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Report to Congressional Requesters

October 2002

MILITARY TREATMENT FACILITIES

Internal Control Activities Need Improvement

GAO-03-168

Contents

Letter

Appendixes

Tables

Abbreviations

DMLSS	Defense Medical Logistics Standard Support
DOD	Department of Defense
IG	Inspector General
JWOD	Javits-Wagner-O'Day Act
MTF	military treatment facility
SSA	Social Security Administration

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, D.C. 20548

October 25, 2002

The Honorable Dennis J. Kucinich
Ranking Minority Member
Subcommittee on National Security, Veterans Affairs
and International Relations
Committee on Government Reform
House of Representatives

The Honorable Janice D. Schakowsky
Ranking Minority Member
Subcommittee on Government Efficiency, Financial Management
and Intergovernmental Relations
Committee on Government Reform
House of Representatives

The $24 billion Military Health System provides health care to over 8 million eligible beneficiaries. Although the Congress has provided sizeable increases in funding for health care over the past few years, the Department of Defense (DOD) has needed supplemental appropriations for 6 of the last 8 fiscal years from 1994 to 2001 because its costs were higher than expected. The growing budgetary pressure increases the risk of not achieving the mission of the organization.

DOD's military treatment facilities (MTF) represent over half of DOD's health care expenditures. Because budgetary pressures sometimes result in agencies reducing key oversight and control activities, you requested that we review key internal controls at selected MTFs in order to determine whether the internal control activities were effectively implemented.

The Comptroller General's five standards of internal control help management to cope with evolving demands and priorities, achieve effective and efficient program results, and are essential for proper stewardship and accountability of government resources. These standards include (1) the existence of a positive and supportive control environment, (2) an assessment of the risks the agency faces from both external and internal sources, (3) an assessment of the quality of performance over time, (4) relevant, reliable, and timely communications among managers and others relating to both internal and external events, and (5) control activities, which are the policies, procedures, techniques, and mechanisms that help ensure that management's directives to mitigate risk are carried

out. This report summarizes the results of our tests of selected internal control activities.

DOD's MTFs are the focus of its health care delivery. Using a case study approach, this report focuses on some targeted key internal control activities that relate to the overall effectiveness and efficiency of the facilities in providing health care services at one large, diverse medical facility from each of the three services.[1] These key internal control activities were in the areas of

- restricting access to care to only those who are eligible;
- identifying patients with third party insurance, and the accuracy and timeliness of the billing and collection process for third party insurance;
- monitoring and analyzing the types and levels of expired drugs turned in for credit or disposal;
- managing personal property accountability; and
- using government purchase cards.

Our objective was to determine whether the targeted internal control activities at the selected medical facilities were effectively implemented. To address this objective, we gained an overall understanding of their operations and performed specific tests and analyses to assess adherence to policies and procedures. Because we tested only selected internal control activities at three locations, we cannot give an overall opinion on internal controls at these facilities or project our results to other facilities. We did not perform a financial audit of the medical facilities, nor did we do the level of internal control testing that would be done in conjunction with a financial audit. Therefore, we cannot give an opinion on their financial condition. Further details on our scope and methodology are included in appendix I.

[1]We chose Eisenhower Army Medical Center, Augusta, Georgia; Naval Medical Center-Portsmouth, Portsmouth, Virginia; and Wilford Hall Air Force Medical Center, San Antonio, Texas, as our case study MTFs. Unaudited financial and operational information provided by each of the three MTFs is shown in app. II.

Results in Brief

The three MTFs we reviewed have not effectively implemented internal control activities in the areas of eligibility, billings and collections, expired drugs, personal property management, and government purchase card usage. Unreliable and inaccurate data, system inadequacies, complicated processes, and a lack of adherence to policies and procedures contributed to the internal control weaknesses we identified. For example, a comparison of Social Security Administration (SSA) death records with hospital treatment records at one location indicated that 41 patients who allegedly had been treated during fiscal year 2001 had died in the prior fiscal year or earlier. Although these matches of information in death records and patients' records could be the result of clerical errors, someone may have fraudulently assumed the identity of a deceased person in order to receive free medical care. Weaknesses in DOD eligibility databases as well as in the facilities' processes and efforts to identify ineligible individuals preclude them from knowing whether individuals are fraudulently obtaining health care services.

The three MTFs also did not identify all patients with third party insurance coverage. In addition, they frequently did not bill those insurers even when they knew that such coverage existed, thereby losing opportunities to collect millions of dollars of reimbursements for services. Moreover, two of the medical facilities did not perform inventories of their expired or obsolete drugs being held for return and could not validate the accuracy of the credits received from manufacturers for their return. None of the three hospitals adequately analyzed trends of their returned drugs or the actual losses related to the expired drugs. Consequently, the MTFs do not have reliable information needed to improve their pharmaceutical inventory management practices and reduce future losses.

Ineffective physical and financial controls over personal property assets and indications of control breakdowns in the use of government purchase cards existed at the three facilities. We found items that were not included in property records as well as weak processes for ensuring that items were actually received and recorded in facility records. Both types of weaknesses increase the risk that pilferable items or other types of assets can be converted to personal use. Lack of controls over the use of the government purchase card also resulted in misuse including potentially fraudulent, improper, abusive, and questionable purchases as evidenced by, at one location, a military cardholder defrauding the government of tens of thousands of dollars by purchasing items for personal use.

We are making recommendations to strengthen the internal control activities over these areas to improve accountability, reduce the abuse of government resources, and enable program directors and managers to make better decisions. In its comments, DOD agreed with our recommendations and briefly outlined both current and planned actions for addressing them.

Background

The medical mission of DOD is to provide and maintain readiness, medical services, and support to the armed forces during military operations and to provide medical services and support to members of the armed forces, their family members, retirees and their families, and eligible survivors of deceased active and retired military personnel. DOD's health care program provides medical services such as surgery and inpatient care, pharmacy services, and mental health care to eligible beneficiaries. This care is delivered through its military hospitals and clinics, known as MTFs, or from contracted civilian-provided care. However, if an eligible beneficiary has commercial insurance and care is provided by the MTF, the government is authorized to bill the insurance company under the Third Party Collections Program established in Public Law 99-272, as amended by Public Law 101-510 (10 U.S.C. 1095). Currently, according to DOD records, over 8 million active duty and retired military personnel along with their dependents and survivors are eligible for health care benefits from the military health care system.

The three medical facilities in our engagement are also DOD medical teaching facilities. Eisenhower trains residents in both surgical and primary care specialties with emphasis on research and state-of-the-art specialty care. Portsmouth is the oldest hospital in the U.S. Navy having provided continuous care since July 1830. It has a medical education program offering internships and residency training programs in medicine, dentistry, psychology, and pastoral care. It is one of three teaching hospitals in the Navy with residency programs in 13 specialty areas. Wilford Hall is the Air Force's largest medical facility. It focuses on military readiness, provides a worldwide referral center for military personnel and their dependents, and provides trauma and emergency medical care for the San Antonio and south Texas civilian communities. It is also the Air Force's foremost provider of medical education, providing the Air Force with 65 percent of its physician specialists and 85 percent of its dental specialists. Appendix II provides more background information about the military facilities.

Internal Controls Not Effectively Implemented

The following five subsections of this report outline opportunities for the three MTFs covered by this review to improve their financial or operating controls and to, in the process, reduce federal costs. DOD auditors' and our work has also reported on a number of these issues at some of the same facilities and recommended improvements. As discussed in appendix I and under the following sections, our work, while not designed to ascertain the extent of each problem, indicates the existence of systemic problems for each of the five areas we reviewed.

