Pension Benefit Payment Errors in 1998 concluded that VA Regional Offices were not effectively managing C&P messages. The audit showed that 44 percent of C&P messages had not been timely and properly processed, or messages were not useful and caused unnecessary work. We estimated that annual C&P benefit payment errors of about $25.5 million could be averted.

- A review of Veterans Benefits Administration's Procedures to Prevent Dual Compensation in 1997 found individuals were receiving concurrent payments of Department of Defense (DoD) active duty reserve training pay and VA disability compensation benefits. The audit found that 90 percent of the potential dual compensation cases reviewed had not had their VA disability compensation offset from their military reserve pay. It was estimated debts valued at $21 million were created as a result of dual compensation payments made between FY 1993 and FY 1995. In addition, audit estimates

indicated that if the condition was not corrected, estimated annual dual compensation payments of $8 million would have continued.

- In our 2002 Follow-up Evaluation of the Causes of Compensation and Pension Overpayments we recommended VA take action to reduce C&P overpayments by: implementing our prior recommendations relating to due process notification procedures and making overpayment prevention a continuous focus area of quality review. Root causes for the preventable overpayments related to the delay in implementing changes in the due process procedures, untimely or inappropriate actions taken by VARO staff which often requires additional or unnecessary work and the need to change claims processing practices that contribute to benefit overpayments. The 2002 review identified $26.6 million in C&P overpayments that could be prevented within our review of an estimated 13,140 cases.

- In an earlier 1996 Review of the Causes of Veterans Benefits Administration's Compensation and Pension Overpayments we focused on identifying the underlying causes of the VBA C&P overpayments and made recommendations of ways to avoid creation of new beneficiary debt. The review found overpayments valued at $26.2 million could be prevented annually, if overpayment cases were properly processed and VBA procedures revised. The report also found that C&P overpayments could be further reduced by at least $4.2 million annually, if VBA simplified the pension program and enhanced communications with beneficiaries regarding their responsibility to timely report beneficiary status changes.

Congressman Evans to Department of Veterans Affairs

Office of Inspector General Responses to Questions for the Record Honorable Lane Evans, Ranking Member Committee on Veterans' Affairs May 8, 2003

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

1. *In an April 6, 2002 memorandum, Secretary Principi reorganized IT management under the Chief Information Officer. Is the reorganization of VA's IT functions complete and adequate? If not, what is the delay?*

   The memo was issued August 6, 2002. In our FY 2002 audit of VA's Information Security Program, we concluded the Department's implementation plan was acceptable and it should provide the organization structure needed to centralize the Department's IT security program. However, in the FY 2002 GISRA Implementation Quarterly Report to the Office of Management and Budget, VA's action plans and milestone dates reflected extended implementation dates into FY 2003–2004 that in our opinion are unacceptable.

   Delay in implementation has not allowed the Department to realize the benefits of a centralized IT security program. These delays have not allowed the Department to realize the benefits of having the resources permanently assigned under the Office of the Chief Information Officer to his operational control and authority to make required changes. Implementation needs to be done as soon as feasible, addressing the field IT organization in greater depth beginning with standardization of organization structure, reporting relationships, staffing structure, policy, financial management, and accounting.

   Our 2002 audit of VA's Information Security Program also concluded that VA's programs and sensitive data continue to be vulnerable to destruction, manipulation, and inappropriate disclosure. This audit determined that planned implementation of milestones established for eliminating key security vulnerabilities will take too long to complete and thereby prevent the Department from effectively strengthening its overall security posture in the near term. As a result, VA's systems and data will continue to be at risk and VA will not comply with the Government Information Security Reform Act.

2. *At the reported 30 to 1 ratio of management effectiveness payback for an investment in IG funding, had Ms. Carson's July 26, 2001 appropriations amendment for an additional $16.2 million in IG funding passed, would VA really have "saved" $486 million dollars/year through management efficiencies as a result?*

   During the last 5 years, the OIG has averaged a 30 to 1 return on investment. While reported monetary benefits can fluctuate annually, we fully expect to maintain this average in future years. Successful OIG performance is also measured in non-monetary terms, such as arrests, indictments, and criminal convictions as well as opportunities for qualitative systemic improvements in VA programs, policies, and procedures that enhance operations, service delivery, compliance, internal controls, and system integrity.

