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ELIMINATING WASTE, FRAUD AND ABUSE IN VETERANS' PROGRAMS

REPORT TO THE

COMMITTEE ON THE BUDGET

FROM THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

108TH CONGRESS

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, September 2, 2003

Hon. JIM NUSSLE,
Chairman, Committee on the Budget
House of Representatives, Washington, DC

DEAR MR. CHAIRMAN: Enclosed with this letter is the report of the Committee on Veterans' Affairs with its findings on means of eliminating waste, fraud and abuse in spending programs under the Committee's jurisdiction.

The Committee conducts regular oversight of veterans programs in accordance with its Oversight Plan for the 108th Congress. Pursuant to the requirement of the Conference Report to Accompany the Concurrent Resolution on the Budget for Fiscal Year 2004, the full Committee held hearings on waste, fraud and abuse in veterans' programs on May 8 and June 10, 2003. The topics of the hearings included barring payment of veterans benefits to fugitive felons, stopping erroneous benefits payments in the Philippines, improving management of long-term care for veterans, ensuring that part-time VA physicians meet their employment obligations, strengthening debt management, and reducing costs in worker's compensation.

Additionally, the Committee has held hearings on the findings of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans, and VA's medical care collections program. As reflected in the enclosed report, the Committee has utilized both the U.S. General Accounting Office and the VA Office of the Inspector General in its oversight and evaluations of spending programs for veterans.

Much of the potential savings in spending programs for veterans the Committee report has identified can be appropriately achieved through improvements in VA program management, and legislation is not recommended. However, the Committee has reported legislation discussed in the enclosed report that would enable VA to significantly increase medical care collections from nonfederal sources. This legislation, H.R. 1562, was requested by the Administration and reported favorably by the Committee, but the House has not acted on it.

The Committee intends to continue its aggressive oversight of spending programs for veterans to ensure that tax dollars are efficiently used in the programs under its jurisdiction, and will continue its efforts to identify changes in law to eliminate waste, fraud

and abuse. The support of the Committee on the Budget in these endeavors is most appreciated.

Sincerely,

CHRISTOPHER H. SMITH,
Chairman

LANE EVANS,
Ranking Democratic Member

ELIMINATING WASTE, FRAUD AND ABUSE IN VETERANS' PROGRAMS

Pursuant to section 301 of the Conference Report to Accompany the Concurrent Resolution on the Budget for Fiscal Year 2004 (H. Con. Res. 95; H. Rept. 108–71), the Committee on Veterans' Affairs is transmitting herewith its findings on means of eliminating waste, fraud, and abuse in spending programs under the Committee's jurisdiction.

ENHANCING MEDICAL CARE COLLECTION AUTHORITY

The Committee is concerned that the Department of Veterans Affairs (VA) health care system is seriously under-funded and unable to meet the demands being placed on it by the health care needs of enrolled veterans. The VA health care system is under obvious stress, as increasing enrollment and rising health care costs have resulted in hundreds of thousands of veterans being forced to wait months, some even more than a year, for an initial appointment. VA recently reported in January 2003 that over 200,000 veterans were waiting six months or more to be seen in VA primary care. This waiting list has been reduced, but VA still fails to meet its own access standards for a very large number of enrolled veterans.

The Committee conducted hearings and other oversight during this Congress and previous Congresses to identify additional funding sources and promote management efficiencies to address the rising demand for VA medical care services. As a consequence of this oversight, on April 2, 2003, H.R. 1562, the Veterans Health Care Cost Recovery Act of 2003, was introduced by Honorable Bob Beauprez; the Committee's Chairman, Honorable Christopher H. Smith; and the Committee's Ranking Member, Honorable Lane Evans; the Subcommittee on Health's Chairman, Honorable Rob Simmons; and the Subcommittee's Ranking Member, Honorable Ciro D. Rodriquez. After subcommittee and full committee consideration, on May 15, 2003, H.R. 1562, as amended, was ordered reported favorably to the House by unanimous voice vote. To date, the House has not acted on this bill.

In 1986, with Public Law 99–272 Congress provided VA authority to collect from third-party insurers of nonservice-connected veterans receiving VA health care. These funds are used by VA to supplement appropriated funds to maintain high quality health care. However, VA is currently unable to collect fully from the sizeable preferred provider sector, which now accounts for a major portion of all health plans in the United States. H.R. 1562, as amended, would enhance the ability of VA to collect reimbursements from third-party insurers by clarifying VA's power to recover costs for medical care provided to veterans at VA facilities covered by preferred provider organizations and other non-traditional coverage.