Inadequate Eligibility Controls Allow for Unauthorized Access to Care

Erroneous eligibility information contained in DOD information systems precluded the MTFs from providing reasonable assurance that medical care was only provided to eligible persons. DOD personnel query a medical management automated information system to determine those who are eligible. However, the three facilities could not readily provide a list from this system of all those who were treated during fiscal year 2001, which could be used to facilitate analysis and detect ineligible persons who were treated. Further, the DOD Inspector General (IG) reported[2] weaknesses in DOD's eligibility database and concluded that ineligible persons could have received medical care, pharmaceuticals, or other benefits. Our work at the three facilities supports the DOD IG's finding that eligibility information contains inaccuracies.

In order to measure the facilities' ability to control access to care, we requested data files of all patients who had been admitted, treated as outpatients, or received pharmaceutical benefits during fiscal year 2001. After considerable effort, just one facility was able to provide a file of beneficiaries who received pharmaceuticals during the year. Using this file, we compared patient name, date of birth, and social security number with similar data contained in the SSA death records and identified 41 patients who received care during fiscal year 2001, and who, according to SSA records, had died prior to the start of fiscal year 2001. The social security numbers of an additional 225 patients matched SSA death records, but the names or dates of birth did not match. The implications of this comparison could reflect something as simple as the erroneous entry of a patient's social security number in the hospital's medical records or clinical staff

[2]Department of Defense, Office of the Inspector General, *Beneficiary Data Supporting the DOD Military Retirement Health Benefits Liability Estimate*, Report No. D-2001-154 (Washington, D.C.: July 5, 2001).

mistakenly dispensing a prescription under a deceased person's records. Or, at the other end of the spectrum, a person could be fraudulently using a deceased person's identification to receive prescriptions and treatment at no cost. Having complete and unique information for each patient, such as name, social security number, and date of birth, is important not only to control access to care but also to assure that clinical care is being provided to the right patient. We have follow-up work under way on these matters.

A July 2001 DOD IG report indicated that questions regarding eligibility are an issue across the MTF network. The DOD IG reviewed the reliability and completeness of DOD's eligibility data as well as management controls in the system used to control access to military-provided health care. The DOD IG reported that these data were reliable 85 percent of the time, and said that quality control and other improvements were needed to improve the accuracy of the eligibility databases. It estimated that about 415,000, or about 5 percent, of the 8.4 million beneficiaries in this database were either ineligible or had incorrect critical data, and that the existence or eligibility of another 10 percent could not be verified. For example, a divorced spouse inappropriately remained eligible in the system for almost 2 years after losing eligibility as result of the divorce from the sponsor.[3] Another example involved a sponsor who was discharged over 20 years ago without benefits yet was listed incorrectly in this system as an eligible active duty retiree.

The DOD IG also found inadequate management controls associated with the implementation of the system used to produce identity cards for military personnel and family members. This military identity card system is important because it is used to update personnel information stored in DOD's eligibility database, which provides information to the military health system. The DOD IG reported weak management controls and little consistency and standardization of policies and procedures to ensure accurate and reliable data entry at the 13 sites the staff visited. The problems occurring most often at these locations include the lack of documented data quality reviews, no retention of source documents, lack of separation of duties between officials responsible for verifying

[3]A sponsor is the active duty service member or retiree. A sponsor may have many other eligible beneficiaries, such as dependent children; current and, in certain instances, a former spouse; and others who by virtue of their relationship to the sponsor are eligible for care at the MTF.

beneficiary eligibility information and officials responsible for issuing the military identification card, and no internal standard operating procedures.

Weaknesses in Billings and Collections Prevent Full Recovery of Millions from Third Party Insurers

Although the MTFs are authorized to bill insurance companies under the Third Party Collections program, millions of dollars are not being collected each year because patient medical records are incomplete, as is the identification and billing of reimbursable care. Patients were not systematically asked to provide current insurance information, thereby hindering the ability to identify all billable care. Even when patient insurance information was obtained, the staff often failed to send a bill to the third party insurer or sent the bill late. Once a bill is successfully processed, collections from third party insurance companies represent 2 percent to 5 percent of the facilities' operating costs each year.

The MTF Uniform Business Office Manual, DOD 6010.15-M, dated April 1997, prescribes procedures for third party collection activities such as the identification of beneficiaries who have other health insurance. It also states that the staff shall obtain written certification from beneficiaries at the time of each inpatient admission or outpatient visit if a certification is not on file or if it has not been updated within 12 months. However, our observations of patient reception at several clinics at the three medical facilities showed that staffs were not systematically obtaining and updating patient insurance information and rarely asked outpatients about third party insurance coverage. In addition, the required DOD Form 2569 used to document third party insurance coverage was often not completed and maintained for either inpatients or outpatients in hospital files or databases. Having a completed form is important because it (1) documents the existence and type of coverage, (2) is used to update insurance data in the automated medical management information system, and (3) authorizes the medical facility to bill insurance companies on behalf of the beneficiary. Our tests of third party insurance documentation for 1 day during each quarter of fiscal year 2001 showed the following results.

- At Eisenhower, only 9 of 60 patients, primarily inpatients, selected had a current completed DOD Form 2569. After our visit, Eisenhower's staff began monitoring the admissions process in an effort to improve the completions of DOD Form 2569 by all non-active-duty inpatients and assigned staff members to ask about insurance while patients wait to receive pharmaceuticals.

- Portsmouth uses an internally developed form to document if patients have private health insurance. For 40 of 60 inpatients selected, Portsmouth had insurance information in the patient billing files.

- Wilford Hall had a completed, current DOD Form 2569 for 41 of the 69 patients selected. Wilford Hall has for some time dedicated personnel on a part-time basis to assist patients in completing the DOD Form 2569 at one of its clinics.

Without completed insurance information forms, recording and maintaining accurate, complete, up-to-date, and verifiable insurance information in facilities' billing systems is not possible. We found instances where the patient record in the automated medical information system contained out-of-date or no insurance coverage information, making system reports incomplete and inaccurate. Reasons given by facility officials for these problems were mostly attributed to staffing constraints and shortages. Consequently, there was little assurance that all reimbursable care was being identified for billing.

In a recent report,[4] the Air Force Audit Agency reported the same condition—insurance information for inpatients was not being obtained and entered into the automated medical information system. For over 70 percent of the non-active-duty inpatient population at 14 MTFs they reviewed, no insurance data were recorded in the system, resulting in lost collections. Air Force auditors sampled the inpatients shown in the system as not having insurance data and determined that those who actually had unrecorded third party coverage had received care valued at $113,330. Projected to the entire population over a 6-year period, Air Force auditors estimated that $14.4 million could have been billed to third party insurers at the 14 Air Force MTFs.

Our tests of billings at the three facilities revealed that even when patient insurance information was available, the staff often did not send a bill. As shown in table 1, about one-third of our nonrepresentative selection of 240 instances of treatment that should have been billed to a third party insurer were not billed.

[4]Air Force Audit Agency, *Follow-up, Third Party Collection Program*, Audit Report 00051011 (Washington, D.C.: Apr. 26, 2001).

Table 1: Results of Third Party Billing Selections by MTF and Workload Type

Hospital/workload	Billed	Not billed	Total
Eisenhower			
• Admissions	16	0	16
• Outpatient visits	10	10	20
• Pharmacy	34	6	40
Subtotal	60	16	76
Portsmouth			
• Admissions	15	2	17
• Outpatient visits	24	16	40
• Pharmacy	22	10	32
Subtotal	61	28	89
Wilford Hall			
• Admissions	14	1	15
• Outpatient visits	17	12	29
• Pharmacy	4	27	31
Subtotal	35	40	75
Total	**156**	**84**	**240**

Source: GAO analysis of DOD data.