3. *Your testimony addresses the lack of oversight in the part-time physician time and attendance issue. However, any individual in the part-time physician's reporting chain could have reported or corrected possible abuse of this system; yet it rarely happened. When was the IG first aware of possible abuse of this system and how did the IG proceed from that revelation? Are other contractual arrangements involving affiliates problematic?*

   From October 1989 through January 1992, the Office of Inspector General (OIG) Hotline and Special Inquiries Division reviewed eight allegations relating to time and attendance of part-time physicians. We substantiated 4 of the

8 allegations pertaining to 15 part-time physicians who worked at 3 VA medical centers. The reviews found that these 15 part-time physicians were absent when they should have been working at VA.

In 1994, we followed up these allegations with an audit to evaluate the management of the time and attendance of part-time physicians working at VA medical centers that are affiliated with medical schools (*Audit of Part Time Physician Time and Attendance at Affiliated VA medical Centers*, Report Number 4R8–A99–074; dated July 28, 1994). We concluded that improvement was needed in the management of part-time physicians time and attendance because they were paid when absent and not charged leave. The Acting Under Secretary for Health agreed and stated that VA medical centers had taken corrective action for deficiencies cited in the report.

From April 2001 to March 2003, we completed 37 Combined Assessment Program (CAP) reviews that evaluated part-time physicians time and attendance issues. We identified problems at 23 of the 37 facilities (62 percent) reviewed. For example, we found:

- Part-time physicians were not present at the medical center during their tours of duty.
- Part-time physicians were improperly paid for on-call status.
- Timekeepers did not verify part-time physicians' attendance.
- Semi-annual desk audits of timekeepers' records were not conducted.
- Part-time physicians did not designate their core hours.
- Required training was not provided to all timekeepers.
- Part-time surgeons' hours of work were not consistent with their workload levels.
- Part-time physicians and their supervisors were not trained on VA time and attendance policies.
- Part-time physicians were granted excused absences when VA criteria were not met.

In response to a request from the Secretary of Veterans Affairs, we audited VHA's management of part-time physician time and attendance from March 2002 through April 2003 (*Audit of Veterans Health administration's Part-Time Physician Time And Attendance*, Report Number 02–01339–85; dated April 23, 2003). We found that VA medical center managers did not ensure that part-time physicians met employment obligations required by their VA appointments. In addition, VHA did not have effective procedures to align physician staffing levels with workload requirements.

Our Contract Review and Evaluation division has found some evidence of problems with other contractual arrangements with affiliates. We are currently performing the additional analysis and review steps necessary to issue a report.

4. *In January 2003, VA reported a regulation change to Congress titled: VA Acquisition Regulation: Simplified Acquisition Procedures for Health-Care resources. This change waives or limits a number of accountability mechanisms related to acquisitions of commercial services or the use of medical equipment or space. This rule seems internally inconsistent regarding rationale for exempting affiliated institutions from posting proposed contract actions on the Government Point of Entry contrasted with its logic for waiving requirements for small business contracts to facilitate open competition for the affiliates. Some elements of the rule are not written in concert with the proposals of VA's May 2002 Acquisition Task Force Report. The Task Force Report generally advocates a balance between empowerment and accountability and supports the competitive process and socioeconomic goal. The rule change waives Small Business Set Asides and waives some requirements for posting proposed contract actions on the Government Point of Entry (FedBizOpps). Has the IG analyzed the impact of this rules change in light of the recommendations of the May 2001 IG memorandum on Procurements and the Recommendations of the Acquisition Task Force? How many of the recommendations of the Acquisition TF have been implemented? What was the savings?*

The OIG has not analyzed the impact of the rules change in light of the considerations for improving VA buying practices in the May 2001 OIG report on

Procurements (which only addressed the procurement of commercial products, not services) or the recommendations of the Task Force.

A recent cursory review of the January 2003 regulation found it to be consistent with the provisions of Public Law 104–262, the Veterans Health Care Eligibility Reform Act of 1996. As noted in the Executive Summary of the Procurement Reform Task Force Report, the Task Force examined acquisition of medical-surgical supplies, high-technology medical equipment, and prosthetic devices, as well as overarching issues including procurement authority and the acquisition workforce. Issues relating to procurements made pursuant to the provisions of Public Law 104–262 were not addressed.

Implementation of the recommendations of the VA's Acquisition Task Force rests with the Department. Therefore, we do not have information on the number of recommendations implemented or reported savings.

