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AGENCY OVERSIGHT: MISSION, MANAGEMENT, AND PERFORMANCE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MARCH 6, 18, AND 20, 1997

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OVERSIGHT OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND THE DEPARTMENT OF LABOR: MISSION, MANAGEMENT, AND PERFORMANCE

THURSDAY, MARCH 6, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:45 p.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, Pappas, Towns, Kucinich, Allen, and Barrett.

Staff present: Lawrence J. Halloran, staff director/counsel; Christopher Allred and Robert A. Newman, professional staff members; and R. Jared Carpenter, clerk.

Mr. SHAYS. I would like to call this hearing to order. This is the Subcommittee on Human Resources of the Committee on Government Reform and Oversight.

The dictionary defines "oversight" as "watchful and responsible care." By this definition, constructive oversight should be vigilant, objective, and careful. It is not an episodic game of "Gotcha" but the methodical examination of program goals and agency performance.

Last week, we began that systematic review of Federal human service departments with testimony from Housing and Urban Development—HUD—Secretary Andrew Cuomo. Today, and in the weeks ahead, we will hear from the General Accounting Office—GAO—and the Inspectors General—IG—of the five Cabinet Departments under the subcommittee's jurisdiction. Their views on program vulnerabilities and opportunities for improvement mark an indispensable starting point for our work throughout this Congress.

We cast our net broadly to match the scope of Federal human service programs. For fiscal year 1998, the five Departments within our purview account for more than $500 billion, or 30 percent of total budget authority and outlays. The two Departments under discussion today, HUD and the Department of Labor, will make total outlays of almost $70 billion next year.

Broad oversight perspective is also essential as each Department faces fundamental questions about its overall mission. In complying with the Government Performance and Results Act—the GPRA. For the first time, Federal agencies must adopt strategic

plans and meet measurable performance standards. The deficiencies, inefficiencies, lapses, or losses described today will tell us where to place our emphasis in consulting with the Departments on GPRA compliance, and where to look for measurable progress and improved performance.

Our oversight mission is to safeguard scarce Government resources from waste, fraud, and abuse, and make sure Federal programs perform as Congress intended to meet human needs. In that effort, we rely heavily on the experience and dedication of our oversight partners, the General Accounting Office and the Inspectors General. To those who are here, we welcome your testimony today and look forward to your continued help in the subcommittee's work.

At this time, I would call Susan Gaffney, the Inspector General of the Department of Housing and Urban Development, and Larry Dyckman, associate director of housing and community development issues, General Accounting Office. And he is accompanied by Richard Hale and Larry Goldsmith.

Ms. Gaffney, are you accompanied by anyone?

Ms. GAFFNEY. No, not at the table.

Mr. SHAYS. I welcome you to sit at the table here and I am going to swear you in, and then I am going to have Mr. Towns make a statement. So I will take care of business and then I will call on you, Mr. Towns.

If you would all raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, the witnesses all have answered in the affirmative.

Mr. Towns, I am sorry.

Mr. TOWNS. Thank you, Mr. Chairman. Let me thank you again for having this hearing today. I think you are right on target.

Last week, Secretary Cuomo testified before this subcommittee that his first two priorities will be resolving the Section 8 crisis and improving the management of HUD. The one point I made to the Secretary was that we should not solve the financial problems of HUD on the backs of the poor. We must find a way to pay for Section 8 contracts, reform our public housing system, and pay market rents, without causing homelessness and massive default of HUD's insured property. This will be a difficult balance to achieve, but it must be done.

Mr. Chairman, both HUD and the Department of Labor have many difficult policy choices to make in the near future. The Inspectors General for these agencies, along with the General Accounting Office, will have an important role to play in helping to make these choices.

I look forward to hearing the testimony, and I yield back the balance of my time.

Mr. SHAYS. I thank the gentlemen.

Mr. Snowbarger, the vice chairman of the subcommittee.

Mr. SNOWBARGER. Nothing, thank you.

Mr. SHAYS. Mr. Kucinich.

Mr. KUCINICH. No.

Mr. SHAYS. Mr. Barrett.

Mr. BARRETT. If I could?

Mr. SHAYS. You are more than welcome to.

Mr. BARRETT. I usually don't have an opening statement, but I have one that I will summarize. I just want to make sure that I get this issue in the record. I want to thank you for holding these timely hearings.

Although HUD's programs continue to pose a risk in terms of their vulnerability to waste, fraud, abuse, and mismanagement, many actions the agency has taken to deal with these problems have had a positive effect. It is clear, however, that additional steps must be taken to improve HUD's mission, management, and performance.

I am especially concerned about the existing internal control weaknesses involved in the sale of federally financed homes HUD acquires through foreclosure. In my hometown of Milwaukee, we are witnessing scams in which investors are purchasing HUD homes under the guise that they will live in the home. According to an article that appeared in the Milwaukee Journal Centennial in August 1996, 40 percent of the people buying foreclosed houses in Milwaukee from HUD falsely claimed they would be owner-occupant.

The article cites city records showing that 88 houses sold in Milwaukee by HUD to self-described owner-occupants between the period January 1, 1995, and March 1, 1996, were not being lived in by the buyers in April 1996. I am convinced that these scams are not unique to Milwaukee.

When bidders misrepresent their intent to live in a home bought from HUD, they unfairly skip over honest investor-bidders and possibly over genuine owner-occupants. These investors are defrauding our Government and are abusing a system that was designed to build healthy neighborhoods and revitalize neighborhoods. I plan to introduce a bill in the near future that would help prevent these scams from occurring in Milwaukee and in other communities around our country.

I won't go into the particulars of the bill, but I urge the members of this committee and every Member of the House of Representatives to join me in working to prevent these abuses. I look forward to hearing the testimony today.

I do have the articles from the paper, and I would ask unanimous consent to have them entered into the record.

I also would note that I have responses from—that I have had with HUD on this issue, and part of the response I have gotten is, this did not cause any loss of funds to HUD, which is probably true. I am not concerned about that as much as I am concerned about these neighborhoods.

Ms. GAFFNEY. I understand.

Mr. BARRETT. That is something that during the course of my 5 minutes I will want to discuss with you.

So I would yield back the balance of my time.

Mr. SHAYS. Thank you, Mr. Barrett.

Mr. BARRETT. I ask unanimous consent to have the articles put in the record.

Mr. SHAYS. Let me take care of that business and ask unanimous consent that all members of the subcommittee be permitted to

make any opening statement. The record will remain open for 3 days for that purpose, and, without objection, so ordered.

And I also ask unanimous consent that all witnesses be permitted to include their written statements in the record. And without objection, so ordered.

And Mr. Barrett, you have requested that information be put in the record?

Mr. BARRETT. Yes.

Mr. SHAYS. Then that will be done, without objection.

[The prepared statements of Hon. Michael Pappas and Hon. Thomas M. Barrett, and the information referred to follow:]

Statement of Congressman Michael Pappas
Before the Subcommittee on Human Resources
and Intergovernmental Relations
"Agency Oversight - The Department of Housing and Urban Development
and the Department of Labor: Mission, Management, and Performance."
March 6, 1997

Mr. Chairman: One of the most important functions of Congress is the oversight of our federal agencies. Each agency's mission and effectiveness must be closely evaluated so as to ensure the American people that their hard earned money is being properly appropriated. I commend this Subcommittee's continuing investigation into the current problems that the Department of Housing and Urban Development and the Department of Labor are currently facing and I am confident that our continued dialogue with these agencies will no doubt lead to improved service to the American people.

I look forward to further discussion on the reports that the General Accounting Office has put forth which outline specific steps and recommendations the agencies and Congress can take to improve the performance of our agencies. I am confident that this Subcommittee via these hearings will get a better understanding of the challenges we all face. Again, I would like to thank you all for coming and our distinguished Chairman for the work done thus far to help these agencies perform to the best of their ability.

Opening Statement of Rep. Tom Barrett
before the Government Reform and Oversight
Subcommittee on Human Resources
Agency Oversight Hearing
"The Department of Housing and Urban Development and
the Department of Labor: Mission, Management and Performance"
March 6, 1997

I would like to thank you, Chairman Shays, for holding these timely hearings to discuss the problems and challenges facing the Departments of Housing and Urban Development (HUD) and Labor (DoL) from the perspective of the General Accounting Office (GAO) and the Offices of Inspector General of each department.

Although HUD's programs continue to pose a risk in terms of their vulnerability to waste, fraud, abuse and mismanagement, many of the actions the agency has taken to deal with these problems have had a positive effect. It is clear, however, that additional steps must be taken to improve HUD's mission, management and performance.

I am especially concerned about existing internal control weaknesses involving the sale of federally-financed homes HUD acquires through foreclosure. In my hometown of Milwaukee, we are witnessing [illegible] scams in which investors are purchasing HUD homes under the guise they will live in the home.

According to an article that appeared in the Milwaukee Journal Sentinel in August of 1996, 40% of the people buying foreclosed

houses in Milwaukee from HUD falsely claimed they would be owner-occupants. The article cites City records showing that 88 houses sold in Milwaukee by HUD to self-described owner-occupants between the period January 1, 1995 and March 1, 1996, were not being lived in by the buyers in April of 1996. I am convinced these scams are not unique to Milwaukee.

When bidders misrepresent their intent to live in a home bought from HUD, they unfairly skip over honest investor bidders, and possibly over genuine owner-occupants. These investors are defrauding our government and are abusing a system that was designed to build healthy neighborhoods and revitalize neighborhoods.

I plan to introduce a bill in the near future that would help prevent these scams from occurring in Milwaukee and in other communities across our country.

Specifically, my bill requires that buyers of HUD properties (self-described as owner-occupants) sign an agreement separate from the HUD sales contract stating they are fully aware they may face the possibility of jail sentences or fines (provided under current law) for intentionally misrepresenting themselves in HUD bidding documents or sales contracts.

In addition, it requires that buyers of HUD properties (who declare in bid documents that they will occupy the property as a

primary residence) to live at the residence for at least one year.

It also requires the Secretary of HUD and the Federal Housing Administrator to establish a procedure to check whether bidders of HUD properties who self-describe themselves as owner-occupants honor their stated intention after they have acquired the property.

Lastly, my bill would ban individuals from participating in HUD programs, if the Secretary determines on the record after the opportunity for a hearing, that a owner-occupant purchaser has violated the provisions of this legislation.

I urge the members of this committee and every member of the House of Representatives to join me in working to prevent abuses in HUD home sale programs. Stopping these scams will help improve the public's trust in HUD's mission and will improve HUD's strategy to increase home ownership and revitalize neighborhoods.

I look forward to the testimony of our witnesses today, and to any insight Inspector General Susan Gaffney may be able to provide on this subject. I will direct my questioning to the Inspector General Gaffney at the appropriate time.

At this time, I would like to enter into the record a copy of my

draft legislation along with a copy of the Milwaukee Journal Sentinel article I referred to earlier in my comments.

MILWAUKEE JOURNAL SENTINEL

From the Journal Sentinel staff

August 1 2 1996

HUD bid abuse found here

Many investment buyers say they'll live in homes, but don't

By Jack Norman
of the Journal Sentinel staff

More than 40% of the people buying foreclosed houses in Milwaukee from the U.S. Department of Housing and Urban Development — so-called HUD houses — apparently falsely claimed that they would be owner-occupants, thereby gaining an advantage in the bidding.

Of 88 houses sold in Milwaukee by HUD to self-described owner-occupants between Jan. 1, 1995, and March 1, 1996, at least 36 were not being lived in by the buyers in April 1996, according to City of Milwaukee property records.

Among those claiming to buy houses as owner-occupants — and not subsequently occupying the houses — was one investor who owns 19 other city properties, 10 investors who own five or more properties in Milwaukee, and a man who bought three condominiums in five months, each time claiming to be an owner-occupant.

The high proportion of apparently false claims of owner-occupancy surprised and alarmed HUD officials.

"We are shocked and very concerned," said Joseph Bates, director of HUD's Wisconsin housing division.

Bates said at least two cases have been referred to

Please see HUD *page 7*

HUD/Many home bids include false claims

the agency's inspector general and that administrative sanctions were being considered against individuals. Such sanctions could include suspension from HUD programs.

A HUD spokesman in Washington, D.C., Victor Lambert, said that while "there have been cases obviously in other cities," the agency has no clear idea of how common the abuse is.

Goal: Stable Neighborhoods

For several years, HUD has focused on increasing owner-occupancy as a key to stabilizing and renovating neighborhoods.

As part of that strategy, HUD gives preference to owner-occupants in the resale of federally financed houses it obtains through foreclosure. If there is a bid from someone who claims he or she will live in the house, all bids from investor-owners are discarded.

Bates said the financial impact of the apparent deceptions was minimal. That's because an investigation by the agency — after the abuses were brought to its attention — determined that in cases "where it appears that investors lied and said that they were owner-occupants," three-fourths of the time "these buyers were the only bidders."

But the abuse is "politically significant," he said, because it undermines HUD's owner-occupancy policy.

"This is a policy the department is behind, and people are finessing it," Bates said.

Two real estate professionals active in HUD sales said false owner-occupancy pledges are common.

"It happens all the time," said Andrea Nembhard, president of Andrea & Associates, a real estate firm which is an active broker for HUD sales.

Andrea & Associates was the broker for eight cases of apparent false owner-occupancy claims.

"The intent is to occupy the unit, but a day or two days after closing, things happen, situations change," Nembhard said.

She cited examples of couples splitting up, of one spouse deciding the house is unsuitable and of a couple who were beaten by neighbors while trying to collect rent at a newly purchased unit.

Mary George, president of Modern Home Mortgage, a South Milwaukee mortgage bank, said she's aware of frequent false claims.

"We see this all the time," she said of attempts to get around the rules.

Smaller Down Payments

Owner-occupants can get loans with much smaller down payments than can investor-owners, she noted.

George was co-bidder on a HUD house, bidding as an owner-occupant. She lives elsewhere.

"I'm co-owner," she said, a claim confirmed by city records. "The other co-owner lives there. That fits into the guidelines."

The bid documents require prospective buyers and their real estate broker to declare whether the bidder will "occupy this property as primary residence" or be an "investor."

Bates said department regulations don't specify any length of time the owner-occupant must live in the house and said the declaration on the bid "is really an expression of intent."

The penalty for false statements is a fine of up to $5,000, imprisonment for up to two years or both.

But HUD does not check whether bidders calling themselves owner-occupants honor their stated intention.

"It's very difficult to police but we're trying to get a handle on it," said HUD spokesman Lambert.

The investigation was prompted by a west side resident who believed an investor was acquiring a HUD house next door by falsely claiming to be an owner-occupant. The Journal Sentinel obtained a listing of sales from HUD and used city records to determine where the owners live.

The resident also contacted U.S. Rep. Tom Barrett (D-Wis.). Barrett said he is drafting legislation to increase penalties for misrepresentation of owner-occupancy status. In an Aug. 2 letter to Rep. Rick Lazio (R-N.Y.), chairman of a House subcommittee on housing and community development, he requested a congressional hearing on the bill.

3 Purchases in 5 Months

In one case, Martin Jupp purchased three units in less than five months, in each case claiming that he would be an owner-occupant. All three purchases were of condominium units in the North Meadows complex on the city's far northwest side.

Jupp's real-estate partner Jerome Becker also bought three North Meadows units during the same period, in two cases saying he was an investor and in the other saying he would be an owner-occupant.

Of the records that showed he made an owner-occupancy claim, Becker said, "That's a mistake."

He also said that Jupp "was going to live in one of the units, but it didn't work out."

"I don't know what's the big deal," he said. "They didn't get any other offers anyway, so what does it make any difference?"

Jupp could not be reached for comment.

In another case, Gloria Loe, who with her husband Robert owns five properties in the city, acknowledged that her primary resident is in West Allis, rather than the south side unit she bought from HUD under an owner-occupant claim.

"But we're over there every day," Loe said, referring to the HUD house.

Another self-declared owner-occupant is Robert Howard, who owns eight city properties but doesn't live in his HUD house.

"I intended to but changed my mind," he said. "I refuse to answer any questions from this point on."

104TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. BARRETT of Wisconsin introduced the following bill; which was referred to the Committee on _____

A BILL

To ensure that purchasers of single family residential properties owned by the Department of Housing and Urban Development are notified of the penalties authorized for intentionally misrepresenting the purchaser's intent to occupy the properties after purchase and that purchasers indicating an intent to use such properties as their principal residences use the properties in such manner.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "Department of Hous-
5 ing and Urban Development Owner-Occupancy Enforce-
6 ment Act".

1 **SEC. 2. NOTICE OF PENALTY FOR FRAUD AND FALSE**
2 **STATEMENTS.**

3 In disposing of any qualified property pursuant to
4 any sale (including any direct, bulk, or competitive sale,
5 or auction), the Secretary of Housing and Urban Develop-
6 ment shall—

7 (1) provide to the purchaser, upon notifying the
8 purchaser of acceptance of the offer to purchase,
9 written notice (separate from any sales contract)
10 that—

11 (A) sets forth the provisions of section
12 1010 of title 18, United States Code, and the
13 maximum fine and maximum term of imprison-
14 ment for violations of such section; and

15 (B) states that an intentionally false state-
16 ment made by a purchaser regarding the pur-
17 chaser's intent to occupy a purchased qualified
18 property may be a violation of section 1010 of
19 title 18, United States Code; and

20 (2) before closing, obtain a written statement,
21 signed by the purchaser, that the purchaser has re-
22 ceived the notice required under paragraph (1).

23 **SEC. 3. REQUIREMENTS RELATING TO OWNER-OCCUPANT**
24 **PURCHASERS.**

25 (a) 1-YEAR RESIDENCY.—Except as provided in sub-

1 property shall use the property as the principal residence
2 of the purchaser for the 1-year period beginning upon pur-
3 chase.

4 (b) EXCEPTIONS.—The Secretary may waive the re-
5 quirement under subsection (a) for an owner-occupant
6 purchaser of a qualified property who demonstrates to the
7 Secretary extenuating circumstances that prevent the pur-
8 chaser from reasonably maintaining principal residency at
9 the qualified property during the period referred to in such
10 subsection.

11 (c) ENFORCEMENT PROCEDURES.—The Secretary
12 shall, by regulation, establish procedures to monitor com-
13 pliance with the requirement under subsection (a) and to
14 provide for waivers under subsection (b). Such regulations
15 shall be issued not later than the expiration of the 6-
16 month period beginning on the date of the enactment of
17 this Act.

18 **SEC. 4. PENALTY.**

19 If the Secretary determines on the record after oppor-
20 tunity for a hearing that an owner-occupant purchaser of
21 a qualified property has violated the requirement under
22 section 3(a), the Secretary shall permanently bar such
23 purchaser—

24 (1) from doing business with the Department of
25 Housing and Urban Development;

1 (2) from participating in any program of the
2 Department of Housing and Urban Development;
3 and
4 (3) from receiving any assistance from the De-
5 partment of Housing and Urban Development.
6 Any penalty imposed under this section shall be in addi-
7 tion to any other penalties authorized under law that may
8 be imposed.
9 **SEC. 5. DEFINITIONS.**
10 For purposes of this Act, the following definitions
11 shall apply:
12 (1) OWNER-OCCUPANT PURCHASER.—The term
13 "owner-occupant purchaser" means a purchaser of a
14 qualified property who, in purchasing the property
15 (including any bidding procedure), indicates to the
16 Secretary an intent to use the property as his or her
17 principal residence.
18 (2) QUALIFIED PROPERTY.—The term "quali-
19 fied property" means any 1- to 4-family property ac-
20 quired by the Secretary pursuant to—
21 (A) foreclosure of a mortgage insured
22 under title II the National Housing Act;
23 (B) foreclosure of a rehabilitation loan
24 under section 312 of the Housing Act of 1964
25 (as in effect before October 1, 1991):

1 (C) foreclosure of a purchase money or as-
2 signed mortgage that is held by the Secretary;
3 (D) assignment by the Secretary of De-
4 fense, pursuant to acquisition of the property
5 under section 1013 of the Demonstration Cities
6 and Metropolitan Development Act of 1966; or
7 (E) foreclosure of a home improvement
8 loan insured under title I of the National Hous-
9 ing Act.
10 (3) SECRETARY.—The term "Secretary" means
11 the Secretary of Housing and Urban Development,
12 except when specifically provided otherwise.

Mr. SHAYS. Mr. Allen, nice to have you here. Do you have any comments?

Mr. ALLEN. No comments.

Mr. SHAYS. We are going to start with you, Ms. Gaffney, and ask you to provide your statement.

And then we will go to you, Mr. Dyckman.

STATEMENT OF SUSAN GAFFNEY, INSPECTOR GENERAL, DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Ms. GAFFNEY. Mr. Chairman, Mr. Towns, members of the subcommittee, I would like to run down with you quickly how I see the major categories of problems at HUD. First of all, we currently have a mission statement that has grown over the years to the point that it is quite vague and very broad.

The last statement that I have heard is that HUD exists to create communities of opportunity. As the mission statement has expanded, broadened, so have the number of HUD programs increased.

At our last count—and we are updating this now, but 2 years ago when we counted, we counted 240 discrete HUD programs and activities. During this same period of time, HUD's staffing has been decreasing dramatically and is projected to continue decreasing. So in my statement I tell you that we had 16,000 employees in 1980, and by the year 2000 we will have 7,500. These two things have happened without any apparent concern in the Congress or at HUD for how they relate.

A third type of problem is that HUD staff really don't know what they are supposed to be doing these days. We had a regional structure a few years ago. We changed that, eliminated the regional structure, said we would now organize along programmatic lines from headquarters assistant secretaries straight through program staff in the field, and, shortly after we did that, we announced that HUD's new approach was going to be place based, seamless delivery at the locality.

In the face of these kinds of changes, HUD staff are just unable to define what precisely they are supposed to be doing.

Within HUD, we have a culture that has typically differentiated program and policy from management. GPRA, that kind of initiative, that's management; that has nothing to do with our programs, with our programmatic assistant secretaries. And what this means, for instance, is, as we downsize, the downsizing isn't done in conjunction with programmatic changes, it happens over there, and the programs continue over here. So we do it on a pro rata share. We just keep cutting them on a pro rata basis.

We also, to be very blunt about this, have a situation at HUD where we are surrounded—every one of our programs is surrounded by very powerful interest groups, and some of these interest groups have huge amounts of money at stake, and they hire very high priced lawyers and other representatives.

We also have a situation, Mr. Chairman, as you alluded to, where decisions—the fiscal consequences of decisions made in the 1970's and 1980's, when a balanced budget was not a primary concern, are now upon us, and the consequences are quite extreme.

We also have a series of management problems. For instance, we have wholly inadequate financial systems and information systems. I don't want to go on. There's a litany of such management problems.

What I would like you to understand is, if you look at this list of problems, that it would be impossible for HUD to perform excellently under these circumstances; nobody could. And I would also like you to understand that they are all intertwined, all these different levels of problems.

The good news is what you heard from Andrew Cuomo last year. I think the good news is, he understands these problems.

Mr. SHAYS. You mean last week?

Ms. GAFFNEY. What did I say, last year? I am sorry. Last week. I am sorry.

He understands these problems, and he is dedicated to do something about them. He also heard about these problems in his confirmation hearings, which was good news, that the Senate cared enough to discuss them.

He is developing an integrated policy program management plan to address these areas of vulnerability that would amount to a massive overhaul of HUD, because it goes to all of—it goes to the mission, it goes to the programs, it goes to the policies, it goes to the people, it goes to the internal systems; all of that has to be overhauled.

The important thing that you need to know is, much as HUD is always blamed for this situation, we didn't get there alone, the Congress was right there with us, and we can't solve these problems without congressional action. And over the past 2 years, despite the fact that legislation has been put forward to reform some of these areas, only one of those pieces of authorizing legislation has been enacted: a consolidation of Indian housing programs.

To the extent HUD has moved forward, for instance, in changing public housing, it has done so through authorizing provisions in appropriations acts. So, if Congress doesn't step to the plate, HUD's ability to change the situation is slight. If Congress steps to the plate and HUD doesn't take it seriously, we are not going to move either.

Two final quick things I would like to say. If Congress and HUD did step to the plate, then we would have to start worrying about two things. One is—and I know this is a concern of yours, Mr. Chairman; I have heard you talk about it before. In this area of program streamlining, consolidation, and devolution, we'd better figure out how we are going to have stewardship, accountability, and oversight.

We keep talking about performance, meaningful performance measures, and we don't have them, and I don't think it's just at HUD. And the illustration I want to give you of that is, under GPRA, people often talk about the PHMAP—the Public Housing Management Assessment Program—at HUD. This is the system we use to score public housing authorities, and then, based on those scores, we call them troubled or not.

That system doesn't consider the quality of housing that people are living in. So we have situations like Camden, NJ, or Memphis,

TN, where people are living in absolute squalor and the public housing authorities are deemed to be good performers.

So my point is, performance measurement counts a whole lot, and we are not near there.

The second point is, we have got to get serious. If we are going to do devolution, we have got to get over this kind of naive belief that the Feds are bad and the States and localities are full of wisdom and integrity in all cases. We still have an obligation for stewardship and accountability, and if they don't meet their obligations, we need to be able to act, take unpleasant actions, against them, and we have not, at HUD, been historically willing to do that.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Gaffney follows:]

STATEMENT OF
SUSAN GAFFNEY, INSPECTOR GENERAL

BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
UNITED STATES HOUSE OF REPRESENTATIVES

ON
HUD'S MISSION, MANAGEMENT, AND PERFORMANCE
MARCH 6, 1997

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to present the views of the Office of Inspector General (OIG) on programmatic and management problems facing the Department of Housing and Urban Development (HUD).

In our semiannual Reports to the Congress, the OIG attempts to provide an overview of HUD's management and performance during the reporting period. In our latest Report to the Congress, as of September 30, 1996, we summed up the situation in the following manner:

> "The last few years have seen notable improvements in some aspects of HUD's performance. HUD and the Congress have, for example, moved to change the landscape of failed public housing and to address serious issues relating to the multifamily insured and assisted housing programs.
>
> "Under current circumstances, however, the prospects for further improvement are dim. HUD's capability to perform is limited by three fundamental issues that have gone unaddressed and can be expected to become more serious over the years. Specifically:
>
> - The number and varied types of HUD programs/initiatives are significantly out of balance with the capability of the constantly dwindling HUD staff to carry out those programs and initiatives.
> - Various components of HUD, especially the Office of Public and Indian Housing and the Office of Multifamily Housing, are not equipped to provide reasonable stewardship over taxpayer funds expended for their programs.
> - HUD's avowed commitment to a 'place-based' program delivery approach is, in important respects, inconsistent with HUD's organization and authorities, which follow discrete HUD program lines.

"We do not believe that these issues can be resolved through easy or quick fixes. Bringing HUD programs in line with HUD staff capability would undoubtedly require a narrower, more precise definition of HUD's mission; and this would in turn provoke outcries from the many constituencies--both within and outside the Department--that have formed around HUD programs.

"Ensuring stewardship and accountability in HUD programs, especially the public and assisted housing programs, needs to start with an acknowledgement that HUD doesn't have and won't have the capability to carefully monitor all aspects of these huge programs. This would have to be followed by an assessment of the risks inherent in various approaches to setting program priorities, and development of systems that accurately measure program performance rather than just regulatory compliance.

"Resolving the inconsistencies between HUD's avowed commitment to a place-based orientation and the realities of HUD's program-based organization would again require a clearer definition of HUD's mission, potentially followed by a major shifting of authorities within the Department.

"In sum, resolution of these three issues would constitute a substantial agenda for both HUD and the Congress. We urge adoption of this agenda, on the grounds that it is fundamental to making HUD the excellent performer that we all want the Department to be."

Secretary Cuomo heard the same type of message during his recent confirmation hearings, and he has committed to acting on it. This past weekend, the Secretary and his Principal Staff held an unprecedented meeting at which they established an integrated management/program/organizational plan of action to address HUD's greatest vulnerabilities. So, there is reason to be optimistic about HUD's resolve to shed its high risk designation. But HUD alone cannot solve these problems. Significant changes in HUD's authorizing legislation are also essential.

To illustrate the magnitude of the task confronting the Department and the Congress, I would like to focus on two issues. First, the most significant programmatic issue facing the Department: what the future will bring for assisted housing programs. Second, the most significant management issue facing the Department: the management of its staff resources.

ASSISTED HOUSING PROGRAMS

Issues relating to the funding, accounting, and monitoring of assisted housing payments represent the largest problem the Department faces. HUD currently spends more than $18 billion per year to provide rent subsidies to about 4.5 million lower-income households. The assistance HUD provides is the most fundamental program for ameliorating the nation's growing need of housing for low income persons. The primary sources of this housing assistance are project based Section 8 payments to multifamily owners, tenant based Section 8, and other subsidy payments to Housing Authorities.

Budget Issues

As you are well aware, renewals of project based section 8 contracts have major budget implications as Congress attempts to balance the Federal budget. If these contracts are not renewed, currently assisted tenants will face sharp increases in their rental payments. For many assisted low income tenants, the slightest such increase could result in their displacement. From the owners' perspective, failure to renew project based Section 8 contracts for heavily assisted projects could sharply reduce project revenues and result in an increase of defaults and insurance claims.

In the late 1970s and early 1980s, it was common for section 8 assistance payments contracts to be written for multiple years. Funds were obligated during the initial contract year with a federal commitment to fund outlays in future years. These long term contracts had a negligible outlay impact in the year in which the appropriation was made. Through this budget mechanism, substantial increases have been made in program levels, evading normal budgetary controls that tended to focus on limiting outlays. The Department has an array of outstanding 20, 15, 10, and 5 year Section 8 contracts.

Because of Congressional efforts to lower Federal budget outlays, new or renewed section 8 contracts are now being made for only one year. The cascading effect of the expiring long term contracts being renewed for one year will have significant budget implications for HUD in future years. For example, in five years, the annual budget authority needed to renew expiring section 8 contracts will be $20.5 billion dollars. This is an increase of nearly $15 billion dollars over 1997 budget authority.

Compounding this problem is the fact that a significant portion of HUD's insured subsidized multifamily housing projects has rents in excess of comparable market rents. Many of HUD's insured projects were developed to increase the stock of affordable housing at a time when few private developments were

being constructed. High interest rates and high construction costs resulted in over financed multifamily housing projects. Market realities did not enter into many of the decisions to develop these HUD projects. Also, annual rent increases were approved based on formulas or budget computations with little comparison to the private market. Consequently, rents associated with these HUD subsidized projects are often much higher than rents at comparable projects.

Last year, HUD proposed legislation to address the contract renewal and excessive rents problems through portfolio reengineering. The proposal met with considerable resistance, and the Congress authorized only a small portfolio reengineering demonstration program. HUD is now working on a revised proposal to meet the same goal: reducing mortgage debt to a level that can be supported by comparable street rents. The restructuring of the debt would allow owners to continue operating the projects and significantly reduce the associated cost of the HUD section 8 subsidy. This restructuring effort would initially be costly, but is intended to be cost effective in the long run. The tax implications of such restructuring for owners remains a complex and contentious issue.

Accounting and Financial Management System Issues

The Department does not have efficient, effective, and integrated financial management systems that can be relied upon to provide timely, accurate, and relevant financial information and reports. While we have seen some progress in the development and implementation of needed systems, the pace has been slow.

To HUD's credit, progress has been made in getting the systems for budgeting and accounting for project based rental assistance programs (TRACS) and the similar system for tenant based assistance (HUDCAPS) up and running. However, certain critical components of these systems that would help to validate the accuracy of assistance payments are still under development.

HUD's system plans only recently began addressing verification of tenant reported income under HUD's multifamily rental assistance programs. For Public and Indian Housing Programs, plans have been developed to use computer matching techniques to verify tenant reported income on a pilot basis. However, in the Department's effort to complete nationwide matching, errors and missing data were found in the Multifamily Tenant Characteristic System (MTCS). MTCS is critical to this matching effort.

The Department is making a concerted effort to develop TRACS as the solution to address weaknesses in the financial control of project-based rental assistance. Critical to this development is the payment processing module, which has not been built. This

module would enable TRACS to generate rental assistance payments requests directly without voucher data from the owners. This would prevent duplicate payments and ensure the accurate submission of tenant data from the owner.

Monitoring Issues

HUD's monitoring of assistance payments is largely ineffective. HUD legislation authorizing subsidy programs includes specific tenant eligibility criteria. Legislation also establishes minimum performance levels to be achieved such as subsidized housing meeting housing quality standards. HUD is not currently equipped to ensure that these legislative mandates are being met.

One of HUD's major goals is to assure that limited Federal assisted housing resources are used as efficiently as possible. A recently issued quality control review, contracted for by HUD's Office of Policy Development and Research, looked into the accuracy of subsidy payments in a nationwide sample. The review found significant subsidy payment errors, including over and under payments. When projected to the population of subsidized tenants, the study found annual overpayments of $788 million and underpayments of $603 million.

In reviewing the accuracy of tenant based assistance, HUD generally relies on the annual audits of Public Housing Authorities (PHAs) by Independent Auditor (IAs). The IAs are required to test for tenant eligibility and test the validity of the operating subsidies. OIG reviews of these annual IA audits have found their primary focus to be on internal controls with little substantive testing. HUD staff may also test tenant subsidy and operating subsidy computations during site reviews; but, due to staffing limitations, such reviews are becoming less and less frequent. We are working with HUD staff to explore ways to increase the testing performed by IAs, and thereby improve the usefulness of the IA reports.

With respect to Section 8 project based assistance, owners draw their monthly subsidy payments through a letter of credit disbursement system. These disbursements are subject to a post review process. HUD field offices are required to review a minimum of 20 percent of the Section 8 disbursements and determine that they are supported by vouchers. They are also required to compare a sampling of vouchers against the TRACS database to assure that tenant information is being updated as required.

In 1996, HUD established a voucher processing Hub in Kansas City. Currently, the Hub has taken over the voucher review process for 17 field offices and is scheduled to take it over all offices by next year. We examined the testing performed by the

Hub and the testing at 5 other field offices. We found, with the exception of one field office, that the Hub was the only place where voucher reviews were being conducted. The good news is that the Hub is doing its job. The bad news is that before establishment of the Hub, this post review effort was largely not happening. Without post reviews, there is no assurance that payments are correct.

Our fiscal year 1994 financial report noted that HUD planned to use TRACS in the future for payment processing. HUD planned to implement an interface with the payment system in 1996. Because of funding problems, this interface is not scheduled for completion until Fiscal Year 1998.

RESOURCE MANAGEMENT

Since 1980, HUD staffing has dropped by 37%--from 16,500 to 10,434--and HUD has committed to a staffing level of only 7,500 by fiscal year 2000. The number of programs and initiatives these employees are responsible for managing is overwhelming. Two years ago, the Secretary asked for the OIG's views on opportunities for terminating, consolidating, and restructuring HUD programs. We conducted a study that, among other things, identified 240 discrete HUD programs and activities. In response to a Congressional request, the OIG is in the process of compiling a current list of discrete HUD programs and activities. I do not expect to find a reduction in the number of programs and activities over the last 2 years. But there are certainly fewer HUD staff than 2 years ago. Subtracting programs seems to be a lot tougher than adding them.

Both HUD and Members of the Congress have proposed legislation to streamline HUD programs, but, with one exception, these legislative proposals have not been enacted. Meanwhile, HUD has proceeded to formulate downsizing plans without regard to their programmatic implications. Generally, staffing reductions have been allocated among the Assistant Secretaries on a pro rata basis. HUD also reorganized itself along program lines, with authority flowing directly from the Assistant Secretaries at Headquarters to the program staff at HUD field offices. Shortly after reorganizing in that manner, HUD proclaimed its commitment to a community-first, place-based (vs. program-based) delivery system.

The OIG believes that HUD's downsizing creates a series of urgent needs that the Department and the Congress must meet. We need, first of all, to come to a definition of HUD's mission that bears some reasonable relationship to HUD's capability to meet that mission. The revised mission statement must then be used as a springboard for a major streamlining of HUD programs and activities.

We must also come to come to an understanding that HUD staff cannot be all things to all people. We owe HUD employees a clear definition of their roles with respect to policy development, providing technical assistance, motivating the community, overseeing program implementation, and taking enforcement action for inadequate performance.

Even with a narrower mission statement, streamlined programs, and a clear understanding of the role of HUD staff, the OIG does not think that the downsized HUD will be able to provide traditional oversight of HUD programs. We believe, instead, that there will still be a compelling need to segregate HUD's workload based on risk, define different HUD oversight strategies for the different risks, establish meaningful performance measures, and develop a real enforcement capability.

Permit me to emphasize the importance of meaningful performance measures and a real enforcement capability. As you know, the point of the Government Performance and Results Act (GPRA) was to ensure meaningful performance plans and performance measures. We must diligently guard against making compliance with this law into a bureaucratic exercise. I have, for instance, heard GPRA advocates cite HUD's Public Housing Management Assessment System (PHMAP) as a model. In fact, PHMAP is the antithesis of what we should be looking for, because it measures management processes and ignores whether we are achieving the desired program outcome, which is decent, safe, and sanitary public housing. As a result, we have situations where public housing authorities are not deemed troubled based on their PHMAP scores, but the residents are in fact living in squalor.

The HUD OIG has complained for years about the Department's reluctance to take enforcement actions against persons and entities that misuse our funds and abuse our programs. In this era of devolution, the issue has become critically important--not just for HUD, but for all Federal agencies. We cannot assume that the States, localities, non-profits, and other recipients of Federal funding will always act with wisdom and integrity. We should be dedicated to establishing meaningful performance measures and oversight, coupled with the resolve to move decisively against cases of fraud or abuse. In this regard, the HUD OIG has proposed a series of legislative measures that we believe would significantly strengthen HUD's enforcement capability. Mr. Chairman, I have sent copies of these proposals to you, as well as to the other Committees having oversight responsibilities for HUD.

In closing, I would like to remind you that I am heartened by Secretary Cuomo's understanding of HUD's areas of high risk, and his determination to fix them. I would also like to note two important pieces of legislation that the OIG believes are moves

in the right direction. HR 2 would bring about a major consolidation of public housing funding, among other things. HR 217 would consolidate Federal programs for homeless assistance.

Mr. Chairman, I would be happy to answer any questions you may have.

Mr. SHAYS. Thank you, Ms. Gaffney.

Mr. Dyckman.

STATEMENTS OF LARRY DYCKMAN, ASSOCIATE DIRECTOR, HOUSING AND COMMUNITY DEVELOPMENT ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY RICHARD HALE, ASSOCIATE DIRECTOR; AND LARRY GOLDSMITH, SENIOR EVALUATOR

Mr. DYCKMAN. Thank you, Mr. Chairman.

Again, I just want to introduce my colleagues. To my far left is Larry Goldsmith. He has done a lot of our high-risk work. And to my left is Rick Hale, who is the assistant director in charge of our multifamily housing work.

As you know, 2 years ago before this subcommittee we discussed the most important management and budgetary problems facing HUD. Unfortunately, a lot still remains undone, and, as Ms. Gaffney says, there are serious problems.

For example, HUD has made progress improving its internal controls, but major problems still persist. HUD has implemented a new management planning and control program intended to identify and rank the major risks in each program and develop strategies to evade these risks. However, we and the Inspector General question the effectiveness of this program.

Furthermore, even though HUD has reported it has significantly reduced the number of material internal control weaknesses, those that remain are very significant and actually encompass most of the Department. For example, the remaining weaknesses affect more than $18 billion in housing subsidy funds that HUD disburses annually.

Much work also remains for HUD to improve its information and financial management systems. For example, major improvements to HUD systems will not be completed before the year 2000. Furthermore, HUD reported in March 1996, that 93 of 116 of its information and financial management systems did not meet the requirements of the Federal Managers' Financial Integrity Act and therefore could not be relied on to provide timely, accurate, and reliable information and reports to management.

I was encouraged last week, when Secretary Cuomo spoke before you, that he is going to be putting together a plan and he feels that within 18 months he will see significant improvement. We will follow and monitor that program and those plans very closely.

Now, in addition to wrestling with critical agencywide management weaknesses, HUD faces a daunting task in managing the costs associated with, one, renewing Section 8 contracts for assisted housing; two, re-engineering the assisted multifamily projects that FHA had insured; and, three, insuring the soundness of public housing.

Overall, the price of renewing Section 8 contracts is high and will increase over the next several years. As you can see on the chart next to you, HUD estimated that it will need over $9 billion in budget authority for fiscal year 1998, to renew contracts covering 1.8 million housing units. The figure to my right shows how the escalating needs for Section 8 budget authority will soon surpass

funding levels for all of HUD's other programs and that Section 8 may grow to over $21 billion slightly past the year 2000.

Now let me turn to portfolio re-engineering. That's the subject of HUD's re-engineering proposal, which consists of more than 8,600 properties containing about 860,000 apartments. The properties provide housing for a diverse population, including families and single adults, as well as those with special needs such as the elderly and the disabled.

Last year, I think, when we testified before the subcommittee, we showed a video which showed the variation in the quality of housing of some of those multifamily projects. These properties have FHA insurance, loans with unpaid principal balances of nearly $18 billion, and receive project-based Section 8 assistance provided under long-term contracts that HUD executed in the 1970's. Over time, Section 8 subsidies for these properties have increased dramatically, and today many of the Section 8 contracts are reaching their expiration.

However, for many properties, reducing the Section 8 subsidies without reducing the outstanding mortgage balances of these properties would lead to default and billions of dollars in claims against FHA's multifamily insurance fund.

HUD's fiscal year 1997 appropriation includes a demonstration program to restructure some of these FHA-insured mortgages and bring income and expenses in line so that it can operate at market rents. These types of proposals recognize the reality that has existed for some time; namely, that the value of many of the properties in the insured Section 8 portfolio are far lower than the mortgages on the properties suggest.

A third major program challenge facing HUD is ensuring the soundness of public housing. About 3 million low-income people, many of whom are elderly, disabled, live in public housing, which is run on a day-to-day basis by about 3,300 local housing authorities. HUD currently provides housing authorities with $5.4 billion a year to help them operate and modernize their projects. However, over time, the authorities' expenses have begun to exceed their funding sources. These are primarily from HUD's operating subsidies and tenants' rents.

Also, as you know, welfare reform could further reduce many tenants' ability to pay rent. With funding for housing authorities increasingly tight, it is crucial for HUD to accurately identify housing authorities having management or budgetary problems and do all that it can to help them address the problems before they become unmanageable.

Last, I would like to comment on something that Ms. Gaffney said, and it's concerning reaching consensus on HUD's mission. Since it was created in 1965, HUD has grown to include some 240 programs and activities and hundreds of billions of dollars in financial commitments.

Over the years, we and others have criticized the inefficiencies in HUD's organization and the deficiencies in its management. Leaders in the administration and in the Congress agree that HUD must, at a minimum, be restructured to better meet the Nation's housing and community development needs.

HUD has proposed major changes, including consolidating programs and devolving responsibility for program design and implementation to States and localities. While some limited yet significant improvements to HUD's existing program structure have been made, a comprehensive re-evaluation of HUD's overall mission and how it delivers its programs has not yet occurred.

This is even more crucial because, as you know, HUD is going through a significant downsizing. It used to have about 13,500 employees not too long ago. Its goal now is to go down to 7,500 employees, and there's a significant question about HUD's capability to manage the myriad of programs it now operates with such a small staff.

What is needed now is for the administration and Congress to agree on the future direction of Federal housing and community development policy and the best organizational and program delivery structures to carry that out. This will involve inherent tradeoffs between the needs of those seeking HUD's assistance and other demands on the Federal budget.

That concludes my remarks, and we would be happy to answer any questions.

[The prepared statement of Mr. Dyckman follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Reform and Oversight, House of Representatives

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HOUSING AND URBAN DEVELOPMENT

HUD's Management Deficiencies, Progress on Reforms, and Issues for Its Future

Statement of Lawrence J. Dyckman,
Associate Director,
Housing and Community Development Issues,
Resources, Community, and Economic
Development Division

GAO/T-RCED-97-89

Mr. Chairman and Members of the Subcommittee:

Two years ago before this Subcommittee, we discussed the most important management and budget problems facing the Department of Housing and Urban Development (HUD) as part of your effort to help set the stage for addressing those problems. We are pleased to return here today to discuss progress that has been made since then and the problems and challenges that remain for both the Congress and HUD.

HUD remains a Department with serious management and budgetary problems. While it has formulated approaches and initiated actions over the last 2 years to address some of its most significant problems, those actions are far from complete. HUD's programs continue to represent large federal loan commitments and discretionary spending, much of which goes for rental assistance to those people who are least able to afford decent housing. Therefore, we believe that controlling spending for these programs will require a continued reexamination–by both the Congress and the administration–of federal housing policies and the type of program delivery systems best suited to carry out those policies.

As we said in a statement to your full Committee on February 12 of this year, the Congress is an important partner in working with executive branch agencies to implement the Government Performance and Results Act (GPRA), which focuses on clarifying missions, setting programmatic goals, and measuring performance toward those goals.[1] Building on GPRA's call to measure performance better and focus on results, the Congress has enacted additional important reforms including (1) the Government Management Reform Act of 1994, which expanded the 1990 Chief Financial Officers (CFO) Act's requirements for financial statements and controls that

[1]Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

can pass the test of an independent audit; and (2) the 1996 Clinger-Cohen Act, which is directed at more effective management and use of information technology to better support agencies' missions and improve program performance.

Our statement today is based on several reports that we have issued and testimony that we have given over the past 2 years as well as our ongoing work. (See app. I for a list of related GAO products). It will focus on (1) the long-standing management deficiencies that hamper HUD's effectiveness, progress made in addressing these problems, and the work remaining in the coming years; (2) the problems in HUD's assisted and public housing programs--which account for the largest portion of its outlays and a vast share of the budget authority HUD expects to need in the future; and, (3) the need to achieve consensus on federal housing policy, HUD's mission, and the resources devoted to achieving that mission.

In summary, we found the following:

- Four long-standing, Department-wide management deficiencies continue to make HUD vulnerable to waste, fraud, abuse, and mismanagement. These deficiencies are weak internal controls, inadequate information and financial management systems, an ineffective organizational structure, and an insufficient mix of staff with the proper skills. While HUD has made progress in addressing these weaknesses, we have determined that much remains to be done and that therefore the Department continues to warrant the focused attention that comes with being designated by GAO as a "high-risk area."[2]

[2]We identified areas throughout the government that are especially vulnerable to waste, fraud, abuse, and mismanagement and termed these "high-risk areas." See GAO's High-Risk Series (GAO/HR-97-1, Feb. 1997).

- HUD faces a variety of problems in its largest assisted and public housing programs. These include how to (1) continue providing Section 8 housing assistance to 3 million families while not undermining the funding for other important housing and community development programs, (2) reduce excess rental subsidies to some insured multifamily properties while minimizing insurance losses to the Federal Housing Administration (FHA) fund and ensuring that those properties meet basic housing quality standards, and (3) help public housing authorities deal with increasingly tight funding levels while ensuring a minimum level of oversight and assistance from HUD for the authorities with management problems.

- The Congress and the administration need to agree on the future direction of federal housing policy and put in place the organizational and program delivery structures that are best suited to carrying out that policy. Doing so will require revisiting fundamental issues about that policy, including whom the federal government will serve, how much will be spent on those being served, and how--via existing systems, block grants, devolution to states, or other means–those policies will be implemented.

BACKGROUND ON HUD'S PROGRAMS AND BUDGET

Established in 1965, HUD is the principal federal agency responsible for programs dealing with housing and community development and fair housing opportunities. Through its programs, HUD provides rental assistance to more than 4 million lower-income households, has insured mortgages for about 23 million homeowners, has helped revitalize over 4,000 communities, and helps ensure that access to housing is equally available to all.

HUD is responsible for the expenditure of significant amounts of tax dollars. The net budget outlays for HUD's programs were close to $25.5 billion in fiscal year

1996, the vast majority of which was for assisted and public housing programs. HUD also is responsible for managing more than $400 billion in mortgage insurance, $464 billion in guarantees of mortgage-backed securities, and about $180 billion in prior years' budget authority for which it has future financial commitments.

HUD'S MANAGEMENT DEFICIENCIES

The HUD scandals of the late 1980s served to focus a great deal of public attention on the management problems at HUD. HUD's information and financial management systems were inadequate, failing to meet program managers' needs or to provide adequate oversight of housing and community development programs. These internal controls weaknesses were a major factor leading to the scandals. The organizational problems at HUD included overlapping and ill-defined responsibilities and authorities between the Department's headquarters and field organizations as well as a fundamental lack of management accountability and responsibility. Finally, an insufficient mix of staff with the proper skills hampered HUD's ability to effectively monitor and oversee its programs.

HUD's slow progress in correcting the fundamental management weaknesses that allowed the scandals to occur and a concern that HUD needed heightened congressional attention led us to designate the Department as a "high-risk area" in January 1994. In February 1995, we reported in more depth on HUD's management deficiencies as part of GAO's biennial High-Risk Series,[3] and, last month, we reported on the corrective actions that HUD has taken or initiated since our February 1995 report.[4] Because HUD is still working to correct its management weaknesses and, in

[3]High-Risk Series: Department of Housing and Urban Development (GAO/HR/95-11, Feb. 1995).

[4]High-Risk Series: Department of Housing and Urban Development (GAO/HR-97-12, Feb. 1997).

some areas, has a long way to go, we have determined that the Department continues to warrant being designated as a "high-risk area."

HUD has made progress in addressing each of the major management deficiencies, but in most cases, much work remains for the Department before its actions will be complete. For example, HUD has made progress improving its internal controls, but major problems persist. HUD has implemented a new management planning and control program intended to identify and rank the major risks in each program and develop strategies to abate those risks. Also, HUD has reported that its number of material internal control weaknesses dropped from over 51 in the early 1990s to only 9 at the end of fiscal year 1995.

However, we and HUD's Inspector General question the effectiveness of the Department's management control program in identifying material weaknesses and assessing front-end risks. For example, we noted in our review of the fiscal years 1995 and 1996 management plans prepared by several of HUD's major program areas that the only risks identified in the management control section of each plan were previously identified material weaknesses and the abatement actions were those previously outlined in HUD's report on compliance with the Federal Managers' Financial Integrity Act. In addition, the Inspector General stated that weaknesses existed in the management control program because HUD's major program areas were not performing front-end risk assessments on new or substantially modified programs, as required.

Furthermore, even though HUD has reduced the number of material internal control weaknesses, some of those remaining weaknesses are significant and long-standing. For example, these remaining material weaknesses (first identified in fiscal years 1983 through 1993) include weaknesses that affect more than $18 billion in subsidy funds that HUD disburses annually, primarily through its Section 8 and Section 236 programs. For both fiscal years 1994 and 1995, HUD's auditors were not

able to express an opinion on the reliability of HUD's consolidated financial statements. The fiscal year 1995 audit of FHA's financial statements continued to identify internal control weaknesses, including a lack of staff and administrative resources for such tasks as performing loss mitigation functions, managing troubled assets, and implementing new automated systems.[5]

Much work also remains for HUD to improve its information and financial management systems. HUD has continued to make progress on these systems over the last 2 years, moving beyond the planning stages to where portions of major new systems are becoming operational. However, some of the projects involving major improvements to HUD's systems will not be completed before the year 2000. Furthermore, HUD reported in March 1996 that 93 out of 116 of its information and financial management systems did not meet the requirements of the Federal Managers' Financial Integrity Act and therefore could not be relied upon to provide timely, accurate, and reliable information and reports to management. As we said in our testimony last month,[6] conclusions about what the government is accomplishing with the taxpayers' money cannot be drawn without adequate program performance and cost information. HUD plans to replace or enhance these systems, but its efforts have been hampered by problems with systems development, funding constraints, and data conversion problems.

HUD has taken a number of steps to address the problems with its organizational structure. It has completed a field reorganization, which was intended to eliminate previously confused lines of authority, enhance communications, reduce levels of review and approval, and improve customer service; transferred direct

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[5]Federal Housing Administration, Audit of Fiscal Year 1995 Financial Statements, prepared by KPMG Peat Marwick LLP for the Office of Inspector General (June 7, 1996).

[6]See footnote 1.

authority for field staff and resources to the Assistant Secretaries in HUD headquarters; and, restructured its 81 field offices. HUD is continuing its reorganization efforts, which will include reducing headquarters staff, redeploying staff, and further streamlining and consolidating field activities. When we recently conducted a telephone survey of HUD's field directors about the Department's reorganization efforts, the respondents rated three areas as good or excellent–HUD's success in improving the lines of program management authority, empowering staff, and improving communications with headquarters and HUD's customers.[7] However, HUD has found that, to some extent, the reorganization has impaired communications across program lines at its field offices. HUD is taking actions, such as adding program integration requirements to senior managers' performance expectations and appraisals, that it believes will alleviate this situation.

HUD has made progress on its efforts to address the problems with staff members' skills. HUD has begun to implement a needs assessment process to plan future training. In addition, HUD has increased staff training and has begun to evaluate the effectiveness of its stepped-up training efforts. While the field directors we surveyed generally believed that the skills of their staff have improved over the past 2 years, 40 percent of these directors rated HUD's current training as less than good. The field directors also said that more training is needed in the use of information systems, the implementation of program regulations, HUD-related technical skills, and interpersonal skills. In addition, we and HUD's Inspector General continue to find staff resource problems in some of HUD's major program areas, including public housing and FHA.

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[7]HUD: Field Directors' Views on Recent Management Initiatives (GAO/RCED-97-34, Feb. 12, 1997).

HUD'S ASSISTED AND PUBLIC HOUSING PROGRAMS FACE DIFFICULT MANAGEMENT AND BUDGET PROBLEMS

In addition to wrestling with critical agencywide management weaknesses, HUD faces a daunting task in managing the costs associated with (1) renewing Section 8 tenant-based certificates for assisted housing, (2) the multifamily projects that FHA has insured, and (3) ensuring the soundness of public housing in a time of intense scrutiny and pressure on all housing programs in light of the move to reduce the budget deficit. As I mentioned earlier, these rental assistance programs serve more than 4 million low-income households; figure1 illustrates the number of households currently receiving Section 8 tenant-based and project-based assistance and the number in public housing.

Figure 1: Number of Households in HUD-funded Assisted and Public Housing

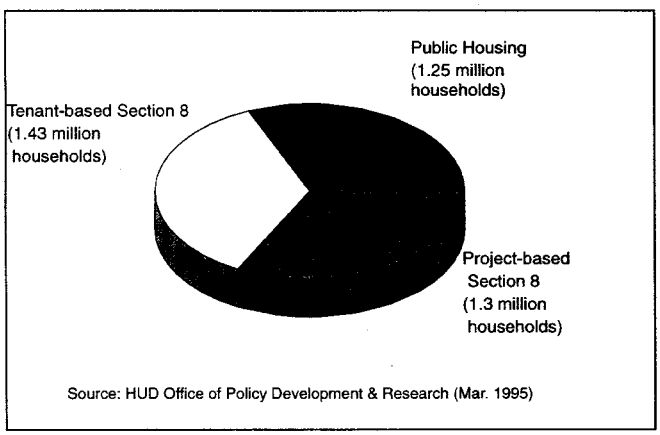
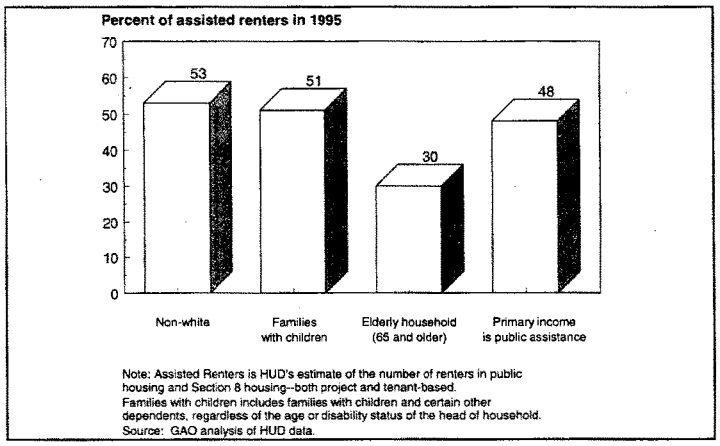


Figure 2 gives you an overall picture of whom HUD's rental assistance programs are serving.

Figure 2: Characteristics of HUD-assisted Renters



Note: Assisted Renters is HUD's estimate of the number of renters in public housing and Section 8 housing--both project and tenant-based.
Families with children includes families with children and certain other dependents, regardless of the age or disability status of the head of household.
Source: GAO analysis of HUD data.

Retaining Support for Important Housing Programs in the Face of the Spiraling Costs of Section 8 Contract Renewals

Under Section 8 of the 1937 Housing Act (as amended), HUD contracts with private property owners to provide housing assistance for low income families. In fiscal year 1998, Section 8 contracts covering 1.8 million housing units will expire, an increase of more than a million over 1997. To the extent that HUD may not have the budget authority to renew these contracts, the currently assisted families could face rent increases or displacement. Moreover, owners of many multifamily properties currently receiving Section 8 assistance will default on their FHA-insured mortgages if

the assistance is withdrawn. (We address in greater detail those properties with FHA-insured loans later in this testimony).

Overall, the price of renewal is high and will increase over the next several years. Figure 3 shows HUD's estimates of over $9 billion for the fiscal year 1998 budget authority it will need to renew contracts covering over 1.8 million housing units; figure 3 also shows how the escalating needs for section 8 budget authority will soon surpass funding levels for all of HUD's other programs. As you can see in figure 4, this budget authority grows to over $21 billion by the year 2006. This amount exceeds HUD's total budget authority of about $19.3 billion in fiscal year 1997. With increases in budget authority of this magnitude forecast for the next 8 years, other long-standing HUD programs with significant funding could be at risk of being funded at levels less than would support their current commitments. These programs include public housing at more than $6 billion, community development block grants at nearly $5 billion, and homeless assistance at nearly $1 billion.

Figure 3: Budget Authority Required to Renew Existing Section 8 Contracts

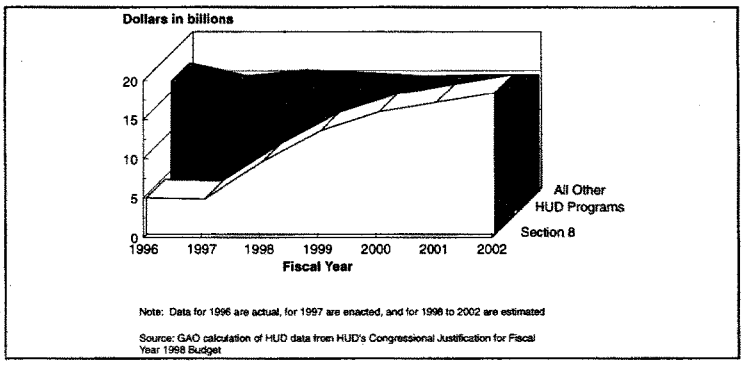
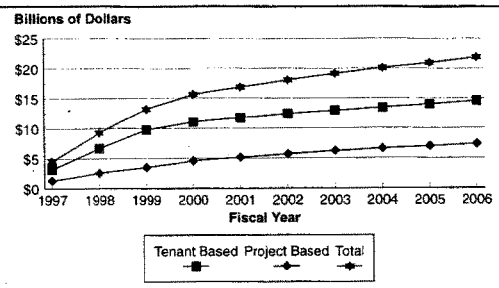


Figure 4: Budget Authority Required to Renew Existing Section 8 Contracts Through Fiscal Year 2006



Source: GAO calculation of HUD data from HUD's Congressional Justification for Fiscal Year 1998 Budget

Funding these programs as well as the Section 8 housing assistance program will be difficult in the face of other agencies' competing budget requests. The challenge for HUD will be to demonstrate that it is operating its programs efficiently, that it has planned realistic reforms that will lead to decreased costs, and that the programs themselves are achieving the goals and policy objectives that the Congress envisioned in creating them.

Costs Associated With Multifamily Projects

Over the past 2 years, HUD has begun the difficult process of attempting to resolve three basic problems affecting its insured Section 8 portfolio: high subsidy costs, high exposure to insurance loss, and the poor physical condition of some properties. In 1995, HUD introduced its "mark-to-market" proposal (subsequently renamed "portfolio reengineering"), through which it sought to (1) reduce subsidies by

setting rents at market levels, (2) reduce the mortgages on those properties as necessary to achieve positive cash flows and terminate the FHA mortgage insurance on them, and (3) replace project-based Section 8 subsidies with portable tenant-based subsidies.

The insured Section 8 portfolio–the subject of the portfolio reengineering proposal–consists of more than 8,600 properties containing just under 859,000 apartments. The properties provide housing for a diverse population, including families and single adults as well as special-needs populations such as the elderly and the disabled. These properties have FHA insurance, loans with unpaid principal balances of nearly $18 billion, and receive project-based Section 8 assistance, much of which HUD provided under long-term contracts executed in the 1970s. Over time, these properties' Section 8 subsidies have increased dramatically, and today many of the Section 8 contracts are reaching their expiration. However, for many properties, reductions in the Section 8 subsidies without a reduction in the outstanding mortgage balances on those properties would lead to defaults and partial claims against FHA's insurance fund. This would happen because, without a continuation of the subsidy, many of the projects would not be economically viable.

Recognizing this predicament–properties that cannot command market rents high enough to cover their federally insured mortgages but which continue to receive excessively costly Section 8 subsidies–HUD proposed to restructure the FHA-insured mortgages and bring income and expenses into line so that they could operate on market rents. HUD's fiscal year 1997 appropriation includes a demonstration program covering those properties with contract rents exceeding 120 percent of fair market rents. For owners who are eligible for and agree to participate in this demonstration, HUD has the flexibility to use tools such as reinsurance, debt forgiveness, and second mortgages to decrease the escalating costs of Section 8 rental assistance, prevent

mortgage defaults, protect residents against dislocation, and resolve associated tax issues.[8]

In 1996, HUD hired Ernst & Young LLP to study a randomly selected sample of 558 properties to obtain information about how HUD's original mark-to-market proposal would affect them. Subsequently, we selected 10 of the properties included in Ernst & Young's study as case studies and hired three licensed real estate appraisal firms to help assess the effects of HUD's proposal on them.[9] Among other things, Ernst & Young found that 60 to 66 percent of the properties in the insured Section 8 portfolio receive above-market rents and that $9.2 billion to $10.2 billion would be required to address deferred maintenance and future capital needs at the properties if they were to compete in the marketplace without project-based subsidies. We believe that for the most part, the methodology and assumptions that Ernst & Young used were reasonable given their study's overall scope. However, for most of the 10 properties we reviewed, the study estimated substantially higher deferred maintenance needs than did the property owners or managers and our contract appraisers.

HUD's initiative to reengineer its portfolio recognizes a reality that has existed for some time–namely, that the value of many of the properties in the insured Section 8 portfolio is far lower than the mortgages on the properties suggest. Addressing the problems of HUD's insured multifamily portfolio will inevitably be costly and difficult. As the Congress evaluates the options for addressing this situation, the fundamental problems that have affected the portfolio and their underlying causes will be important to consider. Any approach that is implemented should address not only the

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[8]For owners who are eligible for but do not choose to participate in the demonstration, contract rents are reduced to 120 percent of fair market rents. For projects with rents below 120 percent of fair market rents, the appropriation requires HUD, if requested by the project owner, to renew the assistance contract for 1 year.

[9]Multifamily Housing: Effects of HUD's Portfolio Reengineering Proposal (GAO/RCED-97-7, Nov. 1, 1996).

high costs of Section 8 subsidies, but also the government's high exposure to insurance loss, the poor physical condition of some of the properties, and the underlying causes of these long-standing problems with the portfolio. The overarching objective should be to implement the process as efficiently and cost-effectively as possible, recognizing not only the interests of the parties directly affected by restructuring but also the impact on the federal government.

Ensuring the Soundness of Public Housing

About 3 million low-income people, many of whom are elderly or disabled, live in public housing, which is operated on a day-to-day basis by local public housing authorities (PHA). HUD currently provides PHAs with $5.4 billion a year to help them operate and modernize their projects. However, over time, the costs for PHAs have begun to exceed the financial resources available to them because their tenants' incomes--on which the amount they pay the PHAs in rent is based--have declined steadily over the last decade. In addition, over the last several years, the amounts appropriated for HUD's operating subsidy to the PHAs have not kept pace with the PHAs' expected costs. The recent welfare reforms could further reduce the rents that the tenants are able to pay if they lose welfare benefits without finding work. With funding for the PHAs increasingly tight, interest has been keen in knowing how well the PHAs are managing their properties and whether HUD has been adequately identifying and helping those PHAs having management problems.

Reducing Housing Authorities' Need for Operating Subsidies

HUD provides the PHAs with an operating subsidy to supplement the rent paid by residents because federal statutory requirements generally limit the amount that tenants may be required to pay to 30 percent of their income. Also, until recently, federal preferences for admission to public housing required the PHAs to give preference to admitting those who are usually the poorest of the poor. By

concentrating the very poor in public housing, these preferences limited the PHAs' ability to meet operating expenses on their own and gave rise to the need for a subsidy from HUD to make up the difference between the rents that the PHAs could charge and what it costs them to operate their projects.

A decline in the average income of public housing residents since 1981 has led to a steady increase in the PHAs' need for operating subsidies. In 1981, the average income of public housing residents was 33 percent of the area median income, but by 1995 the average had dropped to 17 percent. As a result, 1982 operating subsidy needs were $1.5 billion, while in 1996 needs reached $3.1 billion (in nominal dollars). However, for several years in a row now, budgetary pressures and reduced appropriations have meant that HUD could not fully fund the difference between tenants' rents and the PHAs' operating costs--for example, in fiscal year 1996, HUD's subsidy was 90 percent of the PHAs' expected operating costs. In many cases, the effect of reduced operating subsidies can be that the PHAs defer routine maintenance, which, over time, can lead to deteriorated housing conditions and higher accrued needs for major rehabilitation and modernization.

Congress has proposed legislation and HUD has taken steps over the last 2 years to give the PHAs more flexibility in managing their properties to strengthen the long-term viability of this housing. These steps--public and assisted housing reform bills in both the House and Senate[10] and HUD's efforts to relax some requirements--are aimed at encouraging the PHAs to find additional sources of income and allowing them to admit tenants with a broader mix of incomes so that the PHAs have less need for an operating subsidy from HUD. For its part, HUD has attempted to increase incentives for the PHAs to generate additional nonrental income by allowing them to

[10]The House of Representatives passed H.R. 2406, The United States Housing Act of 1996, and the Senate passed S. 1260, the Public Housing Reform and Empowerment Act of 1995. Agreement was not reached on a compromise between the two bills before the 104th Congress adjourned.

keep more of that income to meet their operating expenses. Previously, each dollar of extra income that a PHA generated reduced its subsidy by a dollar, thereby creating a disincentive to generating additional income from sources other than rent.

The Congress, HUD, and many of those in the public housing industry were in general agreement on the financial and other benefits of admitting tenants with a broader mix of incomes to public housing to better ensure public housing's long-term viability. However, neither of the reform bills nor a compromise between the two has been enacted into law. As a result, each of HUD's last two annual appropriations included provisions temporarily repealing the federal preferences as well as other statutory requirements that were seen as limiting the PHAs' management discretion.[11]

The reforms that were contained in H.R. 2406 and S. 1260 would likely improve the long-term viability of public housing. The PHAs have agreed, telling us that reforms such as allowing them to admit tenants with incomes higher than those they currently house will enable them to adjust to possible reductions in the operating subsidies.[12] However, the PHAs also said that they need an adjustment period in which to admit new tenants before the subsidies are significantly cut; industry associations representing PHAs have said that the PHAs need more certainty that these reforms are permanent so that they know that they will not be operating under the old rules in the next new federal fiscal year.

In public housing, just as in a myriad of other HUD programs, there remains a need for HUD and the Congress to reach consensus on whom will be served and at

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[11]For example, each appropriation waived the "one-for-one" replacement requirement, which mandated that the PHAs replace each unit of housing they elect to demolish with another unit or a Section 8 certificate.

[12]Housing and Urban Development: Public and Assisted Housing Reform (GAO/T-RCED-96-25, Oct. 13, 1995).

what cost. While, over time, income mixing can help the PHAs meet more of their operating expenses on their own, adopting such a strategy comes at the expense of those very low-income people who have been given preference for admission to public housing for years. This strategy may also exacerbate worst-case housing needs among the poor, which, according to HUD, are at an all-time high.

Improving HUD's Oversight of Housing Authorities' Performance

With the funding for public housing increasingly tight, knowing how well the PHAs are managing their properties with the resources HUD gives them takes on added importance. However, we recently found that HUD's primary tool for measuring PHAs' performance, the Public Housing Management Assessment Program (PHMAP), needs to be more accurate and useful in order for HUD to ensure that it is identifying all of the PHAs to which it should be targeting its limited oversight and technical assistance resources.[13]

HUD uses PHMAP to annually collect data from each PHA on basic indicators of management performance, such as vacancy rates and operating expenses. The PHAs submit and certify to the accuracy of most of the data on these indicators. On the basis of aggregate performance against these indicators, HUD calculates a score from 0 to 100 for each authority and assigns one of the following three designations: "troubled performer" for a score less than 60, "standard performer" for a score between 60 and less than 90, and "high performer" for a score of 90 or above. Troubled PHAs must enter into a binding agreement with HUD stipulating the problems the authority needs to address and an approach and timetable to resolve them. Standard- and high-performing authorities that fail any indicator must submit a plan for improving their performance in that indicator. HUD requires its field offices

[13]Public Housing: HUD Should Improve the Usefulness and Accuracy of Its Management Assessment Program (GAO/RCED-97-27, Jan. 29, 1997).

to go to troubled PHAs to verify the data that the PHAs submit (and thus, the PHMAP score) when those data would lead to a score high enough to remove the "troubled" designation.

We found HUD needs to do a better job of ensuring that all of its field offices comply with PHMAP's follow-up requirements and use PHMAP scores and other information available to them to better target their limited technical assistance resources. HUD's field offices have the bulk of the Department's responsibility for the day-to-day implementation of PHMAP, including negotiating the binding agreements required of troubled PHAs, approving improvement plans for standard and high performers, and monitoring the PHAs' progress in meeting agreed-upon goals to which they have committed themselves. However, according to the results of a survey of all of HUD's public housing field offices, we found HUD has not been systematically complying with PHMAP's statutory and regulatory follow-up requirements for all housing authorities. For example, in 1995,

- less than 20 percent of the troubled PHAs that should have been operating under a binding agreement with HUD actually were;

- nearly a third of HUD's field offices had not ensured that standard- and high-performing PHAs developed improvement plans for each indicator they failed; and,

- the field offices confirmed the accuracy of the data behind fewer than 30 percent of the troubled PHAs' PHMAP scores that HUD requires them to confirm.

Some field offices cited resource constraints--a lack of staff, travel funds, or expertise--as the main reason for not meeting follow-up requirements, while others opted not to enforce the requirements when they believed the PHAs were already addressing their

problems. Differences in how the field offices interpret their role in helping the PHAs improve performance also played a part in the field offices' oversight and technical assistance activities. Some field offices told us they interpret their role narrowly, generally limiting their assistance to advice, information on complying with HUD's regulations, and suggestions for solving management problems. Others were more willing to get involved in the PHAs' operations by performing tasks such as setting up proper tenant rent records and waiting lists.

The bottom line is that HUD is not maintaining a consistent, minimally acceptable level of oversight at all PHAs. Without this oversight, HUD cannot be reasonably confident that the housing authorities are using federal funds appropriately, managing and maintaining their developments properly, and reporting performance information accurately.

FUTURE FEDERAL HOUSING AND COMMUNITY DEVELOPMENT POLICY: COMING TO CONSENSUS ON HUD'S MISSION

Since it was created in 1965, HUD has grown to include some 240 programs and activities (according to a December 1994 report by HUD's Inspector General) and hundreds of billions of dollars in financial commitments. Through its multiple social and financial roles, it directly or indirectly affects most Americans. Over the years, we and others have criticized the inefficiencies in HUD's organization and the deficiencies in its management. Leaders in the administration and in the Congress agree that HUD must, at a minimum, be restructured to better meet the nation's housing and community development needs. Some policymakers believe that HUD's problems are so great that they can be cured only by dismantling the agency and transferring or eliminating its functions. In its initial Reinvention Blueprint, HUD proposed major changes, including consolidating programs, devolving responsibility for program design and implementation to states and localities, and HUD's assuming the role of overseer and clearinghouse for national models. While some limited, yet significant,

improvements to HUD's existing program structure have been made, a comprehensive redesign of HUD's overall mission and program delivery structure has not occurred. Likewise, various bills to fundamentally restructure HUD's programs to subsidize multifamily rental housing also have been proposed, but thus far none has been enacted.

HUD's programs will remain at high risk to fraud, waste, abuse, and mismanagement until the agency completes more of its planned corrective actions and until the debate over HUD's future–in which the Congress must participate–is settled. In our view, the Congress now has an excellent opportunity to help HUD eliminate the deficiencies that make it a high risk and to align the agency's management responsibilities and capacity by authorizing a major restructuring strategy that focuses HUD's mission and significantly consolidates, reduces, and/or reengineers its many separate program activities. What is needed now is for the administration and the Congress to agree on the future direction of federal housing and community development policy and the organizational and program delivery structures that are best suited to carry out that policy–a process that will involve inherent trade-offs between the needs of those seeking HUD's assistance and other demands on the total federal budget. As the Congress provides input to HUD's and other agencies' strategic plans, as required by GPRA, it can insist that agencies show how their programs are aligned with related efforts in other agencies.[14] Congress can also use the GPRA planning process to seek opportunities to streamline government by comparing the effectiveness of similar program efforts carried out by different agencies.

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[14]In order to successfully implement the initial requirements of GPRA, HUD must prepare, by the end of this fiscal year a strategic plan that includes a statement of its mission.

Mr. Chairman, this concludes our prepared remarks. We will be pleased to respond to any questions that you or other Members of the Subcommittee might have. We in GAO look forward to working with the Congress to help address HUD's management deficiencies and their impact on housing and community development programs.

Mr. SHAYS. I thank you very much.

Before calling on Mr. Towns, I just have to comment that obviously both of your testimonies seem to work in complement with each other, but for you to say HUD's high-risk problems involve weak internal controls, inadequate information and financial systems, ineffective organizational structure, and insufficient mix of staff with the proper skills, it makes you wonder why anyone would want to be Secretary of HUD.

That's the background in which we have to solve the Section 8 problem, the background on which we have to make our local housing authorities more viable and more efficient. It just makes you wonder if we are going to be able to do it no matter who is at the helm.

Mr. Towns, you have the floor.

Mr. TOWNS. Thank you very much, Mr. Chairman. I would like to yield to Mr. Barrett, who has to leave.

Mr. SHAYS. Fine. In fact, we can just call on Mr. Barrett.

Mr. BARRETT. Thank you, Mr. Chairman and Mr. Towns.

I look at the graph up there in terms of the Section 8 pressures and how it is going to conflict and cause us some difficult decisions here, so I certainly don't envy the task that you face, and, frankly, I envy even less the task that we as Congress face in resolving those things.

But I would like to spend my time on my parochial issue, if I may, please, and I apologize to the committee for doing that, but I need some assistance from you on this.

If I could, the letter that I had sent over to the Department in part reads, "While it might be true that these cases resulted in a minimal financial loss to the Federal Government, the inspector general's decision fails to recognize that owner-occupancy misrepresentations can result in real damage to neighborhoods." And, unfortunately, it sends a message that there is nothing wrong with swindling the Government and abusing a system created to build healthy neighborhoods as long as the Government doesn't have to pick up the tab.

And, again, to sort of put this in a framework for you, we had a situation where it was clear that there was an individual that was representing that he was going to live in these homes. The decision both at the national level and the local level was, well, we got our money.

And I am hearing, of course, from the people in the neighborhoods who say, we are trying to rebuild this neighborhood and the response we get from the Federal Government is, well, we don't care, we have gotten our money. And I would like your insight or your thoughts on what we can do to address that problem.

Mr. SHAYS. Could I just ask that, first, is this a problem that both of you are aware of? I mean, it seems to be a pretty serious problem.

Ms. GAFFNEY. I am certainly aware of it.

Mr. DYCKMAN. We haven't done any work directly on that problem——

Mr. SHAYS. OK.

Mr. DYCKMAN [continuing]. Although I have read articles on it.

Mr. BARRETT. I don't mean to——

Mr. SHAYS. No; you misunderstand the purpose for my question. You seem to feel that this is a parochial issue, and I don't view it as that. I view it as a very serious issue and am happy that you are raising it because there are a whole host of reasons why this would be wrong.

We are trying to encourage home ownership, we are trying to encourage neighborhoods to have people own the homes so they care for it, and so I was wondering if you could just give us a general overview before you answered the specific question.

Ms. GAFFNEY. First of all, I have no reason to believe that it is parochial to your part of the country. I would assume that it is all over the property disposition program that this is happening.

I would just like to clarify, and I know, Mr. Barrett, you understand this in our correspondence back and forth. What has happened is, we in fact did look into this. We did an investigation, and we found that the situation was exactly as Mr. Barrett has related, and that is, people were representing that they were going to—they were going to be owner-occupants when, in fact, they had no intention of doing so, and they were causing dysfunctional situations.

We took our investigative results to a U.S. attorney, who declined prosecution on the basis that the Federal Government had not lost any money, and also, I think—to be fair and blunt about this—on the basis that HUD doesn't seem to care a lot about this practice.

We then, when the U.S. attorney declined prosecution, went back to HUD and asked them to take administrative action against the person, and, to tell you the truth, I don't know where that stands. I think you had proposed perhaps criminal sanctions, some kind of increased penalties, for people who engage in this practice.

What I don't know how to do is, first of all, we need to get HUD concerned about this, because if you try to prosecute and you don't have the program people saying they agree it's a problem, it's hard to get prosecutors involved.

But second, unless we can get the prosecutors to accept the cases, it doesn't matter what the penalty is. And I am perfectly willing to work with you to get there.

Mr. BARRETT. And clearly, I don't want to put people in prison for doing this. What I want to do is, I want the problem to stop, because, again, what I hear from the residents of neighborhoods who are trying to rebuild the neighborhood is, it can break the spirit of a neighborhood if you have people who are putting money—and, frankly, if you have someone who is going to lie on a form, like to the Government, chances, I think, are going to be greater they are going to be a lousy landlord. If this is how they treat the system, this is probably how they are going to treat tenants as well.

I recognize where the U.S. attorney's office has bigger fish to fry and there is no financial loss to the Government, but then to have HUD say, well, it's a minimal loss, yes, it's a minimal loss in dollar terms, but it makes me question what the aims and the goals of HUD are. Is it just to run a balance sheet, or is it to try to encourage homeownership, as the chairman said?