Billings were generally better for inpatient admissions, while the billing rates for outpatient visits and pharmacy benefits were much lower. More specifically, our testing of 48 inpatient admissions identified only 3 instances when insurers were not billed. In addition to the 38 outpatient visits not billed, our selection also disclosed patients with third party insurance who used the facilities frequently, but whose insurance had never been billed for any care provided during fiscal year 2001. While all facilities had pharmacy billing problems, the situation was most serious at Wilford Hall, which reported only billing for about $158,000 in pharmacy charges during fiscal year 2001. After we brought this to the attention of Wilford Hall's management, it hired a contractor to supplement its billing staff. As a result, by June 30, 2002, Wilford Hall had billed almost $800,000 in pharmacy charges during the first 9 months of fiscal year 2002, of which $650,000 was billed during the third quarter of the year. Lost forms, clinical data coding or input problems, lack of staff to handle high workloads, missed billings due to clerical oversight, and a complicated multistep billing process were explanations provided for not billing for reimbursable care.

The Air Force Audit Agency also recently reported that military facilities were not effectively recovering the cost of pharmaceuticals provided to patients with private health insurance.[5] Thirteen facilities were not adequately identifying patients with third party insurance, and even when sufficient data were available, billing was not always done. Air Force auditors projected that increased management emphasis in this area would generate increased billings of about $114 million for the 13 Air Force MTFs over a 6-year period. Wilford Hall was one of the facilities included in the Air Force Audit Agency review.

When billing for third party insurance occurred, it was often delayed. DOD standard criteria call for facilities to bill for admissions within 10 business days following completion of the medical record and within 7 business days for outpatient visits. In evaluating the timeliness of billing, we used a more liberal standard of 30 days after treatment for billing admissions and 90 days for outpatients and pharmaceuticals dispensed. Even then, the military facilities still did not bill within those extended time frames in about half the cases, as shown in table 2.

Table 2: Third Party Billing Timeliness for Selected Transactions

Hospital	Billed timely	Billed late	Total bills tested
Eisenhower	25	35	60
Portsmouth	23	38	61
Wilford Hall	28	7	35
Total	**76**	**80**	**156**

Source: GAO analysis of DOD data.

Promptly invoicing insurers for care provided is a sound business practice and should result in improved cash flow for the government. Reasons for delayed billings provided by personnel were staffing shortages, high workloads, and coding delays. Also, officials at all three MTFs cited the current cumbersome billing process, which requires a high degree of manual intervention, as a cause for not billing promptly.

[5]Air Force Audit Agency, *Third Party Collection Program – Pharmaceuticals*, Audit Report 01051015 (Washington, D.C.: Aug. 8, 2001).

Compared to appropriated funds, third party collections represented a relatively small revenue source for the MTFs but could actually be larger. In fiscal year 2001, Eisenhower collected $4.6 million for current and past years' billings, which was about 5 percent of its facility costs, and Portsmouth and Wilford Hall collected about $5.1 million and $4.2 million, respectively, or about 2 percent of their respective facility costs. Collections were derived primarily from admissions and, to a lesser extent, from outpatient care, which includes recoveries for prescription drugs, emergency medical care, and clinical visits.

Weaknesses Precluded Adequate Management of Pharmaceutical Return Goods Program

Management at the three facilities did not have the information needed to evaluate the cost of drugs turned in under the pharmaceutical return goods program. Specifically, pharmacy personnel did not perform inventories of non-narcotic expired drugs being returned to the manufacturers for reuse or destruction, which would help management verify the level and types of drugs being turned in and the accuracy of any credits received. The lack of a review of expired drugs hampers the pharmacy personnel's ability to identify reasons for any unusual trends associated with the drugs turned in and any adjustments needed to current inventory levels.

Pharmacy personnel at the Portsmouth and Wilford Hall facilities did not inventory the non-narcotic drugs turned in for pickup by their respective pharmaceutical return goods contractor. This contractor collects recalled, expired, or deteriorated drugs for a fee and returns them to their respective manufacturers for possible future credits. The contractor also provides each facility with a detailed report of the items returned and credits received. However, the two military facilities cannot verify the accuracy of credits received without having performed their own inventories of the returned items since they do not keep perpetual inventories of non-narcotic drugs, and they did not have records of what they turned in to the contractor. As a result, the hospitals were relying solely on the contractor to identify the actual type and amount of drugs returned to the drugs' manufacturers.

Pharmacy officials at Wilford Hall told us that it was not cost-effective to track non-narcotic expired drugs, but did not provide any analysis or documentation to support this assertion. However, we contacted a pharmacy operations official at a large commercial health care company who stated that it was the company's practice to maintain an inventory of returned drugs by assigning a tracking number for each returned item so the credit received can be reconciled to its related tracking number.

Conversely, Eisenhower pharmacy personnel recently started inventorying the turned in non-narcotic drugs in response to a January 2002 Army Audit Agency report of its pharmaceutical management practices.[6] In this report, Army auditors reported that pharmacy personnel had not established a method for tracking the amount of drugs returned to the manufacturers to make sure related credits were received.

Further, the hospitals did not use the detailed contractor reports to perform a "returned drug" analysis. Therefore, pharmacy personnel are unable to efficiently monitor drug usage or to determine whether unusual trends are occurring and if the inventory levels in the pharmacies are appropriate. Drugs have defined shelf lives, and there is value added in managing the inventories to minimize the levels of expired drugs. A periodic evaluation of expired and/or deteriorated drugs being turned in throughout the year may reveal certain drugs being turned in at consistently high levels and thus indicate a need to adjust the inventory levels to better align them with usage levels. If management reviewed actual performance data and took necessary corrective action to optimize inventory levels, the cost of pharmaceutical operations could be reduced. For example, in July 2001, Portsmouth returned 2,000 tablets of Zocor, a cholesterol-lowering drug, for destruction and received no credit. Since this drug costs the pharmacy about $.50 per tablet, the government lost $1,000 on the purchase of this unused drug.

Weaknesses Preclude Adequate Safeguarding and Management of Personal Property Assets

Although internal control standards require agencies to establish physical control to secure and safeguard vulnerable assets, internal controls over property at Wilford Hall and Portsmouth were ineffective and were only partially effective at Eisenhower due to inaccurate personal property data relative to the existence of these assets. We also found inaccuracies in the areas of completeness and a lack of support for the costs and dates of acquisition of these assets. More specifically, our tests of personal property found examples of items on the property records that could not be located and items that were incorrectly recorded or were not recorded in the property records. In addition, many items in the personal property records had little or no documentation available to support their acquisition values or dates, and the resolution of items discovered missing during physical inventories was significantly delayed.

[6]Army Audit Agency, *Pharmaceutical Management, U.S. Army Medical Command*, Report No. 02-129 (Washington, D.C.: Jan. 25, 2002).

We statistically sampled 100 property items at each facility, attempted to physically locate the items, and compared the facility-assigned bar code and manufacturer's serial number on each item with that shown in the record. Based on the results of tests of existence of personal property items at each location, we assessed the overall effectiveness of each facility's property internal controls. To determine effectiveness, we established three categories of error rates: below 5 percent error was considered effective, from 5 to 10 percent error was considered partially effective, and above 10 percent error was considered ineffective. As such, we estimate that at least 11 percent and 23 percent of the property items could not be found or had serial numbers that did not match those recorded on the books at Wilford Hall and Portsmouth, respectively. Since these percentages are greater than 10 percent, we assessed the internal control activities as ineffective at these two locations. At Eisenhower, we estimate, with 95 percent confidence, that at most 9 percent of the property items could not be found or had serial numbers that did not match those recorded on the books. Since this percentage falls between 5 and 10 percent, we assessed the internal control activities at Eisenhower as partially effective.