Specifically, H.R. 1562, as amended, would deem VA as a "preferred provider" for purposes of collection when a payer has payment arrangements with preferred provider organizations and a covered veteran receives VA health care under an equivalent arrangement. This legislation would prevent a third-party payer from denying or reducing reimbursement to VA solely because VA does not have a participation agreement with that third-party payer. Additionally, the legislation would grant specific authority for VA to recover the cost of providing medical care to non-veterans from any private health plan. Under current law, the collections recovered would be deposited into the Medical Care Collections Fund (MCCF) and treated as offsets to discretionary spending. Subject to annual appropriation, VA can spend the money in the MCCF to provide medical care to veterans.

The Congressional Budget Office (CBO) estimates that under H.R. 1562, as amended, collections from nonfederal sources would increase by $111 million in 2004 and $737 million over the 2004–2008 period. CBO estimates that implementing this legislation would result in net discretionary savings of $24 million in 2004, and $38 million over the 2004–2008 period, assuming appropriation of the estimated collections and after accounting for the typical lag between collections and spending.

IMPROVING MEDICAL CARE COLLECTIONS

In 1997, Congress gave VA the authority to retain third party collections it recovered instead of returning the funds to the U. S. treasury. This authority was requested by the Department as a part of its 5-year plan to obtain 10 percent of its funding from third party collections and other revenue sources. In 1999, the Committee received VA's outsourcing business plan for health care revenue collection. The plan involved consolidating certain revenue collection processes (pre-registration, insurance verification, billing collections, and customer service) into a "Consolidated Revenue Unit" at the network level. Also, in 1997 VA adopted a new fee schedule called "reasonable charge" authorized by Public Law 105–33, the Balanced Budget Act of 1997. By November 2000, VHA had initiated four pilot tests—two in-house and two by contract. VA also received a Price Waterhouse report with 24 major recommendations for improving MCCF revenue operations.

In 2001, the U.S. General Accounting Office (GAO) reported in hearing testimony that for the first time since 1995, VA had reversed the general decline in its third party collections. GAO largely attributed the increase to VA's implementation of the reasonable charges billing system. However, GAO reported recurring problems, including: (1) VA billing times that were 14 times greater on average than the private sector; (2) continuing weaknesses in VA's collections information systems; and (3) a lack of department-wide standardization for collections. The VA's Office of Inspector General (IG) also reported problems and weaknesses in a number of areas, including: (1) determination of veterans' eligibility and entitlement status; (2) verification and coordination of patient care with insurance carriers; (3) medical record documentation of care provided; (4) coding of bills to insurance carriers; (5) billing of insurance carriers; and (6) collection of insurance carriers' delinquent accounts.

VA was also mandated by Congress to acquire and implement a commercial patient financial system. VA is implementing the Patient Financial Services System project, which is intended to improve the business process and information technology in revenue collections. In May of 2002, VA created a new office in the Veterans Health Administration (VHA), the Chief Business Office, to improve collections. However, VA's compliance with established policies and procedures for MCCF management continues to be inconsistent. In his April 1, 2002, to September 30, 2002, Semiannual Report to Congress, the IG reported that deficiencies in the collections system result from the inability to properly bill for services.

The VA's budget proposal for fiscal year 2003 proposed a new outsourcing business plan to reconfigure the revenue collection program. However, of the four network pilot tests, only one produced an outsourcing contract model. VA's budget proposal for fiscal year 2004 indicated VA had made considerable progress in executing its new business plan. The new plan would reconfigure the revenue collection program to include both in-house and contract models.

MCCF collections have shown a steady improvement since fiscal year 2000. Actual collections from third parties have been: $394 million for fiscal year 2000; $540 million for fiscal year 2001; and $690 million for fiscal year 2002. Projected collections are $760 million for fiscal year 2003.

On May 7, 2003, the Subcommittee on Oversight and Investigations held its third oversight hearing on third party collections and received an update from GAO on VA's third-party collections since September of 2001. GAO also provided an overview of continuing operational problems in collections for fiscal year 2002, including missed billing opportunities, insufficient documentation of services for billing, shortages of billing and coding staff, insufficient pursuit of accounts receivable, and unidentified insurance for some patients.

The Deputy Secretary of Veterans Affairs, Honorable Leo S. Mackay also testified at the May 7, 2003, hearing about VA's efforts to improve third party collections. He informed the Subcommittee that the strategies being pursued include establishment of health care industry based performance and operational metrics, technology enhancements and integration of proven business approaches, including establishment of centralized revenue operations centers. He further stated that VA is developing a demonstration project to fully outsource the revenue process functions at a VA Medical Center to test the feasibility of this approach to enhancing revenue. The Committee will conduct oversight of the demonstration projects.