Ms. GAFFNEY. Well, of course, it's the latter.

Mr. BARRETT. But I would like to see the Department far more engaged on this issue than it has been. And it's with mixed feelings that I hear it's not a parochial problem. I am sorry that it exists in places other than my community, but maybe that's what we need to have in order to get the Department to pay some more attention to the problem.

Ms. GAFFNEY. Mr. Barrett, I will help, but I am not the Department. You know, we are going to have to try to do this and get their attention together.

Mr. BARRETT. I am looking for allies anywhere.

Ms. GAFFNEY. You've got it.

Mr. BARRETT. I am happy to hear you are going to help.

Ms. GAFFNEY. OK.

Mr. BARRETT. Again, I will yield back the balance of my time. Thank you, Mr. Chairman.

Mr. SHAYS. Mr. Pappas.

Mr. PAPPAS. Thank you, ladies and gentlemen, thank you.

I have a couple of questions, really, that have been conveyed to me from some of the county governments in the five-county area that I represent in central New Jersey, and each of them has experience in dealing with HUD and HUD programs, specifically the Home Program and the Community Development Block Grant Program. I am hoping that you could shed some light on responding to some of their concerns.

There are many nonprofit agencies that, besides fund-raising from the private sector, really depend upon some of the funds through both programs for capital improvements, and I know that there are some percentages that I believe—and correct me if I am wrong—that there are Federal restrictions as to the percentage of the overall amount that is given that can be allocated for facilities or broad categories. You can correct me if I am wrong in regard to that.

But I think more importantly is the difficulty that some of these nonprofit agencies have. Many of them are operating with mostly volunteers, maybe some who are part-time staff people, who are providing some very critical service to—fulfilling service needs for populations in my counties and throughout the country.

A couple of weeks ago, when Secretary Cuomo was here, I did compliment him that I thought that those two programs worked well, but at the same time I do know, and it has been reiterated to me, that some of the paperwork or some of the reporting that some of these organizations have to follow can become burdensome.

How can we address that while realizing that there has to be some accountability for these public funds that are being used, balance the need to have accountability but also realize that there's a target or target populations that we are trying to assist? And many of these community-based nonprofit agencies play an important role in that social safety net.

How can we better do that?

Ms. GAFFNEY. I am surprised, you know. The two programs that get the highest marks in HUD for being flexible and not burdened with paperwork are Home and CDBG. So I am going to—I am going to have to look into, or maybe you could, after the hearing, tell me specifically what paperwork is bothering people. But it

seems to me that the paperwork in HUD traditionally has surrounded compliance with endless rules and regulations.

I think we need to have two kinds, paperwork and monitoring. One, there has to be some financial accountability; that's clear. And we need audits; I think we can all agree on that.

I think apart from that, we just need to focus on what is the purpose, what is the outcome, what are they supposed to be accomplishing. And I think pretty much if we can verify that they are accomplishing what they are supposed to be accomplishing, we could ignore some of the processes that got them there.

I think to date we tended to concentrate on the processes and often ignore whether they actually got to where they were supposed to.

I don't know if that's helpful.

Mr. PAPPAS. I know, and, again, I am a cheerleader as far as both programs are concerned. I think they are both very effective, but I know over the years, as I have dealt with them in my own county government, that there are those organizations that, for maybe a variety of reasons, are not able—they get awarded the grants but they are not able to actually utilize the funds, and then it gets reverted back, and then it is distributed elsewhere.

And if the need wasn't there, then they wouldn't have applied; and if the entities that were approving or did approve the grant for that particular purpose, they evidently felt it was an important purpose to be filled as well. So then there probably have been a dozen instances that I can think of over the years of programs that have not been completed or projects have not been completed.

I don't know what the answer is. I am not just saying the blame is all on HUD, but I know that there have been situations out in New Jersey that we haven't been able to go from point A to point B, and I am just wondering whether you, through your offices, might try to learn if there is some consistent problem that seems to be causing that more than one place.

Ms. GAFFNEY. I don't think we have ever looked at it that way, but if you could give me some of those instances, we will certainly followup and see if we can find some kind of systemic problem.

Mr. PAPPAS. Thank you.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Let me begin by saying, if Congress provides additional budget authority to renew the Section 8 contract, what regulatory or statutory changes would each of you recommend to improve Section 8? Or would you recommend getting rid of it?

Ms. GAFFNEY. You talked before about caring about the people who need help. With this program of these insured—the multifamily projects that are both insured and assisted through Section 8, we have a situation that isn't, it seems to me, designed to benefit the poor people who need housing. This is a situation where HUD takes all the risk through insurance. The owners put in little equity. The rents are highly above market. There's no incentive for the owners to maintain these properties. So at least 66 percent—two-thirds of them are above market rents. At least 25 percent of them are in extremely distressed situations.

It seems to me that if we are going to go forward with this program of project-based assistance, Mr. Towns, everybody seems to think of the multifamily housing program as a private sector housing program, but we have insulated the owners from every private sector motivation that exists. If we are going to go forward with this type of housing that is tied to particular owners and particular projects, I think we'd better introduce some market incentives, because otherwise we are going to be right back in the same position in another 5, 10, 20 years. That's what I think.

Mr. TOWNS. Thank you, Ms. Gaffney.

Mr. DYCKMAN. I just want to say something general, and then I will turn it over to Mr. Hale.

In the past, we have looked at the cost of Section 8 versus, say, public housing, to see whether or not it's advantageous to go to a vouchering-out system. And there are all kinds of implications of doing that. Cost, of course, is one of them, but you really have to look at each project separately. Some public housing turns out it is cheaper than Section 8. In different parts of the country, depending on housing availabilities and prices of rents, in some cases, Section 8 is less expensive than public housing, so you really have to look at it on a case-by-case, city-by-city basis.

Mr. HALE. Mr. Towns, just to add to that and to pick up on what Ms. Gaffney said, in terms of this whole mark-to-market portfolio re-engineering initiative where we are proposing to reduce the Section 8 subsidies on multifamily properties by writing down mortgages on those properties and then also perhaps providing some sort of tax relief to owners, I think when we are doing that we need to make sure that we are looking at not only the interest of the owners but the interests of the residents and the Federal Government as part of that.

Two things in particular I think that ought to be looked at very closely are: One, when we are going to do that, we should not be offering those kinds of advantages to owners and property managers who have not done an adequate job of supporting the housing that they own and maintain; and, second, I think we ought to look at what kind of commitment we are going to get out of owners when we do that in terms of maintaining the long-term affordability of that housing for the residents. If we are offering something to the owners, we also should get something that makes sense in terms of the Government and the residents out of that deal.

Mr. TOWNS. OK. Thank you very much.

So it is really a problem that you would have to address sort of almost on a regional basis?

Mr. DYCKMAN. Well, the——

Mr. TOWNS. I am really trying to understand how we save some money and at the same time provide quality kind of housing.

Mr. DYCKMAN. It depends on what Section 8 issue we are talking about. If it is a project-based mark-to-market issue, then the issues are a little bit more focused. But if it is concerning taking people from public housing and vouchering them out into Section 8 tenant-based, that might be a different set of issues, and that's what I was addressing in my comment.

Mr. TOWNS. Right.

Ms. GAFFNEY. Can I try to tell you how I see this?

Mr. TOWNS. Sure.

Ms. GAFFNEY. The proposal, in very general terms, for portfolio re-engineering and the way they want to save Section 8 money is, they want to—the HUD wants to mark these mortgages down to the point where the projects can operate at market rents. That means that the Federal Government is going to have to pay a very substantial amount of money. And then, as I understand it, the owners are going to be able to come back and get HUD insurance for their projects, and they will continue to get Section 8 for their projects, and we will start all over again.

Now, how did we get where we are today? We got to where we are because the rents kept increasing. HUD kept raising the rents above market every year. It would seem to me, we still haven't heard how HUD intends to stop doing that.

The more important thing is, we are looking at a situation where the owners had no particular motivation to maintain these properties. They had no equity. They are still not going to have any equity. So we have got to change the design if we are going to save money and if we are going to have affordable housing that is decent; we can't just do it again.

Mr. TOWNS. Right.

One more question, Mr. Chairman?

Mr. SHAYS. Yes.

Mr. TOWNS. I notice the light is on.

Ms. Gaffney, on your written testimony you indicated that HUD does not have efficient and effective financial management systems. Is that because HUD lacks the expertise to design these systems or because HUD lacks the money to purchase them? That's not clear to me.

Ms. GAFFNEY. I think the answer, the basic answer, is that HUD has lacked the will to have such systems because it has not attached priority to having such systems. And that goes back to, the people who have been concerned about having integrated financial systems are kind of the management people in HUD. You know, that's the accountants and the IG and the administrative people. But the program people have had more important things to do. And so there has been a disconnect in getting those people together and making it a Departmental priority. I think that's what Mr. Cuomo plans to change.

Mr. DYCKMAN. If I could just add, I agree completely with the answer Ms. Gaffney gave. As a matter of fact, in 1984 we issued a management review of HUD in which we identified a lack of commitment even then leading up to, I guess, the current day in terms of the problems with and the causes for inadequate financial management systems.

But also I think part of it is also trying to identify your needs and matching your needs with the systems that the people—that the managers need to manage their programs. I think there hasn't been a commitment actually to do that until possibly recently.

Ms. GAFFNEY. We have spent huge amounts of money on systems, huge.

Mr. DYCKMAN. It hasn't been the lack of resources, I don't believe.

Mr. TOWNS. The resources are not the problem?

Ms. GAFFNEY. No.

Mr. DYCKMAN. I mean, surely you could always use more resources, but I don't think that's the crux of the problem.

Mr. TOWNS. The reason I am really sort of staying with this is that the Secretary indicated that he was going to, I think, eliminate, I think, 7,500 employees—or, no, the level would be 7,500 by the year 2000.

Ms. GAFFNEY. Correct.

Mr. TOWNS. And then I am listening to all of these problems.

Ms. GAFFNEY. Right.

Mr. TOWNS. And then I am thinking about the fact that half of the people that are there now will be gone, and for some reason I am beginning to think there would be more problems if you eliminated half of the people that are there.

Or do you feel that you just have a lot of people around who don't know what they are doing, so it doesn't matter?

Ms. GAFFNEY. Not at all. Not at all. That's what I was trying to say to you before. What has happened is, the staff cuts have been made in a totally arbitrary fashion, unrelated to any idea of what that would mean programmatically.

I would say to you, though, that in the systems area, clearly there's going to be a whole big movement to contracting out. I would think, and that's going to raise a whole other set of difficulties because you almost need more highly skilled people to contract out than you need to do it in house, and I don't know if that has been addressed.

But of all the areas that are amenable to contracting out, systems development and implementation is one of the better ones, because that is an area where HUD has difficulty keeping top-flight expertise on staff.

Mr. TOWNS. I am going to close. I wasn't much of a baseball player. When I came to the plate, I used to strike out all the time. I want to know what you mean by, "Congress and HUD both need to step up to the plate"? What do you really mean by that?

Ms. GAFFNEY. What I mean is, I don't think to date that the Congress has accepted responsibility that it has to solve its—it has to do its part to solve these problems. It has been—there have been arguments between the House and the Senate. There has been a lot of negotiating.

But no one has said, this is out of control; we are going to enact legislation to solve this; nor has HUD, for its part, said, until Secretary Cuomo said it, this is out of control; we are going to do our part to solve it. It simply hasn't happened.

Mr. TOWNS. Thank you, Mr. Chairman, for your generosity. Thank you.

Mr. SHAYS. Thank you.

Mr. Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman. It's nice being a freshman when Congress is being attacked for your past activities.

Mr. SHAYS. You only get to enjoy that experience once.

Mr. SNOWBARGER. I understand that. I understand that.

And so that I can figure out to you how to get us out of this mess and not be caught with the same accusations, I want to followup.

It seems to me—and the question, I think, is two parts for both Ms. Gaffney and Mr. Dyckman.

You have mentioned two areas where Congress needs to step up to the plate, not just to this general, overall, it is out of control thing, but one thing I think that Ms. Gaffney mentioned was, in the area of mission, that Congress needs to be a part of that answer, and the other part of it is questioning the will of HUD to carry out the mission once it has been given one.

I would like to hear your comments about what you think Congress' role needs to be at this point in time in addressing both the mission and HUD's will. We have talked about more incentives for the landlords. What are the incentives for HUD that we ought to be looking at to carry out the will—that we might address its mission?

Ms. GAFFNEY. The type of legislation that I am talking about is, there have been bills introduced in the Congress now for the past 2 years to—I don't have this number, but we are now in the business in public housing of providing grants, discretionary grants. And I have no idea; there must be 50 different types of programs under public housing under which we are giving grants. They are little things. It's like the Tenant Opportunity Program, and they are—people call them boutique programs.

And typically, what we do is, we provide all these different types of programs and funds, and then we regulate how the housing authorities administer those funds by the 50 different categories. There have been bills over the last 2 years that would essentially consolidate those streams of funding, give more flexibility to the housing authority in terms of how they spend the funds and then exact more accountability at the end for the results they achieve.

Now, I find it very difficult to understand why legislation like that. Why—we desperately need that? We can't, with the dwindling staff, administer all of those.

The other big area where we must have congressional action, which is clear from that chart, is in this whole Section 8 area. Legislation has been introduced in that area also, I think, for 2 years, and the Congress has not acted.

I would tell you, this Section 8 business has lots of—what shall I call it—interest. I mean, there are a lot of interested parties.

Mr. SNOWBARGER. Yes, I have heard from them.

Mr. DYCKMAN. You know, I took a look—in preparing for this hearing, I read over HUD's fiscal year 1998 budget justification. I have to tell you, if you read that budget justification, it looks like it is an expanding agency. It doesn't look like it's an agency that's trying to focus in on its core missions.

Now, I recognize that it's a policy decision to be made by Congress with assistance from the administration in terms of what is HUD's mission: How many programs do you need to provide homeownership opportunities? How many programs are necessary to provide tenant opportunities programs?

Those are all good programs, but the issue is, when you have an agency that has internal control programs, when they are downsizing, when they have management systems that can't help managers make key decisions, when they cannot get a—not only a clean opinion but any opinion on their financial statements—Ms.

Gaffney can attest to that because she audited them—I think you have an agency that really has to examine its mission, and I think the Congress has a role in doing that.

Now, GPRA, the Government Performance and Results Act, one of its objectives was to help Congress in a consultation process with the agencies when the agencies start to define their missions to come up with strategic plans in how to measure outcomes. I think that would be a very good opportunity in addition to the normal type of oversight hearings that should be held and are being held. I think there's ample opportunity.

Now, of course, on a case-by-case basis, you have different programs that need oversight, but I think in a general nature there is an opportunity for Congress to be part of the solution.

Mr. SNOWBARGER. First of all, I don't know that either one of you addressed the incentives that Congress might be able to use to sort of reinforce the agency's will to carry out the mission. And you are welcome to do that in the next question. Since you avoided it the first time around, you may want to avoid it the second time around, too. One mention was of 50 different programs, and earlier, I think, both of you indicated there were 240 separate programs.

Mr. DYCKMAN. Or activities.

Mr. SNOWBARGER. Is Congress the source of each one of those?

Ms. GAFFNEY. No. Most of them, but not all of them.

Mr. SNOWBARGER. And so what you are suggesting is that Congress should be taking a look, as we have in other areas, at combining those to see if we can't make them more efficient through adding flexibility or granting flexibility?

Ms. GAFFNEY. Yes, yes. And I think there are instances where the Congress—and this is a bitter pill to swallow—should also be considering whether we should terminate some of these programs. And let me give you a couple of examples of the kind of business HUD is in that you might not know about.

HUD insures mortgages for hospitals and for nursing homes, and hospital mortgages in these days of major changes in health care have become increasingly risky. But, listen, someone has to insure hospital mortgages.

I am not opposed to insuring hospital mortgages. I think it is legitimate to ask, is that HUD's role? Maybe HHS should be doing that, or maybe the private sector should be doing that. So, apart from just consolidating, there are questions about terminating, one would think, too.

Mr. SNOWBARGER. Mr. Chairman, if I can ask one more question?

Mr. SHAYS. Sure.

Mr. SNOWBARGER. It goes back more specifically to the Section 8 question, or the issue. Last week, when Secretary Cuomo was in, he mentioned—and I believe maybe, Ms. Gaffney, in your testimony you mentioned that there are places where we are paying 200 percent of fair market value on rents, which I found just amazing. I couldn't figure out how in the world we ever got into that, but apparently it was fairly—the Secretary indicated it is fairly common that we be paying much higher than market rents.

He indicated that the reason for those were basically the contracts that HUD entered into in the first place, at least provisions

in those contracts that provided for some kind of escalator, an automatic escalator.

Why didn't we catch all of these things sooner? How did we end up at a point where we are paying 200 percent on rents?

And frankly, if we are getting ready to renew some of those contracts, are we going to be able to back out of the situation where we are paying 200 percent, or are we going to be stuck? because someone will say, if you pay me 200 percent, you can have the property back; we don't necessarily want the property.

Ms. GAFFNEY. You are absolutely right. You know, this situation is no surprise. People have known about the increasing rents, above market rate, for years. They knew it when they were doing it.

Mr. SNOWBARGER. They understood when we entered into the contracts that they were likely to escalate beyond fair market value?

Ms. GAFFNEY. It is not clear to me that HUD was locked into doing precisely what it did by the original contracts. The reason I question that—I am going to have to find out—is because we, the Office of Inspector General, and HUD for some years now have been trying to get the Office of Housing to change the way it does annual rent adjustments, because the annual rent adjustments are like an escalator. And they have been unwilling to work with us to come up with a new approach.

What bothers me is that HUD is now doing a mark-to-mark demonstration, and we said to them, now is the time to define a new way of setting the annual rents. They still do not have the methodology. So that is what scares me about the future. We still do not have a different way of doing business, and I am afraid we are going to get into this same situation again.

Mr. SNOWBARGER. Mr. Chairman, could we allow Mr. Dyckman some time to respond to that as well?

Mr. SHAYS. Sure. Definitely.

Mr. DYCKMAN. Yes. Again, it is my understanding that these rents were legally arranged and came about simply through incentives in the contracts. Mr. Hale is going to explain it a little.

Mr. HALE. Mr. Snowbarger, most of the problem with this comes under a program that was called New Construction and Substantial Rehabilitation. As you probably know, it started in the 1970's and lasted up until 1983, and when that program was underway, people knew going in that the rents on these properties were, to a large extent, higher than market rents, and that was done for a couple of reasons. One, it was to try stimulate the housing industry; and, two, it was done so that you could build high-quality housing in neighborhoods that were not so good. As one of my colleagues has termed it, you would build an $800-a-month apartment in a $500-a-month neighborhood.

The second thing that has compounded this is that the annual adjustment factors that are used to mark up the rents over time, as Ms. Gaffney pointed out, also were very generous, and they made the problem even worse, so that now we do end up with the problem that over 70 percent of the properties have rents that are more than 120 percent of the market rents that those properties could actually support.

In terms of legal obligations to renew those, it is not so much a legal obligation as the concern is that if you renew them at substantially lower rents, that a great many of those properties would default.

Now, as you also know, in the fiscal year 1997 HUD appropriations bill, those rents were capped at 120 percent of fair market rents, and properties were given the choice of either one of two things. If you were an owner, you could try to get down and make that property work at 120 percent of the FMRs; or, second, you could enter into this voluntary portfolio re-engineering demonstration program, where if you entered into that, then they would reduce your rents down to market rents, but also then make an adjustment in your mortgage to try to allow the property to survive at those lower rents.

Ms. GAFFNEY. But, Rick, could I just say something?

Mr. HALE. Sure.

Ms. GAFFNEY. That is at a point in time, that is when you do the market to market, that is the portfolio re-engineering. What you need to be concerned about is what happens in the 20 years that follow in terms of how rent increases are going to be set, and that has not been refined.

Mr. HALE. No, and Susan is absolutely right. I mean, if we are going to do that, we should not leave everything else the same so that we still have owners that are not caring about their properties, we have HUD with no ability to enforce these properties, to maintain them as decent, safe, and affordable housing and to make sure that the rents remain affordable, that they do not constantly continue to creep upward over the next 20 years, or, as she said, we will be back in the same boat that we are in now, only we will have gone through a massive effort to get there.

Mr. SNOWBARGER. Well, frankly, the thing that concerns me more about what you have said than anything else, Ms. Gaffney, is that you have not been getting cooperation in terms of trying to deal with that problem, and it goes back to the whole question of the role of those within HUD to either cooperate with you or cooperate with us when and if we are able to change the programs.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. They were very helpful questions and helpful answers.

I have a number of questions that I do not think will be long answers; then I want to get into some detail on a few issues.

My sense is, from hearing the Secretary and listening to both of you, that taking management structure aside and systems aside, our two main focuses need to be—maybe three—Section 8, the Public Housing Authorities, the troubled public housing authorities; and, third, I might add, but it is related to management, obviously, too many programs with too few resources. Would you add anything to that list? I realize that there are a lot of other issues that you could look at.

Ms. GAFFNEY. There are, but I think you are correct that those are the major——

Mr. SHAYS. Mr. Dyckman.

Mr. DYCKMAN. There are other problems at HUD. We have issued many reports and recommendations concerning many of the other programs, but those are the key problems, in my estimation.

Mr. SHAYS. Well, since there are many others, I am going to ask each of you to add one to the list that I have given you. The Section 8, the Public Housing Authority, and too many programs with too few resources. What would you add?

Mr. DYCKMAN. I would probably add that restructuring of FHA——

Mr. SHAYS. OK.

Mr. DYCKMAN [continuing]. Whether or not the Government has to ensure 100 percent of the mortgages for single-family homes, and also FHA's multi-family insurance program, whether it is necessary.

We are doing a review, I might add. I have a parochial interest in saying that.

Mr. SHAYS. The bottom line is FHA.

Mr. DYCKMAN. The bottom line is, yes, whether FHA needs to be streamlined or should the status quo remain or made into a different government organization?

Mr. SHAYS. Separated from HUD.

Ms. GAFFNEY. Indian housing programs.

Mr. SHAYS. Secretary Cuomo talked about farming out the responsibility for dealing with the Section 8. While I did not share it with him at the time, I was thinking, my gosh, the danger is that we will be back in the whole Section 8 problem of friends who will get these wonderful contracts to do that negotiation. Would that be a concern?

Ms. GAFFNEY. What was the——

Mr. SHAYS. I want to make sure that I am describing it correctly, but basically one of his suggestions as a possibility is they bring in outside consultants to deal with this problem in various areas around the country, and we know what outside consultants sometimes mean at HUD. Do you have that similar concern?

Ms. GAFFNEY. Oh, contracting out is a major concern to me, because it is clear to me that generally people think contracting out is an easy way out. We are just going to get other folks to do our work for us, you know.

Mr. SHAYS. Right.

Ms. GAFFNEY. But, clearly, the oversight and the amount of work involved in defining the work to be done and overseeing it is incredibly important, or you are just going to be taken for a ride.

Mr. SHAYS. Just try to imagine. I did not mean facetiously if I were Secretary, I cannot imagine why someone would be Secretary, because I know that Mr. Cuomo, Secretary Cuomo enjoys the challenge, but it is almost massive because of what Joe Hale has talked about, the high-risk problems in terms of what I consider the structure and management of HUD. Mr. Dyckman, when you said 240 programs, I forgot, Ms. Gaffney, if you agreed to the 240.

There is a very strong argument that HUD has to look at interdisciplinary problems—crime, security, recreation for kids. They all interact, because kids who are not going to have activities may end up just playing on the elevators and wrecking them in the process.

So I understand why there needs to be an interdisciplinary approach, but that notwithstanding, I tend to sense that maybe one of our recommendations is going to have to be that based on your comments you all have made with your years of experience, that HUD may have to just totally refocus on the core programs, deal with the public housing, deal with the Section 8, and ship out a lot of these other programs, and maybe block grant it, which becomes somewhat controversial to some on your side of the aisle more than mine.

Now, is your sense that in focusing on the core programs, that they are going to have to drop some programs, consolidate?

Ms. GAFFNEY. Yes. Absolutely, yes.

Mr. SHAYS. Would you agree with that?

Mr. DYCKMAN. Yes. Well, yes, it is not so much that they have so many programs, but they seem to have so many programs doing the same thing or very similar things, so I am not suggesting that HUD get out of the business of public housing or vouchers, but why do you need vouchers and certificates? Why do you need so many different mechanisms to deliver the same thing?

So, in a sense, it is consolidation, but it may not necessarily take them out of the basic services that they are providing right now but just to focus better.

Mr. SHAYS. But what I get is a sense that Congress has provided a few new programs over the past few years, but we have not really provided a critical mass of funds, so we have a lot of programs but not really truly well funded.

Mr. DYCKMAN. Well, if a small program requires resources by the agency to oversee it if they are going to do a good job, sometimes it does not cost any more money to oversee a large program versus a small program. I think that is part of their management problems.

Now, in terms of whether they have enough budgetary authority to solve the problems of the cities, of course, they do not, but are we wealthy enough to put all our resources in solving one set of social problems? That is another issue that Congress has to face, obviously.

Mr. SHAYS. We are going to get to the next panel, but the purpose of today's hearing is to just kind of give us an overview; and clearly with HUD, we could focus on a lot of other issues, but we are just trying to—we want you to do exactly what you are doing, and that is put the emphasis on the biggest problems.

But I do not understand about the Section 8, and I do not know if this is the budgetary language that is screwing me up, but obviously if you are paying a certain subsidy right now to the Section 8, I do not understand why it costs us more money, my mind says, to renew. Why more money to renew? Why can't it cost less?

Ms. GAFFNEY. I am going to try, because this is the budget-authority-versus-outlay discussion. I think that is what it is.

Mr. SHAYS. All right.

Ms. GAFFNEY. The crisis is in budget authority, and budget authority is essentially expended at the time of obligation.

Mr. SHAYS. So the authority is ending, and, therefore, from a baseline it is down to zero. In terms of actual outlays——

Ms. GAFFNEY. Actual outlays are not changing at the same rate—there is not a crisis in outlays. They are much too high, and they are increasing steadily. It is the budget authority, because the budget authority for some of these contracts was provided 20 years ago——

Mr. SHAYS. I understand.

Ms. GAFFNEY [continuing]. Thirty years ago in time. Right? So, now, it is all having——

Mr. SHAYS. Let me ask one other question in regard to this. While I am not looking to increase the amount of public housing, but in one sense, if you have a landlord who owns property, particularly in a community, we are paying him twice the true market rate to carry the property. Why does not HUD just say, "Goodbye; you can foreclose; we will just take it over as public housing," and then over time recondition it as their property and hopefully get better benefit? I do not understand why we would reduce the mortgage requirements of the owners of these buildings, give them the benefit, and then just——

Mr. DYCKMAN. It is a tradeoff, because you have—if you do not do something, you may have a foreclosed property, and the Government is afraid that they will take a bigger hit.

Mr. SHAYS. OK. I guess it is the bigger hit issue. Yes?

Ms. GAFFNEY. I think there are two answers. One, HUD has traditionally been reluctant to pay insurance claims, and that means——

Mr. SHAYS. It is an up-front sum, is the problem.

Ms. GAFFNEY [continuing]. That the driving concern has been the financial situation of the insurance fund. But there is another consideration, and that is HUD has not been eager over the years to take enforcement actions of any type against these owners. That is a clear record.

Mr. SHAYS. Let me just make sure that you all feel comfortable or are assured that we are going to focus a good deal of our time on the Section 8 issue, very up front, and hopefully make some recommendations. In our report we will talk about some of our concerns as well of what we do not want to see HUD do. We are going to need both of your help in that regard.

Mr. Towns, are you all set?

Mr. TOWNS. No further questions. I would like to thank the panel for your help.

Ms. GAFFNEY. Thank you, Mr. Towns.

Mr. SHAYS. Well, we enjoy working with——

Ms. GAFFNEY. Nice to see you.

Mr. SHAYS. I would just add as well that both of your organizations, the people in them have been tremendous to work with, and we have appreciated the cooperation we always get from you and feel that we truly are partners in this effort, and it is nice to have such good partners.

Ms. GAFFNEY. Thank you.

Mr. SHAYS. At this time, we will call on Charles Masten, the Inspector General of the Department of Labor, as well as Carlotta Joyner, who is the Director of Educational Planning Issues, General Accounting Office. You both are accompanied by one other individual each, John Getek——

Mr. GETEK. Getek.

Mr. SHAYS [continuing]. And Dr. Harriet C. Ganson. So we will swear all of you in, if you would remain standing. Raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. Thank you. For the record, we will note that all four have responded in the affirmative. This now is the focus on the Department of Labor, and we really appreciate all of you being here. I am sorry we have kept you waiting a bit, and I think we will do it as I called. We will start with the Inspector General, and then we will go to the General Accounting Office.

I am going to leave here for about 5 to 10 minutes, and then I will be back; but what I think I will do is hear your statements and then go. So, Mr. Masten.

STATEMENTS OF CHARLES C. MASTEN, INSPECTOR GENERAL, DEPARTMENT OF LABOR, ACCOMPANIED BY JOHN GETEK, ASSISTANT INSPECTOR GENERAL FOR AUDIT; AND CARLOTTA C. JOYNER, DIRECTOR, EDUCATION AND EMPLOYMENT ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY HARRIET C. GANSON, ASSISTANT DIRECTOR, EDUCATION AND EMPLOYMENT ISSUES, GENERAL ACCOUNTING OFFICE

Mr. MASTEN. Thank you, Mr. Chairman and members of the subcommittee. Thank you for inviting the Office of the Inspector General to discuss management and programmatic issues facing the Department of Labor. I now possess a different role in my capacity as IG, so my views will be my views and not necessarily the official views of the Department or the official views of the IG.

Mr. SHAYS. OK. That is what I thought. I just wanted to make sure they are not your personnel views.

Mr. MASTEN. The views of the IG. I will summarize the four issues that I have detailed in my statement and ask that my entire statement be submitted for the record.

Mr. Chairman, one of the most important issues facing the Department is improving the effectiveness and efficiency of job training programs. While programmatic and legislative improvements have been implemented over the years, our audits of these programs continue to identify recurring problems, especially with respect to program performance and grant management.

Our most significant findings continue to be those programs generally result in short-term, low-wage jobs. It is my opinion that job training service will not be maximized, nor costs minimized, without adequate performance accountability and oversight of grants by the Department.

The second issue that continues to require major departmental and congressional attention is that of ensuring the safety of pension assets, which now total close to $3½ trillion. Specifically, the Department must be effective in ensuring that pension funds are deposited fully to the worker's account in a prompt manner and that these funds are safe while being held in trust by the plan administrators, service providers, or trustees.

Our main recommendations are, No. 1, repeal the ERISA's limited-scope audit provision, which results in inadequate auditing of

almost half of the $2 trillion in pension assets that are subject to the ERISA audit requirements; and, two, that the public accountants and plan administrators be required to report serious ERISA violations directly to the Department in order to ensure that these violations are reported promptly.

It is my understanding that the administration is once again working on introducing a proposal that will address both of these recommendations.

From an investigative perspective, the OIG continues to focus on identifying abuses by service providers, administrators, and others, with respect to union pension funds and investment activities. In fact, my office is currently conducting investigations of more than $200 million in pension assets that are suspected of being abused or defrauded.

The third issue facing the Department would be implementing two major statutory mandates, the Government Performance and Results Act (GPRA), and the Health Insurance Portability and Accountability Act (HIPAA). The main challenge for the Department with respect to GPRA will be ensuring that program agencies develop outcomes-based performance measures needed to assess program impact and that its financial systems are adequate to generate the needed financial and cost information of DOL programs.

With respect to HIPAA, DOL was given significant additional regulatory disclosure and enforcement responsibility related to its administration of ERISA, as well as enhanced authority in the Government's effort to combat health care fraud.

The challenge the Department will be the rapid implementation of its provisions while educating the public on the many requirements and protections, and then enforcing compliance with its requirements. And as the primary criminal investigative entity in DOL with respect to HIPAA fraud, my office will be faced with meeting our statutory responsibilities while providing adequate coverage to other priority areas as our resources continue to erode.

Finally, as far as the Unemployment Insurance System, we have three major concerns. The level of fraud activity related to this program, particularly as a result of fictitious employee schemes; two, the Department's ability to ensure that SESAs convert their computer systems to be ready for the year 2000—not to do this could create inaccuracies in calculating the length and amount of benefits, worker eligibility, and employee tax rates—and three, DOL's recent policies that essentially permit the States to provide electronic access, for a fee, to State UI wage record information for the purpose of consumer credit verification.

That concludes the summary of the four areas in my written statement, and we are prepared to answer any questions any of you may have.

[The prepared statement of Mr. Masten follows:]

FULL STATEMENT OF
CHARLES C. MASTEN
INSPECTOR GENERAL
U.S. DEPARTMENT OF LABOR
BEFORE THE SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES
March 6, 1997

Good Afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for inviting the Office of Inspector General (OIG) to discuss management and programmatic issues facing the Department of Labor (DOL). I am here today in my capacity as the Inspector General and my views may not necessarily reflect the official positions of the Department. I will focus on those areas I believe are currently of major importance to the Department: the effectiveness of DOL's employment and training system, safeguarding pension assets, implementing significant new statutory mandates, and ensuring the integrity of the unemployment insurance system.

ENSURING THE EMPLOYMENT AND TRAINING SYSTEM IS EFFECTIVE AND EFFICIENT

Mr. Chairman, one of the most important issues facing the Department is improving the effectiveness and efficiency of job training programs. This issue has taken on even greater importance with the implementation of the welfare reform legislation that was enacted in the last Congress. It is expected that the Department's job training programs will be a major component of the strategy to train and place welfare recipients into jobs and off the welfare rolls. In addition to existing programs, the Administration is proposing the creation of new DOL programs and services for this purpose, programs which will significantly add to the costs of job training.

Over the years, the OIG has conducted numerous audits and investigations of various aspects of the job training programs administered by the Department and has made numerous recommendations on ways to improve program accountability and performance. A number of these recommendations were accepted and implemented by DOL management, and others were included when the Job Training Partnership Act (JTPA) was amended in 1992. As a result, many ills of the program were addressed, particularly with respect to procurement, contracts, and accounting.

However, OIG audits of DOL employment and training programs continue to identify recurring problems, especially with respect to program performance and grant management. Our most significant finding continues to be that these programs generally result in short-term, low wage jobs. This finding becomes even more critical in view of the enhanced role DOL's employment and training programs will have with the implementation of welfare reform.

A good example to illustrate our concern is our 1996 audit of the Puerto Rico Seasonal and Farmworker Program, which found both poor performance and poor grant management.

This audit disclosed that a Federal investment of $5 million in classroom training resulted in the placement of only 17 individuals in training-related employment that lasted over 90 days, with an average starting wage of $3.90 per hour. Moreover, we found that an investment of $1.4 million in on-the-job training (OJT) funds was of virtually no value to participants because they were trained in ordinary agricultural tasks that many had performed before and that did not enhance their employment opportunities. This is contrary to the purpose of OJT, which is to improve work skills by providing occupational training in an actual work environment. Through OJT the Federal Government subsidizes the wages of OJT participants as a way of reimbursing employers for the "extraordinary costs" associated with training program participants. This did not occur in Puerto Rico.

The audit also found that 75% of the participants of the program were receiving some type of welfare benefit. We found that this helped to inhibit the success of the program because it was more economially beneficial to stay on public assistance. For example, we found that in Puerto Rico, a parent with three children would receive about $978 in monthly welfare benefits (not including health benefits), while the same individual placed in a job by the program would only earn $676 a month with no additional welfare or health benefits. Clearly, if one of the goals of these training programs is to reduce dependency on Federal assistance, the jobs would need to result in a living wage greater than the welfare benefits.

We are also concerned that too many program graduates from the Job Corps Program are placed in short-term, minimum wage jobs, that are often not even related to the occupational training received. And in JTPA's dislocated worker program, where the participant pool is comprised of people with prior work experience and demonstrated skills, we have found wages to be an issue. In an audit issued just last month, we found that the initial re-employment wage rate for former dislocated workers who were retrained was lower than that of a comparable group who had never participated in a retraining program and had obtained jobs. The Employment and Training Administration (ETA) needs to do a better job of finding suitable employment opportunities and placing workers in jobs that pay adequate living wages.

Mr. Chairman, at this crucial point, when DOL programs will be counted on to help welfare recipients obtain permanent jobs, the OIG recommends that the Department make performance accountability and grant management of its existing and proposed employment and training programs and services a top priority.

Paramount to improving performance accountability will be the need to measure the long-term impact of employment and training services on job retention and wages of program participants. Our own experience has been that this is very difficult to track, especially if agencies cannot access Unemployment Insurance (UI) and Social Security Administration (SSA) wage records. While ETA has access to the UI records, they would need special authority to access Social Security wage records for this purpose. By the same token, as part of our oversight role, the OIG often needs to have access to both UI and SSA wage records. Not having this authority has been a problem for us in the past, and it proved to be a major impediment in our ability to assess the long-term impact of the Job Corps program on participants because we could not locate a substantial number of the individuals in our audit sample. While we recognize the difficulties of measuring the impact of a program (i.e., the program's return on the taxpayer's investment), as I will discuss later on in my testimony, all

Government agencies will soon be required to report on this under the Government Performance and Results Act of 1993.

In addition to ensuring a successful program impact, ETA also needs to place greater emphasis on grant management to ensure that funds are spent properly. Our grant audits continue to identify instances of poor grant management by grantees and poor oversight by the Department. We also continue to identify improper charges to the Federal Government by grantees. Moreover, our investigations continue to disclose instances where funds are misused or embezzled, or where the Government has been charged for training and placement services that were not provided.

An important component of grant management is a meaningful audit program. The OIG believes a false sense of security is created by audits conducted under the Single Audit Act and OMB Circular A-133. Single audits, which are the types of audits performed for a great many of the Department's grant programs, are notorious for their lack of significant findings. Also, our 1991 audit report on the effectiveness of the Single Audit Act raised serious concerns about the extent of single audit coverage with respect to DOL programs, especially those administered under the JTPA.

The shortcomings of single audits as applied to JTPA, coupled with the nature of the relationship that exists between the Federal government and its grantees, in which the Governors in effect have the primary responsibility to administer training funds, have combined to create a gap in accountability in the JTPA program. The OIG does its best to fill this gap by conducting the audits and investigations, but more needs to be done.

Mr. Chairman, JTPA services will not be maximized, nor costs minimized, without adequate performance accountability and oversight of grants. This is particularly germane as the role of the Department's job training system is expanded with the advent of welfare reform implementation.

ENSURING PENSION ASSETS ARE SAFEGUARDED

Another programmatic issue that continues to require major departmental and congressional attention is that of ensuring the safety of pension assets. As you may be aware, current pension plan assets now total close to $3.5 trillion. Because of the nature of these assets -- large sums of dollars, entrusted for deposit and long-term investment for a future benefit -- the potential for serious abuses exists. And no-one is really exempt from becoming a victim. Our criminal investigations of pension plan fraud demonstrate that the people being defrauded come from all walks of life. It does not matter whether you are a truck driver or a roofer contributing to an union pension fund, or whether you are a Member of Congress.

My office's most significant concerns in this area are that the Department effectively ensure that pension funds are deposited fully to workers' accounts in a prompt manner and that funds be safe while held in trust.

Jurisdiction

By way of background, oversight responsibility over various aspects of the Nation's pension system and assets rests with four Federal agencies: the Department of Labor's Pension and Welfare Benefits Administration (PWBA); the Internal Revenue Service (IRS); the Pension Benefit Guaranty Corporation (PBGC); and the Department of Labor, Office of Inspector General (OIG).

PWBA is responsible for administering Title I of the Employee Retirement Income Security Act 1974 (ERISA), which governs the rights and financial security of employee benefit plan participants and beneficiaries in the Nation's private pension and welfare benefit plan system. PWBA's responsibilities include the promulgation of regulations, providing interpretations of ERISA, and the enforcement of provisions found in Title I. The IRS is responsible for enforcement of ERISA's Title II tax-related provisions, while PBGC is responsible for Title IV, which provides Government insurance in the event of failure of certain types of pension plans. Title III of ERISA provides the framework for all of the agencies to coordinate their activities.

Under the Inspector General Act of 1978, as amended, the OIG has oversight responsibilities over PWBA's programs and operations. Over the years, the OIG has conducted audits to identify weaknesses in the system and has made recommendations to improve PWBA's oversight of the Nation's pension assets. In addition, the OIG is the investigating unit within DOL for criminal labor racketeering and organized crime matters, and thus, some of the OIG's investigative jurisdiction regarding employee benefit plans overlaps that of PWBA. Within our jurisdiction, we conduct investigations into: (1) labor-related criminal conduct involving unions and/or industries with demonstrated ties to, or influences by, known organized criminal groups, whether they be traditional organized crime groups or newer, non-traditional groups; and (2) significant, prolonged, systematic and related criminal conduct which may be categorized as labor racketeering.

Ensuring Pension Funds are Fully and Appropriately Deposited

A serious problem that has been identified in the pension area is that of ensuring that contributions withheld from employee paychecks are appropriately and promptly deposited by employers or plan sponsors. The Department has taken steps to help ensure this by making regulatory changes that reduce the time from which contributions are withheld or paid by the employee and received by the employer and the time the contribution is considered a plan asset. While these regulations reduce the time in which someone could temporarily use the pension funds inappropriately and then deposit the funds without being detected, they will not prevent individuals inclined to do so from converting funds for their own use. That type of activity needs to be addressed through an aggressive criminal enforcement program. The Government continues to identify instances of employee pension contributions not being deposited properly or funds diverted for the personal use of those administering the assets. Therefore, enforcement and oversight of this area needs to remain a priority of the Department.

Last week, my office issued an audit of the Department's employee contribution project (ECP). This project was initiated by PWBA in May 1995 to address plan administrators' failure

to remit employee contributions to 401(k) pension plans and health plans. The purpose of the OIG audit was to determine if the Department, through the ECP, is adequately addressing the area of employee contributions to ensure that funds in those plans are safeguarded from unscrupulous plan administrators.

Our audit found that PWBA's efforts in this project had a positive impact in protecting plan assets, particularly with respect to increasing enforcement in this area as well as participant awareness of the problem. The latter was evidenced by a significant increase in participant complaints to PWBA. However, we also found that improvements were needed in the targeting of this enforcement initiative as well as in their Case Management Information System. The audit found that PWBA had not focused its investigative resources on plans with the most serious potential for abuse. We attributed this ineffective targeting to the fact that PWBA left the development of enforcement strategies to the discretion of regional directors, but did not conduct a timely evaluation of project results. As a result, enforcement results varied from region to region. Strategies utilized by the regions included reviewing participant complaints, referrals, and leads from plan service providers or administrators; as well as case development through computer targeting or self initiation. It is our opinion that an evaluation of project results would assist management in identifying the most effective targeting strategies, evaluating the success of the project, and determining its future scope and direction. PWBA is now evaluating the results of its ECP project.

We also found that data in PWBA's Case Management System is inaccurate, particularly with respect to information on the sources of cases and occurrences of fiduciary violations. The accuracy of this data is essential in enforcement planning and, when correlated with case results, crucial in assessing the success of the project. In addition, we found that PWBA does not collect data or report on funds that have been misapplied and which are unrecoverable by participants or the Federal Government. By not providing information on unrecoverable assets, as it does for restored assets, PWBA fails to communicate a complete picture of this issue. This partial disclosure may be misleading PWBA clients as to the seriousness of this issue and deprives the Congress and the Department of pertinent information.

Ensuring Pension Assets are Safeguarded While in Trust

The OIG also has long-standing concerns with respect to ensuring that funds are safeguarded while they are held in trust by plan administrators, service providers, or trustees.

Chief among our recommendations in this area is the need to repeal ERISA's limited scope audit provision, which results in inadequate auditing of pension plan assets. Since 1984, the OIG has reported its concerns that employee pension funds are not being adequately audited to ensure that they will be available in the future to pay promised benefits. This provision exempts from audit all pension plan funds that have been invested in institutions such as savings and loans, banks or insurance companies already regulated by Federal or State Governments. At the time ERISA was passed two decades ago, it was assumed that all of the funds invested in those regulated industries were being adequately reviewed. Unfortunately, as we have found from the savings and loan crisis, that is not always the case.

According to PWBA, more than $950 billion in pension plan assets (out of approximately $2 trillion subject to audit requirements under ERISA) are not examined because of the limited scope audit provision. Currently, because of this provision, independent public accountants (IPAs) conducting audits of pension plans cannot render an opinion on the plan's financial statements in accordance with professional auditing standards. It is important to note that the disclaimer of any opinion on the financial statements includes even those assets that are not held by financial institutions. These "no opinion" audits provide no substantive assurance of asset integrity to benefit participants or the Department. Our concerns in this area have been raised in two OIG audits and have subsequently been supported by PWBA, the General Accounting Office, and the American Institute of Certified Public Accountants.

Mr. Chairman, requiring full scope audits of employee benefit plans is a reasonable mandate that would not be a burden on businesses. Currently, at least half of the Nation's pension plan assets are the subject of full scope audits. Moreover, these audits are usually add-ons to routine annual financial audits of a corporation, and therefore, their specific cost is not high. To illustrate the value of a full scope audit versus a limited scope audit, I have attached a copy of opinions from each to my testimony.

The failure to adequately audit pension plans opens the door for many forms of fraud and abuse, including understating required contributions or degrees of risk, and overstating plan investments and valuations. Obviously, these factors can potentially lead to pension plan failures.

The OIG has also recommended that IPAs and plan administrators be required to report serious ERISA violations directly to the Department. This requirement will enhance oversight of pension plan assets, ensure the timely reporting of violations, and involve accountants in the kind of active role that they are supposed to play in the safeguarding of pension assets, by providing a first line of defense to plan participants through their timely and direct reporting of potential problems with employee benefit plans.

Because of the vulnerability of pension assets to fraud and mismanagement, Mr. Chairman, the OIG believes that full scope audits of employee benefit plans and reporting of serious ERISA violations by IPAs and plan administrators are crucial factors in ensuring that pension assets are safeguarded. While legislation to address these concerns has been proposed in past years, a legislative fix has yet to be enacted. It is my understanding that the Administration is working on introducing a proposal that would address both of these recommendations.

From an investigative perspective, the OIG continues to focus on identifying abuses by service providers, administrators, and others, with respect to union pension funds and investment activities. The OIG is currently conducting investigations of more than $200 million in pension assets that are suspected of being abused or defrauded. Our investigations continue to uncover abuses of employee benefit plans in the manner in which pension assets are managed and invested. The size of these plan assets offer inviting targets to unscrupulous service providers and individuals who offer services to the plan administrators such as accountants, attorneys, or investment advisors.

One example of abuses we have identified involves an attorney for an employee benefit plan with over $30 million in assets. In this case, the attorney engaged in a scheme to temporarily divert pension assets to invest in an off-shore, lucrative (yet high-risk) investment scheme. Some $10 million in pension assets were lost in the scheme when the offshore investors stole the money. The attorney, who pled guilty to charges of conspiring to solicit and receive kickbacks related to influencing the investment of the $10 million of pension funds, is currently incarcerated. Other service providers to the fund, an investment advisor, and an accountant, have been charged as well.

The OIG, in conjunction with its probe into labor racketeering in the construction industry, has also been looking into the use of pension plan assets as loans for construction projects and other related loan activity. These cases are very complex in terms of the way the fraud is concealed. An example of this type of activity involved a case where an individual in California pled guilty to charges that he was involved in a scheme to defraud pension funds through the use of construction loans. The defendant, acting as the general managing partner of a partnership, obtained over $10 million in construction financing through a mortgage company from four union pension funds. As part of the loan agreement, the defendant was advanced funds in order to directly pay subcontractors for any work that they performed on the project. To obtain a release for some of the funds, the defendant was obligated to provide the mortgage company with documentation supporting the use of the funds to pay the subcontractors for construction materials and services. The defendant used the money on other unrelated real estate construction projects, while the project that was to be funded with the loan failed. Unfortunately, the pension plans had to absorb the monetary loss.

Ensuring that pension assets are safeguarded is of such importance that the OIG has prepared a 5-year audit plan of potential areas we will be exploring with respect to pensions

IMPLEMENTING NEW SIGNIFICANT STATUTORY MANDATES

In the next year, the Department will be required to implement two major statutory mandates, the Government Performance And Results Act of 1993 and the Health Insurance Portability and Accountability Act of 1996.

The Government Performance And Results Act of 1993

Mr. Chairman, effective fiscal year 1998, the Government Performance and Results Act (GPRA) will require that all Government agencies: establish strategic plans with clear goals, align budgeted resources with those goals, measure performance in achieving those goals, and report the results to the Congress. The fundamental purpose of the law is to increase the performance of Government programs and services by identifying their impact and cost, and then measuring their return on the tax payers' investment.

It is my opinion, Mr. Chairman, that the Department has been making an initial good faith effort to gear up to meet this challenge. For example, the Department has been educating its various components as to the requirements of the law and has been coordinating the development of agency-specific strategic plans. They have also been coordinating with the

Office of Management and Budget, which has overall responsibility for the implementation of the GPRA. Nonetheless, much remains to be accomplished before DOL can effectively meet the intent of the law.

First, the Department needs to ensure that program agencies develop outcomes-based performance measures. It is through these types of measures that the impact of DOL programs and services can be assessed and a determination made as where to continue to place resources. This is particularly critical for the Department's employment and training system. As you may recall, we have raised our concerns that the Department's performance measures in this area are largely based on inputs and outputs and not on long-term outcomes. For example, we may know how many people were placed in a job after completing a training program. What we often do not know is whether that person kept that job and is now self-sufficient as a result of it.

Second, the Department needs to continue improving their financial systems. Since the OIG began auditing its the financial statements, as required under the Chief Financial Officers (CFO) Act, the Department has made significant strides in improving its financial systems and structure. For example, the Department is in the final stages of implementing a centralized financial management structure under the supervision of the Chief Financial Officer. In the past, financial management responsibilities were largely under the direct control of the respective assistant secretaries. This new structure will help ensure the integrity of DOL's finances through timely, consistent, and reliable information coupled with appropriate controls. However, the Department needs to transition from financial accounting to cost accounting and to Improve its agency-level financial systems. These two changes will be needed to ensure the Department's ability in generating the financial and cost information that will be necessary to determine the return on investment of agency programs and services.

Absent these improvements, the Department will likely be limited in their ability to assess the impact of their programs, make decisions on allocation of resources and, report to Congress as required by GPRA.

The Health Insurance Portability and Accountability Act of 1996

The fundamental purpose of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 is to provide greater security in workers' health care coverage and to address the issue of health care fraud. With the passage of this Act, the Department of Labor was given significant additional regulatory, disclosure, and enforcement responsibilities related to their administration of ERISA, and the Department will have enhanced authorities in the Government's effort to combat health care fraud.

Under HIPAA , the Department will have shared responsibilities with the Departments of Health and Human Services and Treasury with respect to portability, access, and renewability of health plans and for enforcement, as related to health care fraud. The Department will also have sole responsibilities for certain disclosure and enforcement activities. PWBA will be responsible for drafting regulations, providing interpretations and customer service, and conducting civil enforcement. A challenge to the Department in implementing this law is the fact that Congress intended this to be a rapid process and built into the new law a compressed

timetable for the development of regulations. For example, under HIPAA, the Department is required to issue, by April 1, 1997, regulations on the portability provisions which address pre-existing conditions and certification of previous health coverage. Plans will then be subject to the portability provisions as soon a new plans year starts after June 30, 1997. In effect, most plans will not come under the new requirements until after January 1, 1998. The Department will need to continue to quickly educate the public on the many of the new requirements and protections afforded under the law. Then, the Department will be required to enforce compliance with HIPAA requirements.

With respect to the OIG, we will continue to be the primary criminal investigative entity with respect to health care fraud in certain ERISA-covered health care plans such as union-affiliated health plans, MEWAs, and single employer plans, as well as Federal health care programs administered by the Department of Labor, which include the Federal Employees' Compensation Act (FECA), Black Lung, and Longshore and Harbor Workers' Compensation Act programs.

As an example, our labor racketeering investigative program is finding more and more problems with "bogus unions". Our investigations have found that these "unions" are a ruse for selling health plans which are often fraudulent. These "unions" generally do not provide representation to members with respect to labor-management issues. However, under ERISA, health plans associated with unions are not covered under state regulation, and these bogus unions often escape state scrutiny. Therefore, it is left to the Federal Government to identify and investigate these schemes. By way of illustration, in just one case, members of one of these "unions" were left with $6 million in unpaid medical claims.

The FECA program, which provides benefits to most Federal employees who are injured or killed on the job, costs $1.8 billion annually. Our investigations related to this program continue to identify claimants that are not disabled or otherwise not entitled to benefits, or who do not report outside earned income to avoid a reduction in their benefits. We also continue to identify medical providers who submit unnecessary and/or fraudulent claims for reimbursement.

HIPAA provides Federal agencies involved in combating health care fraud with significant new tools, including the creation of a series of criminal violations and greater authority to utilize existing civil monetary penalties. Clearly, it is the intent of Congress that these agencies intensify their investigative programs in this area. The OIG is in the process of drafting appropriate regulations related to civil monetary penalties and once they are in place, we expect to aggressively use these new tools to fight fraud and abuse in the health care programs under our jurisdiction.

The main challenge for the OIG in meeting our responsibilities under this law will be allocating resources to this area, while providing adequate coverage in other priority areas, as our resources continue to erode. While PWBA was provided with additional resources for their regulatory and enforcement responsibilities under the Act, the OIG was not.

ENSURING THE INTEGRITY OF UNEMPLOYMENT INSURANCE SYSTEM

Another programmatic area in which we have concerns is that of ensuring the integrity of the Unemployment Insurance (UI) system. UI benefits are the initial financial support provided to workers who lose their job through no fault of their own. Its mission, coupled with the fact that this is a multi-billion dollar program, makes its monitoring and efficient operation extremely important. As a result, we are devoting a fair amount of resources to this area.

We are very concerned about the level of fraud activity related to this program. As with any multi-billion dollar Federal benefit program, there are those, both claimants and those responsible for administering the program, who would attempt to defraud it. We continue to identify fraudulent claims for benefits by individuals and embezzlement by employees of the program (particularly at the state level). We are particularly concerned with what seems to be a rise in fictitious employers schemes perpetrated against the UI system in which individuals set-up fictitious employer accounts and, after establishing themselves as a liable employer and making minimal tax payments, file numerous fraudulent claims under assumed names and social security numbers. Many of these schemes are carried out in multiple states. My office will continue to address these cases to the extent allowed by our resources.

A second major concern will be the Department's ability to assist State Employment Security Agencies in converting their computer systems to be ready for the year 2000. Failure to upgrade the computer systems to be year 2000 ready can result in inaccuracies in the calculations of length and amount of benefits, worker eligibility, and employer tax rates. The Department is aware of the need for this upgrade and is working on a plan to address this issue.

We are also concerned about DOL's recent policy that essentially permits the States to provide electronic access, for a fee, to state UI wage record information for the purpose of consumer credit verification. This "service," provided by states to private interests, is sanctioned by ETA's Unemployment Insurance Service, which issued a Program Letter in June 1996 that allows the disclosure of wage record information if certain conditions are met. The OIG is concerned about this policy and the effect it may have on program operations. The Program Letter creates a major exception to the longstanding policy of confidentiality of UI wage records. The policy also raises questions as to whether UI administrative funds, which are Federally appropriated, are being used for non-program purposes. Finally, the protection of both employer and employee confidentiality is of great concern. We will be conducting an audit in which we will examine states' contracts with the private credit services as well as their arrangements with subscribers, and will also look at controls in place to protect confidentiality and account for UI funds used for this purpose.

OPPORTUNITY FOR SAVINGS:
DOL FOREIGN LABOR CERTIFICATION PROGRAMS

In your letter of invitation, you also asked us to identify any opportunities for savings within the Department and we have identified one such area. In May 1996, we issued an audit on two of the Department's foreign labor programs: DOL's employment-based permanent program and the temporary H-1B Labor Condition Application immigration program. In our

opinion, while ETA was doing all it could within its authority, neither program met its legislative intent of protecting U.S. workers' jobs or wages.

With respect to the permanent program, we projected that virtually all aliens who were certified during our audit period (Fiscal Year 1993), and who eventually obtained permanent resident status, were in the U.S. at the time the employer filed the application, of which three quarters were already working for the petitioning employer. We also found that, despite a costly and time-consuming recruitment process, the required test of the labor market did not result in the hiring of U.S. workers over foreign labor.

The H-1B program for temporary employment, which is intended to provide U.S. businesses with timely access to "the best and the brightest," does not always supply highly skilled, unique individuals. Instead, we concluded it serves as a probationary try-out employment program for illegal aliens, foreign students, and foreign visitors to determine if they will be sponsored for permanent status.

Moreover, while the only protection the H-1B program provides the U.S. worker is that the employer is required to pay the prevailing wage (to protect the erosion of wages of U.S. workers) we found this was not the case. We projected that over three quarters of the H-1B employers could not document that the wage specified in their Labor Condition Application was the wage actually paid. Even where the employer adequately documented the actual wage paid, we found that 19 percent of the aliens were paid less than the wage the employer specified on the Labor Condition Application would be paid to the alien.

Overall, we concluded the permanent program was little more than a paper exercise anc that the H-1B program amounted to a rubber stamp of employers' applications. We recommended these two DOL programs be eliminated as they currently exist and replaced with programs that fulfill Congress's intent — to protect American workers jobs and wages. We also recommended that, if DOL has a continuing role in the redesigned program, the costs of DOL's activities be fully recovered by charging user fees to the employers who benefit from the program.

The President's balanced budget proposal would amend the Immigration and Nationality Act to require that employers pay user fees to cover the Department's costs of administering these programs. While the OIG supports this provision as long as DOL is involved in the labor certification programs, we continue to believe DOL should be removed from the process unless a more meaningful role is defined.

Mr. Chairman, this concludes my prepared statement, I would be pleased to answer any questions that you or other Subcommittee Members may have.

Mr. SHAYS. Thank you very much. Ms. Joyner.

Ms. JOYNER. Yes. Mr. Chairman, members of the subcommittee, we, too, are pleased to be here with you today to talk about the challenges facing the Department of Labor in carrying out its mission. There are two major challenges that I will summarize briefly and, I have a longer statement, which you have received already.

The first of these is the challenge to provide effective employment training programs that meet the needs of the diverse target populations and to do so in a cost-efficient manner; and the second is to ensure worker protection in a way that is in a flexible, regulatory structure.

I would also like to talk about how we believe Labor's ability to meet these challenges will be enhanced by the improved management initiatives that are envisioned by recent legislation.

With about $34 billion and 16,000 staff in fiscal 1997, Labor's programs touch the lives of nearly every American because of their breadth, from job training to helping people get jobs, income security when unemployed, and working conditions when employed. We have provided a chart over here that gives some information about this.

Just as an overview, as a reminder, there are 24 different units into which the Department is organized. The chart over here does not show the over 1,000 field offices around the country, which, in addition, carry out the mission of the Department. It also does not show, as a chart could not, the extent to which these activities are decentralized in nature.

For example, assuming the information one might want to have, such as the non-billable Fed offices, where they are on the staff, that kind of information is available only from the individual units, not from the central office.

As you can see, on the chart—I do not know if you can see that well—would it be helpful to tip that a little bit?

Mr. SHAYS. The chart is a little small, if we just lift it up right over here, Chris. Maybe somebody could help you.

Ms. JOYNER. OK. Good. What I will be talking about is the yellow marks around the middle of the chart, so I can direct your attention there, if that helps, to the program activities.

Well, you see, that is the problem. There are so many units that the text has to be so small that you cannot see it.

Mr. SHAYS. OK. Flip the bottom down there. You can slide it down a little bit, and then we will be all set. Good. Thank you for asking.

Ms. JOYNER. All right. We would hate to spend the money and make the chart and have you not be able to see it.

Mr. SHAYS. That is all right. I am happy you are doing this.

Ms. JOYNER. OK. If you look at the middle level, on "Program Activities," the Bureau of Labor Statistics is the one to the far left. Obviously, that has an important role in gathering information on labor statistics, including the CPI. Of course, there is a major issue now as to how to revise that. But we will be focusing more on the other program offices to the right of that.

The two offices responsible for the work force development activities are the Employment and Training Administration, the second box and—all the way to the right—the Veteran's Employment and

Training Service. The charge that these two offices within Labor face in mainly the work force development mission is that they are doing this in the context of many more programs than just the ones for which they are responsible.

If you will recall, the last time we testified here, we pointed out the 163 different employment training programs under 15 agencies. All 37 of these at that time were not even in the Department of Labor. We have not gone back to recount those or to recalculate the $20 billion estimated for those programs at that time, but what we do know is that a problem remains that instead of there being a coherent work force development system to meet the needs of people in this country, we have a fragmented system with some of those overlapping target groups and questionable outcomes. This has been said before as well.

Now, as you know, consolidation legislation was considered in the last Congress, and you would have had some interest in that. The Congress was unable to reach agreement on how to consolidate the programs.

The Labor Department has moved ahead with this to try to help the States, who themselves have tried on their own to integrate these programs. The Labor Department has used initiatives, for example, one-stop career centers, and has tried to the extent that it is possible without the legislative change, to try to overcome this kind of fragmentation. But that has not been enough to fix the problem. It has also implemented consumer initiatives to get more information about the outcomes of some of the programs.

But as you are aware, too, with the recent welfare reform legislation, even more people will be needing assistance in getting jobs and being trained for jobs, and the system really is not there to help them. In the Washington Post this morning, there is an article about the difficulty that employers face in trying to bring people off the welfare rolls into jobs, and the biggest problem—and it is not a surprise to us—is it is not so much the skills, it is employability. That is something that we have addressed in one of our reports, and, in fact, I have testified on that matter once before this subcommittee on the need to focus on employability skills as well as specific job skills.

Another major challenge has to do with worker protection issues; that is accounted for by the other four agencies on that row of program agencies on the chart: Employment Standards Administration, Mine Safety and Health, Occupational Safety and Health, and Pension and Welfare Benefits Administration. The major challenge here is to provide this regulatory oversight in a way that is less burdensome and at the same time more effective.

The Department, again, has made some progress in this direction, and OSHA, for example, illustrates some of that, with much more partnership initiatives with companies to supplement their tradition enforcement approach. But that has not been without criticism and without some difficulties there as well.

We have also pointed out some opportunities for them to leverage their resources through sharing information with contracting agencies. What we found was over $38 billion in Federal contracts were going to 261 companies that nevertheless had been cited for significant penalties for safety and health violations. And so we have

made some recommendations to extend, if you will, their opportunities in that way.

In worker protection as well, congressional action poses some new challenges and some new activities for them. The Congress awarded them additional funds last year to examine ways to substantially improve their wage determination process under Davis-Bacon, a controversial law. They are now launched into a major effort to try to find better ways to do that, and while this has been previously mentioned, they have new responsibility under the health insurance portability law to establish some regulations and subsequently to enforce them.

I really do think that some improved management practices will help them meet both of these challenges. The Government Performance and Results Act, as has been mentioned, is really the centerpiece for that, for moving Labor, as other departments, to a more results-focused, results-oriented management.

And there are other pieces of legislation that have been employed in parts of that. The CFO Act, the Chief Financial Officers Act; the Paperwork Reduction Act, and Clinger-Cohen. Together these will put them in a position as they move to full implementation with these, to do several things that are crucial: to have some integrated information about their mission and strategic priorities, the performance data to evaluate their performance toward those goals, to relate their information and resources and technology to those goals, and then to have some accurate and audited financial information about how they are spending their resources toward those goals.

Labor is taking some action in these directions. We feel that this mission is an urgent one. I am sure you share that concern about people when they are unemployed, when they are injured in the work place, about employers trying to find competent workers and understand the regulations that they are having to deal with, and then the potential of wasted money that we really cannot afford to waste. So we are very encouraged and hope that these management approaches will help them do better.

[The prepared statement of Ms. Joyner follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources,
Committee on Government Reform and Oversight,
House of Representatives

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DEPARTMENT OF LABOR

Challenges in Ensuring Workforce Development and Worker Protection

Statement of Carlotta C. Joyner, Director
Education and Employment Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-85

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the challenges faced by the Department of Labor in carrying out its mission in a cost-efficient and effective fashion.

With a budget of about $34 billion and about 16,000 staff in fiscal year 1997, Labor's mission is to foster, promote, and develop the welfare of U.S. wage earners; improve their working conditions; and advance opportunities for profitable employment. Over the past several years, the U.S. work environment has changed in such a way that achieving this mission is more difficult. For example, the strength of international competition has made us increasingly aware of the need for a skilled labor force. At the same time, large numbers of individuals in this country remain unprepared for such employment. Also, changes in employer/employee relations, such as increased use of part-time and contract employees, pose new challenges for worker protection. In addition, the public is demanding more accountability from government agencies such as Labor–more assurance that their tax dollars are not being wasted and that government is operated according to sound business practices.

Today, I would like to discuss two major challenges Labor faces in achieving its mission: first, providing effective employment and training programs that meet the diverse needs of its target populations in a cost-efficient manner and, second, ensuring worker protection within a flexible regulatory structure. In addition, I want to discuss how Labor's ability to meet these challenges would be enhanced by the improved management envisioned by recent legislation.

In summary, although Labor has historically been the focal point for workforce development activities, it faces the challenge of meeting those goals within the context of an uncoordinated system of multiple employment and training programs operated by numerous departments and agencies. In previous testimony before this Subcommittee,[1] we reported that, in fiscal year 1995, 163 federal employment training programs were spread across 15 departments and agencies (37 programs were in Labor), with a total budget of over $20.4 billion. Although we have not recounted the programs and appropriations, we are confident that the same problem still exists. Rather than a coherent workforce development system, we continue to have a patchwork of federal programs with similar goals, conflicting requirements, overlapping target populations, and questionable outcomes. As you know, comprehensive legislation that would have addressed this fragmentation was considered but not passed by the 104th Congress. In the absence of consolidation legislation, Labor has gone ahead with some reforms, such as planning grants for one-stop career centers, but the actions it has taken have not been enough to fix the problems. Now, passage of the recent welfare reforms puts even greater demands on an employment training system that appears unprepared to respond.

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[1]Department of Labor: Rethinking the Federal Role in Worker Protection and Workforce Development (GAO/T-HEHS-95-125, Apr. 4, 1995).

A second major challenge for Labor is to develop regulatory strategies that ensure the well-being of the nations' workers in a less burdensome, more effective manner. Labor has made some changes since we last testified, which are perhaps best illustrated by actions at the Occupational Safety and Health Administration (OSHA), such as its partnership initiatives with companies. But OSHA's actions have not been without controversy, and substantial challenges remain there and at other Labor components with worker protection responsibilities. Congressional action poses new challenges in the worker protection area as well. Labor has committed to redesigning its Davis-Bacon wage determination process with additional funds appropriated by the Congress. Labor also must issue and enforce regulations to implement the new health care portability law.

In meeting these mission challenges, Labor will need to become more effective at managing its organization. The Department of Labor, like other federal agencies, is confronted by management problems that impede its ability to carry out its mission efficiently and effectively. Major pieces of legislation that provide a statutory framework for improving agency operations and accountability include (1) the 1993 Government Performance and Results Act (GPRA), which requires agencies to focus on results as they define their missions and desired outcomes, measure performance, and use that performance information; (2) the expanded Chief Financial Officers (CFO) Act of 1990, which requires agencies to prepare financial statements that can pass the test of an independent audit and provide decisionmakers reliable financial information; and (3) the 1995 Paperwork Reduction Act and the 1996 Clinger-Cohen Act, which are intended to help agencies better manage their information resources and make wiser investments in information technology. Labor has made progress in response to each of these initiatives, but work remains to be done before the goal of improved management is reached.

BACKGROUND

Labor, established as a Department in 1913, administers and enforces a variety of federal labor laws guaranteeing workers' rights to a workplace free from safety and health hazards, a minimum hourly wage and overtime pay, family and medical leave, freedom from employment discrimination, and unemployment insurance. Labor also protects workers' pension rights; provides for job training programs; helps workers find jobs; works to strengthen free collective bargaining; and keeps track of changes in employment, prices, and other national economic measures. Although Labor seeks to assist all Americans who need and want to work, special efforts are made to meet the unique job market problems of youths, older workers, economically disadvantaged and dislocated workers, and other groups.

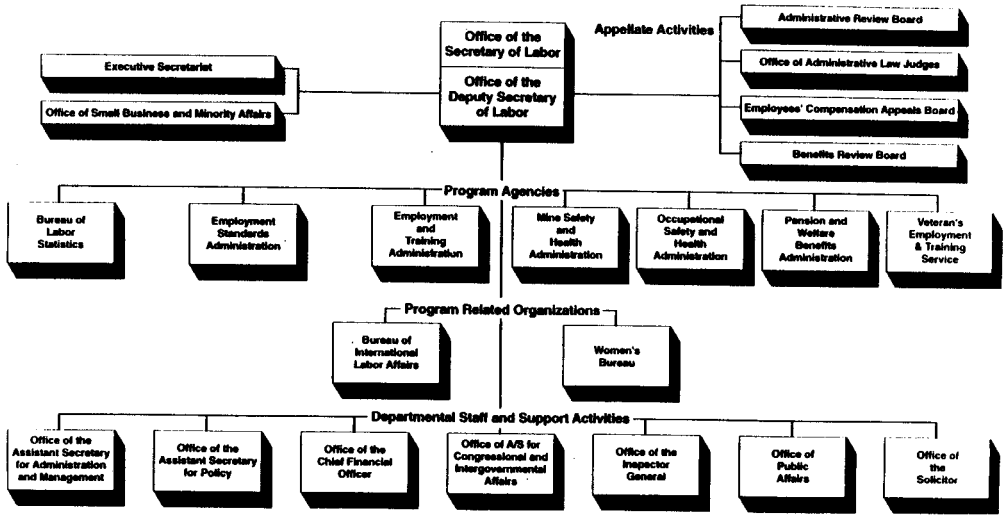
In fiscal year 1997, Labor has an estimated budget of $34.4 billion and is authorized 16,614 full-time-equivalent (FTE) staff-years. About three-fourths of Labor's budget is composed of mandatory spending on income maintenance programs, such as the unemployment insurance program. The administration's fiscal year 1998 budget request is $37.9 billion in budget authority and 17,143 FTE staff. The budget request includes $12

billion for Labor's major budget themes–an increase of $1.7 billion over fiscal year 1997. Included in the request for fiscal year 1998 is $750 million in mandatory funding for a new welfare-to-work jobs program.

Labor's many program activities fall into two major categories: enhancing workers' skills through job training and ensuring worker protection.[2] Figure 1 shows the organizational structure of the Department.

[2]Labor also is responsible for developing economic statistics, such as the Consumer Price Index (CPI). Labor's fiscal year 1998 budget requests $17.5 million to update and improve its key economic reporting systems, of which $2.1 million is for the first year of a multiyear initiative to revise and upgrade the CPI.

Figure 1: Department of Labor Organization Chart



Labor's workforce development responsibilities are housed in the Employment and Training Administration (ETA) and the Veterans' Employment and Training Service. Together, they have a fiscal year 1997 budget of about $6.5 billion and 1,595 FTEs. Labor employment and training programs include multiple programs authorized by the Job Training Partnership Act (JTPA), such as those for economically disadvantaged adults and youth and workers who lose their jobs because of plant closings or downsizing and Job Corps, an intensive residential program for severely disadvantaged youth. Other activities include support for the Employment Service and the Veterans' Employment Program. Table 1 shows Labor's appropriations and staff-year spending for fiscal year 1997.

Labor has four units responsible for most of its worker protection programs: the Employment Standards Administration, the Pension and Welfare Benefits Administration, OSHA, and the Mine Safety and Health Administration. Together, these units have 9,020 FTEs and a budget of $915 million for fiscal year 1997.

Table 1: Department of Labor Appropriations and Staff-Year Spending, Fiscal Year 1997

Category	Fiscal year 1997 appropriations (in millions)	Full-time-equivalent staff-years
Unemployment insurance and other income maintenance expenses	$26,467	[a]
Employment and training[b]	6,460	1,595
Worker protection	915	9,020
Employment Standards Administration	316	3,942
Pension and Welfare Benefits Administration	77	639
Occupational Safety and Health Administration	325	2,241
Mine Safety and Health Administration	197	2,198
Pension Benefits Guaranty Corporation	10	731
Bureau of Labor Statistics	361	2,544
Departmental management	165	2,274
Office of Inspector General	47	450
Total	**$34,425**	**16,614**

[a]Included under employment and training.

[b]Includes ETA and Veterans' Employment and Training Service.

Source: Department of Labor.

WORKFORCE DEVELOPMENT MISSION
IS CHALLENGED BY MULTIPLE PROGRAMS

Our work has demonstrated that the federal government has a patchwork of job training programs characterized by overlap and duplication, resulting in the potential for wasted resources and reduced service quality.[3] We have also noted in past work the limited information available on employment and training program outcomes and effectiveness.[4] Further, it is uncertain how this fragmented system will be able to meet the employment demands of those affected by the recent welfare reform legislation.

Multiple Employment Programs With Limited Information

A major challenge for Labor is to facilitate workforce development within the context of a conglomeration of programs operated by Labor and 14 other federal departments and agencies. Table 2 shows the number of different employment training programs that existed in fiscal year 1995, their target groups, and fiscal year 1995 appropriations. For example, we found that 9 programs targeting economically disadvantaged individuals had similar goals; often served the same categories of people; and provided many of the same services using separate, often parallel, delivery structures.

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[3]Multiple Employment Training Programs: Information Crosswalk on 163 Employment Training Programs (GAO/HEHS-95-85FS, Feb. 14, 1995) and Multiple Employment Training Programs: Major Overhaul Needed to Reduce Costs, Streamline the Bureaucracy, and Improve Results (GAO/T-HEHS-95-53, Jan. 10, 1995).

[4]Multiple Employment Training Programs: Basic Program Data Often Missing (GAO/T-HEHS-94-239, Sept. 28, 1994) and Multiple Employment Training Programs: Most Federal Agencies Do Not Know if Their Programs Are Working Effectively (GAO/HEHS-94-88, Mar. 2, 1994).

Table 2: Number of Employment Training Programs and Fiscal Year 1995 Appropriations, by Target Group

	Employment training programs			Fiscal year 1995 appropriations (in millions)	
Target groups	Total	At labor	At other agencies (# of agencies)	Total	Labor
Youth	19	7	12 (5)	$2,848	$2,441
Veterans	16	4	12 (2)	1,092	175
Dislocated workers	10	8	2 (2)	1,647	1,574
Native Americans	10	1	9 (3)	121	64
Economically disadvantaged	9	3	6 (4)	3,220	947
Women/minorities	6	0	6 (3)	69	0
Migrants	5	1	4 (1)	100	86
Homeless	5	1	4 (3)	11	0
Older workers	4	2	2 (1)	562	46[illegible]
Refugees	4	0	4 (1)	109	0
Not categorized	75	10	65 (10)	10,635	1,094
Total	**163**	**37**	**126**	**$20,414**	**$6,844**

Consolidating federal employment training programs could probably reduce the cost of providing job training services because of the efficiencies achieved through eliminating duplicative administrative activities. Although the amount of money spent administering employment training programs cannot be readily quantified and is generally not even tracked by program, we believe it is substantial. For that reason, we identified consolidation of job training programs as an option the Congress could consider to reduce the deficit.[5] Alternatively, the Congress could spend the same amount of money and serve more people.

[5]Addressing the Deficit: Updating the Budgetary Implications of Selected GAO Work (GAO/OCG-96-5, June 28, 1996).

Further, consolidating similar employment and training programs could result in improved opportunities to increase effectiveness in service delivery. For example, consolidating programs could improve the assistance provided to the target populations because individuals would be more likely to receive the mix of services needed to achieve training or placement goals. And, getting needed services might be less confusing and frustrating to clients, employers, and administrators.

In anticipation of federal consolidation legislation, and to improve their local service delivery, many states are moving ahead with their own consolidation plans.[6] Labor has engaged in several efforts to assist states in these consolidation efforts. For example, Labor has promoted the development of "one-stop career centers." These centers are designed to transform an array of employment training programs into an integrated service delivery system for job-seekers and employers. Labor expects them to identify the jobs that are available, the skills they require, and the institutions that have proven track records of preparing people for new work. This information will probably be available largely through computer links. As of February 1996, 54 states and jurisdictions had received planning or implementation grants to establish one-stop centers.

In addition, Labor and the Department of Education jointly administer the school-to-work program--a program designed to build integrated learning and employment opportunities for youth. The proposed fiscal year 1998 budget includes $200 million for each agency to ensure that "seed capital" grants to states and communities continue.

Not only are Labor's employment training programs part of a fragmented system but, despite spending billions of dollars each year, many federal agencies operating these programs do not know if their programs are really helping people find jobs. From our past work, a common theme has emerged: Most agencies lack very basic information needed to manage their programs. In one of our reviews, we found that 60 percent of the 77 programs could not provide current and complete information on how many people were served in fiscal year 1993. Programs also lack outcome data. In our review of 62 programs targeting the economically disadvantaged, we found that less than half of the programs obtained data on whether or not participants obtained jobs after they received services.

To its credit, Labor has collected much basic information, including outcome data, on its major employment training programs, such as Job Corps and other programs funded under JTPA. It has also conducted some evaluations to assess the impact of its programs. However, our reviews have shown that existing performance measures and studies still do not provide the kind of information that would provide confidence that

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[6]The 104th Congress considered legislation to reform and consolidate federal employment training programs. Measures were adopted in both the House and Senate; but, after extended consideration, a conference report was not agreed upon.

funds are being spent to the greatest advantage of participants. Our reviews of the Job Corps program illustrate some of the weaknesses in current data collection and evaluation efforts.[7]

Job Corps is a national employment training program that provides severely disadvantaged youth with comprehensive services, generally in a residential setting, at a cost of about $1 billion a year to serve 66,000 participants. Job Corps has a list of performance measures on which the over 100 individual centers are ranked each year. Moreover, to demonstrate the effectiveness of Job Corps, Labor cites the positive results of a national impact study. We have raised questions, however, about how valuable the information from these sources is in determining whether the high costs are justified by program outcomes.

Jobs Corps reported that, nationally, 59 percent of its students obtained jobs in fiscal year 1993. However, when we surveyed a sample of employers identified in Job Corps records, we were left with serious concerns about the validity of reported job placement information. Despite Job Corps placement verification procedures, we found that about 15 percent of the reported placements in our sample were potentially invalid. In addition, we found that about half of the jobs obtained by students from the sites we visited were low-skill jobs--such as fast food worker--unrelated to the training provided by Job Corps.