Additionally, we also estimated the specific existence error rates at each location. Based on our review, we estimate that the percentage of items that facility officials would not be able to find, or would find with serial numbers different than those listed in the property records, would be 31 percent at Portsmouth, 4 percent at Eisenhower, and 17 percent at Wilford Hall.[7] Almost all of the personal property items that could not be located were lower priced (under $5,000) or pilferable items that had been recorded as accountable assets. Examples of these items included a personal digital assistant (i.e., a Palm Pilot™); a cellular telephone; computer monitors; color printers; a handheld radio; and various pieces of medical equipment such as a stretcher, electric beds, and intravenous pumps. Officials stated that many of the pieces of medical equipment are portable and may move from one location to another with patients. However, for the office equipment items, no explanation was provided as to where they could be or what had happened to them. Property record errors were not limited to low dollar value items. For example, Wilford Hall officials told us that a $1 million magnetic resonance imaging scanner

[7]The 95 percent confidence interval extends from 21 percent to 41 percent for Portsmouth, from 1 percent to 10 percent for Eisenhower, and from 10 percent to 27 percent for Wilford Hall.

was returned to the contractor in September 2001. However, the scanner was still on Wilford Hall's records at the time our sample items were selected in October 2001, and not removed from the MTF's records until November 2001. In addition to the sample items that could not be located, serial number errors where the facility-assigned bar code matched but the serial number did not were prevalent in property of all dollar values. Appendix III summarizes the results of our personal property existence testing.

Tests of property items traced from their physical locations to the property records showed similar types of errors. We found instances where the serial numbers in the property records did not match the serial numbers on the personal property, although the bar codes did match. In addition, other items such as a laptop computer, a Sony monitor, and a sterilizer were not recorded in the property records. Recording these items accurately in the property records is an important step to improving accountability and financial control over these assets and, along with periodic inventory, preventing theft or improper use of government property.

In addition to the weaknesses found in the physical controls over personal property assets, the three facilities provided little or no independent documentation to adequately support the cost or acquisition dates of their personal property items. Eisenhower and Wilford Hall had no supporting documentation readily available for any of the items in the sample, while Portsmouth's property management staff mostly provided internally generated purchase orders and requests in support of the estimated cost and acquisition dates of many personal property items. Based on our review, we estimate that Portsmouth would not be able to provide independent documentation for 93 percent of the items in the property records.[8] Internal control standards for the federal government require that all transactions be clearly and completely documented, and that this documentation be readily available for examination. We previously reported that DOD guidance on proper documentation and retention was inadequate.[9] The documentation problems we found suggest that these issues still exist.

[8]The 95 percent confidence interval extends from 86 percent to 98 percent.

[9]U.S. General Accounting Office, *Internal Controls: DOD Records Retention Practices Hamper Accountability*, GAO/AIMD/OSI-00-48R (Washington, D.C.: Feb. 4, 2000).

Taking a periodic physical inventory of personal property and resolving discrepancies in a timely manner are key internal control activities for property accountability. However, although all three facilities take periodic physical inventories, Portsmouth and Wilford Hall had long delays in researching personal property items not located during their physical inventories and finalizing inventory results, weakening personal property accountability. At Portsmouth and Wilford Hall, missing inventory items were not promptly researched as required by the DOD Financial Management Regulation. This regulation requires that an inquiry be initiated immediately after discovery of the loss, damage, or destruction of government property and that a "Financial Liability Investigation of Property Loss" form be completed. At Wilford Hall, research was still ongoing in May 2002 for items missing during the May 2001 annual inventory. Further, neither of these locations had completed their 2001 physical inventories as of May 2002, indicating a lack of management emphasis on the importance of personal property accountability. These delays make it more difficult to research and investigate the cause of the loss of the personal property items, and lessen the effectiveness of the physical inventory process as a key internal control activity.

Weaknesses in Government Purchase Card Program Resulted in Misuse

Purchase card program internal control weaknesses make medical facilities vulnerable to fraudulent and abusive purchases and place the government at financial risk for the purchases. As a result, the ability to buy items or services that may be (1) potentially fraudulent, (2) improper, and (3) abusive or questionable increases. These purchase card weaknesses are similar to those identified in our previous work at two Navy sites in San Diego, California,[10] and at five Army sites (one being Eisenhower),[11] both of which found a weak control environment and ineffective internal controls, which allowed potentially fraudulent, improper, and abusive purchases. The work at Eisenhower is the result of

[10]U.S. General Accounting Office, *Purchase Cards: Control Weaknesses Leave Two Navy Units Vulnerable to Fraud and Abuse*, GAO-02-32 (Washington, D.C.: Nov. 30, 2001).

[11]U.S. General Accounting Office, *Purchase Cards: Control Weaknesses Leave Army Vulnerable to Fraud, Waste, and Abuse*, GAO-02-732 (Washington, D.C.: June 27, 2002), and *Purchase Cards: Control Weaknesses Leave Army Vulnerable to Fraud, Waste, and Abuse*, GAO-02-844T (Washington, D.C.: July 17, 2002).

statistical sampling and data mining,[12] while only data mining was used to review purchase card transactions at Portsmouth and Wilford Hall. Because we did not select statistical samples at these two locations, we cannot conclude as to the effectiveness of key internal controls. However, our tests indicated the same type of control breakdowns as seen in other work, indicating that these facilities could have similar problems.

A potentially fraudulent purchase by a cardholder is defined as one made that is unauthorized and intended for personal use. Potentially fraudulent purchases can also result from compromised accounts in which a purchase card or account number is stolen and used by someone other than the cardholder to make a potentially fraudulent purchase. At Eisenhower, an Army investigation found that a military cardholder defrauded the government of $30,000 with purchases of a computer, purses, rings, and clothing for personal use and as a result had been sentenced to 18 months in prison. The cardholder took advantage of a situation wherein the cardholder's approving official was on temporary duty for several months. The cardholder believed that the alternate approving official would certify the statement for payment without reviewing the transactions or their documentation. These fraudulent transactions were not discovered until the resource manager who monitored the unit's budget noticed a large increase in spending by the cardholder. The cardholder had destroyed all documentation for the 3-month period during which these transactions took place. These fraudulent transactions might not have occurred if the cardholder had known that the approving official would review the transactions. At a minimum, prompt approving official review would have detected the fraudulent transactions.

Although our data mining tests do not allow us to determine the extent of improper purchases at the three locations, we did find instances of two types of improper purchases—split purchases and purchases from nonmandatory sources. Split purchases occur when a cardholder divides a single purchase into more than one transaction to avoid the requirement to obtain competitive bids for purchases over the $2,500 micropurchase threshold or to avoid other established credit limits as prohibited by the

[12]In our work, data mining involved the manual or electronic sorting of purchase card data to identify and select for further follow-up and analysis transactions with unusual or questionable characteristics.

Federal Acquisition Regulation.[13] Of the 17 sets of transactions reviewed at Wilford Hall that appeared to be split purchases, officials could not provide invoices or other third party documentation for 15 of these sets of transactions to determine whether they were actual split purchases. However, a cardholder and another official acknowledged that two of the selected transactions were split purchases. For example, one transaction set contained 19 orders that were placed to the same vendor on the same day. These 19 orders totaled over $7,200. Officials agreed that this set of transactions was a split purchase because the buyer knew all the requirements and probably knew the total was above the threshold and still placed the orders at one time.

Another type of improper purchase occurs when cardholders do not buy from mandatory sources of supply. Various laws and regulations require the purchase of certain products from designated sources such as the Javits-Wagner-O'Day Act (JWOD) vendors. The program created by this act is a mandatory source of supply for all federal entities.[14] The JWOD program generates jobs and training for Americans who are blind or have severe disabilities by requiring federal agencies to purchase supplies and services furnished by nonprofit agencies, such as the National Industries for the Blind and the National Institute for the Severely Handicapped. At Portsmouth and Wilford Hall, items such as day planner refills, other miscellaneous office supplies, and plastic utensils were bought from a commercial source when they, or substantially similar products, could have been bought from JWOD vendors. Further, Portsmouth and Wilford Hall did not have documentation to show that the cardholders had checked item availability from these vendors before purchasing them elsewhere.