5. *Your testimony addressed problems noted when VA contracts for health care. Key issues are lack of needs assessment, potential conflict of interest in the decision process [affiliate involvement], and documentation errors. Will the rule chance (identified in question #4 above), essentially permitting a less open process [especially regarding affiliates], help or hurt the procurement efficiency?*

   The proposed rules change will have no impact on our conclusions regarding the procurement process for healthcare resource contracts. Whether awarded competitively or non-competitively, improvement is needed. The regulations implement the provisions of the existing Public Law. There are other existing laws, regulations and internal VA policies that require VA officials to conduct a needs assessment, and ensure that there are no conflicts of interest, documentation errors or other problems with contract administration. While these contracts may be awarded without competition or public announcement, they are not awarded without some level of internal review and are subject to oversight.

6. *VA provides certain Voc-Rehab services at overseas locations [especially Europe] using contractors. How have the costs of these Voc-Rehab contracts changed in the last six years and do changes to the terms and conditions of the contracts adequately account for the price changes?*

   The four VR&E Regional Offices who participate in overseas contracting are Houston (South and Central America, Mexico), Hawaii (Pacific), Manila (themselves), and Washington (Europe and Africa). According to VBA, except for the Washington Regional Office (WRO), none of these other offices have witnessed noticeable changes in their costs, terms, and conditions of their contracts.

   In FY 2003, VBA reported that general operating expense funding requirements for contractors in Europe more than doubled because of the National Acquisition Strategy (NAS) contract. In prior years, VBA negotiated small contracts with individual case managers. These independent contractors were willing to work at reduced rates out of their homes and each contractor handled his/her own tax burden. According to VBA officials, only one contractor bid for the entire Foreign Area solicitation was received under NAS in FY 2003. That contractor submitted a bid to VA's Contracting Officer and was awarded the contract at their asking price. As the sole contractor, the contractor assumed the foreign and domestic tax burdens for their employees, committed resources to design and implement a client database, assumed training and travel for their case managers, and hired an administrative assistant. The VA Contracting Officer accepted her bid and authorized an award based on the contractor's justification.

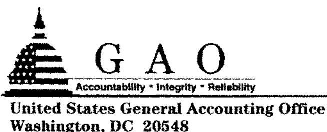
   The WRO, which oversees the European area, did not set these new prices, but must adhere to the terms of the contract as awarded. In addition, VBA advised that the number of veterans served in foreign areas by the Washington Regional Office has doubled in the past two years—307 veterans served in FY 2001 versus 617 veterans served in FY 2003.

   The FY 2003 prices were negotiated and approved by the National Acquisition Strategy Contracting Officer and the projected total value of those services is less than $1 million annually. As a result, the materiality of the funds associ-

ated with the contracts is not considered sufficiently high to initiate an audit at this time.

7. *The IG reports significant savings as a result of terminating benefits to "fleeing felons" as provided by the current law. Anecdotal evidence suggests that some of these purported "fleeing felons" are actually homeless mentally ill veterans who may not even be aware of a warrant and whom law officials are not interested in prosecuting. Does the IG have any data concerning the number of fleeing felons whose benefits have been terminated and who have been identified to appropriate law enforcement officials who decline to prosecute?*

The OIG has recently forwarded the initial exact matches to the Department to initiate benefit adjustments. To date, the IG has not received any data concerning the number of fleeing felons whose benefits have been terminated and who have been identified to appropriate law enforcement officials who decline to prosecute.



United States General Accounting Office
Washington, DC 20548

July 2, 2003

The Honorable Christopher H. Smith
Chairman, Committee on Veterans' Affairs
House of Representatives

The enclosed information responds to the post-hearing questions in your letter of June 2, 2003 concerning our testimony before the Committee on May 8, 2003, on the Department of Veterans Affairs' (VA) efforts to identify and eliminate fraud, waste, abuse and mismanagement in their programs. If you have any questions or would like to discuss this information, please contact me at (202) 512-7101.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Enclosure

This enclosure details your questions and our responses, which supplement information in our testimony before your Committee, *Department of Veterans Affairs: Key Management Challenges in Health and Disability Programs* (GAO-03-756T, Washington, D.C.: May 8, 2003).