The last comprehensive study of the effectiveness of the Job Corps program, which supported the cost-effectiveness of the program, was published more than 15 years ago. More recently, audits by Labor's Inspector General, media reports, and congressional oversight hearings have surfaced issues about the quality of training and outcomes. In 1994, Labor initiated a major impact evaluation of the Jobs Corps program. This study, the initial results of which are expected to be available in 1998, should be extremely useful to inform decisions about the future of the program.

Welfare Act Work Requirements Pose Challenges for Workforce Development Programs

The passage of the recent welfare reform legislation is likely to have an impact on the structure and delivery of employment and training programs at the state and local levels.[8] Because of the work requirements imposed by that legislation, many individuals formerly on welfare will be needing job assistance and training services. The responsibility for service delivery lies with state and local offices, yet Labor has an

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[7]Job Corps: High Costs and Mixed Results Raise Questions About Program's Effectiveness (GAO/HEHS-95-180, June 30, 1995).

[8]Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

important role because of its expertise and experience. Labor can encourage and facilitate, as appropriate, the integration of employment and training services that may be required to meet the needs of the welfare population.

How to serve those individuals transitioning from welfare to work, while at the same time meeting the service needs of dislocated workers and other client populations, is a challenge for Labor. Concerns have been raised about the availability of appropriate jobs, the level of training and skills required for jobs, the impact of competition for low-skilled jobs on the wages of low-skilled workers, and the extent to which the current employment training system can absorb and provide needed services to the expanded welfare population.

In addition, it is critical that Labor and other agencies providing services consider the employment training needs of welfare clients in the process of providing job placement assistance. Our work on promising employment training practices shows that providing occupational skills alone is not the answer. Equally, or perhaps even more, important are employability skills--the ability not only to get a job but to keep a job.[9] Concerns have been raised that in the rush to place welfare clients in jobs, if the appropriate mix of skills is not provided, many clients potentially will lose their jobs and go back on welfare.

It is too early to determine the direction or magnitude of the changes that will occur as a result of these pressures. At the same time, Labor can begin to monitor the situation and be responsive to the needs of states and localities as they transition individuals from welfare to work. For example, our work on identifying strategies used by successful employment training projects is the type of information that can be shared with states to assist their efforts.

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[9]Employment Training: Successful Projects Share Common Strategy (GAO/HEHS-96-108, May 7, 1996). In addition to improving employability skills, we identified three other key features that successful projects incorporated in their strategy: (1) ensuring participant commitment to training and getting a job, (2) removing barriers that might limit a client's ability to finish training and get and keep a job, and (3) linking occupational skills training with the local labor market.

OPPORTUNITIES EXIST TO IMPROVE
LABOR'S WORKER PROTECTION EFFORTS

When we testified before this Committee almost 2 years ago about the overall federal role in worker protection,[10] we stressed the need for Labor to change its approach to one that was more service oriented and made more efficient use of agency resources. Some evidence exists that Labor has moved in that direction, especially in OSHA. But this change has not been without controversy, and further opportunities exist to develop alternative regulatory approaches.

In addition to the overall need to consider alternatives to current regulatory approaches, Labor faces regulatory challenges in two specific areas: (1) redesigning the wage determination process under the Davis-Bacon Act and (2) as a result of recent legislative action, developing and enforcing regulations regarding portability of employer-provided health insurance.

Implementing Alternative
Regulatory Approaches

Labor, like other regulatory agencies, is faced with balancing the emphasis it places on different strategies for carrying out its mission. These strategies include (1) establishing workplace standards that directly set the terms and conditions of employment and relying on Labor's enforcement efforts, in combination with judicial review, to enforce these standards and (2) encouraging the direct resolution of workplace problems by the parties themselves. In a June 1994 report[11] describing actual employer and employee experiences with worker protection regulations, we summarized the concern of both employers and unions that agencies change their approaches toward regulation. They urged agencies to develop a more service-oriented approach: improving information access and educational assistance to employers, workers, and unions and permitting more input into agency standard setting and enforcement efforts. Responding to these concerns would put more emphasis on giving parties the tools to resolve problems themselves, as well as make enforcement less of a "gotcha" exercise and more one that recognizes good faith compliance efforts. These changes would also have the potential for improving the way limited agency resources are used for regulatory purposes.

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[10]Department of Labor: Rethinking the Federal Role in Worker Protection and Workforce Development (GAO/T-HEHS-95-125, Apr. 4, 1995).

[11]Workplace Regulation: Information on Selected Employer and Union Experiences (GAO/HEHS-94-138, Vol. 1, June 30, 1994).

Changes in OSHA's regulatory approach illustrate Labor's action in this direction. In May 1995, the administration announced three regulatory reform initiatives to "enhance safety, trim paperwork, and transform OSHA." This action was considered necessary because, despite OSHA's efforts, the number of workplace injuries and illnesses was still too high, with over 6,000 workers dying each year from workplace injuries and 6 million suffering nonfatal workplace injuries. In addition, the administration acknowledged that the public saw OSHA as driven too often by numbers and rules, not by smart enforcement and results. The first initiative, the "New OSHA," called for OSHA to change its fundamental operating paradigm from one of command and control to one that provides employers a real choice between partnership and a traditional enforcement relationship. The second initiative, "Common Sense Regulation," called for a change in approach by identifying clear and sensible priorities, focusing on key building block rules, eliminating or updating and clarifying out-of-date and confusing standards, and emphasizing interaction with business and labor in the development of rules. The third initiative, "Results, Not Red Tape," called for OSHA to change the way it works on a day-to-day basis by focusing on the most serious hazards and the most dangerous workplaces and by insisting on results instead of red tape.

OSHA has continued to operate with this approach, but it has not done so without criticism. For example, the administration's fiscal year 1998 budget request includes an increase of $8.4 million for OSHA's partnership initiatives. These initiatives include such activities as cooperative compliance programs, which build on the "Maine 200 program," initiated as a pilot in 1993. Cooperative compliance programs offer companies with high numbers of workplace injuries or illnesses a chance to conduct self-inspections to identify workplace hazards and develop worksite safety and health action plans. In return for such participation, these companies may have a lower priority on the primary target inspection list. For employers who decline the offer of a partnership, the traditional enforcement approach is used. According to trade news press, while many people have praised the partnership initiatives, others have raised questions such as the following:

- What data should be used to identify companies with high numbers of injuries (workers' compensation claims or claims rates or other data)?

- Has the effectiveness of the pilot effort been demonstrated well enough to extend it nationwide?

- Has the emphasis on partnerships been at the expense of effective enforcement actions against companies continuing to violate the standards?

Further opportunities exist for OSHA to leverage its resources and demonstrate "smarter" enforcement. For example, in a recent study, we found that the federal government awarded $38 billion in federal contracts during fiscal year 1994 to at least 261 corporate parent companies with worksites where there had been violations of safety and

health regulations.[12] We pointed out that agencies could use awarding federal contracts as a vehicle to encourage companies to improve workplace safety and health or–if companies refuse to improve working conditions–debar or suspend federal contractors for violation of safety and health regulations. One of our recommendations was that OSHA work with the General Services Administration and the Interagency Committee on Debarment and Suspension on policies and procedures regarding how safety and health records of federal contractors could be shared to help agency awarding and debarring officials in their decisionmaking. Labor recently told us that some discussions have occurred between OSHA and the Interagency Committee, but final decisions have not been reached on any new policies and procedures.[13]

Improving the Davis-Bacon
Wage Determination Process

The Wage and Hour Division within Labor's Employment Standards Administration has responsibility for administering the Davis-Bacon Act. This act requires that workers on federal construction projects in excess of $2,000 be paid the wages and fringe benefits that the Secretary of Labor determines to be "prevailing" in their locality for their class of worker. The act itself has been controversial throughout its more than 60 years of existence. Much of the controversy has hinged on whether Labor sets prevailing wage rates that are, in fact, higher than those prevailing in the area–thus artificially inflating federal construction costs.[14]

Labor has acknowledged weaknesses in its wage determination process that call into question the integrity and accuracy of some of its wage determinations. For this reason, it requested funds to develop, evaluate, and implement alternative reliable methodologies or procedures that would yield accurate and timely wage determinations at a reasonable cost. Labor's fiscal year 1997 budget request included $3.7 million for that purpose. The conference report accompanying the Department's appropriation requested that we review these implementation activities to determine whether they will achieve their goals. We will do so and report our findings to the Appropriation Committees, as requested, when Labor has completed its work.

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[12]Occupational Safety and Health: Violations of Safety and Health Regulations by Federal Contractors (GAO/HEHS-96-157, Aug. 23, 1996).

[13]Several newspaper accounts, however, have reported that in a Feb. 18, 1997, meeting with A.F.L.-C.I.O. leaders, the Vice President announced that the administration is developing guidance requiring a company's record on labor laws and violations of safety and health laws to be considered in awarding federal contracts.

[14]Davis-Bacon Act: Process Changes Could Raise Confidence That Wage Rates Are Based on Accurate Data (GAO/HEHS-96-130, May 31, 1996).

Labor took some actions that we recommended in our May 1996 report as a short-term solution to reduce its vulnerability to the use of fraudulent or inaccurate data in the wage determination process. These actions, including increased verification of information provided by employers, will at least reduce some of the vulnerabilities of the existing process. The larger challenge facing Labor, however, is to substantially examine and improve the overall process.

Health Insurance Portability

Labor's Pension and Welfare Benefits Administration (PWBA) has significant new regulatory, interpretive, enforcement, and disclosure responsibilities associated with implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These responsibilities stem from Labor's role in enforcing and administering the Employee Retirement Income Security Act of 1974 (ERISA), which regulates the 2.5 million private sector, employment-based health benefit plans that cover an estimated 125 million workers and their families. HIPAA amended ERISA to provide for improved portability and continuity of health coverage. The HIPAA portability provisions are designed to improve the availability and portability of health insurance coverage by (1) limiting exclusions for preexisting conditions and providing credit for previous coverage, (2) guaranteeing availability of health coverage for small employers, (3) prohibiting discrimination against employees and dependents on the basis of health status, and (4) guaranteeing renewability of health coverage for employers and individuals. These provisions will make it much easier for workers to change jobs and maintain health care coverage. And, according to Labor, millions more who have been unwilling to leave their job for a better one out of concern that they would lose their health care coverage would also benefit.

The Congress set a very short timeframe for implementing these protections: Although the act was only signed into law on August 21, 1996, the regulations to carry out the portability provisions must be issued by April 1, 1997. Labor is working with the Department of Health and Human Services and the Treasury Department to meet that date because these provisions–called "shared provisions"–involve overlapping responsibilities of the three departments. In a statement before the Senate Committee on Labor and Human Resources in February of this year, the Assistant Secretary of Labor for PWBA said the three departments are "on track" to meet that goal.[15] The regulations issued by April 1 will target the preexisting condition limitation and certification of previous health coverage portions of the portability provisions. The regulations will reflect comments received in response to a December notice in the Federal Register and will be fully effective when issued. Nevertheless, Labor intends to ask for public comments after they are issued and consider the need for any changes on the basis of the

[15]Statement of Olena Berg, Assistant Secretary of Labor, PWBA, before the Senate Committee on Labor and Human Resources, Feb. 11, 1997.

comments. Work will continue on other portions of the portability provisions after publication of the first set of regulations.

STATUTORY FRAMEWORK FOR IMPROVING LABOR'S MANAGEMENT PRACTICES

Adopting improved management practices can help Labor become more effective in achieving its mission of improving workforce skills and protecting workers. Recognizing that federal agencies have not always brought the needed discipline to their management activities, recent legislation provides a framework for addressing long-standing management challenges. The centerpiece of this framework is the 1993 Government Performance and Results Act. Other elements are the 1990 Chief Financial Officers Act, the 1995 Paperwork Reduction Act, and the 1996 Clinger-Cohen Act. These laws each responded to a need for accurate, reliable information for executive branch and congressional decision-making. Labor has begun to implement these laws which, in combination, provide a powerful framework for developing (1) fully integrated information about Labor's mission and strategic priorities, (2) performance data to evaluate the achievement of those goals, (3) the relationship of information technology investments to the achievement of performance goals, and (4) accurate and audited financial information about the costs of achieving mission outcomes.

Improving Mission Performance and Results

GPRA is aimed at improving program performance. It requires that agencies consult with the Congress and other stakeholders to clearly define their missions. It also requires that they establish long-term strategic goals, as well as annual goals linked to them. They must then measure their performance against the goals they have set and report publicly on how well they are doing. In addition to ongoing performance monitoring, agencies are expected to perform discrete evaluation studies of their programs, and to use information obtained from these evaluations to improve the programs.[16]

In moving toward an increased emphasis on program performance and results, Labor has begun developing an agencywide plan that describes its mission, goals, and objectives. According to the Office of Management and Budget (OMB), developing an overall mission and goals is a formidable challenge for Labor because of the diversity of the functions performed by its different offices. OMB officials have told us that the different offices in Labor have developed draft strategic plans that describe their respective goals and performance indicators. For example, ETA's plan describes its mission, its strategies for

[16]Executive Guide: Effectively Implementing the Government Performance and Results Act (GAO/GGD-96-118, June 1996) and Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

achieving its employment and training objectives, and the measures it will use to assess program outcomes. These plans were submitted to OMB with the Department's most recent budget submission. Although Labor is not required to submit the strategic plans to the Congress and OMB until September 1997, this year's early submission was used to obtain informal review and feedback on the draft plans.

According to OMB, Labor is committed to developing a strategic approach that includes measurable outcomes. OMB's review of Labor's plans indicated that some parts of the Department are doing better than others, especially in identifying measures to assess results. At the same time, OMB recognizes that developing such measures may be more difficult for some offices than for others because of the differences in the specificity of goals and difficulty of quantifying some outcomes.[17]

According to Labor, it is continuing to make progress in meeting GPRA legislative mandates. Over the next few months, Labor officials will continue discussions with OMB as well as consultations with the Congress and the stakeholders.

OSHA, as one of the GPRA pilot agencies, has been involved in a number of activities geared toward making the management improvements envisioned by the act. It has developed a draft strategic plan that identifies its performance goals and measures, and it has been working to develop a comprehensive performance measurement system that will focus on outcomes to measure its own effectiveness. OSHA and state representatives have discussed the application of this comprehensive system to OSHA's monitoring of state safety and health programs. Although we have not reviewed the quality of OSHA's performance measures, these types of planning and assessment efforts are consistent with those set out in GPRA to promote a results orientation in reviewing programs. This system, when fully implemented, will also be responsive to recommendations we made in a February 1994 report.[18]

Labor's decentralized organizational structure makes adopting the better management practices described in GPRA quite challenging. Labor has 24 component offices or units, with over 1,000 field offices, to support its various functional responsibilities. Establishing departmental goals and monitoring outcome measures is a

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[17]By June 1997, we will be reporting on the prospects for governmentwide compliance with GPRA.

[18]In Occupational Safety and Health: Changes Needed in the Combined Federal-State Approach (GAO/HEHS-94-10, Feb. 28, 1994), we recommended that OSHA emphasize measures of program outcome and evaluations of the effectiveness of specific program features as it assesses both its own activities and those of the state-operated occupational safety and health programs it is statutorily responsible for overseeing.

means by which the Department can ensure that its operations are working together toward achieving its mission.

Improving Financial Reporting

The CFO Act was designed to remedy decades of serious neglect in federal financial management operations and reporting. It created a foundation for improving federal financial management and accountability by establishing a financial management leadership structure and requirements for long-range planning, audited financial statements, and strengthened accountability reporting. The act created chief financial officer positions at each of the major agencies, most of which were to be filled by presidential appointment. Under the CFO Act, as expanded in 1994, Labor, as well as all other 23 major agencies, must prepare an annual financial statement, beginning in fiscal year 1996.

Since 1986, Labor has produced audited departmentwide financial statements, thus complying with this requirement of the CFO Act. Producing audited financial statements that comply with the act involves obtaining an independent auditor's opinion on the Department's financial statements, report on the internal control structure, and report on compliance with laws and regulations. By meeting these requirements, Labor has been instilling accountability and oversight into its financial activities. Labor also has a chief financial officer, in compliance with the act.

Improving Information Management
and the Use of Information Technology

The Paperwork Reduction Act of 1995 is the overarching statute dealing with the acquisition and management of information resources by federal agencies. The Clinger-Cohen Act of 1996 reinforces this theme, by elaborating on requirements that promote the use of information technology to better support agencies' missions and to improve program performance. Among their many provisions are requirements that agencies set goals, measure performance, and report on progress in improving the efficiency and effectiveness of information management generally--and specifically, the acquisition and use of information technology.

The Paperwork Reduction Act is based on the concept that information resources should support agency mission and performance. An information resources management plan should delineate what resources are needed, as well as how the agency plans to minimize the paperwork burden on the public and the cost to the government to collect the information. The Clinger-Cohen Act sets forth requirements for information technology investment to ensure that agencies have a system to prioritize investments. Clinger-Cohen also requires that a qualified senior-level chief information officer be appointed to guide all major information resource management activities.

Labor has made some efforts to improve its information management systems; for example, it has appointed a chief information officer. OMB, in 1996, raised a question regarding this individual's also serving as the Assistant Secretary for Administration and Management. The Clinger-Cohen Act requires that information resources management be the primary function of the chief information officer. Because it is unclear whether one individual can fulfill the responsibilities required by both positions, OMB has asked Labor to evaluate its approach and report back to OMB in a year.

In past work, we have identified weaknesses in Labor's information management practices. For example, our review of Labor's field offices demonstrated the lack of centrally located information on key departmental functions, such as field office locations, staffing, and costs. We eventually identified 1,074 field offices,[19] having constructed a profile of information about these field offices from information Labor provided.[20] But constructing this profile was difficult. In response to our request for this information, Labor's Office of the Assistant Secretary for Administration and Management queried the individual components and assembled a list of 1,037 field offices. We identified other offices using documents Labor provided, which brought the total to 1,056. When Labor reviewed a draft of the report, it amended the list again to add 18 more offices and bring the total to 1,074. Consequently, we had to report as a limitation of our findings that there was no assurance that all the information provided used consistent definitions and collection methods.

In our report on Labor's Davis-Bacon wage determination process,[21] we also identified limited computer capabilities as a reason for the process' vulnerability to use of fraudulent or inaccurate data. We found a lack of both computer software and hardware that could assist wage analysts in their reviews. For example, Labor offices did not have computer software that could detect grossly inaccurate data reported in Labor's surveys to obtain wage data. And the hardware was so outdated that the computers had too little memory to store historical data on prior wage determinations, which would have allowed wage analysts to compare current data with prior recommendations for wage determinations in a given locality.

The OIG cited areas in which Labor needs to improve its information management practices, especially those used to support financial accounting systems. For example, the OIG reported on ETA's system for accounting for the Job Corps program's real and

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[19]We defined a "field office" as any type of office other than a headquarters office--for example, a regional office, district office, or area office--established by a Labor component.

[20]Education and Labor: Information on the Departments' Field Offices (GAO/HEHS-96-178, Sept. 16, 1996).

[21]GAO/HEHS-96-130, May 31, 1996.

personal property. The OIG noted that ETA's systems were insufficient, relying primarily on manual spreadsheets; were not integrated with Labor's general ledger; and were not reconcilable to Job Corps contractor reports. As a result, there was insufficient accountability for Job Corps real property expenditures.[22]

This year, we added two new areas to our "high-risk" issues, both of which apply to Labor as well as to all other government agencies.[23] The first area, information security, generally involves an agency's ability to adequately protect information from unauthorized access. Ensuring information security is an ongoing challenge for Labor, especially given the sensitivity of some of the employee information being collected.

The second area involves the need for computer systems to be changed to accommodate dates beyond the year 1999. This "year 2000" problem stems from the common practice of abbreviating years by their last two digits. Thus, miscalculations in all kinds of activities–such as benefit payments, for example–could occur because the computer system would interpret 00 as 1900 instead of 2000. Labor, along with other agencies that maintain temporal-based systems, is faced with the challenge of developing strategies to deal with this potential problem area in the near future.

CONCLUSION

Labor's programs touch the lives of nearly every American because of the Department's responsibilities for employment training, job placement, and income security for workers when they are unemployed, as well as workplace conditions. Labor's mission is an urgent one. Each day or week or year of unemployment or underemployment is one too many for individuals and their families. Every instance of a worker injured on the job or not paid legal wages is one that should not occur. Every employer frustrated in attempts to find competent workers or to understand and comply with complex or unclear regulations contributes to productivity losses our country can ill afford. And every dollar wasted in carrying out the Department's mission is one we cannot afford to waste.

Labor currently has a budget of about $34 billion and about 16,000 staff to carry out its program activities. Over the years, however, our work has questioned the effectiveness of these programs and called for more efficient use of these substantial resources.

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[22]Office of Inspector General, U.S. Department of Labor, Semiannual Report to the Congress (Washington, D.C.: U.S. Department of Labor, Apr. 1-Sept. 30, 1996).

[23]High-Risk Series: Information Management and Technology (GAO/HR-97-9, Feb. 1997). See also, High-Risk Series: An Overview (GAO/HR-97-1, Feb. 1997) and High-Risk Series: Quick Reference Guide (GAO/HR-97-2, Feb. 1997).

Like other agencies, Labor must focus more on the results of its activities and on obtaining the information it needs for a more focused, results-oriented management decision-making process. GPRA and the CFO, Paperwork Reduction, and Clinger-Cohen Acts give Labor the statutory framework it needs to manage for results. Labor has begun to improve its management practices in ways that are consistent with that legislation, but implementation is not yet far enough along for it to fully yield the benefits envisioned.

We are hopeful that the changes Labor is making in its approach to management will help it better address the two challenges we have identified:

- developing employment skills through programs that meet the needs of a diverse workforce in the most cost-effective way and

- effectively ensuring the well-being of the nations' workers while reducing the burden of providing that protection.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee might have.

For more information on this testimony, call Harriet C. Ganson, Assistant Director, at (202) 512-9045. Joan Denomme and Jacqueline Harpp also contributed to this statement.

Mr. SHAYS. Thank you for your comments, and we will begin with Mr. Towns.

Mr. TOWNS. Thank you, Mr. Chairman. Let me begin with you, Ms. Joyner. You have had the opportunity to evaluate a lot of training programs during your tenure. What would you consider one of the best programs? Could you give, say, like some programs that you think are doing well that you have evaluated?

Ms. JOYNER. Well, there are several ways to look at the data. I think that the more or less recent studies that we have issued, what we did was look at not a fundings-free program, that is not to say whether it is JTPA, Title II(a) or Job Corps or anyone of those, but what we tried to do was to look at individual programs onsite and to see where they seem to be successful and what really made them successful, and we think that kind of critique is useful, particularly more so than trying to see whether all the programs funded in a certain way are useful—are really working.

And as I mentioned before, in our work on strategies used by successful programs, we identified four key characteristics that seem to be common to them. The Labor Department tells us that they are now using that information, trying to distribute that message through the JTPA programs, and then States are using it as they are trying to integrate their work force development activities.

I mentioned one of those, which was that the successful programs seem to be those that focus on employability skills, not just training them to be a welder, but how can they learn to get to work on time and why that is important; to identify the kind of barriers that face them, and to alleviate those barriers, whether it is child care or transportation, that sort of thing; and also to make sure that there is motivation to succeed, either to bring into their program the priorities to those people who are ready to change or help them develop that; or when you are doing discreet-skills development, to tie it to the local labor market needs rather than just train them in construction even if there are no construction opportunities where they have been trained.

Mr. TOWNS. Thank you. Youth programs have the same problem that many of the other agencies have, training programs. They are all over the lot. You have Veteran's Administration and they are everywhere. Isn't that part of our problem, that we cannot centralize them?

Ms. JOYNER. Well, it is. You are referring probably to the Table 2 in our testimony——

Mr. TOWNS. That is correct.

Ms. JOYNER [continuing]. Where we talk about, at least at that time, in 1995, the fact that there were 19 training programs that targeted youth—not just that youth could be in them, but really targeted toward youth; that seven of those programs were in Labor and that there were five different agencies——

Mr. TOWNS. In Veterans——

Ms. JOYNER. A total of five. Right. And the same thing with all of these. We think that is a problem. We think there are a couple of reasons why the multiple programs is a multiple series of problems. Again, although we cannot quantify the amount, we are certain that there are administrative—we are losing some money here administratively by running so many different programs.

It also is very frustrating for the young person. Let's say you want some job training. Where do you go? Which place do you go to? And you may go to one, and it is not the right one, so you have to start all over and go somewhere else, and so the service quality is not going to be as good as if you had a more integrated approach to work with this enrollment.

Mr. TOWNS. And I also think that in terms of duplication problems——

Ms. JOYNER. Oh, absolutely.

Mr. TOWNS. I think that is a real issue, and I think that is something that we cannot afford the luxury of that anymore.

Ms. JOYNER. That is right. To give you an example, one instance that the one-stop centers are trying to avoid is in the past when someone would go into one location, they might be given a test to find out what their interests and their skills were. They would fill in an application form, and then they would be sent somewhere else to get one piece of their service and do the whole thing over again.

And then if they need another service, another piece of the total package of what they need, they would have to go to another location, take another set of tests, fill in another application form. There was cost involved as well as the frustration to the person trying to get a service.

Mr. TOWNS. Based on the information that you have been able to collect and that you say, in terms of what you feel makes up an effective program, how do we get that information out to job-training programs in the State?

Ms. JOYNER. Well, we have been told by the Labor Department that they have—well, they asked for many copies of our report. I know that. I had their number at one time. And, in fact, when I testified before this committee as a result of that study——

Mr. TOWNS. I remember.

Ms. JOYNER [continuing]. The Assistant Secretary was here, and he said he made a commitment to get it out, at least through the JTPA system, and I believe he has, to the service-delivery areas. They have more recently told us that as they are working with States that are trying to approach job training in a more coordinated way, that they are supplying that information, and also what the Labor Department learned; they also issued a report a couple of years ago and what works and what does not in employment training, in education as well as in the employment training programs. I hope that they have been trying to make copies of that available throughout the country as well.

Mr. TOWNS. Good. Let me just switch over to you, Mr. Masten. Under the new welfare reform law, what will be the Department's role in ensuring that welfare recipients get effective employment counseling and training?

Mr. MASTEN. Mr. Towns, do you want to ask that question again? I want to make sure I understand exactly——

Mr. TOWNS. In the new welfare reform law, what is the Department's role in ensuring that welfare recipients get effective employment counseling and training? They would have a role in this, wouldn't they?

Mr. MASTEN. They would have a role in it. The number of training programs in the Department of Labor will play a major part in the strategy of getting a lot of the recipients off of the welfare rolls, but as far as the specific function of the Department of Labor the welfare reform legislation itself, I cannot give you the various specifics of it. All of the training programs in the Department of Labor will be part of the overall strategy to reduce the number of recipients on welfare.

Mr. TOWNS. Yes. But I would think they would be involved in counseling and training. I hope so.

Mr. MASTEN. That is right, but I am of the opinion that the GPRA-mandated legislation that is on the books that is forcing the Department of Labor, as well as the federally run agencies, to come up with outcome performance measurements, which sadly are the problems.

When I look at a training program as it involves welfare recipients and any other group, the bottom line, these individuals should be able to get jobs that will pay them a salary that will get them off of welfare and put them into a job which they have been trained for. It has been my experience that that has not been the case in most of the programs.

Mr. TOWNS. Right. Well, let me close it by saying that I think that your Department—the Labor Department, I should say—will play a major role in making certain that counseling, the kind of support of services, and whatever that needs to be done has to happen in order for this thing to be—for it to be successful or effective, and that I would just point it out that I am sure it is not your responsibility totally, but I think that you have a role, and I am happy to know at least that something is being discussed.

Mr. MASTEN. It is one of the problem areas. As I say, what I look at, I look at the bottom line of those training programs to get someone off of welfare. I grant you, in teaching them the skills to get them to work on time, to be able to conduct an interview, that is fine; but they should also be able to leave that area and get a job that is going to pay them a living salary. They should get a job in the area in which they have been trained for, and I think that is what the GPRA will demand that the Department of Labor and all the other agencies put on the table in the future.

Mr. TOWNS. Thank you.

Mr. SNOWBARGER. Let me followup. We have talked a lot about outcome-based performance measures. Other than the fact that you are now required to do this by law, what value is there in using the outcomes-based performance measures?

Mr. MASTEN. Well, for example, JTPA training; if you are trained to be an accountant or a junior bookkeeper, you are training to be a junior bookkeeper and you spend 18 months in that training, if you set the outcome measurement as being how many people get jobs as a bookkeeper as a result of the training, you will be able to determine if that program is working.

By the same token, if you add on the training and the return on the investment if that person was a recipient of welfare prior to going into that training program, is likely to get a job, and as a result of the training, get off of welfare, it is another measurement that would be in keeping with the GPRA.

Mr. SNOWBARGER. Prior to GPRA, what measures were being used?

Mr. MASTEN. The measurement was to get the person in any job, not particularly in the job for which they were trained.

Mr. GETEK. I would say entered employment; sometimes it was the number of hours worked. Some programs—for example, the Job Corps is 20 hours per week, would be one of the criteria. Some would measure the amount of dollars that were earned in a particular hour.

Mr. SNOWBARGER. And we are saying at this point that those are appropriate measures?

Mr. GETEK. Those are beginning measures. Those are more output measures. We think that over a period of time, someone needs to measure what the total outcome is and what the result is of those outcomes. And, again, somebody getting a livable wage over some period of time and holding a job for some period of time other than say, 20 hours a week, would give you some measure of the return on investment.

Mr. SNOWBARGER. How long have you been providing these kinds of programs?

Mr. GETEK. These programs go back to, I believe, the MDTA program, which was in the late 1960's.

Mr. SNOWBARGER. My final question is: why has it taken so long to figure out that we have not been measuring programs in the right way? Do you want me to make that rhetorical? I would be happy to.

Ms. JOYNER. Could I comment? I take your question to be a general one about result/outcome-oriented measurement, which is very important for job training, as it is important for all of Labor's activities, really. And I guess what I would say is that it is much easier to measure the short-term effects. It is much easier to measure what you are doing and the immediate output or what happens, how many got in a job, than it is to really know 2 years later whether they are self-sufficient.

That takes a greater expenditure of resources. Someone has to be willing to collect the data over that period of time, and ultimately, if you want to know if it was the program that was responsible, you might even need to do some sort of impact evaluations, which raises the cost up even higher. You might need to deny the program to someone in order to compare it, as is being done now with Job Corps.

If we need definitively to know the outcome, the impact, of Job Corps, you are going to have to compare it with a group that did not get Job Corps. That gets into issues of political acceptability, of your son cannot get into Job Corps because this is an experimental study.

Mr. SNOWBARGER. You mean that Job Corps may not do for their son what they have been told it would do.

Ms. JOYNER. Absolutely, because these people—programs are run by people who believe they are doing a good job, and I think, by and large, want to do a good job; so there is always a difficulty in convincing people that it will be better to forego giving this believed good to everyone for the sake of really knowing what works and what does not.

So I think absent a real, clear message, in fact, even from the Congress, that we believe it is worth spending some money to track these participants and get outcome measures and do the studies, but it has been a hard thing to do.

And I guess what I wanted to add is while we are on the issue of outcomes, is to look over some of the worker protection programs. Take OSHA as an example. OSHA has always been required in approving State-operated programs in which the States have the option to run their own programs, that the States had to have a program as effective as that of OSHA.

We did a lot of studies in the late 1980's and early 1990's on OSHA, and repeated: what is the issue? The OSHA had no idea how effective it was, so how was it going to know whether the States were as effective? And what was classically done was if you do things our way and the process measures match, we will believe the results are good. And in that area as well, we recommended and they agreed to, and are now moving toward actually establishing some results in that area, too. So that they are now holding inspectors accountable to cite people and to find violations. They are holding programs accountable to conduct special emphasis, let's say, on trenching or in construction that actually reduce injuries in construction.

So it is a focus on the results, not on some interim measure like citing them for violations.

Mr. SNOWBARGER. Well, then, a question to both of you is, is GPRA a sufficient message from Congress that we want to know the effectiveness of these programs, or do we need to be saying something more?

Mr. MASTEN. Well, I think it is very sufficient, and as I said earlier, not only just for the Department of Labor, but for the entire Government, because when you get the basic outcome, and then you know the return on your investment, the taxpayer will know whether or not it is worth putting the money out to have the program in the first place. And if it is not, then the decision comes back on Congress to do away with the program.

Mr. SNOWBARGER. Let me ask one final question, Mr. Chairman. You talked about 163 different programs in 15 different agencies, only 37 of them in the Department of Labor. Why did you let these guys do that?

Mr. MASTEN. I like your style.

Mr. SNOWBARGER. Like you say, I only have 1 year to do this, so I am going to take advantage of it.

But in all seriousness, here we have a Department of Labor who, I presume that your mission is, you know, employment and training administration, and yet you have only captured 37 out of 163 programs for your own little bailiwick here, I would think, just in terms of empire-building, you would want all of them in your department. But beyond that, I mean, it seems to me that somebody should have been telling us at some point that, wait a minute. You have that program; it is just over here, and you are duplicating if you are not on this program, or that particular concern can be accommodated with this program with just a little bit of flexibility.

Ms. JOYNER. I would say this is actually a point where your two panels today have something in common——

Mr. SNOWBARGER. Yes.

Ms. JOYNER [continuing]. Which is, here is a problem; let's create a new program to fix it, and then one ends up ultimately with lots of programs addressing the same general issue.

Mr. SNOWBARGER. Well, the thing that concerns me is not only duplication of programs, but the fact that we have got them spread over 15 agencies.

Ms. JOYNER. Right. In this case, you have the added factor. That is right.

Mr. SNOWBARGER. That means you have absolutely no coordination of those things. Again, I think your point is well taken with HUD. Why did they develop 240 without telling us, "We can do that already," or "Give us just a little bit more authority in this program, and we can do it there"?

Thank you, Mr. Chairman.

Mr. TOWNS. Let me just say this to Mr. Masten. You know, you have been before this committee on several occasions and I am impressed by you and I know that you are a knowledgeable person, and I just want to go back to something. I cannot leave it. I tried to go back to New York without raising it.

The form is a big thing. Let's face it, and everybody has to get up for it. You mentioned about the fact that if something is not working, then Congress needs to get rid of it.

But there are a lot of things that go into that process that we have to know in terms of information, in terms of being able to monitor it, so my question is basically this. Does the Department of Labor have the necessary personnel, computer system to monitor the employment counseling and training programs for welfare recipients throughout the country? Because it seems to me that that would fall under that department. I mean, that is my thinking, and I must admit, I cannot say. I have only been here a year.

Mr. MASTEN. OK. First of all, Congressman Towns, let me state for the record, when I said get rid of the program, I said, if the return on the investment was not sufficient. I gave the two comparisons of outcomes; I said, if it is not sufficient—then a decision will have to be made on whether or not to get rid of it. OK?

Not just get rid of it if it is not working, because we make recommendations on most of our audits as to what we believe will make a program better. We make those recommendations to give the program managers an opportunity to make them better. So if you can make it better, do it; but if you cannot make it better and the return is not adequate, then I am saying that their responsibility is to make a decision to get rid of it.

To answer your next question on whether or not the Department of Labor has a management information system——

Mr. TOWNS. In place.

Mr. MASTEN [continuing]. In place, the answer is no.

Mr. GETEK. It could be better because the role of the Federal Government, I do not believe, in the past few years has been what it ought to be. There is not enough monitoring out there of the things that you have just spoken about, the counseling and the other areas that affect people who are coming into the program. It is left, at least for JTPA, up to the Governors to institute systems.

The Employment and Training Administration has general oversight, but over the prior few years, there have not been a lot of Federal folks down there looking at whether people are getting counseling and education and those kinds of things, and I believe those were policy decisions. And for the program to work, I truly believe that you have to have an increased amount of Federal oversight. It has to work certainly in conjunction with the people at the local level, but it also has to be that level.

Mr. SNOWBARGER. Yes, Ms. Joyner?

Ms. JOYNER. If I could go back to the first part of your question and the previous one related, it is the comment about the relationship between the Department of Labor, its employment and training programs, and welfare reform. The point is to recognize, of course, that under welfare reform each State will be in control of what each State chooses to do, how they choose to implement their requirements for work.

They have some flexibility, not as much as they had in the past, as to what kind of training would meet the work requirement, and how in that State they are going to integrate their getting people on welfare into jobs with the existing job-training structure. So we have some interests in knowing and some concern that that may not operate as well as it might at the State level.

Basically, there have been different bureaucracies in each State. I mean, there are the people who do employment training, and there are the people who handle the welfare programs, and they had a job training program, as you know, specifically for welfare recipients. There have been several, most recently the Jobs Program, which now is—it is gone as an official program.

So there is the pot of money for the States to use, and our sense is that one of the things the Department of Labor, the Federal Department of Labor can do is a part of a more informal attempting, as we touched on before, more States are trying to do more integration, working with them.

It is not so much a matter of the Department of Labor telling them what they have to do—that is not a role that is envisioned for them in this—but it is more a matter, I think, of getting information out, making Department of Labor resources available. Also, from the standpoint of Labor-operated programs, dealing with potentially more people coming in and how to balance the needs of more former welfare recipients who now are needing job training—expanding even beyond the substantial number of welfare recipients who are already being aided by Labor programs.

Mr. TOWNS. Let me just say this. I understand the way we process and I understand flexibility and I understand one region might help find something to be successful and another region might—I understand all of that, believe me. Trust me, I do, but I think that somewhere along the line, you need to come up with a pilot project of some of the five States to be able to feed information in so we will know what we are doing. That is my concern.

This is a major effort we are going through here, and I think that we should have some data someplace, and I do not think we should just leave it to the States because, after all, it is still Federal money, that they are using, and that is my concern. And they are probably going to come back and back and back and back, and I

just would like to know what we are doing and what they are doing with that money, and then maybe we can learn something. That is all.

Maybe pick five States, seven States, or nine States, but I think that it has to be done in order for all of us to feel comfortable. I really do.

Ms. JOYNER. We have several studies under way. Some of them are in a group other than my own—our income security group—but we are also working with them trying to do some studies. As you suggest, we believe they need to be done to see what is happening in States and how the job-training needs and job-placement needs of welfare recipients are being met in different States and what can we learn from that.

Mr. TOWNS. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. One of the reasons why I believe we have lots of different programs and similar programs in different departments is that each chairman of the standing committee wanted a little piece of the action, and they did it through their committee. It never ceases to amaze me. My first surprise when I was a freshman was, why did the Department of Agriculture get into housing? But we have rural housing that goes through them. That was always a surprise to me.

But the way HUD views its responsibilities, they view their need as interdisciplinary, so they are going to focus in on recreation, and they are focusing in on job training, and Labor is going to focus in on that. One of the big things that we tried to do, in the Republican Congress last time around was we tried to use some task force, so we would start to use three committees that we deal with. We have one committee dealing with one department and another committee dealing with another department and another committee dealing with another department, but they all dealt with the same issue, and we tried to bring it all together.

Our problem is that we tried to overreach. I do not think we are going to significantly reorganize the Department of Labor, but I wonder if, like with HUD, if there should not be some reorganization. So my first question is going to deal with the program agencies.

I want each of you to tell me the program agency that you think is run the most efficiently and the one that has the most challenges.

Mr. MASTEN. I could really take a stab and say the OIG is definitely in—[laughter.]

There is no question about that.

Mr. SHAYS. Now, where do I see that on program agencies up there?

Mr. MASTEN. I have a small program within the OIG. I will tell them about it.

Mr. SHAYS. OK.

Mr. MASTEN. First of all, Mr. Chairman, we have not done an audit to discern——

Mr. SHAYS. And I do not want this to come back and haunt you in the Department, and they say, "What do you mean?" I will put it this way: Which are you the least concerned about, and which do you have the greatest concern?

Mr. MASTEN. At this point, I am least concerned about BLS.

Mr. SHAYS. OK. I am going to ask you to——

Mr. MASTEN. OK.

Mr. SHAYS [continuing]. Basically because they have had an ongoing mission, it is pretty consistent year to year and so on.

Mr. MASTEN. Exactly.

Mr. SHAYS. OK.

Mr. MASTEN. And I would have—so I would like to say I have more concern with the Employment and Training Administration——

Mr. SHAYS. OK.

Mr. MASTEN [continuing]. Because it encompasses most of the training programs that are part of the strategy of the new welfare reform and getting the welfare recipients off the rolls. So that would be a major concern, because they have the programs that are going to arrange a part of that strategy.

Mr. SHAYS. Now, you are going to tell us the relationship that you have with your subordinates, whether they feel they can be totally up front and honest without having any judgment on your part.

Mr. MASTEN. That is really the position that I am in now, because they are totally up front. [Laughter.]

Mr. SHAYS. So where would be——

Mr. GETEK. You have to go where the money is, and that is the Employment and Training Administration——

Mr. SHAYS. OK.

Mr. GETEK [continuing]. And they have an impact on a whole lot of things, and the proposals that are coming out for welfare reform certainly are going to affect the Employment and Training Administration.

Mr. SHAYS. OK. Well, Ms. Joyner?

Ms. JOYNER. Well, first of all, your question about most efficiently managed, I would not have a basis to answer that at all.

Mr. SHAYS. OK.

Ms. JOYNER. We have not—we did——

Mr. SHAYS. What shows up on your radar screen the least?

Ms. JOYNER. We also have organizationally that another unit, and I have to admit, within GAO rather than my own that does more work with the pension and welfare benefits.

Mr. SHAYS. OK.

Ms. JOYNER. But I know that they have had some concerns in the past, which are less so now, about some of the pension issues and enforcement issues there. I would share my colleague's concern.

We, too, try to follow the dollar, and if you are looking at things that you have gotten in the Employment and Training Administration with a large flow through of money there, that would certainly be one that is on the screen. Let me put it that way.

Mr. SHAYS. OK. Which is the one that shows up the least in matters, you hear about the least, the least criticism?

Ms. JOYNER. I really am uncomfortable with that.

Ms. GANSON. I would echo that I do not have a basis for taking an opinion on which is the most efficient. I would say that the Employment and Training Administration definitely has the challenge

of dealing with all these different employment and training programs.

I would also say that the Occupational Safety and Health Administration has a real challenge in terms of changing the way it operates——

Mr. SHAYS. Yes.

Ms. GANSON [continuing]. Which it has over time, and I think is really in the spirit of GPRA in terms of becoming more customer-oriented.

Mr. SHAYS. The bottom line there is we know that if they had to inspect every facility, they would do it about once every hundred years.

Ms. GANSON. Yes.

Mr. SHAYS. So they have to—the main project and——

Ms. GANSON. Right. So I do think that they are, in terms really taking that challenge head on.

Mr. SHAYS. Now, we have not talked much about—first, when you talked about employment, is it fair for me to think of the Veterans' Employment and Training Services faced some of the same challenges as the Employment and Training Administration? Do you have some of the same challenges?

Mr. GETEK. The programs are similar, except you are targeting the veterans' groups certainly, and——

Mr. SHAYS. But it surprised me when I was in the State of Connecticut as a Member of Congress, that I was talking about how we did not have any veterans' assistance in our land, and then I found out the Department of Labor did. You know, the VA did not, but the Department of Labor did, and that was just surprising to me how we were——

Ms. JOYNER. Well, it is somewhat different, too, in that the major activities under the Veterans' Employment Training Services are the people that they find at employment service centers—employment offices around the country. The LVERs and the DVOPs—we'll have to think what all this stands for—but there are people who are designated to work with disabled veterans and other veterans in general.

They are federally funded, but they are working under the direction of the State programs, so that when an unemployed person goes into the Employment Service and says, "I am looking for work," if you are a vet, then you immediately are provided with assistance from these people onsite. What, in fact, we are doing is, starting now, is responding to a request from the House Veterans' Affairs Committee to try to find out more about how that is working. But it is quite different from, say, funding a JTPA program for youth. That is a different kind of activity program.

Mr. SHAYS. When the private sector looks to Government, they use as their guideline basically three people at the most should make a decision on one issue. Then there is some sense of ownership and some sense of worth on the part of the employee. In the Federal level sometimes I hear numbers of 9 or 10 people make a decision; therefore, no one feels they have made a decision.

And I am wondering when we talk about—I am leading this to HUD, but you all could respond to it—I am just wondering if in the whole process of downsizing, if we are able to restructure so less

people have to pass judgment, when they are, in fact, gone, we might not have enough people to do the job.

Ms. JOYNER. It might have an increased sense of accountability on the part of each person.

Mr. SHAYS. Well, that would be one obvious benefit, but I guess what I am saying to you is, if we continue the same structure where everyone has to pass judgment, then you may need a lot more people; but if we are willing to have less people make the decision, I am wondering if then we would not be able to develop enough.

I think the big challenge for Government is our pay scale, particularly in terms of Social Security, but I could say it for the Department of Labor and HUD as well. The most that we pay that employee as a Federal employee might be $120,000, where if they were in the private sector, they would be making hundreds of thousands of dollars, and this, in some cases, forces us to hire outside consultants because we cannot get the top-skilled person always. We have a lot of skilled people, but they take a significant reduction, particularly on the systems side.

Another question: Let me just end with this issue. I asked you in terms of the administration within the program agencies, and you were in some cases telling me about the program as well and weighing that in your decision of which might be the one with the biggest challenge. When I look at the pension and welfare benefits and wonder if that is not a gigantic potential problem for us, based on some of your comments, what is the biggest problem as it relates to pensions?

Mr. MASTEN. First of all, Mr. Chairman, understand that the pension system involves so much money, it provides the opportunity for a lot of fraud and abuse. It also draws very sophisticated and very intelligent people into that system who can mask fraud and abuse at certain levels and so timely to determine this.

Mr. SHAYS. OK.

Mr. MASTEN. Because of some of the controls that are in place now, fraud could be taking place in any number of areas many, many years prior to it ever coming to light——

Mr. SHAYS. Interesting.

Mr. MASTEN [continuing]. Because we simply do not have control procedures in place to catch it. The audit was—excuse me—John can go into more detail on it, but that is one of the biggest things. There is so much money there and so much opportunity for fraud and abuse, it is so timely to detect.

Mr. SHAYS. OK.

Mr. GETEK. Repealing the limited-scope audit provision, we believe, will go a long way because then you will have the public accounting firms that are doing the audits now giving an opinion on all of the dollars.

Mr. SHAYS. Why do we have a limited-scope audit? What was the basis for that?

Mr. GETEK. I believe when the ERISA laws were passed, institutions like savings and loans and regulated insurance companies were exempt because they believed they were reviewed enough, but obviously the savings-and-loan crisis that we are aware of causes some questions in that area.

When an accountant gives an opinion, it certainly shows the amount of work that they have done. When they do not give an opinion, there is no review of the assets that are in the plan. Removing the limited scope provision certainly goes a long way to ensure that the control environment is there and if there is something wrong, that people, who are in positions of authority, will be alerted.

Mr. SHAYS. OK. Now, and the political restraint is just that the organizations would be fighting us to not have the kind of——

Mr. GETEK. Well, we believe—AICPA is in favor of this now, I believe, as well as the GAO.

Mr. SHAYS. OK. Any other comment about the pensions? OK. I am going to end, unless my colleagues have any questions, just asking each of you to tell me the one question that you wish we had asked.

Mr. MASTEN. One of the questions, obviously enough, is how my office can continue to do more with less when the program agencies are given more responsibility and more money to initiate programs for which I am going to have oversight responsibility. With my financial resources, how am I going to be able to take on the additional responsibility and carry out my mission?

Mr. SHAYS. And just briefly tell me what were your resources 2 years ago versus now. Are they about the same, or they have gone down?

Mr. MASTEN. Down. They have definitely gone down, Mr. Chairman. In fact, I recall that I had to go to the Secretary in this last go-round and ask for $500,000 so that I would not have to lay off anyone.

Mr. SHAYS. OK. But is your personnel still pretty static, or is it actually——

Mr. MASTEN. My personnel has gone down as well because it was mandated that we get down to a certain FTE every year to the year ninety——

Mr. SHAYS. Nine.

Mr. MASTEN [continuing]. 1999, and we have not met that. In addition to the need for resources, we have the oversight responsibility. We have had to rearrange our entire priorities in order to address certain things. We do not have money, for example, to conduct national audits. We have to go to small audits and change our priorities, and that leaves the big problem that you had focused on.

Mr. SHAYS. Well, we have five departments to oversee, and I think that we made a decision that we were going to focus on HHS, and basically in Labor I feel that we focus the least amount on, and there I think that we have to do a lot more this year. The advantage is that we have staff now who have worked for 2 years, so I feel like we are going to be able to accomplish a little bit more, and I really look forward to seeing if we can provide a little more oversight on our side, and we might be more sympathetic for your position, too, as well. We will not ask you to do more, though.

OK. Ms. Joyner, a question that you wish we had asked or——

Ms. JOYNER. Yes. It is a matter of following up on the amount of inquiry that you were following earlier, when you talked about the different departments and which ones faced the most challenges and which were most efficiently run and so forth, and trying

to work across the different program agencies. I was hoping that you would then go ahead and ask what could be done to integrate the activities and really focusing on a smaller number of issues instead of focusing on the broader issue——

Mr. SHAYS. I would like to ask you to respond to that question. I mean, we get involved in reorganization. The committee gets involved in establishing the price, but the whole issue of reorganization is an issue that we did not spend any time on in the last years, and it is something I am eager to get into.

Ms. JOYNER. OK.

Mr. SHAYS. So do you want to just give me a taste of what you might suggest?

Ms. JOYNER. OK. Yes. But what I think will play—will help in this regard is not necessarily the boxes on the chart——

Mr. SHAYS. Yes.

Ms. JOYNER [continuing]. But it is, in fact, your consultation role with the agencies, as required by the Government Performance and Results Act. They are expected to come up with agency-wide mission statements and goal statements and measures that they will use to track performance toward that. I would encourage you to ask them to talk with you about their worker protection activities as a whole rather than what is OSHA doing, you know, what are each of the other agencies doing, too. How are you pulling together all of your resources in the whole department toward that particular part of your mission, and how might you improve that, and how will you tell me next year what result, what progress you made toward it, and, similarly, in any other mission.

Mr. SHAYS. The individual we would call I would think would have a primary responsibility to the under secretaries in each of the departments.

Ms. JOYNER. I am not sure how the departments are handling their consultation with——

Mr. SHAYS. The under secretary in Labor is really the management person whose prime responsibility is——

Mr. MASTEN. The deputy secretary.

Mr. SHAYS. I am sorry. I call it the "under secretary," and you call it the "deputy secretary"?

Mr. MASTEN. Right. The under secretary, I believe, was in the good old days.

Mr. SHAYS. OK. The No. 2 person in the department is the one who is usually in charge of the administrative function.

Mr. MASTEN. That is correct.

Mr. SHAYS. OK. Well, you have whetted our appetite, and this is really the purpose for these hearings, and I thank you very much, and we look forward again to working with you. And it is something that I just think we have a lot of opportunities, so I look forward to that.

I will say to you, my sense is that this Republican Congress—it tends to not focus a lot of time and attention in a favorable way on the Department of Labor—is going to be a little more receptive to making some significant changes without feeling like we have to totally reinvent the Department of Labor. And I think if that is the case, then we might see some real progress.

Do you have any comment you want to make?

Mr. TOWNS. No. Thank you, Mr. Chairman.

Mr. SHAYS. Do you feel a lot better having asked that one question that you were considering waiting and going home and not asking? Do you feel better now?

Mr. TOWNS. I feel much better, Mr. Chairman.

Mr. SHAYS. Thank you very much. This is a partnership, if you do not know, among all of us. Thank you. I will now close this hearing.

[Whereupon, at 4 p.m., the subcommittee was adjourned.]

OVERSIGHT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE DEPARTMENT OF VETERANS AFFAIRS: MISSION, MANAGEMENT, AND PERFORMANCE

TUESDAY, MARCH 18, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, Gilman, Pappas, and Kucinich.

Staff present: Lawrence J. Halloran, staff director and counsel; Robert Newman, and Marcia Sayer, professional staff members; R. Jared Carpenter, clerk; Ron Stroman, minority professional staff; and Jean Gosa, minority administrative clerk.

Mr. SHAYS. I'd like to call this hearing to order and to welcome our witnesses and our guests, as well. This hearing continues the subcommittee's review of the cabinet departments within our oversight jurisdiction. We asked the Inspectors General, the IGs, and the General Accounting Office, or GAO, to comment on the mission, management, and performance of the Department of Health and Human Services and the Department of Veterans Affairs.

Together, these two Departments will spend $417 billion next fiscal year—fully one-quarter of total Federal outlays. Seventy-seven percent of those outlays, or $320 billion, will be spent purchasing or providing health care.

In the last Congress, this subcommittee held eight hearings examining ways to improve the Federal effort against health care fraud. Our persistence, particularly that of our subcommittee colleague, Mr. Schiff, was rewarded when these proposals were included in the Kennedy-Kassebaum Health Care Bill signed by the President.

The most significant of those proposals made fraud against all health care providers a Federal criminal offense. Consistent with legislative proposals offered by the subcommittee's ranking member, Mr. Towns, the new law also gives the Department of Justice, the HHS—Health and Human Services—IG, and others increased stable funding to wage the fight against health care fraud.

So some progress has been made to improve the performance and protect the integrity of Federal health care programs. But, as we

will hear in today's testimony, HHS and VA programs remain vulnerable to waste, mismanagement, and fraud.

Our subsequent oversight hearings and the focus of our consultations with the departments on the implementation of the Government Performance and Results Act will be guided to a great extent by the views expressed today by our capable oversight partners, the Inspectors General of the General Accounting Office.

And so, again, I'd like to welcome our guests and recognize our two members, Mr. Snowbarger, who is the vice chairman of the subcommittee. Do you have any opening comments?

Mr. SNOWBARGER. No. Thanks, Mr. Chairman.

Mr. SHAYS. Our gentleman from New Jersey, would you like to make a comment?

Mr. PAPPAS. No, thank you.

Mr. SHAYS. OK. Now, I would note that presently we have no member from the minority side here. Mr. Towns, who has been a very faithful partner, is still in New York. But this is the kind of hearing that, frankly, we work on a bipartisan basis, and sometimes I've left this committee and given the gavel to Mr. Towns. So we're equal partners in this process. And I'll invite the minority counsel to ask questions if there's something the minority feels that we need to get on the record.

So we'll do that. And at this time, we have before us Ms. June Gibbs Brown, the Inspector General of the Department of Health and Human Services, and Michael Mangano is accompanying her; he will not have a statement, but will respond.

And then Richard Hembra, Assistant Comptroller General for Health, Education and Human Services, General Accounting Office, accompanied by Marsha Lillie-Blanton, and also Thomas G. Dowdal.

Mr. DOWDAL. Dowdal. Right.

Mr. SHAYS. Did I say it right?

Mr. DOWDAL. Yes.

Mr. SHAYS. OK. What I need to do, as you know, we swear in Members of Congress, we swear everybody who comes before the committee, and that way we don't have to get into a value judgment. So we're just going to do what we always do.

[Witnesses sworn.]

Mr. SHAYS. OK. For the record, all our witnesses have responded in the affirmative, and we will start with you, Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman.

Mr. SHAYS. And I'm going to ask that you turn that mike on. We're going to use the clock only as a basis of knowing how long you've spoken. But we want your statement on the record. And actually, if I could, two housekeeping things before we begin. I would ask unanimous consent that all members of the subcommittee be permitted to place any opening statement in the record and that the record remain open for 3 days for that purpose. Without objection, so ordered.

And I ask further unanimous consent that all witnesses be permitted to include their written statements in the record. And without objection, so ordered. We're going to have the clock on for 5 minutes and then we'll roll it over again. OK? And just do it auto-

matically. Leave it on red for a second, just so we keep track. And then flip it again.

Is the other mike not working? Seriously? You know, before we begin, I'd just like to see if it's plugged in here, Jared, so——

Ms. BROWN. I think it's the switch.

Mr. SHAYS. And then if you could just check. Yes. That is on.

STATEMENTS OF JUNE GIBBS BROWN, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; RICHARD L. HEMBRA, ASSISTANT COMPTROLLER GENERAL FOR HEALTH, EDUCATION AND HUMAN SERVICES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY MARSHA LILLIE-BLANTON, ASSOCIATE DIRECTOR FOR HEALTH SERVICES, QUALITY AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE; AND THOMAS G. DOWDAL, ASSISTANT DIRECTOR FOR HEALTH FINANCING AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE

Ms. BROWN. Thank you, Mr. Chairman, for the opportunity to present this panel what we think are some of the greatest challenges to the HHS program outlays.

Mr. SHAYS. OK.

Ms. BROWN. I would like to single out for your consideration three program areas in Medicare, home health, hospice, and durable medical equipment.

Far and away, the home health benefit is one, of the most vulnerable components of the Medicare program. Expenditures have increased five-fold. The number of visits has more than doubled over the past 6 years, from $3.5 billion, for approximately 2 million beneficiaries, in 1990, to $16.9 billion for 3.7 million beneficiaries, in 1996.

By comparison, spending in the Medicare program as a whole grew 84 percent over that same period. Unfortunately, fraud and abuse significantly impact the high growth rates of home health. We have now completed audits of eight home health agencies in Florida, Pennsylvania, and California. These audits revealed error rates for these agencies ranging from 19 to 64 percent. We found visits that were not reasonable or necessary, patients that were not home-bound, services not properly authorized by a physician, and bills for services not rendered.

Preliminary data from additional audits underway in the other States indicate similarly high error rates. We also found extreme and seemingly unjustifiable variation in services rendered by home health agencies, with an average of 33 visits per episode for lower cost providers and 102 for higher cost agencies. We have recommended more effective reviews of home health agencies, case management, adequate funding of fiscal intermediaries, and more involvement of beneficiaries through explanation of benefits and their own certification for home bound status.

However, the problems are so pervasive that a legislative restructuring of Medicare's payment system is called for. Options include prospective payment, capitation payments, beneficiary cost-sharing, and benefit targeting. We are also concerned about the

substantial growth in Medicare payments for the lengths of stays for patients in hospice care.

Our 1994 review of Medicare hospice eligibility in Puerto Rico disclosed large numbers of hospice beneficiaries who were not terminally ill and, therefore, not eligible for the benefit. Twenty million dollars was inappropriately paid for services rendered to them. In audits of 12 large hospices located in Illinois, Florida, Texas and California, we found that 65 percent of the patients who were in hospice over 210 days, or 7 months, did not qualify for the benefit. These audits identified $83 million in overpayments.

A particular vulnerability exists with regard to hospice services provided to nursing home residents. We will continue to investigate hospice providers who are blatantly enrolling Medicare beneficiaries that do not qualify for the benefit. HCFA took strong action to resolve the problem in Puerto Rico, including decertification of problem providers. So we know that strong management action can go a long way to solving this problem.

However, we believe that congressional action is also warranted. We recommend legislation to reduce Medicare payments after 210 days. This would provide appropriate incentives to the hospices to enroll only those beneficiaries who meet Medicare guidelines, while still affording them some financial protection and resources to care for patients who live longer than expected. We also recommend reducing hospice payments for patients living in nursing homes to more accurately reflect the increment of additional services provided by the hospices to them.

More progress has been made in dealing with this problematic area. Particularly, HCFA established four durable medical equipment regional carriers, or DMERCs, who specialize in making Medicare payments for these items. Unfortunately, we continue to see problems in the durable medical equipment. Our studies have found overutilization of wound care supplies, overutilization and false billing of incontinence supplies, fraudulent billing for body jackets, and excessive payments for oxygen services, nebulizer drugs and interim nutrition therapy. Like the hospice program, problems are particularly pronounced in a nursing home setting.

I am happy to report that in addition to discovering problems, we are also developing new and effective ways to deal with them. One good example of this is the problem with incontinence supplies. And I have a chart here which I would like to call your attention to. Our exposure of these billing abuses couple with a coordinated national investigation involving more than 20 separate cases in a concentrated effort by the Health Care Financing Administration's durable medical equipment carriers, has turned the escalated reimbursements downward. By the end of fiscal year 1995, the abusive practices we identified had all but disappeared, and Medicare is now saving more than $104 million per year as a result.

While such administrative remedies can be effective, we believe that fundamental reforms are also needed. We recommend legislation to authorize competitive bidding, to make it easier for the Health Care Financing Administration to reduce inherently unreasonable payment levels, and to fold payments for some supplies into the payments made to nursing homes.

Home health, hospice and medical equipment and supplies are serious vulnerabilities. We have other concerns, as well, and we continue to find false bills for lab services, excessive prices for prescription drugs, and inappropriate billing of hospital outpatient services, for example. Once again, I appreciate the opportunity to appear before you today and share with you some of our concerns related to waste, fraud and abuse in HHS programs.

I'd be happy to respond to any questions.

[The prepared statement of Ms. Brown follows:]

HHS High Risk Areas:

Home Health, Medical Equipment and Supplies, and Hospice Benefits.

Testimony of
June Gibbs Brown, Inspector General
Department of Health and Human Services

Hearing before the
House Committee on Government Reform and Oversight

- Subcommittee on Human Resources

March 18, 1997

Office of Inspector General
Department of Health and Human Services

March 18, 1997

Testimony of
June Gibbs Brown, Inspector General
Department of Health and Human Services

Good Morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services. I am accompanied by our Principal Deputy Inspector General, Michael F. Mangano. You asked our office to identify areas of waste, fraud, abuse, and opportunities for cost savings in the Department's programs. We continue to believe that the greatest challenges and opportunities lie within the Medicare program, specifically in the areas of home health, medical equipment and supplies and hospice benefits, especially when provided in nursing facility settings. Today, we will provide you an update of our work on these subjects.

As this Subcommittee is aware, Medicare is one of our nation's most important social programs. It provides health care coverage for more than 38 million elderly or disabled Americans. Because of the huge sums of money being spent, $191 billion in FY 1996, there will always be individuals or companies that attempt to defraud the Medicare program. It is not enough to simply identify improper billings and recommend recovery of the Medicare reimbursements. As we gain more understanding of these abuses, we also explore the root causes of the vulnerabilities and work with the Health Care Financing Administration and the Congress to bring about positive protections in the programs. First, I would like to review our experience with the Medicare home health benefit.

HOME HEALTH

Medicare Part A pays for home health services for beneficiaries who are homebound, in need of care on an intermittent basis, and under the care of a physician who both establishes a plan of care and periodically reviews it. Beneficiaries receive numerous services including part-time or intermittent skilled nursing care and home health aide services, physical speech and occupational therapy, medical equipment and supplies, and medical social services. The benefit is unlimited as long as the services are considered medically necessary.

Rapid Growth. The home health benefit is one of the fastest growing components of the Medicare program. In FY 1990, Medicare spent $3.5 billion for home health services for approximately two million beneficiaries. By FY 1996, expenditures had grown five-fold to $16.9 billion, and the number of beneficiaries increased to 3.7 million. Home health expenditures now account for 8.8 percent of total Medicare spending, compared to 3.5 percent in 1990. In addition to the increasing number of home health beneficiaries, utilization has doubled, from an average of 36 visits per Medicare beneficiary receiving home health benefits in 1990 to 76 visits in 1996. The Congressional Budget Office estimates that spending for home health services will reach $31 billion by 2002.

The reasons for the rapid growth of home health expenditures are numerous. Some of the growth is appropriate and expected due to changes made to the benefit, demographic trends, and

technological advances. Court cases have also liberalized coverage of the benefit so that more beneficiaries can receive care for longer periods. There are many new medical technologies, such as infusion therapies, which can now be provided at home that in past years would only have been delivered in hospitals. In addition, we know that a growing and aging Medicare population will result in increased home health costs. The trend toward providing more care in the community instead of institutions has also impacted the use of home health services. Finally, growth can be attributed to the fundamental structure of the benefit as well as problems with the management of the home health benefit.

Fraud and Abuse. Unfortunately, fraud and abuse also significantly impact the high growth rates of home health. Over the past several years, we have issued evaluations and audits that have identified numerous types of fraud and abuse problems. The home health benefit is particularly susceptible to exploitation compared to other types of health services because the care is provided in patients' homes with limited supervision.

We have now completed audits of eight home health agencies in Florida, Pennsylvania, and California. These audits revealed that the agency error rates--the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines--varied from 19 to 64 percent. We found visits that were not considered reasonable or necessary, visits for patients who were not homebound, visits improperly or not even authorized by a physician, and visits which were not provided to Medicare beneficiaries. Preliminary data from additional audits underway in other States indicate similarly high error rates. We are therefore concerned that such high error rates may be commonplace.

Unexplained Variation. We are also concerned about the extreme variation in payments to home health agencies and the fact that such variations are growing without clear justification. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies (those with visits per episode above the national average) provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102. We found that private for-profit home health agencies tended to be the more costly. Additionally, we have found that home health agencies in four southeastern States--Tennessee, Alabama, Mississippi, and Georgia--averaged twice as many visits per Medicare beneficiary as home health agencies in all other States. These four States averaged approximately 100 visits per episode compared to approximately 54 for all other States.

Our analysis indicates that beneficiary age, race, gender, qualifying condition, principal diagnostic codes, and overall quality of care do not account for these variations. It appears to us that the differences are due mostly to the discretion afforded home health agencies to influence the amount of care given to their clients.

Looking for Solutions. Our work has shown repeatedly that there is a need for greater control and protection from fraud and abuse. However, we must proceed cautiously to ensure that any measures to control the benefit do not harm those beneficiaries who truly need these services. Our focus must be on protecting the benefit as well as controlling expenditures and minimizing the potential for fraud and abuse.

To learn more about how this might be done, we examined practices of private insurance companies, State Medicaid agencies, the Department of Veterans Affairs, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and numerous health maintenance organizations (HMOs) manage their home health care programs. While their benefit structures were similar to Medicare's, they did try to control costs in ways that Medicare does not. For example, some place limits on the number of visits or caps on the dollar amount that can be paid. Many tried to target their programs more specifically to the individualized needs of their beneficiaries. They also undertook more intensive utilization control measures such as reviews of physician referral rates, post-pay edits, and utilization profiling combined with physician education.

We found that HMO's provide home health care for only one-fourth the cost of the Medicare fee-for-service program. The HMOs that responded to our survey spent an average of $882 per beneficiary in 1994 compared to Medicare's fee-for-service cost of $3,464. They do this by using case managers to review and approve patient care. These case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes and cost savings on a monthly basis, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. They carefully control both the number and kind of visits, constantly evaluating the care provided.

Administrative Remedies. Based on these practices and on our own analysis of weaknesses which we found, we have made several recommendations aimed at controlling Medicare expenditures and reducing the potential for fraud, waste and abuse. These recommendations include more effective reviews of home health agencies, funding case management programs in the fiscal intermediaries, ensuring that fiscal intermediaries have adequate resources to detect inappropriate claims, and requiring beneficiaries to certify their "homebound" status.

Legislative Changes. However, we believe that management actions like these will not be sufficient. The problems are so commonplace that a restructuring of Medicare's payment system is called for. Options include prospective payment, capitation of payment for services, beneficiary cost sharing, and benefit targeting.

Given the current rapid growth rate, substantial savings can be attained by preventing abuse and constraining over utilization of this benefit. The amount would, of course, depend on the success of payment control methods or the type of benefit restructuring enacted into law. Any estimate of savings is sensitive to many factors such as the actual home health growth rate, growing use of Medicare managed care and behavioral changes due to any legislative or regulatory changes. However, to give a general sense of the problem and of potential savings, a 10 percent reduction of payments last year would have saved $1.7 billion, and a 20 percent reduction would have saved $3.4 billion.

HOSPICE

The Medicare hospice benefit was established in 1983 and may be elected by Medicare beneficiaries who are diagnosed with a terminal illness and have a life expectancy of 6 months or

less. Hospice is the provision of palliative care, usually in the home, where the dying person can be in contact with family and friends.

Rapid Growth. Total hospice payments have increased dramatically. In 1995 Medicare paid approximately $2 billion for hospice services, more than 24 times the amount spent in 1986. In contrast, Medicare expenditures for home health services grew about 5 times during the same time period. We are concerned about the substantial growth in hospice payments and lengths of stay for patients in hospice.

General Fraud and Abuse. We have recently undertaken a number of studies related to Medicare's hospice benefit. We found that certain providers are misusing the benefit by enrolling a high number of ineligible beneficiaries. In 1994, we completed a review of Medicare hospice eligibility in Puerto Rico. This study disclosed large numbers of beneficiaries in hospice care who were not terminally ill and therefore not eligible for the benefit. We estimate that $20 million was inappropriately paid for services rendered to ineligible patients in Puerto Rico.

With the Puerto Rico results as background, we began a broader review of this important benefit. We have also audited 12 large hospices located in Illinois, Florida, Texas, and California. We found, on average, that 65 percent of the patients in hospice over 210 days did not qualify for the benefit. From these audits we identified $83 million in overpayments. In addition to the problem of overpayments, these audits discovered other problems regarding internal controls, questionable hospice marketing practices, and potential illegal incentives to refer nursing home patients to hospices. We have ongoing investigations.

Special Vulnerabilities for Nursing Home Patients. Beginning in 1986, Medicaid nursing home patients were allowed to elect hospice care. Recently we have begun to look closely at hospice patients residing in nursing homes. We are finding that nationally approximately one-fifth of hospice patients residing in nursing homes were ineligible for the benefit. Approximately one-third of those that lived beyond 210 days had been ineligible for the benefit when they enrolled.

When a nursing home patient elects hospice, the hospice assumes responsibility for the professional management of the patient's medical care, but the nursing home continues to provide the patient's room, board and other services. The payment system for hospice patients residing in nursing homes is complex, involving a transfer of funds from the State Medicaid program to the hospice and then a payment by the hospice to the nursing home. The average amount that the States transfer to the hospices is $73 per day per patient. The hospice may transfer some, all, or more than this back to the nursing home to cover routine daily needs. The hospice also receives the same level of payment from Medicare for providing hospice services to these patients as it does for patients residing at home--$96 per day. The end result is that both the nursing home and hospice receive payment for providing services to beneficiaries residing in nursing facilities. We are currently looking at the type and frequency of the services being provided to these patients. Many times we are finding that hospices are providing routine care that is being provided by the nursing home, and usually fewer services than they provide to patients at home.

Another factor affecting the increase in hospice payments may be the 1990 repeal of the 210 day limit for hospice care. Prior to 1990, hospices were more conservative in deciding who would be admitted under the benefit and when to admit the patient. If the patient lived beyond 210 days (7 months), the hospice would have to absorb the cost of providing care to the patient since Medicare would not pay beyond this time. Repeal of the 210 day limit shifted the financial risk for patients living longer from the hospice to Medicare. Prior to the repeal of this limit, less than 6 percent of hospice patients lived beyond 210 days. In early 1996, however, approximately 14 percent of patients had lengths of stays longer than 210 days.

Let me be clear that we recognize that some of the longer stays may be a positive development, perhaps reflecting the fact that hospices are providing care that is beneficial to the patients and resulting in longer life. Furthermore, we recognize how difficult it is to predict how long even a seriously ill person may live, and we fully expect that some hospice patients will live beyond initial estimates made by physicians. What we are concerned about is patients whose medical condition never did support a prognosis of death within 6 months (as required for eligibility for the Medicare hospice benefit). For example, our audits found patients with "unspecified" debility, or with Alzheimer disease or other chronic or lingering conditions which at the time of admission to the hospice program were not likely to be terminal within six months.

We are very concerned about these patients not only because their admission to the hospice program may be contrary to Medicare guidelines, but also because their health and well being could be jeopardized. Election to the palliative care offered by this program requires beneficiaries to voluntarily relinquish their right to curative care for their terminal condition under the regular Medicare program. However, it may be that curative care is what they need. Being deprived of it for more than 210 days could be harmful to them. It is true that these patients may decide to return to the regular Medicare program. However, once they have been in hospice care for more than 210 days, they never again have the right to choose hospice care should they ever need it.

Administrative Remedies. We will continue to investigate hospice providers who are blatantly enrolling Medicare beneficiaries that do not qualify for the benefit. We are also urging the Health Care Financing Administration to provide better oversight of the hospice program by educating the provider community and examining hospice claims more closely.

Legislative Amendments. However, we believe that Congressional action is warranted to address inappropriate growth of the hospice benefit. Consideration should be given to reducing Medicare payments for hospice patients living in nursing homes. This would be consistent with the overlap of services received by these patients under both the nursing home and hospice programs. In addition, it may be appropriate to reduce Medicare payments for hospice patients after 210 days. This would result in hospices appropriately sharing the risk for recruiting patients. It would provide an incentive for them to ensure that only those beneficiaries who meet Medicare guidelines are enrolled in the program, while still affording a level of financial protection for them and resources to serve those patients who outlive the six month prognosis.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Medicare Part B pays for medically necessary medical equipment and supplies furnished in a beneficiary's home when ordered by a physician. Durable medical equipment consists of items that can withstand repeated use and include oxygen equipment, hospital beds and wheelchairs. Medical supplies include catheters, ostomy, incontinence and wound care supplies.

General Fraud and Abuse. Over the years, we have devoted significant resources to issues involving medical equipment and supplies. We have seen problems associated with filing claims for equipment that was never delivered, upcoding, unbundling, providing unnecessary equipment, and excessive payment rates. The widespread problems in this area have been due in part to high profit margins, ease of entry into the system, and weaknesses in payment safeguard functions. Some of our more significant work in this area includes:

- **Enteral Nutrition Therapy** -- We found that Medicare payments for enteral nutrients are excessive. Nursing homes and other third party payers are able to purchase enteral products at rates 17 to 48 percent less than Medicare allows. Even a 17 percent reduction in Medicare payments would have saved the program $45 million in 1994.

- **Wound Care Supplies** -- We found that questionable payments of wound care supplies may have accounted for as much as two-thirds of the $98 million Medicare allowed for these items from June 1994 through February 1995.

- **Incontinence Supplies** -- We found that questionable billing practices may account for almost half of the $230 million allowed for incontinence supplies in 1993. We have convictions for providers billing for incontinence supplies that were never delivered.

- **Oxygen Services** -- We found that Medicare, on the average, allowed 174 percent more than the Veterans Administration reimbursement for oxygen concentrators. We also found significant variation in the services provided to beneficiaries associated with oxygen concentrators. Reducing Medicare's payment to one that is more compatible with Veterans Administration prices, while still adjusting for difference in procurement requirements and methods, could save Medicare $200 million per year. At the same time, standards for services and quality assurance can and should be tightened.

- **Orthotic Body Jackets** -- We reported that 95 percent of claims paid by Medicare ($14 million in 1992) were for non-legitimate devices. We have also obtained convictions of entities that billed Medicare for body jackets when they actually provided seat pads.

- **Nebulizer Drugs** -- We found that Medicare and its beneficiaries could have saved $37 million if they had used the payment methodology used by Medicaid for nebulizer drugs.

Special Problems in Nursing Homes. We have particular concern when medical supplies and services have been furnished in a nursing facility setting. Above and beyond any payment that might be made by Medicare Part A for skilled nursing home care or by Medicaid or private

insurance for long term nursing home care, Medicare Part B pays for services and supplies provided to Medicare beneficiaries residing in a nursing home. The service provider is the one who bills Medicare for this, not the nursing home. In fact, the nursing home may have very little to do with authorizing or overseeing the service provided and has little to say about the cost to either the Medicare program or the beneficiary. We have found that no single individual or institution is held responsible by Medicare for managing the beneficiary's care and medical services while in a nursing home. Without appropriate oversight, the opportunity and incentive certainly exists to aggressively market and promote excessive and unnecessary items and services.

For example, a Medicare Part B provider who offers therapy services to residents of nursing homes can easily gain a market for his or her services. The patient is happy to receive services of any kind, with the expectation that they may help medically or socially, and the nursing home staff is relieved of patient care during the time the provider is delivering therapy services to the patient. While such services and supplies must be authorized by a physician, we have found that the oversight of physicians in these cases is often very weak. When suppliers deliver unneeded and unordered supplies to nursing homes for patients and bill Medicare, the nursing home has little incentive, except for limited storage space, to return the supplies.

In the nursing home setting, we have also become increasingly concerned about the cost shifting between Part A and Part B of the Medicare program in the provision of services for skilled nursing facilities. The Health Care Financing Administration determines the daily rate it will pay for care in a skilled nursing facility. This rate is calculated to include the totality of services, including room and board, nursing care, and other routine services. However, for some additional services, such as enteral nutrition, rehabilitation therapy, surgical dressings, incontinence supplies, and braces, skilled nursing facilities are permitted to bill Part B of Medicare separately.

Administrative Remedies. I am pleased to report that, in addition to discovering problems, we are also developing new and effective ways to deal with them. One good example is the problem with incontinence supplies which I mentioned above. Our exposure of these billing abuses, coupled with a coordinated nationwide investigation involving more than 20 separate cases and a concerted effort by the Health Care Financing Administration's durable medical equipment carriers has turned the escalating reimbursements downward. By the end of FY 1995, the abusive practices we had identified had all but disappeared and Medicare is now saving more than $104 million per year as a result.

Legislative Amendments. While this kind of action is good news, it is not enough of a solution. It is important to get at the underlying systems which leave Medicare so vulnerable to this kind of abuse.

Because of our concerns related to nursing home payments, we believe it is appropriate to enact global payment restructuring. Structural changes can include combining payment for supplies and equipment into the nursing facility daily rate, consolidated billing, competitive bidding strategies, and capitation payments. Each of these strategies attempts to take advantage of the ability of nursing facilities to more economically provide services and supplies to their patients

with the cost savings passed on to Medicare. Additionally, these payment mechanisms recognize the importance of the nursing facility in achieving a more cost effective program. Since nursing facilities are significantly involved in the planning and provision of patient care, they arguably, are the most appropriate entity to scrutinize providers and determine the most cost effective methods of obtaining and utilizing the services and supplies needed to meet the medical needs of their patients.

We believe that changing the payment incentives in the nursing home area will be effective in reducing some of the abuses we have found with durable medical equipment. However, additional action which specifically addresses durable medical equipment, such as conducting site visits to oversee suppliers, requiring suppliers to obtain surety bonds, and charging application fees should also correct abuses. Finally, additional legislative modifications such as making it easier for the Health Care Financing Administration to reduce inherently unreasonable payment levels and authorizing competitive bidding should be considered.

OTHER AREAS OF CONCERN

Other programmatic areas which are of continuing concern to us are lab services, prescription drug prices, and non-physician outpatient services. Following is a brief summary of our findings and recommendations in this area.