STRENGTHENING DEBT MANAGEMENT

According to the IG's *Report of the Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 2002 and 2001*, Report No. 02–0163847, January 23, 2003, as of December 2002, debts owed to the VA totaled $3 billion. The majority of these (52 percent) were active vendee loans. The debts owed to the VA are derived from the payment of home loan guaranties; direct home loans; life insurance loans; Medical Care Collections

Fund receivables; and compensation, pension, and educational benefits overpayments.

The IG made several recommendations to the Department concerning its debt management activities. During testimony on May 8, 2003, Honorable Richard Griffin, VA Inspector General, reported that the Strategic Plan for 2003–2008 shows that VA is addressing his recommendations to be more aggressive in collecting debts; improve debt avoidance practices; and streamline and improve debt waiver decisions. The IG also stressed that debt management activities could be improved.

The Committee will continue its oversight and working with VA to ensure that the IG's recommendations are implemented.

RESTRUCTURING CAPITAL ASSETS

As a result of improved technologies, new treatments and national changes in practice patterns of health care professionals, VA has shifted its focus from inpatient to outpatient care. This shift resulted in many instances of shortened lengths of stay when hospitalization is required and established needs for many new outpatient facilities. Consequently, many structures formerly used for inpatient care have been converted for new uses. However, the vacant space that cannot be converted for effective uses has become a significant burden and waste of VA resources that could be used for direct health care for veterans.

GAO concluded in 1999 that VA's existing infrastructure could be the biggest obstacle confronting its ongoing transformation efforts. During a hearing before the Subcommittee on Health in 1999, GAO pointed out that although VA was addressing some realignment issues, it did not have a plan in place to identify buildings that were no longer needed to meet veterans' health care needs. GAO 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 veterans' homes.

In addition, GAO reported that most delivery locations had mission-critical buildings that VA considers functionally obsolete. The functional obsolescence included inpatient rooms that failed to meet contemporary standards for patient privacy; outpatient clinics with too few examination rooms; and buildings with life safety concerns.

In 1999, based on recommendations and actions of the Committee, VA began an effort to realign its capital assets, primarily buildings, to better serve veterans' needs as well as institute other needed efficiencies. The Capital Asset Realignment for Enhanced Services (CARES) initiative includes: (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 to be considered included: (1) partnering with other public or private providers; (2) purchasing care from other providers; (3) replacing obsolete assets with modern ones; and (4) consolidating services

duplicated at multiple locations serving the same market. CARES is the most ambitious such effort undertaken by VA.

Recent data from VA's CARES office provided an overview of VA facilities as follows: VA owns 5,044 buildings and 118.5 million square feet. The average age of VA buildings is 50.4 years. The replacement life cycle at the current rate of investment is 155 years. VA operates 162 hospitals, 677 community-based outpatient clinics, 137 nursing home units and 43 domiciliaries.

During the CARES process, 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 might allow VA to operate more efficiently and effectively while ensuring access consistent with its standards for travel time. Efficiencies through economies of scale have been identified in 30 geographic areas where two or more major health care delivery sites were located in close proximity and or provided duplicative inpatient and outpatient health care services. Also six high priority collocations of regional benefits offices with medical centers have been proposed. VA has also identified more than 70 opportunities for partnering with DOD to better align the infrastructure of both agencies. Twenty-one of the collaborations or joint ventures with DOD are considered high priority. Four years after GAO recommended the formation of CARES, VA expects to issue its final plans by the end of 2003.

An exemplary model of public/private partnering supported by the Committee is proposed at the site of the former Fitzsimons Army Medical Center in Aurora, Colorado. This multi-acre tract was deeded by the federal government to Colorado University to enable it to consolidate one of the largest regional medical, educational and biomedical research complexes in the country. Discussions are underway between VA and DOD to negotiate a joint venture to construct and staff a Regional Federal Medical Center, sharing resources, services and research with the University of Colorado at that site. H.R. 116, as amended, was reported by the Committee on July 14, 2003, to authorize the Secretary of Veterans Affairs, in consultation with the Secretary of Defense, to construct, lease, or modify major medical facilities at the site of the former Fitzsimons Army Medical Center, Aurora, Colorado.

The Committee will continue to monitor carefully the progress of CARES and expects to hold a public hearing after the plan has been completed.

IMPROVING EFFICIENCY AND ACCESS THROUGH VA-DOD SHARING

For approximately twenty years, the Committee has promoted the sharing of health care resources between the Departments of Veterans Affairs and Defense (DOD). The goal of sharing between the two Departments is to improve the quality of health care for VA and DOD beneficiaries and to reduce costs that exist in both Departments. By collaborating, the two Departments can improve access to care and reduce the overall costs of furnishing that care to both veterans and the military beneficiary population.