Each location had examples of either abusive or questionable purchase card transactions. Abusive transactions are those that were authorized, but the items purchased were at an excessive cost or for a questionable government need or both. Abuse can also be viewed as when the conduct of a government organization, program, activity, or function falls short of societal expectations of prudent behavior. One example of an abusive transaction was the purchase of a $650 Sony digital camera at Wilford Hall that was justified as needed to "take photos for Christmas party and other

[13]The *Federal Acquisition Regulation* is the primary source of the uniform policies and procedures for acquisition by all executive agencies.

[14]*Federal Acquisition Regulation*, Part 8.7.

events put on for squadron morale boosters," while the digital camera bought by the pass office to update its badge security system only cost $350. The purchase of the more expensive model for the reasons given was excessive, and a more modest camera could have been bought.

Questionable transactions are those that appear to be improper or abusive but for which there is insufficient documentation to conclude either. Many of the transactions we selected in the data mining were without supporting documentation, which makes a firm determination of their legitimacy impossible without a thorough investigation. Also, we have found that the lack of documentation can be an indicator of fraud, as in the $30,000 Eisenhower fraud case. Questionable purchases often do not easily fit within generic governmentwide guidelines on purchases that are acceptable for the purchase card program. Because they tend to raise questions about their reasonableness and subject the activity to criticism, they require a higher level of prepurchase review and documentation than other purchases. An example of a questionable transaction involved the purchase of food by a psychiatric clinic at Portsmouth. Hospital officials stated that the planning of meals, purchasing of food at local groceries, and its subsequent preparation is a commonly prescribed therapy for certain patients, and the hospital pays for the food. While this may be true, there was no advance approval of this transaction and military facility officials provided no other documentation authorizing this activity as legitimate. Because there are limitations on the purchase of food with a government purchase card, it seems reasonable to expect that each of these particular transactions be closely reviewed and approved and be well documented and justified before the purchase, not after.

In addition to fraudulent, improper, and abusive or questionable purchases, the medical facilities lacked documentation of (1) advance approval, (2) independent receiving, and (3) invoices or other means to independently verify both the quantity and price of purchases for the items we reviewed.

Many of the government purchase card transactions we reviewed at these facilities did not have documentation of advance approval. At Eisenhower, we estimated that 60 percent of the items purchased with the government purchase card lacked advance approval.[15] Portsmouth lacked advance approval documentation for 40 of the 50 nonrepresentatively selected transactions we reviewed, but officials claim that all items purchased and

[15]The 95 percent confidence interval extends from 48 percent to 71 percent.

recorded in their Defense Medical Logistics Standard Support (DMLSS) system have been through the approval process. However, once an item is approved and recorded in this system, subsequent reorders of the same item do not need any other approval. In other words, after the initial order, there is no separation of duties between the approving and ordering official. At Wilford Hall, which lacked advance approval documentation for 14 of the 50 nonrepresentatively selected transactions reviewed, several of the transactions were purchases of briefcases for war reserves appearing on project allowance lists. Officials said that as long as the items were on an allowance list, then they were authorized to buy them without any other necessary paperwork. Our selected items were on these approved project allowance lists, and no other advance approval documents with supervisor review and signature were available. Both the automated DMLSS system and war reserve approval processes do not prevent cardholders from buying items, such as these briefcases, for possible personal use.

Leaving a cardholder solely responsible for a procurement action without some type of documented approval puts the cardholder at risk and makes the government inappropriately vulnerable. A segregation of duties so that someone other than the cardholder is involved in the purchase improves the likelihood that both the cardholder and the government are protected from fraud, waste, and abuse. Advance approval is an appropriate internal control activity and can be achieved without requiring the formal contracting procedures that could impede timely purchases and increase costs. For example, blanket approval for routine purchases within set dollar limits involves minimal cost, but provides reasonable control. For nonroutine purchases involving significant expenditures, advance approval, even through informal processes, appears to be an important internal control activity.

The wide range of items lacking documentation of independent receiving could be the result of the type of documentation maintained at the facilities. Independent receiving by someone other than the cardholder is a basic internal control activity that provides additional assurance that purchased items are not acquired for personal use and that the purchased items come into the possession of the government. We estimated that 71 percent of the transactions at Eisenhower lacked documentation of independent receiving.[16] Of the 50 nonrepresentatively selected

[16]The 95 percent confidence interval extends from 60 percent to 81 percent.

transactions reviewed at each of the other two locations, 12 from Wilford Hall and 2 from Portsmouth lacked documentation of independent receipt.

Portsmouth's medical logistics system, which was different from those in place at Eisenhower and Wilford Hall, allows the person receiving the item to document the receipt directly into the system. This process makes the receipt documentation more readily available than paper files since it tracks the name and date of receipt. For 48 of the 50 items we reviewed, system records showed a different person ordering and receiving the goods. However, we did not test the system's access controls over the segregation of the ordering and receiving functions. Having receipt documentation recorded directly in the system is efficient and acceptable, but only if the system controls are adequate.

A large number of the transactions reviewed did not have independent documentation such as an invoice available to verify both quantity and price information. We estimated that 26 percent of the transactions at Eisenhower lacked an invoice or other independent documentation.[17] Of the 50 nonrepresentatively selected items reviewed at the other two locations, 20 and 18 lacked invoices or other independent documentation at Wilford Hall and Portsmouth, respectively. Internal control standards require that transactions be clearly documented and that support be readily available for examination. A valid invoice to show what was purchased and the price paid is a basic transaction document, and a missing invoice is an indicator of potential fraud, as was demonstrated in the $30,000 fraud case at Eisenhower. Without this independent documentation, supervisors and management cannot be certain that the items purchased are appropriate and that government funds were properly used. For example, some transactions had no documentation supporting the description, quantity, or price for items or services bought from vendors such as a jewelry store, an automobile audio accessory store, a dry cleaner, a camera store, and a carpet retailer. While officials told us that these transactions were for valid government reasons, they could not provide any documentation supporting the purchases. Without a vendor invoice, a thorough review is necessary to determine whether the transaction was proper or potentially fraudulent, improper, or abusive. Also, independent receiving cannot confirm that all purchased items were received if no invoice or other documentation supporting the quantity is available.

[17]The 95 percent confidence interval extends from 17 percent to 38 percent.

Conclusions

Collectively, the weaknesses found and their effects as demonstrated by our work indicate the existence of financial management problems at the three MTFs. Because selected internal controls at the facilities have not been effectively implemented, management at these facilities does not have reasonable assurance that only eligible patients are receiving care, the government has been properly reimbursed for care from third party insurers, personal property and expired drugs can be accounted for, and purchase cards are used properly. The same issues and recommendations identified in our other work related to purchase card usage are also applicable to the MTFs. As a result of these control weaknesses, millions of dollars that could be used for patient care may be unnecessarily spent for ineligible patients, unused pharmaceuticals, or unneeded purchases.

Recommendations for Executive Action

Because having sound financial and management practices affects the ability of program directors and managers to make better decisions and achieve results, we recommend that the Under Secretary of Defense for Personnel and Readiness and the military services' Surgeons General, in conjunction with the senior management at the three MTFs, as appropriate,

- develop a strategy to make short-term and long-term improvements in data quality in the automated eligibility, cost, and clinical health care systems;
- develop and utilize analytical tools for facilitating the identification of erroneous records in the eligibility, cost, and clinical health care systems such as comparisons between SSA records and facility automated medical management records;
- reiterate through correspondence with MTF personnel the importance of
  - completing or updating the DOD Form 2569, as required, to document whether each health care beneficiary has third party insurance;
  - entering patient insurance coverage information into the automated medical information system so that more complete and accurate reports can be generated to better identify reimbursable care for billing;

- billing third party insurance carriers promptly for admissions, outpatient visits, and pharmacy care, including items identified in our testing as well as other care not billed; and

- collecting third party reimbursements due to the government to the fullest extent allowed as required by DOD policy;

- require MTFs to maintain an itemized list of the names and quantities of drugs to be returned to the pharmaceutical return goods contractor for credit or disposal, and require MTFs to routinely monitor and evaluate, based on the management reports provided by the contractor and the pharmaceutical prime vendor, the credits received from the returns of drugs and net losses of those drugs to use as an indicator in determining whether on hand inventory levels are appropriate;

- require property office management to maintain, and have readily available, independent documentation supporting the cost and date of acquisition for all accountable personal property;

- require property office management to promptly report the loss of any personal property items detected during their periodic physical inventories, and to adjust the property records accordingly; and

- review and modify the existing processes and requirements to improve documentation of purchase card transaction approvals, independent receipt of the items, and invoices to better verify costs and quantities.