- **Lab Services** - We are nearing completion of a three-year investigative initiative called "LabScam." LabScam is targeted at abusive marketing and billing practices by the Nation's largest independent clinical laboratories. This project evolved from a 1992 case against National Health Laboratories involving "unbundling" of tests. Unbundling is the practice of running specimens through a single piece of automated multi-channel laboratory equipment and then billing separately for each component test. The frequency of testing for the Medicare population increased 96 percent from 1986 to 1993, while the population increased by 14 percent.

  In coordination with other Federal and State law enforcement agencies, our LabScam investigation has generated receivables and recoveries to date of over $800 million. We have recommended the Health Care Financing Administration periodically evaluate the national fee schedule to ensure that it is in line with the prices that physicians pay for clinical laboratory tests and to develop policies and procedures to ensure that the Medicare program benefits from reduced prices when panels are ordered on behalf of Medicare patients.

- **Prescription Drugs** - Medicare beneficiaries receive limited coverage only under this benefit which covers certain prescription drugs, mostly administered by physicians, and used for cancer/pain management, dialysis, organ transplantation, and immunization. Medicare paid nearly $2 billion in 1995 for over 700 million drug units, as compared to $663 million in 1992.

Medicare drug allowances are based on average wholesale prices which are recommended by manufacturers but do not accurately reflect actual wholesale prices. This results in payments significantly more than those paid by Medicaid, mail-order pharmacies, and even some pharmacies. We have recommended that Medicare payments for prescription drugs be based on acquisition costs paid by the biller subject to a median limit. Potential savings could be as much as $450 million per year based on adoption of this recommendation.

- **Non-Physician Outpatient Services Claims** - Since the inception of the prospective payment system in 1983, hospitals have improperly billed Medicare for non-physician outpatient services that are included in the hospital's inpatient payment. We have issued a series of four reports identifying about $115 million in Medicare overpayments to hospitals for improper billings from 1983 through 1991. A fifth report has revealed that the problem continues, and has identified over $27 million in improper billings and subsequent payments from 1992 through 1994. Since an improper billing pattern has been repeatedly demonstrated among the hospital community, the identified claims are being subjected to the Federal False Claims Act. To date, over $100 million has been recovered.

HHS MANAGEMENT ISSUES

You stated in your letter inviting us to participate in this hearing that you would like to know what steps the Department has taken to meet the requirements of the Government Performance and Results Act, and what has been learned from the audits required by the Chief Financial Officers Act.

Since the passage of the Government Performance and Results Act of 1993 (GPRA), the Department of Health and Human Service has taken steps to come into full compliance with the Act by September 1997. Currently, HHS and its components are preparing for congressional consultation and continuing consultation with partners and other stakeholders to obtain the required buy-in for the FY 1999 performance plans and objectives, which flow from and support the strategic plans. For example, the Office of Child Support Enforcement participated in the two-year GPRA pilot phase. During the pilot project, the Office of Child Support Enforcement forged a Federal-State partnership which achieved several goals. Among their accomplishments, the Federal-State partners developed and reached consensus on a National strategic plan with a mission, vision, goals and objectives, as well as on outcome measures for each of the Strategic plan goals and objectives so that progress may be tracked. All agree that reaching consensus among partners and stakeholders on the strategic goals and objectives and developing performance measures are among the most challenging aspects of implementing GPRA.

The Government Management Reform Act (GMRA) broadened the Chief Financial Officers (CFO) Act by requiring annual audited financial statements both HHS-Wide and selected Operating agencies beginning FY 1996. These initial audits have been challenging to everyone involved--to HHS management, in terms of addressing accounting and reporting issues required to prepare financial statements, and to the OIG, which is charged to audit the statements, in terms

of developing an audit approach that accomodates the complexity and resource demands of auditing the programs and systems of the Department's magnitude.

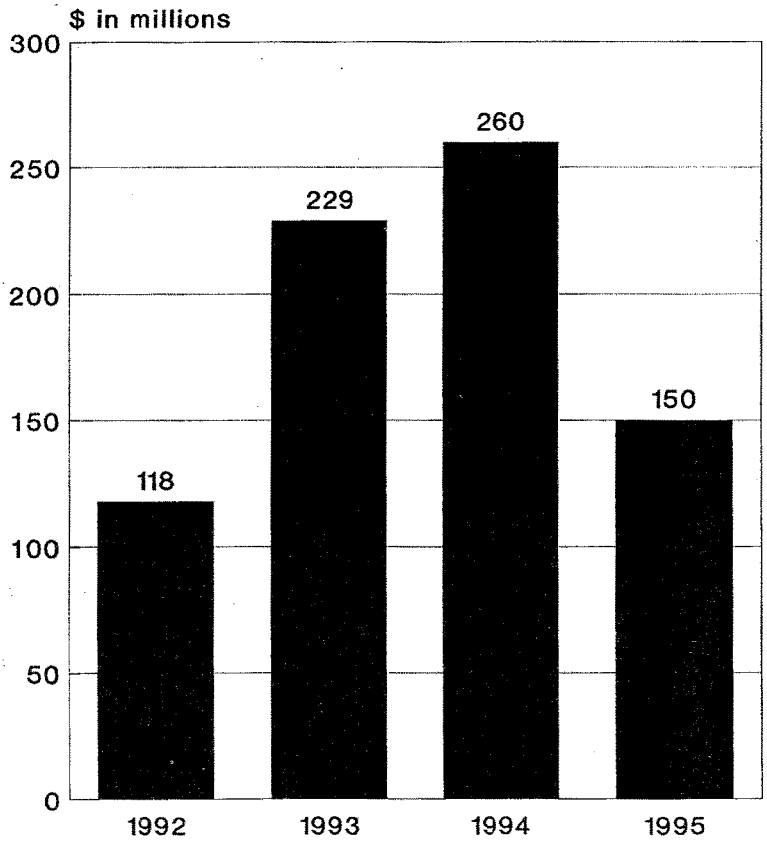
HHS is a highly diversified organization consisting of some 12 separate operating divisions with many decentralized management control systems. Our largest and most complex financial statement audit covers the Health Care Financing Administration with expenditures of over 15 percent of the Federal budget. We have 12 financial statement audits ongoing (8 HHS organizational components and 4 major control systems) in varying stages of completion. These will provide the coverage for our audit opinion on the Fiscal Year 1996 Department-wide financial statements. Because of the complexity and high risk of the HCFA programs, OMB and GAO granted the Department an extension until June 1997 to complete the HCFA and HHS-wide audits and to submit these two audited financial statements. Our audits are surfacing a number of management control issues that will warrant corrective action by HHS management, and which, in turn, will further the Department's progress in strengthening its financial management systems.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you some of our concerns related to the Medicare program. I would be happy to make our reports available to the Subcommittee and to respond to any questions you may have.

Incontinence Supplies

Medicare Payments



Mr. SHAYS. Thank you, Ms. Brown. Mr. Hembra.

Mr. HEMBRA. For many years, GAO, the IG, and others have looked at individual HHS programs. In fact, I think it would be pretty clear that you could structure a given hearing and spend hours speaking to any particular program. Instead, today, I'd like to elevate the discussion and focus on three interrelated challenges that we believe face HHS. These are issues that get at the core of how HHS manages its programs, and they transcend any individual agency within HHS or its programs. We also believe that if HHS can successfully meet these challenges, it's going to go a long way to improve its efficiency and effectiveness.

Let me begin with the first challenge that we see, and that I would put under the "umbrella" of program results. Like many other Federal organizations, HHS has a long history of having problems with accountability, the effectiveness of its coordination, how it provides effective oversight.

I don't find this surprising. If you look at the Department, it's one of the largest in the Federal Government. Last year, its budget was about $320 billion. Next year it could climb to $375 billion. It has 11 key operating divisions. It has 300 programs. It has 60,000 employees. It has numerous contractors it relies on. It has tens of thousands of grantees it looks to. And, it has partnerships it has formed with other Federal Government agencies, with the State governments and local jurisdictions.

Expressing the frustration that the Congress has had with management, in general, a few years ago, Congress put into place a number of pieces of legislation, such as the Government Performance and Results Act, the Government Management Review Act, the Chief Financial Officer's Act. And all of these had one thing in common. They all focused the spotlight on instilling discipline in how Federal departments and agencies managed their set of responsibilities.

With GPRA, we've got an opportunity now, for HHS to define a cohesive mission, develop a 5-year strategic plan, set into place specific performance goals, and identify ways in which to adequately and accurately measure how the department is carrying out its responsibilities. With regard to GPRA, I think we would share the view that the next 6 months are quite critical.

By the end of this fiscal year, HHS, along with other Federal Government agencies, have to put together that 5-year strategic plan, and it has to begin to position itself to determine whether or not its programs are doing what they were intended to do. So we have a very challenging period ahead of us with regard to this Department. The second issue has to do with having timely and reliable information. The Paperwork Reduction Act, the Clinger-Cohen Act all set in place an information framework that would support a performance-based work environment.

This is very appropriate, because, once again, HHS has long managed with incomplete and unreliable information. And not to mention the fact that they have had to rely, because of the size and the way that it carries out its responsibilities, on numerous other partners to provide it with information on how its programs are working.

I think welfare reform is a classic example. It brings with it a new set of requirements for HHS. It demands accurate and timely information from the States on how they're carrying out their welfare reform responsibilities. And we're talking about, in recent years, one of the most major social paradigm shifts in how we deal with supporting low income families.

The last issue, which ties back to the Inspector General's comments, focus on vulnerable programs. I think it is unfair for a department like HHS to look to others such as GAO, the Inspector General, the Office of Management and Budget, to identify for it where its program vulnerabilities lie. And this is certainly the case with Medicare. It's a classic example, that, even though HHS and HCFA have known for decades of problems within the Medicare program, it wasn't until several years ago that GAO and others identified Medicare as very high-risk, and began to put in place a set of actions to get HHS and HCFA better focused on how to deal with the problems associated with Medicare.

With regard to vulnerable programs, we can't just simply look at something like Medicare, that consumes a large part of HHS' budget, and say, "That is the vulnerable program." I think this is a department that has an opportunity to constantly look at its programs, be proactive, be vigilant in saying to itself, "Where do our vulnerabilities lie and what do we need to do about them?"

And I think this all ties back to the tools that are now available through GPRA, through GMPA, through CFO and the CIO legislation, to give——

Mr. SHAYS. You speak in tongues, sir.

Mr. HEMBRA. Yes. I do. To give this Department an opportunity to begin to live up to the American public's expectation and function in a more efficient and effective manner. And with that, I would be happy to respond to any questions.

[The prepared statement of Mr. Hembra follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources,
Committee on Government Reform and Oversight,
House of Representatives

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Management Challenges and Opportunities

Statement of Richard L. Hembra
Assistant Comptroller General
Health, Education, and Human Services Division

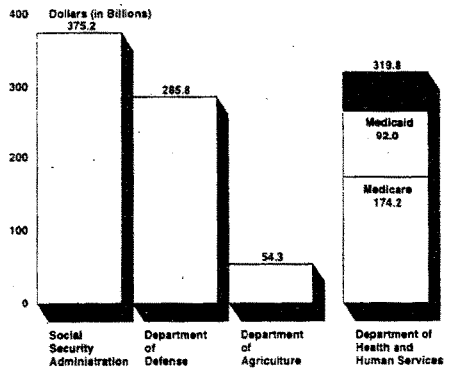
GAO/T-HEHS-97-98

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the challenges facing the Department of Health and Human Services (HHS) in carrying out its mission effectively and cost-efficiently.

A department of the size and complexity of HHS deserves careful oversight. It is one of the largest federal departments: in fiscal year 1996, HHS had budget outlays of $319.8 billion and a workforce of over 57,000. HHS is the largest grant-making agency in the federal government, providing approximately 60,000 grants per year. Its Medicare program is the nation's largest health insurer, annually handling more than 800 million claims; Medicare alone spends far more than most cabinet departments. (See fig. 1.) The Food and Drug Administration's (FDA) activities to regulate the safety of food and cosmetics and the safety and effectiveness of drugs and medical devices affect products representing $.25 out of every $1 in U.S. consumer spending.

Figure 1: Budget Outlays of the Four Largest Federal Agencies, FY 1996



Note: The Department of the Treasury's budget outlay was $364.6 billion; however, $344 billion of that total was interest on the public debt.

Moreover, HHS' many missions affect the health and well-being of every person in the country. HHS provides health insurance for about one in every five Americans, including elderly and disabled people and poor children. Its agencies ensure the safety of food,

drugs, and medical devices; help to contain the outbreak of infectious diseases; conduct groundbreaking medical research on curing and preventing disease; provide health care services to populations, such as Native Americans, who might otherwise lack such services; provide income support for needy children and families; and support many services to help elderly people remain independent.

Over the years, GAO, the Inspector General (IG) and others have examined programs and suggested numerous improvements for many HHS programs. Today, however, I would like to highlight three challenges HHS faces in meeting its mission. These challenges focus on core problems that often obstruct HHS' effective functioning. By successfully addressing these underlying problems, HHS will be much better positioned to manage its responsibilities effectively and efficiently and to assure the Congress and the American people that it is fulfilling its vital missions.

In summary, the first challenge HHS faces is its ability to define its mission, objectives, and measures of success and increase its accountability to taxpayers. Because of the size and scope of its mission and the resulting organizational complexity, managing and coordinating HHS' programs so that the public gets the best possible results are especially difficult. The Department has eleven operating divisions responsible for more than 300 diverse programs. HHS has not always succeeded in managing the wide range of activities its agencies carry out or fixing accountability for meeting the goals of its mission. Another complicating factor is that HHS needs to work with the governments of the 50 states and the District of Columbia to implement its programs, in addition to thousands of private-sector grantees. Developing better ways of managing is essential if HHS is to meet its goals.

The 1993 Government Performance and Results Act (GPRA), 1990 Chief Financial Officers Act, and Government Management Reform Act of 1994 now require federal agencies to be more accountable for the results of their efforts and their stewardship of taxpayer dollars. GPRA presents HHS with opportunities to bring discipline to management of all levels of the Department, define the types of information it needs to implement and assess its programs, and identify ways to progress toward accomplishing its goals. GPRA also poses a challenge to HHS, however, because meeting the law's requirements to prepare strategic plans, design performance measures, and assess and report on program accomplishments will not be an easy task. Similarly, HHS has found it difficult to develop the financial information necessary to permit an audit of its financial statements.

The second challenge confronting HHS–one that it shares with most other federal agencies–is ensuring that it has the information systems it needs to manage and evaluate its programs and to track its progress in meeting performance goals. Managers must have reliable information both to implement their programs in a way that best serves the public and to assure the American people that federal programs are performing responsibly and

well. This is especially challenging for the Department because it relies so much on contractors, grantees, and state and local governments as its information partners.

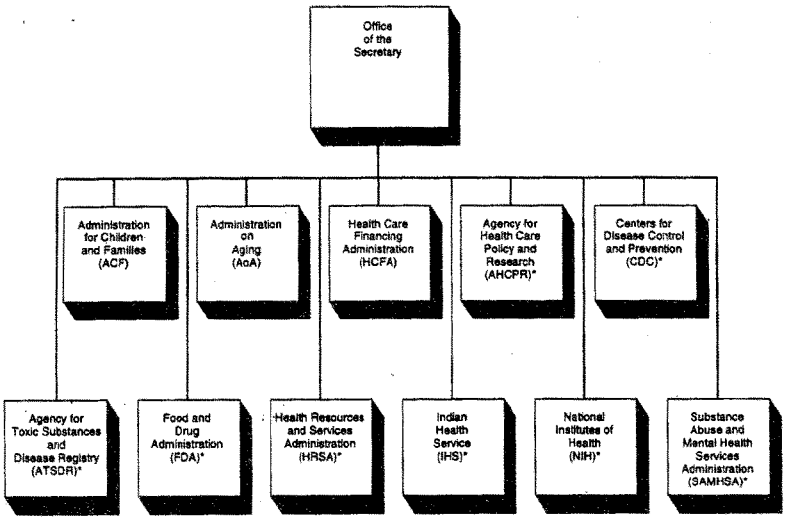
Finally, HHS responsibilities require it to constantly combat fraud, waste, abuse, and mismanagement. HHS has several programs that are vulnerable to such exploitation. For example, the size and nature of Medicare, which accounts for over half of HHS' total budget, make this program particularly vulnerable. HHS needs to be vigilant now and in the future because its programs will probably continue to be the targets of fraud and abuse and because waste and mismanagement can have such serious effects on taxpayers and program beneficiaries.

SCOPE OF HHS' RESPONSIBILITIES MAKES COORDINATION AND ACCOUNTABILITY DIFFICULT

The sheer size and complexity of HHS' responsibilities create unique challenges. HHS comprises several large agencies, each of which manages a number of programs, whose many parts also must be administered. (See fig. 2.) For example, the $10.2 billion National Institutes of Health (NIH) is only one of the agencies in the Public Health Service (PHS), yet NIH includes 17 separate health institutes, the National Library of Medicine and the National Center for Human Genome Research.[1] The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs, as well as several quality-of-care programs such as those authorized by the Clinical Laboratory Improvement Amendments of 1988. The Administration for Children and Families (ACF) is responsible for about 60 programs, including the new federal-state welfare program; child support enforcement; and Head Start, which alone serves about 800,000 children.

[1]Budget outlay for fiscal year 1996.

Figure 2: HHS' Major Operating Divisions



Note: Operating divisions marked with an asterisk are part of PHS.

This array of interrelated activities and responsibilities makes it especially important for HHS managers to work together to address the Department's overarching program goals. HHS must improve coordination and accountability among its own agencies as well as work successfully with other federal agencies with related responsibilities, state and local governments, and private-sector grantees.

Better Internal and External Coordination Could Improve Program Results and More Efficiently Use Federal Funds

Coordination among HHS programs with related responsibilities is essential to efficiently and effectively meet program goals. Moreover, many programs under HHS share goals with or relate closely to programs administered by other federal agencies. In addition to coordinating the activities of its own agencies, HHS must also coordinate its efforts with these other agencies. Furthermore, a number of HHS programs, including Medicaid and the welfare block grants, require both federal and state involvement. Therefore, HHS must work with all the state governments–and at times local jurisdictions–to coordinate implementation of these programs.

One program area that requires HHS to focus on both internal and external coordination is alcohol and other drug abuse treatment and prevention. Several years ago, we reported that abuse of alcohol and other substances was a leading cause of death and accidents among Indian people.[2] Yet HHS agencies responsible for research and services for preventing and treating substance abuse–the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration (SAMHSA)–had no process to link their expertise with that of the Indian Health Service (IHS), the agency charged with improving the health of American Indians and Alaskan Natives. We recommended that the IHS and the other HHS agencies work together to develop a plan to address substance abuse-related problems among these people. It wasn't until 1996, however, that HHS had developed and implemented such a plan for interagency collaboration on planning, research, evaluation, and training. Although long overdue, this plan should help HHS strategically allocate limited federal resources to address a major public health problem in IHS service areas.

Programs addressing alcohol and other drug abuse issues involve not only several HHS agencies–including SAMHSA, NIH, ACF, and the Centers for Disease Control and Prevention–but also in 15 other federal agencies. These include the Departments of

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[2]Indian Health Service: Basic Services Mostly Available; Substance Abuse Problems Need Attention (GAO/HRD-93-48, Apr. 9, 1993).

Veterans Affairs, Education, Housing and Urban Development, and Justice.[3] HHS also administers 58 programs that address the problems of at-risk and delinquent youths. An additional 73 programs focused on such youths involve 15 other federal Departments and agencies, including the Departments of Justice, Education, Labor, Agriculture, and Housing and Urban Development.[4]

Accountability for Meeting
Program Goals Needs More Emphasis

In addition to complicating coordination efforts, the size and scope of HHS' responsibilities also challenge the Department's ability to maintain accountability for meeting its mission goals. We have reported an example of this difficulty concerning the Rural Health Clinic (RHC) program, which is administered by HCFA.[5] Established two decades ago by federal law, the program allows RHCs to receive higher Medicare and Medicaid reimbursement to support health care professionals, including nurse practitioners and physician assistants, in underserved areas. The program was designed to improve access to health care in areas too sparsely populated to sustain a physician practice. RHC program goals are similar to those of many programs in the Health Resources and Services Administration (HRSA), the HHS agency charged with ensuring that underserved and other vulnerable populations receive quality health care. HCFA has relied on HRSA criteria for identifying geographic areas where providers could qualify for higher Medicaid or Medicare payments under RHC. As the program has grown, however, neither HCFA nor HRSA has been held accountable for ensuring that its resources have been directed at improving access in rural, underserved areas.

In our review of 144 RHCs in four states, some clinics clearly improved access in rural underserved areas; however, many clinics were in more populated areas that already had well-developed health care delivery systems. Nevertheless, once certified, all RHCs are eligible for the higher reimbursements, even after they may no longer be located in rural or underserved areas. These higher reimbursements continue indefinitely because neither HCFA nor HRSA routinely recertifies the geographic area or the provider as eligible for such reimbursements. The RHC program is adrift, in part because neither HCFA nor HRSA has accepted responsibility for routinely measuring or monitoring the RHC program's results.

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[3]See Drug and Alcohol Abuse: Billions Spent Annually for Treatment and Prevention Activities (GAO/HEHS-97-12, Oct. 8, 1996).

[4]See At-Risk and Delinquent Youth: Multiple Federal Programs Raise Efficiency Questions (GAO/HEHS-96-34, Mar. 6, 1996).

[5]Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996).

In administering programs that are the joint responsibility of the state and federal governments or that involve many local grantees, HHS must continually balance program flexibility with oversight and maintaining program controls. A case in point is Head Start, which was designed to ensure maximum local autonomy. The accountability structure for overseeing the program is not conducive to strong internal controls. For example, although all Head Start programs are governed by a single set of performance standards, these standards are largely self-enforcing. Grantees report annually on the extent to which they have complied with the performance standards. Although HHS does have a triennial monitoring system, several HHS IG reports have raised questions about accountability in Head Start. For example, a May 1993 report found significant differences between the number of services grantees reported they had provided and the number they had actually documented in their files. The IG also found that grantee files and records were often incomplete, inconsistent, and hard to review.[6]

The Medicaid program provides another example of the balancing act between flexibility and accountability. Federal statutes and regulations give states substantial flexibility in designing and administering their Medicaid programs. HCFA is authorized to provide states with even greater latitude by waiving certain statutory requirements. Such waivers permit states, for example, to provide managed care services or home and community-based service alternatives to long-term care. Although HCFA performs structural reviews of waiver programs during the planning stage, as programs are implemented and continue to operate, problems have developed in some states. Flexibility can be positive for beneficiaries as well as the states; however, HCFA's ongoing monitoring and oversight are important to ensure the appropriate use of federal funds. The need for accountability will be even more pronounced if the need for waivers to enroll beneficiaries in managed care is eliminated, as the President has proposed in his fiscal year 1998 budget.

With welfare reform, though states have more flexibility, HHS' important responsibilities continue. The recent welfare reform law replaces Aid to Families With Dependent Children (AFDC) with block grants to states, a program known as Temporary Assistance for Needy Families (TANF).[7] The law has fundamentally changed HHS and state responsibilities in providing income support to needy families. States may design and implement their own assistance programs within federal guidelines, and HHS has a broad range of responsibilities for ensuring accountability from the states. Some of these

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[6]Evaluating Head Start Expansion through Performance Indicators, HHS OIG, OEI-09-91-00762 (May 1993) and Summarization of Concerns With the Financial Management Systems and Control Structures Found at Head Start Grantees, HHS OIG, A-17-93-00001 (Sept. 1993).

[7]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193.

duties include setting standards for states to earn performance bonuses that reward them for achieving program goals, monitoring work participation rates, and ensuring that states maintain spending for poor families. Although the law has explicitly limited HHS' power to regulate the states' implementation of the law and reduced the federal welfare workforce, HHS must enforce certain aspects of the law.

GPRA AND RELATED LEGISLATION PROVIDE FRAMEWORK FOR IMPROVED PROGRAM PERFORMANCE, COST SAVINGS, AND ACCOUNTABILITY

The complexity of HHS' responsibilities makes it especially important for the Department to integrate program goals and activities at a departmental planning level. As we have just pointed out, the Department needs to become more accountable for its responsibilities. Concerned that federal agencies such as HHS have not always effectively managed their activities to ensure accountability, the Congress has created a legislative framework to address long-standing management challenges throughout the federal government. The centerpiece of this framework is GPRA. Other elements include the Chief Financial Officers Act and the Government Management Reform Act. These laws respond to the need for appropriate, reliable information for executive branch and congressional decision-making.[8]

HHS is in the process of implementing these laws, which combine to provide a useful framework for developing (1) fully integrated information about HHS' mission and strategic priorities, (2) performance data to evaluate the achievement of those goals, and (3) accurate and audited financial information about the costs of achieving mission goals. The type of strategic planning and performance measurement GPRA requires is familiar to HHS. Some agencies in HHS have experimented--some very successfully--with results-oriented management. HHS, however, has not had experience with the type of far-reaching, coordinated reform required by GPRA.

HHS Faces Opportunities and Challenges in Complying With GPRA Requirements

GPRA provides HHS with a good opportunity to improve program performance. Under GPRA, every major federal agency--and in many cases, bureaus in each agency--must now ask some basic questions: What is our mission? What are our goals and how will we achieve them? How can we measure our performance? How will we use that information to improve? GPRA forces federal agencies to shift their focus from such traditional concerns as staffing and activity levels to a single overriding concern: results.

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[8]Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

Specifically, GPRA directs agencies to consult with the Congress and obtain the views of other stakeholders and to clearly define their missions. It also requires them to establish long-term strategic goals as well as annual goals linked to the strategic goals. Agencies must then measure their performance according to their goals and report to the President and the Congress on their success. In addition to ongoing performance monitoring, agencies are expected to identify performance gaps in their programs and to use information from these evaluations to improve programs.[9]

Meeting the GPRA requirements will challenge HHS for several reasons. Some of HHS' major programs have never been fully responsible for measuring and improving program performance. For example, the Medicaid program has historically paid claims for medical services and paid limited attention to monitoring program results for the majority of beneficiaries. Other HHS functions, such as those related to research, are not as conducive to results-based management as others are. In addition, because many HHS programs are operated by states, localities, or nongovernmental organizations, HHS agencies will have to develop a way to make their many partners accountable for program results. Moreover, the data necessary for meaningful performance measurement may not be currently available or may not be comparable from state to state. The immense changes spurred by recently enacted welfare reform also add to the complexity of HHS' task. Nonetheless, GPRA could greatly improve HHS performance–a vital goal when resources are limited and public demands are high.

HHS Has Experience With Results-Based Management Reforms

HHS is familiar with the kind of results-oriented management promoted by GPRA. Healthy People 2000, the PHS' national public health initiative that seeks to improve the health of all Americans, exemplifies an HHS results-based management effort. In consultation with HHS stakeholders, other government agencies, and the public health community, PHS developed a series of outcome-based public health goals and measures.

The Congress has incorporated Healthy People 2000 objectives into national legislation. Under the Maternal and Child Health Program, for example, HHS is required to report on the states' progress toward meeting the maternal and child health objectives in Healthy People 2000. The broad acceptance by the public health community of certain measures developed for these reports has encouraged states and localities to create comparable databases and to mobilize to meet program goals.

When it passed GPRA, the Congress understood that most agencies would need to make fundamental management changes to implement this law properly and that these

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[9]Executive Guide: Effectively Implementing the Government Performance and Results Act (GAO/GGD-96-118, June 1996) and Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

changes would not come quickly or easily. To facilitate this process, GPRA included a pilot phase during which federal agencies could gain experience in implementing key parts of the law to provide valuable lessons for the rest of the government.

The Office of Management and Budget (OMB) designated about 70 pilot tests in 26 federal entities for performance planning and reporting. Two pilots were in HHS' jurisdiction: one in ACF's Office of Child Support Enforcement (OCSE) and the other in FDA's Prescription Drug User Fee Program. The pilots helped OCSE and FDA identify and move toward performance goals. OMB based its selection of OCSE in part on OCSE's previous efforts to develop a 5-year strategic plan; its ability to quantify program goals, such as child support collections; and the involvement of state and local governments as key program administrators. In October 1996, we reported that OCSE's GPRA pilot had made progress in redirecting its management of the child support enforcement program toward results.[10] For example, OCSE approved national goals and objectives focused on key program outcomes such as increasing the number of paternities established, support orders obtained, and collections received. At the time of our review, OCSE and the states had begun to develop performance measures as statistical tools for measuring state progress toward meeting program goals.

A second HHS GPRA pilot involves the Prescription Drug User Fee Act of 1992 (PDUFA), which allows FDA to collect user fees from drug companies seeking approval to market drugs. The law dedicates the revenues to expediting FDA's reviews of human drug applications. The act established time-specific performance goals to be met by the end of fiscal year 1997. To satisfy these objectives, FDA consulted with its stakeholders to determine appropriate performance indicators and target levels and developed output-oriented performance goals. In its Fourth Annual Performance Review, for fiscal year 1996, FDA reported that the PDUFA program had exceeded its performance goals, improving the speed and efficiency of the drug review process.

Status of HHS GPRA Implementation

GPRA requires that federal agencies develop strategic plans for a period of at least 5 years and submit them to the Congress and OMB no later than September 30, 1997. These plans must include the agency's mission statement; identify the agency's long-term strategic goals; and describe how the agency intends to meet these goals through its activities and its human, capital, information, and other resources.

GPRA also requires agencies to submit an annual performance plan to OMB; the first plans are due in the fall of 1997. The annual performance plan should directly link the strategic goals in the agency's strategic plan to managers' and employees' daily activities.

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[10]Child Support Enforcement: Reorienting Management Toward Achieving Better Program Results (GAO/HEHS/GGD-97-14, Oct. 25, 1996).

This plan should include the annual performance goals for the agency's programs as listed in the budget, a summary of the necessary resources to conduct these activities, the performance measures that will gauge the progress toward those goals, and a discussion of how the performance information will be verified.

Although governmentwide implementation of GPRA has not yet officially begun, HHS is working with OMB to meet its deadlines for submitting its strategic plan and first annual performance plan. HHS officials have acknowledged, however, that the Department, "must confront some fundamental issues that are central to the successful implementation of GPRA in HHS over the next year. At a minimum, there remains an enormous amount of work to be done."[11] HHS officials do expect to meet the September deadlines, however, for both strategic and performance plans, they said. HHS has drafted its strategic plan, but it is not yet ready for public release.

Strategic plans must consider the views of the Congress and other stakeholders. To ensure that these views are considered, GPRA requires agencies to consult with the Congress and solicit stakeholders' views as they develop their plans. The Department plans to begin congressional consultations in April and to send 200 to 300 stakeholders copies of the draft strategic plan in June, HHS officials said. HHS currently plans to release the draft plan to the public on the Internet.

HHS operating divisions are now developing performance plans, which should include performance measures and objectives linked to data systems. To prepare for the development of GPRA's annual performance plans, HHS officials asked each of its operating divisions to provide performance objectives and measures for at least one program activity. Officials also asked operating divisions to describe their strategies for aggregating program activities for their performance plans for the fiscal year 1999 budget. Last summer, OMB reported that the performance measurement aspects of GPRA pose the greatest challenge to HHS. At the beginning of this calendar year, however, even the agencies most advanced in their GPRA preparations had not yet finished developing performance measures. Nor had many programs taken the next steps to relate the appropriate performance objectives and measures to the resources needed to accomplish program strategies.

Required Financial Statement Audits Are Ongoing at HHS

To provide decisionmakers with reliable, consistent financial data on the operations of federal agencies, the Government Management Reform Act of 1994 requires each

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[11] Integrating Performance Measurement Into the Budget Process, Subcommittee Report of HHS' Chief Financial Officers Council, GPRA Implementation Committee (Washington, D.C.: Jan. 21, 1997).

department and major independent agency to submit to OMB an audited agencywide financial statement beginning in fiscal year 1996. The magnitude of this task for HHS is extraordinary. HHS expenses exceed $300 billion a year. Over 80 percent of this amount was spent by HCFA, primarily for the Medicare and Medicaid programs. Although the IG tried to audit HCFA's financial statements in prior years, the IG could not express an opinion on the reliability of these statements primarily because of inadequate supporting documentation for reported amounts. HHS and HCFA management are working to resolve these issues so that an audit can be performed.

The current HHS-wide financial statement audit is designed to follow up on previously reported issues and to address whether program expenditures, such as Medicare benefit payments, complied with laws and regulations and were properly reported. In addition, the audits will evaluate the effectiveness of the agency's related internal controls. The IG will report the results of this audit when it is completed.

RELIABLE AND COMPREHENSIVE MANAGEMENT INFORMATION SYSTEMS CRUCIAL TO HHS' SUCCESS

Nothing is more crucial to effectively managing an enterprise of HHS' size and scope than accurate information about programs and their effects. The desire of the American people for accountable government, expressed in the GPRA's mandate for measurable performance goals, underscores the critical need for accurate information. In recognition of the importance of agencies' properly managing their information systems, the Congress passed the Paperwork Reduction Act of 1995 to guide them in this effort. The law addresses the acquisition and management of information resources by federal agencies. The Clinger-Cohen Act of 1996 elaborates on requirements that promote the use of information technology to better support agencies' missions and to improve program performance. Among these acts' provisions are requirements that agencies set goals, measure performance, and report on progress in improving the efficiency and effectiveness of information management generally--and, specifically, the acquisition and use of information technology.

Because HHS' responsibilities involve large health insurance programs, extensive grant-making activities, and vital regulatory responsibilities, the Department must use effective information systems. To implement its programs and meet its responsibilities successfully, HHS must have access to data that are both reliable and appropriate to the task. Without such data, HHS cannot inform the Congress or the American people of its progress toward meeting its performance goals. Creating and implementing the sophisticated systems that will give HHS managers the data they need, however, present another major challenge. Because several important HHS programs, including Medicaid and TANF, are joint federal-state efforts, the current lack of comparable data across states increases the difficulty of obtaining timely and reliable data.

HCFA Needs Better Information About Enrollees and Services to Manage Medicaid Program

Medicaid, a joint federal-state program administered by HCFA, provides health coverage for 36 million low-income people, including 17.6 million children. Medicaid also pays for nursing home coverage for low-income elderly and other vulnerable members of society, accounting for almost half of total national spending for nursing home care. The Medicaid program's federal fiscal year 1996 expenditures totaled about $92 billion, with state expenditures totaling about $68 billion.

Despite Medicaid's magnitude, the federal government has only limited data on its results, and the accuracy of these data is questionable. Using information supplied by the states, HCFA creates a statistical report that has data about beneficiaries served, their eligibility categories, types of services they received, and vendor payments. HCFA also generates a regular financial report. The usefulness of both of these reports, however, is compromised by problems with the state data's accuracy and consistency. Some of these problems stem from collecting data from 50 states and the District of Columbia, which do not all use identical definitions for data categories. Another problem is the difficulty of relating the information that is in these two reports. Problems in data quality and in the ability to link data across data sources make it difficult for HCFA and others to analyze and evaluate Medicaid's results. For example, HCFA's Medicaid managed care program has been plagued by duplicate reporting on the number of enrollees. Having an inaccurate count from the states makes it difficult to assess the effect of managed care on Medicaid expenditures.

Some of Medicaid's long-standing data problems could worsen because of the program's growing reliance on managed care to provide health services to beneficiaries. The proportion of Medicaid beneficiaries enrolled in managed care, as reported by HCFA, quadrupled from about 10 percent in 1991 to about 40 percent in 1996. Because Medicaid pays many managed care organizations a defined fee for providing a range of services, HCFA usually lacks the detailed utilization data available under fee-for-service billing. This, in turn, makes evaluating the program's success even more difficult.

Welfare Reform Presents HHS With Many Information Challenges

The new welfare reform law gives HHS new administrative and oversight responsibilities, the performance of which will rely on state-provided data. One of HHS' major new administrative requirements is for the child support enforcement program. Using state-provided data, HHS is to establish a national directory of newly hired employees and registry of child support orders to strengthen child support enforcement. Another information management challenge for HHS is ensuring that the states provide comparable and reliable data to help it fulfill its oversight responsibilities under the new

legislation. HHS will need such information to ensure that states are enforcing the federal 5-year time limit on receiving welfare benefits, meeting minimum work participation rates, and maintaining a certain level of welfare spending. Enforcing this limit, for example, will be difficult because information on the total amount of time someone has received welfare is often unavailable in a state, let alone across states. In addition, HHS will need to collect state data to assess penalties and provide performance bonuses. With the increased flexibility of states in designing their programs, obtaining comparable and reliable data to assess the effect of welfare reform on children and families could be difficult for HHS.

FDA Needs to Improve Its System for Monitoring Medical Device Problems

Another possible problem in managing information systems is a failure to use the information appropriately to advance program goals. We recently reported on such a problem concerning FDA's medical device adverse event reporting system, used to gather information about problems with marketed medical devices.[12] Medical devices range in complexity from simple tongue depressors to heart pacemakers. The reporting system enables FDA and the medical device industry to work together to take corrective action on device problems and, when appropriate, to alert the public to potentially hazardous devices to prevent injury or death.

FDA has not systematically acted to ensure that the reported problems have received prompt attention and appropriate resolution. As a result, FDA's adverse event reporting system has not always provided the intended early warning about problem medical devices. Because the increased volume of adverse event reports resulting from changes in the law made it difficult for FDA to process and review reports in a timely manner, the agency chose to give priority to death and serious injury reports. As result, FDA delayed processing and reviewing almost 50,000 malfunction reports for nearly 2 years. Malfunction reports are essential in alerting FDA to potentially serious device problems before they result in death or serious injury.

Moreover, although FDA contends that it notifies manufacturers and user facilities about imminent hazards and industrywide safety concerns, it does not routinely document the corrective actions it takes–or those taken by manufacturers–to address reported medical device problems. As a result, it is unclear how manufacturers and FDA have responded to device problems reported by user facilities. Feedback to medical device users could increase knowledge about medical device performance, improve patient safety awareness, and help users make purchase decisions. FDA, however, does not routinely

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[12]Medical Device Reporting: Improvements Needed in FDA's System for Monitoring Problems With Approved Devices (GAO/HEHS-97-21, Jan. 29, 1997).

communicate the results of analyses of medical device problems and corrective actions to the medical device user facility community.

Implementation of Medicare
Claims Processing System at Risk

Finally, another information management challenge facing HHS involves the Medicare program, which accounts for over half of HHS' annual budget. An important initiative to improve Medicare claims processing activity could create problems if it is not carefully implemented. To better protect Medicare from fraud and abuse, HCFA has begun to acquire a new claims processing system, the Medicare Transaction System (MTS). HCFA expects MTS to replace the nine different processing systems it currently uses by the year 2000. We have previously reported on the benefits and risks associated with this effort.[13] The intent of using a single automated system is to allow HCFA to improve administrative efficiency, better manage contractors, and place greater emphasis on safeguarding program dollars and improving beneficiary and provider service. In response to some of the risks we identified, HCFA revised its initial approach for developing and installing MTS, reducing the potential for problems stemming from large-scale system failures. We also reported on risks related to difficulties in defining the system's requirements, inadequate investment analysis, and significant schedule problems. HCFA is working on these concerns. We plan to continue evaluating HCFA's efforts on this important initiative.

Another critical task for HCFA involves revising computerized systems to accommodate dates beyond the year 1999. This year 2000 problem stems from the common practice of abbreviating years by their last two digits. Thus, miscalculations in all kinds of activities–such as benefit payments–could occur because the computer system would interpret 00 as 1900 instead of the year 2000. HHS, along with other agencies that maintain time-based systems, must develop strategies to resolve this potential problem in the near future.

SAFEGUARDING VULNERABLE PROGRAMS
REQUIRES CONSTANT VIGILANCE
AND INNOVATION

With HHS' broad range of programs, large number of grantees and contractors, huge volume of vendor payments, and millions of beneficiaries, the Department must always be vigilant in protecting its programs from fraud, abuse, mismanagement, and waste. The sheer dollar size of HHS' programs makes them attractive targets, and the consequences can be severe. HHS needs to improve its processes for identifying and preventing fraud,

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[13]High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1997) and Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

abuse, mismanagement, and waste and maintain constant vigilance in the future. The Medicare program offers an example of how important such efforts are.

One of the long-standing management challenges HHS faces is safeguarding Medicare, the government's second largest social program. Medicare provides health insurance for 37 million elderly and disabled Americans; federal Medicare expenditures were $174 billion in fiscal year 1996. Medicare's expansive size and mission make it vulnerable to exploitation. That wrongdoers continue to find ways to dodge safeguards illustrates the dynamic nature of fraud and abuse and the need for constant vigilance and increasingly sophisticated ways to protect the program.

Both the Congress and HCFA have made important legislative and administrative changes to address chronic payment safeguard problems. Because of the hundreds of billions of dollars at stake, however, the government must exercise unflagging oversight and effective management for the foreseeable future to protect Medicare from waste, fraud, abuse, and mismanagement. Two factors heighten the continuing need to control claims fraud and abuse in Medicare. First, although growth in Medicare costs has moderated somewhat in the last 2 years, many believe even this lower growth rate cannot be sustained. Second, the Medicare trust fund that pays for hospital and other institutional services is expected to be depleted within the next 5 years.

Infusion of Resources and Leadership From HCFA Should Help Lessen Vulnerabilities of Medicare Fee-for-Service Program

HCFA administers Medicare largely through a structure of claims processing contractors. Medicare contractors--insurance companies such as Blue Cross and Blue Shield--use federal funds to pay health care providers and beneficiaries and are reimbursed for their administrative expenses. HCFA has largely delegated its effort to guard against inappropriate payments to these contractors, giving them broad discretion in acting to protect Medicare program dollars. As a result, significant variations exist in contractors' implementation of Medicare's payment safeguard policies.

A pattern of unstable funding for antifraud and abuse activities since 1989 has made it more difficult to guard the large Medicare program. For example, although the number of Medicare claims climbed 70 percent--to 822 million--between 1989 and 1996, resources committed to claims review, without adjusting for inflation, grew less than 11 percent during that period. Passage of the Health Insurance Portability and Accountability Act of 1996 adds new funds to fight fraud and abuse starting in 1997, but this additional funding will still leave per claim safeguard funding in 2003 at about one-half the 1989 level, after adjusting for inflation.

The inadequate funding of Medicare's claims scrutiny activities has hurt contractors' efforts to review the medical necessity of services billed to the program. For example,

we reported in 1996 that, because of the small number of claims selected for review, home health agencies billing for noncovered services were less likely to be caught than was the case 10 years earlier.[14] Besides covering so few claims, paper reviews of home health claims are simply limited in their ability to detect claims for noncovered care. In the case of a large home health organization we investigated, claims passed review scrutiny even for visits never made because company staff allegedly falsified medical records.

As we noted in many reports and testimonies in recent years, HCFA has not aggressively managed the Medicare claims processing function. HCFA has not taken a leadership role, for example, in managing how contractors select the criteria used to identify claims that may not be eligible for payment or in helping contractors with this task. The agency has not systematically aggregated information on contractors' medical policies or their related use of prepayment screens. As a result, HCFA has not adequately assessed the relative performance of contractors or helped share with all contractors the experience of some in using effective claims screening controls. One of our studies revealed, for example, that 10 of 17 contractors reviewed lacked screens for echocardiography, Medicare payments for which exceeded those for any other diagnostic test in fiscal year 1994 and which increased in use nationwide by over 50 percent between 1992 and 1994.[15] We estimated that Medicare could have denied at least $10.5 million in echocardiography payments made in 1993 if just seven contractors that did not screen these procedures had applied the medical necessity screens used by other contractors.

Legislative and Other Initiatives Improve HCFA's Ability to Fight Fraud and Abuse

The 1996 Health Insurance Portability and Accountability Act will gradually increase the funding for pursuing health care fraud and abuse, including HCFA's audit and related activities. For fiscal year 1997, the act boosts the claims processing contractors' budget for program safeguard activities 10 percent over 1996; by 2003, the level will be 80 percent higher than for 1996.

Operation Restore Trust is an antifraud initiative involving three HHS agencies–the IG, HCFA, and the Administration on Aging–and the Department of Justice and various state and local agencies. This effort currently targets Medicare abuse and misuse in five states that together account for over one-third of all Medicare beneficiaries and focuses on fast-

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[14]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[15]Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

growing services: home health care, nursing homes, and medical equipment and supplies. In its first year, Operation Restore Trust reported recovering $42.3 million in inappropriate payments. It also resulted in many convictions, fines, and exclusions of fraudulent providers. IG officials believe that the major achievement of this initiative will be continued coordination of the participating agencies and greater awareness of the effectiveness of constant vigilance.

The Health Insurance Portability and Accountability Act has built upon Operation Restore Trust by establishing a program run jointly by the Departments of Justice and HHS to coordinate federal, state, and local law enforcement efforts against fraud in Medicare and other health care programs. The program also establishes a national health care fraud data collection program, specifies health care fraud as a separate criminal offense, and increases criminal penalties.

HCFA has taken other actions to improve Medicare's fraud detection activities. These include efforts to adopt fraud and abuse detection software and to reduce Medicare's vulnerability to abusive billing as well as to prevent fraudulent or excluded providers from continuing to bill the program. For example, HCFA will assign new identification numbers--National Provider Identifiers--to every provider and supplier in the Medicare program and require the use of these numbers for billing purposes. The numbers assigned to providers and suppliers are unique and will identify them throughout their Medicare participation.

HCFA Could Reduce Costs of Medicare Managed Care Program

Programs can also be vulnerable to excess payments because the method for setting prices is flawed. An example of this is the process for setting rates for Medicare risk-contract health maintenance organizations (HMO). Our recent studies have revealed shortcomings in Medicare's risk contract program that affect both taxpayers and beneficiaries. Because of difficulties in establishing capitation rates, Medicare pays some HMOs too much each year, needlessly spending at least hundreds of millions of dollars a year from the program's trust funds. HMOs tend to attract Medicare beneficiaries whose need for care when joining is low. Although the payment formula includes a crude risk adjustor to correct for this tendency, it is not precise enough to account for its full effect.[16] The Physician Payment Review Commission recently estimated that annual excess payments to HMOs nationwide could total $2 billion.

A second problem with Medicare's risk-contract program is that HCFA has neither adequately enforced nor made beneficiaries aware of HMOs' compliance with federal

[16]Medicare HMOS: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates (GAO/T-HEHS-97-82, Feb. 27, 1997).

standards. We have reported on the need for HCFA to more actively serve beneficiaries enrolling in HMOs.[17] HCFA conducted only paper reviews of HMOs' quality assurance plans. Moreover, the agency was reluctant to act against HMOs that used abusive sales practices, unduly delayed appeals of decisions to deny coverage, or exhibited patterns of poor-quality care.

HCFA also misses an opportunity to supplement its regulatory efforts by not sufficiently informing Medicare beneficiaries about competing HMOs. For example, HCFA does not provide beneficiaries with any of the comparative consumer guides that the federal government and other employer-based health insurance programs routinely distribute to employees and retirees. Public disclosure of information, such as comparative disenrollment rates, could help beneficiaries choose among competing HMOs and encourage HMOs to better market their plans and serve enrollees.

Most recent legislative proposals to reform Medicare would expand the program's use of prepaid health plans, which illustrates the importance of addressing these issues. Risk-contract HMOs currently enroll about 10 percent of Medicare's beneficiaries, and such enrollment has grown rapidly. In just 2 years--between August 1994 and August 1996--the number of risk HMOs nationwide rose from 141 to 229 and enrollment grew by over 80 percent, from about 2.1 million to 3.8 million beneficiaries. The Congressional Budget Office projects that, under one Medicare reform scenario that would encourage beneficiaries to join HMOs, enrollment in risk HMOs and other prepaid plans could grow to 25 percent of all beneficiaries by 2002. If HCFA does not correct its rate setting and standards enforcement problems, these proposals could actually increase Medicare costs rather than control cost growth as intended.

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In conclusion, although our reviews and studies and those of others have found problems with HHS' many programs, we recognize the difficulties that HHS faces in managing a large and diverse array of activities. Considering, however, the extent to which the American people rely on HHS for essential services and support, it is critical for the Department to focus on achieving its many missions as effectively and efficiently as possible. GPRA provides HHS with an excellent opportunity to orient its management toward producing the results its programs are intended to achieve and to engage in regular self-assessment. As you know, we have already committed to working with the Congress as it reviews draft and final HHS strategic and performance plans and other submissions under GPRA. We urge the administration and the Congress to use this

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[17]Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995) and Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

opportunity to provide the kind of continual oversight needed for a Department of HHS' size, diversity, vulnerability, and importance.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or members of the Subcommittee might have.

For more information on this testimony, please call William Scanlon, Director, Health Financing and Systems, (202) 512-4561; Bernice Steinhardt, Director, Health Services Quality and Public Health, (202) 512-6543; and Jane Ross, Director, Income Security, (202) 512-7215.

Mr. SHAYS. Thank you. We've been joined by Mr. Gilman, the chairman of the International Relations Committee, as well as Mr. Kucinich. And what I'm going to do—I'm going to yield my time to Mr. Gilman, because I know he has other places to go. I'm particularly nice to this gentleman, because when I was first elected, he was, even then, a seasoned veteran, and he was very nice to me. So——

Mr. GILMAN. Thank you, Mr. Chairman. You've been very nice to all of us, to take care of all of our problems. And I want to commend you, Chairman Shays, for your diligent work, and for the opportunity to review, learn, and discuss the important issues confronting a number of our Government agencies.

And I thank our panelists for being here today, to help us better understand where we're going and why. We are all concerned, of course, as we try to reduce and eliminate unneeded Federal programs, to try to reduce the Federal bureaucracy and Federal spending, and cutting regulatory red tape, and returning some common sense to the numerous Government regulations out there.

I particularly welcome the opportunity for this committee to hear testimony from the General Accounting Office and the Office of the Inspector General concerning the budget and operations of the Veterans Administration. And I realize that panel hasn't testified yet.

And I regret I'm not going to be able to stand by, but my assistant, Todd Berger, will be here, and will be taking some notes. And I look forward to reading your testimony. Like many other Government agencies, the VA is reacting to efforts to balance the budget by finding new ways to improve efficiency.

And as many of you are aware, the VA has been involved in a Nation-wide relocation of its resources. And that's being done, supposedly, to make certain that health care funds are going to be distributed in the most equitable manner between the various regions. However, under the plan, VA facilities in the Northeast are being particularly hard hit.

VA officials have assured me that no veteran is going to be denied future care despite reductions in funding. However, many of us, particularly those of us in the Northeast, remain skeptical with regard to that claim. And while we welcome the goal of greater efficiency, I have concerns that the veterans' needs are going to fall victim to the goal, particularly in the area of veterans' health care.

And at a time when our veterans population is growing older, efficiency is an administrative, not a medical concept, and it is my chief concern that in the future, under this evolving VERA plan, a decision to refuse treatment to a veteran will be a medical judgment, not an efficiency decision.

It's a simple fact that many of our veterans in the Northeast fall into special categories: the mentally ill, the homeless, alcoholics, drug abusers, and spinal cord injured. These veterans clearly have conditions which are neither easily treated on an outpatient basis nor more efficient to treat in such outpatient conditions.

However, they are still deserving of basic triage rights. And I hope that in the future, these veterans are going to be allowed to have their status and place in our VA health system be determined by a physician, through a medical examination, and not through any administrative evaluation of their application before such an

examination. Medical judgment on treating these future cases should never be superseded by the goal of efficiency. To do so would be nothing short of the beginning of the breakdown in the relationship between our national Government and our veterans.

So Mr. Chairman, I look forward to further testimony and working with you on this serious problem. And with your permission, I'm going to leave several questions to be answered as part of the record. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. Mr. Snowbarger.

Mr. SNOWBARGER. Thank you, Mr. Chairman. I think my questions are for Mr. Hembra. You were referring to vulnerable programs. I presume you mean programs that are vulnerable to fraud and abuse. Is that an accurate statement? Or——

Mr. HEMBRA. I think the common definition that we've used in the Government has to do with fraud, waste, and abuse. I'm not sure that we should necessarily hold ourselves to that definition. It's one thing to identify a key program and put it on a high risk list and say we're going to focus a lot of attention on that. But within the Department of HHS, I think there are other——

Mr. SHAYS. Excuse me. Can I have you put the mike a little closer to you? Yes.

Mr. HEMBRA. I think within HHS, there are clearly other programs worth looking at for different reasons. And I think you have to extend that to the beneficiaries of the programs. And a couple that come to my mind—one is Head Start. Head Start, right now, is about a $3.5 billion program. It has over 1,400 grantees that it looks to to administer the program. It provides benefits to young children around 4 years of age. It's serving a population, I think, of over 800,000. GAO and the Inspector General have found problems with that program. To me, that's one that warrants closer scrutiny by HHS and the Administration of Children and Families.

I think another area that offers vulnerability is——

Mr. SNOWBARGER. Can I interrupt?

Mr. HEMBRA. Yes.

Mr. SNOWBARGER. I'm not quite sure I understand why you were suggesting that Head Start be looked at, and for what reason.

Mr. HEMBRA. Well, I think because of the amount of money that's going into the program, because of the number of grantees that the money is flowing into to provide services. I think because of the vulnerable population served, that being a young children population, and past problems that HHS and ACF have had with how the grantees have administered those programs, problems that have surfaced in the day-to-day operation of the Head Start centers, and what has been historically problems with getting corrective action taken.

Mr. SNOWBARGER. Are these accounting problems? I mean, the ability of the agency to determine whether or not the money has been spent properly, maybe not in a fraudulent way, but——

Mr. HEMBRA. I think it goes beyond just how the money is being spent, although it certainly ties to that. But when you look at—you're looking at problems that could affect the health and safety of children—the adequacy of the facilities and things of that nature. And it's for those reasons that I would suggest that you can't

just simply look to a large dollar program and say, "That's the one that, perhaps, is most vulnerable."

Mr. SNOWBARGER. Could you identify for us, maybe, specific vulnerabilities that would lead you to focus on home health, nursing homes, medical equipment, supplies, hospice, the programs that we've been talking about this morning?

Mr. HEMBRA. Yes. I think we can certainly do that. In fact, maybe I'll ask Mr. Dowdal if he could respond to that.

Mr. DOWDAL. There's been a lot of growth in the number of suppliers of services in that area. There's been lots of identified problems by both the Inspector General's office and our office related to medical supplies being billed by the agencies. There's been tremendous growth in the number of visits per person who receives home health care. And the growth in the number of home health agencies has been very high.

There are a lot of questions about whether the services that are being provided are covered by Medicare. There's many other issues like that surrounding all three of those areas—home health, SNFs, and durable medical equipment.

Mr. SNOWBARGER. To what do you attribute the growing number of suppliers, growing number of visits per patient? Why do we see all those things going up so much?

Mr. DOWDAL. Some of the reason is that once people figure out there's a way they can get a lot of money out of a program, then other people find out about it and want to get into that same action. And you end up with a lot more agencies or suppliers. And a lot of them are not as legitimate as they're supposed to be. Now, there's been some steps made to try to identify ways of making sure that the suppliers that get into the program are legitimate and have a real business and are not just some fly by night. But there's still that problem going on.

Mr. SNOWBARGER. Has the growth in this field maybe outstripped the agency's ability to control and account for how they're spending——

Mr. DOWDAL. There was a combination of factors, that was part of the problem, too. In fact, over the period from 1989 to 1996, the money available to do the reviews and the checking on that actually decreased. And that led to less ability to review claims. For example, home health agencies in 1987—they were looking at approximately 60 percent of the claims that came in to make sure that they were valid.

Today, they're looking at less than 3 percent. Well, last year they were. Now, the Kassebaum-Kennedy bill did get us some additional money, so we expect that the percentage will go up again, but not anywhere near as high as it was back in the mid eighties.

Mr. SNOWBARGER. Are these contracts for services and supplies currently competitively bid? I think one of you mentioned maybe a need to see it goes to competitive bid—or, suggested that.

Mr. DOWDAL. Currently, their Medicare doesn't competitively bid for that. There is some demonstration programs that they're getting started—one of them in the durable medical equipment area down in—I believe it's South Carolina. We have discussed in the past the issues related to getting competitive bids, at least on some

kinds of items where there—you know, you don't have to worry about the big difference in quality.

You know, where you get your Depends—it's not going to matter which company, because they're all going to be giving you the same thing. Items like that. We think there's opportunities for at least trying competitive bidding.

Mr. SNOWBARGER. Ms. Brown. I saw you reaching for the microphone.

Ms. BROWN. Yes.

Mr. SNOWBARGER. OK. Mike.

Mr. MANGANO. Actually, the only one of these three industries that would be subject to—that potentially could be subject to competitive bidding, would be the durable medical equipment industry, itself. Right now, the Health Care Financing Administration does not have the opportunity to wholesale competitively bid. Nor do they have the opportunity to reduce prices when they're inherently unreasonable.

HCFA is required to go through a regulatory process, which can take 2 to 4 years, to reduce those prices. In the meantime, they're losing millions of dollars. These are two kinds of abilities that any insurance company in this business has. We think it's particularly a difficult problem when you get into nursing homes. Durable medical equipment companies basically market their goods to nursing homes because there are a lot of patients there.

When Ms. Brown was showing you that chart on incontinence supplies, all of that $100 million that was lost each year was because of things that were billed that should never have been billed. These were incontinence supplies that were billed when they weren't really in connection with a prosthetic device as is required by the regulations on medical equipment.

Most of these billings were in areas of nursing homes, where they could go in and sell things. Mr. Chairman you may remember about a year ago when Ms. Brown came in and showed a female urinary collection pouch. This was an incontinence supply that was being billed, when actually what was being delivered to the nursing homes were adult diapers. That's the kind of abuse that occurs here.

We think that HCFA ought to have the ability to competitively bid, reduce inherently unreasonable costs and, in the case of nursing homes, consolidate the billing for supplies. The nursing home is going to bill for supplies, not the individual DME suppliers who are billing for each individual beneficiary.

Mr. SNOWBARGER. What's been the success of HHS in following up on things that are improperly billed in terms of getting return of the money and that type of thing?

Mr. MANGANO. Well, I think we've got a real good record in capturing people when they do bill that way. But you have to understand that we're dealing on an exception basis. That is, we go out there and find out when somebody tells us that somebody is inappropriately billing, or prospectively, when we go in and we see billings having an extraordinary increase in one particular year.

But just to give you an idea, the Medicare program last year had 800 million claims for Medicare Part B, of which durable medical equipment would be a part of. It's impossible for us to try and

catch all of these abuses. Once we do catch them, though, we do get good cooperation from the U.S. attorneys to apply damages to these cases. But I also want to give you the other side of that.

Many of these companies are small, and the money is gone by the time we get around to court cases. One particular case would be a typical example of a home health agency in which we found that 70 percent of the claims were erroneous. But they were basically a holding company for a lot of subcontractors. By the time we caught up with them, they went Chapter 11 and there was no more money to be gotten back for Uncle Sam.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. Mr. Kucinich.

Mr. KUCINICH. Thank you very much, Mr. Chairman and members of the committee. I appreciate this opportunity to ask some questions. And there's an area that I'd like to focus in on. As a member of the Ohio Senate before I came to Congress, I was responsible for helping to promote a rather wide-ranging inspection of the Government's policies with respect to Medicare HMOs.

And our State Senate Health Committee actually held a dozen hearings on the policies of HMOs in the State of Ohio. And those hearings produced substantial evidence of HMOs attempting to deny care merely to promote their own profits at the expense of the health of their patients. I see in today's front page of the New York Times that we have a national problem which relates to HMOs not—or constructively denying the appeal rights of millions of elderly Americans.

We understand. I mean, all of us in politics understand. There's only one reason that they would do it, because the way the system is set up, the less money the HMOs spend, the more money they make.

Now, that being the case, I have just a few questions. First of all, the Department, I understand, has been looking at this, but have you done—to Ms. Brown—have you done any investigation of the number of appeals that have been required, the number of appeals that have been denied, and have you come to a conclusion about how many people may have tried to appeal, but couldn't because of the way the system is set up?

Ms. BROWN. Yes, sir. We just finished four reports of different aspects of the—of this particular area—and found some of the things that were reported in the morning paper, including the fact that most people didn't realize they had appeal rights; therefore, didn't exercise them, or they found that it was very difficult to exercise those rights.

These weren't investigations which are, again, into criminal or civil matters. But we have done a lot of background work to let us know what that environment is so we could continue working in there.

Mr. KUCINICH. How would you, Mr. Chairman—how would the Department let the millions of Americans that are in this program know about their appeal rights? Do you send them notices? What do you do?

Mr. MANGANO. Yes. The primary way that the Medicare program lets its beneficiaries know about that, is through the medical handbook that they issue each year. When we had completed these re-

views that Ms. Brown just mentioned, we had recommended that the Health Care Financing Administration take a more vigorous approach to letting the beneficiaries know about their appeal rights.

They have agreed to make changes in their handbook, as well as to put bulletins out to beneficiaries to let them know what their appeal rights are. One of the difficulties here is that, in an HMO, they get one fee to provide all the health care needs for the Medicare beneficiaries. And a lot of this is the responsibility of the HMO to do it. So HCFA's role should be two fold. One, to let its beneficiaries know what its rights are. And when those rights have been violated, to intervene at that point.

Mr. KUCINICH. Mr. Chairman, I would suggest that the Department has more of a responsibility than what has been taken here. Because this is—these are taxpayers' moneys. That money does not belong to the HMOs, I will suggest. These are Federal tax dollars. And my question to you is: what are you doing to make sure people are aware of their rights to appeal?

Because, my background is also in committees, and I can tell you that a single shot theory of committee, like putting it into a handbook is not adequate. And it seems to me that you ought to have some structured series of messages to communicate to this national population of elderly so that they will know, so that it's common knowledge that if you are not sure of what your rights are, that you can refer to—that you can be repeatedly advised as to what your rights are so they can be exercised.

Mr. MANGANO. Yes.

Mr. KUCINICH. Now, I mean, what are you—you mentioned the handbook. You mentioned some bulletins. But what——

Mr. MANGANO. Yes. We're doing even more than that. One of the alliances that we formed in our office was in working with the Administration on Aging, which has a network of ombudsmen across the country that deal with all matters relating to senior citizens, particularly in nursing homes.

One of the things we're doing is passing on to them the kinds of things we're finding out as problems is our reviews. They're putting forth forums in a variety of parts of the country to let the public know about that.

We're also working with the AARP. Ms. Brown was interviewed for an article for their publication that will be coming up very soon. We're going to be supplying that publication with a lot of do's and don't's, things that beneficiaries ought to be careful about. And when you see this problem, let our office know about it or let the Medicare program know about it, as well.

Mr. KUCINICH. Are you prepared to cancel the contracts of any HMOs that are aggressively refusing the appeal rights of the elderly who are in this program?

Mr. MANGANO. OK. Of course, we don't have any program responsibility over the Medicare program. But if we found that an individual HMO was denying a person's rights, we would take action against them. We would recommend that the Medicare program take actions in terms of disallowances and excluding them from the program.

Mr. KUCINICH. One final question, Mr. Chairman. Have you——

Mr. SHAYS. The gentleman has 10 minutes, so if you——

Mr. KUCINICH. OK. Great. Well, thank you, Mr. Chairman. Have you any information of a single HMO in America which has been—whose contract has been canceled because of their practices in dealing with their elderly patients?

Mr. MANGANO. I am aware of several that have been canceled. In fact, I can think of one or two that the OIG got involved in in which we did initial audits and investigations in the Medicare program and canceled them from their program.

Mr. KUCINICH. Are you going—will the Department followup—and maybe the Inspector would say this—will the Department followup on the court order that was issued by Judge Marquez, setting the July 1st deadline? He gave certain—a certain prescription, if you will, for remedying what he felt were some defects in the administration of the program. Are you intending to followup on that or are you going to appeal the Judge's ruling?

Ms. BROWN. Well, we have had several meetings with the Department regarding our findings. Managed care in Medicare is a fairly new area. All of the incentives are quite different than the incentives were for people who had basically—too much money was being paid out. Because of the nature of HMOs, we have a whole new set of incentives here for people to take advantage of. We have the authority for any kind of patient abuse or neglect, which could be one of the concerns here—in neglect—to have them eliminated from the program.

We've had quite a few meetings, but, I don't know exactly what they're going to do on the Judge's decision yet. But the Department is very concerned about it. We have done quite a bit of work in the area so we can bring the Secretary up to date on what's actually happening out there. I'd be glad to supply that for the record when I find out more about that particular decision.

Mr. KUCINICH. I think it would be helpful for at least this Member. And perhaps the others would agree.

Ms. BROWN. OK.

Mr. KUCINICH. For us to get some information about what the Department intends to do to—in a comprehensive way—to be certain that anyone whose—finds their services denied, reduced or terminated, is able to appeal that, that we would be fully informed as to what's being done to make sure that all the participants, the millions of participants in this program, will have their rights defended.

Because what's happening, Mr. Chairman, is that there is an active marketing campaign to draw millions and millions more of elderly Americans into this program. And the people who are doing the marketing could care less about providing care to the elderly. There's a transition from health as a right in a democratic society to health as a market driven commodity.

And what I believe is we need the Department to be more than just a casual observer in this, we need you to be the umpires. And if somebody does something and they're out, they ought to be out. And you're the only ones who can do that for the American people. And if we are going to continue to see this transit to managed care paradigm, where HMO Medicare has more and more patients—and they're predicting that the growth may triple within the next 10

years—then, you know, the responses that we receive in committees like this have to be more substantial and definitive about the rights which patients have.

Because it's the articulation of those rights which will make the programs that you are involved in real. And I suggest that perhaps it's time for a patients' bill of rights codified, so that we are not in a position where we have to learn of elderly people who have every right to decent health care being denied it or being refused the information which would enable them to get better care. This is the other side of the issue the President raised about the gag order.

Mr. SHAYS. Yes.

Mr. KUCINICH. It's one thing for a physician to be told that he cannot give the information to his patient so that his or her patient could proceed to get better health care and exercise more options, and it's another thing—and it's still another thing to constructively deny that person an opportunity to get good health care because they don't even know what their appeal rights are. Thank you.

Mr. SHAYS. I thank the gentleman. Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman. Thank you folks for being here. I have two unrelated questions—unrelated to each other and unrelated to what we've been hearing you folks talk about so far. But I read an article in the February 27, 1997, issue of the Washington Times in which the point was made that the U.S. Health Care Financing Administration, which is a part of the Department of Health and Human Services, will pay some $400 million to 41 New York hospitals simply to train 2,000 fewer medical residents, which would be a 20 percent decrease. Is that true?

Mr. MANGANO. Yes, it is.

Ms. BROWN. Yes.

Mr. PAPPAS. Why are we doing that when market forces, I think, should be the ones to dictate how many people enter a particular field?

Mr. MANGANO. Of course, that was not our decision. That was the decision of the Health Care Financing Administration. Basically what they were responding to is the growing notion, as people are aware, that there is a glut of physicians in this country, and there are too many in training to meet the market needs. So what HCFA basically did was said, "We'll help downsize the number of physicians by paying teaching hospitals not to train them."

So I believe that particular program will last—it's either 4 to 6 years in which they'll be reducing the number of physicians by 20 percent in New York. And they're giving an incentive to the hospital to reduce the number of residents and interns in training by paying the hospital as though they were there.

Mr. PAPPAS. How long has this been going on?

Mr. MANGANO. This was just announced in February.

Mr. PAPPAS. OK. And the figure is approximately $400 million?

Mr. MANGANO. That is correct.

Mr. PAPPAS. Is that just for 41 New York hospitals?

Mr. MANGANO. That is correct.

Mr. PAPPAS. And is the $400 million just for 1 year or is it for that 4- to 6-year period?

Mr. MANGANO. I believe it is for the entire period.

Mr. PAPPAS. And what about other hospitals in other parts of the country?

Mr. MANGANO. Of course, as soon as they announced this program, hospitals in other parts of the country have asked to get in on this. HCFA has—this is under their demonstration authority. They're demonstrating whether this is a good approach or not a good approach. So the position of HCFA is they have one State that they're working with. And that's the State of New York. And usually under these demonstration projects, if it works out well there, they may decide to expand it to other States. But they may not.

Mr. PAPPAS. Mr. Chairman, I would just say that I would question whether this is an advisable expenditure for us to be making. I certainly would like your comments. I was——

Mr. SHAYS. Well, if the gentleman would yield?

Mr. PAPPAS. Sure.

Mr. SHAYS. I mean, the purpose of this hearing is not to delve too deeply into any particular issue, but to just kind of whet our appetite and yours and know where you're coming from, and for us to then decide how we want to allocate our very scarce resources. And this may be an area that we need to look at.

Mr. PAPPAS. OK.

Mr. HEMBRA. Mr. Pappas, I might add something. We need to understand—for years and years and years, teaching hospitals were basically reimbursed with additional payments—both Medicare and Medicaid—to teach physicians as part of their set of responsibilities relative to the Medicare/Medicaid population that were treated in those facilities. And I think that amount of money is—off the top of my head—something like about $6 billion a year that go toward graduate medical education payments.

And this begins to completely move back, recognizing what is an overabundance of physicians. And from what we have read—we have not looked closely at it, because it's a new policy change—but the way in which the media has covered it, it's not very clear whether this has been well-thought-through by HHS and HCFA.

Mr. PAPPAS. I would——

Ms. LILLIE-BLANTON. Could I also respond?

Mr. PAPPAS. Yes. Sure.

Ms. LILLIE-BLANTON. Because I think what's important, as you've mentioned, is that we really are faced with an oversupply of physicians in this country. And in all fairness to HCFA, I would say the attempt was, how do you begin to reduce that supply? But we've got a broader issue, I would say, to look at. And that is the training of foreign physicians, which, in many cases, have benefited from those resources and the dollars.

We also have to realize that many of those foreign physicians who have trained to those dollars have been providing care to medically underserved areas. So as we cut the supply of physicians in one area, we've got to look at its potential consequences for another area. And then I would say, within HHS, we need to look at the multiple health professions development initiatives, some of which actually is continuing to provide funding for the training of new providers.

And so, while on one level we realize we've got an oversupply of providers, on another level we know we have problems in the dis-

tribution of providers. And so I would say that, on the issue of human resources development, it is a broader issue from a policy perspective for us to look at how this Nation should handle its problems of human resources in health professions.

Mr. PAPPAS. I would appreciate—not here—but some additional information other than what I have read in the newspaper about that particular program. So if you could supply that for me—whoever—I would appreciate it. Point other than trying to verify if this is the case, the point I will just mention and then I'll move on is, I question whether this is an appropriate role for HHS and the cost.

These are comments. The other issue is one that I dealt with in another meeting of the subcommittee on another subject, where we have representatives of another department—USDA—and three agencies that are part of HHS—FDA, the National Institutes of Health, and the Center for Disease Control. We're talking about an issue of—I guess it's—I'll just forget the technical term—mad cow disease. What is the technical term?

Do you remember? OK. It's easy for you to say. And the question I asked the three agencies from one department and another department all involved in research—and I guess, just a comment that I felt it was—I was surprised that there was not one of these agencies that was designated or agreed upon as the "lead agency." And I would just encourage you folks to encourage that as just a policy that, evidently, has not been instituted.

Because, if we're looking for greater accountability, as, I think, the taxpayers require, and, certainly, we want, and I'm sure you want, as well. I think that as a matter of course, there should be a lead agency involved in any kind of a joint research project or joint project, because if something goes wrong, there's going to be a lot of finger pointing. And it doesn't make it easier for folks like yourselves, in particular. Thank you, Mr. Chairman.

Mr. SHAYS. Thank the gentleman. For someone who likes to get at waste, fraud, and abuse, HHS is a candy store. And for just a variety of reasons. And it's not a Republican-Democrat issue. I'm just looking and thinking how we could use our entire committee staff just to look at one area. You have the Administration for Children and Families. You have the Administration on Aging. And you have the Health Care Financing Administration (HCFA), Agency for Health Care Policy and Research, Center for Disease Control, Agency for Toxic Substances, Disease Registry, Food and Drug Administration (FDA), Health Resource and Service Administration, Indian Health Services—I mean, I'm just thinking how we could spend so much time dealing with the pathetic success of health care in Indian reservations—National Institutes of Health, Substance Abuse and Mental Health Service Administration.

I'm just wondering, when you look at a department so large I think when you added Social Security in with it there, the budget was larger than the gross domestic product of Canada. I'm not quite sure that's right, now that I've said it, but close to it. I'm just curious how you all decide which wrongdoing, what area of fraud you're going to get at, what area of waste you're going to get at, given that you could almost just close your eyes and do that? Is

that what you do—close your eyes and just kind of put your finger down, and say, "OK. This is it?"

Ms. BROWN. No, sir. And it's a pretty complicated process. Of course, we're constantly doing various research to see where there are anomalies in the payment schemes that are going on. And that often points, as it did in the incontinence supplies chart where we have a sudden spurt, and it isn't accountable because of some new disease or increase in patient population or something of that nature.

We're constantly looking at all of those to see whether or not there is some new scheme that has emerged that has allowed people to over bill certain programs. We look at all of the HHS programs, actually. But now that the new health legislation has passed, we do have a limitation we didn't have before. We have increased resources as a result of that, all of those resources that were voted in for health care have to be used just on health care.

Mr. SHAYS. Right.

Ms. BROWN. And that's about 70 percent of our budget. It's about 30 percent, then, that is used for all the other programs. So for the first year, we're having to track very carefully exactly how much goes into each area. So that's one constraint.

Mr. HEMBRA. From GAO's standpoint, we have a pretty disciplined approach to planning strategically and in a more tactical fashion. As you're well aware, Mr. Chairman, a good part of that is working with the committees on both the House and Senate, to ensure that the work that we do best fits the needs of the authorization, the appropriations, the budget, and the oversight committees.

Mr. SHAYS. Does GAO—is it more legislatively directed in that sense? Let me ask it this way: does the Inspector General's office have a little freer hand in what it looks at? And is the GAO a little more guided by congressional areas of focus?

Mr. HEMBRA. I'd like to let June speak first to this.

Ms. BROWN. Yes. We have independence that has been provided to us under the IG Act. So that, the Department or Congress—nobody can really tell us how to use our resources. And I have the responsibility, then. We have a long planning process. We have a strategic plan we go through. We look at all the emerging areas like home health and some of the new effects on nursing homes and hospice, when laws change and so forth.

Mr. SHAYS. But you're open to suggestions as well as requests?

Ms. BROWN. Absolutely.

Mr. SHAYS. And sometimes you do work that's just in response to requests you, obviously, then, had to have deemed were necessary areas.

Ms. BROWN. Yes. But we encourage both Department officials and Members of Congress, if they are aware of any problem area, to let us know. There have been a few cases where we've had to turn that down because the priority was lower.

Mr. SHAYS. Right.

Ms. BROWN. And we have that authority. But of course, that's where we get a lot of the good leads that would show us where problems——

Mr. SHAYS. Does the GAO?

Mr. HEMBRA. Yes. From a GAO standpoint, I think currently, if you look across GAO, probably about 85 percent of our work is what we call congressionally directed.

Mr. SHAYS. Gotcha.

Mr. HEMBRA. Either through legislative mandates or through specific requests that come in from committees or even individual Members.

Mr. SHAYS. And some of those legislative mandates are continual, ad infinitum? They are annual requirements that you have to look at?

Mr. HEMBRA. They are. But they're much less today than they were in the past. We've worked pretty successfully with the leadership on both the House and Senate side to eliminate a number of those. Of course, our resource base has dropped considerably over the last couple years. But we do have flexibility. I don't want to suggest that we sit back and wait for someone from the Hill to ask us to do a job.

Mr. SHAYS. No. If you see an area that you want to look at, you can look at it?

Mr. HEMBRA. Yes. Within the resource constraints. Absolutely.

Mr. SHAYS. Right.

Mr. HEMBRA. And we do that quite a lot.

Mr. SHAYS. OK. In terms of the presentation of the Inspector General focus on home care, medical equipment and supplies and hospice benefits, let me just get a sense of this. We had fascinating hearings on the whole issue of medical supplies and pricing. And let me just say, I made a reference to it in my opening statement.

This committee takes tremendous pride in Title II of the health care reform bill, which had three titles. Title II was the whole issue of getting at health care fraud, making health care fraud a Federal offense for all payers, private and public. And that was the work of both Jay Owens, the Inspector General, as well as the administration.

But that was a big plus. What we didn't do was see any movement toward legislation that we developed based on our hearings, dealing with the repricing of durable goods. I want to just understand if the system is still as crazy as I recall it, that, basically, we have rules and regulations that we the Government and we the buyers have to follow, that basically outline what we will pay for a good and service, and that if it is underpriced, we end up with no sellers.

In other words, there's no law that requires a seller to buy if we aren't paying a market rate. If we pay an above-market rate, we obviously have a lot of sellers, but we don't have—but we have the requirement that we have to buy at that price unless we go through a process to refigure the pricing mechanism. Now, this is what I want to go through.

Now, basically, we follow section 1842BA of the Social Security Act, and we have to determine that it's grossly excessive or grossly deficient—our pricing. Is that correct?

Ms. BROWN. Yes, sir.

Mr. DOWDAL. Yes.

Mr. SHAYS. So if it's very excessive or very deficient, technically, we don't meet the test. We can overpay if its very excessive and very deficient, but we can't reprice unless it's grossly deficient?

Ms. BROWN. Yes. And there's a long process that you have to go through.

Mr. SHAYS. Yes.

Ms. BROWN. The same as changing any regulatory matters, which takes 2 to 3 years. So I know you've held hearings in the past where we've presented some of this data and have brought the public's attention to it, which I certainly applaud. Because we need some mechanisms for adjusting prices in such a fast changing market as this. We need the authority to do competitive bidding when that's appropriate as well.

Mr. SHAYS. Yes. My recollection was confirmed, that we did issue a report on this, but we need to followup. Does GAO want to respond to this? Did you all get into this?

Mr. DOWDAL. Yes. We've done a number of jobs where we've recommended that more authority be given to the agency to reduce prices when they're obviously out of whack with what the market is paying for them. We've been issuing reports on that since the late eighties, in fact.

Mr. SHAYS. OK. Well, this is one thing that I, certainly, am going to spend some of my time on, because the only thing gross about the system is that we allow it to continue. If it's excessive, we should change the price. So that will be one thing. And I appreciate you highlighting that. Did you want to respond in any way?

Ms. BROWN. Well, I only mentioned that there are things like oxygen concentrators, which we have reported on. And we're paying twice what the VA is paying. And they're able to competitively bid, where HHS is not.

Mr. SHAYS. Now, twice is astounding. The explanation on the other side would be that VA buys in bulk and it—Medicare and Medicaid would be buying in—is it both Medicare and Medicaid that we're talking about?