In 1982, Congress enacted Public Law 97–174, (the Sharing Act) to foster more effective sharing of health care resources between

VA and DOD. The law was enacted not only to remove legal barriers, but also to provide incentives for military and VA health care facilities to engage in health resources sharing through local agreements, joint ventures, national sharing initiatives, and other collaborative efforts pointed to better and more efficient use of Federal health care resources. The Sharing Act provides broad authority to both VA and DOD to share health resources across the spectrum of health care and health-related activities. With the advent of the Sharing Act, a flurry of VA-DOD sharing activity occurred, and hundreds of agreements were executed among military and VA medical centers and their clinics. However, over the succeeding years, sharing waned as military health care shifted from a facilities-based system to the TRICARE program that relies on private health care networks.

On July 27, 2001, Chairman Smith introduced H.R. 2667, the Department of Defense-Department of Veterans Affairs Health Resources Access Improvement Act of 2001. H.R. 2667 sought to establish a health care facilities sharing demonstration project in keeping with the intent of the original legislation for VA-DOD sharing. Under the bill, five qualifying sites would be selected for participation in a demonstration project. The purpose of the demonstration project was to identify and measure the advantages of sharing and work through the challenges of the two systems becoming true partners in health care delivery. The two Departments' medical information systems are incompatible, but this legislation would have created a framework for greater technology compatibility. By improving such communication, the Departments could better ensure continuity of care, equality of access, uniform quality of service and seamless transmission of data. Most of the original concepts and objectives of H.R. 2667 were incorporated in Subtitle VII of Public Law 107–314, the Bob Stump National Defense Authorization Act for Fiscal Year 2003.

On March 7, 2002, the Subcommittee on Health and the Committee on Armed Services Subcommittee on Military Personnel held a joint hearing to examine collaboration and health resources sharing by the two Departments, including consideration of H.R. 2667. Chairman Smith testified to urge both subcommittees to aggressively increase resource sharing between these two health care systems. Defense Under Secretary David S. Chu assured the Committees that he and VA Deputy Secretary Mackay share a common vision of quality health care for the men and women serving our country, their families, and those that have served. According to Under Secretary Chu, the cooperative efforts of DOD and VA are focused on a proactive partnership that meets the missions of both agencies while benefiting the servicemember, veteran and taxpayer with new initiatives and increased efficiency.

On June 3 and June 17, 2003, the Committee held hearings to receive the Final Report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans (PTF). One of the four organizing principles which this task force used in developing recommendations was that committed leadership from VA and DOD is essential to achieve VA-DOD collaboration to improve health care for veterans and military retirees. The PTF found that VA and DOD should maximize the use of resources and infrastruc-

ture that each Department currently retains individually. Dr. Gail Wilensky, Co-Chair of the PTF, stated in her June 3, 2003, testimony, "The goal of improved collaboration between VA and DOD is not collaboration for the sake of collaboration, but rather that, through such activity, VA and DOD can improve timely access to quality health care and reduce the overall costs of furnishing services."

H.R. 1911, to amend title 38, United States Code, to enhance cooperation and the sharing of resources between the Department of Veterans Affairs and the Department of Defense, introduced by Honorable John Boozman, was passed by the House on May 21, 2003, and would establish a DOD-VA Joint Executive Committee to: (1) expand oversight of collaborative efforts beyond health care issues to include benefits and other areas as determined by the cochairs; and (2) promote increased resource sharing.

Existing law allows each Department to determine individually the number of employees each would designate to support the committee, but requires each one to share equally in the cost, notwithstanding parity in the numbers. It also requires a permanent staff be assigned to the committee. This bill would delete these personnel requirements, thereby enhancing the flexibility of each Department to use its personnel in the most efficient manner possible, while at the same time authorizing the establishment of subordinate committees and work groups as deemed appropriate by the cochairs.

Existing law specifically authorizes the recommendations of the committee for sharing of resources to improve access, quality, and cost effectiveness. Under H.R. 1911, the committee would also identify changes in policies to improve services, efficiencies, and opportunities for collaboration for delivery of benefits and services to beneficiaries of both Departments.

According to CBO, this bill would have a negligible cost. Although CBO did not project any cost savings in its reported estimate, the Committee expects that cost savings would result from the enactment of this bill, as it would further promote the sharing between VA and DOD and create new methods by which the two Departments would share resources and eliminate duplicate activities. The substance of H.R. 1911 was incorporated into H.R. 1588, the National Defense Authorization Act for Fiscal Year 2004, which the House passed on May 22, 2003.