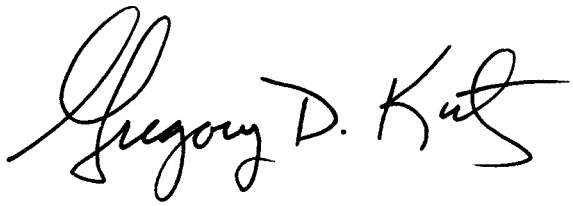
Agency Comments and Our Evaluation

DOD provided written comments on a draft of this report. DOD concurred with our recommendations and identified corrective actions planned and underway related to eligibility for health care and collections from third party insurers. In addition, both the Deputy Secretary of Defense and the Executive Director of the TRICARE Management Activity have recently issued guidance on the use of government purchase cards. DOD's comments are reprinted in appendix IV. DOD also provided additional comments, which we have incorporated as appropriate or responded to at the end of appendix IV.

Unless you publicly announce its contents earlier, we plan no further distribution of this report until 15 days from the date of this letter. At that

time, we will send copies of this report to the Chairmen of the Subcommittee on National Security, Veterans Affairs and International Relations and the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations; House Committee on Government Reform and other congressional committees. We are also sending copies to the Secretary of Defense; the Under Secretary of Defense for Personnel and Readiness; the Surgeon General of the Air Force; the Surgeon General of the Army; the Surgeon General of the Navy; the Secretary of the Air Force; the Secretary of the Army; the Secretary of the Navy; and the Commanders of Eisenhower, Portsmouth, and Wilford Hall. Copies will be made available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please contact Linda Garrison at (404) 679-1902 or by e-mail at garrisonl@gao.gov if you or your staffs have any questions about this report. An additional contact and staff acknowledgments are listed in appendix V.



Gregory D. Kutz
Director
Financial Management and Assurance

William M. Solis
Director
Defense Capabilities and Management

Scope and Methodology

We used a case study approach to review key internal control activities in five areas—eligibility, third party billings and collections, pharmacy expired drugs, personal property management, and government purchase card usage at three MTFs. Our work was performed at three large, diverse medical facilities—Eisenhower Army Medical Center, Augusta, Georgia (Eisenhower); Naval Medical Center Portsmouth, Portsmouth, Virginia (Portsmouth); and Wilford Hall Air Force Medical Center, San Antonio, Texas (Wilford Hall). We also performed work at the TRICARE Management Activity in Falls Church, Virginia.

This was not a financial audit; as a result, we do not render an opinion on the internal controls or any financial data or financial statements. Also, the results of our review cannot be projected beyond the three case study MTFs. Since we were not testing the internal controls as a part of a financial audit, we did not perform tests of the general or application electronic data processing controls. We also did not assess the overall control environment or perform a comprehensive risk assessment nor did we independently verify DOD's financial information used in this report.

To determine whether the key internal control activities were effectively implemented, we reviewed applicable laws and regulations; our *Standards for Internal Control in the Federal Government* (GAO/AIMD-00-21.3.1, November 1999); and our *Internal Control Standards: Internal Control Management and Evaluation Tool* (GAO-01-1008G, August 2001). We obtained an overview of the process and gained an understanding of the policies, procedures, techniques, and mechanisms used to help ensure that management's directives were carried out. We interviewed and observed management and personnel at the three MTFs and the TRICARE Management Activity. We also reviewed relevant audit reports from defense audit agencies and the DOD IG. Further, we performed targeted analyses of fiscal year 2001 transactions and control activities in the five areas.

To determine whether control activities used to identify those eligible for care were effective, we observed whether staff members in various clinics and sites throughout the MTFs were asking patients for military identification cards and querying the clinical system for eligibility status, and compared a file of all patients receiving prescriptions in fiscal year 2001 at one facility to an SSA file of all persons who had died in order to identify patients who either had erroneous social security numbers in the clinical system or who might be ineligible for care. The other two facilities were unable to readily provide comparable information.

To determine the effectiveness of the third party billing and collection internal control activities, we (1) tested a nonrepresentative selection of patients from 1 day each quarter during fiscal year 2001 to determine whether the facilities were systematically obtaining and updating patient insurance information, (2) tested a nonrepresentative selection of incidents of patient care that should have been billed, (3) reviewed the timeliness of a selection of third party insurance bills, and (4) analyzed the third party insurance collections.

To determine whether control activities over expired and obsolete drugs were effective, we (1) observed the pharmaceutical returned goods contractor pickup of expired drugs, (2) discussed with pharmacy and contractor personnel procedures and requirements for inventorying the expired drugs collected, and (3) obtained contractor-provided inventory lists of expired drugs turned in.

To determine the effectiveness of the control activities over personal property management, we performed tests of the existence, completeness, and accuracy of the cost and acquisition date recorded in the personal property records. To test existence, within each medical center we stratified the population of personal property items by the dollar value recorded as the purchase price for the item. We selected a stratified random probability sample of 100 personal property items recorded on the property records at each of the three facilities. With these statistically valid random probability samples, each transaction in the property records had a nonzero probability of being included, and that probability could be computed for any transaction. Each sample item was subsequently weighted in the analysis to account statistically for all the property records in the population at that location, including those that were not selected.

For each property item in the sample, we tested the physical existence of the item and compared the facility-assigned bar code and serial number in the property record to that attached to the property item. An error was recorded if MTF personnel (1) could not locate the item or (2) located the item, but the serial number on the item did not match that in the property record. We also examined the documentation supporting the date and cost of acquisition for each property item in the sample.

Because we followed a probability procedure based on random selections of property items, our sample for each facility is only one of a large number of samples that we might have drawn. Since each sample could have produced different estimates, we express our confidence in the precision

of our particular samples' results (that is, the sampling error) as 95 percent two-sided confidence intervals. These are intervals that would contain the actual population value for 95 percent of the samples we could have drawn. As a result, we are 95 percent confident that each of the confidence intervals in this report will include the true (unknown) values in the study population.

We also generated one-sided 95 percent confidence intervals around the overall results at each MTF and used them to assess whether the controls at each MTF over personal property were effective, ineffective, or partially effective. If the upper limit of a one-sided 95 percent confidence interval was 5 percent or less, we considered the controls effective. If the lower limit of a one-sided 95 percent confidence interval was 10 percent or more, we considered the controls ineffective. Otherwise, we considered the controls partially effective.

Although we projected the results of our samples to the population of items recorded in the property records at each of the medical centers, the results cannot be projected to the population of all property records at all of the MTFs.

In addition to our review of the existence of items recorded in the property records and the accuracy of the facility-assigned bar codes and serial numbers of the items, we also tested the completeness of the property records by selecting an item located next to all items in our sample that they were able to find. We then traced the bar code and serial number of the item back to the property records.

In order to test the accuracy of the cost and acquisition date recorded in the personal property records for the sample items, we obtained and reviewed any supporting documentation available from property management personnel.

To test internal control activities in the use of the government purchase card, we utilized two different approaches. To test the implementation of specific control activities at Eisenhower, 150 transactions were selected in a stratified random probability sample drawn from the population of transactions paid from October 1, 2000, through July 31, 2001. The methodology for the statistical sample is presented in the June 2002 GAO report, *Purchase Cards: Control Weaknesses Leave Army Vulnerable to Fraud, Waste, and Abuse* (GAO-02-732). The statistical sample allowed for projection of an estimate of the percentage of transactions for which each

control activity tested was not performed. We also evaluated the control environment and did data mining at Eisenhower.