Mr. MANGANO. Our reviews were in the Medicare area.

Mr. SHAYS. Right.

Mr. MANGANO. And just to give you the specific figures, VA pays about $128 a month for an oxygen concentrator, Medicare pays $345 for one.

Mr. SHAYS. I mean, it just boggles my mind.

Mr. MANGANO. That is correct.

Mr. SHAYS. Now, the other thing that boggled my mind—I'd just like both of you to respond, both GAO and Inspector General. We have a system where if doctors submit bills, we—my recollection is that we review 1 percent of the bills and about 4 percent of the billing charges, and that we pay it and then have to go back and try to capture it. It's only in those bills that we check. Is that process still continued? Has HCFA changed that system at all?

Mr. MANGANO. The process is really driven by some pieces of legislation that require Medicare to pay its bills within a time limit, I believe it's within 30 days.

Mr. SHAYS. Right.

Mr. MANGANO. And they must pay those bills within that timeframe. As a result, what the Medicare program does, primarily—

is does a lot of post-payment review. But as we've mentioned earlier, only about 2 percent of the claims ever go through that post-payment review. The only way they can catch it prospectively is through what they call ADITs.

Mr. SHAYS. Is that the auto-adjudicated system that we're talking——

Mr. MANGANO. Yes. There's—that's correct. There are ADITs that the contractors—the Medicare contractors, the insurance company which runs the program—have in their system. So, if a bill looks grossly out of whack, it rings a bell on and ADIT. They can go in and look at the particular bill.

Mr. SHAYS. But the fact is that if someone broke their ankle and had a chest x-ray, that bill would get through the system.

Mr. HEMBRA. That is correct.

Mr. SHAYS. Because we don't have an auto-adjudicated system that would get that disconnect.

Mr. HEMBRA. Right.

Mr. SHAYS. And have we seen any process since our hearings last year on that?

Mr. HEMBRA. Not really.

Mr. SHAYS. OK. You almost feel overwhelmed. Both those two areas just strike me as being such absurdities. So I'm going to continue a little bit and then—do you have any more questions for this panel? You can just turn the clock off. That's the one power of a chairman: I control the clock.

I love it. In terms of the whole information systems, we're learning that the IRS may have wasted $3 billion. When I look at it, I find that the details don't support $3 billion, but support hundreds of millions if not billions. Are we in the same danger with HHS, with its information systems?

But the problem is that if a business had such an important element of its business—information systems—they would spend $1 million or $2 million to hire the best and the brightest. And they would pay them and they would get their money back ten fold. Here, we're limited, I gather, by what a civil servant can make. Is part of the problem that we don't have the expertise? First, I want to know, do we have a problem with information systems? I'd like for you to expand a little bit more, since the Comptroller General, you introduced it. And are we in danger of coming to concluding that we, too, have wasted hundreds of million, if not billions of dollars in information systems, and don't presently have a good system or systems?

Mr. HEMBRA. If you look back, Mr. Chairman, what you find is, as information needs would surface, you would see agencies pretty much creating stand alone, stove pipe systems to deal with a specific information need. And of course, with the advancement of technology, clearly the capability has expanded tremendously.

If you look at HHS—and you could go down specifically and look at Medicare, because there is a multi-million dollar system's investment that's being made now with regard to the Medicare transaction system, which will ultimately replace about nine different information systems that HCFA and its contractors use in processing claims.

Is HHS vulnerable with regard to information systems? GAO has a lot of work across the Government that says, "Of course." And there has been millions and hundreds of millions of dollars wasted. Fortunately, I think——

Mr. SHAYS. And you're working with Mr. Horn's committee on this area—management systems?

Mr. HEMBRA. Yes. That is correct. That is correct. Fortunately, there's a couple of things happening. In general, and if—take you back to my statement—the Paperwork Reduction Act, the Clinger-Cohen Act and the creation of Chief Information Officers, were all geared toward bringing some sense of order to how agencies went about determining what its information management needs were and how they were going to go about phasing those in.

We had looked early at HCFA's Medicare transaction system, found some problems that they were having, and have been working pretty closely with HCFA on MTS. And so I think there's less likelihood of seeing something similar to IRS happening within HCFA and its Medicare program. I think one thing that HHS has to do to make sure that it doesn't get out of hand, is make sure that it integrates its information management needs as part of it overall GPRA process of developing a strategic plan.

You can't do that outside of the process. It's an integral part of what's going on. The second thing HHS, I believe, HHS needs to take a look at is, with regard to the Chief Information Officer as well as the Chief Financial Officer—the Secretary has chosen to triple hat an individual within the Department, the Assistant Secretary for Management and Budget, giving that individual also the title of Chief Information Officer and Chief Financial Officer.

Clearly, with regard to the Chief Information Officer, we don't believe that that's consistent with the legislation. And it certainly calls into question whether one individual has the capacity at a senior management level to carry that wide range of responsibilities.

Mr. SHAYS. Have you conveyed that concern?

Mr. HEMBRA. That information has been discussed, but there's been no change within HHS.

Mr. SHAYS. OK.

Ms. LILLIE-BLANTON. Could I respond to that also?

Mr. SHAYS. Sure. Sure.

Ms. LILLIE-BLANTON. I think there is a particular challenge in developing information systems for HHS. And that's, in part, because HHS works so closely with States. And I think welfare reform is an example of that, but Medicaid is also an example, where you are relying on data and information systems which are collected at the State and local level.

And we now have a major restructuring in our system of welfare. The Federal Government, HHS in particular, is to monitor compliance with that, but it's got to monitor compliance based on information that is supplied by the States. And you have, in many cases, States with very limited data information capacity, management information systems.

And it just presents, I would say, a major challenge for HHS to assistant, to develop, to monitor, with the information that will come from different States, sometimes which may not be com-

parably collected, sometimes which may not have the same kind of control system, sometimes sexual harassment just may very well be different types of information.

So I would say that there is a particular challenge. We have seen, with the experience of Medicaid, that even when there is some Federal oversight in trying to assist with—because the Federal Government does collect—has two different data systems for the Medicaid program that it collects. But even with those, we have some very serious problems in the data that is collected through HHS data information systems. So it is a very serious problem.

Mr. SHAYS. Now, as you talk, I'm thinking that in my home town we have two companies that, 10 years ago, didn't exist. And today they're billion dollar companies. And yet they realize in 10 years they may not exist again. The change is so rapid. And I've been wondering for a while if one of the best arguments for why we need to try to have government do a little less, and then do everything else better, is that it just may not be able to keep up with the change.

One of my concerns in Government is that too many people make the decision before it finally comes to fruition, whereas in the private sector now, they've empowered two or three people in that chain to ultimately make very big decisions. Do you want to comment?

Let me just tell you my plan. I'm going to invite either staffs to ask a few questions if they want, only because really what we're just trying to do is flush out where we want to focus our time. And so, it's really, I think, appropriate to have our staff weigh in here if they want. But did you want to say something first?

Ms. BROWN. Well, I wanted to comment on the new system that they're developing, that——

Mr. SHAYS. They being—and for which system?

Ms. BROWN. I'm sorry. HCFA is developing——

Mr. SHAYS. OK.

Ms. BROWN [continuing]. For Medicare.

Mr. SHAYS. Right.

Ms. BROWN. And this will be a gigantic system that is far larger than any insurance company, of course, would have.

Mr. SHAYS. This is MTS or——

Ms. BROWN. MTS. Yes. We are able to bring a lot of things to their attention, particularly through doing the financial system audits. We have identified a lot of problem areas and a lot of areas that have to be treated differently in the system. So we have a process for working with them on that, which I think will help a great deal. I did want to point out that there is not requirement, not even the capability for them—being HCFA—demanding the Social Security number of the providers until this latest legislation passed—Kassebaum-Kennedy.

HCFA didn't have unique provider numbers, either. And both of those are going to seriously undermine the effectiveness of a system. So I think they do need Social Security numbers. Even when we exclude somebody from the program, there's no way of tracking how many other areas they might be billing in.

Mr. SHAYS. Let me just say—I'm going to call on the majority counsel—but my purpose is to ask if there was a question that you

wish we had asked, if you want to respond to the question we never asked you, but wished we did. And also, I find that those who come and testify who say the least sometimes have more time to think about something they want to say. So with the power invested in me, I'm going to provide the three of you who didn't make opening statements to get some closing words and see if you're willing to risk saying a comment that your boss may not like.

Mr. DOWDAL. Well, that's never stopped me before.

Mr. SHAYS. Good. Well, we'll come to you in a second. OK. Do you have a question you want to——

Mr. HALLORAN. Yes. I just would ask each of you to comment on block grants in general and the kinds of accountability systems you see that the Department should use in maintaining the flexibility that are built in the block grants and, yet, being able to provide the accountability that you want and we want in terms of the money that's spent. It's a difficult balance. You talked about data problems, which is one area. But where have you seen in the block grant programs we have, where has it worked, and what kind of emerging problems might you see as we roll out bigger block grants such as the welfare reform?

Ms. LILLIE-BLANTON. Well, actually, let me just give you something that I would say HHS is doing now that might be an approach to use, because I think we have had problems with block grants in the past. HHS has begun to develop what is called performance partnership grants. And they've used that approach with SAMHSA, the Substance Abuse and Mental Health Services Administration, and CDC. In the process of the performance partnership grants, there is negotiation with States on the goals and outcomes that they want to see achieved. And so, rather than holding a State——

Mr. HALLORAN. And the form of the data that will prove it? Is that part of the deal?

Ms. LILLIE-BLANTON. The process has varied, but certainly—I'd have to look back to find out how specific and how prescriptive they are in the data goals, the data elements that would be used to document outcomes. But certainly, along with the broad objectives—the broad goals are objectives, which are measurable objectives. At least with that process you have a way of working with an entity—a State or, in some cases, it could be a local community—in trying to negotiate what you want to achieve, even if you didn't look at all the details of how it's achieved.

So certainly, I would say the goals and the outcomes would be an approach that we could use that still give States some decent flexibility in how they design their programs, but at least the accountability system, from the point of the Federal Government, can be monitored because you have defined what you wanted to achieve. That's a part of the pilot efforts that are now underway.

It's still not certain how well that can work with the broad array of what—of programs that HHS has. Welfare reform, for example, is an example where that is a little different. And when I talked about the demands on welfare reform—just to take a couple of them—one are the time limits and the work force participation requirements.

In that case, Congress has to set some goals, measurable goals. But the data systems, at this point, are not in place to document and monitor them. So it is a balancing act. With the performance partnership grants, I think, are a way that we could try to work on some level. When you move to goals that are so broad, that cut across all the States, such as welfare reform, it means we've got to talk about more uniform data collection systems that can help guide and develop.

And you know, it could mean resources to assist in developing those infrastructures. But otherwise, I think that we will be comparing apples and oranges even as we give out performance bonuses—for example, for declines in out of wedlock births. I think that that just becomes problematic, but yet, the intent is a desirable goal.

Ms. BROWN. If I could comment. The President's council on integrity and efficiency, which is a group of all the Presidential appointed Inspectors General, did a study on just this. It isn't recommending one way or another, but it explains what vehicles could be included in any legislation or other provisions of a grant, and what the results might be. If the grant doesn't provide for oversight, there would be no way, in spite of any efforts and whatever data we had, we would not be able to go in and audit against anything.

So that would be one extreme. This report goes on and explains some of the possible vehicles for gaining some level of oversight. I'd be glad to provide that report so you could get a balance of all the IGs' views.

Mr. SHAYS. Ms. Brown or Mr. Hembra. Is there any question you wished we had asked that—I mean, there's a lot of things we could have—but—so nothing—Mr. Mangano, do you have any comment you wanted to—?

Mr. MANGANO. No. I don't think so.

Mr. SHAYS. Ms. Brown, any comment? Mr. Dowdal.

Mr. DOWDAL. Yes. I think I'd like to re-emphasize that the GPRA process provides a real good opportunity for everyone to take a look at the processes and everything that the agency has, to meet the goals that have been given to it under the laws. And by using that opportunity to better design their systems for controlling costs, I think HCFA can get around a lot of the problems that currently are evident in the waste and abuse and fraud and mismanagement area. So I think—I hope that the GPRA process works as well as it should.

Mr. SHAYS. Knowing what your mission is and how you're going to carry it out is obviously very important. I find that it also—we try to do it—obviously, the task is much easier in our own offices. But knowing your mission, your strategy, your projects, and your tactics, and getting your staff to talk about it is very energizing. So it can be a tremendous tool if it's used well.

And I know that you both are expressing concern. You know, I guess this year is the moment of truth of whether the departments take it seriously or not and take advantage of it. Let me say that we're going to go to our next panel, but the dialog, obviously, continues. You know that you can pick up the phone any time and we feel that we can do the same.

So I'll just emphasize, again, my interest in making sure that we look at the worst of the worst or look at the areas where we can have the greatest impact and change, given that there is so much that we can look at. And given that we have this problem on this side, we also understand that you have that same challenge. So we're very patient when we see something that doesn't work, and say, "My gosh, why didn't you all get at it?" Because you've got more than enough to do. So thank you very much.

[The information referred to follows:]

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April 1, 1997

The Honorable June Gibbs Brown
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Brown:

At the March 8, 1997, hearing "Agency Oversight -- The Department of Health and Human Services: Mission, Management, and Performance," Representative Benjamin Gilman (R-NY) submitted the following question:

> Questions have been raised with regard to the implementation of the National Childhood Vaccine Injury Act of 1986, specifically with the long period of time it takes for a vaccine-injured individual to receive compensation. Has the Inspector been made aware of this problem, and if so what can you report?

Please provide written responses for inclusion in the hearing record by May 1, 1997. We will forward a copy of your responses to Rep. Gilman. If you find any difficulty responding by May 1, please contact me immediately. Thank you.

Sincerely,

R. Jared Carpenter
Subcommittee Clerk

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 8 1997

The Honorable Christopher Shays
Chairman, Subcommittee on Human Resources
Committee on Government Reform and Oversight
House of Representatives
Washington, D.C. 20515-6143

Dear Mr. Shays:

Your staff requested a written response to a question from Representative Benjamin Gilman asking about the National Childhood Vaccine Injury Act of 1986. This was raised pursuant to our testimony before your subcommittee on March 18, 1997. Mr. Gilman's specific question was whether the Inspector General's Office was aware of a problem with timely compensation for vaccine-injured individuals.

We are not aware of any present problems with timely resolution of cases. In December 1992, we issued a report reviewing the structure and operations of the National Vaccine Injury Compensation Program. A copy of the report is enclosed. At that time the program was struggling to handle a large influx of retrospective cases which were causing delays. However, we found that once a case was assigned, it was handled efficiently. We found that in our sample of prospective cases, none missed the 14-month statutory requirement for processing. At the time, we recommended that the claims court, in consultation with the Public Health Service and the Department of Justice, further streamline the process to eliminate the backlog and ensure future efficient procedures. The program office now reports it has cleared its backlog of retrospective cases and is currently processing prospective cases well within the statutory requirement of 14 months.

If you have additional questions, please contact me; or your staff may call Helen Albert, Director of External Affairs, at 619-0275.

Sincerely,

June G Brown

June Gibbs Grown
Inspector General

Enclosure

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM: A PROGRAM REVIEW

DECEMBER 1992

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

This report was prepared in the New York Regional Office under the direction of Regional Inspector General Thomas F. Tully and Deputy Regional Inspector General Alan S. Meyer. Project staff included:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM: A PROGRAM REVIEW

DECEMBER 1992 02-91-01460

EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to review the structure and operations of the National Vaccine Injury Compensation Program (VICP).

BACKGROUND

The VICP is a Federal "no-fault" system which was intended to stabilize the vaccine manufacturing industry and to establish a streamlined process to compensate persons who have suffered injuries due to certain vaccines. The VICP involves three government entities: the Public Health Service (PHS) in the Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the United States Court of Claims (Claims Court). After a claim is submitted to the Claims Court, physicians at PHS review each case based on the Vaccine Injury Table and send their recommendations for or against compensation to the Claims Court, where a hearing takes place. With DOJ attorneys representing the government and private attorneys representing petitioners, a special master, appointed by the Claims Court, makes a final ruling and determines the amount of the award.

In conducting the inspection, policies, written procedures and operational guidelines for the program were reviewed to determine how the program is organized and how it attempts to meet its legislative and regulatory goals. Flow charts of the processes were constructed. Next, from the universe of 2,347 cases in the PHS database a statistical analysis was done and 90 cases were selected for review. The team also interviewed 23 key government officials and 31 petitioners and their attorneys.

FINDINGS

The Program is Currently Struggling To Handle A Large, Unanticipated Influx of Retrospective Cases

At the current production level of approximately 37 cases a month, it will take approximately seven years to complete all of the retrospective cases. As of February 1992, 739 retrospective cases had been completed, leaving 3,356 cases to handle. Some government officials feel that the current production rate will increase due to changes in legislation, the increased experience of the program staff, and an anticipated increase in case dismissals.

Cases are Delayed Due To a Front-end Backlog Resulting From Scheduling Constraints and Lack of Resources

The large influx of retrospective cases has necessitated that the chief special master control intake into the system, resulting in a backlog. No guidelines exist for the

special master's scheduling of cases. They are not necessarily assigned in order of filing. Approximately 2,500 cases have not been scheduled and are backlogged.

Respondents identify specific resources which they consider insufficient to handle the backlog. The chief special master recommends more staff attorneys at the Claims Court and the chief medical officer suggests additional reviewers. The PHS staff also cite a shortage of both pediatric neurologists and infectious disease specialists willing to testify.

The Case Process is Efficient Except for the Front-End Backlog

An analysis of the flow of cases in the PHS database shows that once a case is assigned, it is handled efficiently. Delays exist only at the front end for retrospective cases. The program is meeting deadlines for prospective cases, handling them in a timely and efficient manner.

Our review of program policies and procedures, reinforced by the responses of government officials, shows the program to be well-organized. Each step in the process is clearly delineated and no unnecessary duplication is apparent. Coordination and communication among the Federal agencies is strong. Their roles and responsibilities are clearly defined. Petitioners and their attorneys are generally satisfied with their experience in the program.

A Significant Portion of PHS Medical Review Recommendations Not To Compensate are Overturned by the Special Masters

A review of all completed cases, as of August 1991, reveals that 58 percent of the cases that the PHS medical staff recommended not be compensated were compensated. Several government officials cite two major factors which account for the reversal rate: lack of corroboration of evidence and various interpretations of the Vaccine Injury Table.

The Present Vaccine Injury Table Does Not Reflect The Latest Scientific Evidence

A recent Institute of Medicine (IOM) study found a lack of causal relationship between certain vaccines and injuries on the existing Vaccine Injury Table. Some government officials estimate that if future cases are decided only on the basis of the latest scientific evidence, the compensation rate would be significantly lower.

Government Officials We Interviewed Support Annuities and The Use of Brokers

Most government officials believe annuities are the best way to pay the award and brokers are needed to buy the annuities. Annuities assure long-term benefits, avoid mismanagement of funds, and are less expensive for the government.

RECOMMENDATIONS

The PHS, DOJ and Claims Court should:

Inventory the Backlog to Set Priorities and Better Estimate Future Resource Needs

The Claims Court, in consultation with PHS and DOJ, should evaluate the existing workload to determine which cases it should handle first, what mix of resources will be needed to handle them, and how best to handle more complicated cases.

Further Streamline the Process

Some suggestions include: assuring more complete filing of petitions, appointing one objective expert witness per case, processing damage determinations more quickly, and using past damage decisions as a basis for future ones.

Use Latest Scientific Information

The HHS should support proposed legislation to revise the Vaccine Injury Table to reflect the latest scientific information available, particularly changes recommended by the IOM.

Improve Contact with Petitioners and their Attorneys

Emphasize Use of Annuities

COMMENTS

Comments on the draft report received from PHS, the Assistant Secretary for Planning and Evaluation and the Assistant Secretary for Management and Budget generally concur with the recommendations of this report. However, PHS pointed out that its role in the process is a limited one. We agree. We have directed our recommendations to the Department of Justice and the Claims Court as well as PHS. Suggestions for changes in the wording, clarifications of the text and any technical changes have for the most part been incorporated into the final report. The actual comments received are in Appendix D.

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INTRODUCTION

PURPOSE

The purpose of this inspection is to review the structure and operations of the National Vaccine Injury Compensation Program (VICP).

BACKGROUND

Immunization Goals and Vaccine Injuries

State laws generally require that children be immunized against seven infectious childhood diseases (diphtheria, tetanus, pertussis [whooping cough], measles, mumps, rubella and polio) before entering day care or school. If a large enough proportion of the population is immunized, the disease will not spread significantly and the entire population will benefit. Thus, it is important that vaccines in this country remain in adequate supply and be fairly priced.

Since the advent of these vaccines the occurrence of the diseases they prevent has decreased substantially in the general population. People are often no longer aware of the dangers of the diseases. Before the vaccines, epidemics of the diseases they prevent caused widespread death and disability.

Immunization is not entirely without risk, however. While severe adverse reactions rarely occur, they are a tragedy for the individual children and families who suffer them. Parents of these injured and deceased children originally sought damages from vaccine manufacturers through tort litigation. Tort law requires that the plaintiff prove negligence on the part of the manufacturer or person who administered the vaccine. This process often took years and consumed inordinate amounts of money.

The rapid growth of lawsuits and the increased manufacturer liability adversely affected the vaccine supply. Vaccine prices rose and some manufacturers left the business. By the mid-1980s there was only one manufacturer for polio vaccine, one for measles, mumps and rubella (MMR) vaccine, and two for diphtheria, tetanus and pertussis (DTP) vaccine.

Legislation

In response to this mounting public health concern, several bills were introduced and debated in congressional hearings on the issues of fair compensation and adequate vaccine supply. Ultimately, the National Childhood Vaccine Injury Act of 1986 (the Act) became law. This legislation attempted to ensure both fairness to injured persons and protection for the Federal immunization program. It was designed to serve two vital public purposes: (1) to provide prompt and fair compensation to the few children who died or were injured as a result of routine immunization; and (2) to

reduce the adverse impact of the tort system on vaccine supply, cost and innovation.

To fulfill the part of the Act that deals with fair compensation, the VICP (Subtitle 2 of Title XXI of Public Health Service Act) became effective on October 1, 1988. Subtitle 2 was later amended by the Omnibus Reconciliation Act (OBRA) of 1987, by the 1988 and 1989 amendments, by the Vaccine and Immunization Amendments of 1990, and most recently by the Health Information, Health Promotion, and Vaccine Injury Compensation Amendments of 1991, signed into law on November 26, 1991.

Subtitle 1 of Title XXI of the PHS Act also establishes the National Vaccine Program (NVP) to achieve prevention of infectious diseases through immunization and prevention of adverse reaction to vaccines. The National Vaccine Advisory Committee (NVAC) (Section 2105 of the PHS Act) advises and makes recommendations to the director of the NVP.

Another legislated activity, the Advisory Commission on Childhood Vaccines (Section 2119 of the PHS Act) advises the Secretary on how the VICP is being implemented and how it is accomplishing its goals. It has prepared a policy paper which discusses options to be considered for the future direction of the program.

The Assistant Secretary for Health has also established a PHS-wide task force to make recommendations on the future direction of the VICP, including proposing legislation to deal with the influx of claims, as well as the long-range future of the program.

Program Description

The VICP is a Federal "no-fault" system which compensates families whose children have had serious adverse reactions to vaccines for the following childhood diseases: diphtheria, tetanus, whooping cough, poliomyelitis, measles, mumps and rubella.

The program, which began to consider petitions as of February 1, 1989, differentiates between claims based on immunization prior to the Act's effective date of October 1, 1988 (retrospective cases), and those based on immunizations on or after that date (prospective cases). A deadline of January 31, 1991 was set for filing claims in retrospective cases.

Retrospective and prospective cases are subject to different rules and remedies as described in Table I below. Compensation for retrospective cases comes from an annual appropriation of $80 million. Compensation for prospective cases is given to a maximum of 150 claimants per year, and is financed through an excise tax on childhood vaccines. In both types of cases, awards for death cases are fixed at $250,000 plus attorney fees and costs.

TABLE I: COMPARISON OF RETROSPECTIVE AND PROSPECTIVE CASES

	RETROSPECTIVE	PROSPECTIVE
DATE OF VACCINE	Prior to 10/1/88	On or after 10/1/88
SCHEDULING	Non-sequentially	Sequentially
DEADLINE FOR DECISION ON CASE	32 months	14 months
# OF CLAIMS FILED BY 2/18/92	4,095	220
# OF DECISIONS BY 2/18/92	789	50
COMPENSATED	303 (38.4%)*	21 (40%)**
NOT COMPENSATED	90 (11.4%)*	7 (14%)**
DISMISSED	396 (50.2%)*	22 (44%)**
AWARDS BY 2/18/92	$192 million	$10.5 million
FUNDING SOURCE	Annual Congressional appropriation of $80,000,000	Vaccine Injury Compensation Trust Funded by vaccine excise tax
ALLOWED AWARD AMOUNTS:		
INJURY	Unlimited	Unlimited
DEATH	$250,000 plus attorney fees & costs	Up to $250,000 after pain and suffering + attorney fees & costs
ATTORNEY'S FEES & COSTS	$30,000***	Unlimited
BASIS OF AWARDS	Estimated future unreimbursable rehabilitative and related medical expenses; actual and future loss of earnings; attorney's fees & costs.	Actual past and estimated future unreimbursable rehabilitative and related medical expenses; actual and future loss of earnings; actual and projected pain and suffering; attorney's fees & costs.

* Percentage of completed retrospective cases.

** Percentage of completed prospective cases.

*** This amount also includes petitioner's actual and projected pain and suffering and loss of earnings.

The VICP consists of three government entities: the Public Health Service (PHS) in the Department of Health and Human Services (HHS), the Department of Justice (DOJ), and the United States Court of Claims (Claims Court) which work together to process the cases.

Families of injured or deceased children submit petitions for compensation to the Claims Court which sends a copy to the PHS. The petitioner must prove program entitlement as well as losses and expenses. After a petition is filed, the chief special master in the Claims Court assigns the case to a special master and puts it on the schedule of upcoming cases.

The PHS medical experts, in the Division of Vaccine Injury Compensation (DVIC), evaluate the case and offer an opinion as to whether or not the petitioner is eligible. The PHS Office of General Counsel (OGC) reviews this opinion and forwards it to DOJ. Within 90 days of the original filing, DOJ writes a report incorporating the PHS medical evaluation with a legal response; extensions may, however, be requested and due to the backlog of retrospective cases almost always occur for these. Attorneys from the DOJ and petitioner attorneys then argue the case before a special master in a formal hearing. Prior to the hearing, a great deal of factual and expert preparation is undertaken by the DOJ attorneys and petitioner's attorneys in order to present the case.

Both the PHS medical experts and the special masters are required by statute to use the Vaccine Injury Table when deciding whether an injury is compensable. This table outlines the injuries compensable under the program and the time-frames in which they must have occurred. This table is intended to avoid controversy over which disabilities are potentially caused by vaccines. It is accompanied by "Qualifications and Aids to Interpretation" to allow for easier interpretation.

The final decision on a case is made by a special master of the Claims Court. This decision will become a final judgement if no motion for review is filed within 30 days or if the Claims Court affirms the decision of the special master. A case may be compensated or not compensated or it may be dismissed. When a case is dismissed it is no longer under consideration for a potential award. Their judgement is final, unless either the claimant or HHS requests a review by a Claims Court judge. Further review is available in the United States Court of Appeals.

The Act gives special masters a great deal of leeway as decision-makers. They are not bound by common law or statutory rules of evidence, but are guided by them. They can tailor each hearing to the individual circumstances as they choose, but are constrained by the principle that their decisions may be reversed.

Once a decision is made to compensate, the award amount is negotiated. A life-care planner assesses the present and future needs of the disabled person and their costs, and recommends an award amount. The special master determines the actual amount. The entire process for retrospective cases, from time of initial petition to

final decision, originally was to occur in 14-months, was increased to 20-months in 1990 and, since the 1991 amendments to 32 months. The entire process for prospective cases must occur in 14 months.

It should be noted that compensation for retrospective cases begins at date of judgement and the petitioner is not paid for any expenses incurred before then. However, compensation for prospective cases is for past and estimated future expenses.

Amendments to the Act signed November 1991, delete a provision which terminates the entire program if funding is insufficient. These amendments also change the due date for an evaluation report on the program to January 1, 1993; extend the adjudication time for retrospective cases an additional 12 months for a total of 32 months; allow for compensation to be paid in one installment instead of four; and give the petitioner the option to stay in the program if the deadline is not met. Before the latter change, the Claims Court lost jurisdiction over the case and the petitioner could then seek recourse only in the tort system.

The January 31, 1991 deadline for filing retrospective cases resulted in more than 3,500 cases being filed in the five preceding months. As of February 1992, 4,095 pre-1988 and 220 post-1988 petitions were filed. Of these, 739 retrospective cases have been adjudicated: 281 in favor of the petitioner, 84 against and 374 dismissed. Individual awards total $192 million. Of the 220 prospective cases filed, 50 have been adjudicated: 21 in favor of the petitioner, 7 against, and 22 dismissed. Individual awards total $10.5 million, well within the amount in the trust fund.

Reports

A Boston University recently completed a report for the Administrative Conference of the United States, which summarized the first year of the VICP program and included recommendations for its improvement. Also, the Committee on Governmental Processes of the Administrative Conference as a result of the Boston University study has made a series of recommendations for improvements in the VICP. Some call for more effective dissemination of information, simplification of the eligibility process, new guidelines for determining award amounts, and extensions in time frames for completing cases.

In 1991, the Assistant Secretary for Planning and Evaluation (ASPE) contracted with an actuarial firm to generate estimates on the costs of retrospective awards. The estimates reflect different assumptions with respect to the number of cases compensated, but uniform assumptions on award amounts by claim type and vaccine category. The estimates range from a high of $2.6 billion to a low of $1.6 billion.

The Secretary, as mandated by law, requested the Institute of Medicine (IOM) to form a committee to conduct a review to determine whether pertussis and rubella vaccines cause adverse effects and what those effects are. Its report, completed in

August 1991, found a lack of causal relationship between these vaccines and certain injuries on the vaccine table.

Finally, the Office of Inspector General (OIG) Office of Audit Services (OAS) conducted two related studies. The first looked at the timeliness of attorney fee payments in the VICP. It found the average time for PHS to process attorney payments was 22.6 days. The second reviewed an alleged conflict-of-interest involving the above mentioned IOM committee. The OAS initially verified the conflict-of-interest of two committee members. One person resigned. After further review in the second case, it was determined that no conflict actually existed, although there was an appearance of possible conflict-of-interest.

Concerns about several program operation issues which have direct impact on the program's cost, prompted ASPE to request the OIG to review the program's operations. Additionally, OGC requested the OIG to examine PHS's use of brokers.

METHODOLOGY

We reviewed policies, written procedures and operational guidelines for the program to determine how the program is organized and how it attempts to meet its legislative and regulatory goals. A flow chart was constructed to show the agency roles and processes involved in handling cases. Another flow chart was created to show the process of damage determination.

The universe of 2,347 cases in PHS's database as of August 1991 (1,800 petitions filed had not yet been entered into the database) was stratified by whether the case was open or closed. A random sample of 45 cases was then selected from each strata. The inspection team reviewed these 90 case files to: verify data contained in the PHS's database; get a clearer understanding of how the VICP process works, including the operational process used for decision-making in each case; and identify specific attorneys and petitioners to be interviewed during the study. The 90 cases are described in greater detail in Appendix B.

A survival analysis of all 2,347 cases included in PHS's database through August 1991 was done to evaluate timeliness of decisions and trends in awards. See Appendix C. With respect to this analysis, it should be kept in mind that this data set did not include all the cases received by PHS. Eighteen hundred cases filed had not yet been entered into the computer. Therefore, the results of this analysis should be interpreted with caution. Once a complete data set is developed, the relationships noted here may change appreciably.

The team interviewed 23 key government officials or those acting on behalf of the government from HHS, DOJ, the Claims Court, and the National Vaccine Advisory Commission. They include five administrators, four physicians, five agency attorneys, two special masters, three other government officials, two brokers and two life-care

planners. They were asked their views of and their experience with the program and their recommendations for its improvement.

Additionally, the team interviewed by telephone 31 non-government individuals. These included 17 petitioners' attorneys, 12 parents (6 of whom represented themselves, known as pro se) selected from the closed cases reviewed, a medical expert, and a parents' advocate. They were asked their views of the program and their recommendations for its improvement. Although an effort was made to interview all 33 attorneys and their clients identified from the closed cases, 16 attorneys could not be reached or did not want to be interviewed. Also, many attorneys did not agree to having their clients interviewed for a variety of reasons. For example, some attorneys had lost contact with their clients, some clients spoke no English, and some clients did not want to speak with us. Many attorneys said their clients would become unnecessarily distraught if they had to discuss the painful subject of their disabled children.

FINDINGS

THE PROGRAM IS CURRENTLY STRUGGLING TO HANDLE A LARGE, UNANTICIPATED INFLUX OF RETROSPECTIVE CASES

At the current production level it will take approximately seven years to complete all of the retrospective cases.

The program is currently struggling to deal with a large, unanticipated influx of retrospective cases. An analysis of PHS's FY 1991 and 1992 program output status reports shows that the VICP adjudicates an average of 37 retrospective cases a month. This includes compensated, not compensated and dismissed cases. As of February 1992, 739 retrospective cases had been completed, leaving an additional 3,356 cases to handle. If the number of cases completed monthly does not change, it will take approximately seven years to complete all the retrospective cases.

However, some government officials feel that the production rate will increase due to changes in legislation, the increased experience of the program staff, and an anticipated increase in dismissals. The chief special master believes the production rate has already increased since he has accelerated the assignment of cases. More experience will be needed to ascertain the effects. However, if this increase continues, the time needed to complete the retrospective cases would be substantially reduced.

Although the statutory deadline was extended for an additional 12 months, the program will only be able to complete one-third of the retrospective cases by the new deadline.

Because the greatest number of retrospective cases were filed in September 1990, we used June 1993, 32 months, later as the deadline for completion of all these cases. With an average adjudication rate of 37 cases a month, 1,368 retrospective cases of the total 4,095 filed will be adjudicated by the deadline, leaving 2,727 cases to be completed. Were the deadline to be extended another twelve months, an additional 444 cases would be completed within the deadline.

If program output were to double, half the retrospective cases would still not be completed by the deadline; if it were to triple, 35 percent would not be completed. Actually, completing 95 percent of the retrospective cases by the statutory deadline would require a five-fold increase in the production rate.

These projections are approximations based simply on experience. Completed cases have been scheduled and adjudicated in a variety of ways which may not necessarily be typical of future case development.

Although most government respondents feel positive about having time requirements for handling cases, almost one-half consider these requirements unrealistic in light of the large number of pending cases.

Almost one-half (43 percent) of government officials could not even give an estimate of how long it will take to complete the cases. Those who answered offered estimates ranging from two to five years.

The delays are of concern to petitioners and their attorneys because of the lack of retrospective payment.

The time required to process the remaining cases will depend in part on the case mix.

The results of the survival analysis indicate that, for the cases found on the PHS data set as of August 26, 1991, the median time to completion of a case is approximately 15 months, well within the statutory time frames. Further, the results indicate that some aspects of the cases, including whether the patient died, the type of vaccine involved, when the case was filed, and whether the case was handled pro se or not, significantly affect the length of time it takes to handle a case.

It should be kept in mind that this data set did not include all of the cases filed. A number of cases had yet to be entered into the computer. It is possible that the addition of these cases may increase the median time to completion if it were found that cases were entered into the data set in a differential manner. This may indeed be the case given the large influx of cases that occurred during September 1990.

CASES ARE DELAYED DUE TO A FRONT-END BACKLOG RESULTING FROM SCHEDULING CONSTRAINTS AND LACK OF RESOURCES

The large influx of 3,500 retrospective cases has necessitated that the chief special master control intake into the system.

This large influx of cases, filed in or around September 1990 and January 1991, has compelled the chief special master to decide the order in which they are handled. No guidelines exist for this ordering and cases are not necessarily assigned in order of filing. The chief special master must consider available resources throughout the program when scheduling cases.

In order to handle the large number of cases, the chief special master has: held several informal meetings with representatives from DOJ and PHS and petitioner's counsel to develop a schedule; grouped cases according to type of vaccine; grouped cases geographically so that attorneys with many cases can have them heard at the same time in the same place; and dismissed many cases for lack of information.

The approximately 2,500 cases which have not been scheduled make up the front-end backlog. In March 1992, the chief special master estimated that the Claims Court had begun assigning 40 to 60 cases a month and dismissing an additional 40 a month after preliminary review of the petitions. As this preliminary review is a new development in the process, its effect is not yet reflected in any available data.

It is not yet clear what will happen if this front-end bottleneck is opened. We can anticipate the system would get backed up in other places, but cannot predict exactly where or how much.

Specific resources considered insufficient to handle the backlog are staff attorneys, pediatricians, pediatric neurologists, and infectious disease specialists.

According to the chief special master, more staff attorneys at the Claims Court would be a key addition. Staff attorneys conduct preliminary reviews of cases to determine whether or not they meet statutory requirements and to ensure that complete case files are forwarded to the chief special master. This facilitates scheduling and leads to appropriate dismissal of cases at an early stage.

According to the PHS chief medical officer, the medical review staff of six pediatricians reviews approximately 60 cases a month, an average of two days per case per doctor. The time needed for this initial review, further review required after additional information is submitted, discussions with DOJ, and for other activities leaves no buffer in the system. Additional reviewers would be necessary if the case load increases. Difficulty recruiting competent pediatricians has currently left three positions vacant. The PHS staff attribute these vacancies to the unwillingness of many physicians to do such work, because it removes them from patient care and requires them to make review decisions in a controversial area.

The PHS staff cite a shortage of both pediatric neurologists and infectious disease specialists willing to testify. The PHS staff also believe the small number of available expert witnesses is and will continue to be a limiting factor. Recently, five cases were dismissed in one month because the petitioners could not find experts to testify in support of their cases. Some petitioners also mention difficulty in finding attorneys willing to represent them.

THE CASE PROCESS IS EFFICIENT EXCEPT FOR THE FRONT-END BACKLOG

Once a case is assigned, it is handled efficiently.

An analysis of the flow of cases in the PHS database as of August 1991, from the date the claim was filed to the date of judgement, shows that delays exist with retrospective cases only at the front-end of the process. Once filed, entered into the PHS database and scheduled for review, the median time for both retrospective and prospective cases to reach a special master decision is 15 months. However, our analysis indicates that most of the processing time appears to be absorbed in the early stages, from the time a case is filed to the PHS OGC report date. This analysis is explained further in appendix C.

This 15-month completion period is well ahead of the current 32-month statutory deadline for retrospective cases. Of the 594 retrospective cases adjudicated by August

Some also mention that under the circumstances, with limited staff and a large caseload, the system is working as well as it can.

Half the petitioners and their attorneys agree the program is operating efficiently. Several say that it works better than the Federal and State court systems; others remark that, in their experience, the process has been relatively smooth. Those who do not think the program is operating efficiently (32 percent) voice concerns about its lack of consistency, timeliness and overly bureaucratic process. The remaining respondents did not render an opinion.

No unnecessary duplication of effort exists.

A review of program policies and procedures reveals very little duplication of effort. It is, however, required at certain points in the process. For example, PHS, DOJ, and the Claims Court each review a case. This is necessary since each party must come to an independent conclusion in order to negotiate and resolve the case.

Most government officials who believe duplication of effort exists agree it is necessary to fairly adjudicate a case. Some government officials, however, identify areas where duplication of effort is perhaps not necessary, such as double data entry and the flow of paperwork between the PHS and DOJ.

Roles and responsibilities are clearly defined.

Flow chart I shows that the functions and responsibilities of each government entity are, for the most part, clearly outlined.

All government officials, except the special masters, feel their office role is clearly defined. Most say the Act is very specific and that clear written procedures are available.

The special masters interviewed do not feel their office role is clearly defined. One asks, "Should [I] be inquisitor or traditional judge?" Special masters can question witnesses, call their own expert and generally be more involved throughout the whole process than a judge usually is.

All government officials, including the special masters, think that their individual roles in the program are clearly defined. All feel they have clear job descriptions and performance plans and know what is expected of them. Although the special masters say the role of their office may not be well-defined, they believe their personal responsibilities in the program have evolved more clearly because of their increased case experience.

1991, fifty-four percent were completed within 10 months; 91 percent within 15 months; and 96 percent within 20 months.

The program is meeting deadlines for prospective cases and handling them in a timely and efficient manner. Of the 126 prospective cases filed before August 1991, none have missed the 14-month statutory requirement.

While agreeing that cases are handled in a timely manner, government officials, petitioners and their attorneys mention factors which delay a case once it is in the system. Most frequently mentioned is the long time it takes for a case to be assigned and to get into the system, because of the large influx of retrospective cases.

Government officials often cite incomplete records submitted with the initial petitions as a cause of delay. Petitioners and their attorneys agree that delays in getting evidence and medical records occasionally slow the process. Ninety percent of petitioners and attorneys say they were required to submit additional material or evidence after the case was filed. Sixty-two percent of petitioners and attorneys report that getting medical records was the most common problem they encountered in preparing their petition.

The review of 90 cases shows that additional information, mostly medical records, was requested in fifty-six percent of the closed cases.

A PHS official reports cases are sometimes stalled at the point where damages are determined. Another government official reflects the views of many when he says, "Once entitlement is determined, damage determination should not go through this lengthy process. Too much time is taken here."

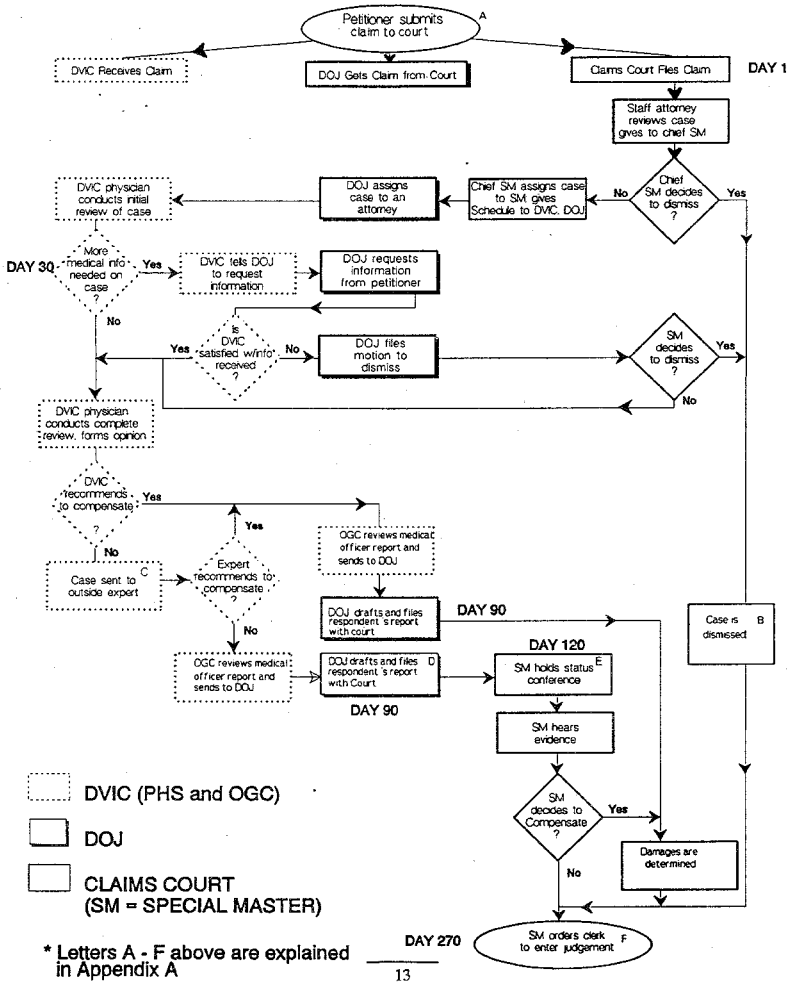
The program appears to be generally well-organized with good procedures.

Our review of program policies and procedures shows the program structure to be well-organized, with each step in the process clearly delineated. This is demonstrated in flow chart I.

Three-quarters of government officials and half the petitioners and their attorneys consider the program to be well-organized with a sound and logical structure. Government officials most frequently mention that the program has developed effective procedures and guidelines, that roles have evolved more clearly over time, and that staff have gained more experience. Petitioners' attorneys note that the program is less costly and faster than State and Federal courts; some also feel that it has improved over time with better procedures. Thirty-five percent of petitioners and their attorneys say that the program is not well-organized, most frequently mentioning that the Claims Court is overrun.

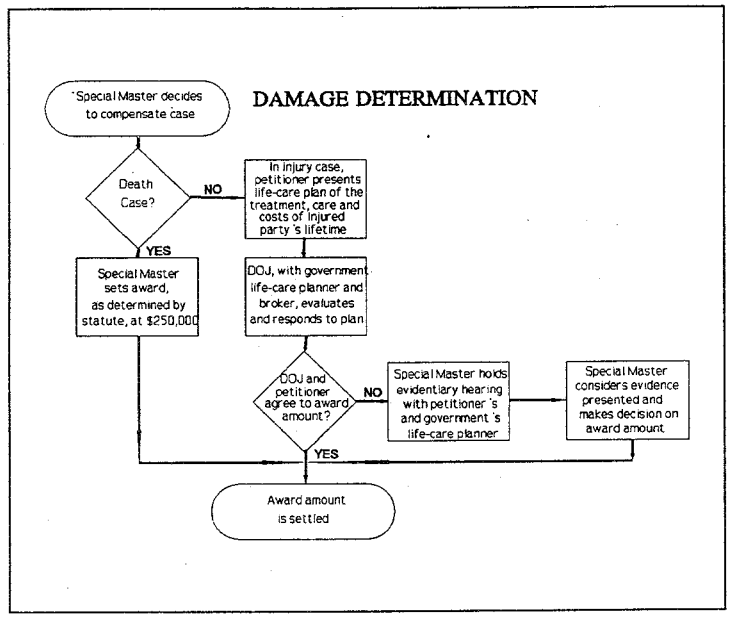
Almost three-quarters (74 percent) of government officials feel the program is operating efficiently. They most frequently cite the program's effective processes.

FLOW CHART I



* Letters A - F above are explained in Appendix A

FLOW CHART II



Coordination and communication among the Federal agencies is strong.

Flow chart I demonstrates clear-cut avenues for coordination. For example, should a PHS doctor require additional records to complete the medical review, the request will be made to the petitioner through DOJ to help assure compliance.

Almost three-quarters (74 percent) of government officials rate communication among all parties as good (22 percent) or excellent (52 percent). The PHS staff feel particularly positive about communication within their own division. Many government officials say that, while there is room for improvement, they respect each other's efforts and work at keeping communication open. One states, "there are real attempts by the heads of different parts to keep communication open." Several consider the new total quality management (TQM) group, which includes members from PHS, DOJ, and OGC, an excellent mechanism for communication and cooperation.

Status conferences between the special master and both sides involved in the case also facilitate open communication. Once a case is assigned, these conferences are held to speed up and simplify the decision-making process. The special master conducts these informal conferences with the petitioners' attorneys, possibly the petitioners, and the DOJ attorneys, either by telephone or in person, to focus issues and to give each party the opportunity to address the other's position.

A majority of government officials rate coordination between government agencies good or excellent. They know where responsibilities lie and who to call on specific issues.

Petitioners and their attorneys are generally satisfied with their experience in the program.

The experience of petitioners and attorneys has been positive. Seventy-six percent say that government officials have been generally helpful. They mention that the representatives were cooperative, readily available and promoted a good working relationship. A majority (79 percent) also say they were kept informed about their case while it was being decided. On the other hand, some petitioners and their attorneys report that before a case is assigned to a DOJ attorney, they are unable to find out its status. They would like a contact person for that purpose. Other petitioners believe that the program should be better publicized.

A SIGNIFICANT PORTION OF PHS MEDICAL REVIEW RECOMMENDATIONS NOT TO COMPENSATE ARE OVERTURNED BY THE SPECIAL MASTERS

A review of all completed cases as of August 1991 reveals that 58 percent of cases that the PHS medical staff recommended not be compensated were compensated. During the seven-month period from June 1989 to January 1990 (when DOJ was not representing the government), eighty percent of the medical review recommendations not to compensate were compensated. In contrast, when DOJ has argued the case, 52 percent of recommendations not to compensate have been compensated.

One special master believes the reversal rate is currently lower than 52 percent. He feels that, with experience, the special masters have become more comfortable in their role and in making decisions, leading to fewer compensated cases. Additionally, he believes that cases which had more substantive evidence submitted with the original petition were put into the system first, and were more likely to have been compensated.

Several government officials cite two major factors which account for the reversal rate: lack of corroborating evidence and differing interpretations of the Vaccine Injury Table. Disputes occur over what constitutes appropriate evidence. Additionally, the character of expert witnesses and the potential conflict between testimony and records or legal evidence also lead to disagreement. A related reason is the interpretation of the Vaccine Injury Table. Although the Aids to Interpretation assist with the

interpretation of the table, there is still room for differences of opinion. Therefore, each special master may interpret the table differently. The DOJ and HHS both support stronger corroboration of evidence requirements.

Of those who have an opinion, government officials are almost evenly divided about whether they believe cases have generally been decided appropriately. Many government officials who feel cases have been decided appropriately mention that, with DOJ's involvement, decisions are more balanced and fairer. Some also believe that decisions have been appropriate within the framework of the present Vaccine Injury Table and the evidence presented.

Most government officials who feel cases have not generally been decided appropriately do not believe all compensated decisions have been scientifically based. Many also think that too much emphasis has been given to petitioners' testimony, as opposed to medical records. One government respondent notes that PHS medical decisions and special master decisions are based on two different sets of factors: the former relies primarily on medical records, while the latter additionally considers testimony and affidavits.

Of those petitioners and their attorneys with an opinion, a majority (78 percent) feel that, based on their own experience, cases have generally been decided appropriately. More than half feel satisfied with the final decision in their own case. However, none of the petitioners who represented themselves (pro se) are satisfied: all of their cases have been dismissed for lack of evidence.

Only a small percentage of cases are appealed which could be interpreted to mean petitioners and their attorneys are generally satisfied with their case outcomes. To appeal a case after the special master decision, either party files a motion for review with the Claims Court judge. As of November 1991, 86 motions for review were filed, 60 by the petitioner and the remaining 26 by DOJ. After the judge's decision either party has 60 days to file a further appeal to the United States Court of Appeals for the Federal Circuit. Since the program's inception, very few cases have actually gone to the next appeal step. Currently, there are approximately five DOJ appeals and 15 petitioner appeals at this level.

THE PRESENT VACCINE INJURY TABLE DOES NOT REFLECT THE LATEST SCIENTIFIC EVIDENCE

A recent Institute of Medicine (IOM) study found a lack of causal relationship between certain vaccines and injuries on the existing Vaccine Injury Table.

The IOM committee sponsored a public meeting to solicit medical and scientific data and comments on the nature, frequency, and circumstances of adverse events following pertussis and rubella vaccines. It then reviewed existing research about 17 adverse events for pertussis vaccine and three adverse events for rubella vaccine. The

committee organized its conclusions into five categories reflecting the causal relationships between the vaccines and the adverse events.

Based on the study findings the HHS and the Advisory Commission have made recommendations for changes. The primary changes would remove seizure disorder and shock-collapse from the presumption of causation for pertussis vaccines. On the other hand, chronic arthritis would be added for rubella vaccine, but only on a showing of vaccine involvement. Some government officials estimate that if future cases are decided only on the basis of the latest scientific evidence, the compensation rate would be significantly lower.

GOVERNMENT OFFICIALS WE INTERVIEWED SUPPORT ANNUITIES AND THE USE OF BROKERS

Of those government officials offering opinions, almost all believe that annuities are the best way to pay the award. Eighty-three percent say annuities alone are best; the remaining 17 percent think that the award should be paid in a combination of lump sum and annuity. According to those who favor annuities, annuities assure long-term benefits for the child, avoid mismanagement of funds, are less expensive for the government because the insurance company assumes some of the risk, and give the petitioner tax benefits.

Although all government officials agree certified brokers are necessary to buy the annuities, some express concerns that their costs are too high. Many mention that brokers perform a necessary function by shopping for the best deal, actually servicing the annuity during the course of the petitioner's life, and providing support to DOJ during damage determinations.

The brokers have recently demonstrated their value. Originally, the program had to pay compensation in death and injury cases in four equal installments. This restriction limited the number of insurance companies willing to sell annuities to PHS. Those companies charged higher than normal rates because they were not getting the full cost of the annuity up front. The November 1991 Amendments to the Act, which allow for compensation to be paid in one installment instead of four, have made it possible for the brokers to renegotiate several annuities. Brokers were able to arrange for the program to make the remaining payments on several annuities and to renegotiate many annuity proposals. In total, the PHS has reportedly saved $7.7 million through these actions. The brokers' fees had already been paid by the insurance companies, so PHS did not incur any additional costs to achieve the savings. If annuities are to be the preferred payment approach, brokers are essential since insurance companies only deal with credentialed individuals.

APPENDIX A

FLOW CHART NOTES

TIME FRAMES

Generally, prospective and retrospective cases should be resolved in 420 days (14 months): 240 days from filing date to the special master's decision plus the maximum allowable suspension time of 180 days. However, the special master can suspend proceedings in any case several times and at various stages in the process. Also, due to the unexpected influx of retrospective cases, the retrospective cases have been given the 420 days plus additional extensions of 18 months, for a total of 32 months from filing date to the special master decision. Since the suspension times may differ from case to case, the time frames incorporated into this flow chart do not include any suspensions.

A: SUBMITTING CLAIMS AND "FRONT-LOADING"

The VICP was designed to get all the case information at the time of filing (called "front loading" the information) so all the issues and evidence are presented at the start. The petitioner's initial claim (the petition) must be complete in that it clearly outlines the petitioner's full case. This petition must include all medical and potentially relevant records and affidavits. A complete petition is essential: it reduces delays that occur when additional information has to be requested; permits a detailed evaluation of the case by the respondent (DOJ) and the special master; and is necessary for the timely adjudication of the case.

B: DISMISSALS

The special master may dismiss a case at any time during the process. Dismissal can occur if the petitioner received an award in the tort system, if no evidence was offered for a doctor to form an opinion, or if the Claims Court does not have jurisdiction over the case.

C: OUTSIDE EXPERT

Whenever the PHS staff physician decides a case is not compensable, it is sent to an outside medical expert who is not on the PHS staff. The expert may request additional information, especially medical tests, just as the staff physician does in order to form an opinion on the case. This opinion becomes the official PHS decision, referred to as the "internal report."

D: RESPONDENT'S REPORT

Prepared by DOJ attorneys, this document serves as PHS's answer to the petition. It incorporates the medical arguments made by the PHS physician or outside expert on whether or not PHS considers a case compensable and any relevant legal issues.

E: STATUS CONFERENCE

After reviewing the petition and respondent's report, the special master conducts an informal, "off-the-record," Rule 5 conference either by telephone or in person. The purpose of the conference is to speed and simplify the decision-making process. During the conference each party is given the opportunity to address the other's position. The special master offers his or her tentative view as to the merits of the case. Also, the petitioner, respondent, and special master establish which issues remain to be addressed. These conferences occasionally lead to settlement.

The special master often holds additional status conferences, usually by telephone, to expedite the processing of the case. Either party may request such a conference at any time. At these conferences, the parties may either suggest ways to process the case more efficiently, or make the special master aware of new case developments.

F: SPECIAL MASTER ORDERS CLERK TO ENTER JUDGEMENT

Within 240 days of the claim's filing date, the special master must issue a final decision determining whether or not an award of compensation shall be made and, if so, its amount. If neither party files a motion for review within 30 days of the special master's decision, the clerk enters judgement by day 270. Compensation, in awarded retrospective cases, is paid from this date of judgement.

NOTE:

In all cases the processes and time frames presented both in the flow chart and in the flow chart notes are those set forth in regulations and procedures; they may be different due to requested extensions or other unknown factors.

APPENDIX B

DESCRIPTION OF 90 CASES IN THE CASE FILE REVIEW

	number	*percent*
Case Status:		
Closed (case went through hearing)	25	28%
Dismissed early in process (no hearing)	20	22%
Open, awaiting PHS review	28	31%
Open, in or past PHS review	17	19%
Other Characteristics: (not mutually exclusive)		
Pro se	18	20%
Outside expert used	15	17%
DPT	66	73%
Injuries: (not mutually exclusive)		
Seizure disorder	53	59%
Encephalopathy	39	43%
Mental retardation/developmental delay	16	18%
Death	14	16%
Hypotonic/hyporesponsive collapse	11	12%
Anaphylactic shock	3	3%
Other	25	28%
Date Vaccine Administered: (closest approximation to date of injury)		
1972 and before	32	35.5%
1973 to 1982	32	35.5%
1983 to present	26	29%
Special Master Decision:		
Compensate	18	20%
Not Compensate	8	9%
Dismiss	20	22%
Other	1	1%
Information Not Available	2	2%
Not Applicable (case still open)	41	46%

APPENDIX C

DESCRIPTION OF THE ANALYSIS OF THE PHS DATABASE

To supplement the field work for this inspection, coded data were obtained that described a portion of the claims filed with the U.S. Public Health Service (PHS) Vaccine Injury Compensation Program (VICP). This data was analyzed to describe the program and delineate the effects on completion times of different characteristics ascribed to each case. This Appendix describes the results of that analysis.

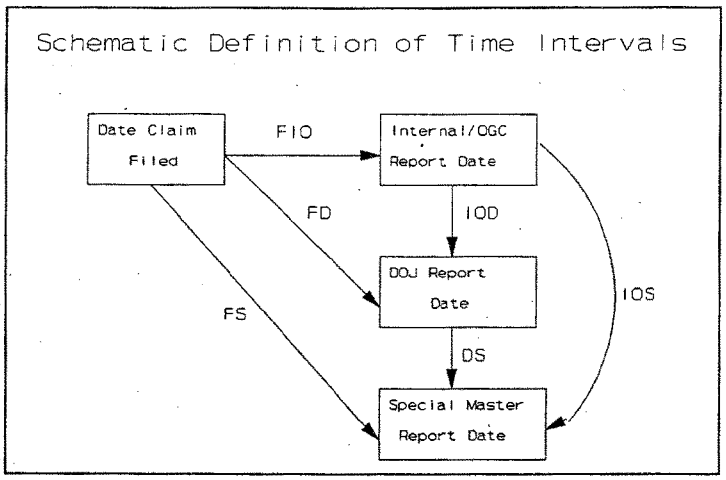
Description of Data Set

We received from the PHS a copy of their automated data that was current to August 26, 1991. A total of 2,478 cases were represented by the data in the file.

This analysis is structured on the presumed flow of cases filed with the VICP. Although up to 13 milestone dates are possible on the files provided, we have concerned ourselves with only four of these dates. These four dates include the date the claim was filed (Date Claim Filed), the later of the date of the internal report or the OGC (Office of General Counsel) report date (Internal/OGC Report Date), the DOJ (Department of Justice) report date (DOJ Report Date), and the Special Master (SM) report date (Special Master Report Date). This last date also served to define when a case was closed. We then defined intervals, measured in months, between each of these dates. These intervals are shown in the schematic drawing presented in Figure A. Cases were dropped that did not adhere to this sequence or were missing other important data. Of the original 2,478 cases, 60 were dropped because either the patients birth date was missing or the birth date followed a case's filing date. A further 71 cases were dropped because other dates in their file were out of sequence. Thus a total of 131 cases, 5.3 percent, were dropped due to bad dates. Except for unknown values in the individual variables that may lead to dropping a case from a specific analysis, the resulting 2,347 cases were included in the analysis presented here.

This analysis will show median times, in months, for each of the intervals illustrated in the figure. The most important is the interval labelled FS, the time from filing the claim until the Special Master report date. The analysis will concentrate on this interval. Results for the intervals labelled FD, the time from filing until the DOJ report date, and FIO, the time from filing until the internal or PHS report date, IOD, the time form internal or OGC report date until DOJ report date, DS, the time from DOJ report date until SM report date and IOS, the time from internal or PHS report data until SM report date, will be presented briefly in Table III.

Figure 1



For this analysis, one other variable, besides the intervals, was constructed to encode information not originally available on the file provided by PHS. During the period June 1, 1989 to December 31, 1989 the Department of Justice withdrew from the process. An indicator variable was created for cases completed during this period, whether they were dismissed, compensated or not compensated. Sixty-one completed cases fell into this group.

Eleven other indicator variables were created for this analysis, generally for use in the models applied to the data. These were constructed from data available in the files supplied by PHS. These additional variables define the type of vaccine given, the dates of filing for the cases, whether the patient died and whether the case was filed pro se or not.

For the cases represented in this data set, four outcomes can be defined as of Aug. 26, 1991. At this point in time the cases were either; (1) still open; (2) dismissed; (3) closed and compensated; or (4) closed and not compensated. Cases were designated as still open if no SM report date was recorded on the file. The other categories were determined by the coding found in the SM recommendation variable. Table I presents the status of the cases used in this analysis by these four categories. For the analysis presented here, two classes of completed cases were defined. One class included all completed cases, compensated, not compensated and dismissed. A second class

excluded the dismissed cases. This applied mostly to the analysis involving linear models, to be discussed below.

Table I

SM Recommendation	N	% of Tot.
Not Completed	1728	73.6
Compensated	246	10.5
Not Compensated	94	4.0
Dismissed	279	11.9
Total	2347	100.0

Methods

The main thrust of this analysis was to describe the time its takes to complete a case. We also wanted to know what factors associated with these cases might account for changes or differences in these completion times. To do this, methods associated with the analysis of survival times were employed. Ordinarily, these methods are concerned with the time elapsed to the failure of a study element from some selected starting time. For this analysis, we defined a failure as the closing of a case. Thus, the survival time is the interval from when the case is first filed until one of our endpoints is reached. For the most part, this will be the special master report date.

To determine median times to completion, we obtained Kaplan-Meier (KM) estimates[1]. This analysis provides estimates of the time it takes for 50 percent of the cases to reach the end of the defined time interval using censored data. Censored data occurs because, as of Aug. 26, 1991, cases were still open and at varying points in the process. We do not know when these cases will close. This approach is necessary because any estimate that relies solely on completed cases will give biased estimates. The results are expressed as the median time to completion, in months, for all cases. The KM estimates were obtained using PROC LIFETEST from the SAS statistics package for personal computers[2].

To test the effects of concomitant variables on the time it takes to complete a case, Cox regression techniques for life table data are used[3]. These techniques take the form of what is known as proportional hazards (PH) regression models. Using the interval from when the claim was filed until the Special Master report date (The interval labeled FS in Figure A.) as an example, once a claim is filed, it is at "risk" of being settled (receiving a SM recommendation) at any time following the filing date. This risk of settlement can be a function of certain characteristics of the cases in the data set. For example, are pro se cases settled sooner or later than non pro se cases?

Is there a similar difference for cases where the patient died? And how does the interaction of these two variables (pro se and death of the patient) effect the time to settlement? The PH regression model allows us to put all of these variables into a single equation and attempt to determine the independent affect of each of these characteristics. For each of the characteristics, we will be estimating the relative increase in risk of settlement for those with the characteristic as opposed to those without the characteristic. If the value of the relative risk is greater than one, then the presence of the variable increases the hazard rate, that is, decreases the length of time to complete a case. If the value is less than one, then the variable is likely to decrease the hazard rate, or increase the length of time to complete a case.

The SAS statistical program PROC PHREG for the personal computer was used to fit these models[4]. With this proportional hazards model, the exponential of the coefficients gives the relative risk described above. The model also assumes that the risk is constant over the follow up period. To test for the significance of each variable (and the ensuing relative risk), Wald chi-square statistics[5] with the appropriate degrees of freedom are calculated. Given p values of less than 0.05 would indicate that the relative risk is significantly different from 1.0.

Results

The results presented in Table II indicate that 50 percent of the cases are completed within 15 months of the filing date. This is true whether or not dismissed cases are included. The data also indicate that most of this time appears to be absorbed in the early stages of the process, from the time the case is filed until the Internal or PHS report date.

Overall, the characteristics of the cases analyzed here do not seem to change the total time it takes to complete a case except in two areas. Table IV provides the KM estimates of the median time to completion for each of the characteristics separately, using the interval from the date filed to the SM report date. Where no data is indicated in the table, less than 50 percent of the cases were completed as of Aug. 26, 1991. The first from this generalization involves the pro se cases. When the dismissed cases are included, half the cases handled pro se are completed within 13 months. When the dismissed cases are excluded, this median time to completion increases to 18 months. These results would indicate that the pro se cases are handled differently. It is possible that they are dismissed sooner and when not dismissed, take longer to complete.

The second area of difference stems from the type of vaccine used. Those cases involving the intravenous polio vaccine (IPV) vaccine look to take longer to complete. The median time to completion is 20 months, with or without the dismissed cases.

Looking at Figure B, approximately 80 percent of the dismissed cases close within 10 months. This compares to about 39 percent of the closed cases. Ninety-nine percent of the open cases are younger than 21 months. This data would indicate that for the

cases found in the data set, the vast majority are being handled within the statutory limits of 32 months.

The results of the proportional hazards regression analysis (Table IV.) show that cases filed before 7/90 (variable B790) are more likely to be completed earlier (approximately 5 times more likely) than cases filed during the third quarter of 1990 (the referent category.) Conversely, cases involving the IPV vaccine are less likely to be settled earlier that cases involving the DTP vaccine (approximately a quarter as likely.) Both of these variables are statistically significant.

Including dismissed cases, all of the variables indicating when the case was filed are significantly related to the time it take to close a case. This is also true for type of vaccine (IVP compared to DPT) and pro se status. These results are essentially consistent with the univariate results presented in Table III. However, the multivariate model indicates that death is significantly related to the time to close a case. When the dismissed cases are excluded, death remains significant. When dismissed cases are excluded, only cases filed before July, 1990 take significantly shorter lengths of time to complete. Those cases associated with the IVP vaccine take significantly longer. The effect of pro se cases also becomes non-significant. Again an indication that pro se cases are probably more likely to be dismissed.

Table II

Median Time Between Intervals

From Date	To Date: Internal OGC Report	DOJ Report	Special Master Report
Date Filed	12	13	15
Internal OGC Report		3	11
DOJ Report			no data

(Dismissed cases included.)

From Date	To Date: Internal OGC Report	DOJ Report	Special Master Report
Date Filed	13	13	15
Internal OGC Report		3	11
DOJ Report			no data

(Dismissed cases excluded.)

Table III

Median Number of Months to Completion

	Dismissed Cases	
	Included	Excluded
All Cases	15	15
Period Filed		
Before 7/90	13	13
7/90-9/90	no data	no data
10/90-12/90	no data	no data
1991	no data	no data
Date Vaccine Administered		
Prior to 10/88	15	15
After 10/88	14	14
Patient Died		
Yes	14	14
No	15	15
Case is pro se		
Yes	13	18
No	15	15
Vaccination Type		
DPT	14	15
IPV	20	20
Measles	16	16
Other, Unkn.	37	no data

Figure A

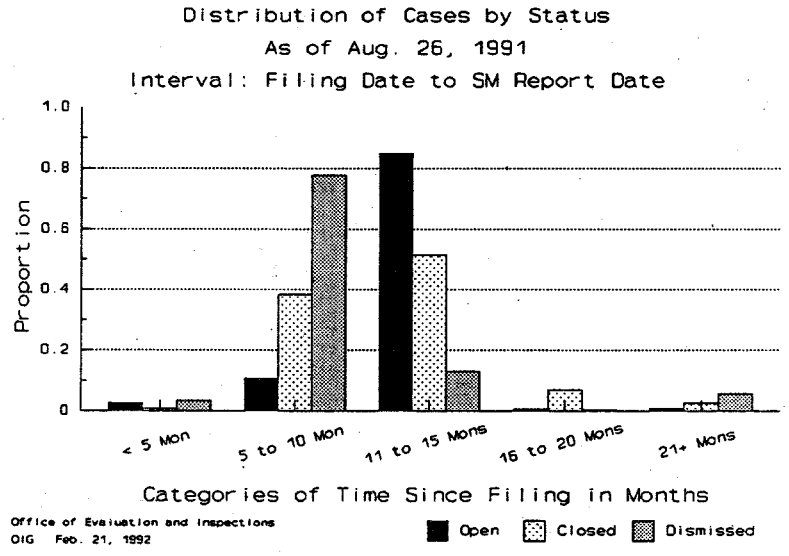

Distribution of Cases by Status
As of Aug. 26, 1991
Interval: Filing Date to SM Report Date
Proportion
1.0
0.8
0.6
0.4
0.2
0
< 5 Mon
5 to 10 Mon
11 to 15 Mons
16 to 20 Mons
21+ Mons
Categories of Time Since Filing in Months
Office of Evaluation and Inspections
OIG Feb. 21, 1992
Open
Closed
Dismissed

Table IV
Proportional Hazards Regression
Date Filed to Special Master Report Date
Dismissed Cases Included

Variable	Relative Risk	95% conf. int. Lower	Upper	p Value
Prospective Case	1.10	0.60	1.99	0.641
Case Filed before 7/90	5.17	4.03	6.62	<0.001
Case Filed 4th Qrt.,FY1990	4.79	3.70	6.20	<0.001
Case Filed During FY1991	14.40	6.79	30.53	<0.001
Patient Died	1.31	1.06	1.63	0.013
IPV Vaccine Given	0.25	0.17	0.35	<0.001
MMP Vaccine Given	0.76	0.58	0.99	0.045
Other Vaccine Given	0.98	0.59	1.64	0.949
PRO SE Case	3.05	2.44	3.81	<0.001
Claim Filed after 1/31/91	0.13	0.02	1.05	0.055

Dismissed Cases Excluded

Variable	Relative Risk	95% conf. int. Lower	Upper	p Value
Prospective Case	1.55	1.04	2.33	0.031
Case Filed before 7/90	5.26	4.02	6.87	<0.001
Case Filed 4th Qrt.,FY1990	1.26	0.80	1.98	0.319
Case Filed During FY1991	2.45	0.57	10.47	0.228
Patient Died	1.43	1.13	1.81	0.003
PV Vaccine Given	0.47	0.29	0.75	0.002
MMP Vaccine Given	0.75	0.52	1.08	0.125
Other Vaccine Given	1.47	0.46	4.71	0.514
PRO SE Case	1.47	0.95	2.28	0.084
Claim Filed after 1/31/91	0.89	0.08	9.93	0.924

Literature Cited

1. Kaplan, E.L. and Meier, P. 1958. Nonparametric estimation from incomplete observations. Journal of the American Statistical Association. 53:457-481.

2. SAS Institute Inc. 1988. SAS Technical Report: P-179 Additional SAS/STAT Procedures, Release 6.03. Cary, NC.

3. Cox, D.R. 1972. Regression models and life tables (with discussion). Journal of the Royal Statistical Society B. 34:187-220.

4. SAS Institute Inc. 1991. SAS Technical Report P-217, SAS/STAT Software: The PHREG Procedure, Version 6. Cary, NC.

5. Kalbfleisch, J.D. and Prentice, R.L. 1980. The Statistical Analysis of Failure Time Data, New York, John Wiley & Sons, Inc.

APPENDIX D

COMMENTS TO THE DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date OCT 9 1992

RECEIVED 10/16/92

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "The National Vaccine Injury Compensation Program: A Review"

To Acting Inspector General, OS

Attached are the Public Health Service comments on the subject OIG report. We agree that the changes recommended in this report would improve the management and increase the efficiency of the Vaccine Injury Compensation Program. Our comments describe the actions underway or planned to address these changes. In addition, we offer a series of technical comments for your consideration.

James O. Mason

James O. Mason, M.D., Dr.P.H.

Attachment

IG	
PDIG	
DIG-AS	
DIG-EI	✓
DIG-OI	
AIG-MP	
OGC/IG	
EX SEC	✓
DATE SENT	10/13

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "THE NATIONAL VACCINE INJURY COMPENSATION PROGRAM: A REVIEW," OEI-02-91-01460

OIG Recommendation:

The PHS, Department of Justice, and Claims Court should:

- inventory the backlog (of petitions for compensation submitted to the U.S. Court of Claims) to set priorities and better estimate future resource needs,
- further streamline the process,
- use latest scientific evidence,
- improve contacts with petitioners and their attorneys, and
- emphasize use of annuities.

PHS Comments

While this recommendation is not directed specifically to PHS, we nevertheless concur that the recommended changes would improve the management and increase the efficiency of the Vaccine Injury Compensation Program (VICP). The PHS components involved in the VICP will continue to work with the Department of Justice and the Claims Court to resolve the retrospective cases as quickly as the availability of resources will permit and, concurrently, apply improved skills and techniques to maintaining the efficient processing of prospective cases.

The program has been working with a PHS Task Force on the VICP to change the Vaccine Injury Table and the Qualifications and Aids to Interpretation to reflect current science. The Task Force finalized its recommendations for changes to the Table and Aids after intensive review by several scientific and policy groups. The Office of Management and Budget recently approved these proposed revisions both as part of a Notice of Proposed Rulemaking and a legislative package.

We agree with the objective of the recommendation to improve contact with petitioners and their attorneys. However, PHS is limited by its role in the process. The Claims Court has the sole authority to assign cases for adjudication. As such, they should provide information to petitioners and their attorneys on the status of unassigned cases. PHS' Division of Vaccine Injury Compensation (DVIC) regularly receives calls from claimants or their attorneys on active cases and responds as information allows.

The DVIC has been working with the Advisory Committee on Childhood Vaccines' (ACCV) newly formed Subcommittee on Process.

This Subcommittee is responsible for seeking, receiving, and analyzing systematic feedback from interested parents' groups, petitioners' attorneys, and others on implementation of the VICP. The ACCV has also offered petitioners and their attorneys the opportunity to communicate concerns and suggestions for improving the process.

In addition to our comments on the recommendation, we suggest that two subjects be clarified in the final report. First, on pages 10 and C-4, the report indicates that the longest period of time for processing cases is the time from the date a claim is filed to the date of the Office of the General Counsel/PHS report. This incorrectly suggests that PHS is delaying the processing of claims. It would be more appropriate to track from the time the claim is filed to the date the Special Master assigns the case and schedules the respondent report date. OIG may not be able to determine this interval since this information is not in the program's database. Therefore, we suggest that the report simply indicate that the program does not begin to process cases until they are scheduled by the Court, and that is the reason for the delay.

The second clarification recommended would be to delete the sentence on page 19 regarding the need to better publicize the HHS Hotline telephone number. A lawsuit was filed, and subsequently withdrawn, charging that there was insufficient publicity for this special number. Even though this suit was withdrawn, the program has recently distributed a new poster along with a set of questions and answers regarding the program. These materials, which were developed to further inform vaccine administrators throughout the country about programmatic issues, include the 800-Hotline number.

Technical Comments

Page 2, first paragraph, first sentence. The words "Section 2110" should be replaced with "Subtitle 2 of Title XXI."

Page 2, first paragraph, second sentence. The following changes should be made:

- "Section 2110" should be replace by "Subtitle 2,"
- the phrase "by the 1988 and 1989 amendments," should be inserted after "1987," and

- the words "Health Information, Health Promotion, and" should be inserted before "Vaccine Injury Compensation Amendments of 1991."

Page 2, second paragraph, first sentence. The phrase "(in Subtitle 1 of Title XXI of the PHS Act)" should be inserted after "Act."

Page 2, second paragraph, second sentence. The phrase "(Section 2105 of the PHS Act)" should be inserted after "(NVAC)."

Page 2, second paragraph, last sentence. This sentence should be deleted from the final report.

Page 2, third paragraph, first sentence. The phrase "(Section 2119 of the PHS Act)" should be inserted after "Vaccines."

Page 3, Table I. Cells in the table should be revised as follows:

- for both the "retrospective" and "prospective" cells under "basis of awards," the words "of rehabilitative, and related" should be inserted between "medical expenses,"
- the "prospective" cell under "basis of awards" should be revised by adding "up to $250,000" after "pain and suffering," and
- the word "and loss of earnings" should be added at the end of footnote "***."

Page 5, second paragraph, first sentence. The word "entire" should be inserted before the phrase "...program if funding is insufficient."

Page 5, second paragraph, last sentence. The end of this sentence should be rewritten as follows: "...and the petitioner could then seek recourse only in the tort system."

Page 5, third paragraph, last sentence. A comma should be inserted after the word "million."

Page 5, fourth paragraph, first sentence. The beginning of this sentence should be revised as follows: "A Boston University professor recently completed...."

Page 9, second paragraph from bottom of page, first sentence. The words "and petitioner's counsel" should be inserted after "from DOJ and PHS."

Page 10, second paragraph from bottom of page, second sentence. This sentence should be rewritten as follows: "Once scheduled for review, the medium time for both retrospective and prospective cases to reach a special master decision is 15 months."

Page 10, second paragraph from bottom of page, third sentence. The words "date the case is scheduled by the Court" should be inserted in place of "PHS OGC report date."

Page 14, last paragraph, last sentence. Insert "PHS" in place of "VICP."

Page 15, second paragraph, last sentence. The sentence beginning "Representatives from HHS, DOJ and the Claims Court..." should be deleted since this is an inaccurate statement.

Page 17, first paragraph, first sentence. The words "the PHS Task Force has" should be replaced with "HHS and the Advisory Commission have."

Page 17, first paragraph, second sentence. The word "encephalopathy" and the comma after "seizure disorder" should be deleted.

Page 17, last paragraph. In the three places it is shown, "VICP" should be replaced with "PHS."

Page C-1, third paragraph, second sentence. In the two places it is shown, "OGC" should be replaced with "PHS."

Page C-4, third paragraph, last sentence. "OGC" should be replaced with "PHS."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

AUG 11 1992

TO: Bryan B. Mitchell
Principal Deputy Inspector General

FROM: Assistant Secretary
for Planning and Evaluation

SUBJECT: OIG Draft Report: "The National Vaccine Injury Compensation Program: A Program Review," OEI-02-91-01460 -- *COMMENTS*

Thank you for submitting for my review and comment the draft report on "The National Vaccine Injury Compensation Program: A Program Review." As you know, we and the Public Health Service (PHS) have been very interested in examining the Vaccine Injury Compensation Program (VICP) and looking for improvements in its operation. Your report was informative on these issues and will help as we proceed to propose changes. We suggest that upon completion of this report that it be made available to the Advisory Commission on Childhood Vaccines as its charge is to advise Secretary Sullivan on issues facing the VICP.