MANAGING LONG-TERM CARE FOR VETERANS

In 1999, Public Law 106–117, the Veterans' Millennium Health Care and Benefits Act, was enacted to ensure VA better meets the needs of its aging patient population. The Act required VA for the first time to provide nursing home care and certain non-institutional long-term care services to eligible veterans. Some studies have shown that appropriate use of case management in long-term care can reduce both the number and the intensity of expensive acute care hospitalizations. Due to recent reports the Committee has received from VA, the Committee is concerned about VA's ability to meet the nursing home care needs of veterans in accordance with the law, particularly considering the World War II generation's increasing needs for long-term care.

At the May 8, 2003, Committee hearing on waste, fraud, and abuse, Members raised issues related to VA's role in meeting the long-term health care needs of veterans. On May 22, 2003, the Subcommittee on Health held a follow-up hearing to examine existing VA long-term care programs and expenditures and appraise VA's strategy for addressing future long-term care needs of aging and disabled veterans.

To better meet its oversight responsibilities in this area, the Committee requested that GAO provide the Committee with a report on VA's implementation of the Millennium Act, including analysis of current trends and forecasts in nursing home utilization and long-term care expenditures by the Department. The Committee also asked GAO to examine VA's management of its in-house nursing home programs to improve efficiency and assure appropriate utilization and access in consonance with the Millennium Act.

GAO will examine the use of nursing homes VA operates, as well as the contract care it purchased between fiscal years 1998 and 2002. The scope of the study will include examining the expenditures VA incurred to provide nursing home care to these veterans, the extent of the use of nursing homes and how their expenditures have varied by VA's 21 health care networks, and the degree to which policy differs among VA's networks on the type and extent of nursing home care provided to veterans. GAO has agreed to complete its work and issue a report to the Committee by the fall of 2003. This next report will provide the Committee with a basis for further oversight of VA long-term care programs.

REDUCING COSTS IN WORKER'S COMPENSATION

VHA has 214,000 employees and is the largest health care system in the United States. Under the Federal Employees Compensation Program, employees are eligible for Worker's Compensation Program benefit payments for lost wages and medical treatment for the specific disability associated with a work-related injury.

In 1998, the IG audited VA's Federal Employee Compensation Act program and concluded the program was not effectively managed. *Audit of VA's Worker's Compensation Program Cost*, Report No. 8D2–G01–067, July 1, 1998. The IG estimated VA could reduce future payments by $247 million, by returning to work current claimants who are no longer disabled.

In order to decrease program liability, VA issued Directive 7700 on July 8, 1998, to ensure a safe and healthy workplace for VA employees, and VHA issued specific related directives. Also, the VA's Office of Occupational Safety and Health initiated a case management and injury prevention project designed to reduce compensation costs and the rate of new compensation claims.

The IG *Audit of High-Risk Areas in the Veterans Health Administration's Workers' Compensation*, Report No. 99–00046, December 21, 1999, found that the lack of effective case management practices placed the Department at risk for program abuse, fraud, and unnecessary costs. In April 1999, the IG provided VA with a handbook for "VA Facility Workers Compensation Program Case Management and Fraud Detection." 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 in-

creased to approximately $151 million, which caused the IG to begin a follow-up audit.

On May 8, 2003, the IG in testimony before the Committee stated, ". . . VA continues to be at risk for program abuse, fraud, and unnecessary costs because prior IG program recommendations have not been fully implemented." At the urging of the Committee, the Office of Inspector General is conducting further audits of the Workers' Compensation Program. No legislation is recommended by the Department to address this issue.

IMPROVING MANAGEMENT OF PART-TIME PHYSICIANS

VA currently employs 5,129 part-time physicians at a combined salary of $400 million with poor or no accountability as to much of their time and attendance. Problems with part-time physician time and attendance have frequently been reported by the IG Combined Assessment Program. In some instances, the affiliated medical school determines assignments and work schedules for all the physicians on the VA payroll in violation of VA policy.

At the May 8, 2003, Committee hearing, the IG also testified concerning the findings in the *Audit of the Veterans Health Administration's Part-Time Physician Time and Attendance*, Report No. 02–001339–85, April 23, 2003. The IG testified that the audit found that the VHA's management controls were not effective in ensuring that part-time physicians met their employment obligations and that physician staffing was not aligned properly with workload requirements. The IG further testified that some VA medical centers do not keep duty schedules and timekeepers do not know which physicians are supposed to be on duty.