For Portsmouth and Wilford Hall, we obtained files of all purchase card transactions made during fiscal year 2001. From these files, we tested a nonrepresentative selection of 50 transactions for each medical facility to test the implementation of specific control activities and to determine if indications exist of potentially fraudulent, improper, and abusive or questionable transactions. Our data mining included identifying transactions with certain vendors that had a more likely chance of selling items that would be unauthorized or that would be personal items. Because of the large number of transactions that met these criteria, we did not look at all potential abuses of the purchase card. We requested that each facility provide all documentation supporting the purchases and each of the control activities. If no documentation was provided, or if the documentation provided indicated there were further issues, we obtained additional information through interviews with cardholders and other hospital or purchase card officials. While we identified some potentially fraudulent, improper, and abusive or questionable transactions, our work was not designed to identify, and we cannot determine, the extent of potentially fraudulent, improper, or abusive transactions. The data mining techniques used at Wilford Hall and Portsmouth did not allow for a projection of an estimate of the effectiveness of key internal control activities.

Although we projected the results of the purchase card sample to the populations of transactions at Eisenhower, the results cannot be projected to the population of all purchase card transactions at all of the MTFs.

We briefed DOD officials at the three MTFs and at the TRICARE Management Activity on the details of our review, including our findings and conclusions. We requested comments through the DOD Office of the Inspector General, which distributed the report to the appropriate officials. We received written comments from the Office of the Assistant Secretary of Defense for Health Affairs, which also included copies of comments from the Surgeons General of the Air Force, Army, and Navy. DOD's response, including additional comments and a technical comment are reprinted in appendix IV. However, we did not reprint the comments from the three Surgeons General that formed the basis of the DOD response. We performed our work from August 2001 through June 2002 in accordance with U.S. generally accepted government auditing standards.

Financial and Operational Information at Selected MTFs (Unaudited)

Table 3: Fiscal Year 2001 Financial and Operational Information at Selected MTFs (Unaudited)

	Eisenhower Army Medical Center Augusta, Ga.	Naval Medical Center-Portsmouth Portsmouth, Va.	Wilford Hall Air Force Medical Center San Antonio, Tex.
Budget allocation – original at 10/1/00	$92,565,000	$210,578,000	$133,136,000
Budget allocation – supplemental	5,100,000	39,496,000	30,217,000
Reimbursements earned	7,202,000	14,130,000	11,411,000
Budget – overall budget authority at 9/30/01	104,867,000	264,204,000	174,764,000
Obligations at 9/30/01			
Civilian pay	42,723,000	63,643,000	38,014,000
Contracts	17,010,000	92,507,000	20,105,000
Supplies	40,721,000	89,903,000	78,374,000
Equipment	1,957,000	1,772,000	7,719,000
Other	2,456,000	16,379,000	30,552,000
Full-time equivalent employees			
Civilian	954	1,194	879
Military	1,178	2,361	3,658
Contract	286	643	424
Inpatient admissions	5,361	17,612	15,423
Outpatient visits	596,247	1,450,504	854,292
Pharmacy prescriptions filled	2,808,923	2,464,304	2,602,827

Source: GAO presentation of DOD data.

Results of Personal Property Existence Testing

Table 4 displays overall estimated existence error rates and associated two-sided 95 percent confidence intervals for personal property at each of the three facilities, as well as error rates for personal property with a recorded purchase price of $1,000,000 or more.

Table 4: Error Rates for Personal Property

Installation	Portsmouth	Eisenhower	Wilford Hall
Total items sampled	100	100	100
Estimated overall percentage of errors[a]	31%	4%	17%
95 percent confidence interval	21-41%	1-10%	10-27%
Actual percentage and number of errors in $1,000,000+ stratum[b] (100% testing performed)	11% (1 of 9)	0% (0 of 4)	88% (7 of 8)

[a]An error is defined as DOD officials not locating an item or locating an item with a serial number different from that which was recorded in the property record.

[b]All but one error that occurred in this $1,000,000+ stratum was due to manufacturers' serial numbers that did not match the facility-assigned bar codes shown in the records as opposed to missing property.

Source: GAO analysis of DOD data.

Comments from the Department of Defense

See comment 1.

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

SEP 27 2002

Mr. Gregory D. Kutz
Director, Financial Management and Assurance
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Kutz:

This is the Department of Defense (DoD) response to the GAO draft report, GAO-02-860, "MILITARY TREATMENT FACILITIES: Internal Control Activities Need Improvement," dated August 8, 2002 (GAO Code 192037).

In general, the DoD concurs with the overall GAO draft report. Specific comments and recommendations on the draft report are incorporated into our response.

The Department is appreciative of the GAO's surfacing of the five specific areas of MTF operations at the selected MTFs that require increased management involvement and oversight. Our comments address the GAO's recommendations and the five areas reviewed (enclosed).

Please feel free to direct any questions regarding this reply to my project officers, Major Henri Hammond (functional) at (703) 681-1724 or Mr. Gunther Zimmerman (GAO/IG Liaison) at (703) 681-7889 extension 1229.

Sincerely,

E. P. Wyatt
for William Winkenwerder, Jr., MD

Enclosures:
1. Response to GAO Recommendations
2. Additional Comments
3. Technical Comments
4. Air Force Surgeon General Comments

GAO DRAFT REPORT – DATED AUGUST 8, 2002
(GAO CODE 192037)

"MILITARY TREATMENT FACILIITES: INTERNAL CONTROL ACTIVITIES NEED IMPROVEMENT"

DEPARTMENT OF DEFENSE COMMENTS

To improve financial and management practices to afford program directors and managers better decision making tools to make better decisions and achieve results, the GAO recommended the Under Secretary of Defense for Personnel and Readiness and the Surgeons General, in conjunction with the senior management of the three military treatment facilities, as appropriate:

RECOMMENDATION 1: Develop a strategy to make short term improvements in data quality in the automated eligibility, cost, and clinical health care systems.

DOD RESPONSE: Concur.

RECOMMENDATION 2: Develop and utilize analytical tools for facilitating the identification of erroneous records in the eligible, cost and clinical health care systems such as comparisons between Social Security Administration records and facility automated medical management records.

DOD RESPONSE: Concur.

RECOMMENDATION 3: Reiterate through correspondence with military treatment facility personnel the importance of: a) completing or updating the DoD Form 2569, as required, to document whether or not each health care beneficiary has third party insurance; b) entering patient insurance coverage information into the automated medical information system so that more complete and accurate reports could be generated to better identify reimbursement care for billing; c) billing third party insurance carriers promptly for admissions, outpatient visits, and pharmacy care, including items identified in our testing as well as other care not billed; and d) collecting third party reimbursement due to the government to the fullest extent allowed as required by DoD policy.

DOD RESPONSE: Concur. These are appropriate recommendations. All possible efforts must be made to ensure this important program is properly managed and maintained. DoD also recommends that MTF leadership be held accountable for this program. It is evident that MTFs with involved and committed leadership, programs are more successful.

RECOMMENDATION 4: Require military treatment facility pharmacies to maintain a listing of all drugs returned to the contractor for credit or disposal and to routinely measure and analyze the type and net loss relating to the drugs being returned to determine if adjustments need to be made in the volume or type of items being ordered.

Enclosure 1 to Memo
GAO Draft Report
Page 1 of 2

DOD RESPONSE: Concur.

RECOMMENDATION 5: Require property office management to maintain, and have readily available, independent documentation supporting the cost and date of acquisition for all accountable personal property.

DOD RESPONISE: Concur.

RECOMMENDATION 6: Require property office management to promptly report the loss of any personal property items directed during their periodic physical inventors; and to adjust the property records accordingly.