We do, however, have a technical comment. On page 16, the sentence discussing the Department of Justice (DOJ) proposal to provide for stronger corroboration of evidence should be modified to "HHS and DOJ support stronger corroboration of evidence requirements."

If you have any questions, please call Elise Smith on 690-6870.

Martin H. Gerry

cc: Michael Mangano

IG
PDIG
OIG-AS
OIG-EI ✓
OIG-OI
AIG-MP
OGC/IG ✓
EX SEC ✓
DATE SENT 8/11

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

AUG 14 1992

TO: Bryan Mitchell
Acting Inspector General

FROM: Arnold R. Tompkins
Assistant Secretary for Management and Budget

SUBJECT: Comments on "The National Vaccine Injury Compensation Program: A Program Review"

We read with interest the above referenced draft report. As you know, there has been a good deal of interest in this program and its operations since its inception. There are several comments we believe would strengthen the report.

Executive Summary

- Both page i of the Executive Summary and page 9 of the report contain a section headed by "Cases are delayed due to a front-end backlog resulting from scheduling constraints and lack of resources." The primary cause of the backlog is the large unanticipated influx of cases filed around the statutory deadline. While admittedly, administrative resources did not match well with this influx, these resources *per se* were not the primary issue. Even if additional resources of this type were available and all cases had been processed immediately, the resources to pay this level of claims is neither authorized by law nor appropriated. This then, is the true limiting step.

- On page ii of the Executive Summary, the report states that "Respondents identify specific resources which they consider insufficient to handle the backlog." This is not a completely accurate statement. The program can and is handling the backlog, albeit at a rate slower than some of the respondents would prefer.

- On page i of the Executive Summary, the number of cases referred to in the last paragraph of the "Background" section is not consistent with the number of cases cited only two paragraphs later. Apparently the difference is attributable to the fact that the HHS data base does not include all cases. If so, are the cases not in the data base significantly different from the ones in the data base? This should be clarified.

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Updating For Most Current Information

- On page 8 of the findings section, the OIG raises the concern that "the program will only be able to complete one-third of the retrospective cases by the new deadline." This statement seems to fail to recognize the enactment of the Vaccine Injury Compensation Amendments of 1991. These amendments gave the petitioner the option of remaining in the program beyond the statutory deadline if that is the preference of the petitioner.

Recommendations

- We would suggest modifying the first recommendation regarding the need to set priorities to better estimate future resource needs. Given the fact that, without a change in law, resources are available only to compensate a portion of the retrospective cases annually, it is conceivable that it may take as long as seven or eight years to pay all retrospective claims. With this in mind, we believe the recommendation should be amended to ask that PHS, DoJ and the Claims Court to develop a methodology to compensate parties in an equitable manner. Those considering this recommendation might ask: Should the last claim filed be adjudicated and paid prior to one that was filed months before the filing deadline? How can claims be arranged to assure that a basic rule of fairness is applied to the timing of payments?

- Discussion about reasons why Special Masters overturn the recommendations of the government's medical and legal staff could be strengthened. In only one instance is an interview with a Special Master cited. To understand as clearly as possible why decisions are overturned, OIG should interview all Special Masters and attempt to quantify the reasons for disagreement. Understanding the reasons why government expert staff is successful in only fifty percent of the cases may suggest additional reforms.

- On page 18, some of the recommendations appear to be resolving non-existent problems or seem incompatible with each other. For example, recommendations include action to streamline the process. The first streamlining idea is to assure more complete filing of the petitions at the front end in order to avoid the backlog. However, the only backlog which has been experienced in the program is for the pre-1988 claims, not for the post-1988 claims. All pre-1988 claims have already been filed and it is expected that no additional pre-1988 claims will be accepted. Another streamlining recommendation is to "use past damages decisions as a basis for future ones." This appears to be incompatible with the recommendation to "use latest scientific information" to determine compensation. The OIG report recommends revisions to the vaccine injury table as

well as stronger "Aids to Interpretation" which are not consistent with how previous claims were determined.

RECOMMENDATIONS

The PHS, DOJ and Claims Court should:

Inventory the Backlog to Set Priorities and Better Estimate Future Resource Needs

The Claims Court, in consultation with PHS and DOJ, should evaluate the existing workload to determine which cases it should handle first, what mix of resources will be needed to handle them, and how best to handle more complicated cases. In particular, Claims Court staff attorneys could be added to identify priority cases and those likely to be dismissed. A medical review contract may be an option if more medical review expertise is required.

Our analysis of case characteristics and handling times (See Appendix C) indicates that some aspect of cases, such as whether the patient died, the type of vaccine used, when the case was filed, and whether it was handled pro se, affect the length of time to process the case. Perhaps these and other factors can be used to schedule the cases more efficiently or to help determine the expertise required.

Further Streamline the Process

To help make the process more expeditious and non-adversarial, the agencies should review the following ideas:

* Assure more complete filing of petitions, particularly medical evidence by giving more guidance to petitioners and their attorneys.
* Due to the scarcity of expert witnesses, have one objective expert witness per case appointed by the special master, as opposed to one for the petitioner and one for the government.
* Use past damages decisions as a basis for future ones.
* Process damages determinations more quickly.

Use Latest Scientific Information

The Department of Health and Human Services should support its Task Force's proposed legislation to revise the Vaccine Injury Table to reflect the latest scientific information available, such as the IOM study. The Aids to Interpretation should include sufficient detail so the table can be interpreted more consistently.

Improve Contact with Petitioners and their Attorneys

The program should designate a contact person in the Claims Court to respond to the questions and concerns of petitioners and their attorneys, especially those questions about cases not yet assigned.

Emphasize Use of Annuities

The special masters should continue using annuities as the primary settlement option in injury cases.

COMMENTS

Comments on the draft report received from PHS, the Assistant Secretary for Policy and Evaluation and the Assistant Secretary for Management and Budget (ASMB) generally concur with the recommendations of this report. However, PHS pointed out that its role in the process is a limited one. We agree. We have directed our recommendations to the DOJ and the Claims Court as well as PHS. Suggestions for changes in the wording, clarifications of the text and any technical changes have for the most part been incorporated into the final report. The actual comments received are in Appendix D.

The PHS stated that the report incorrectly suggests that PHS is delaying the processing of claims because we did not track the date the claim is filed to the date the special master assigns and schedules the case. We are aware that delays were experienced from the time of the case filing to scheduling. However, those dates are not included in the program's database. We thus were unable to include it in our analysis.

Lastly, ASMB stated that the true limiting step of the program is that the resources to pay the level of claims submitted are neither authorized by law nor appropriated. We understand their point. We nevertheless believe that a more effective process can shed light on the extent of the problem and the true extent of the resources needed. In response to ASMB's recommendation to develop a methodology to compensate parties in an equitable manner, we note that this was not within the scope of the inspection. The ASMB also observed that since all retrospective cases have been filed at this time, the recommendation to assure more complete filing of petitions at the front end, and to give more guidance to petitioners and their attorneys is not necessary. However, many retrospective cases require additional information after the initial filing. To clarify matters we have eliminated the phrase "at the front end" from the recommendation.

Mr. SHAYS. Our next panel is going to focus on the Department of Veterans Affairs: William Merriman, Deputy Inspector General, Department of Veterans Affairs, accompanied by Michael Sullivan, Assistant Inspector General, Department of Veterans Affairs, and David Baine, Director of Federal Health Care Delivery Issues, General Accounting Office. Mr. Baine, do you have anyone else accompanying you? Could you, in the mike, tell us who will be accompanying you? How many? One or two? OK. Would you state the name for us so our transcriber can——

Mr. BAINE. Sure, Mr. Chairman. This is Mr. Jim Linz, an assistant director in our group, who has been involved in veterans programs for more than 15 years.

Mr. SHAYS. Well, it's great to have him accompany you, and we'll swear all—now, do we have anyone else? Do we have—good, OK. We're all set there, then. I'm going to ask you to stand at this time so I can swear you in.

[Witnesses sworn.]

Mr. SHAYS. Thank you. For the record, all four have responded in the affirmative. And we're going to start first with Mr. Merriman, who is the Inspector General. And then we'll go to you, Mr. Baine.

Mr. MERRIMAN. Mr. Chairman and members of the subcommittee.

Mr. SHAYS. Excuse me. If we could just switch these names around up front here, just to make sure we've got them matching here. Thank you. All set? I'm sorry. Thank you.

STATEMENTS OF WILLIAM MERRIMAN, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL SULLIVAN, ASSISTANT INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS; DAVID P. BAINE, DIRECTOR OF FEDERAL HEALTH CARE DELIVERY ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JIM LINZ, ASSISTANT DIRECTOR, FEDERAL HEALTH CARE DELIVERY ISSUES, GENERAL ACCOUNTING OFFICE

Mr. MERRIMAN. Mr. Chairman and members of the subcommittee, I'm pleased to be here today to discuss the Department of Veterans Affairs. With your permission, I'd like to enter my prepared statement for the record and use this opportunity to summarize some of the key issues facing the VA. When the IG testified before the subcommittee 2 years ago, VA was at the crossroads of change.

Since then, VA has made notable progress. While VA works continuously at improvement, it remains faced with what appears to be overwhelming challenges for the 21st century. Amongst these challenges include responding to the changing health care needs of veterans and providing more accurate and timely benefits. While VA has made progress, there remains much to be done. Also, since many of the changes implemented by VA are in the early stages, it will take some time before we are able to evaluate the results.

Regardless, the IG remains focused on working with Congress and VA in efforts to constantly improve VA's programs and activities. To this end, I would like to briefly elaborate on three areas. Collectively, these areas embrace matters critical to the accom-

plishment of VA's mission and reflect major themes pursued by the IG. In the area of health care, a VA goal is to move from an in-patient to an out-patient based system.

In recent years, the IG has conducted a series of audits and evaluations which address this goal. For example, we've determined that the lack of reasonable staffing methodologies resulted in unexplained disparities in the allocation of resources. While VHA developed the veterans equitable resource allocation model to address resources based on work load, the use of this model will require close management attention and monitoring.

VHA initiated a reorganization in 1995. While this represents a major milestone in the reform of VA's health care system, it is too early to determine whether it will produce the intended results. Although the IG is optimistic, the scope and pace of reorganization presents special challenges for VHA to ensure the continuation of high quality health care.

Another important challenge facing the VA involves reducing the backlog in claims and appeals. VHA has about 327,000 claims currently pending and an average processing time of about 5 months per claim. IG efforts are focusing on ways to help VA reduce processing times and improve the accuracy of benefits. We are nearing completion of a series of related reviews. We will issue a summary report later this year. On management accountability, the enactment of several pieces of legislation in recent years, such as the Chief Financial Officer's Act and the Government Performance and Results Act, have provided a statutory framework for enhancing the performance and improving accountability.

In regard to our audits of VA's consolidated financial statements, significant improvements in financial report reliability have been achieved. While VA's efforts over the last 5 years have enabled us to provide this year's unqualified opinion, work remains to be done to assure control weaknesses are continually addressed. Our early reviews of the implementation of GPRA show that VA was a long way from achieving the ultimate goal using performance measures as a tool for improving VA operations.

However, VA has made significant progress in the area as the Chief Financial Officer has been working with all VA activities to shift VA's focus to overall program results. Before closing, I'd like to address two additional matters important to cost effective management of both VA and the Federal Government. First, continuation of our authority to conduct post-award audits of Federal Supply Schedule contracts for medical supplies and equipment and for pharmaceuticals is at risk.

Proposed regulatory changes would severely limit our ability to conduct such audits. Our work in this area combined with the benefits already realized has convinced us that the elimination of the right to conduct post-award audits of FSS contracts will result in higher health care costs for the VA.

Mr. SHAYS. Before you continue, who is advocating that change?

Mr. MERRIMAN. There's a proposed change for the Federal FAR, Federal Acquisition Regulations, that we're negotiating with GSA at the current time. Industry is advocating a change to the Federal Acquisitions Regulations which would remove our right to conduct post-award contract audits.

Mr. SHAYS. That's for all departments or just the VA?

Mr. MERRIMAN. That would be for GSA and the VA for those Federal Supply Schedules that are managed by the two departments. The General Services Administration has a responsibility for managing the Federal Supply Schedules. They delegate the responsibilities for pharmaceuticals and for medical supplies and equipment to the VA to manage. So if a rule were to be passed that eliminated the right to contract audits, we would not be able to do it in medical supplies and equipment.

There's separate legislation that might allow us to still audit pharmaceuticals. But the proponents of this rule would say that the IG still has the authority under the IG Act. We do if fraud is suspected. We could conduct an investigation. We could do an audit. But we have a program with the department where we do the contract auditing for them on a reimbursable basis. And we've delivered, in the last 3—a little over 3 years—about $50 million have been returned to the Government based upon our efforts.

Mr. SHAYS. Now, is this a proposed rule that you're having to comment on? Is this already in process?

Mr. MERRIMAN. The rule has been proposed. It's still in the comment stage. The comments are being considered by GSA at this time. We are working with them.

Mr. SHAYS. Yes. I'm going to just come back in a second on that. Why don't you finish your statement?

Mr. MERRIMAN. OK. Second, the IG audited VA's OWC program, the workman's compensation program, in 1993 as a part of a governmentwide review. To address the report's findings, VA moved accountability and responsibility for these costs from the central office to facility level. Each facility is required to monitor its OWC program and return employees to duty as soon as possible in order to reduce costs.

We initiated a pilot investigative project with selected VA medical centers to help them identify individuals receiving OWC payments under fraudulent circumstances. I believe there is a potential for significant savings to the Government in this area. This concludes my statement, Mr. Chairman. I'd be pleased to respond to any questions you might have.

[The prepared statement of Mr. Merriman follows:]

STATEMENT OF MR. WILLIAM T. MERRIMAN
DEPUTY INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON HUMAN RESOURCES

HEARING ON DEPARTMENT OVERSIGHT: MISSION, MANAGEMENT, AND PERFORMANCE
MARCH 18, 1997

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to provide an overview of programmatic issues facing the Department of Veterans Affairs (VA), and the activities of the VA Office of Inspector General (OIG) in promoting efficient and cost effective management of VA programs. There are three subject areas which I wish to highlight for the Subcommittee's attention:

- *Measures to Improve the Economy and Efficiency of VA Healthcare Operations*
- *Measures to Improve the Timeliness and Accuracy of VA Benefit Claims and Appeals Processing*
- *Measures to Establish or Enhance Management Accountability for Results of VA Program Operations*

Collectively, these three subject areas embrace most of the matters critical to the effective accomplishment of VA's mission and reflect the major strategic themes pursued by my office in our reviews of VA programs and activities. As you may recall, we reported to this committee in May 1995 that VA was attempting to abandon past practices which were inefficient and costly, and to become more business-like. Our audits, evaluations, and inspections show that VA is making progress in many of its major mission areas.

In my assessment of these issue areas I will also address actions taken by VA to meet the requirements of the Government Performance and Results Act, and discuss what has been learned from our audits of VA Consolidated Financial Statements. Finally, I will report on two government-wide areas, Workers Compensation and Procurement reviews, where we have placed special emphasis

on cooperative initiatives with VA management to ensure our Nation's veterans and taxpayers receive value for their investment.

Measures to Improve the Economy and Efficiency of VA Healthcare Operations

The Veterans Health Administration (VHA) is faced with significant challenges in moving from an inpatient hospital based health care delivery system to a modern primary/managed care outpatient based system. During the past few years, we have conducted a series of audits and evaluations which emphasized the need for change, identified impediments to progress, and recommended corrective measures. Among the significant issues we reviewed were:

- The appropriateness and equity of the allocation of resources in VHA.
- Whether VHA affiliations with medical schools were working well.
- The effectiveness of medical care cost recovery.
- The validity and usefulness of management information and other data used by VHA managers for decision-making.
- Reorganization of VHA.
- Quality management.

The Under Secretary for Health addressed many of these issues and, based on his analysis of VHA operations, developed a vision statement in 1996, *Prescription for Change*, in which he describes a framework for reinvention built upon five mission goals:

- Excellence in Healthcare Value
- Excellence in Service as Defined by Customers
- Excellence in Education and Research
- Exceptional Accountability
- Recognition by Staff as an Employer of Choice.

In the following, I summarize our work related to these areas and the VHA planned and ongoing actions.

1. <u>The Appropriateness and Equity of the Allocation of Resources in VHA</u>

VHA operates a system of 173 medical facilities organized in 22 Veterans Integrated Service Networks (VISNs). During Fiscal Year (FY) 1996, the system employed 200,000 medical professionals and support personnel, and spent about $17 billion providing medical services to 2.9 million veterans. Additionally, about

$257 million was spent to conduct medical research. Finally, about $1.5 billion was spent training medical students from universities and medical schools affiliated with VA medical centers.

Audits and reviews conducted since FY 1994 found that appropriated medical care funds were not equitably and effectively allocated to provide all veterans comparable access to medical service throughout our Nation. The lack of reasonable staffing guidelines or methodologies resulted in unexplained disparities in clinical and administrative staffing levels among similar medical centers and inequitable access to veterans medical care. We have analyzed physician staffing, nurse staffing, and administrative staffing and, in each review, found unexplained inconsistencies in staffing levels which were not related to workload. Additionally, our audits of VHA surgical programs found under utilization of buildings, equipment, and staff resources. The following paragraphs summarize our work:

- ***Inconsistency in Physician Staffing Among Medical Centers***
  In Fiscal Year 1996, VA employed over 20,000 Full Time Equivalent (FTE) attending physicians and residents at a cost of $2 billion annually. Our past reviews found significant physician staffing disparity among medical centers with similar missions, workloads, and levels of affiliation. For example, two highly affiliated medical centers had about the same number of patients but significantly different physician staffing levels. One medical center had 36,773 unique patients and 422.8 physician FTE, for a patient-to-physician ratio of 87 to 1. The other medical center had 36,144 patients and 216.7 physician FTE for a ratio of 166 to 1 -- almost twice the number of physicians as the first medical center.

- ***Nurse Staffing***
  In 1996 VHA medical facilities employed about 59,000 nursing FTE at a cost of about $3 billion. In response to our prior work, VHA adopted a new nurse staffing methodology that featured local medical center expert-panels to determine staffing requirements. The new model was not mandatory and did not require benchmarking against other medical centers. Thus, the model had little impact on correcting disparate nurse staffing among medical centers. Current VHA statistical data indicates that disparities in nurse staffing similar to that found for physician staffing continue.

- ***Administrative Staffing***
  Our 1996 review of VA medical center administrative staffing found significant variances in staffing the four largest administrative services (Medical Administration, Human Resources, Fiscal, and Acquisition and Materiel Management) among similar medical centers. These 4 services employed about 31,000 FTE costing $1 billion. Staffing guidelines or performance indicators were not developed to determine medical center administrative staffing needs. As in our evaluation of physician and nurse staffing, the review found that some medical centers used significantly more administrative resources than others to meet similar workload demands, providing further evidence for the need to reassess resource allocation and consolidate and streamline functions.

- ***Utilization of Surgical Resources***
  Our prior reviews found surgical specialty programs which were not efficient or economical because workload was too low at some facilities, or more importantly, the workload was not sufficient to maintain minimally acceptable surgeon skills. VHA agreed with our recommendations to concentrate certain surgical specialty workloads at selected facilities, but experienced difficulties carrying out the cost saving initiatives, because some medical centers were exempted from minimum workload requirements.

VHA Actions to Address Issues

Congress and VHA management have acknowledged the existence of staffing and resource allocation disparities, and taken steps which will address many of our concerns as part of various initiatives to restructure the VA healthcare system. Among these initiatives are:

Veterans Equitable Resource Allocation (VERA) - Congressional recognition of the inequity created by VA's historical incremental resource allocation process resulted in Public Law 104-204, the *VA/HUD and Independent Agencies Appropriations for Fiscal Year 1997. The Act* requires VA to provide Congress a plan to allocate funds and personnel in a way that ensures that veterans with similar economic status and eligibility priority have similar access to VA care regardless of where they reside. VHA developed the Veterans Equitable Resource Allocation model (VERA), a system designed to allocate resources based on workload/capitation, to meet Congress' mandate. As VHA's newest resource allocation model, VERA is VHA's fifth attempt in the last 10 years to develop an equitable resource allocation system. The prior systems included: Blended Rates,

Resource Planning and Management, and the Resource Allocation Methodologies I and II. Using VERA, VHA plans to increase the reallocation of medical care appropriation funding in FY 1997, from higher cost VISNs to lower cost VISNs. VERA is less complex and easier to understand than its predecessors, and it makes more use of quantitative measures to distribute most patient care and non-patient care resources. The use of VERA will require close management attention and monitoring by oversight activities to ensure successful implementation.

Capitation Fund Allocation - VHA's planned move to a capitation-based resource allocation methodology in FY 1998 should help address resource allocation disparities. Under capitation, funding would be allocated on a per patient basis, reducing allocations to those facilities that have high staff to patient ratios and requiring those facilities to evaluate their operations and find ways to become more efficient.

Performance Measurement, Clinical Guidelines, and Benchmarking - Development of performance measures for clinical and administrative activities, clinical guidelines, and clinical pathways will help managers evaluate operations and maximize the services they can provide. Benchmarking involves identification of best practices and dissemination of information about these practices to all facilities.

Improved Management Information - Development of improved management information and cost accounting systems will provide managers more useful and accurate information on resources (inputs), workload produced (outputs), and quality of service (outcomes), for decision making.

Integration - VHA integrated selected facilities and services during implementation of the VISN concept. This integration of facilities and services results in consolidation and streamlining of functions within VISNs, and eliminates duplication of services and improves efficiency.

These initiatives have potential for addressing resource allocation problems. However, VHA managers at all levels must have the collective institutional will to use these tools and to take the steps necessary to bring about real change. The OIG will continue to monitor VHA's progress in improving the balance in staffing and other resources.

2. Whether VHA Affiliations with Medical Schools Were Working Well

A second issue critical to VHA mission accomplishment is the reevaluation of VA's association with our Nation's medical schools. The opportunities and stature which results from association with medical education and research are generally recognized to have sustained or improved the quality of VA clinical care. Over the past 50 years these affiliations have evolved into complex relationships that have given medical schools substantial influence in all VA activities, including patient care, medical education, and research. VA medical centers and medical schools operate numerous integrated programs and share staff, facilities, equipment, and other resources.

Each year more than 100,000 residents and students receive all or part of their training at VA facilities. In Fiscal Year 1995, VA budget data showed that about $1.5 billion was spent (about 9 percent of VA's medical care and research budget) to directly or indirectly support affiliation activities, including the costs of training about 9 percent of the medical residents in the U.S. About 75 percent of VA's 173 medical centers are affiliated with medical schools, and about 70 percent of VA staff physicians have medical school faculty appointments. The following illustrates the scope of VA-medical school affiliations and related activities:

- VA funded about 8, 900 medical resident positions at an estimated cost of $341 million.
- About 10,100 of VA's 14,500 full-time and part-time staff physicians (70 percent) held medical school faculty appointments.
- About 86 medical centers used 305 scarce medical specialist (SMS) contracts to purchase about $49 million in services from affiliated medical schools.
- Fifty-seven medical centers had 196 sharing agreements with affiliated medical schools to provide or to purchase services valued at $50 million.
- VA supported about 1,800 research projects funded by $289 million from research appropriations and $378 million from the medical care appropriation.

Our audits and reviews have found that the resources which should have been devoted to VA's patient care mission have sometimes been inappropriately used as a consequence of the training and research priorities of affiliated medical schools,

and VA medical centers frequently did not get what they paid for in scarce medical services contracts and other agreements with medical schools. The OIG has performed a series of audits of various affiliation related programs and activities to address concerns about balance and economic fairness, and the level of medical school influence in VA operations. The audits found that VHA needed to take action on three broad fronts:

Management of physician resources - VHA needed to provide better control and accountability over the time and services provided by VA physicians and residents associated with affiliated medical schools to ensure VA received the level of services due.

Contractual agreements with medical schools - VHA needed to apply improved business and procurement practices in their dealings with medical schools to ensure the interests of the government were protected.

Management of information - VHA needed to improve management information systems relating to affiliation operations and resources consumed in affiliation related activities, to improve the equity of resource allocation and accomplish the Congressional mandate for consistent access to care for all veterans.

Our recent reviews indicate that VHA management is addressing these issues by their actions to implement audit recommendations and by their initiatives to restructure the VA healthcare system. Notable examples of such initiatives include VHA's implementation of special advisory group recommendations to improve the targeting and management of VA resident training and medical research resources to better meet future VA healthcare system needs.

We recently issued a summary report on affiliation-related audits in which we reported that VHA should follow through on the restructuring initiatives and should take two additional actions to continue the momentum towards improving the balance in VA-medical school relationships. First, we recommended that VHA should direct medical center officials to avoid entering into questionable special arrangements with affiliates. Many of the problems identified in our audits resulted from informal arrangements between medical centers and medical schools that were not in accordance with VA policy or sound management practices. Second, we recommended that VHA redesign and renegotiate existing affiliation agreements to better reflect the broad scope, complex elements, and economic realities of today's affiliations and the health care industry, and current VA priorities and management philosophy. The Under Secretary for Health incorporated our recommendations with those of his own task force which should

result in significant improvement in the affiliation relationship. We will followup on the implementation of the recommendations.

3. The Effectiveness of Medical Care Cost Recovery (MCCR)

Since enactment of the Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) in 1986, VA has been authorized to seek reimbursement from third party health insurers for the cost of medical care furnished to insured non-service connected (NSC) veterans treated at VA. Several measures were enacted since which further expanded medical care cost recovery authority.

- The Budget Reconciliation Act of 1990 (P.L 101-508 authorized: (i) a revolving fund to pay for MCCR operations with program recoveries; (ii) collection of costs of medical care provided to insured service connected (SC) veterans treated for NSC conditions from third party payers; (iii) expansion of "discretionary care" veterans included in the means test copayment program; and, (iv) expansion of the categories of veterans charged per diem copayment for hospitalization and nursing home care, and copayment for medications.

- The Veterans Benefits Act of 1992 (P.L. 102-568): (i) established exemptions from the medication copayment program for veterans whose income did not exceed the maximum annual rate of pension; (ii) authorized VA to collect information from financial institutions and to recover medical care costs from health insurance of veterans with SC disabilities treated for NSC conditions; and, (iii) extended the medication copayment program for 5 additional years.

VA reported recovering medical care costs of about $557.2 million during Fiscal Year 1996, including recovery of debts established during previous years. Several audits and reviews showed that VA needed to improve means testing procedures, improve the identification of insured veterans treated for non-service connected conditions, and increase resources to maximize recoveries of costs associated with such care. VHA has taken effective action to improve means testing, but VHA has not uniformly documented the appropriate healthcare codes for all care provided veterans in VA facilities. The lack of proper healthcare codes may have been one of the primary reasons VA has not received the maximum reimbursement for care provided to insured veterans treated for non-service connected conditions.

The need for proper medical care cost recovery actions has become more important as VA has proposed to Congress that the Department be authorized to bill Medicare for veterans who are Medicare-eligible.

In FY 1996, the costs of recovering the $557 million were $123 million. During FY 1997, the OIG plans to conduct an evaluation of the efficiency of the MCCR program and compare VA collection costs with private sector costs.

4. The Validity and Usefulness of Management Information and Other Data Used by VHA Managers for Decision-Making

Improvement in information management will be critical to success in reforming the Veterans Health Administration. VHA often lacked accurate, reliable, or comprehensive management information and cost accounting systems to support decision-making, and to facilitate oversight by Congress and others. We have noted that steps are being taken that should improve the current situation.

Decision Support System (DSS) After several years of testing and development, VHA purchased a new healthcare information system in FY 1995 - the Decision Support System (DSS). DSS is a commercially produced data base system that will link clinical workload data with resource and cost data from existing VA data sources to provide better management information about clinical care practices and costs. DSS capabilities include the ability to provide detailed comparative data for clinical services and individual practitioners, and to aggregate data for roll-up comparisons at facility, VISN, or national levels. DSS applications are designed for use in such areas as continuous quality improvement, utilization management, outcome management, patient-specific cost accounting, and performance measurement.

DSS can help managers at all levels to more precisely assess provider production and productivity-efficiency, to accurately account for resources expended in clinical and non-clinical activities, and to determine actual variations in costs and resource requirements attributable to: differences in patient acuity, complexity of care, special clinical programs, medical education, or research. Installation of DSS is scheduled to be completed at all medical centers within 3 years.

Although DSS has the potential to significantly improve VHA cost accounting and management information capabilities, we have had concerns about the VA information infrastructure from which DSS will derive its source data. Some of the data in existing clinical and financial systems is incomplete, inconsistent, and inaccurate, and would limit the effectiveness of DSS in providing relevant and useful management and cost information. In a June 1996 report, we found that to improve DSS implementation, continued VHA attention was needed to: adopt standard industry codes for outpatient services; develop standard methods to calculate workloads; establish procedures to ensure the compatibility of DSS and

other VHA and medical center data; and develop guidelines so DSS reports meet the needs of managers and other data users.

VHA top management has demonstrated commitment to implementing an improved and integrated management information system. As part of the efforts to ensure successful DSS implementation, VHA is developing standard data sets and definitions, and common DSS report methodologies, which should facilitate uniformity of data for reports produced by DSS.

DSS should enhance VHA's cost accounting and management information, although continued VHA effort will be required to change the culture of the information users at many operating and management levels. Managers and other users will have to put aside past experiences with old forms of management information, and make concerted efforts to use the new management information to its full capabilities in managing VHA healthcare operations.

5. Reorganization of VHA

VHA's reorganization plan received Congressional approval in September 1995, and was initiated in October 1995. It represents a major step in reform of the Nation's largest integrated healthcare system. The restructuring is intended to make healthcare management more interdisciplinary and focused on product lines such as primary care or long term care, and to decentralize management to the VISNs.

VHA's prior field management structure consisted of 4 regions, each providing oversight to 36 to 45 independent medical centers. The four regions reported to the Under Secretary for Health. Under the new plan, the regions were abolished and medical centers lost their budgetary and operational independence. The new structure has the 173 medical facilities organized as components of 22 Veterans Integrated Service Networks or VISNs. The VISN Director has budgetary and operational authority over the medical facilities in the VISN, and reports to the Chief Network Officer in Headquarters. Thus, the reorganization flattens VHA's structure by eliminating the 4 intermediary regions, and contracts the span of organization from 173 independent operational entities to 22.

Coincidental with creation of the VISNs, VHA is also expanding ambulatory services to achieve the greatest possible healthcare value. VHA is developing strategic 5-year plans to show how VHA will align its resources with patient needs, integrate geographically close services, and enhance existing referral mechanisms. The plans are expected to address what new ambulatory care sites,

such as community-based clinics, are needed, and use non-physician caregivers to expand patient services.

Additionally, the Veterans Health Care Eligibility Reform Act of 1996 has simplified eligibility rules and expanded veterans eligibility for obtaining medical care. This legislation enhanced the ability of VHA to realign resources from an inpatient to an ambulatory/primary care delivery system. However, while eligibility reform is expected to improve the efficiency and effectiveness of VA healthcare delivery, it could also significantly increase VHA workload, and therefore operating costs.

We believe it should be VA's goal to establish sufficient appropriate outcome measures that Congress and the American people could assess whether VA had an effective or an ineffective year. Our prior recommendations to develop criteria to assess the effectiveness of VHA facilities and outcomes were neither well received nor implemented, and as a consequence, it has been difficult for the OIG and others to measure outcome and mission accomplishment. However, VHA has now indicated that VISN directors will be held accountable for meeting performance goals cited in performance contracts, and we have seen VHA progress in implementing the requirements of the Government Performance and Results Act. I will discuss this issue in greater detail later in this testimony.

VHA's reorganization marks an era of reform for VA. It represents a change from a system having substantial central office oversight of operations, to a management system based on decentralized decision-making. It is grounded in the belief that greater empowerment of local management will lead to risk taking, innovation, and greater efficiency and effectiveness. It is too early to determine whether the reorganization will succeed in accomplishing those objectives. However, we are convinced that success will ultimately depend on the development of appropriate performance criteria, adequate data systems and visibility over results of operations, and a commitment to truly hold managers accountable for meeting performance expectations. Our audits and inspections will focus on evaluating the performance of VHA's operations.

6. ***Quality Management***

While the OIG is optimistic about VHA's broad-based reorganization moving into a decentralized management environment, the massive scope and rapid pace of the reorganization effort present special challenges for VHA managers to ensure the continuing provision and assurance of high quality health care. The OIG is concerned for example, that the importance of using direct quality measures to

assess the continuing quality of care or to identify and correct possible treatment practice problems continually needs to be emphasized during the reorganization process. OIG believes that the quality management (QM) programs, including direct quality measures, are needed, particularly in such a complex health care system, to avoid the potential for a decline in the quality of VA health care. Examples of our concerns in the QM area follow:

First, VHA managers redesignated the former Office of Quality Management as the Office of Performance Management. We recognize that VHA stipulates in its "Vision for Change" that "...quality management considerations drive the [VHA] planning activities and underlie all ongoing operations." However, in our deliberations with VHA managers, we noted that there is an emphasis on the use of surrogate quality measures such as patient satisfaction. While we endorse the need to ensure high quality customer service and satisfaction, we do not believe that patients' perceptions of their treatment alone can identify treatment practices that may not comport with accepted treatment standards. Second, VHA heavily emphasizes its use of medical record reviews by the External Peer Review Program (EPRP) to monitor and attest to the quality of health care at all VA medical centers. We are in the process of evaluating the effectiveness of the EPRP and will issue a report later this year. Finally, VHA's Office of Medical Inspector (OMI) is the centralized VHA organization that can provide the Under Secretary for Health with professionally-based, independent opinions on the quality of VHA health care. We believe that the OMI is an important element in assuring high quality care, and ultimately patient safety. We have evaluated the role and staff of the OMI, and provided the Under Secretary with our recommendations, which are under discussion at this time.

Measures to Improve the Timeliness and Accuracy of Benefit Claims and Appeals Processing

Another important departmental challenge involves the efforts of the Veterans Benefits Administration (VBA) as it provides benefits and services to veterans and their families. Of specific note is VBA's current emphasis to reduce the backlog in pending beneficiary claims and appeals.

The VBA is staffed with about 14,000 employees and distributes about $20.9 billion annually in compensation and pension (C&P) and education benefits. During the 12 months ending February 28, 1997, VBA made decisions on 2.7 million C&P claims. Action on 327,000 claims is currently pending. For the

127,000 original compensation claims completed, the average processing time was 144 days.

VBA also guarantees approximately 300,000 home loans annually, valued at about $30 billion, and in FY 1996, paid foreclosure claims totaling about $ 430 million. VA also assumes ownership of some properties, rather than pay a claim to the mortgage lender. As of September 30, 1996, VA had approximately 10,000 properties in its inventory.

Additionally, VBA staff provide vocational rehabilitation counseling and vocational rehabilitation benefits, and provide oversight to incompetent beneficiaries. Finally, VBA administers life insurance programs for service persons and veterans. During FY 1996, the face value of outstanding polices totaled over $25 billion, and about $900 million in death claims are paid annually.

VBA has initiated several internal reengineering efforts and has been the subject of congressionally mandated studies and reviews to assess its organizational structure, business process, and study the reasons for untimely actions and backlogs. Our audit efforts have been directed at reviewing such issues as VBA's use of income verification, delivery of benefits and services, and claims and appeals processing.

1. VBA's Income Verification Match Program

During the early 1980s, the OIG began a series of "State Wage Matches" to verify that beneficiary-provided income and employment information was accurate. Claimants for income or disability based benefits (Pension, Unemployability Compensation) periodically provide such information, and VBA adjudicators use the information to determine entitlement, continued entitlement, or the amount of benefit to which the claimant is entitled.

Matches were conducted of VA compensation and pension records and State employment and earnings files. These matches found that about 10 percent of pension claimants provided VA erroneous employment or earning information which resulted in the inappropriate receipt of benefits. During the course of the matches, we identified instances of false or fraudulent information, which ultimately resulted in creation of overpayments totaling $53 million and avoidance of future potential overpayments totaling $7 million. In addition, over 6,000 cases of suspected fraud were referred to U.S. Attorneys. In some cases, claimants were gainfully employed full-time, and the frauds had occurred for up to 20 to 25 years without detection by the claims adjudication system.

We proposed legislation and the Congress agreed to authorize the Internal Revenue Service (IRS) to provide VA access to IRS income information. VBA took over the income verification matching (IVM) process from us in the late 1980s. Our 1996 review of VBA's IVM Program concluded that there were opportunities to streamline the income verification process which would reduce program costs and improve services to beneficiaries. We also found that 46 percent of income discrepancy cases did not need to be referred to VA regional offices (VAROs) for adjudicative action. By using enhanced automated screening for case referrals, and increasing the minimum income discrepancy amount, about 38,000 case referrals could be eliminated, reducing annual program costs by $6.7 million. This would increase VBA's cost benefit ratio for the IVM program (program costs versus benefit adjustments) from $1 to $5 to as much as $1 to $10, and allow transfer of IVM staffing resources to perform other VBA work.

We are currently conducting an audit of VA's compensation and pension records to identify veterans who have died and continue to receive VBA payments. While our results are preliminary, we have identified instances where inappropriate payments were made after the death of the beneficiary. We will be making recommendations to address this problem.

2. *Effectiveness of Benefit Award Notification*

Our recent evaluation of benefit award notification found that modifying the award adjustment procedures coupled with enhanced beneficiary dial-in telephone inquiry services could reduce or eliminate some beneficiary overpayments. These revised procedures would streamline due process notice and response procedures, and eliminate some delays in adjusting benefits which annually result in overpayments to beneficiaries estimated to total $24.5 million. VBA agreed with our recommendations and plans to revise operating procedures once all legal considerations are addressed.

3. *Claims Processing*

VBA has historically experienced significant backlogs of pending compensation and pension (C&P) claims. At the end of FY 1994 there were about 474,000 claims pending and at the end of FY 1995 there were about 385,000 pending claims. Large backlogs of claims adversely affected timeliness of claims processing. For example, in FY 1994 initial claims for disability compensation remained pending an average 213 days. In FY 1995, VBA made progress in reducing processing time to 161 days.

VBA plans to address the timeliness of claims processing issue further through improved training, organizational changes, and modernization efforts. The Department has reviewed claims processing, and is currently considering a number of field restructuring approaches.

Claims processing timeliness is also affected by outdated automated data processing and communication systems. VBA's modernization initiatives are at a critical point of implementation as VETSNET, VBA's new processing system, is scheduled to be implemented by early 1998.

Veterans service organizations and Congressional oversight committees continue to be concerned about the timeliness of claims processing. At the request of Congress, the National Academy of Public Administration is currently conducting a comprehensive assessment of VBA's benefits claims adjudication process. We have met with them and shared our views. The report of the Veterans' Claims Adjudication Commission, in which we had participation, also highlights a number of potential changes to program operations that should be considered.

We are nearing completion of a series of reviews of VBA claims processing that includes 13 completed projects and 6 projects which are on-going or planned. These reviews cover a wide range of issues including evaluation of business processes, evaluation of the accuracy of claims adjudication decisions, identification of steps to ensure the accuracy of payments and avoidance of overpayment, evaluation of the reliability of data used for claims adjudication, and other issues. We will issue a summary report on our findings later this year.

4. *Appeals Processing*

Contributing to the length of time it takes to address a veteran's claim is the appeals process. The 1988 Judicial Review Act established the Court of Veterans Appeals (COVA) and expanded due process requirements which has further impacted timeliness of appeals processing. Since COVA was established processing time for an appeal with one remand went from 746 to over 1,200 days. Implementation of the Board of Veterans Appeals (BVA) Administrative Act of 1994 has contributed to recently reduced case processing times and the backlog of pending cases. The Department's Blue Ribbon Panel on Claims Processing and the BVA Select Panel on Productivity Improvement identified ways to improve claims processing and recognized that training and modernization efforts were the key to achieving processing improvements.

While the Department has made progress in reducing case processing times, there is concern about the quality of decision making at the regional office level which is impacting on the completion of veteran appeals. During FY 1995, BVA completed decisions on 28,195 appeals but more than two-thirds contained: (i) errors requiring reversal, or (ii) were remanded to the regional office for additional claims development. The cases that were returned to regional offices added work to an already existing backlog.

Our audit of VBA's appeals processing found that VA needed to take additional actions to reduce the impact of the appeals process on the timeliness of veterans benefits claims decisions. Our audit recommendations included actions to: limit the scope of appellate review to an evaluation of the veteran's conditions as they existed at the time the decision was appealed; test an expanded role and use of hearings by VA regional office hearing officers; and, eliminate the requirement for statements of the case when expanded ratings provide appropriate legal citations. The processing time for a statement of the case adds about 70 days to the appeal process. VBA management agreed with our recommendations and will recommend statutory changes in appeals processing.

Measures to Establish or Enhance Management Accountability for Results of VA Program Operations

A statutory frame for improving management, budgeting, and reporting of results has been created through the enactment of the Chief Financial Officers Act, Government Performance and Results Act, Government Management Reform Act, Federal Financial Management Improvement Act, and the Information Technology Act. Implementation of these laws should result in the improvement of government operations by focusing agency management on mission, establishing performance goals that stress outcomes, linking resources with mission accomplishment, the accurate reporting of financial information, and the reporting of results of operations. Agency implementation of these laws should provide the Congress and the Executive with clear reports on what is to be accomplished within available resources; how well those resources were used; and audited financial information on the costs of achieving the results.

Our audits and reviews of VA's programs help the department address the challenges presented in these laws by providing a data base of audited information on how efficiently and effectively missions are accomplished. We have reviewed

the Department's early attempts to implement the GPRA, and annually audit implementation of the CFO Act.

1. ***Audit of VA's Consolidated Financial Statement***

In regard to our audits of VA's Consolidated Financial Statements, I believe that some of the greatest benefit of the audits is in the auditing process itself. Our audits of the financial statements under the CFO Act have focused increased and appropriate attention on financial management and the supporting data processing systems. Such emphasis is needed so that VA can operate in a more business-like manner. Implementation of a new core financial management system in VA during FYs 1995 and 1996 has significantly improved the auditability and reliability of financial management information in the Department. As a result of the audit process, significant improvements in financial report reliability have been achieved, as illustrated in the following history of our audit work.

In FY 1991, our first audit report presented a qualified opinion on the reasonableness of the financial statements with five material conditions. Four years later, our FY 1995 audit opinion remained qualified, but with only two material conditions.

In our most recent audit, we provided the Department with an unqualified opinion on FY 1996 year end balances contained in VA's statement of Financial Position (i.e., balance sheet). The FY 1995 year end balances and the various FY 1996 operating and budgetary statements remained qualified to the extent prior property and receivable errors affect those statements. The clean opinion on the FY 1996 year end balances is a significant milestone in VA's development of financial statements under the Chief Financial Officers Act as it reflects the correction of two long-standing material weaknesses. Additionally, having sound FY 1996 year end balances provides VA reliable baseline data for eliminating the remaining qualifications pertaining to the operating and budgetary statements. These improvements are noteworthy.

While the Department's efforts over the last 5 years have enabled us to provide an unqualified opinion on the reasonableness of the ending balances of the FY 1996 Consolidated Financial Statements, work remains to be done to assure control weaknesses are addressed. Among the deficiencies we have noted is the automated data processing (ADP) system for the VA Life Insurance Program, which is outdated and cumbersome, and has been noted as a material weakness for several years. Another area of concern is that VA's information systems need stronger controls to ensure that VA ADP facilities adequately protect financial data

from unauthorized access and modification. Also, we have reported for several years that management needs to ensure that unneeded obligations are being canceled in a timely manner so that the funds released can be directed to other valid requirements.

The audited financial statements provide Department managers, Office of Management and Budget, and Congressional staff offices with independently validated, credible financial information for monitoring and evaluating the effectiveness of VA programs, and for evaluating the true, long-term costs of budgetary alternatives and proposals. The following examples present information that can be gleaned from the reports of audit of VA's Financial Statements:

- Show the total unfunded long-term costs of VA programs that taxpayers are committed to pay in the future. Examples include the unfunded liabilities for compensation and pension benefits ($240 billion), Workers Compensation ($1.7 billion), and accrued employee annual leave ($856 million).

- Make it possible to measure the total long-term cost impact for any compensation and pension benefit changes being considered by Congress, Office of Management and Budget, or program managers. The unfunded liability for compensation and pension benefits is the actuarial estimate of the total long-term veterans benefits costs based on existing laws. The actuarial computation used for the estimate provides a reliable methodology for measuring the total cost impact of proposed policy decisions.

- Give visibility to the future liabilities associated with VA's loan guaranty program ($4.2 billion) and life insurance programs ($12.9 billion) and reports on the adequacy of funds/reserves available to cover these liabilities.

Audited financial information and functioning financial systems are critical to Department objectives of accurately measuring the cost of services provided veterans and others. The financial statement process has focused attention on financial systems and provided the impetus for modernizing and upgrading systems, and implementing technological initiatives such as increased use of electronic data interchange and credit cards to improve financial management.

In addition, the audit of the VA Consolidated Financial Statements provides us with the means to identify opportunities for improving the Department's ability to operate more economically and/or effectively. From the financial statement audits, we identify areas of concern and place them into the audit planning process for

review in detail as resources become available. For example, Financial Statement Audits identified the following issues for further review:

- Collecting accounts receivable - Vendor receivables were not effectively offset against future payments. The two main reasons for ineffective offsets were that the system did not allow for partial offsets and system-wide offsets were managed by individual stations. For example, one vendor owed VA $3,000. Subsequently, 40 payments totaling $14,400 were made to the vendor. Because none were $3,000 or larger, offsets did not occur. In another case, a vendor owed VA $18,390, but over the next 3 years VA paid the vendor over $11 million. The station wrote-off the $18,390 receivable as uncollectable.

- Duplicate payments to vendors and beneficiaries - VA was processing invoices twice because the system did not have basic controls which would have prevented the same invoice from being transmitted twice. VA detected some, but not all, duplicates after payment had been made.

The priority and importance placed on the CFO Act audits by OIG is evident by the priority given and resources we devote to VA's consolidated financial statement audit. Benefits are significant, but the audit is costly and uses an increasing proportion of audit resources, thus reducing staff available for other program audits that provided significant monetary benefits in the past. Financial statement audits use about 25 to 30 percent of available audit staff time.

2. ***Government Performance and Results Act (GPRA)***

Our early reviews of the implementation of GPRA showed that while VA had made progress implementing strategic plans, the department was a long way from achieving the ultimate goal of using performance measurement as a tool for improving the efficiency, effectiveness, and economy of VA operations. For example, Departmental strategic plans either did not include program or performance measures, or incorporated measures which were not sufficiently specific and quantifiable to measure whether goals and objectives were achieved. We recommended establishing:

- More specific and quantifiable performance measurements to assess whether goals and objectives were achieved.

- Management responsibility and accountability for the development and implementation of the strategic plan.

To achieve the results expected by GPRA, VA must have an effective means to integrate financial and performance information for decision-making. In particular, VA needed to establish program goals, objectives, and yardsticks to measure program performance which are unambiguous, quantifiable, and measurable. Additionally, Congress and VA management need to receive program performance data and management information which is current, relevant, reliable, and accurate, to effectively measure performance and results of operations.

The Chief Financial Officer has been working with all Department activities to shift the focus of performance measurement from program inputs to program results. As a result, the Department has developed measures to show how well VA's programs are meeting key Departmental objectives and goals.

In the Veterans Health Administration, organizational goals were developed to articulate the Under Secretary's vision. For the first time, specific performance agreements were made between the Under Secretary for Health and senior managers. Measures were developed to gauge VISN and overall organization progress toward achieving the objective of moving toward an outpatient and primary care focus. For example:

- Objective was to decrease the bed days of care per 1,000 unique users by 20 percent. In actual performance, VHA achieved a 21 percent reduction in 1996, which was greater than the 11 percent achieved in 1995. (Accountability Report page 14.)

- Objective was to increase the percentage of appropriate surgical and invasive diagnostic procedures performed on an ambulatory basis to 50 percent by September 1996. VHA achieved 52 percent in FY 1996, versus 39 percent in FY 1995, and 35 percent in FY 1994. (Accountability Report, chart on page 15.)

- Medical care cost recovery program uses an efficiency performance measure of: costs should not exceed 20 percent of recoveries. VHA achieved 21 percent in FY 1996, attributing the increase from the prior year's 17 percent to lower amounts collected from third party insurers and additional costs of implementing a new automated system. Several initiatives are underway to increase collections. (Accountability Report, page 17 and 18.)

In the Veterans Benefits Administration (VBA), management developed, during FY 1996 and as part of VA's FY 1998 Budget process, a fully integrated business

plan. (Accountability Report, page 23.) Performance measures were established for each major business line, a few examples of which follow:

- A performance goal for award of benefits was to reduce the number of C&P claims pending by 8.5 percent and VBA achieved a reduction of 11 percent for FY 1996. (Accountability Report, page 25.)

- Another performance goal was to reduce the average number of days to process claims. Achievement exceeded the goal in FY 1996 for original compensation, dependency and indemnity, and pension claims. (Accountability Report, page 25.)

- Life Insurance Program had an objective of maintaining the lowest possible unit cost for VA-administered Insurance programs with a goal of $25 for administrative costs per account. VBA actually achieved $23.68 for FY 1996. (Accountability Report, page 33.)

We will continue to work with the Department on the development of specific measures and include analyses in our reviews to determine whether the measures are being met.

3. *Other Accountability-Related Acts*

The Federal Financial Management Improvement Act of 1996 requires agencies to implement and maintain financial management systems that substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Government Standard General Ledger (SGL) at the transaction level. In addition, the annual audit of an agency's financial statements must report whether the agency's financial management systems comply with these requirements.

The purpose of the new law is to ensure that all assets, liabilities, revenues, expenditures and/or expenses, and the full costs of programs and activities of the federal government are consistently and accurately recorded, monitored, and uniformly reported. These elements are being added to our annual audit of VA's financial statements.

The Information Technology Management Reform Act of 1996 (ITMRA) requires agencies to:

- Provide for the selection, management, and evaluation of information technology investments.
- Integrate information resources management operations and decisions with processes for making budget, financial, and program decisions.
- Identify quantifiable measurements for determining the net benefits and risks of proposed information technology investments.
- Provide senior agency management with timely information regarding the progress of an information system investment that includes milestones for measuring progress that is independently verifiable.

VA is awarding two contracts to meet future information technology needs--Procurement of Computer Hardware and Software (PCHS) and Procurement of Automated Information Resources Solutions (PAIRS). The PCHS contract has been awarded and is valued at $1.5 billion. During FY 1997, we will assess the effectiveness of agency compliance with ITMRA requirements through audits of the PCHS and planned PAIRS procurements.

Other Emphasis Areas

I would like to address two additional matters important to cost effective management both of VA operations and the Federal government at large - procurement of supplies, equipment, and services; and holding down costs of the worker's compensation program.

1. ***Procurement Reviews***

The Federal Supply Schedule (FSS) program provides Federal agencies with a simplified procedure for purchasing commonly used supplies and services. The FSS program is managed primarily by the General Services Administration (GSA). GSA has delegated authority to VA to issue and manage FSS contracts for pharmaceuticals and medical/surgical supplies and equipment. During FY 1996, sales against VA-issued FSS contracts were valued at $2.4 billion. VA has program responsibility for auditing its FSS contracts. These audits provide VA with an important tool that helps determine whether the Government received the prices it was entitled to, or whether the Government was overcharged.

The Office of Inspector General, in a joint effort with the Office of General Counsel and Office of Acquisition and Materiel Management, conducts post-award contract reviews for the VA. This joint initiative has proven to be a highly efficient and cost effective process that has produced significant monetary benefits for the Department. As indicated in the following table, for the period beginning in October 1993 (when the VA started conducting FSS contract reviews in-house) through January 1997, dollar recoveries associated with the contract audits exceeded $52 million.

Dollar Recoveries

FY	Total Recovered	Amount to VA
1994	$ 8,108,273	$ 8,108,273
1995	11,908,875	11,222,375
1996	27,995,627	23,252,127
1997 (Jan. 30)	4,141,298	4,141,298
Total	$52,154,073	$46,724,073

The $46.7 million in recoveries returned to VA and the monies saved by using the audit results in negotiating fair and reasonable pricing means more dollars to treat more veterans. Dollar recoveries from contractors are returned to the VA Supply Fund to be used to better serve our Nation's veterans. Our contract reviews have also resulted in other Federal agencies that purchase items from the FSS contracts getting better prices. The following examples illustrate the types of recoveries we have made.

- A contractor who sold surgical suturing devices and staples to the Federal government under a FSS contract awarded by VA paid the Federal government $10 million to settle a potential False Claims Act case. During contract negotiations for this 5-year, $54-million contract, the contractor certified in its disclosure that the Federal government was not being offered the Most Favored Customer discount because the best discounts were given to a large buying group who committed to purchase larger volumes of the contractor's products than the Federal government purchased. Relying on the contractor's disclosure, the Federal government agreed to a lesser discount. Our post-award audit revealed that the large buying group was not the customer receiving the largest discounts. Numerous other customers, many of whom purchased far less than the Federal government, were receiving significantly larger discounts. The audit also showed that the contractor provided certain suturing devices free of charge to a majority of its commercial customers and

did not disclose this program to the Federal government . The audit concluded that as a result of the inaccurate and incomplete disclosures, the Federal government was paying higher prices for items than comparable non-Federal government customers.

- A pharmaceutical company paid the Federal government $7.5 million to settle a False Claims Act case after a post award audit of the Federal Supply Schedule contract. Our audit disclosed that the contractor failed to provide current, accurate, and complete pricing disclosures during contract negotiations. During contract negotiations, the contractor produced a commercial prices list and certified that no discounts from these prices were offered to any customers. Relying on these disclosures, the VA contracting officer negotiated discounted prices which represented most favored customer pricing. The OIG audit of the contractor's records identified a larger number of customers who purchased these products at discounts, which resulted in significantly lower prices than the Federal government was paying under its contract. In addition, the OIG audit revealed that the contractor gave significant rebates and other incentives to comparable commercial customers which were not disclosed to the Federal government in the contractor's certified pricing disclosures.

Also, while the $52 million recovered from contractors is significant, it represents only a portion of the potential recoveries. Contract audits have resulted in a heightened awareness by contractors of supply schedule terms and conditions which, in turn, has resulted in a dramatic increase in voluntary disclosures whereby contractors voluntarily come to the VA and offer VA a refund. For example, prior to FY 1994, VA had almost no voluntary disclosures; since then, VA has had 11 voluntary disclosures with refund offers in excess of $9 million.

Our goal in conducting contract reviews is to ensure that the Federal government receives fair and reasonable prices for medical/surgical supplies and equipment, and pharmaceuticals. Continuation of our authority to conduct post-award audits of FSS contracts is at risk. Proposed regulatory changes would severely limit our ability to conduct such audits. Our work in this area, combined with the benefits already realized, has convinced us that the elimination of the right to conduct post-award audits of FSS contracts will result in the taxpayer paying higher costs. It will also result in higher health care costs for the Federal government .

2. *Office of Workers' Compensation Programs (OWCP)*

The Federal Employees' Compensation Act (FECA), passed in 1916, authorizes benefits for disability or death resulting from an injury sustained in the performance of duty. The U.S. Department of Labor (DOL), OWCP, administers the FECA program for all Federal agencies. OWCP benefit payments have two components - salary payments and payments for medical treatment for the specific disability. Medical treatment includes all necessary care, including hospitalization.

Department of Labor information indicates that payments made to injured Federal workers exceed $1.56 billion per year for just 10 of the government's departments and agencies and approximately $140-145 million per year for VA.

The OIG audited VA's FECA program in 1993 as part of a government-wide review sponsored by the President's Council on Integrity and Efficiency. The program was not effectively managed. By returning current claimants to work who are no longer disabled, we estimated VA could reduce future payments by $232 million. The Department of Labor calculates savings based on the age of the recipient at the time of removal up to age 70, the life expectancy of these individuals. In 1993, an estimated $11 million of annual FECA costs could have been avoided by returning work-capable claimants to work. In addition, an estimated $17.8 million in annual FECA compensation costs could not be verified because medical centers did not have case files in some cases and did not have current medical information for other claimants. Further, medical centers did not consistently offer light duty positions to partially recovered employees and they did not aggressively challenge some claims that should have been challenged. Similar conditions were reported in a 1985 OIG report.

To address the report's findings, the Department moved accountability and responsibility for the FECA costs from the Central Office to the facility level. Each facility was required to monitor its chargeback rolls and return employees to duty as soon as possible in order to reduce FECA costs.

Currently, the OIG's Office of Investigations is undertaking a pilot project with selected VA medical centers to identify and remove from the FECA rolls individuals receiving payments under fraudulent circumstances. VA medical center management is highly interested in participating in the investigation since each facility must pay a percentage of the FECA cost incurred for its nonworking employees. Monies paid out in fraudulent claims submitted reduce the dollars available for veterans' health care.

One of our investigative offices, working closely with a VISN Director, identified a number of suspects who have been defrauding the system by certifying that they

are unable to work and have no income when, in fact, they currently are, or have been, employed in the private sector. Evidence obtained through undercover work and numerous surveillances resulted in the issuance of seven arrest warrants by a U.S. District Court. Arrests were made in July 1996. Civil complaints also were filed against three of these individuals seeking civil fraud penalties as well. The impact of removing these individuals from the OWCP rolls is approximately $2 million (based on the age of the recipient at the time of removal up to age 70, the life expectancy of these individuals). Most recipients of workers' compensation benefits, who are considered long-term recipients (on the rolls for 2 years or more), receive payments for an average of 25 years. A few examples follow:

- A former VAMC food service foreman pleaded guilty in U.S. District Court to charges of workers' compensation fraud and conspiracy. An investigation disclosed that the employee had established a limousine service in which he served as the owner, operator, and driver while receiving $122,000 in workers' compensation payments for an alleged injury to his lower back in July 1990. At his sentencing, he faces both criminal fines and civil penalties totaling approximately $400,000. Estimated total cost impact as a result of his conviction and termination from this program is approximately $940,000. It should be noted that the employee's spouse, also a VA employee and head of the labor relations branch at the VAMC, also was indicted for conspiracy and pleaded guilty in February 1997.

- A former VA licensed practical nurse pleaded guilty in U.S. District Court to one count of a false statement to obtain workers' compensation benefits. An investigation disclosed that the nurse has collected $210,000 in workers' compensation benefits since March 1980. During the period March 1980 to July 1996, she was employed with six different nursing services. The United States Attorney's Office is going forward in its effort to obtain civil damages. The total monetary impact could exceed $500,000.

- A former Director of a VA Regional Educational Medical Center has received $450,000 in workers' compensation benefits since October 1987, and has claimed on Department of Labor forms that he has not been employed. Investigation has disclosed that the employee owns a real estate management company, and has reported to several business information services that he maintains a private medical practice. A Federal search warrant was recently executed and a warrant for his arrest has been issued. At present, the individual is out of the country. We are in the process of seizing monies the individual has in various financial institutions to prevent him from diverting funds out of the United States.

A natural adjunct to these types of investigations is to analyze the information available to us in an attempt to uncover indicators of provider fraud. This is in line with our mission to reduce overall health care fraud activities. As an example, a joint investigation by the VAOIG and several other Federal and state agencies has focused on a health care provider in the southwest. It is alleged that the health care provider has treated numerous Federal employees, several of which have provided information that he has billed for services not provided and has continued the Federal employees on OWCP even when they recovered from their injuries.

OWCP medical bills were also reviewed at one VAMC during a consolidated financial statement audit. In 1 month, duplicate bills occurred in 22 percent of the cases reviewed and billings were late in 12 percent of the cases. A review of bills for the next month found duplicate billings in 25 percent and late billings in 9 percent of the cases. In addition, benefits were paid for treatment unrelated to the employees' injuries. During 2 months, the claimants' medical procedures were unrelated to their injuries in 10 percent and 30 percent of the total claims, respectively. In one example, a bill was submitted for diagnostic procedures on the claimant's mouth when the work-related condition was a back disorder.

During FY 1997, the OIG plans to continue the investigative activity and to conduct an audit of the workers' compensation program costs to determine whether VA has reimbursed OWCP for payments made to medical providers for duplicate bills or bills unrelated to employees' injuries.

This concludes my statement, Mr. Chairman. I will be pleased to respond to any questions you or other subcommittee members may have.

Mr. SHAYS. Thank you. Mr. Baine.

Mr. BAINE. Thank you, Mr. Chairman. Good morning.

Mr. SHAYS. Good morning.

Mr. BAINE. As you know, the effectiveness of VA's programs and activities has a profound effect on the welfare of our Nation's 26 million veterans. In fiscal year 1996, VA's approximately 222,000 workers delivered a wide array of medical, disability, pension, housing, insurance, education, and burial services at a cost of nearly $38 billion. Two years ago, we testified before this subcommittee on some of the challenges facing, specifically, the VA health care system.

Today, I would like to discuss VA's progress in addressing those challenges. In addition, I would like to touch briefly on some issues facing the Veterans Benefits Administration, VA's efforts to implement the Government Performance and Results Act and other recent legislation to improve the management of Government programs and changes that could be made in veterans benefits and in the operation of VA programs to help reduce the budget deficit.

Mr. SHAYS. I don't think you have enough time to do all that.

Mr. BAINE. I probably don't. But I'm going to try. We believe significant improvements have occurred in the efficiency of the VA health care system. VA's new veterans integrated service network structure clearly values efficiency and customer service. This reorganization contains several elements that we believe hold promise for providing the management framework needed to realize the system's full potential.

Consistent with the requirements of GPRA, the Veterans Health Administration established five basic goals for its health care system. And under each goal, it has established objectives and performance measures for gauging the progress toward meeting those goals. Under its new structure, VA has consolidated management of nearby hospitals to reduce administrative costs, increased the use of ambulatory surgery, and reduced the average lengths of stay.

Under Dr. Kizer's leadership, the VA has a new emphasis on both efficiency and customer service. A few years ago, Mr. Chairman, we testified that VA could reduce inconsistencies in veterans' access to care by better matching medical centers' resources to the volumes and demographic makeup of veterans requesting services at the VA meld centers. Next month, VA plans to implement a new resource allocation system.

Under this system, the networks that have the highest costs per veteran user will lose funds while networks with the lowest cost per veteran user will gain funds. We applaud VA's effort to try to develop a straightforward, simple method for allocating resources. We don't believe, however, that VA has determined the right amount of dollars that need to be shifted to ensure equity of access, primarily because it has not ascertained the reasons for differences between the costs per veterans in each of the networks.

VA recognizes that its allocation system is not perfect and is continuing to explore ways to improve it. For example, both VA and we are currently trying to develop the data to more fully explore the potential effects of population-based allocations.

In our testimony 2 years ago, we focused on several major challenges facing VA, the first of which was uneven access to health care. During the last 2 years, VA has made a lot of progress in this area. First, eligibility for VA health care was expanded. Now all veterans are eligible for comprehensive in-patient and out-patient care subject to the availability of resources. Second, VA has begun to establish community-based out-patient clinics to improve veterans' access to out-patient care. Third, VA's contracting authority was revised last year by the Congress to make it easier for VA to buy services from private providers.

A second major challenge was the decline in use of VA hospitals. As VA's effort to increase the efficiency of its health care system have gained momentum during the last 2 years, the decline in VA hospital use has accelerated. As work loads continue to decline at the hospitals, VA's investment in its hospital's infrastructure increasingly detracts for its ability to shift resources to other needs.

A third major challenge was identifying and addressing unmet health care needs of veterans. We suggested that the health care system retarget resources to provide care for higher income veterans with non-service connected conditions toward lower income veterans and those without adequate health care insurance. VA, however, through its current legislative proposals, appears to be going in the other direction.

Like VHA, VBA also faces several important challenges in administering its comp and pen programs. First, the disability rating schedule has not been economically validated for the last 45 years. Second, VA could be unable to issue compensation and pension checks at the beginning of the year 2000.

Mr. SHAYS. Let me just—I don't quite—since I'm the only Member here right now.

Mr. BAINE. OK.

Mr. SHAYS. And so we can be a little more informal here.

Mr. BAINE. Sure.

Mr. SHAYS. I don't understand what you just said about the 45 years, not being validated. What do you mean? What hasn't been validated?

Mr. BAINE. The disability rating schedule is made up of two primary components—there's a medical component and an economic component. The economic component hasn't been validated by VA for the last 45 years. And what that means, Mr. Chairman, is those diseases or compensatable diseases for which compensation was paid 45 years ago—for example, somebody lost an arm and got X number of dollars.

As time has gone on in the last 45 years, mental illness, for example, has taken on more of an important role, but the economics of this condition have not been looked at for 45 years.

Mr. SHAYS. I understand.

Mr. BAINE. Third, veterans frequently wait over 2 years for resolution of disability compensation and pensions claims. And fourth, hundreds of millions of dollars in overpayments of compensation and pension benefits are made because VBA so far hasn't focused much on the prevention of such payments.

Let me turn now real briefly to VA's implementation of the Government Performance and Results Act, the Chief Financial Officer Act and information management legislation.

While VA has not completed its GPRA strategic plan, its budget submission includes many of the elements that will be included in that plan in September. The budget submissions for both the major administrations also included strategic planning documents. Similarly, VA has established a sound financial management structure, as Mr. Merriman has pointed out, and is in the process of trying to appoint a Chief Information Officer. However, OMB has some concerns about whether VA's appointment of its Chief Financial Officer as the information officer will comply with the Clinger-Cohen legislation.

Mr. Chairman, we periodically report to the Congress on options for reducing the budget deficit, and issued a report last week in which 10 specific suggestions, or 10 specific options were included for the VA. And I won't dwell on that. But those are included in our statement, and we'd be glad to talk about any one of them. Thank you very much.

[The prepared statement of Mr. Baine follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Human Resources,
Committee on Government Reform and Oversight,
House of Representatives

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DEPARTMENT OF VETERANS AFFAIRS

Programmatic and Management Challenges Facing the Department

Statement of David P. Baine, Director
Planning and Reporting
Health, Education, and Human Services Division

GAO/T-HEHS-97-97

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss some of the major challenges facing the Department of Veterans Affairs (VA) and some of the options for deficit reduction through changes in VA benefits and programs.

VA has a profound effect on the welfare of our nation's 26 million veterans. In fiscal year 1996, VA's approximately 222,000 workers--nearly 1 for every 120 veterans--delivered a wide array of medical, disability compensation, pension, housing, insurance, education, and burial services in more than 1,000 facilities at a cost of over $38.1 billion.

Two years ago, we testified before this Subcommittee that VA was at a crossroad in the evolution of its health care system.[1] The average daily workload in its hospitals had dropped almost 56 percent during the preceding 25 years, and further declines appeared likely. At the same time, demand for outpatient care, nursing home care, and certain specialized services was expanding, taxing VA's ability to meet veterans' needs in those areas. We noted at that time that decisions made over the next few years about VA's role in health care would have significant implications for veterans, taxpayers, and private health care providers.

Today, I would like to discuss some of actions taken to increase the efficiency of the VA health care system and VA's progress in addressing the challenges discussed 2 years ago. In addition, I will discuss

- challenges facing the Veterans Benefits Administration (VBA) in administering compensation and pension benefits,
- VA's efforts to implement the Government Performance Review Act (GPRA) and other recent legislation designed to improve the management of government programs, and
- changes that could be made in veterans' benefits and in the operation of VA programs to help reduce the budget deficit.

My comments are based primarily on the results of reviews conducted during the past several years by this and other divisions of the General Accounting Office.[2]

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[1]VA Health Care: Challenges and Options for the Future (GAO/T-HEHS/95-147, May 9, 1995).

[2]A list of related GAO testimonies and reports appears at the end of this testimony.

In summary, significant improvements have occurred in the efficiency of the VA health care system since we last appeared before this Subcommittee. VA's new management and Veterans Integrated Service Network (VISN) structure clearly values efficiency and customer service. In addition, legislation was enacted (1) expanding eligibility for VA health care (P.L. 104-262), (2) making it easier for VA to contract for and sell services to the private sector (P.L. 104-262), and (3) requiring VA to develop a plan for more equitably allocating resources to its VISNs (P.L. 104-204). These decisions bring with them both solutions to old problems and significant new challenges, such as developing an enrollment process consistent with the priorities established under the eligibility reform legislation and determining when to buy services from the private sector rather than provide them in VA facilities.

VBA also faces multiple challenges. For example,

- the disability rating schedule has not been updated for over 45 years, meaning that ratings may no longer accurately reflect the loss in earning capacity resulting from service-connected disabilities;

- VA faces the prospect of late or inaccurate compensation and pension payments to millions of veterans if it is unable to resolve the "year 2000" computer problem;

- veterans often wait over 2 years for resolution of compensation and pension claims by the time the appeals process has been completed; and

- VA could avoid millions of dollars in overpayments of compensation and pension benefits by strengthening its ability to prevent such payments.

Recent legislation, including GPRA, the Chief Financial Officers (CFO) Act, and the Paperwork Reduction Act, provides a basis for addressing long-standing management challenges. VA has begun to use the legislation to improve its mission performance and results, its financial reporting, and its information resources management. For example, it included strategic plans for its health and benefits programs in its fiscal year 1998 budget submission. VA has been preparing audited financial statements since 1986, well in advance of the requirements imposed by the CFO Act.

Finally, multiple options exist for supporting deficit reduction through changes in VA benefits and programs. Although some of the changes could be achieved through administrative action, others would require legislation. The options include (1) redefining compensation benefits to eliminate compensation for diseases that are not related to military service, (2) imposing higher cost sharing for nursing home and other long-term care services, (3) limiting enrollment in the VA health care system, and (4) closing underused hospitals.

BACKGROUND

The United States has a long tradition of providing benefits to those injured in military service, but the role of the federal government in providing for the health care needs of other veterans has evolved and expanded over time.

In the nation's early years, the federal role was limited to direct financial payments to veterans injured during combat; direct medical and hospital care was provided by the individual colonies, states, and communities. The Continental Congress, seeking to encourage enlistments during the Revolutionary War, provided federal compensation for veterans injured during the war and their dependents. Similarly, the first U.S. Congress passed a veterans' compensation law.

The federal role in veterans' health care significantly expanded during and following the Civil War. During the war, the government operated temporary hospitals and domiciliaries in various parts of the country for disabled soldiers until they were physically able to return to their homes. Following the war, the number of disabled veterans unable to cope with the economic struggle of civilian life became so great that the government built a number of "homes" to provide domiciliary care. Incidental medical and hospital care was provided to residents for all diseases and injuries.

The modern era of veterans' benefits began with the onset of World War I. During World War I, a series of new veterans' benefits was added: voluntary life insurance, allotments to take care of the family during military service, reeducation of those disabled, disability compensation, and medical and hospital care for those suffering from wounds or diseases incurred in the service.

During World War I, Public Health Service (PHS) hospitals treated returning veterans, and, at the end of the war, several military hospitals were transferred to PHS to enable it to continue serving the growing veteran population. In 1921, those PHS hospitals primarily serving veterans were transferred to the then newly formed Veterans' Bureau.

During the 1920s, three federal agencies–the Veterans' Bureau, the Bureau of Pensions in the Interior Department, and the National Home for Disabled Volunteer Soldiers–administered various benefits for veterans. With the establishment of the Veterans Administration in 1930, previously fragmented services for veterans were consolidated under one agency.

The responsibilities and programs of the Veterans Administration grew significantly during the ensuing decades. For example,

- the VA health care system grew from 54 hospitals in 1930 to include 173 hospitals, more than 375 outpatient clinics, 130 nursing homes, and 39 domiciliaries in 1996;

- the World War II GI Bill is said to have affected the American way of life more than any other law since the Homestead Act almost a century before, and further educational assistance acts were passed for the benefit of veterans of the Korean conflict, the Vietnam era, the Persian Gulf War, and the current all-volunteer force; and

- in 1973, the Veterans Administration assumed responsibility for the National Cemetery Service, and VA is now charged with the operation of all national cemeteries, except for Arlington National Cemetery.

In 1989, the Department of Veterans Affairs was established as a cabinet-level agency. VA's major benefits programs are divided among

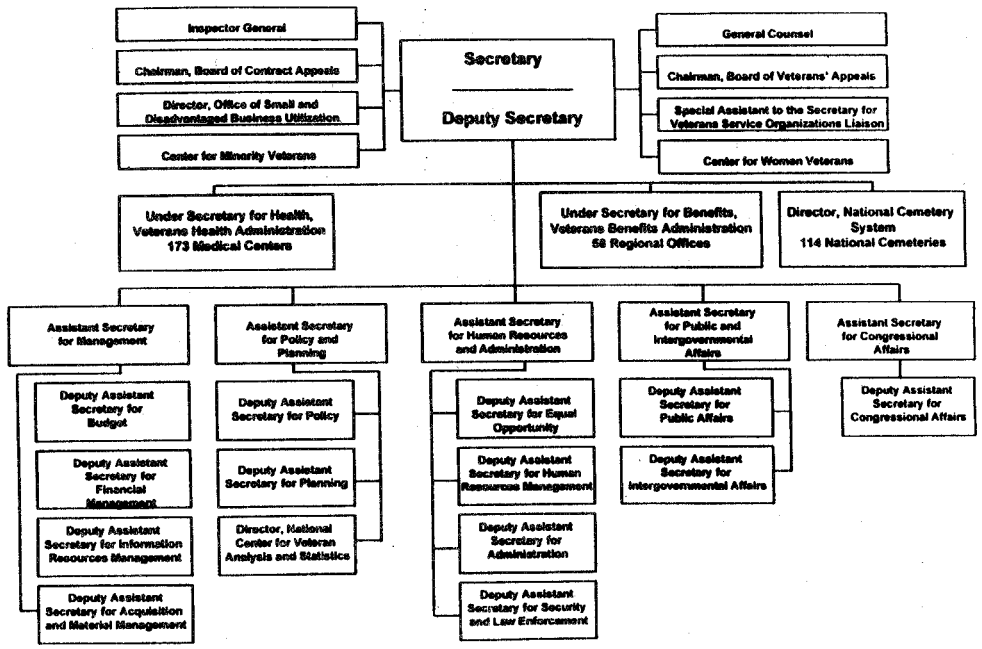
- the Veterans Health Administration (VHA), headed by the Under Secretary for Health;

- the Veterans Benefits Administration, headed by the Under Secretary for Benefits, which administers compensation for service-connected disabilities, pensions for low-income war veterans, education loans, life insurance, and home loans; and

- the National Cemetery Service, headed by a Director.

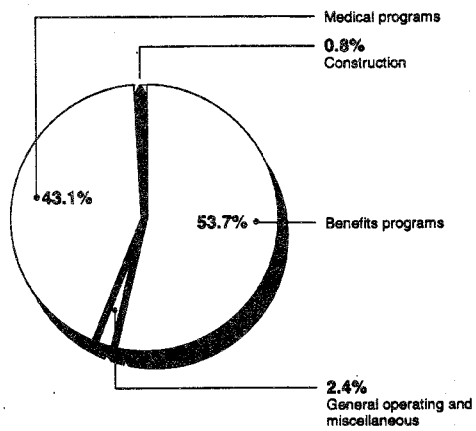
Figure 1 shows the organizational structure of VA.

Figure 1: Department of Veterans Affairs Organization Chart



For fiscal year 1998, VA is seeking an appropriation of about $40.1 billion. Of this amount, about 54 percent is for benefit programs, primarily for compensation and pension payments, and 43 percent for medical programs. (See fig. 2.)

Figure 2: VA's Fiscal Year 1998 Appropriation Request



VA's budget authority is split between mandatory programs ($22.4 billion) and discretionary programs ($18.7 billion). Mandatory programs include compensation and pension payments, certain readjustment benefits, housing benefits, and life insurance programs. Discretionary programs include medical care, construction, the National Cemetery System, and departmental administration.

VA's fiscal year 1998 budget request includes two major proposals affecting its health care program. First, VA proposes legislation to allow it to retain recoveries from private health insurance and veteran copayments. Currently, most such recoveries are returned to the Treasury; VA is allowed to retain enough funds to offset the costs of its recovery program. Second, VA proposes to test the feasibility of billing Medicare for health care services provided to higher-income veterans who have

Medicare eligibility, commonly referred to as Medicare subvention. These initiatives would, VA believes, allow it to support a 30-percent lower unit cost for its health care services, serve 20 percent more veterans, and obtain 10 percent of the VA health care budget from nonappropriated sources by 2002.

VHA HAS MADE SIGNIFICANT PROGRESS IN IMPROVING THE EFFICIENCY OF ITS HEALTH CARE SYSTEM

In our testimony 2 years ago, we pointed out that VA lagged far behind the private sector in improving the efficiency of its health care system. Specifically, we said that the VA system lacked

- oversight procedures to effectively assess the operations of its medical centers,
- systems to shift significant resources among medical centers to provide consistent access to VA care,
- information systems capable of effectively coordinating patient care among VA facilities, and
- a corporate culture that valued economy and efficiency.

VA has made significant progress in improving the efficiency of its health care system. For example, it has consolidated management of nearby hospitals to reduce administrative costs, increased the use of ambulatory surgery, and reduced average lengths of stay. Under the leadership of the Under Secretary for Health, VA has a new emphasis on both economy and efficiency and customer service.

Performance Measures Developed to Hold Managers Accountable

Two years ago, we told you that VA's central office lacked much of the systemwide information it needed to effectively (1) monitor the performance of its medical centers, (2) ensure that corrective actions are taken when problems are identified, and (3) identify and disseminate information on innovative programs. Since then, VA has established a new decentralized management structure and established performance measures to hold managers accountable for improving efficiency and ensuring the quality of services.

VA reorganized its health care facilities into 22 VISNs. This reorganization contains several elements that hold promise for providing the management framework needed to realize the system's full potential for efficiency improvements. First, VA plans to hold network directors accountable for VISN's performance by using, among

other things, cost-effectiveness goals and measures that establish accountability for operating efficiently to contain or reduce costs. Second, the Under Secretary for Health (1) distributed criteria that could guide VISN directors in developing the types of efficiency initiatives capable of yielding large savings and (2) gave VISN and facility directors authority to realign medical centers to achieve efficiencies. Finally, VHA developed a new method for allocating funds to its VISNs with the intent of creating additional incentives to improve efficiency.

Consistent with the requirements of GPRA, VHA established five basic goals for its health care system. These goals are to

- provide excellence in health care value,
- provide excellence in service as defined by customers,
- provide excellence in education and research,
- be an organization that is characterized by exceptional accountability, and
- be an employer of choice.

Under each goal, VHA established objectives and performance measures for gauging progress toward meeting both the specific objectives and overall program goals. For example, VHA's performance measures include goals to

- decrease the number of bed-days of care provided per 1,000 unique users by 20 percent from the 1996 level,
- increase the percentage of patients reporting their care as "very good to excellent" by 5 percent annually,
- enroll 80 percent of patients in primary care, and
- increase the number of medical care residents trained in primary care.