The IG provided several examples that showed 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. Based on a review at five VA medical centers, the audit specifically found:

1. There was no documented evidence of any patient care workload (patient encounters, operating room time, progress notes, physician orders, or network log times) for 33 percent of the time in a 14-day review, where 223 part-time physicians were scheduled for at least four hours of duty.
2. Part-time physicians did not complete a minimal amount of patient care time (at least one hour in surgery or at least two progress notes, doctors orders, or encounters per hour worked) on 53 percent of days the physicians were scheduled to work at least four hours.
3. Surgeons spent 38 percent of their available time on patient care obligations. Of the 153 surgeons reviewed, 70 spent less than 25 percent of their available time in direct patient care.
4. Part-time surgeons at six VA medical centers reviewed were performing surgery at the affiliated medical schools during their VA tours of duty.
5. Attending physicians at four VA medical centers reviewed were not present to supervise the residents' treatment of patients in six of 29 clinics reviewed.

The Committee was advised that the IG had provided the Under Secretary for Health with recommendations for corrective actions. Specifically, the IG recommended that improvements include quarterly audits of physician time and attendance. The Under Secretary generally agreed with the recommendations.

The Committee plans to monitor this matter through oversight hearings and briefings with VA officials to ensure that these recommendations are fully implemented.

IMPROVING MANAGEMENT OF CONTRACTING, PROCUREMENT AND ACQUISITION

The IG's testimony at the May 8 2003, hearing indicated the existence of ineffective management practices involving the procurement of health care items and contracting for health care services or resources, especially when service contracts involved an affiliated institution as a party. An IG audit of procurement practices found VA facilities often failed to use VA national purchasing or Federal Supply Service options, and often chose less cost-efficient options such as local procurement. Studies advocate a more centralized focus for the purchase of health care items, but too often this course of action is not followed because of a lack of VA procurement oversight.

The IG also commented on the lack of rigor in contracting for health care resources, noting an absence of evidence that VA had assessed its actual needs or that the contract was in the Government's best interests. The IG noted the potential conflict of interest in the general process. Other IG concerns involved construction contracting, purchase card activities, and inventory management—all of which lack adequate oversight at critical points in their respective processes. On June 10, 2003, at the Committee's second hearing on waste, fraud and abuse, Deputy Secretary Mackay acknowledged that problems exist with VA's report to Congress regarding contracts for services other than scarce medical specialties. The Committee believes that improved management of contracting, procurement and acquisitions has the potential for considerable savings and the Committee intends to conduct further oversight of these areas.

BARRING BENEFITS FOR FUGITIVE FELONS

In 1996, Congress enacted Public Law 104–193, which barred fugitive felons from receiving Supplemental Security Insurance from the Social Security Administration and food stamps from the Department of Agriculture. The intent of the law was to discontinue the means of federal support that allow fugitive felons to continue to flee. However, the law did not prevent a fugitive felon who was a veteran from receiving benefits from the Department of Veterans Affairs (VA).

In 2001, the Committee on Veterans' Affairs reported H.R. 1291, as amended, to prohibit veterans who are fugitives from receiving benefits. The bill became Public Law 107–103. Under the law, a fugitive felon is defined as fleeing to avoid prosecution, or custody or confinement after conviction, for an offense or an attempt to commit an offense which is a felony under the laws of the place from which the veteran flees. The benefits barred include those for serv-

ice-connected disabilities; dependency and indemnity compensation for surviving spouses of service-connected veterans; nonservice-connected disability/death pension; hospital, nursing home, domiciliary and outpatient care; insurance; educational entitlements; training and rehabilitation benefits for veterans with service-connected disabilities; and housing and small business loans.

Public Law 107–103 requires the Secretary to furnish to any Federal, State, or local law enforcement official in specific circumstances and upon written request the most current address maintained by the Secretary of a person who is eligible for a VA benefit. The Secretary is also required to enter into memoranda of understanding with Federal law enforcement agencies and may enter into agreements with State and local law enforcement agencies for purposes of furnishing information to such agencies.

On May 8, 2003, the IG testified before the Committee on efforts to identify fugitive felons. In response to Public Law 107–103, the IG has established a fugitive felon program to identify VA benefits recipients and VA employees who are fugitives from justice. Mr. Griffin provided details of the program:

> 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.

Based on computer matches to date, the IG has projected savings related to the identification of improper and erroneous VA payments to exceed $209 million annually. The IG has also completed memoranda of understanding or agreements with the U.S. Marshals Service, the States of California and New York, and the National Crime Information Center. These data matching efforts have already identified more than 11,000 potential fugitive beneficiaries and VA employees. The Committee intends to monitor and encourage the implementation of the IG's fugitive felon program through oversight hearings and briefings with VA officials. No further legislative action is recommended by the Department to address this issue.