DOD RESPONSE: Concur.

RECOMMENDATION 7: Review and modify the existing processes and requirements to improve documentation of purchase card transaction approvals, independent receipt of the items, and invoices to better verify costs and quantities.

DOD RESPONSE: Concur.

Enclosure 1 to Memo
GAO Draft Report
Page 2 of 2

GAO DRAFT REPORT – DATED AUGUST 8, 2002
(GAO CODE 192037)

"MILITARY TREATMENT FACILIITES: INTERNAL CONTROL ACTIVITIES NEED IMPROVEMENT"

ADDITIONAL COMMENTS

General Comments

- Page 5. Inadequate Eligibility Controls Allow for Unauthorized Access to Care. The GAO identified that erroneous eligibility information contained in DoD information systems precluded the military treatment facilities (MTFs) from providing reasonable assurance that medical care was only provided to eligible beneficiaries. The essence of GAO's comments concentrated on system problems. It is important to re-emphasize that MTF personnel only confirm and verify data in DEERS to check eligibility, not establish nor disestablish entitlement. Specific improvements are being fostered internally within the MTFs to check eligibility for care and recoup ID cards that are found to be fraudulent. These steps will help improve the access to care for only those who are eligible.

- Page 7. Weaknesses in Billings and Collections Prevent Full Recovery of Millions from Third Party Insurers. GAO identified that millions of dollars are not being collected each year because patient medical records are incomplete, and that patients are not asked to provide current information thereby hindering the ability to identify all billable care. The Services are addressing this problem by seeking new automation products to allow verification of Other Health Insurance (OHI), examining business case models to allow medical record dictation, regionalization of billings offices, revenue cycle procedure manuals, modification to current billing office guidance, and patient coding solutions to improve accuracy. These efforts are aimed at improving the billing and collection capabilities to foster maximum recoupment.

- Page 12. Weaknesses Precluded Adequate Management of Pharmaceutical Returned Goods Program. GAO identified that Wilford Hall Medical Center (WHMC) did not inventory the non-narcotic drugs turned in for pickup by a return goods contractor. The GAO further indicated that Wilford Hall could not verify the accuracy of credits for returned drugs and credits received. Lastly, the GAO indicated that pharmacy officials at Wilford Hall told them that it was not cost effective to track non-narcotics expired drugs. **Comment:** Specific findings may have been misstated due to lack of complete understanding of local procedures and the fact that Wilford Hall Medical Center was transitioning from one material information management system to another at the time of the audit.

See comment 2.

Enclosure 2 to Memo
GAO Draft Report
Page 1 of 3

See comment 3.

- Page 13. The GAO indicated that they were unable to find the property records at Wilford Hall for a $1 million Magnetic Resonance Imaging (MRI) scanner. GAO asserts that the MRI was removed from service in September 2001 with no documentation available to show what had happened to it, or whether or not it had any residual value. **Comment**: Wilford Hall did have documentation available to show that the MRI was returned for credit and an inventory loss transaction was processed. Copies of the supporting documentation were provided to the auditor, yet it was still identified as an audit finding.

- Page 16. Weaknesses in Government Purchase Card Program Resulted in Misuse. The Government Credit Card Programs need improvement. The TRICARE Management Activity will direct the Military Department Surgeons General to identify Government Purchase Card Programs as annual assessable units and to include them in their annual statements of assurance.

Eligibility Controls for Access to Care

Based upon a DoD IG audit, Evaluation of the Investigative Environment in Which the Defense Enrollment Eligibility Reporting System (DEERS) Operates (Project # 70F-9029), the IG recommended in Recommendation B.1. "The ASD(HA) direct military treatment facility Commanders to comply with existing policy that requires a) 100 percent eligibility checks using DEERS prior to treating military personnel or their dependents; b) confiscating identification cards from ineligibility individuals who seek military medial care and forwarding those cards to local authorities; and c) initiate administrative recoupment action for costs incurred when suspected ineligible individuals obtain unauthorized military medical benefits."

To conform to the requirements, the Office of the Assistant Secretary of Defense (Health Affairs) has created a new Department of Defense Instruction (DoDI) which implements policy for eliminating the fraudulent use of Identification Cards (ID) issued to Members of the Uniformed Services, their dependents, and other eligible individuals for health care provided in the Military Health System (MHS) Medical Treatment Facilities (MTFs). The new DoDI also implements policy, assigns responsibilities and prescribes procedures for MTFs regarding the verification and confiscation of ID Cards.

When issued, the DoDI will outline prescribed procedures to the Services and their MTFs for reviewing ID cards to determine eligibility for care, procedures for confiscation of fraudulent ID cards, and the recoupment of DHP funding spent for the delivery of medical care.

The draft DoDI is currently undergoing Departmental coordination. The ASD(HA) has sent the SD Form 106 to the Military Departments for review.

Enclosure 2 to Memo
GAO Draft Report
Page 2 of 3

Management Control Program

The TRICARE Management Activity (TMA), the operational component of the Assistant Secretary of Defense (Health Affairs), instituted a Management Control Program (MCP) in April 2001 to assist in the oversight of the MHS and the Defense Health Program (DHP). The TMA MCP consists of two distinct oversight initiatives, the TMA Management Control Program and the Defense Health Program (DHP) Enterprise Management Control Program. The DHP Enterprise program is designed to provide the Military Departments with subject areas in which MHS policy is issued to the Military Departments for inclusion in the Services list of assessable units (AUs) issued to their MTFs. Representatives from the three Military Departments meet quarterly as the DHP Management Control Program Work Group to review and address management control issues relevant to the Services and MTFs. The result is the development of DHP AUs forwarded to the Military Departments for implementation. AU reviews are consolidated into the Military Department's Annual Statements of Assurance as required by the Federal Managers' Financial Integrity Act (FMFIA).

Third Party Collection Program (TPC)

The Department fully supports the findings identified by the GAO regarding the loss of funds not being collected under TPC due to incomplete patient medical records, inadequate insurance identification procedures and weak billing and collecting procedures. The corrective actions identified by the GAO should help the Department in its continuing education with the Services and MTFs of how the TPC can improve.

Government Purchase Card Program

On June 21, 2002, the Deputy Secretary of Defense directed management at all levels to ensure the necessary oversight of government charge cards and education to eliminate fraud, misuse, and abuse of these charge cards. The Executive Director, TMA issued guidance on July 8, 2002 to the TMA Directors providing policy and information on responsibilities for the use of Government Charge Cards.

GAO DRAFT REPORT – DATED AUGUST 8, 2002

(GAO CODE 192037)

"MILITARY TREATMENT FACILIITES: INTERNAL CONTROL ACTIVITIES NEED IMPROVEMENT"

TECHNICAL COMMENTS

- Page 23. Fourth Recommendation. **Recommend** rewriting the recommendation to read "Require military treatment facility pharmacies and/or medical logistics offices to maintain an itemized list of all drugs and quantities to be returned to the pharmaceutical return goods contractor for credit or disposal. Further, require MTF's to routinely monitor and evaluate, from the management reports provided by the contractor and pharmaceutical prime vendor, the credits received from the returns and the drugs and net losses of those drugs to determine if on hand inventory adjustment are appropriate." Revised recommendation more accurately reflects the current process for controlling returned pharmaceuticals and the process to determine the impact on the inventory resulting from returns.

Enclosure 3 to Memo
GAO Draft Report
Page 1 of 1

The following are GAO's comments on the Department of Defense's letter dated September 27, 2002.

GAO Comments

1. Report number was changed to reflect issuance in fiscal year 2003.

2. The MTF did not maintain a list of non-narcotic drugs awaiting pick up by the contractor in either its former system or the one to which it was transitioning.

3. We have not been provided documentation indicating that the MRI was returned for credit. The point of the finding is that the property records were inaccurate at the time of our review.

GAO Contact and Staff Acknowledgments

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