Contracts with individual VISN directors reflect these goals and performance measures. In addition, each VISN has developed a business/strategic plan. The plans are generally organized around the five broad goals.

VA Plans to Implement a New Method for Allocating Resources

Two years ago, we testified that VA could reduce inconsistencies in veterans' access to care by better matching medical centers' resources to the volume and

demographic makeup of eligible veterans requesting services at each medical center. Although VA had developed a new resource allocation system, the Resource Planning and Management (RPM) system, we pointed out that the system had shifted few resources among medical centers and allocated resources on the basis of prior workload without any consideration of the incomes or service-connected status of veterans who make up that workload.

Last year, Public Law 104-204 directed VA to prepare a resource allocation plan that would ensure similar access to VA care for veterans who have similar economic status and eligibility priority, taking into account expected workload and promoting the efficient use of resources to the extent feasible. VA developed the Veterans Equitable Resource Allocation (VERA) system in response to the congressional requirement. Next month, VA plans to begin shifting resources among VISNs using the new system. The system is based on calculations of the cost per veteran-user in each VISN. VISNs that have the highest costs per veteran-user will lose funds, while VISNs with the lowest costs per veteran-user will get additional funds. Adjustments are included for the higher labor costs in some VISNs and for differences in the costs of medical education, research, equipment, and nonrecurring maintenance.

We applaud VA's efforts to develop a simple, straightforward method for allocating resources. However, we have the same basic concern about VERA that we had about RPM. That is, VA has not determined the "right" amount of dollars that need to be shifted to ensure equity of access. Our concern is based on the fact that VA has not adequately determined the reasons for differences between VISNs in costs per veteran-user. Without a better understanding of why the costs vary, VA cannot, with any certainty, determine the appropriate amount of resources to shift among VISNs.

VA data can give starkly different pictures of the comparability of veterans' access to VA care depending on the basis used for the comparison. For example, basing a comparison of equity of access on the percentage of the total veteran population in a VISN that is provided VA services would suggest that veterans in the Sunbelt generally have better access to VA care than do veterans from the Midwest and Northeast. Over 18 percent of veterans in VISN 18 (Phoenix) received VA services in 1995, compared with slightly over 8 percent of veterans in VISN 4 (Pittsburgh). Similarly, about 15 percent of veterans in VISN 9 (Nashville) received VA health care services in fiscal year 1995, compared with about 8 percent of those in VISN 11 (Ann Arbor). Such data could suggest the need to shift resources from VISNs where VA has a high market share of the veteran population to VISNs where VA has lower market shares.

On the other hand, the higher market shares might be justified because of differences in the demographics of the veteran populations. For example, there may be more low-income, uninsured veterans in the Sunbelt states who rely on VA for their

health care. Similarly, differences in health status of users or a decision to provide a higher intensity of services to a smaller population might justify differences in market share. For example, to the extent that a higher proportion of the total veteran population is composed of category A veterans (primarily veterans with service-connected disabilities or low incomes), a higher market share of the total veteran population might not reflect an inequity. We are attempting to develop data on the demographics of the veteran population by VISN to better understand the basis for differing market shares.

Other VA data suggest that VISNs in the Northeast and Midwest may receive more than their fair share of VA resources. For example, VISN 18 received $3,197 per veteran served in fiscal year 1996, compared with $4,829 per veteran served in VISN 4. Similarly, VISN 9 received $4,071, compared with $4,360 in VISN 11.

Both VERA data and data from prior allocation models suggest that differences in efficiency are a major factor in the variation in spending per veteran-user. Veteran-users in VISN 3 (Bronx) are hospitalized over three times as often as are veterans in VISN 18. In addition, VA found that VISNs that have higher costs per veteran-user also tend to have more doctors and nurses per patient, and provide more bed-days of care per patient than the VISNs with lower costs per veteran-user.

While differences in efficiency may help explain the wide variation in spending per veteran-user and justify some shifts in resources to increase equity, VA has not adequately explored other factors that might justify a portion of the higher costs or explain why certain VISNs have lower costs per veteran-user. In developing VERA, VA determined that differences in the age of veteran-users were not a significant factor explaining cost differences between VISNs. It did not, however, explore the role other factors, such as the following, may have played in the cost variations.

- Differences in the percentage of veteran-users receiving compensation for service-connected disabilities or low-income pensions for nonservice-connected disabilities could affect a VISN's cost per veteran-user. These costs could be affected because veterans with (1) service-connected disabilities rated at 50 percent or higher or (2) nonservice-connected pensions use a higher volume of services than higher-income veterans with nonservice-connected disabilities. For example, we found that among veteran-users living within 5 miles of a VA outpatient clinic, nonservice-connected veterans receiving low-income VA pensions used an average of 17 visits per user, compared with an average of 11 visits for other nonservice-connected users.[3]

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[3]VA Health Care: How Distance From VA Facilities Affects Veterans' Use of VA Services (GAO/HEHS-96-31, Dec. 20, 1995).

- Differences in veteran-users' health insurance coverage could also affect a VISN's cost per veteran-user because veterans with public or private health insurance may use VA care to supplement services they obtain from private sector providers rather than rely on VA for comprehensive care. For example, we found that only about half of the Medicare-eligible veterans using VA health care relied on VA for all of their care. As a result, VISNs serving higher percentages of Medicare-eligible and privately insured veterans could expect to have lower costs per veteran.[4]

- Finally, differences in the extent of incidental use of VA services could affect cost per veteran-user. Incidental use could artificially decrease the VISN's average cost of care for veterans who regularly use VA and overstate the VISN market share of the veteran population.

VA also has not developed data showing that the VISNs with lower than average expenditures per veteran-user need additional funds. In other words, it has not determined how much an efficient and well-managed VISN should be spending on each veteran-user. VISNs' draft business/strategic plans generally discuss how they will use the additional funds. Those plans have not, however, been reviewed and approved by central office.

Some VISN plans indicate that the additional funds will be used to reduce waiting times or increase the number of staff per patient. Others, however, indicate that the funds will be used to attract additional users. Giving additional funds to a VISN with no strings attached appears to enable VISNs with the largest market shares of the veteran population to further expand their market share. This does not appear to be consistent with the efficient use of resources that was one of the objectives of Public Law 104-204.

The simplicity of VERA and the variety of health care needs and coverages of veterans also create the potential for VISNs to focus their marketing efforts on those individuals least likely to use extensive health care services. In fact, VERA gives VISNs financial incentives to focus their marketing efforts on attracting veterans with limited health care needs. VA officials told us that they are aware of the potential for gaming and have performance indicators in place that will allow them to detect any unusual activity that might suggest gaming. For example, VHA said that it will be monitoring to identify

- unexpected increases in basic care workload,

- significant changes in the special care workload,

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[4]Veterans' Health Care: Use of VA Services by Medicare-Eligible Veterans (GAO/HEHS-95-13, Oct. 24, 1994).

- inappropriate movement of special care services from inpatient to outpatient settings,
- fluctuations in numbers of high-cost procedures,
- increases in waiting times, and
- changes in customer satisfaction.

One way to develop a resource allocation system that would be consistent with the provisions of Public Law 104-204, easy to administer, and less subject to gaming would be to base the allocation on the veteran population in each VISN, with adjustments based on the numbers of veterans in each of the priority categories for enrollment in the VA health care system. To lessen the incentive for VISNs to target enrollment toward younger, healthier veterans with private insurance, separate rates could be established for various categories of veterans, on the basis of VA's historical cost and utilization data. We are currently developing data to more fully explore this option.

VA recognizes that VERA is not a perfect system and is continuing to explore options for improving its resource allocation methods. For example, VA, like GAO, is developing data to more fully explore the potential effects of population-based allocations. It plans, however, to go forward with allocations using VERA through fiscal year 1998 in order to provide needed financial incentives for certain VISNs to focus on efficiency improvements. Otherwise, allocations tied to historic budgets might delay needed efficiency improvements until another allocation method could be developed.

VA Continues to Implement Its Decision Support System but Concerns Continue

Without accurate and complete cost and utilization data, VA managers cannot effectively decide when to contract for services rather than provide them directly, how to set prices for services it sells to other providers, or how to bill insurers for care provided to privately insured veterans. Accurate utilization data are also essential to help ensure quality and to prevent abuse.

Since February 1994, VA has been phasing in at its facilities a new Decision Support System (DSS) that uses commercially available software to help provide managers data on patterns of care and patient outcomes as well as their resource and cost implications. While DSS has the potential to significantly improve VA's ability to manage its health care operations, the ultimate usefulness of the system will depend not on the software but on the completeness and accuracy of the data going into the

system. If DSS is not able to provide reliable information, VA facilities and VISNs will either continue to make decisions on the basis of unreliable information or spend valuable time and resources developing their own data systems.

Two years ago, we recommended that VA identify data that are needed to support decision-making and ensure that these data are complete, accurate, consistent, and reconciled monthly.[5] VA plans to begin implementing DSS at the final group of VA facilities this month. VA still, however, has not adequately focused on improving the completeness and reliability of data entered into the feeder systems. It has, however, started to reconcile DSS data on a monthly basis.

Although the draft business/strategic plans developed by the 22 VISNs generally discuss goals and timetables for implementing DSS throughout the network, they identify no plans for improving the completeness and accuracy of the data feeding into DSS.

THE VA HEALTH CARE SYSTEM CONTINUES TO FACE MAJOR CHALLENGES

In our testimony 2 years ago, we focused on four major challenges facing VA because of a rapidly changing health care marketplace. Specifically, VA was faced with

- unequal access to health care services because of complex VA eligibility requirements, limited outpatient facilities, and uneven distribution of resources;
- a continuing decline in the number of hospital patients that threatened the economic viability of its hospitals;
- unmet needs, including the acute care needs of uninsured veterans not living close to a VA hospital, and the needs of special care populations such as those who are blind, paralyzed, or suffering from post traumatic stress disorder; and
- the growing long-term care needs of an aging veteran population.

Significant progress has been made in addressing the first challenge–improving veterans' access to VA outpatient care. The remaining challenges, however, remain largely unchanged. In fact, VA's progress in improving the efficiency of its hospitals has accelerated the decline in hospital workload, heightening the need to address the future of VA hospitals. In addition, VA's plans to attract new users focus primarily on

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[5]VA Health Care Delivery: Top Management Leadership Critical to Success of Decision Support System (GAO/AIMD-95-182, Sept. 29, 1995).

attracting insured and higher-income veterans with other health care options rather than on addressing the unmet needs of veterans with service-connected conditions and low-income veterans.

Progress Has Been Made in Improving Access to Outpatient Care

The first major challenge facing VA health care 2 years ago was the uneven access to health care caused by complex VA eligibility requirements, limited outpatient facilities, and uneven distribution of resources. We noted at the time that veterans' ability to obtain needed health care services from VA frequently depended on where they lived and the VA facility that served them.

During the past 2 years, much progress has been made in improving veterans' access to care.

- Eligibility for VA health care was expanded, eliminating the hard-to-administer "obviate the need for hospitalization" provision that limited most veterans' access to routine outpatient care. All veterans are now eligible for comprehensive inpatient and outpatient care subject to the availability of resources.

- VA established community-based outpatient clinics (CBOC) to improve veterans' access to outpatient care. Until 1995, VA required its hospitals to meet rigid criteria to establish outpatient clinics apart from the hospitals. These criteria included a minimum number of veterans to be served in a clinic and a minimum distance that clinics had to be from the VA hospitals. In encouraging its hospitals to consider establishing CBOCs, previously known as "access points," VA eliminated many of its restrictions concerning the workload and location of proposed clinics. In addition, VA policy now encourages hospitals to provide care not only in VA-operated facilities, but also by contracting with other providers. Although only 12 CBOCs were operational by September 1996, plans had been developed to establish hundreds of additional clinics.

- VA's contracting authority was revised to make it easier for VA to buy services from private providers and to sell services to the private sector. Previously, VA's authority was restricted primarily to purchasing services from and selling services to other government health care facilities and VA's medical school affiliates. Using its expanded contracting authority, VA is moving quickly to establish additional CBOCs.

Efficiency Improvements Accelerate Decline in Hospital Use

The second major challenge facing VA health care 2 years ago was the declining use of VA hospitals. Between 1969 and 1994, the average daily workload in VA hospitals declined by about 56 percent. VA reduced its operating beds by about 50 percent, closing or converting to other uses about 50,000 hospital beds.

VA now finds itself increasingly a victim of its own success and faced with what to do with so much unused inpatient infrastructure. As VA's efforts to increase the efficiency of its health care system gained momentum during the past 2 years, the decline in VA hospital use accelerated. Between 1994 and 1996, the average daily workload in VA hospitals dropped over 20 percent (from 39,953 patients in 1994 to 31,679 in 1996). Operating beds dropped from 53,093 in 1994 to 45,798 in 1996.

Hospital use in the VA system varies dramatically. Last year, we reported that the Northern California Health Care System, a part of VISN 21, was supporting the hospital care needs of its users with about 2 beds per 1,000 users.[6] Some VISNs, however, have over 20 hospital beds per veteran-user. As a result, further significant declines in operating beds are likely as the variation in hospital use is reduced. For example, VISN 5 (Baltimore) estimates that its acute hospital beds will have decreased by 58 percent by 2002 (from 1,087 in fiscal year 1995 to 460 in 2002).

Recent VA actions to establish preadmission reviews for all scheduled hospital admissions and continuing stay reviews for those admitted–actions we have advocated for over 10 years–should further reduce hospital use. VA may not realize the full potential from these reviews, however, unless physicians' incentives to minimize inappropriate inpatient care are increased. VISN 5 (Baltimore), for example, uses its reviews primarily for data collection, evaluation, and monitoring. The program does not act as a gatekeeper, and inpatient care is not denied on the basis of results of the preadmission reviews. Reviews at the VISN 5 hospitals in Martinsburg, West Virginia, and Washington, D.C., show that over 50 percent of patients admitted since the program was initiated did not need acute hospital care.

As workload continues to decline at VA hospitals, VA's investment in its hospital infrastructure increasingly detracts from its ability to shift resources to other needs, such as expanding access for veterans living long distances from VA facilities.

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[6]VA Health Care: Travis Construction Project Is Not Justified (GAO/HEHS-96-198, Sept. 3, 1996).

Veterans More Likely to Have Unmet Needs for Specialized Care Services Than Acute Care Services

The third major challenge that faced VA health care 2 years ago was identifying and addressing the unmet health care needs of veterans. With the growth of public and private health benefits programs, more than 9 out of 10 veterans now have alternate health insurance coverage. Still, about 2.6 million veterans had neither public nor private health insurance in 1990 to help pay for needed health care services. Without a demonstrated ability to pay for care, individuals' access to health care is restricted, increasing their vulnerability to the consequences of poor health. Lacking insurance, people often postpone obtaining care until their conditions become more serious and require more costly medical services.

Most veterans who lack insurance coverage, however, are able to obtain needed hospital care through public programs and VA. Still, VA's 1992 National Survey of Veterans estimated that about 159,000 veterans were unable to get needed hospital care in 1992 and about 288,000 were unable to obtain needed outpatient services. By far the most common reason veterans cited for not obtaining needed care was that they could not afford to pay for it.

While the cost of care may have prevented veterans from obtaining care from private sector hospitals, it appears to be an unlikely reason for not seeking care from VA. All veterans are currently eligible for hospital care, and about 9 to 11 million are eligible for free care. Other veterans are required to make only nominal copayments.

Many of the problems veterans face in obtaining health care services appear to relate to distance from a VA facility. For example, our analysis of 1992 National Survey of Veterans data estimates that fewer than half of the 159,000 veterans who did not obtain needed hospital care lived within 25 miles of a VA hospital. By comparison, we estimate that over 90 percent lived within 25 miles of a private sector hospital.

Of the estimated 288,000 veterans unable to obtain needed outpatient care during 1992, almost 70 percent lived within 5 miles of a non-VA doctor's office or outpatient facility. As was the case with veterans unable to obtain needed hospital care, those unable to obtain needed outpatient care generally indicated that they could not afford to obtain needed care from private providers. Only 13 percent of the veterans unable to obtain needed outpatient services reported that they lived within 5 miles of a VA facility, where they could generally have received free care.

Veterans' needs for specialized services cannot always be met through other public or private sector programs. Frequently, such services are either unavailable in the private sector, or are not extensively covered under other public and private

insurance. Space and resource limits in VA specialized treatment programs can result in unmet needs, as in the following cases.

- Specialized VA posttraumatic stress disorder programs are operating at or beyond capacity, and waiting lists exist, particularly for inpatient treatment. Although private insurance generally includes mental health benefits, private sector providers generally lack the expertise in treating war-related stress that exists in the VA system.

- Inadequate numbers of beds are available in the VA system to care for homeless veterans. For example, VA had only 11 beds available in the San Francisco area to meet the needs of an estimated 2,000 to 3,000 homeless veterans.

- Public and private insurance do not provide extensive coverage of long-term psychiatric care. Veterans needing such services must either rely on state programs or the VA system to meet their needs.

- VA is a national leader both in research on and treatment and rehabilitation of people with spinal cord injuries. Similarly, it is a leader in programs to treat and rehabilitate the blind. Although such services are available in the private sector, the costs of such services can be catastrophic.

Legislation enacted last year that expanded VA's ability to contract with private sector facilities and providers gives VA an opportunity to better meet the health care needs of low-income veterans and those with service-connected conditions who previously were unable to obtain needed care because VA facilities were geographically inaccessible.

Two years ago, we suggested that the VA health care system retarget resources used to provide care for higher-income veterans with nonservice-connected conditions toward lower-income veterans and those with service-connected conditions whose health care needs were not being met.[7] VA, however, through its current legislative proposals, appears to be focusing its marketing efforts on attracting higher-income veterans with other health care options rather than using its expanded contracting authority to target its available resources toward meeting the needs of service-connected and uninsured veterans who lack other health care options.

Data from VA's Income Eligibility Verification System show that about 15 percent of the veterans using VA facilities who have no service-connected disabilities have incomes of $20,000 or more. VA could use the resources spent to provide

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[7]VA Health Care: Retargeting Needed to Better Meet Veterans' Changing Needs (GAO/HEHS-95-39, Apr. 21, 1995).

services to such higher-income nonservice-connected veterans to strengthen its ability to fulfill its safety net mission. For example, the resources could be used to

- expand outreach to medically underserved populations, such as homeless veterans;
- expand programs that address special care needs; or
- contract for hospital and other service for lower-income, uninsured veterans who do not live near VA facilities.

Our review of the draft strategic plans developed by the 22 VISNs, however, found little mention of plans to conduct outreach to veterans with limited health care options or special care needs. Nor did these plans specifically address expanding services for low-income uninsured veterans.

The establishment of additional community-based outpatient clinics will address the unmet needs of some uninsured veterans. Most of the resources spent on CBOCs, however, will likely be spent on veterans who have other health care options. This reduces the resources available to provide services to uninsured veterans.

The legislative proposals contained in VA's fiscal year 1998 budget request would target veterans with other health care options. VA claims that it will be able to cut its per-user costs by 30 percent only if it is given funds to expand the number of veterans it serves by 20 percent and allowed to keep all of the funds it recovers from private health insurance and Medicare. The new users VA anticipates attracting either have private health insurance or are higher-income Medicare beneficiaries. The proposal to allow VA to keep all medical care cost recoveries could create strong financial incentives for VA to market its services to veterans who have no service-connected disabilities as well as private insurance.

Similarly, VA is seeking authority to bill and retain recoveries from Medicare for services provided to higher-income Medicare-eligible veterans. Like recoveries from private health insurance, such Medicare subvention would create incentives for VA to market services to higher-income veterans with both Medicare and Medigap coverage rather than to lower-income Medicare-eligible veterans.

VA's proposals create the potential for its receiving duplicate payments for services provided to privately insured and Medicare-eligible veterans. In other words, unless changes are made in how VA develops its budget request, it would receive both an appropriation to cover its costs of providing services to privately insured and higher-income Medicare-eligible veterans and payments from insurers and Medicare to cover those same costs.

Although the 22 VISNs' draft strategic plans discuss efforts to increase market share and attract new users, few plans contain any mention of targeting marketing efforts to veterans potentially having the greatest need for VA services--veterans with service-connected disabilities and those with low incomes and no health insurance.

Long-Term Care Needs of an Aging Population

As the nation's large World War II and Korean War veteran populations age, their health care needs are increasingly shifting from acute hospital care toward nursing home and other long-term care services. But Medicare and most private health insurance cover only short-term, post-acute nursing home and home health care. Although private long-term care insurance is a growing market, the high cost of policies places such coverage out of reach of many veterans. As a result, most veterans must pay for long-term nursing home and home care services out of pocket until they spend down most of their income and assets and qualify for Medicaid assistance. After qualifying for Medicaid, they are required to apply almost all of their income toward the cost of their care.

About a third of veterans are 65 years old or older, with the fastest growing group of veterans being those 85 years old or older. This older group raises particular concerns because the need for nursing home and other long-term care services increases with the age of the beneficiary population. Over 50 percent of those over 85 years of age are in need of nursing home care, compared with about 13 percent of those 65 to 69 years old.

THE VETERANS BENEFITS ADMINISTRATION FACES MULTIPLE CHALLENGES

VBA also faces several important challenges in administering VA compensation and pension programs. Specifically,

- the disability rating schedule has not been updated for over 45 years and no longer reflects the lost earning potential resulting from some disabilities;
- VA, like other federal agencies, could be unable to issue compensation and pension checks at the beginning of the year 2000 unless it is able to reprogram its computers to recognize the next century;
- veterans frequently wait over 2 years for resolution of disability compensation and pension claims; and
- hundreds of millions of dollars in overpayments of compensation and pension benefits are made because VBA does not focus on prevention.

Updating the Disability Rating Schedule

VA's disability program is required by law to compensate veterans for the average loss in earning capacity in civilian occupations that results from injuries or conditions incurred or aggravated during military service. These injuries or conditions are referred to as "service-connected" disabilities. Veterans with such disabilities are entitled to monthly cash benefits under this program even if they are working and regardless of the amount they earn.

In fiscal year 1995, VA paid about $11.3 billion to approximately 2.2 million veterans who were on VA's disability rolls at that time. Over the past 50 years, the number of veterans on the disability rolls has remained fairly constant.

The amount of compensation veterans with service-connected conditions receive is based on the "percentage evaluation," commonly called the disability rating, that VA assigns to these conditions. VA uses its "Schedule for Rating Disabilities" to determine which rating to assign to a veteran's particular condition. VA is required by law to readjust the schedule periodically on the basis of "experience."

Since the 1945 version of the schedule was developed, questions have been raised on a number of occasions about the basis for these disability ratings and whether they reflect veterans' current loss in earning capacity. Although the ratings in the schedule have not changed substantially since 1945, dramatic changes have occurred in the labor market and in society. VA has done little since 1945 to help ensure that disability ratings correspond to disabled veterans' average loss in earning capacity. Basing disability ratings at least in part on judgments of loss in functional capacity would help to ensure that veterans are compensated to an extent commensurate with their economic losses and that compensation funds are distributed equitably.

Addressing the Year 2000 Computer Problem

VA, like other federal agencies, faces serious problems with its computer systems that will occur in the year 2000. This year, we added the "year 2000 computer problem" to our list of "high-risk" federal management areas.[8] Unless agency computers are reprogrammed, the year 2000 will be interpreted as 1900. This could create a major problem for VA, beginning in January 2000, with its monthly processing of over 3 million disability compensation and pension checks, totaling about $1.5

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[8] 1997 High-Risk Series: Information Management and Technology (GAO/HR-97-9, Feb. 1997).

billion, to veterans and their survivors. Unless the "year 2000" problem is corrected, VA's computer system for processing these checks will either produce inaccurate checks, or produce no checks at all. VA would then have to process the checks manually, causing severe delays to veterans and survivors in receiving their benefits.

VA needs to move quickly to (1) inventory its mission-critical systems; (2) develop conversion strategies and plans; and (3) dedicate sufficient resources to conversion, and adequate testing, of computer systems before January 1, 2000. We recently published draft guidance for agencies to use in planning, managing, and evaluating their efforts to deal with this problem.[9] We are currently reviewing VBA's efforts to deal with the "year 2000" problem and plan to report to the Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, this spring.

Improving Claims Processing for Compensation and Pension Benefits

Slow claims processing and poor service to customers have long been recognized as critical concerns for VA. As early as 1990, VA began encouraging regional offices to develop and implement improvements in their claims processing systems; but instead of decreasing, processing times and backlogs increased. At the end of fiscal year 1994, almost 500,000 claims were waiting for a VA decision. About 65,000 of these claims were initial disability compensation claims. On average, veterans waited over 7 months for their initial disability claims to be decided; if veterans appealed these decisions, they could wait well over 2 years for a final decision.

In 1995, we reported that VA needed better assessments to guide its claims processing improvements.[10] We stated that VA had not developed adequate evaluation plans to allow it to judge the relative merit of its various initiatives. Without such information, VA will not have a sound basis for determining what additional changes, if any, should be made and for guiding future improvement efforts. In addition, VA did not have a formal mechanism to disseminate information about the content and effectiveness of various regional office initiatives to allow other regional offices to learn from the experiences.

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[9]Year 2000 Computing Crisis: An Assessment Guide (GAO/AIMD-10.1.4, Exposure Draft, Feb. 1997).

[10]Veterans' Benefits: Better Assessments Needed to Guide Claims Processing Improvements (GAO/HEHS-95-25, Jan. 13, 1995).

VA is proposing a redesign of its claims processing system that would incorporate several initiatives. VA has conducted a business process reengineering effort on its compensation and pension claims processing system. VA has also established claims processing goals that include completing original compensation claims within 53 days by eliminating unnecessary tasks, reducing the number of hand-offs involved in the process, making information technology changes, and providing additional training for rating specialists. However, it is unclear at this time how successful these initiatives will be, how they will be evaluated, and how regional offices' experiences will be shared. VBA officials told us that the claims backlog has been reduced from 500,000 to about 326,000 as a result of VBA's actions.

Preventing Overpayments

Despite its responsibility to ensure accurate benefit payments, VA continues to overpay veterans and their survivors hundreds of millions of dollars in compensation and pension benefits each year. For example, at the end of 1996, VA's outstanding overpayments exceeded $500 million.

VA has the capability to prevent millions of dollars in overpayments but has not done so because it has not focused on prevention. For example, we reported in April 1995 that VA did not use available information, such as when beneficiaries will become eligible for Social Security benefits, to prevent related overpayments from occurring.[11] Furthermore, VA did not systematically collect, analyze, and use information on the specific causes of overpayments that would help it target preventive efforts.

VA has taken actions in response to our 1995 report, but some actions have not been completed. For example, VA has installed programming changes that will identify beneficiaries who will soon become eligible for Social Security benefits. However, it has not completed its analysis of other causes of overpayments nor developed strategies for targeting additional preventive efforts.

VA IS RESPONDING TO RECENT LEGISLATIVE MANAGEMENT REFORM REQUIREMENTS

The Congress, through recent legislation, established a framework to help federal agencies (1) improve their ability to address long-standing management challenges and (2) meet the need for accurate and reliable information for executive branch and congressional decision-making. This framework includes

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[11]Veterans' Benefits: VA Can Prevent Millions in Compensation and Pension Overpayments (GAO/HEHS-95-88, Apr. 28, 1995).

- GPRA, which is designed to improve federal agencies' performance by requiring them to focus on their missions and goals, and on the results they provide to their customers--for VA, veterans, and their families;

- the CFO Act of 1990, as amended by the Government Management Reform Act, designed to improve the timeliness, reliability, usefulness, and consistency of financial information in federal agencies; and

- the Paperwork Reduction Act of 1995 and the Clinger-Cohen Act of 1996, which are intended to improve agencies' ability to use information technology to support their missions and improve performance.

VA has begun to implement these acts, which can help it (1) develop fully integrated information about its mission and strategic priorities, (2) develop and maintain performance data to evaluate achievement of its goals, (3) develop accurate and audited financial information about the costs of achieving VA's results-oriented mission, and (4) improve the relationship of information technology to the achievement of performance goals.

Improving Mission Performance and Results

GPRA requires that agencies consult with the Congress and other stakeholders to clearly define their missions. It also requires that they establish long-term strategic goals, as well as annual goals linked to them. They must then measure their performance against the goals they have set and report publicly on how well they are doing. In addition to ongoing performance monitoring, agencies are expected to identify performance gaps in their programs, and to use information obtained from these analyses to improve the programs.[12] Under GPRA, VA and other federal agencies must complete strategic plans by September 30, 1997.

While VA has not yet completed its GPRA strategic plan, its fiscal year 1998 budget submission to the Congress includes some of the elements of the GPRA planning process. The budget submissions for both of VA's largest components--VHA and VBA--included strategic planning documents. Both the VHA and VBA plans included overall mission statements; identification of customers and stakeholders; program goals and objectives; and performance measures related to the goals and objectives.

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[12]Executive Guide: Effectively Implementing the Government Performance and Results Act (GAO/GGD-96-118, June 1996) and Managing for Results: Using GPRA to Assist Congressional and Executive Branch Decisionmaking (GAO/T-GGD-97-43, Feb. 12, 1997).

VHA's strategic plan, as stated in its fiscal year 1998 budget submission, is based on five goals developed in March 1996 by the Under Secretary for Health.[13] VHA then attached objectives and performance measures to each goal. For the first goal--"Provide Excellence in Healthcare Value"--VHA stated three objectives: (1) deliver the best health care outcomes at the lowest cost to the largest number of eligible veterans, (2) change VHA from a hospital-based to an ambulatory-based system, and (3) establish primary care as the central focus of patient treatment. To measure progress toward achieving VHA's goals, it proposed eight performance measures. For the second objective, for example, VHA plans to increase the percentage of appropriate surgical and invasive diagnostic procedures performed on an ambulatory basis from 52 percent in fiscal year 1996 to 65 percent in fiscal year 1998.

VBA's strategic planning process began in July 1995, with definitions of its mission, goals, and core performance measures. As stated in the fiscal year 1998 budget submission, VBA's mission is to "provide benefits and services to veterans and their families in a responsive, timely and compassionate manner in recognition of their service to the nation." To accomplish this mission, VBA has set out four goals: (1) improve responsiveness to customer needs and expectations, (2) improve service delivery and benefit claims processing, (3) ensure the best value for the available taxpayers' dollar, and (4) ensure a satisfying and rewarding work environment. The plan is then broken down by VBA's major program areas. For example, the Compensation and Pension program area has performance indicators to measure progress in meeting VBA's goal of improving service delivery and benefit claims processing by

- reducing the processing time for original compensation and pension claims from 144 days in fiscal year 1996 to 53 days in fiscal year 2002 and

- raising the accuracy rate for original compensation claims from 90 percent in fiscal year 1996 to 97 percent in fiscal year 2002.

We are currently reviewing VA and other agencies' initial implementation of GPRA. As required under the legislation, we will report by June 1, 1997, on GPRA implementation and the prospects for governmentwide compliance.

We would be happy to assist the Congress in reviewing draft and final VA submissions under GPRA, including strategic plans, performance plans, performance reports, evaluations, and related VA performance information.

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[13]Under Secretary for Health, Prescription for Change (Washington, D.C.: VA, Mar. 1996).

Improving Financial Management
And Accountability

The CFO Act was designed to remedy decades of serious neglect in federal financial management and accountability by establishing a financial management leadership structure and requirements for long-range planning, audited financial statements, and strengthened accountability reporting. The act created CFO positions and a financial management structure at each of the major agencies. The CFO Act, as expanded in 1994, requires VA, as well as other major agencies, to prepare annual financial statements, beginning with those for fiscal year 1996.

VA has established a sound financial management structure; in addition to the Assistant Secretary for Management, who serves as CFO, VHA and VBA each has a CFO. Also, VHA plans to have a CFO position in each of its 22 VISNs. VA met the requirement to prepare, and have audited, annual financial statements beginning with those for fiscal year 1986.

VA's response to the CFO Act has led to a number of financial management improvements, including

- the installation of VA's Financial Management System, which gives VA, for the first time, an integrated financial management system;,
- improvements in reporting of receivables and property management, due to the implementation of the financial management system, that resulted in the first issuance by a VA Inspector General of an unqualified opinion on VA's Statement of Financial Position on September 30, 1996;[14] and
- the consolidation of debt collection activities at VBA's Debt Management Center in St. Paul, Minnesota, to take full advantage of debt management tools.

The Inspector General's audit of VA's fiscal year 1996 financial statement disclosed six internal control weaknesses that expose VA to significant financial risks:

- errors in accounting for property, plant, and equipment, which could result in a future qualification of opinion if not corrected;
- errors by medical facilities in recording estimated amounts of unbilled services and in estimating uncollectible amounts;

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[14]Office of Inspector General, Audit of Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 1996 and 1995, 7AF-G10-051 (Washington, D.C.: VA, Feb. 25, 1997).

- failure to cancel approximately $69 million in open obligations that should have been cancelled before the end of the fiscal year–funds that could have been reprogrammed and used for other valid needs if they had been identified before the appropriations expired;

- an outdated data processing system for VA's life insurance programs that has the potential to adversely affect the complete and accurate processing of insurance transactions and the integrity of the financial information generated by the system;

- insufficient VA management emphasis on, and oversight of, VA data processing facilities to ensure that data processing systems are protected from unauthorized access and modification of data; and

- lack of an integrated financial accounting system for VA's Housing Credit Assistance Program which, when coupled with the complexities of accounting requirements under credit reform, increases the risk of financial reporting error.

Improving Information Management
and the Use of Information Technology

The Paperwork Reduction Act of 1995 provides basic guidance to federal agencies on acquiring and managing information resources. It is based on the concept that information resources should support agency missions and performance. It requires that information resources management plans delineate the resources that are needed and explain how the agency plans to minimize the paperwork burden on the public and the cost to the government of collecting information. The Clinger-Cohen Act of 1996 reinforces this guidance, and adds requirements designed to promote the use of information technology to better support agencies' missions and performance. It is primarily concerned with the need to ensure that agencies have systems to prioritize information technology investments. Clinger-Cohen also requires that a qualified senior-level chief information officer be appointed to guide all major information resource management activities. Both acts require agencies to set goals, measure performance, and report on progress in improving the efficiency and effectiveness of information management in general, and the acquisition and use of information technology in particular.

VA has made efforts to improve its information management systems, including the appointment of the Assistant Secretary for Management as VA's Chief Information Officer. The Clinger-Cohen Act requires, however, that information resources management be the primary function of an agency's chief information officer. This is not the case in VA, because the Assistant Secretary for Management is not only VA's Chief Information Officer, but is also responsible for its Offices of Financial Management, Budget and Acquisition, and Material Management. The Office of Management and Budget (OMB) has questioned whether information management is

the "primary function" of the Assistant Secretary for Management, and whether VA is in compliance with the Clinger-Cohen Act. In August 1996, OMB asked VA to reevaluate the placement of its chief information officer function and report within a year on how it will come into compliance with the Clinger-Cohen requirement.

VBA's information technology efforts have yielded some improvements in its hardware and software capabilities. However, our reviews of information management in VBA have identified problems that need to be addressed. One is the need for VBA to develop credible strategic business and information resources management plans.[15] VBA has undertaken several initiatives to improve claims processing efficiency and reduce its large backlog of unprocessed claims. But it has done so without an overall business strategy clearly setting forth how it would achieve its goals. Instead, VBA has used stopgap measures to deal with its claims processing problems. While these measures have improved processing times and reduced the claims backlog, VA needs to find other solutions.

Another challenge for VBA is to do a better job of managing its information technology development projects as investments. Our reviews of VBA's information technology initiatives show that VBA lacks the critical cost, benefit, and risk information to determine whether investments it is considering are worthwhile.[16] The next step would be to determine what it needs to meet its information resource management priorities. VBA needs to develop the tools needed to follow a three-phased management approach for selecting, controlling, and evaluating information technology-related projects. It also needs to develop a process to rank and prioritize information technology investments as a consolidated portfolio.

A third challenge for VBA is to improve its software development capability. Once agencies have identified their top priority information technology projects, they must be able to determine whether the project should be developed in-house or contracted out. Our review of VBA's software development capabilities found that, on a scale of software development maturity, VBA was in the "least mature" category.[17] Thus, VBA cannot reliably develop and maintain high-quality software within existing cost and schedule constraints. This, in turn, places VBA's information technology modernization efforts at significant risk. We made several recommendations to address this issue. These recommendations and VA's responses follow:

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[15]Veterans' Benefits Modernization: Management and Technical Weaknesses Must Be Overcome if Modernization Is to Succeed (GAO/T-AIMD-96-103, June 19, 1996).

[16]VBA Information Technology Investment (GAO/AIMD-97-10R, Oct. 18, 1996).

[17]Software Capability Evaluation: VA's Software Development Process Is Immature (GAO/AIMD-96-60, June 19, 1996).

- Obtain expert advice on developing high-quality software. VBA is working with the Air Force, under an interagency agreement, to implement this recommendation.

- Develop a plan to achieve a higher level of software development maturity. VBA has developed such a plan and has taken other actions to improve software development maturity.

- Require that future software development contracts specify that services be obtained from contractors with at least a level 2 (on a scale of 1 to 5, with 5 being the highest level) rating. According to VBA, it plans to award a general software contract with a provision regarding the necessary software development skills.

OPTIONS FOR REDUCING THE BUDGET DEFICIT THROUGH CHANGES IN VA PROGRAMS AND BENEFITS

We periodically report to the Congress on options for reducing the budget deficit. Our latest report, issued March 14, 1997, identified a series of potential changes in veterans' benefits and VA programs that could contribute many billions of dollars toward deficit reduction over the next 5 years.[18] Some of the options involve management improvements that could be achieved by the agency. Others, however, would require fundamental policy changes in veterans' benefits, including changes in entitlement programs.

Eliminate Veterans' Disability Compensation for Nonservice-Connected Diseases

During 1996, VA paid approximately $1.7 billion in disability compensation payments to veterans with diseases neither caused nor aggravated by military service. In 1996, the Congressional Budget Office (CBO) reported that about 230,000 veterans were receiving about $1.1 billion annually in VA compensation for these diseases. Other countries we contacted do not compensate veterans under such circumstances. If disability compensation payments to veterans with nonservice-connected, disease-related disabilities were eliminated in future cases, 5-year savings could, CBO estimated, exceed $400 million.

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[18] Addressing the Deficit: Budgetary Implications of Selected GAO Work for Fiscal Year 1998 (GAO/OCG-97-2, Mar. 14, 1997).

Eliminate Certain VA Contracts
With State Approving Agencies

In fiscal year 1994, VA spent more than $1 billion in educational assistance benefits to more than 450,000 beneficiaries. In addition, it spent over $12 million on contracts with state approving agencies to assess whether schools and training programs offer education of sufficient quality for veterans to receive VA education assistance benefits when attending them. An estimated $10.5 million of the $12 million paid to state approving agencies was spent to conduct assessments that overlapped assessments performed by the Department of Education. CBO estimated that at least $50 million could be saved over the next 5 years if the Congress directed VA to discontinue contracting with state approving agencies to review and approve educational programs at schools that have already been reviewed and certified by Education.

Impose Cost Sharing for
Veterans' Long-Term Care Services

State veterans' homes recover as much as 50 percent of the costs of operating their facilities through charges to veterans receiving services. Similarly, Oregon recovers about 14 percent of the costs of nursing home care provided under its Medicaid program through estate recoveries. In fiscal year 1990, VA recovered less than one-tenth of 1 percent of its costs for providing nursing home care through beneficiary copayments.

Potential recoveries appear to be greater within the VA system than under Medicaid. Home ownership is significantly higher among VA hospital users than among Medicaid recipients, and veterans living in VA nursing homes generally contribute less toward the cost of their care than do Medicaid recipients, allowing veterans to build larger estates.

If the Congress authorized VA to increase cost sharing for VA nursing home care by adopting cost sharing requirements similar to those imposed by most state veterans' homes and implementing an estate recovery program similar to those operated by many states under their Medicaid programs, billions of dollars could be saved through the increased revenues. For example, if VA recovered 25 percent of its costs of providing nursing home care through a combination of cost sharing and estate recoveries, it would save about $3.4 billion over the next 5 years.

Establish Independent
Preadmission Certification

VA hospitals too often admit patients whose care could be more efficiently provided in alternative settings, such as outpatient clinics or nursing homes. Our

studies and those of VA researchers and the VA Inspector General have found that over 40 percent of VA hospital admissions and days of care were not medically necessary.

Private health insurers generally require their policyholders (or their physicians) to obtain authorization from them or their agent prior to admission to a hospital. Failure to obtain such preadmission certification can result in denial of insurance coverage or a reduction in payment.

We have recommended that VA establish an independent preadmission certification program.[19] Although VA, in September 1996, required its VISNs to establish a preadmission review program, the review programs are run by the hospitals rather than by external reviewers and do not provide any direct financial incentive for facilities to adhere to the decisions of their reviewers. While the preadmission reviews are likely to have some effect on inappropriate admissions, they may not be effective unless coupled with a financial penalty for noncompliance with review findings.

CBO estimated that if VA were to establish precertification procedures similar to those used by private health insurers which, result in a 40-percent reduction in admissions and days of care, VA's medical care spending could be reduced by $8.4 billion over 5 years.

Delay Funding of Veterans' Medical Facilities

Historically, VA has submitted a budget request for hundreds of millions of dollars in major health care construction projects. The requests have typically included construction or renovation of one or more hospitals.

Long-term commitments for any major construction or renovation of predominantly inpatient facilities in today's rapidly changing health care environment are accompanied by high levels of financial risk. VA's recent commitment to a major realignment of its health care system magnifies such risk by creating additional uncertainty. In addition, we believe that analyzing alternatives to major construction projects is entirely consistent with VA's suggested realignment criteria. Delaying funding for major construction projects until the alternatives can be fully analyzed may result in more prudent and economical use of already scarce federal resources.

The potential savings of delaying funding for VA hospital construction are uncertain in the absence of an assessment of VA's needs based on its own realignment

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[19]VA Health Care: Opportunities for Service Delivery Efficiencies Within Existing Resources (GAO/HEHS-96-121, July 25, 1996).

criteria. CBO estimates that if the Congress did not approve funding of any major construction projects until after VA has completed its realignment, savings totaling more than $1.2 billion could be achieved over 5 years.

VA's fiscal year 1998 budget submission and its recent decision not to pursue construction of a new VA hospital in East Central Florida are consistent with this option. VA is seeking only $48 million for major medical construction for fiscal year 1998.

Close Underused Hospitals

Although VA took over 50,000 hospital beds out of service between 1970 and 1995, it did not close any hospitals on the basis of declining utilization. With the declining veteran population, new technologies, and VA's efforts to improve the efficiency of its health care system, significant further declines in demand for VA hospital care are likely.

While closing wards saves some money by reducing staffing costs, the cost per patient treated rises because the fixed costs of facility operation are disbursed over fewer patients. At some point, closing a hospital and providing care either through another VA hospital or through contracts with community hospitals may become less costly than simply taking beds out of service.

Potential savings from hospital closures are difficult to estimate because of uncertainties about which facilities would be closed, the increased costs that would be incurred in providing care through other VA hospitals or contracts with community hospitals, and the disposition of the closed facilities.

Limit Growth of VA
Medical Care Account

As discussed earlier, the VA health care system should be able to significantly contribute to deficit reduction during the next 5 years. First, the system does not need to expend the level of resources that VA has previously estimated to meet the health care needs of veterans. These resources are overstated because VA did not adequately consider the declining demand for VA hospital care in estimating its resource needs and because eligibility for VA care has been reformed–which, according to VA, will allow it to divert 20 percent of its hospital admissions to less costly outpatient settings. Second, VA could reduce its operating costs by billions of dollars over the next 5 years by completing a wide range of efficiency actions. VA recognizes that it can reduce its costs per user by 30 percent over the next 5 years but plans to use the savings to expand its market share by 20 percent.

We recently recommended that VA provide the Congress information on the savings achieved through improved efficiency in support of its budget request. We noted that providing the Congress with information on factors, such as inflation and creation of new programs, which increase resource needs, without providing information on changes that could reduce or offset those needs leaves the Congress with little basis for determining appropriate funding levels. VA, however, has been unwilling to provide such information to the Congress.

One way for the Congress to respond to VA's unwillingness to provide information on savings from improved efficiency would be to limit the VA medical care appropriation at the fiscal year 1997 level for the next 5 years. CBO estimates that this would result in almost $9 billion in savings.

Limit Enrollment in
VA Health Care System

Recently enacted legislation expands eligibility for VA health benefits to make all veterans eligible for comprehensive inpatient and outpatient services, subject to the availability of resources. The legislation also requires VA to establish a system of enrollment for VA health care benefits and establishes enrollment priorities to be applied, within appropriated resources. The lowest priority for enrollment is veterans with no service-connected disabilities and high enough incomes to place them in the discretionary care category.

VA, however, does not currently provide the Congress enough information on the types of veterans it serves to enable the Congress to make informed judgments about which portion of VA's proposed workload to fund. We found that about 15 percent of veterans with no service-connected disabilities who use VA medical centers have sufficiently high incomes to place them in the lowest priority category under the new patient enrollment system. If the Congress funded the VA health care system to cover only the expected enrollment of veterans in higher priority enrollment categories, such as veterans with service-connected disabilities and veterans without the means to obtain public or private insurance to meet their basic health care needs, CBO estimates that $1.7 billion in budget authority, adjusted for inflation, could be saved over 5 years.

Reduce Outpatient Pharmacy Costs

VA pharmacies dispense to veterans over 2,000 types of medications and medical supplies that are available over-the-counter (OTC) through local retail outlets. Such products were dispensed more than 15 million times in 1995 at an estimated cost of $165 million. The most frequently dispensed items include aspirin, dietary supplements, and alcohol prep pads.

Unlike VA, other public and private health programs cover few, if any, OTC products for their beneficiaries. Our assessment of VA's operating practices suggests several ways that budget savings could be achieved. First, VA could more narrowly define when to provide OTC products, reducing the number of OTC products available to veterans on an outpatient basis. Second, VA could collect copayments for all OTC products. CBO estimated that these steps could save over $350 million over the next 5 years.

Extend Expiring Authorities

Legislation initially enacted in 1990 gave VA access to Internal Revenue Service tax data and Social Security Administration earnings records to help VA verify incomes reported by beneficiaries. Since then, millions of dollars in savings have been achieved in VA's health and pension programs as a result of VA's income verification program.

Authority for the program will, however, expire on September 30, 1998. Extending the authority could generate over $115 million in savings between fiscal years 1999 and 2002.

CONCLUSION

VA is using the management framework created by recent legislation in major restructuring of its health and benefits programs. Both VHA and VBA have developed strategic plans.
Those plans, and progress toward meeting the goals contained in them, are included in VA's fiscal year 1998 budget submission. Similarly, VA is a leader in attempting to develop sound financial management, having prepared audited financial statements for over 10 years. However, VA has not fully complied with recent legislation in the area of information management, and it is working with OMB to resolve differences with respect to its compliance with the Paperwork Reduction Act and the Clinger-Cohen Act.

VA's progress in strengthening its management should help it address the multiple challenges facing its health and benefits programs. Under the leadership of the Under Secretary for Health, the VA health care system has made significant progress during the past 2 years in improving both its efficiency and its image. In addition, actions to expand eligibility, make it easier for VA to buy services from and sell services to the private sector, improve access, and reduce waiting times place VA in a better position to compete with private sector providers for declining numbers of veterans.

VA and the Congress, however, are faced with difficult choices.

- Should VA hospitals be opened to veterans' dependents or other nonveterans as a way of increasing efficiency and preserving the system? What effect would such decisions have on private sector hospitals?

- To what extent should the government attempt to capture market share from private sector providers? Should the government subsidize its facilities in order to capture market share?

- Should some of VA's acute care hospitals be closed, converted to other uses, transferred to states or local communities, or sold to developers?

- Should VA remain primarily a direct provider of veterans' health care or become a virtual health care system in which it contracts with private sector providers rather than operating its own facilities?

- To what extent should the VA system address the unmet needs of uninsured veterans and those with service-connected disabilities?

Decisions regarding these and other questions will have far-reaching effects on veterans, taxpayers, veterans facilities and the VA employees working in them, and private providers.

Because of the historic inefficiency of the VA system, the changes currently taking place provide many opportunities for the VA health care system to contribute toward deficit reduction while still improving services to current users. Limiting the system to current users, however, could facilitate declines in hospital use and lead ultimately to closure of VA hospitals.

The declining veteran population in the United States, in concert with the increased availability of community-based care, makes preserving the current acute care workload of existing VA health care facilities exceedingly difficult. VA will have to attract an ever-increasing proportion of the veteran population if it is to keep its acute care hospitals open. VA's fiscal year 1998 budget submission outlines its strategy for preserving its hospitals: it wants to increase its users by 20 percent in order to make more efficient use of existing VA facilities. The new users VA is targeting generally have other health care options available to them.

The cost of maintaining VA's direct delivery infrastructure limits VA's ability to ensure similarly situated veterans equal access to VA health care. VA's interest in providing services to veterans in the discretionary care category at VA hospitals and

outpatient clinics is likely to limit its ability to provide services to low-income and service-connected veterans through the use of contract care.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee might have.

For more information on this testimony, call Jim Linz, Assistant Director, at (202) 512-7110. Greg Whitney also contributed to this statement.

Mr. SHAYS. Thank you. Let me just say that a lot of your statement was not given orally but is on the record for our staff. And when Members of Congress say they're going to read your statement, that's a stretch. But I do know that the staffs will read them in preparation for our hearings. I'm trying to develop a theory that may just fall flat on its face. I'm just going to focus now on Gulf war illnesses and so on, just as a means at looking at the mission of the VA. So it has greater implications.

You, Mr. Baine, drew on it in the fact that you said that compensation hasn't been really looked at in 45 years for disability. I have a general theory that clearly, first off, the VA and the DOD and the CIA all want, in my judgment, that any of our soldiers who fought in the Persian Gulf to be justly diagnosed, treated, and compensated. But I don't think the system is allowing that to happen.

And one of my general theories is that the VA has just not responded to the whole issue of biological or chemical exposure. In other words, that they don't have the expertise, so they have a doctor that has no health care expertise in chemical exposure. And what I've learned since I've basically questioned the VA's ability to look at chemical exposure, is that the medical science, in general, doesn't know how to diagnose or treat chemical exposure. And there are very few people in the country who have any expertise in it.

My point is, when I look at the VA, do I see a dynamic organization that is quick to change or do I see an organization that is very slow to change? And more specifically, have either of you looked at the issue of the skills of the doctor versus the kinds of challenges that our soldiers faced, not just in the Persian Gulf but earlier.

Mr. BAINE. I might—go ahead.

Mr. MERRIMAN. I'd say that it might be looked at as an organization that is slow to change because of its size and how it's developed over the years. But when you think about the skills that are available to the VA, you have to look in terms of the VA physicians, themselves, and the employees of the affiliations that they've developed over the years. So at least theoretically, they have access to medical expertise that goes beyond the VA's employed VA physicians.

Mr. SHAYS. In other words, the Westhaven Hospital in Connecticut draws on Yale University?

Mr. MERRIMAN. Many of them have dual appointments.

Mr. SHAYS. Right.

Mr. MERRIMAN. OK. So there is that to be considered. I'm sorry. The second part?

Mr. SHAYS. Just the issue of its ability to respond to change. And then the second is, do you feel that the expertise—the health expertise—matches the health needs of our veterans?

Mr. MERRIMAN. I would say——

Mr. SHAYS. And I gave, as an analogy, the whole issue of chemical exposure.

Mr. MERRIMAN. Right. I would look at it differently. I'd look at the needs of the veterans might be more toward not necessarily what happened to them in war time, but diseases now that they've grown older. We would have taken issue in the past with the focus on specialty care in the VA, some of which, perhaps, was driven

with affiliation relationships. And we would have said that there needed to be more of an emphasis on primary care.

They are moving toward that. They are using some of their leverage now to ensure that more of the residents or trainees that come into the VA system, are trained in primary care to meet the overall multi-system problems of an aging veterans population.

Mr. SHAYS. You're making an argument that the large population are aging veterans that may have illnesses that aren't directly related to their service.

Mr. MERRIMAN. Well, interrelated.

Mr. SHAYS. Interrelated. OK. It doesn't really address the potential warfare of the eighties and beyond, the issue of—if it's not an area you focused in on, I don't want to push you on it.

Mr. MERRIMAN. We haven't. That's about as far as I can go on it.

Mr. SHAYS. OK.

Mr. BAINE. Mr. Chairman, could——

Mr. SHAYS. Your response was helpful. Yes. Thank you.

Mr. BAINE. Could I just make one comment?

Mr. SHAYS. Sure, you can make as many comments as you want.

Mr. BAINE. I agree with Mr. Merriman in terms of the VA having traditionally been fairly slow to change because it's a large organization and it's a big boat to turn around. In the last 2, 3 years, however, Dr. Kizer has attempted to turn the boat around in many respects. With regard to your specific question, I think that is a concern that we have, too. When folks from the Persian Gulf conflict get into the VA system are they treated in the same way as everybody else that goes in the VA, or are there special things that the VA is doing.

And that's something that we're trying to look at right now. We've just started some work to see whether there's any difference between somebody who perhaps has been exposed to chemical and biological agents, how they're treated vis-a-vis how anybody else is treated in the VA hospital.

Mr. SHAYS. Well, you raised the question of the associations of universities. Westhaven had in its protocol for questioning Persian Gulf veterans early on, questions about chemical exposure and so on, because the doctor who was responsible was a doctor who focused in on work place illnesses. So there was this—but that was almost by luck, that they got into that issue a little sooner.

Mr. BAINE. That's what we're trying to explore, is see the extent to which those kinds of things are happening in the VA system.

Mr. SHAYS. Now, Dr. Kizer's name has come up more than once today. Do you think he's been relatively successful in trying to bring about change in the VA?

Mr. BAINE. My own personal belief is that he has. You have to——

Mr. SHAYS. First off, let me just ask—do you give him credit for trying to start with? Do both of you feel that he's trying to make major changes?

Mr. MERRIMAN. Oh, yes.

Mr. BAINE. Yes, sir.

Mr. SHAYS. So both of you are on record as saying that he's making major effort here?

Mr. BAINE. Right.

Mr. MERRIMAN. That is correct.

Mr. SHAYS. And your sense is he's having an impact, that the Department is responding.

Mr. BAINE. I don't think there's any question that he's having an impact.

Mr. MERRIMAN. I agree.

Mr. BAINE. I mean, if you go out into the field, to the networks and to the medical centers, you will, I think, come away with the appreciation that he is having an impact.

Mr. SHAYS. Mr. Merriman.

Mr. BAINE. People have various views of that.

Mr. SHAYS. Right. They may not agree with the change, but—yes. Mr. Merriman, do you feel——

Mr. MERRIMAN. I agree. And his relationship with our office is a whole different world than what we have been used to in the past, even in the planning process.

Mr. SHAYS. What? Trying to respond to your concerns and criticisms? In other words, what is different about that relationship?

Mr. MERRIMAN. First of all, his willingness to participate in the development of our projects.

Mr. SHAYS. OK.

Mr. MERRIMAN. He, personally, will give us suggestions to include in our plan, which we will discuss with him, and put in or not in as we see fit. But his willingness to discuss our recommendations, to sit down and have a good thorough discussion of it, and take action on problems that we're finding.

If he agrees with us early on in our audit, he won't wait until we conclude the process. He will initiate action when he sees it. On the other hand, if he questions our methodology, he'll demand proof that we're right. But we have a very good working relationship with him. And I think he does deserve a lot of credit for the changes that are happening in VHA.

Mr. SHAYS. What would the VA disagree most with your written testimony? Not what you said, because you were both pretty positive about the VA. Where would you have your biggest disagreement with the VA? I'll start with Mr. Baine.

Mr. BAINE. My——

Mr. SHAYS. Yes.

Mr. BAINE. My sense is that VA would probably disagree most with our characterization of its intention to target higher income non-service connected veterans to enhance its patient base.

Mr. SHAYS. OK.

Mr. BAINE. That's my——

Mr. SHAYS. I'm going to come back to that. What would you say that your biggest disagreement with——

Mr. MERRIMAN. Other than perhaps not identifying more positive aspects of their work, I don't know the——

Mr. SHAYS. They just want you to talk about the positive.

Mr. MERRIMAN. We tried to provide a balance.

Mr. SHAYS. So we know they're normal. OK.

Mr. BAINE. It's always interesting, because one of the things that we've tried to do over the last several years, as a courtesy to VA, when we prepare a testimony like this, is go talk to the pro-

grammatic people. And Jim and I had that experience a few days ago. And there were 40 people in the room and it was fair to say that most—somebody disagreed with almost everything.

Mr. SHAYS. Let the record reflect the sarcasm. OK. I still want you all to be son of a bitches a little bit. Otherwise——

Mr. MERRIMAN. We're allowed to do that.

Mr. SHAYS. Sons of bitches? The district I represent, the 4th Congressional District in Connecticut, has 10 towns and a number of hospitals. Four of those hospitals are concentrated in about a five-town area. And studies show that we may only need one of them to provide acute care. Some of the hospitals could refocus and provide other care, but acute care we only need one hospital the size—one-fourth of what we have now, basically.

When I look at a VA hospital, I would think that you have the same challenges in some areas. What's wrong, though, with the VA trying to expand its client base for economies of scale? Otherwise, there may be no hospital if it can't become more efficient. So what would be wrong with the VA focusing in on increasing its enrollment?

Mr. BAINE. There's nothing specifically wrong, Mr. Shays, with the VA trying to expand its patient base. Our concern is that there are a fair number of veterans that have special care needs.

Mr. SHAYS. Right.

Mr. BAINE. And you pointed out some of them—spinal cord injury, PTSD, chemical and biological injuries or illnesses—those kinds of things that VA is specifically tasked and expected to provide care for. As it moves toward a re-engineered health care system it seems to us, at the present time, that VA is targeting folks who can provide an income stream to VA to supplement the appropriation that it gets.

Mr. SHAYS. Yes.

Mr. BAINE. And they has been a concern of ours for several years. It's one where Dr. Kizer doesn't necessarily agree with us. But we believe that it's a valid concern. And with regard to your comment about—in your district there are four or five hospitals in five towns—VA is facing essentially the same thing.

It's taken about 50,000 beds out of service or converted those beds to other uses over the last 20 years or so. And it is facing the same kinds of things that those hospitals in your district are facing. Now, the question actually becomes—and it's a question for both the Congress and the administration, it seems to me—what portion of the $17 billion health care budget should go for the maintenance of the infrastructure.

There's a choice to be made. Are you going to maintain the infrastructure at the current level, or are you going to change the mix and try to provide veterans benefit in maybe a different way?

Mr. SHAYS. Which the veterans are looking at out-patient clinics and expanding them, obviously. But that can potentially take away its client base from its acute care or it sometimes can feed into the system.

Mr. BAINE. Yes.

Mr. SHAYS. But there are some of us that take the unpopular view, but hold it quite dearly, that I would like a veteran to be able

to have a veterans' card that enabled them to go to any hospital in the world—in the country, rather.

Mr. BAINE. Right.

Mr. SHAYS. And be able to get a care that would be special to that veteran, not necessarily in a VA facility. Have either of you looked at the economics of that issue? Not the political viability. Maybe the political viability tells you don't want to look at the economic viability.

Mr. MERRIMAN. We have not. No.

Mr. SHAYS. OK.

Mr. BAINE. No. We haven't looked specifically at the economics of the thing. We have, however, looked at VA's initiative to establish these community-based out-patient clinics.

Mr. SHAYS. What——

Mr. BAINE. The first batch of 12, I think it was, or 15, perhaps—and, basically, what we found was that a large portion of the population that was going to be served by those community-based outpatient clinics or access points, as VA was calling them then, were veterans who were non-service connected and higher income. So the outreach effort reached the population who, perhaps, could either pay some portion of the cost of their care through copays or, as in some of the VA legislative proposals, they were Medicare eligible.

Mr. SHAYS. Let me just get into one other area that—in the President's budget, it says the Veterans Health Administration is the Nation's largest trainer of health care professionals. About 108,000 students a year get some or all of their training in VA facilities through affiliations with over 1,000 educational institutions.

The program provides training to medical, dental, nursing and associated health care professional student to support VA and national work force needs. Have you looked into this—in other words, we're looking at training hospitals in Medicare and Medicaid and how we pay for it. But the VA, evidently, is the largest trainer of doctors. Is that through the VA funded system that we have this?

Mr. BAINE. Yes. It's through the VA funded system. As Bill said, with the affiliated institutions.

Mr. SHAYS. Right.

Mr. BAINE. With the—VA has affiliation agreements with—I've forgotten exactly how many universities and medical schools. And VA sees it as part of its mission, the mission to train residents and other health care providers. We've done some work with regard to the affiliation agreements. Bill's group has done a fair amount of work with regard to the affiliation agreements and found some problems.

Mr. SHAYS. Yes. Let me ask him. Mr. Merriman, I'm going to have you respond. But I'll introduce this question. Is it almost the sense that the tail is wagging the dog? Is the VA saying what they want or is it the affiliates saying what they want?

Mr. MERRIMAN. We had problems in the past that we thought that the VA wasn't using the leverage it had to direct the affiliations along the lines that would be more appropriate for the department. It's another area that Dr. Kizer came to us on, asking for what we had found in the past with respect to affiliation problems. And he had a major initiative to go out and restructure the

agreements with the affiliations and the Department. I guess I'd ask Mr. Sullivan to elaborate a little bit more on some of our work in that area.

Mr. SULLIVAN. Yes. In regard to the number of affiliations, the VA—in their 173 hospitals—120 of them are affiliated with major universities around the country. Dr. Kizer, in one of his initiatives in which we also participated, has addressed the resident issue, the issue you brought up earlier—or Mr. Pappas, I believe, brought up about the schools being paid not to train residents and so forth.

Mr. SHAYS. Yes.

Mr. SULLIVAN. Dr. Kizer's study has resulted in a decrease in the number of residents that are being trained by VA. I think his program calls for a 3-year process where the number of residents decrease by X percent each year.

Mr. SHAYS. Does it represent a cost to the VA or a benefit? In other words, sometimes you get the residents and they stay up 30, 40 hours before getting any rest and do a lot of the yeoman work. So how does the VA view this, as more of a benefit or a cost?

Mr. SULLIVAN. I think it becomes a benefit. We had problems in the past about overuse of the residents in place of the attending physicians that VA would expect to have caring for their patients. But I think the decrease in cost is also vital. I think that has helped, and will help in the future as they have a decrease in the number of residents.

Mr. BAINE. One other of the tensions, I think, in the business with the affiliations agreements and the residents and so forth is that historically and traditionally, many of the specialties and subspecialties have been trained in VA facilities. As VA moves to a more primary care type model, that's creating some tension with the affiliated institutions as to whether we're going to have primary care doctors or whether we're going to have specialists and subspecialists.

Mr. SHAYS. When I was in the Peace Corps, they were constantly doing tests on—trying to determine what volunteer—let me back up. They had a high rate of volunteers not finishing their assignments—in some cases more than 50 percent. So they'd invest money. They'd send a volunteer to a country. The village would be excited. And the next thing, the volunteer leaves and the village is very unhappy.

And we made more enemies than friends sometimes. So there was a study to decide—a lot of studies to decide who would make it and who wouldn't. And I began to think that, in some cases, they were playing with our minds. I mean, they took married couples and would say some things to one select group. And they would take another group—in the experience that I had—and say something quite different, and see how we would react.

Then when I got my MBA, I read some of the studies that they had done on us, which, having been in Government a long time, I get the feeling sometimes the Government is quite willing to do things that in the private sector we wouldn't condone in terms of using the Army, in a sense, as guinea pigs for seeing where we're headed here and what would be the outcome.

And I'm raising, maybe, a sensitive question: do you have information that would make us want to look at this? Is there a tend-

ency to use the veteran population as an opportunity to do certain tests—psychological or physical—that we might not see happen in the private sector? Do they represent a control group that becomes a real temptation for the associate hospitals?

Mr. MERRIMAN. That was a long introduction to a question. I don't think that it's any different than any normal teaching hospital. In other words, the residents are there for training. And an individual patient may be looked at by more—more physicians in training than normally would be the case. But I think it's a——

Mr. SHAYS. OK. I'm looking at the issue of a company culture, in a sense. We know that the military much less sensitive than the private sector to the USAFE chemicals. You can have a soldier in the Persian Gulf spraying lindane on Iraqi soldiers as a disinfect, et cetera, in an enclosed tent without ventilation and without any effort to accommodate temperature.

And they can do it all day long, day in and day out, whereas in this country we would never, ever allow that to happen. We can have chemicals on military bases that are exposed to the environment that we would not allow in the private sector. We aren't closing down some military bases because of chemical abuse and clean-up costs. I'm just talking about a culture. Is there a culture in the VA that is more similar to the DOD model than the private sector model?

Mr. BAINE. My experience, and, I think, that of Jim would indicate that that, perhaps, was more of a problem 20 years ago than it is now.

Mr. SHAYS. OK.

Mr. BAINE. In terms of experimentation and those kinds of things, there have been some instances where VA was doing research on atomically exposed veterans and so forth. And there were some stories and tales that came out of those experiences. My sense is that there is much less of that now, although we haven't done any specific work about that.

Mr. SHAYS. Let me say this—if either of you have a sense that that may not be accurate, I would want the committee to be notified.

Mr. BAINE. We'll do that.

Mr. SHAYS. I realize that it would be foolish to comment on something you don't have any—your point is that you don't have the concern I have. But if you find that there may be in a certain area, I would want you to contact the committee and then we could pursue it quietly and see if there's any substance to it.

Mr. BAINE. We'd be glad to.

Mr. SHAYS. Any closing comments that any of the four of you want to make before we adjourn? Mr. Sullivan.

Mr. SULLIVAN. I just might mention two issues: benchmarking and broadcasting. I think what we're finding in a system as large as VA is, that there's a number of good things that go on around the country that we found in our audits.

We like to report those things. And what we tell the Department is, they should broadcast those things. And we found a number of those things along those lines. I think that's something we have to bring forward to the committee: the good and the bad.

Mr. SHAYS. OK. Mr. Linz, do you have any comment you want to make?

Mr. LINZ. Yes. One of the things I'd like to go back to is——

Mr. SHAYS. Just put the mike a little closer and push it down a little bit.

Mr. LINZ. One of the things I'd like to go back to is a comment you made earlier about having four hospitals in your district and maybe only needing one.

Mr. SHAYS. Right.

Mr. LINZ. And also the question of, well, what's wrong with VA attracting additional users. It creates a difficult policy decision because every patient VA attracts is one more patient taken away from a private sector hospital. So that's kind of the problem.

Mr. SHAYS. Yes.

Mr. LINZ. If you've got a community that has one private sector hospital and one VA hospital, which one do you want to save?

Mr. SHAYS. Yes. But the bottom line is, we delude ourselves if we think we're going to save a VA facility that is totally underutilized. I mean, the bottom line is, let's be up front and make a decision now rather than let it be strangled to death by underutilization.

Mr. BAINE. The issue, Mr. Chairman, of the VA infrastructure for health care, I believe is going to be an issue for some time. And it's an issue which the Members of Congress are going to have to face.

Mr. SHAYS. Yes.

Mr. BAINE. And it's a real, real tough one, because it involves employees. You know, there are 220,000 employees in VA. And when you close a facility, that affects a lot of employees.

Mr. SHAYS. It does. But if we can make the veterans, themselves, players in this process—if they know what the alternative is—what this country needs is some brave people who look at their own areas and say, "Hey, listen. We've got to deal with this now."

Mr. LINZ. Mr. Chairman, the work we did several years ago on the veterans' health programs in other countries basically showed that as veterans in those countries were given greater access to community hospitals, that demand for care in their veterans hospitals further declined, and eventually both Australia, Canada, the United Kingdom ended up closing their veterans facilities. They now provide all of the veterans care essentially through public hospitals and——

Mr. SHAYS. The model that I particularly like is for a veteran to be able—I think the veterans obviously feel that—a variety of things. One, if they are dependent on the local hospital, that this so-called card that I make reference to could disappear overnight because there's not an infrastructure and a lobby group that could keep it, necessarily.

So that's one legitimate concern. But my view is that the veterans hospital should be those hospitals that carve out particular expertise, and that we give the very best service to those veterans who have those particular needs. Transportation costs are so much less now that even moving people from one State to another, providing they get really great care, there's an acceptance level there.

So let me just do one last thing that I wish I had done before I had asked what I thought was the last question. On the post-award audits: I was trying to think, well, why would the Government want to allow people to cheat the system either intentionally or not intentionally, but, ultimately, short change the taxpayers by denying a post-audit. And I gather the post-audit can be expensive for the private sector? Is that the argument?

Mr. MERRIMAN. Can be expensive in the private sector?

Mr. SHAYS. In other words, that they have to, then, respond after the fact?

Mr. MERRIMAN. They would argue that there's cost involved to the post-award audit. Obviously there's some. But in today's modern environment, what we do is pull their automated sales tapes and compare them. What we're really looking for—they come to us, and we say—we strike a contract with them and say that we want the best price that you give for a comparable customer.

We may not always be the comparable customer for what we're buying. So we may not get the lowest price. But we want the best price for a comparable customer. And that if there's been adjustments to these prices over time, that we'd like to know about it and realize the benefits from it. That's what we're checking for. And basically, we can do that fairly quickly by pulling their automated sales tapes and taking a look at what their sales are.

Mr. SHAYS. So there's not as big a cost to them other than to defend their actions, but there could be a big cost to them if, in fact, they had not followed the law the way they're supposed to and then had to adjust their price, which would be a legitimate reason to want the post-audit?

Mr. MERRIMAN. Yes.

Mr. SHAYS. I'm trying to think logically why the people who defend the taxpayers would even honor this process. I'm trying to be a little sympathetic to why I'm surprised that this is already in the stage where we're in comment, and wondering who would have wanted to promote it. So we're going to obviously do some checking on this.

Mr. MERRIMAN. You'll find it comes under the mantle of procurement reform. And there's many good things being done to streamline procurement and to reform it. This is an area that, I think, we've demonstrated, needs to have the oversight that we're providing to it.

Mr. SHAYS. Yes.

Mr. MERRIMAN. And it can't be done on a pre-award basis, which is what some people would say.

Mr. SHAYS. A pre-award basis means once the price is there, you've got to live with it?

Mr. MERRIMAN. That's right. They'd say that when the contractor comes in, we have the opportunity to audit his proposal at that time. But the kinds of contracts we're dealing with in pharmaceuticals and medical supplies and equipment deal with hundreds of contractors coming in for contracts that stretch over years with thousands of items on them. We cannot catch all the problems at that point.

Mr. SHAYS. And I think I have sympathy for their view. Their view might be that if you told them that they had to sell for less,

they wouldn't have sold. So in other words, if they were selling a particular good at $100, and you determine they had sold it to someone else for $90, you could then go back and say, "For all of those, we want the $90 price instead of the $100 price." They would have to take that hit of $10.

Whereas, if you did it up front, they might say, "We may have sold it for $10 somewhere else, but we made a mistake. We're not going to sell it to the Government for $10, so we'll just lose out on the sale." In other words, the advantage of doing it up front is they say, "Fine, we won't sell." Whereas, doing it after the fact, they've already sold it and then have to make up the dollars. I'm trying to think of the most logical argument for why it's gotten this far. That seems logical to me.

Mr. MERRIMAN. All we would say is, either up front or afterwards, abide by your contract.

Mr. SHAYS. OK.

Mr. MERRIMAN. And commercial contracts aren't immune to these same things.

Mr. SHAYS. OK.

Mr. MERRIMAN. We've seen commercial contracts where one commercial firm will put in a provision that they have a right to audit the contracts of their suppliers, or that they have a right to price reductions.

Mr. SHAYS. Right. Well, that's a very strong argument. Well, this will be something we'll take a look at in the committee, and then maybe do even more on it. But we have a comment period that's ending pretty quickly?

Mr. MERRIMAN. I believe the comment period has ended. Comments are being considered by GSA at this time.

Mr. SHAYS. OK. I thank you. Any other additional comment before we adjourn? With that, thank you for all your good work. I look forward to working with you all again. This hearing is adjourned.

[Whereupon, at 12:15 p.m., the subcommittee was adjourned.]

[Additional information submitted for the record follows:]

MAY 12 1997

The Honorable Christopher Shays
Chairman
Subcommittee on Human Resources
Committee on Government Reform and Oversight
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your April 1, 1997 letter in which you requested our response to the following questions that were provided by Representative Benjamin Gilman:

1) We have heard a lot of talk about inequity in funding and demand for services among the various VISNs. Are you aware of any specific cases, where veterans were turned away from receiving care for these reasons? If so, what were the circumstances behind this rejection of care?

2) The VA has claimed that it needs to modernize its health care system by moving away from an inpatient based system to an outpatient one. What about the specialty cases (mentally ill, alcoholism/drug abuse, and homeless veterans)? Is it more efficient to treat these cases on an outpatient basis?

Regarding the first question, my office has acquired no empirical evidence that veterans have been denied care because of inequitable funding or disparate demand for services among Veterans Integrated Service Networks (VISNs). While my office receives complaints from veterans alleging denial of medical care services, such complaints usually relate to eligibility and entitlement issues. No allegations related to denials of care due to either the level of funding of VA facilities, or the demand for medical care, have been substantiated. The Under Secretary for Health may be able to provide your office additional information, particularly regarding what actions the Veterans Health Administration (VHA) might take if it appeared necessary to deny care to otherwise eligible veterans.

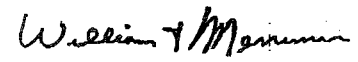
Regarding the second question, my Office of Healthcare Inspections recently conducted a study that addressed the impact on homeless veterans of reductions in VHA inpatient substance abuse treatment programs, while moving more toward outpatient programs. Our preliminary report to the Under Secretary for Health noted that the majority of homeless veterans could be treated efficiently on an outpatient basis, provided they had safe residential housing and social support resources during both the intensive treatment and aftercare periods.

Based on the opinions of VA clinicians and researchers in the field of addiction medicine, we recommended that VHA retain a core of inpatient acute substance abuse treatment program beds within each VISN. This would enable VHA to provide substance abuse treatment to homeless and other veterans who have serious psychiatric and medical conditions, and as well as the treatment of those veterans who cannot be treated on an outpatient basis. When we have received the comments on the draft report we will be able to issue a final report and ensure that your office receives a copy.

We have not performed any other audits or reviews of specialty programs that would address the efficiency of treating patients on an outpatient basis. The Under Secretary for Health may have further information regarding this issue as well, particularly regarding VHA's Special Emphasis Programs for the homeless and mentally ill.

Thank you for this opportunity to provide comments regarding these important issues affecting the treatment and care of our veteran patients. If you have any questions or need additional information, please contact me or Mr. Michael G. Sullivan, Assistant Inspector General for Auditing, at (202) 565-4625.

Sincerely,



WILLIAM T. MERRIMAN
Deputy Inspector General

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

MAR 18 1997

The Honorable Christopher Shays
Chairman, Subcommittee on Human Resources
and Intergovernmental Relations
Committee on Government Reform and Oversight
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Earlier today, Mr. David P. Baine, representing the General Accounting Office (GAO), presented testimony before your subcommittee on programmatic and management challenges facing the Department of Veterans Affairs (VA). We have reviewed Mr. Baine's statement, and there are several concerns regarding it that we wish to share with you.

While GAO acknowledges many of VA's ongoing and planned improvements to our programs, its analysis contains certain inaccurate statements and conclusions as well as some omissions. Regrettably, the testimony reflects information that is now substantially out of date and is silent on much of the progress the Department has made since GAO issued the reports that it cites.

I am particularly disappointed with GAO's testimony regarding the Veterans Equitable Resource Allocation (VERA) methodology, which the Veterans Health Administration (VHA) will put into effect on April 1. The VERA plan, which is in response to a statutory mandate in section 429 of the FY 1997 VA-HUD Appropriations Act (Public Law 104-204), is a vast improvement over VHA's past approaches to resource allocations. It corrects major inequities in funding among various geographic regions and greatly simplifies an overly complicated process so that it is now understandable to VHA's managers in the field and to the veterans we serve. Nevertheless, GAO faults VHA for moving ahead with VERA in accordance with the statutory deadline because VHA lacked certain data regarding prospective VA patients that GAO says could be used to bring VERA closer to what it apparently would view as a more perfect system. However, GAO knows, as VHA stated in the VERA report, that that kind of data is not currently available, that VHA is making every effort to develop it, and that VHA will take it into account in an appropriate way in future iterations of VERA.

The Department has been working for over 2 years to transform our healthcare system into an integrated network that is responsive to our patients' needs for comprehensive care assuring the right care is given at the right time, in

the right setting, and in the most cost effective way possible. To fundamentally restructure a national system of health care and put into place information systems, financial systems, personnel management systems, and staff that can see the vision and move the system forward in so short a time is in itself a remarkable accomplishment. We look forward to providing you accurate details about this accomplishment.

I also believe that in the area of veterans' benefits, GAO's testimony does not reflect current progress. GAO stated that one of the challenges facing Veterans Benefits Administration (VBA) is that the Disability Rating Schedule had not been updated for over 45 years and no longer reflected lost earning potential. In point of fact, VBA has radically revamped the Schedule in the past few years to reflect contemporary medicine and the evaluative process. In November 1996, the then Deputy Under Secretary for Benefits took issue with GAO's assessment of the Rating Schedule. He noted that the Schedule as structured represented a consensus among Congress, VA, and the veteran community about an equitable way to determine compensation for America's disabled veterans.

With respect to the Year 2000 issue, the testimony is silent on critical achievements VBA has accomplished: contractors and interested third parties have written, approved, and scrutinized a comprehensive plan for "fixing" Year 2000 data fields. In managing its information technology development projects, VBA has acquired a systems integration contractor to take a macro-level view of its capital plans and investments and to tie the Information Technology Plan into support of VBA's business.

The changes briefly cited here are the result of literally thousands of hours of work by VA staff, consultants, and stakeholders with a goal to streamlining VA's business processes for optimal service to our clients: our nation's veterans and their beneficiaries. We look forward to discussing those service improvements with you and your staff. We also look forward to presenting testimony before your subcommittee in the near future so that we can clarify and correct information GAO has presented to you and your colleagues.