STOPPING ERRONEOUS BENEFITS PAYMENTS IN THE PHILIPPINES

The VA Regional Office in Manila, Republic of the Philippines, has long struggled with fraudulent activity due to a combination of factors, including the relatively large amount of VA payments, poverty and a lack of economic opportunity for indigenous persons. The two main types of cases involve deceased payees and false claims. In April 2001, the IG instituted a "Philippines Benefit Review" at the request of the Manila Regional Office, which was seeking assistance in combating fraud associated with false claims.

During the six-week operational phase of the review, the team conducted 1,134 interviews and 2,391 fingerprint comparisons, reviewed 2,600 files, took 1,100 digital photographs, initiated nine criminal cases, and obtained one search warrant. Five hundred ninety-four beneficiaries were identified for suspension or termination of benefits. Criminal investigations initiated during the review were turned over to the Philippines National Police.

At the May 8, 2003, Committee hearing, the IG testified on the results of the benefits review, and indicated that his office was looking at other areas outside the continental United States where large numbers of veterans and dependents reside. According to the IG, 78,000 benefits recipients outside the continental United States are receiving approximately $49 million per month in benefits, including $2.9 million to 5,100 veterans and other beneficiaries in Germany, and $28 million to 42,000 veterans and other beneficiaries in Puerto Rico.

To date, the Philippines Benefit Review has resulted in cost savings to VA of approximately $2.5 million in overpayments, and a projected 5-year cost avoidance of over $21 million. The Committee believes that these investigations of fraud outside the continental United States should be aggressively pursued and intends to continue its oversight of them. No legislative action is recommended by the Department to address this issue.

IMPROVING VOCATIONAL REHABILITATION DATA

VA's Vocational Rehabilitation and Employment Program provides services and assistance necessary to enable veterans with service-connected disabilities to become employable and obtain suitable employment. This program also helps certain veterans with service-connected disabilities achieve functional independence in daily activities. Program performance against these outcomes is measured by the rehabilitation rate, which is defined as the number of veterans who were rehabilitated during a period of time compared to the total number that left the program during that period. VA's *Annual Accountability Report for FY 2000* showed the rehabilitation rate for the year was 65 percent, which exceeded the goal of 60 percent.

On February 6, 2003, the Office of Inspector General released a report, *Accuracy of VA Data Used to Compute the Rehabilitation Rate for Fiscal Year 2000*, Report No. 01–01613–52, that showed the data used to compute the rehabilitation rate for fiscal year 2000 were not accurate. The counseling, evaluation and rehabilitation folders of 94 randomly selected veterans were reviewed for fiscal year 2000. The audit revealed that 7 of the 94 veterans left the program during prior or subsequent years and should not have been included in the computation of the rehabilitation rate that fiscal year. Of the remaining veterans in the sample, 57 were classified as rehabilitated and 30 were classified as discontinued. Based on the evidence in the veterans' folders, the IG determined that VA regional office personnel incorrectly classified 15 of 57 veterans as rehabilitated. However, no errors occurred among the 30 decisions to classify veterans as discontinued. VA officials could not readily explain the reasons for the discrepancies. They speculated that pressure to achieve the performance measure target for the reha-

bilitation rate may have influenced the inappropriate decisions to declare veterans rehabilitated.

The IG could not estimate the actual rehabilitation rate the program achieved for fiscal year 2000, because regional office personnel did not timely classify veterans as rehabilitated or discontinued. As a result, an unknown number of veterans were improperly excluded from the total number of veterans who left the program during the year. Because of the significant discrepancies identified, the IG could not attest to the accuracy of the rehabilitation rate included in VA's *Annual Accountability Report for FY 2000*.

The IG recommended additional training for regional office personnel who make classification decisions and improved supervisor accountability. Additionally, the IG recommended strengthened oversight of VA regional office personnel to ensure that classification decisions are timely and accurate. The Under Secretary for Benefits concurred with the IG's recommendations and provided acceptable implementation plans.

Other accuracy problems in VA's vocational rehabilitation program have also been identified. On January 31, 2003, the VA released its *FY 2002 Performance and Accountability Report*. Part of this report addressed accuracy of outcome decisions and accuracy of evaluation and planning services for veterans applying for vocational rehabilitation. In 2002, program managers conducted their own quality reviews on 3,243 vocational rehabilitation cases. The survey found a 19 percent error rate in rehabilitation rate outcome decisions.

The IG report did not estimate entitlement, administrative, or cost implications of VA errors that resulted in an overstated vocational rehabilitation rate. No legislative action is recommended by the Department. The Committee expects to hold a public hearing to further examine this matter and provide additional oversight.