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

1. **Ms. Bascetta, your testimony included a chart depicting VA's nursing home care programs, subdivided by in-house, community, and state homes. The chart shows a decline in in-house and community activity and some growth in state home census. Is VA moving in the right or wrong direction in its nursing home programs, given the issue of the aging veteran population on which your testimony is also based? What are the implications from GAO's point of view, in VA's movement away from traditional long-term care?**

We are concerned that VA has not developed an integrated long-term care policy model, including traditional long-term care that fully considers the projected future needs of this population and VA's role in meeting this need. It is particularly troublesome that VA has not fully integrated long-term care into the CARES planning process given the aging of the veteran population. The veteran population most in need of nursing home care—veterans 85 years old or older—is expected to increase from almost 640,000 to over 1 million by 2012 and remain at about that level through 2023. Until VA develops an integrated long-term care policy model, it will not be able to determine if its nursing home care units in 131 locations and other nursing home care services it pays for provide equitable access to veterans now or in the future.

2. **Your testimony mentioned that efficiency could be improved through health care asset realignment and other management actions—such as partnering with other public and private providers, consolidating duplicative care provided by multiple locations serving the same geographic areas. Aren't these same efficiencies part of the current CARES market analysis and process? Could you please cite one or two examples of areas where you believe the greatest improvements should or could be made?**

Yes, VA's CARES process is designed to identify opportunities to achieve such efficiencies. The greatest improvements could be realized in 30 areas where two or more major health care delivery locations that are in close proximity provide duplicative inpatient and outpatient services. VA considers delivery locations to be in close proximity if they are within 60 miles of one another for acute care and within 120 miles for tertiary care. Additional efficiencies may also be achieved in 28 geographic areas where existing delivery locations have low acute medicine workloads, which VA has defined as serving less than 40 hospital patients per day.

3. What have you learned about VA's new strategic planning initiatives to address nursing home and other long-term care issues at the same time that VA implements its CARES initiative?

VA did not include a fully integrated analysis of nursing homes and related noninstitutional services in its Capital Asset Realignment for Enhanced Services (CARES) initiative because initial projections of nursing home need exceeded VA's current nursing home capacity and VA said that the projections did not reflect its long-term care policy. VA has developed a separate process to provide projections for nursing home and noninstitutional long-term care service needs and plans to use these projections as part of its strategic planning process to address long-term care issues at the same time that VA implements its CARES initiative. We have ongoing work to review VA's current and future provision of long-term care services.

4. Your testimony discussed the broad discretion given to each of the 21 networks to decide what nursing home care is offered, which has resulted in inequitable access to nursing home care. What suggestions would you make to ensure equitable access?

At your request, we are conducting work on nursing home workload and expenses. It is premature for us to make specific recommendations on how to ensure equitable access to nursing home services. However, we are concerned about the broad discretion VA policy provides to networks in deciding what nursing home care to offer veterans who may receive it on a discretionary basis. This is significant because about two-thirds of veterans receiving nursing home care are recipients of discretionary nursing home care. Without a more developed policy specifying what similarly situated veterans will be provided, veterans may not have access to similar nursing home services across the country. In addition, VA oversight of noninstitutional long-term care services is inadequate as we reported in our examination of access to these services. Access to these services is largely based on where a veteran lives rather than the veteran's need for service, in part because VA has not provided adequate emphasis and guidance for providing noninstitutional services.

5. Ms. Bascetta, I note your testimony suggests on five occasions needed fundamental "program design" changes to the disability compensation system or VA's rating schedule [pages 3, 21, 22, 23, and 27].

I am particularly interested in a comparison of the payment amounts of veterans who are severely disabled with that of private industry. Would it be advisable to do such a comparison as part of a comprehensive re-write of the rating schedule?

Yes, data comparing VA disability compensation payments to payments by other disability programs would be valuable to VA and the Congress in considering changes

in program design, and in updating the Schedule for Rating Disabilities. First, in its Strategic Plan for fiscal years 2001-2006, VA established "placeholders" for outcome-based performance measures for its disability programs. These include a measure of the extent to which veterans receiving VA disability compensation are better off than like-circumstanced non-veterans. VA plans to start a program evaluation of the disability compensation program in 2004; this evaluation could develop the data needed to assess VA's assistance to disabled veterans. The data from this program evaluation could, in turn, be used in updating the rating schedule. Second, such data could be part of an update of the labor market data underlying the Schedule for Rating Disabilities. If the Congress chose to direct that VA conduct such an update, it could require that VA collect data on VA payments to disabled veterans compared with payments by other disability programs to disabled non-veterans.

6. As your testimony points out, VA's rating schedule was initially written in 1945 for a society in which manual or physical labor predominated. VA could be over compensating some veterans while under compensating – or denying compensation entirely – to others.

What's the best way to go about updating the rating schedule? Engage the National Academy of Sciences, a congressional or Presidential commission?

The National Academy of Sciences or a high-level commission could bring together the expertise needed to assess how well the current Schedule for Rating Disabilities compensates disabled veterans for loss of earning capacity, and recommend updates to the schedule. However, we have no preference as to how this work should be organized, as long as the result is a schedule that ensures that veterans receive fair evaluations of their disabilities, consistent with the program's statutory purpose. In our January 1997 report on the rating schedule, we noted that a study to assess the average loss of earning capacity associated with specific service-connected disabilities could cost between $5 and $10 million. While such a study would be more expensive today, it would be a small fraction of the more than $26 billion in cash disability benefits that VA paid in fiscal year 2002.

VA already has the authority it needs to revise the Schedule for Rating Disabilities to account for changed economic conditions since 1945, but has chosen not to update the schedule. In the late 1960s, VA conducted an Economic Validation of the Rating Schedule (ECVARS), which found that many ratings underestimated or overestimated veterans' average loss in earning capacity. VA proposed revisions to the rating schedule based on ECVARS, but did not adopt them. In August 2002, we recommended that VA use its annual performance plans to delineate strategies for and progress in updating the labor market data used in its disability determinations process. VA did not concur, because it has no plans to update its labor market data, or to update the rating schedule based on economic factors. According to VA, the schedule represents a consensus among VA, the Congress, and veterans' organizations, and it would be difficult politically to fundamentally revise the schedule. We recognize these difficulties, but note that, because the rating schedule

has not been updated to reflect changing labor market experience, it is inconsistent with its statutory purpose to compensate veterans for loss of earning capacity.

If the Congress determines that the Schedule for Rating Disabilities should be updated to reflect current economic conditions, it can direct VA to do so. In our testimony (p. 19), we noted that we suggested this to the Congress in our January 1997 report on the rating schedule.

VA might need additional legislative authority to address our other finding on the rating schedule – that it does not fully reflect the impact of medical and technological advances that affect disabled veterans' ability to work. As we noted in our testimony (p. 20), VA has only a limited ability to update the rating schedule to fully capture the benefits afforded by treatment advances and assistive technologies. This is due to the limited role of treatment in the program's design; VA's ability to assess veterans' disabilities under corrected conditions is limited.

VA did not concur with our August 2002 recommendation that it study and report to the Congress on the effects that a comprehensive consideration of medical treatment and assistive technologies would have on its disability programs' eligibility criteria and benefit package. VA believes this would represent a radical change from the current programs, and it questioned whether stakeholders in the Congress and the veterans' community would accept such a change. The Congress could consider directing VA to conduct such a study, to at least identify legislative actions that would be needed to implement and fund significant program design changes.

7. **The current rating schedule essentially is based on compensating the veteran based on average loss of earning power. But some argue that compensation should also be based on pain and suffering. Please comment.**

   NOTE: In addition to GAO, the following organizations have called for re-examining the criteria underlying VA's rating schedule.

   1956 Omar Bradley Commission
   1971 VA Economic Validation
   1974 20th Century Fund
   1983 Grace Commission
   1995 Veterans' Claims Adjudication Commission
   1999 Commission on Servicemembers and Veterans Transition Assistance

VA is required by law to maintain a rating schedule based on loss of earning power. We cannot say whether the schedule should also be based on veterans' pain and suffering from injuries or conditions incurred or aggravated during their military service. Adding pain and suffering to the disability compensation program's fundamental purpose is a decision for the Congress. If the Congress determines that

Dole Act of 1980[2] authorizes federal agencies to execute license agreements with commercial entities to promote the development of federally owned inventions and to collect royalties for such licenses. The act also gives universities and other entities the right to retain title to and profit from the inventions arising from their federally funded research, provided they adhere to certain requirements. In turn, the government retains the right to use the inventions without paying royalties.

[2] The Bayh-Dole Act is the common name for the Patent and Trademark Laws Amendments of 1980 (P.L. 96-517, Dec. 12, 1980).