REDUCING ERRORS IN EDUCATIONAL ASSISTANCE CLAIMS

The VA's *FY 2002 Performance and Accountability Report* noted quality assurance deficiencies in education claims. Of the 1,541 cases reviewed, 100 had payment errors and 340 had service errors (some cases had more than one service error). Payment errors mean the monthly educational assistance allowances of beneficiaries are being underpaid or overpaid. Service errors largely deal with eligibility and entitlement determinations. Within the category of service errors, development and due process notification errors were 21 and 22 percent, respectively. The Committee finds these error rates unacceptable. For 2001 and 2002, payment accuracy remained virtually the same, 92.0 percent and 92.6 percent, respectively. The report noted that VA must continue periodic refresher training in these areas until improvement is shown.

The accountability and performance report also noted workforce challenges. In fiscal year 2002, the VA Education Service employed 864 Full-Time Equivalent Employees (FTEE) in administering its programs for about 465,000 veterans, active-duty servicemembers, reservists, and survivors/dependents. About 50 percent of the education adjudicators were trainees at the beginning of fiscal year 2002, although turnover decreased during the year. The VA Edu-

cation Service is developing standardized training for its employees. The first phase, covering claims processing tasks, will be completed in the summer of 2003.

The Committee notes that the report did not estimate the amount that could be saved by reduction of payment errors in education claims. However, the report showed that VA obligated $1.77 billion in this program during fiscal year 2002 and the Committee believes that the savings could be substantial. The Committee plans continued close oversight of the Department's efforts to reduce error rates in its educational assistance claims. No legislative action is recommended by the Department to address this issue.

PREVENTING PENSION OVERPAYMENTS

VA's improved pension program provides financial assistance based upon need to certain wartime veterans with disabilities not related to military service. This needs-based program has an income limitation, and it is designed to pay benefits on a graduated scale whereby the person with the least amount of income, and therefore with the greater need, receives the greater amount of pension. There are income exclusions in determining a person's income for pension purposes, including the exclusion of certain unreimbursed medical expenses. At the request of the Under Secretary for Benefits, the IG conducted an audit of beneficiaries receiving increased benefits as a result of unreimbursed medical expense claims. The objectives were to: (1) evaluate the effectiveness and efficiency of Veterans Benefits Administration (VBA) procedures for verification of these claims; (2) identify the extent of unsupported claims and processing errors; (3) determine the extent of any potential program fraud; and (4) determine causes and identify solutions for deficiencies.

During fiscal year 2001, VA paid $2.9 billion in pension benefits to 507,149 veterans and their survivors. On September 30, 2002, the Office of Inspector General released a report, *Audit of Veterans Benefits Administration Benefit Payments Involving Unreimbursed Medical Expense Claims*, Report No. 00–00061–169. The audit found that some pension beneficiaries are inappropriately submitting unreimbursed medical expense claims, significantly increasing the level of benefit payments. The IG reported that processing errors and potential program fraud have occurred because regional offices are not effectively managing the processing of these claims.

Erroneous benefit payments occurred due to the following:

Overpayments

1. Medicare (Part B) premium expenses were claimed, but not actually paid.
2. Income and net worth were not properly reported.
3. Continuing Medical Expense Deductions—expenses allowed prospectively if they are recurring or reasonably predictable (i.e., nursing home fees)—were not properly adjusted to reflect actual lower costs.
4. Claimed nursing home costs were not reduced for Medicaid reimbursements.

5. Other processing errors occurred because claims were not fully developed or mathematical errors were made in computing them.

Underpayments

1. Medicare (Part B) premiums paid were not properly claimed or adjusted by VBA to reflect increases in annual expenses.
2. Claims were not fully developed or mathematical errors were made in computing claim amounts.

Potential Program Fraud

1. Income, net worth or unreimbursed medical expenses were not properly reported.
2. Claims were for expenses that had already been reimbursed.
3. Veterans' deaths were not timely reported to VA, and not all pension checks were returned.

According to the IG, processing errors and potential program fraud annually result in overpayments of up to $124.7 million and underpayments of up to $19.9 million. The Under Secretary for Benefits provided acceptable implementation plans to the IG. The Committee will continue oversight of the VA pension program to ensure the issues of processing errors and program fraud are adequately addressed. No legislative action is recommended by the Department to address these issues.

IMPROVING CAPABILITY OF THE OFFICE OF THE INSPECTOR GENERAL

The Committee notes that the VA Office of Inspector General is the smallest of the statutory Inspectors General relative to the size of the parent agency. The IG has a proven record resulting in savings for the VA by elimination of waste, fraud, abuse and management inefficiencies by finding meaningful cost avoidance opportunities. For every dollar invested in the IG, the department realizes savings or cost avoidance estimated at thirty dollars. Committee efforts resulted in increased IG capabilities, with an additional 92 FTEE authorized in 2003, and should result in annual savings of over $180 million VA-wide.