Sincerely yours,

Jesse Brown

JB:vz

cc: The Honorable Edolphus Towns
Mr. David P. Baine

OVERSIGHT OF THE DEPARTMENT OF EDUCATION: MISSION, MANAGEMENT, AND PERFORMANCE

THURSDAY, MARCH 20, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Snowbarger, Towns, and Kucinich.

Staff present: Lawrence J. Halloran, staff director and counsel; Doris F. Jacobs, associate counsel; Robert Newman, professional staff member; R. Jared Carpenter, clerk; Ronald Stroman, minority professional staff member; and Ellen Rayner, minority chief clerk.

Mr. SHAYS. I would like to call this hearing to order, and welcome our witnesses and our guests.

According to the President's 1998 budget, the Federal Government plays a crucial, if limited, role in providing education for a lifetime, from pre-school to adult career training. Leading that effort, the Department of Education will spend $32 billion next year on programs touching almost every aspect of American learning, from helping States teach disadvantaged elementary school students to providing college tuition assistance.

Our witnesses today will help the subcommittee understand how well the Department of Education meets its crucial mission, and how well the Department limits its role in deference to the primary responsibility of State and local educators. Both are important measures of the Department's performance.

Last year, both the Inspector General and the General Accounting Office told the subcommittee of serious problems with the Department's management and oversight of student aid programs. Of particular concern was virtually unregulated access to Federal tuition funds by private, for-profit institutions, or proprietary schools, without regard to the quality of their programs. Again this year GAO, the General Accounting Office, concluded complicated procedures, flawed structures, and weak management of student aid programs pose a high risk of waste and abuse of Federal funds.

Today, the IG and GAO will review what progress has been made, and what problems remain, in the effort to maximize the ef-

fectiveness and maintain the integrity of Federal tuition assistance programs.

Our second panel will comment on the Department's performance as an intergovernmental partner with the States, counties, cities, towns, and villages in the crucial task of educating Americans, young and old.

This is a very interesting hearing for us. We appreciate the witnesses who will appear before us, and at this time I would like to invite vice chairman of the subcommittee, Vince Snowbarger, if he has any comments.

Mr. SNOWBARGER. I will pass, Mr. Chairman. Thank you.

Mr. SHAYS. Thank you.

We have two panels. Our first panel is Thomas R. Bloom, Inspector General of the Department of Education, accompanied by Steven McNamara, Assistant Inspector General for Audit and Dianne Van Riper, Assistant Inspector General for Investigations. We also have Ms. Cornelia Blanchette, Associate Director of Education and Employment Issues, U.S. General Accounting Office, accompanied by Eleanor Johnson, Assistant Director of Education and Employment Issues.

Would there be anyone else who might be responding to a question?

Ms. JOHNSON. Yes.

Mr. SHAYS. We have Harriet Ganson and Jay Eglin, if you both would stand as well when we swear witnesses. That way we won't have to swear you in later. We swear in all our witnesses, including Members of Congress, when they testify; so if you would stand we will administer the oath. Raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, all of our witnesses have responded in the affirmative. I guess we will start with Mr. Bloom. Is that the way you want to start?

What I want to do, we are going to turn on the light. It is 5 minutes and then we will leave the red on a little bit, and then we will turn the green on again just to give you a sense of how long you are talking. Your testimony is important so you should feel to give it as you choose.

I might at this time, even though the minority isn't here, but this is pretty standard practice, just do two housekeeping orders, I ask unanimous consent that all members of the subcommittee be permitted to place any opening statement in the record and that the record remain open for 3 days for that purpose, and without objection, so ordered.

I also ask further unanimous consent that all witnesses be permitted to include their written statements in the record. And without objection, so ordered.

So you can kind of ad-lib a bit if you want, but your full statement will be put in the record. Mr. Bloom.

STATEMENTS OF THOMAS R. BLOOM, INSPECTOR GENERAL, U.S. DEPARTMENT OF EDUCATION, ACCOMPANIED BY STEVE MCNAMARA, ASSISTANT INSPECTOR GENERAL FOR AUDIT; DIANNE VAN RIPER, ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS; AND CORNELIA M. BLANCHETTE, ASSOCIATE DIRECTOR, EDUCATION AND EMPLOYMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ELEANOR JOHNSON, ASSISTANT DIRECTOR, EDUCATION AND EMPLOYMENT ISSUES; HARRIET GANSON, ASSISTANT DIRECTOR; AND JAY EGLIN, ASSISTANT DIRECTOR

Mr. BLOOM. Thank you, Mr. Chairman, Mr. Snowbarger. I do have Steve McNamara, who is the Assistant Inspector General for Audits, and Dianne Van Riper, Assistant Inspector General for Investigations to help me answer some more detailed questions.

You have asked us to address management and programmatic issues at the Department of Education. We have submitted to you a quite lengthy written testimony that we would like submitted for the record. We believe we have highlighted a lot of important issues in that testimony. But I would like to take a few minutes to highlight three or four of those issues that we think are the most important.

The first issue would be I guess under the umbrella of systems and data integrity and personnel in the systems area.

In the area of student financial assistance programs, we really have many of the characteristics of a good commercial bank. We make a lot of loans or we guarantee a lot of loans. In fact, our portfolio each year increases about $40 billion, for a current total portfolio of about $110 billion that we either own through the direct loan program or guaranteed through the FFEL program, so we are very much like a bank.

As a former private sector bank consultant, I know a little bit about the banking industry, and banks are becoming more and more like technology companies. And the more—the better a bank is in technology in dealing with data and dealing with information, the more successful they are.

So I'd like to kind of draw an analogy. If the Department of Education in some instances is a lot like a bank and a successful bank is a good technology company, the Department of Education, to be the most efficient and effective, should have a lot of characteristics of a good technology company. We should have well-integrated, well-designed systems to provide timely, accurate, and complete data. And you need the people power to make that happen. And that would start with a strong chief information officer.

This will come as no surprise to anyone, but the Department has a long way to go before they would be recognized as an outstanding technology company. And we believe there is a lot of effort that needs to be put in that area. It is a formidable task, though.

I was reading an article just a couple of weeks ago that said in the Washington, DC, area there is a shortage of over 18,000 technical people, systems people. There is a huge shortage in the Washington, DC, area, and being in the Government sector, that shortage is probably even more acute.

So it is a formidable task that the Department has to get us up to strength in the human resource effort but one that we really

need to have a concerted effort to make sure that we have the best technology people that we could possibly have. So systems is a very important area, and we spend a lot of time in our written testimony talking about the importance of that.

The last time I was here, you may recall, I addressed the vocational school situation, and I just want to highlight two things I highlighted last time. One is we believe that differentiation should be made between the way that trade schools, non-degree granting schools are regulated and the way a 4-year institution is regulated, and we just wanted to emphasize that again. We also want to emphasize the fact that we believe that non-degree granting programs need to have performance measures. We believe that there ought to be regulated performance measures.

We have emphasized what we call the 70/70 where we believe at least 70 percent of the folks that start a trade school should graduate and 70 percent of those ought to have jobs. And I think those ought to graduate with jobs, and we believe those ought to be the minimum standards, and you have heard us talk about that before.

Another important area has to do with a report that we have issued very recently. It has to do with matching income levels on the applications for student financial aid to what people put on their tax returns and the information that the IRS has. Currently, we do not and cannot verify the student loan application information with the IRS.

We did do an aggregate audit within the last year and we found that in 4 percent of the instances, there was an understatement of income if you compared what the IRS has and what is on the application. In 4 percent of the cases our students said their income was less than what they reported to the IRS. And I am a strong believer in privacy. I am a CPA and a strong believer in income privacy. But I do believe that if you are getting Federal money, that the Department, with all the safeguards that are necessary, ought to be able to match an individual's adjusted gross income on their tax return to what was submitted in application.

The law here, I guess, is fairly complicated, but I believe there probably needs to be a legislative fix to get the IRS on top of that.

The last thing I want to mention is the year 2000 problem. You have probably heard others talk about it. I don't think the Department of Education is in any worse shape than any of the private sector companies or the other Government Departments, but it is important. It is something we need to focus on. It is something that the Department needs to focus on and it is something that we will be keeping our eyes on. Those are my comments for the oral testimony.

Mr. SHAYS. Thank you very much.

[The prepared statement of Mr. Bloom follows:]

Thomas R. Bloom
Inspector General
U.S. Department of Education

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to testify about management and programmatic issues at the Department of Education and areas of fraud, waste and abuse we have identified in the Department's programs and operations.

My testimony today will focus on the Student Financial Assistance Programs (SFA programs), that is, the loan and grant programs under Title IV of the Higher Education Act (HEA). As this Subcommittee is well aware from previous hearings as well as Office of Inspector General (OIG) and General Accounting Office (GAO) reports, these programs have consistently been identified as high-risk and the most vulnerable to fraud, waste and abuse. I will highlight three broad risk areas and the following specific issues:

I. Management Information and Delivery Systems

- Lack of Integration
- Data Integrity Problems
- Insufficient Managerial and Technical Skills
- NSLDS Cost Overruns
- The "Year 2000 Problem"

II. Management and Programmatic Issues

- Management of the Two SFA Loan Programs
- Need for Measurable Performance Standards
- Consolidation of Defaulted Loans
- Reconciliation Process in the Direct Loan Program
- Monitoring and Oversight of Schools
- Implementation of 1992 HEA Amendments
- The Departmental Financial Statement Audit
- Compliance with the Government Performance and Results Act

III. Areas of Fraud, Waste and Abuse

- Need for Income Verification Using IRS Data
- Due Diligence Fraud by Lenders
- Failure by Schools to Pay Refunds of Grants and Loans
- Screening for Prior Defaulters
- Improper Claims by Guaranty Agencies
- Impact of Ability-to-Benefit Students on School Default Rates
- Professional Judgment Fraud and Abuse
- Pell Eligibility for High-Default Schools

I. Management Information and Delivery Systems

The Department oversees the delivery of approximately $40 billion per year in student financial aid and a total $120 billion portfolio through the use of "stovepipe" information and delivery systems which cost roughly $300 million per year to operate. These systems are not integrated, do not share a common

systems architecture, and do not provide the timely, accurate and complete data needed to manage effectively the SFA programs and a portfolio of this size. The Department has a number of major improvement initiatives underway to address these problems, but at present it has neither a permanent Chief Information Officer nor a final information resources management strategic plan to provide direction and a cohesive strategy. In addition, we do not believe the Department has a sufficient number of the type and caliber of information systems personnel necessary to complete successfully an undertaking of this magnitude and be ready to operate effectively in the future.

The OIG, GAO, and the Advisory Committee on Student Financial Assistance have all reported on many aspects of these systems problems. Congress has long had concerns in this area; indeed, the HEA itself directs the Department to integrate the National Student Loan Data System (NSLDS) with the Pell Grant databases by January 1, 1994, a deadline which the Department has not met. Legislative accountability initiatives, in particular the Chief Financial Officers Act (CFO Act), the Government Performance and Results Act (GPRA), and the Clinger-Cohen Act, clearly emphasize the need for effective information systems.

Other federal agencies have inadequate information systems and have made costly mistakes in attempting to develop and modernize them. This should serve as a caution to the Department. GAO's high-risk series report on information,

management and technology contained recommendations for mitigating risks associated with investment control, system development and technical infrastructure which provide important lessons for the Department and other agencies developing large information systems.

I have designated oversight of SFA program systems development and operations to be one of the OIG's highest priorities and an area where we will concentrate significant resources. I have created a systems audit group to provide oversight of our efforts to review the Department's systems development and implementation. Given the highly complex nature of the systems problems, we are in the process of engaging contractors with the necessary expertise to assist OIG.

Let me summarize some of the information systems-related issues on which we intend to focus attention.

Lack of Integration -- The Department's Office of Postsecondary Education (OPE) currently uses 12 major program delivery and information systems to operate the SFA programs. Additionally, SFA systems interact with the Department's financial management systems which control budget execution, record financial transactions, and manage payments. These program and financial management systems are operated by a multitude of contractors, on a variety of different platforms, using different software. This fragmented data information system

simply is not cost effective or capable of providing the quality of data required to manage the large and complex SFA programs and portfolio. Specific examples of the resulting inefficiencies include:

- Institutions must report data to multiple systems, often in different formats;
- Systems track institutions using different identification numbers;
- Institutions must interact with different contractors running the different systems;
- Systems maintain redundant data, increasing the storage cost and risk of data inconsistencies; and
- "Stovepipe" systems do not provide adequate management information across programs.

It is vital for the Department to develop integrated information systems to allow it to operate effectively and monitor the SFA programs in the next century. This is an area in which significant cost savings can be realized in the long run if timely, smart and forward-thinking decisions are made now about systems design.

The Department's proposed solution for integrating the SFA programs is a project called "Easy Access for Students and Institutions" or " EASI." At this time, the project is at the conceptual stage of developing the architecture that would be necessary for a completely integrated SFA delivery and information system. While I support the intent of Project EASI, I must concur with GAO's recent assessment that "Project EASI has had a tentative start" and that it "is a long-term

undertaking" that will not solve the integration problem anytime soon. We believe its successful development and implementation will require a dedicated senior level project manager and technically proficient staff.

Data Integrity of NSLDS and PEPS -- Two crucial databases for the SFA programs are unreliable: the NSLDS and the Postsecondary Education Participants System (PEPS). NSLDS contains information on loan data, and PEPS was designed to contain all information on schools participating in the SFA programs.

We have long known and reported that the Federal Family Education Loan program (FFELP) loan status information received by the Department from guaranty agencies is in many instances inaccurate, and remains so when incorporated into the NSLDS, thereby rendering that database unreliable. In 1996, we reported that the guaranty agencies' overstatement of the number of FFELP loans in repayment remained in the NSLDS and that there was evidence of loans in an open status with zero balances. We recommended that the Department require guaranty agencies to reconcile loan level data on a monthly basis with the lenders. We also recommended that the Department add an edit check to reject loans with an incorrect status, quantify the rejected loans and require the guaranty agencies to correct the information. The Department has not implemented our recommendations. However, the Department did initiate a major data integrity project in December 1996 which entails visiting guaranty agencies and reconciling

their databases to NSLDS. We are currently conducting an audit to determine the reasons for inaccurate data in the NSLDS.

The independent auditors of the Department's financial statements, Price Waterhouse, whose work OIG oversaw, corroborated OIG's findings about NSLDS data inaccuracy. Because of questions about the accuracy of the NSLDS data on FFELP loans received from the guaranty agencies, Price Waterhouse was unable to render an opinion as to whether the Department's loan loss liability estimates for fiscal year 1995 were materially correct. For fiscal year 1996, Price Waterhouse is working with the Department and the guaranty agencies to obtain the necessary information.

Inaccurate loan data limits the Department's ability to use its database to determine the reasonableness of FFELP lender billings for interest and special allowance and may result in the overpayment of loan reinsurance to guaranty agencies. It also impairs the Department's ability to monitor borrowers. While I cannot quantify the excess cost of these inefficiencies precisely, we have reason to believe that it is substantial. For example, in 1993 we reported that the California Student Aid Commission (CSAC), the California state guaranty agency, had overstated its loans in repayment by about $1.5 billion. As a result, CSAC received $16.4 million in excess reinsurance payments in one year because it claimed more reinsurance payments than it was entitled to receive.

PEPS was designed and established several years ago to replace the Institutional Data System (IDS), which we reported in 1989 was inadequate. However, the Department has continued to operate two parallel systems, both of which are insufficient. Current work has shown that PEPS suffers from the same problems that plagued the IDS. To compensate, the Department has established additional subsystems, which not only creates additional expense but is inconsistent with the push for systems integration.

Technically Qualified Management and Staff -- The Department is at a critical juncture in information systems development and needs experienced senior management and personnel who have a high level of technical expertise. We are concerned about whether the Department is currently prepared to meet this challenge, particularly in light of fact that the position of Chief Information Officer recently became vacant. The Department's information resources management strategic plan was issued in draft in April 1996, prior to the appointment of the previous acting Chief Information Officer. Efforts were begun to update it under the previous acting Chief Information Officer, but have not yet been completed. The right decisions must be made now about systems design in order to have the systems necessary to run these financial programs effectively and efficiently and avoid unnecessary costs.

In our June 1996 Management Report concerning OPE, we reported that OPE had a shortage of qualified technical staff. We realize it is difficult to find highly qualified personnel with sufficient technical expertise in a very competitive job market where the Department is competing with the private sector (where such persons can command higher compensation) and other federal agencies. However, obtaining and maintaining this highly skilled staff is imperative if the Department is to be successful in running their financial programs.

To the Department's credit, it is attempting to upgrade its staff capabilities in the area of computer technology. In August 1996, the Department hired a new director of OPE's Program Systems Service who has extensive experience in information systems. However, the vacant Chief Information Officer position remains to be filled with an experienced information systems manager with the authority to ensure that future information technology investments are consistent with a rational, cost-effective, department-wide information and delivery systems architecture.

NSLDS Cost Overruns -- I have already noted the need for the Department to upgrade and integrate the NSLDS system. In attempting to do so, the Department has incurred significant cost overruns in the operation of the NSLDS, attributed by the Department to inaccurate estimates of usage costs. We will be addressing the issue in the near future and we will be paying particular attention to the contracting

process for the recompetition of the NSLDS. We will look at the reasonableness of cost and the extent to which the system is integrated with the many other computer systems the Department uses for the SFA programs.

Preparation for Year 2000 -- GAO recently added the "Year 2000 Problem" to its list of government-wide high-risk issues. The two-digit format used by most computer systems to record dates will cause problems in the year 2000, because many computer systems will assume that the "00" date represents 1900 rather than 2000. The problem could result in erroneous data or system crashes throughout government. The Department has much work to accomplish in the next three years to ensure that its information systems will not be negatively impacted by this Year 2000 problem. The Department is in the process of identifying the systems that are susceptible to the problem and determining the steps to make the necessary corrections. Because this project is so vital to the Department's ability to function after the year 2000, my office will closely monitor its progress.

II. Management and Programmatic Issues

The Department's management of the SFA programs has commanded considerable scrutiny over the years from OIG, GAO and Congress. Most notably, the Senate Permanent Subcommittee on Investigations held a series of hearings

from 1990 through 1995, highlighting fraud, waste, abuse and mismanagement in the SFA programs. Since 1988 the OIG has devoted the majority of our resources to the SFA programs, focusing on the management and programmatic issues that allowed the problems to continue.

The problems in the SFA programs have stemmed from the basic structural design of the programs and the lack of specificity in the authorizing statute, poor design and operations of the SFA delivery systems, and inadequate gatekeeping, monitoring and oversight of program participants. These longstanding management and programmatic problems are the basis for the high-risk designation of the SFA programs by the GAO, with which I concur.

Management of the Two SFA Loan Programs -- In July 1994, the Department successfully phased in the new Federal Direct Loan Program (FDLP) in less than a year, a formidable challenge for any organization. In 1996, at the request of a Subcommittee of the House Economic and Educational Opportunities Committee (since renamed the House Education and the Workforce Committee), OIG completed a management review assessing whether the separate management structure established within OPE to launch and administer the FDLP separate from the FFELP was efficient.

We concluded that in order to implement the FDLP expeditiously, the Department acted reasonably by establishing a dedicated task force, which was successful in implementing the FDLP within the strict statutory timeframes. However, we also concluded that the manner in which the FDLP was implemented resulted in: inefficiencies; strained working relations; poor communication and cooperation; inappropriate alignment of functional units between FDLP and FFELP; and a delay in the development of the strategic plan for the SFA programs. As we recommended, the Department has reintegrated the loan programs' staffs.

Our review also identified a lack of qualified staff in the Program Systems Service which is responsible for the SFA contract administration. Given the amount of systems contracting involved in the administration of the SFA programs and the magnitude of current contracting activities, the absence of technically proficient staff in this area poses a significant risk to the Department. A Subcommittee of the House Committee on Education and the Workplace has expressed concern about the Department's contracting process. I share their concerns and accordingly, have included in the OIG 1997-98 audit workplan several audits in this critical area.

The Need for Measurable Performance Standards -- I testified before this Subcommittee in June 1996 that OIG audits and investigations of non-degree-granting, vocational trade schools have demonstrated the inadequacy of accrediting

agencies to assure the quality of training at those schools that participate in the SFA programs. Since I strongly believe that what you measure is what you get, I recommended to you that Congress legislate numerical, absolute and verifiable standards which those schools would have to meet in order to be eligible to participate in the SFA programs. Student outcomes are critical performance standards to measure the success of trade schools, and completion and job placements are the most important. The HEA itself defines such schools as institutions that prepare students for "gainful employment in a recognized occupation."

One OIG investigation revealed that at two related cosmetology schools in Chicago over a two-year period, it cost taxpayers approximately $485,000 in SFA program funds for each of eight state cosmetology licenses, because so few students completed the program relative to the large numbers for whom the school received Pell Grants. Although this is not the norm, it is also not an isolated example. I submit that had there been performance standards for vocational trade schools that included completion and job placement, this waste of federal funds would in all likelihood not have occurred.

In response to an OIG audit report on accrediting agencies' shortcomings in developing and implementing student outcome standards, the Department has taken the position that performance standards for schools need not necessarily be

measurable and may serve only as goals and not as absolute bases for achieving or maintaining accreditation.

In addition, the Department rejected our recommendation to collect and compile performance data on institutions in the SFA programs from accrediting agencies. We strongly believe that these data are critical to measure the outcomes of the SFA programs and that the Department would significantly enhance its ability to comply with GPRA by collecting this information.

We continue to believe that accrediting agencies are inadequate gatekeepers for assuring the quality of participating vocational trade schools. A recent OIG audit of the accrediting agency process revealed that on-site reviews conducted by six accrediting agencies were infrequent, typically occurring only every 4 to 9 years, and lasted only several days. We believe more frequent on-site visits are necessary. We also recommended that the Department ensure that accrediting agencies are notified of serious deficiencies disclosed in program reviews, audits, and other oversight activities, to allow them to better target their high-risk reviews.

Congress has mandated completion and job placement performance standards before. With respect to short-term programs of less than 600 clock hours, a school must have a verified 70-percent completion and placement rates in order to continue to receive SFA program funds. Even this is a modest standard,

because it requires that only 49 percent (less than one of every two) of students enrolled in vocational training get a job in the field for which they are trained. We believe that Congress should seriously consider a similar provision as a gatekeeping mechanism for all non-degree-granting, vocational schools in the upcoming HEA reauthorization.

Consolidation of Defaulted FFELP Loans Into the FDLP -- Last year we issued an audit report on the consolidation of defaulted loans held by the Department into the FDLP. We questioned the cost effectiveness of consolidating these defaulted loans, due to the up-front cost to consolidate ($38 million for an estimated 80,000 defaulted borrowers), the loss of revenues under available collection methods, the unlikely prospect of sufficient payments under FDLP consolidation repayment options, and the likelihood of re-defaults. We also questioned why the Department would consolidate these loans under FDLP when they had available an income-contingent repayment option for defaulted FFELP loans held by the Department. We recommended that the Department stop actively pursuing such consolidations pending a study to demonstrate the cost effectiveness of the process. The Department agreed to the study.

Another potential issue relating to income contingent repayment is the potential for masking default rates of FFELP schools whose students take advantage of the opportunity to consolidate their defaulted FFELP loans into a new

FDLP loan. Such a loan would not be counted as a defaulted loan for purposes of the school's cohort default rate under current regulations. We will be looking at this issue.

Reconciliation Process in the FDLP -- Over the last year, we have audited sixteen FDLP schools as part of our review of that new loan program. Overall, we did not find any material cash management problems in the FDLP at these schools. However, nine of the sixteen schools experienced problems with the reconciliation process. Reconciliation is extremely critical to ensuring that loan transactions reported by schools are accounted for completely and accurately. OIG has informed the Department of some of our concerns about FDLP reconciliation. Specifically, we suggested that the Department:

- reconcile specific advances with detail disbursement transactions and excess cash activity reported by the school, and
- provide adequate assurance that individual loan balances reflected in the Department's database are accurate.

We are aware that modifications will be made to the reconciliation process to provide the school with a student's net loan balance according to the Department's data each time any disbursements, adjustments or cancellations are reported on a loan. However, this process places complete reliance on the schools to determine whether loan balances reflected in the Department's database are identical to those

on their internal student accounting records. This is insufficient to assure the accuracy of data in the Department's database.

Monitoring and Oversight of Schools -- In December 1993, we issued a performance audit report on the effectiveness of the Department's monitoring and oversight of institutions participating in the SFA programs. We recommended changes to the mission, structure, hiring and training practices; better targeting of reviews; establishment of performance standards; enhanced computer utilization; and establishment of reporting standards that together will increase the return on the Department's limited resources.

The Department has initiated a major effort to overhaul and redesign the institutional program review function, known as the "Institutional Participation and Oversight Service (IPOS) challenge." The Department's plans include a case management approach for its oversight of schools by both field and headquarters staff. A cornerstone of the effort is a risk analysis, still under development, to target schools for review. The risk model is scheduled to be pilot tested in April of this year. While we are supportive of this effort, we have several concerns. First, as I noted above with regard to SFA program systems problems, the data from the information systems being used to determine which schools are high-risk is incomplete and in some cases inaccurate. Second, we question whether adequate resources are now being devoted to effective monitoring of schools while the IPOS

challenge is in the development stage. We are concerned that IPOS has a number of other priorities that are competing with program reviews for the staff resources available. These include recertification of schools (discussed below) and tracking the independent audits submitted by schools. We will be evaluating the IPOS operations in the coming months.

Implementation of 1992 HEA Amendments -- As previously discussed, the HEA amendments provided the Department a number of new enforcement authorities to limit the participation of questionable schools in the SFA programs. These authorities include: the requirement that all schools be recertified within five years of the Act; provisional certification of marginal schools for up to three years; a 50-percent limitation on the percentage of ability-to-benefit students; and the "85/15 rule" which requires proprietary schools to obtain at least 15 percent of their revenue from non-Title IV sources.

Last year we reported that the Department could not complete all recertifications within the statutory timeframe, and that some schools were recertified that did not meet the standards for full certification. The Department has still not completed all the recertifications, but has enlisted the assistance of the field review staff. However, we still question the thoroughness of these recertifications, because as of June 1996, some schools that we believe should have been terminated were provisionally certified. Ongoing work also has shown

the number of schools provisionally certified is rapidly increasing. Provisionally certified schools are supposed to get a higher level of scrutiny from the Department. We question whether this is the case with the limited Departmental review resources.

We have also noted that the Department has provided inconsistent guidance for implementation of the "85/15 rule," and its monitoring system, consisting essentially of self reporting, is not adequate to assure that schools falling below the 15 percent level in non-Title IV revenues are removed. We also question the effectiveness of the Department's implementation of the 50 percent limit on ability-to-benefit students. The Department has been unable to provide us data on the number of schools that have been removed from the SFA programs as a result of these new requirements, and our own preliminary conclusion from ongoing work reflects that only a few schools have been removed from the programs based upon these new requirements. Since thousands of schools participate in the SFA programs, this appears to us to be unreasonably low.

Lessons Learned from Department's Financial Statement Audit -- The Department issued the Annual Accountability Report for Fiscal Year 1995 in September 1996. This marked the first year an independent audit was conducted of consolidated Department-wide financial statements. The Department prepared

these consolidated statements one year earlier than required by the Government Management Reform Act 1994 (the successor to the CFO Act).

The results of the audit confirmed our previous work; many of the control weaknesses identified by the auditors related to the SFA programs, and they are discussed throughout this testimony. In summary, the auditors concluded that the loan-loss liability estimate reported in the Department's consolidated financial statements for the FFELP could not be supported by sufficient and reliable accounting information. For this reason, the auditors were unable to express an opinion on the consolidated financial statements.

Government Performance and Results Act (GPRA) -- The Department has made good progress thus far in implementing the requirements of the GPRA. Indeed, the Department was ahead of schedule in producing its strategic plan, which is not due until September 1997. OIG was involved in the development of the first version of the strategic plan. The Department is currently in the process of revising the plan, and has a tracking system in place to measure its progress on implementing the plan.

The GPRA requires performance plans for each program administered by the Department, and the Department just recently submitted to the House and Senate Appropriations Committees draft performance plans for seventeen of its largest

programs, including the SFA loan and grant programs. We are initiating a review of the Department's proposed indicators of performance.

I have already discussed OIG's recommendations concerning the need for statutory performance standards that are numerical and absolute as a gatekeeping mechanism for short-term trade schools that participate in the SFA programs. We believe this would be consistent with the principles of the GPRA. We are concerned that the Department has rejected our recommendation that it collect data from accrediting agencies on student outcomes, because we believe, as I have already discussed, that this is very important for GPRA purposes.

III. Areas of Fraud, Waste and Abuse

The third broad category I will address is fraud, waste and abuse issues relating to the SFA programs, and I will highlight some of the most important.

IRS Match -- Based upon our match of IRS tax returns with student loan applications for over two million students who were awarded Pell Grants, we found that for award year 1995-96, at least 102,000 students were over-awarded a total of approximately $109 million in Pell Grants. These students failed to report or under-reported their income on the student aid application. On January 29, 1997,

we issued our audit report recommending the Department be permitted to verify the income reported by students on the student aid application with the IRS.

Due Diligence Fraud by Lenders in Loan Servicing Current law and regulations require that lenders perform certain specified activities (known as "due diligence") in order to collect on federally insured loans as a prerequisite to being reimbursed by the guaranty agencies for defaults. The current system compensates lenders based upon their performance of due diligence activity, and not based upon their success in collecting. We have found a pattern of lenders who fail to conduct the mandated due diligence activities and then falsify documentation to reflect that they have met the due diligence requirements. In just two such cases, the fraudulent claims for reinsurance amounted to almost $40 million. We believe that some other outcome-based method of compensation for lenders should be considered.

Failure To Pay Refunds -- Based primarily upon our on-going investigations, OIG continues to believe that failure on the part of schools to make required refunds of SFA program funds (both loans and grants) when students fail to enroll or withdraw to be a significant abuse in the SFA programs. It is also one that is very hard to fix at the back-end, because we have found it difficult to recoup money from school owners for their failure to pay refunds, and even when we do, it is difficult to obtain redress for victimized students. For example, in one California

case, a federal jury recently found a former school owner guilty of a number of crimes in connection with his failure to pay at least $6.3 million in refunds. However, we also found that he had no unencumbered assets to attach or seize, and students on whose behalf loan refunds were not made remain liable for those loans plus interest.

Administrative back-end fixes have also proved ineffective. If a school is terminated for failure to pay refunds, it has little or no incentive to pay past liabilities. The Department is limited in its ability to collect from corporate owners. We have also seen a number of instances where schools with refund liabilities were allowed to remain in the SFA programs based on a promise to repay over a long period of time and without interest; this almost invariably resulted in eventual closure of the school without the refunds being paid and additional students being victimized.

A related management problem is that the Department has no data on refund liabilities of schools. Therefore, we cannot quantify with any degree of certainty the magnitude of the problem, and the Department cannot take administrative action in a timely manner.

We have therefore recommended at every available opportunity since 1992 to the Department and to Congress in testimony (including before this

Subcommittee in 1995) another more pro-active fix. School owners should be required to report and certify their refund liabilities on at least an annual basis so that the Department can identify schools that are delinquent and the extent of the liabilities. This would allow the Department to initiate timely corrective actions, and it is would contribute important data to the risk analysis model under development in connection with the IPOS challenge described above. In addition, OIG would be able to use this certification for criminal or civil fraud prosecution purposes. We recently repeated the recommendation in a memorandum to the Assistant Secretary for Postsecondary Education and asked for an action plan; we have received no response. Accordingly, I plan to recommend again to Congress that the HEA be amended to include this requirement.

Screening for Prior Defaulters -- As a result of our 1992 audit report identifying weakness in the screening of student applications for SFA program funds, the Department implemented an edit check for prior defaulters which now matches the student data at the Central Processor with the NSLDS default data and flags for school financial aid administrators those applications by prior defaulters. We estimated that this edit procedure could save the Department and the taxpayers $800,000 a day in ineligible funds being disbursed to previous defaulters.

However, these savings depend on the financial aid administrators taking appropriate action with respect to the flagged applications. Our preliminary results in an on-going audit reflect that some financial aid administrators are ignoring the default flag and awarding aid, thus circumventing the controls and making ineligible awards. We will be performing additional audit work to determine the extent of the problem and make recommendations for corrective action.

Improper Claims by Guaranty Agencies -- We continue to find that guaranty agencies are retaining excessive amounts from payoffs on the consolidation of defaulted loans by improperly reporting the consolidations to the Department as collections on defaulted loans. Guaranty agencies are allowed to retain 18.5 percent on consolidations to cover their expenses, but are allowed to retain 27 percent on collections. We issued audit reports on six guaranty agencies that recommended the refund of over $4 million of improperly retained funds.

We first identified this problem in 1994, and issued an SFA Action Memorandum to the Department in February 1994. We recommended that the Department issue guidance to the guaranty agencies to stop the incorrect reporting and retention of funds, and to identify and recoup the amount of excess consolidation loan payments retained by the guaranty agencies. The Department quickly responded by publishing guidance in March 1994, but it appears that some

guaranty agencies have ignored the guidance, and the Department has not acted effectively to assure that the abuse is corrected.

Impact of Ability-to-Benefit Students on School Default Rates -- We long ago identified abuse in connection with the award of student aid to students without a high school diploma or GED certificate on the basis that they had the "ability to benefit" from the training offered. This is particularly true in the short-term trade schools which typically have a large percentage of such students. In the 1992 HEA Reauthorization Act, Congress responded by placing a limit of 50 percent on a school's total enrollment of such students.

We recently completed a study on the relationship between the level of ability-to-benefit students and the student loan default and graduation rates for a sample of proprietary and vocational schools. The data demonstrate that schools that admit ability-to-benefit students place SFA program funds at a greater risk than schools that do not admit such students. We suggested that the Congress and the Department consider statutory changes to further reduce the number of ability-to-benefit students or eliminate them from eligibility for SFA program funds. We also suggested alternatives to safeguard the SFA program funds if the current 50-percent limit remains in place, such as limiting the amount of SFA program funds to schools that admit high percentages of ability-to-benefit students.

Professional Judgment -- We recently completed our audit field work on abuse of professional judgment by school financial aid administrators to override or change processed applicant data to determine the appropriate Pell Grant awards. We concluded that abuse of professional judgment at the 19 schools we reviewed resulted in at least $775,000 in Pell Grant over-awards. In addition, an OIG investigation of a Maryland vocational trade school found evidence of widespread fraud consisting of false documentation of professional judgment decisions which resulted in inflated student aid awards of at least $600,000. Our audit will recommend reforms to the statutory needs analysis process and more focused monitoring by the Department of schools at which the use of professional judgment exceeds the norm.

Pell Eligibility for High-Default Schools -- In the Appropriations Act for FY 1997, Congress included a prohibition on the participation in the Pell Grant program of those schools that were removed from the loan programs for high default rates. We are currently studying the impact of this provision, but based upon our experience with proprietary trade schools, we believe it is a good anti-fraud, waste, and abuse measure and should be incorporated into the HEA during the upcoming reauthorization so that it will have effect for more than one year at a time.

We have seen several costly cases where schools removed from the loan programs drove up their Pell Grant receipts by using fraudulent or abusive practices.

For example, at the IADE schools in California, which were the subject of congressional hearings, the owners and financial aid director engaged in a scheme to retain Pell Grant monies for no-show students after losing their eligibility for loans. IADE's owners and officers are alleged to have defrauded the government of over $1 million for the period covered by the indictment. OIG's investigation recently resulted in an indictment of one of the owners and the financial aid director.

Another OIG investigation in Chicago resulted in an indictment of owners of a beauty school chain which, after being restricted in its use of loans and ultimately being removed from participating in the loan program for high default rates, substantially increased its Pell receipts by aggressive recruitment tactics of unlikely cosmetology student, by substantially and arbitrarily increasing the up-front equipment charge, and drawing down and retaining Pell Grants for no-show students. For the two-year period covered by the indictment, it is alleged that the school owners defrauded the government of at least $1.3 million.

This concludes my remarks. I will be happy to answer any questions you may have.

Mr. SHAYS. Ms. Blanchette.

Ms. BLANCHETTE. We are pleased to be here today to discuss challenges the Department of Education faces in carrying out its mission.

To begin, I'd like to focus your attention on two charts that we have brought to set the context for our comments.

Mr. SHAYS. Can you hold on 1 second? Might I interrupt your statement, I am deciding whether we quickly vote now. We have 10 minutes. Is your statement about 10 minutes?

Ms. BLANCHETTE. It is shorter than 10 minutes.

The SHAYS. Then we will hear you out and go vote.

Ms. BLANCHETTE. As shown in the first chart to my right, more than $500 billion a year is spent on education in the United States, with the Department and other Federal agencies contributing about 9 percent of the total. The 9 percent does not include Federal student financial aid. That aid is in the "all other" category.

The importance of education to the well-being of the Nation is reflected in the second chart to my right. It shows the link between education and employment. The higher the level of education, the lower the unemployment rate.

This morning I will discuss two major challenges the Department faces in striving to achieve its mission. First, ensuring access to postsecondary institutions while protecting the financial interests of the Federal Government; and second, promoting access to and excellence in elementary, secondary, and adult education. My discussion is based on work we have done over several years.

The postsecondary student aid programs make available billions of dollars in loans and grants to promote access. However, access is becoming more and more problematic, particularly for low-income students as the cost of attending college increases.

For example, a public college education has become less affordable in the last 15 years, a period during which tuition has risen nearly three times as fast as household income. Students and their families have responded to this affordability gap by drawing more heavily on their own resources and greatly increasing their borrowing.

A growing proportion of Federal student aid for postsecondary education has been through loans rather than grants. Policymakers have expressed concern that this trend in financial aid patterns has diminished college access for low-income students. Work we have done on the relative effectiveness of grants and loans in helping students stay in college until graduation indicates that this concern may be valid.

While the Department's student aid programs have provided millions of students access to postsecondary education, the Department has been less successful in protecting the financial interest of U.S. taxpayers. Student aid programs still suffer from complex processes, structural limitations, and management weaknesses. In fiscal year 1996, for example, while the Department made more than $40 billion available in student aid, the Federal Government paid out over $2.5 billion to make good its guarantee on defaulted student loans. Student aid programs have many participants and each program has its own complicated, cumbersome processes. Further, with both the FFEL and direct loan programs, the Depart-

ment has two programs that are similar in purpose but operate differently.

Structural limitations are twofold. First, the Federal Government bears almost all the risk for loan losses, and, second, the loan programs now have more high-risk students who are from low-income families who attend proprietary schools than in the past. While both circumstances increase access, they also jeopardize the Federal investment.

Management weaknesses include: (1), not adequately overseeing schools that participate in the program, thereby allowing extensive fraud, abuse, and mismanagement; (2), managing each program through a separate administrative instruct with poor or little communication among programs; and (3), using inadequate management information systems that contain unreliable data. Both the Congress and the Department have made changes that have likely resulted in some improvements; however, these changes have not been sufficient to resolve the Department's difficulties in managing the student aid programs.

In promoting access and excellence in elementary, secondary, and adult education programs, the Department provides over $11 billion. The challenge for the Department in this arena is ensuring that these programs are providing the intended outcomes. To do this, the Department must make sure the programs have clearly defined objectives and that it has complete, accurate, and timely information about the programs's operations. In some circumstances, the Department doesn't have these prerequisites.

The possible second challenge involves the proposed partnership to Rebuild America's Schools Act, which if enacted would be administered by the Department. If this proposed solution to the Nation's school facilities problem is enacted into law, the Department's challenge will be to ensure that the Department has qualified staff to administer the program and financial and information management systems to provide complete, accurate, and timely operational data.

To meet its challenges, the Department must adopt improved management practices, the Results Act, the expanded CFO Act, the Paperwork Reduction Act, and the Clinger-Cohen Act provide powerful tools in the form of a statutory framework for improving agency operations and accountability. The Department has made progress in implementing these laws but work remains to be done.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or any members of the subcommittee have.

Mr. SHAYS. Thank you.

[The prepared statement of Ms. Blanchette follows:]

Statement of Cornelia M. Blanchette, Associate Director
Education and Employment Issues
Health, Education, and Human Services Division

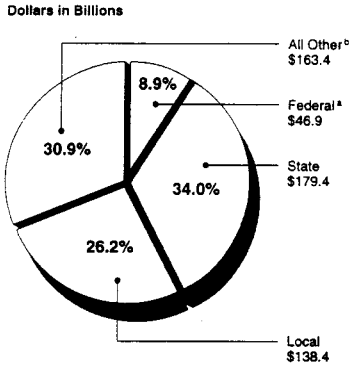
Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss several challenges the Department of Education faces in carrying out its mission in a cost-efficient and effective manner.

The Department was created in 1980 with a mission that involves two major kinds of institutions in which education is provided: (1) preschools and elementary and secondary schools and (2) postsecondary institutions. With a staff of about 4,600 in fiscal year 1997 and a budget of about $29 billion, the Department manages the federal investment in education and leads the nation's long-term effort to improve the quality of education. Specifically, the Department promotes access and equity in education, provides financial aid to postsecondary students, and develops information and provides research on best practices to improve the quality of education.

With the Department's support, education is a state responsibility under local control. As shown in figure 1, the nation spends more than $500 billion a year on education, with state, local, and private expenditures accounting for about 90 percent of this spending.

Figure 1: Total Expenditures for Education in U.S., 1995-96



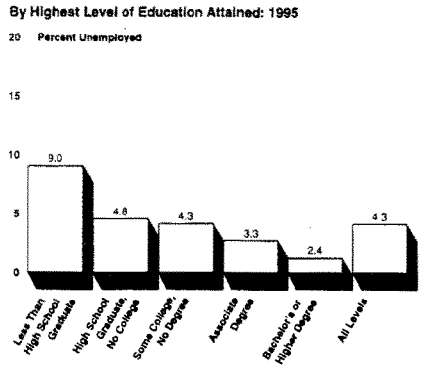
[a]Includes expenditures of all federal agencies.

[b]Federally supported student aid that goes to higher education institutions through students' tuition payments is shown under "All Other" rather than under "Federal." Such payments would add substantial amounts and several percentage points to the federal share.

Source: U.S. Department of Education.

Although the cornerstone of our nation's future is a sound educational system that meets the diverse needs of all Americans, some 2,000 students drop out of school each day, and large numbers of students graduate from school lacking the skills sought by employers. The strength of international competition has reinforced the link between education and employment, which is shown in figure 2.

Figure 2: Unemployment Rates of Persons 25 Years and Over by Highest Level of Education Attained, 1995



Source: U.S. Department of Education.

At the same time, the nation's school-age population has become increasingly poor, racially and ethnically diverse, and at risk of school failure. In addition, the Department has had a history of management problems. We identified significant operational deficiencies in our 1993 management review and our high-risk series[1] that affect the Department's ability to protect the financial interests of the government and to manage

[1]High-Risk Series: Guaranteed Student Loans (GAO/HR-93-2, Dec. 1992); High-Risk Series: Student Financial Aid (GAO/HR-95-10, Feb. 1995); and High-Risk Series: Student Financial Aid (GAO/HR-97-11, Feb. 1997).

itself efficiently and effectively. The current environment places considerable pressure on the Department to correct these deficiencies. The public is demanding more accountability from government agencies--more assurance that tax dollars are not being wasted and that government is operated in accordance with sound management practices.

Today, I would like to discuss two major challenges the Department faces in achieving its mission: first, ensuring access to postsecondary institutions, while at the same time protecting the financial interests of the government, and second, promoting access to and excellence in elementary, secondary, and adult education. In addition, I want to discuss how the Department's ability to meet these challenges could be enhanced by the improved management that the Congress envisioned in passing recent legislation. My discussion today is based on work we have done over several years.[2]

In summary, although the Department has made progress in ensuring access to postsecondary education and in providing financial accountability, challenges remain, especially in providing educational access to low-income and minority students in an era of rising tuition costs and in protecting the financial interests of the federal government. The student aid programs make available billions of dollars in loans and grants to promote access to education. But these programs continue to be hampered by problems with process complexity, structure, and program management. The student aid process is a complicated one--it has several participants who play different roles as well as various processes for each of the grant or loan programs. The federal government continues to bear a major portion of the risk for loan losses. Moreover, management shortcomings, especially inadequate management information systems that contain unreliable data, contribute to the Department's difficulties.

The Department also faces challenges in promoting access to and excellence in preschool, elementary, secondary, and adult education programs. Through leadership and leverage, the Department works with states and local education agencies to effect changes intended to improve the nation's educational system. Demonstrating accountability is dependent on having clearly defined objectives, valid assessment instruments, and accurate program data. However, in some instances, the Department does not have these prerequisites. For example, in our work on programs funded under the Adult Education Act, we found that the Department had difficult ensuring accountability for results, primarily because the program did not have clearly defined objectives. In addition, it is unclear whether the Department has the resources it needs to manage its funds, including funds for the proposed Partnership to Rebuild America's Schools Act of 1997 and for helping schools integrate technology into the curriculum to make students technologically literate. Similarly, the Department only has selected information on the implementation of the title 1 program, the largest single federal elementary and secondary grant program, for which $7.7 billion was appropriated in fiscal

[2]A list of related GAO products appears at the end of this testimony.

year 1997. Thus, the Department does not have the informational basis to determine whether mid-course changes are necessary.

In meeting these challenges, the Department will need to improve its management. Major pieces of recent legislation provide powerful tools in the form of a statutory framework for improving agency operations and accountability. These laws include (1) the 1993 Government Performance and Results Act (GPRA), which requires agencies to focus on results as they define their missions and desired outcomes, measure performance, and use that information to improve programs; (2) the expanded Chief Financial Officers (CFO) Act, which requires agencies to prepare financial statements that can pass the test of an independent audit; and provide reliable financial information; and (3) the 1995 Paperwork Reduction Act and the 1996 Clinger-Cohen Act, which are intended to help agencies better manage their information resources and make wiser investments in information technology. The Department has made progress in implementing these laws, but work remains to be done before the goal of improved management can be reached.

BACKGROUND

The Department of Education's basic functions are to provide financial resources, primarily through student loans and grants for higher education; provide research and information on best practices in education; and ensure that publicly funded schools and education programs observe civil rights laws.[3] It administers a variety of grant and contract programs that provide aid for disadvantaged children; aid for children and adults with disabilities; student loans and grants for higher education; vocational and adult education; and research and evaluation, as well as a variety of smaller programs, such as the gifted and talented education program.

According to its own data, the Department currently administers approximately 180 programs, including the federal student financial aid programs established under title IV of the Higher Education Act of 1965, as amended (HEA). These programs–the Federal Family Education Loan Program (FFELP), the Ford Direct Loan Program (FDLP), the Federal Pell Grant Program, the Federal Perkins Loan Program, and several smaller

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[3]The Department, through its Office for Civil Rights, is responsible for enforcing the following civil rights laws as they relate to schools at all levels: (1) title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, or national origin; (2) title IX of the Education Amendments of 1972, which prohibits discrimination on the basis of sex in education programs and activities; (3) section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability; (4) the Age Discrimination Act of 1975, which prohibits discrimination on the basis of age; and (5) title II of the Americans With Disabilities Act of 1990, which prohibits public entities from discriminating on the basis of disability.

financial aid programs–fund approximately 75 percent of all postsecondary student financial aid in the nation. The two largest elementary/secondary programs are title I of the Elementary and Secondary Education Act, which helps support the education of over 6 million disadvantaged children in more than 50,000 schools nationwide–about one-half of the nation's public schools–and special education programs that assist over 5 million children with disabilities from birth through age 21 in meeting their educational and developmental needs.

For fiscal year 1997, the Department has an estimated budget of $29.4 billion and is authorized 4,613 full-time-equivalent (FTE) staff-years. The administration's fiscal year 1998 budget request is for $39.5 billion and 4,560 FTE staff. This represents an increase of about $10 billion, $5 billion of which the administration wants to use to assist states in acquiring funds for school construction.

Although the federal share of total education expenditures is only about 9 percent, federal education spending leverages much more. For example, the fiscal year 1998 budget request of $12.7 billion for postsecondary student aid programs is expected to generate $47.2 billion for more than 8 million students. And $4 billion in federal appropriations for special education is expected to leverage about $50 billion in state and local funds.

ENSURING ACCESS TO POSTSECONDARY INSTITUTIONS WHILE PROTECTING FEDERAL FINANCIAL INTERESTS

Through its student aid programs, the Department has enabled millions of students to attend postsecondary educational institutions; however, the current economic conditions make continuing to ensure such access difficult. Rising tuition, coupled with the shift to providing loans instead of grants, could result in fewer low income and minority students' staying in college. At the same time the Department is concerned with access, its ongoing challenge is to improve its processes to ensure financial accountability in its postsecondary student aid programs, particularly FFELP, FDLP, and the Pell Grant Program. In 1990, we designated the student financial aid program one of 17 federal high-risk programs likely to cause the loss of substantial amounts of federal money because of their vulnerabilities to waste, fraud, abuse, and mismanagement. Although the Department has acted to correct many problems and improve program controls, significant vulnerabilities remain, and we have included the student financial aid program in our 1997 list of 25 high-risk programs.

Ensuring Equal Access Is Becoming More Difficult

The Department's success in meeting one of its major challenges–ensuring access to postsecondary institutions–is critical to the economic well-being of the nation's citizens. As shown in figure 2, level of education is closely linked to unemployment. In addition, level of education is a strong determinant of wage earnings. For example,

college graduates earn much more than those with only a high school education, and the differential has been increasing. According to Department data, in 1985 the median annual income of full-time male workers 25 years and over was $41,892 for college graduates and $26,609 for those with high school diplomas only, a difference of $15,283. By 1994, the difference between these two groups had grown to $21,191. Low-income and minority students have traditionally been underrepresented among college students, and access is becoming more and more problematic as the cost of attending college increases. For example, as we reported to the Congress in August 1996,[4] a public college education has become less affordable in the last 15 years as tuition has risen nearly three times as fast as household income. The average tuition for full-time in-state students increased from $804 per year to $2,689, or 234 percent, and median household income, from $17,710 to $32,264, or 82 percent. Students and their families have responded to this "affordability gap" by drawing more heavily on their own financial resources and increasing their borrowing. For example, the annual average student loan at 4-year public schools rose from $518 per full-time student in fiscal year 1980 to $2,417 in fiscal year 1995, an increase of 367 percent, which is almost five times the 74-percent increase in the cost of living–as measured by the consumer price index–for the same period. If this trend continues, rising tuition levels may deter many students from attending college.

The Department's primary mechanism for ensuring access to postsecondary institutions is the federal student financial aid programs--principally FFELP, FDLP, and the Pell Grant Program. While federal student financial aid has been substantial in the past, recent trends may inhibit broader college access. A growing proportion of federal aid has taken the form of loans rather than grants since the 1970s. For example, from 1977 to 1980, grant aid exceeded loan aid; since 1985, however, loan aid has been about triple the amount of grant aid. With federal grant aid declining in relative terms, students and their families have had to shoulder a greater share of college expenses. Many policymakers have expressed concern that this trend in college costs and in financial aid patterns, which increases students' net costs for higher education, has diminished college access–both entry and attendance through graduation–for low-income students.

Our work supports this belief with respect to attendance through graduation.[5] We concluded from our work that financial aid packages with relatively high grant levels may improve low-income students' access to higher education more than packages that rely more on loans. In addition, our analysis indicated that the sooner low-income students receive grant assistance, the more likely they are to stay in college. We found that grants were most effective in reducing low-income students' dropout probabilities in the first

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[4]Higher Education: Tuition Increasing Faster Than Household Income and Public Colleges' Costs (GAO/HEHS-96-154, Aug. 15, 1996).

[5]Higher Education: Restructuring Student Aid Could Reduce Low-Income Student Dropout Rate (GAO/HEHS-95-48, Mar. 23, 1995).

year. For these students, an additional $1,000 grant reduced the dropout probability by 23 percent. In the second year, the additional grant reduced dropout probability by 8 percent, while in the third year it had no statistically discernable effect. Therefore, we believe that restructuring federal grant programs to feature frontloading[6] could improve low-income students' dropout rates with little or no change in each student's overall 4-year allocation of grants and loans. We suggested that, if the Congress was interested in increasing the number of low-income students who stay in college, it could direct the Department to conduct a pilot program for frontloading federal grants. The Congress has yet to act on this suggestion.

Recurring Problems Hamper the Department's Ability to Protect Federal Financial Interests

Although major federal student aid programs, such as FFELP, FDLP, and the Pell Grant Program, have succeeded in providing students access to billions of dollars for postsecondary education, our work has shown that the Department has been less successful in protecting the financial interests of the U.S. taxpayers.[7] For example, in fiscal year 1996, while the Department made more than $40 billion available in student aid, the federal government paid out over $2.5 billion to make good its guarantee on defaulted student loans.

The Congress addressed many of the student aid deficiencies that we, the Department's Office of Inspector General (OIG), and others had identified in the past through the 1992 and 1993 amendments to HEA. For example, the amendments required that financial and compliance audits of guaranty agencies be conducted annually rather than every 2 years. The Department also has planned and taken a number of actions to correct its financial accountability problems, such as reorganizing the Office of Postsecondary Education to permit it to better administer and oversee federal student aid programs and developing several new information systems to provide more accurate and timely information. Many of the Department's actions are likely to have played a major role in reducing the amount of student loan defaults from $2.7 billion in fiscal year 1992 to $2.5 billion in fiscal year 1996 and in increasing collections on defaulted student loans

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[6]Frontloading grants entails giving students mostly grant aid in the first year and increasingly substituting loan aid in subsequent years, culminating in an aid package consisting mostly of loans in the final school year.

[7]GAO/HR-97-11, Feb. 1997; Financial Audit: Federal Family Education Loan Program's Financial Statements for Fiscal Years 1994 and 1993 (GAO/AIMD-96-22, Feb. 26, 1996); Student Financial Aid: Data Not Fully Utilized to Identify Inappropriately Awarded Loans and Grants (GAO/HEHS-95-89, July 11, 1995); and Financial Management: Education's Student Loan Program Controls Over Lenders Need Improvement (GAO/AIMD-93-33, Sept. 9, 1993).

from $1 billion in fiscal year 1992 to $2.1 billion in fiscal year 1996. However, the Department's actions have not completely resolved many of the underlying problems, and, therefore, vulnerabilities remain.

At the core of the Department's financial accountability difficulties are persistent problems with the individual student aid programs' processes, structure, and management. These problems include (1) overly complex processes, (2) inadequate financial risk to lenders or state guaranty agencies for defaulted loans, and (3) management shortcomings.[8]

Our work has shown that the student aid programs have many participants and involve complicated, cumbersome processes. Three principal participants–students, schools, and the Department of Education–are involved in all the financial aid programs; two additional participants–lenders and guaranty agencies–also have roles in FFELP. In general, each student aid program has its own processes, which include procedures for student applications, school verifications of eligibility, and lenders or other servicing organizations that collect payments. Further, the introduction of FDLP, originally viewed as a potential replacement for FFELP, has added a new dimension of complexity. Rather than replacing FFELP as initially planned, FDLP now operates along side it. Essentially, this means that the Department has two programs that are similar in purpose but that operate differently.

The structure of the student aid programs makes protecting the financial interests of the government difficult for the Department for two reasons. First, because HEA placed nearly all the financial risk for defaults on the federal government, it continues to bear a major portion of the risk for FFELP and FDLP loan losses. And, although the 1992 and 1993 amendments to HEA established slightly more risk sharing, the current structure still makes protecting the taxpayers' financial interests difficult. Protecting the financial interests of the government is also difficult because the loan programs now serve more students from low-income families and those attending proprietary schools than in the past. As the number of these higher-risk borrowers has increased, so has the number of defaults. Both of these conditions enhance access for low-income students, yet a tension exists because they jeopardize financial accountability.

Management shortcomings also continue as a major problem and contribute to the Department's financial accountability difficulties. In the past, congressional hearings and investigations, reports by the Department's OIG, our reports, and other studies and evaluations have shown that the Department (1) did not adequately oversee schools that participated in the programs; (2) managed each title IV program through a separate administrative structure, with poor or little communication among programs; (3) used inadequate management information systems that contained unreliable data; and (4) did

[8]GAO/HR-97-11, Feb. 1997.

not have sufficient and reliable student loan data to determine the Department's liability for outstanding loan guarantees. These problems cannot be quickly or easily fixed. The Department has taken many actions, such as improving gatekeeping procedures for determining which schools may participate, to address these problems. However, the Department's management problems, such as administrative inefficiencies resulting from the separate administrative structures used to manage each title IV program, have not yet been resolved.

Improved Gatekeeping Has Somewhat Enhanced Protection of Federal Financial Interests

We testified before this Subcommittee last June on issues related to "gatekeeping"–the process for ensuring that students are receiving title IV aid to attend only schools that provide quality education and training.[9] At that time, we noted the history of concern about the integrity of title IV programs stemming from our work, that of the Department's OIG, and the Congress–work that led to the conclusion that extensive abuse and mismanagement existed in these programs. For example, some schools received Pell grant funds for students who never applied for the grants or enrolled in or attended the schools. In one instance, a chain of proprietary schools falsified student records and misrepresented the quality of its educational programs to increase its revenues from students receiving Pell grants.

In recent years, the Congress has enacted legislation to improve oversight of participating schools by such means as setting maximum default rates that schools cannot exceed and still participate in the title IV programs. Legislation also has strengthened the role of the Department, states, and accrediting agencies–referred to as "the triad"–in determining school eligibility. HEA recognizes the triad as having shared responsibility for gatekeeping. As part of this triad, the Department (1) verifies schools' eligibility and certifies their financial and administrative capacity and (2) grants recognition to accrediting agencies.[10] The Department has improved the gatekeeping process by such actions as requiring all schools to have annual financial and compliance audits, increasing the number of program reviews, hiring additional staff to conduct the reviews, and beginning to develop a new database of school information to help Department staff monitor schools' performance.

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[9]Higher Education: Ensuring Quality Education From Proprietary Institutions (GAO/T-HEHS-96-158, June 6, 1996).

[10]For their part, states license and use a variety of approaches to regulate schools in the normal course of regulating commerce within their borders, and accrediting agencies provide nongovernmental, peer evaluation of schools and programs to ensure a consistent level of quality.

Nevertheless, as we reported in our recent high-risk report,[11] several weaknesses continue to cause concern. For example, the Department's OIG identified problems with the recertification process that could increase the likelihood that schools not in compliance with eligibility requirements are able to continue to participate in title IV programs. A review of a sample of Department recertification actions showed that 27 percent of schools sampled had violations such as unpaid debts or failures to meet financial responsibility requirements.[12] The Department acknowledged that some recertifications should not have been made and stated that it was taking action to make current financial data available for future recertification reviews.

The Department is also implementing a gatekeeping initiative designed to focus resources on high-risk schools: the Institutional Participation and Oversight Service (IPOS) Challenge. Under the IPOS Challenge, the Department plans to use a computer model to identify schools for review on the basis of their risk of noncompliance. Because this initiative has only recently been undertaken, it is too soon to assess its effectiveness.

CHALLENGES IN PROMOTING ACCESS AND EXCELLENCE IN ELEMENTARY, SECONDARY, AND ADULT EDUCATION PROGRAMS

Excellence in education in America has become a major concern for the public, and both the Congress and the Department have promoted initiatives to improve the quality of American education. These efforts include improving the quality of the physical environment in which students learn, ensuring schools have the ability to use the technology needed to provide children with an education appropriate for the 21st century, creating and promoting national standards to shape curriculum and guide test development in order to measure reading and math achievement, supporting efforts to improve the quality of teachers and teacher preparation programs, and ensuring equal access to education. Major legislative efforts, such as Goals 2000: Educate America Act, the Improving America's School Act, and the School-to-Work Opportunities Act, are examples of efforts focusing on improving the quality of America's public education.

Because the federal role in funding elementary and secondary education is relatively small, and states and local governments have the primary responsibility for and control of education programs, the Department faces a significant challenge in ensuring access and promoting excellence. Its tools are providing leadership, financial leverage, and technical assistance and information. The Department exercises leadership by

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[11]GAO/HR-97-11, Feb. 1997.

[12]OIG, Subsequent Review to Follow-Up Review on Selected Gatekeeping Operations, ACN: 11-60004 (Washington, D.C.: U.S. Department of Education, June 7, 1996).

shining a spotlight on important national education issues, facilitating communication on quality issues, and fostering intergovernmental and public/private partnerships. However, when one considers how it leverages resources and provides technical assistance and information, the extent to which Department funds are fostering excellence and are being spent efficiently and effectively is unclear. Two questions arise: Does the Department of Education know if its programs are working? And does the Department have the resources to manage its funds and provide the needed information and technical assistance?

More Information Is Needed to Determine How the Department's Programs Are Working

The Department is responsible for funding over $11 billion in elementary and secondary programs, including title 1, special education, vocational education, adult education, and Safe and Drug Free Schools. A major challenge facing the Department is ensuring that these programs are providing the intended outcomes. To do this the Department's programs must have clearly defined objectives and complete, accurate, and timely program data.

Title 1 of the Elementary and Secondary Education Act is the largest federal elementary and secondary education grant program, with about $7.7 billion appropriated in fiscal year 1997. Its purpose is to promote access to and equity in education for low-income students. The Congress modified the program in 1994, strengthening its accountability provisions and encouraging the concentration of funds to serve more disadvantaged children. At this time, the Department does not have the information it needs to determine whether the funding is being targeted as intended. Although the Department has asked for $10 million in its fiscal year 1998 budget request to evaluate the impact of title 1, it has only just begun a small study of selected school districts to look at targeting so that necessary mid-course modifications can be identified. The ultimate impact of the 1994 program modifications could be diminished if the funding changes are not being implemented as intended.

As another example, we found in our work on the programs funded under the Adult Education Act[13] that the State Grant Program, which funds local programs intended to address the educational needs of millions of adults, had difficulty ensuring that the programs met these needs. The lack of clearly defined program objectives was one of the reasons for the difficulty. The broad objectives of the State Grant Program give the states

[13]The Adult Education Act was designed, in part, to help states fund programs to help adults acquire the basic skills needed for literate functioning, benefit from job training, and continue their education at least through high school. Grants are made to states on the basis of the number of people in each state who are at least 16 years of age, are not required to be in school, and lack a high school diploma.

flexibility to set their own priorities but, as some argue, they do not provide states with sufficient direction for measuring results. Amendments to the act required the Department to improve accountability by developing model indicators that states could adopt and use to evaluate local programs. However, experts disagree about whether developing indicators will help states to define measurable program objectives, evaluate local programs, and collect more accurate data.

Additional Departmental Resources May Be Needed to Manage Funds and Provide Information and Technical Assistance

Recently, we have been examining two of the most basic elements of education–the financing systems that undergird public education[14] and the buildings within which education takes place.[15] For example, in our school facilities series, we documented that officials estimated that a third of our nation's schools had serious facilities problems and that it would take $112 billion to bring our schools into good overall condition. In January, the administration used our reports as the basis for proposing the Partnership to Rebuild America's Schools Act, which, if enacted, would be administered by the Department.

Several members of the Congress have raised issues associated with this proposed solution to improve schools' conditions, such as whether the types of financial and information management problems that we discussed earlier regarding postsecondary federal financial aid programs would develop in the administration of this new program, whether the Department has qualified staff to administer the program, and whether information systems to monitor it and account for the funds are available and operational.

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[14]School Finance: State Efforts to Reduce Funding Gaps Between Poor and Wealthy Districts (GAO/HEHS-97-31, Feb. 5, 1997); School Finance: Three States' Experiences With Equity in School Funding (GAO/HEHS-96-39, Dec. 19, 1995); School Finance: Trends in U.S. Education Spending (GAO/HEHS-95-235, Sept. 15, 1995); and School Finance: Options for Improving Measures of Effort and Equity in Title I (GAO/HEHS-96-142, Aug. 30, 1996).

[15]We documented the nature and extent of facilities' problems in our series on school facilities: School Facilities: Condition of America's Schools (GAO/HEHS-95-61, Feb. 1, 1995); School Facilities: America's Schools Not Designed or Equipped for 21st Century (GAO/HEHS-95-95, Apr. 4, 1995); School Facilities: Accessibility for the Disabled Still an Issue (GAO/HEHS-96-73, Dec. 29, 1995); School Facilities: States' Financial and Technical Support Varies (GAO/HEHS-96-27, Nov. 28, 1995); School Facilities: America's Schools Report Differing Conditions (GAO/HEHS-96-103, June 14, 1996); and School Facilities: Profiles of School Condition by State (GAO/HEHS-96-148, June 24, 1996).

The administration has also been promoting excellence and access by supporting technology, both through the leadership role of the President and the Office of the Secretary and through the technology programs the Department oversees. In the 1998 budget, the administration has doubled the amount of money requested for educational technology to help schools integrate technology into the curriculum in order to increase students' technological literacy and improve the quality of instruction in core subjects. In our facilities work, we found that schools had large technology infrastructure needs that the Department's Technology Literacy Challenge Grants would only start to address.[16] Again, as in the school construction situation, the Department is facing a large need with relatively small amounts of funds.

STATUTORY FRAMEWORK FOR IMPROVING THE DEPARTMENT'S MANAGEMENT PRACTICES

Adopting improved management practices can help the Department become more effective in achieving its mission of ensuring equal access to education and promoting educational excellence. Recognizing that federal agencies have not always brought the needed discipline to their management activities, the Congress in recent legislation provided a framework for addressing long-standing management challenges. The centerpiece of this framework is GPRA; other elements are the 1990 CFO Act, the 1995 Paperwork Reduction Act, and the 1996 Clinger-Cohen Act. These laws each responded to a need for more accurate, reliable information for executive branch and congressional decision-making. The Department has begun to implement these laws, which, in combination, provide it with a framework for developing (1) fully integrated information about the Department's mission and strategic priorities, (2) performance data to evaluate progress toward the achievement of those goals, (3) the relationship of information technology investments to the achievement of performance goals, and (4) accurate and audited financial information about the costs of achieving mission outcomes.

Efforts in Planning and Resource Management

The Department has a history of management problems. In our 1993 review of the Department, we identified operational deficiencies such as lack of management vision, lack of a formal planning process, poor human resource management, and inadequate commitment to management issues by the Department leadership.[17] In addition, financial and information management were serious problems throughout the Department, and not confined to postsecondary programs. Further, recent legislation--Goals 2000: Educate America Act, the School-to-Work Opportunities Act, and the Student

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[16]GAO/HEHS-95-95, Apr. 4, 1995.

[17]Department of Education: Long-Standing Management Problems Hamper Reforms (GAO/HRD-93-47, May 28, 1993).

Loan Reform Act–requires strong management improvements to support sound implementation.

In response to our recommendations as well as to new legislative responsibilities, the Department has taken steps to improve its management approach. It has developed a strategic plan that describes its mission, priorities, and performance indicators, using as its framework the key elements of GPRA. Specifically, it has begun the process of working with the Office of Management and Budget (OMB) to meet the GPRA requirement that agencies prepare strategic plans that establish long-term goals and develop annual performance plans linked to these long-term goals. GPRA also requires that agencies consult with the Congress and other stakeholders to clearly define their missions. Accordingly, the Department has begun discussions with the Congress and others about the challenges it faces and the kinds of support it needs to move forward in achieving its goals.

According to OMB, the Department has developed a fairly broad plan. OMB raised two issues during its review of the plan: (1) the lack of specificity in program performance plans and (2) the extent to which the objectives and indicators were beyond the agency's span of control or influence. With respect to the first concern, during the past few months the Department has been developing specific performance plans for all programs. Regarding the second concern, the Department responded to OMB by describing the nature of its education goals and by recognizing that those goals are shared by many entities. According to the Department, the plan's objectives and indicators recognize the multilevel, intergovernmental nature of federal education support and the need for effective performance partnerships to achieve jointly sought outcomes. At the same time, the Department is updating the strategic plan and intends to differentiate those objectives and indicators that are under the Department's full control more clearly from those that require action from state education agencies, local districts, or postsecondary institutions for effective results.

Results-oriented management may also involve reviewing programs that have the same or similar goals and objectives, but continue to be administered separately by one or more federal agencies, to see whether opportunities exist to consolidate and improve efficiencies. When we testified before this Subcommittee 2 years ago,[18] we identified potential education program consolidation opportunities. Program consolidation could not only reduce administrative costs, but the Department could better focus its management resources on evaluating and improving the quality of its programs. For example, our review of federal programs that serve at-risk or delinquent youth revealed that 131 programs served this target group in fiscal year 1995, 10 of which were

[18]Department of Education: Information on Consolidation Opportunities and Student Aid (GAO/T-HEHS-95-130, Apr. 6, 1995).

administered by the Department of Education.[19] This service delivery approach raises questions concerning efficiency. Our work suggests that efficiencies might be gained by having a smaller number of consolidated programs for at-risk or delinquent youth. For example, it would probably be more efficient to have one program covering a service/target-group combination, administered by a single federal office, than several programs administered by several different offices.

The Department is continuing its long-term efforts to streamline its operations. In its fiscal year 1998 budget, it has proposed the elimination of 10 programs–representing more than $400 million in funding–that have achieved their purpose; that duplicate other programs; or that are better supported by state, local, or private sources. Our work suggests that the Department needs to continue its efforts to eliminate duplicative or wasteful programs.

The CFO Act, as expanded, requires the Department of Education as well as the 23 other major federal agencies to prepare and have audited annual financial statements beginning with those for 1996. Fiscal year 1995 was the first year the Department prepared agencywide financial statements and had them audited. However, the independent auditor could not determine whether the financial statements were fairly presented because of the insufficient and unreliable FFELP student loan data underlying the Department's estimate of $13 billion for loan guarantees. Furthermore, because guaranty agencies and lenders have a crucial role in the implementation and ultimate cost of FFELP, the auditors stressed the need for the Department to complete steps under way for improving oversight of guaranty agencies and lenders. Until such problems are fully resolved, the Department will continue to lack the financial information necessary to effectively budget for and manage the program or to accurately estimate the government's liabilities.

In an effort to prepare auditable fiscal year 1996 financial statements, the Department's CFO has requested data from the top 10 guaranty agencies to be used as a basis for computing the liability for loan guarantees. In addition, the Department's independent auditor has developed agreed upon procedures to be applied by these agencies' independent auditors to test the reliability of the requested data. Uncertainty still exists as to whether this new methodology will work; decisions on the effectiveness of the approach will be made later this year once all the data are collected.

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[19] At-Risk and Delinquent Youth: Multiple Federal Programs Raise Efficiency Questions (GAO/HEHS-96-34, Mar. 6, 1996).

Improving Information Resources Management
Critical to Data Quality and Systems Integration

Our work has shown that the Department does not have a sound, integrated information technology strategy to manage its portfolio of information systems. It faces a particularly difficult challenge in improving its information systems for the student aid programs. The Department's National Student Loan Data System (NSLDS), which became partially operational in November 1994, enables schools, lenders, and guaranty agencies to transmit updated loan status data to the Department. However, the Department has not yet integrated the numerous separate data systems used to support individual student aid programs, often because the various "stovepipe" systems have incompatible data in nonstandard formats. As a result, program managers often lack accurate, complete, and timely data to manage and oversee the student aid program.

The lack of an integrated system also results in unnecessary manual effort on the part of users and redundant data being submitted and stored in numerous databases, resulting in additional costs to the Department as well as the chance for errors in the data. For example, a Department consultant showed that a simple address change for a college financial aid administrator would require a minimum of 19 manual and automated steps performed by a series of Department contractors who would have to enter the change in their respective systems from printed reports generated by another system. Another problem with this multiple-system environment is a lack of common identifiers for schools. Without these, tracking students and institutions across systems is difficult. The 1992 HEA amendments required the Department to establish common identifiers for students and schools not later than July 1, 1993. The Department's current plans, however, do not call for developing and implementing common identifiers for schools until academic year 1999.

Data integrity problems also exist. The lack of a fully functional and integrated title IV-wide recipient database hinders program monitoring and data quality assurance. For example, the current system cannot always identify where a student is enrolled, even after an award is made and thousands of dollars in student aid are disbursed.

Although the Department has improved its student aid data systems somewhat, major improvements are still needed. Both we and OIG reported in 1996[20] that the Department had not adequately tested the accuracy and validity of the loan data in NSLDS. During the past year, the Department has been developing a major reengineering project, Easy Access for Students and Institutions, to redesign the entire title IV student aid program delivery system to integrate the management and control functions for the title IV programs. Although activity on this project, which had waned in previous

[20]Department of Education: Status of Actions to Improve the Management of Student Financial Aid (GAO/HEHS-96-143, July 12, 1996).

months, has recently been renewed, carrying out the project is expected to be a long-term undertaking.

The Department also faces a challenge in improving its agencywide information resources management, not just that related to the student aid programs. The legislative framework, especially that provided by the Clinger-Cohen Act, offers guidance for achieving goals in this area. The Clinger-Cohen Act requires, among other things, that federal agencies improve the efficiency and effectiveness of operations through the use of information technology by establishing goals to improve the delivery of services to the public through the effective use of information technology; preparing an annual report on the progress in achieving goals as part of its budget submission to the Congress; and ensuring that performance measures are prescribed for any information technology that it uses or acquires and that it measures how well the information technology supports Department programs. The Department could benefit greatly from fully implementing the law. Full implementation of the Clinger-Cohen Act would provide another opportunity to correct many of the Department's student financial aid system weaknesses as well as to improve other information systems that support the Department's mission.

The Clinger-Cohen Act also requires that a qualified senior-level chief information officer be appointed to guide all major information resource management activities. The Department has recently appointed an Acting Chief Information Officer and, according to OMB, is to be actively recruiting an individual to fill this position on a permanent basis. This individual is responsible for developing an information resources management plan and overseeing information technology investments.

In addition, the Department has highlighted the use of information technology for improved dissemination and customer service in its fiscal year 1998 budget summary. New initiatives include (1) a data warehousing effort that would simplify the internal use of databases, (2) a data conversion effort needed to comply with year 2000 requirements,[21] and (3) a modeling project to develop an architectural framework and uniform operating standards for all Department data systems to eliminate duplication in collection and storage of data.

CONCLUSIONS

In carrying out its mission, the Department has a careful balancing act to perform. Education is a function reserved to the states, yet this federal department is expected to provide leadership on national education issues. For example, in fostering higher quality elementary and secondary education, the Department can promote national standards for

[21]This year GAO added the "year 2000" problem as a high-risk issue because of the complexities involved in changing computer systems to accommodate dates beyond the year 1999.

educational performance and teacher training–but not impose them. It is expected to provide state and local education agencies flexibility in using federal funds and freedom from unnecessary regulatory burden, yet it must have enough information about programs and how money is spent to be accountable to American taxpayers for the federal funds administered at the state and local levels. It is expected to monitor programs and provide technical assistance, but its resources may not be sufficient to provide reasonable coverage.

Although the Department has made progress in improving many management functions, it still has a long way to go. Over the years, our work has shown that the Department has not done a good job of minimizing risks and managing the federal investment, especially in postsecondary student aid programs. We also have concerns about whether the Department knows how well new or newly modified programs, like title 1, are being implemented; to what extent established programs are working; or whether it has the resources to effectively and efficiently provide needed information and technical assistance. Like other departments, the Department of Education needs to focus more on the results of its activities and on obtaining the information it needs for a more focused, results-oriented management decision-making process. GPRA, the CFO Act, and the Paperwork Reduction and Clinger-Cohen Acts give the Department the statutory framework it needs to manage for results.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or members of the Subcommittee might have.

For more information on this testimony, call Harriet Ganson, Assistant Director, at (202) 512-9045; Jay Eglin, Assistant Director, at (202) 512-7009; or Eleanor Johnson, Assistant Director, at (202) 512-7209. Joan Denomme and Joel Marus also contributed to this statement.

Mr. SHAYS. This is a challenge. I have a feeling that this is going to be a weird day because this is a motion to adjourn. I think this may be the only vote but there may be other motions to adjourn, so I am hoping we will be back in 15 minutes, but if we are not, we will try to call up and give you an idea. We are in temporary recess.

[Brief Recess.]

Mr. SHAYS. Sorry for the delay. I thought there was going to be a second vote. What do I know? We will start with the vice chairman.

Mr. SNOWBARGER. Thank you, Mr. Chairman. I am hoping that I can formulate this question correctly.

I have always had some concern about the heavy involvement of the Federal Government in these student loans, particularly in direct student loans. And that concern has been on two fronts. No. 1, can we do it efficiently? No. 2, are we interfering, perhaps, with the private sector; are we competing with the private sector?

I was just able to read the beginning section, the overview of this report, and glanced through the testimony that you provided in writing, and very frankly, my questions have not been answered. In fact, my questions have been heightened. And my concern is, can the Federal Government be effectively involved in these programs given the fact that it requires a massive amount of data gathering, analysis? Sooner or later we have to get into probably collection efforts, on and on. I mean, can we do this efficiently? Are there better ways to do it?

Ms. BLANCHETTE. I guess we can both take a stab at it. I'll make a couple of points and then turn it over to the IG and then perhaps Mr. Eglin, our Assistant Director, who handles most of our higher education work would have some further comments.

A couple of observations, the Department spent a lot of effort, dollars and staff years, I'm sure, in terms of giving special focus to the direct loan program. And one of the comments and observations we made earlier in testimony was that perhaps it was to the detriment of the guaranteed student loan program. Because of that focus, the Department has actually done a pretty good job to date.

Second observation: A lot of the activity involved with direct lending is actually done by servicers under contract, not directly by the Department: Servicers collect loans; service the loans while the student is in school; and do other activities that you would think the Department does because of the nature of the program but it is done under contract to the Department. And so that makes up for some of the perhaps shortfalls of the Department if it had to do those things.

Mr. BLOOM. I would certainly agree with those comments. But let me start and say that the FFEL program, which is a guaranteed student loan program, was severely broke 5 years ago, 6 years ago. And so something dramatic needed to be done.

The good news about the direct student loan program is that it has focused the FFEL program to become a much, much better program. It concerns me that it took kind of what I think of as a dramatic move to get this old legislative program, which at the last hearing I think I showed you how it worked. It is a very cumbersome program. But they have come a long way. The FFEL pro-

gram has come a long way with the added competition of direct loans.

The GAO is right. There was a lot of emphasis placed on the direct loan program and it has come up reasonably well and reasonably efficient, but not as efficient as it could be if this was a technology company.

So I guess we are better off now than we were 5 years ago, and I think most people would agree to that. Whether that's ideal or not, that's a good and fair question, one that could be debated on a lot of different fronts.

Mr. SNOWBARGER. Well, both of you said in one way or another, we are doing a good job or we are doing a much better job. Who is "we"? What are we referring to? Are we talking about both loan programs? Are we talking about the direct loan program versus the guaranteed loan program? Who is doing a good job?

Mr. BLOOM. Well, let me take a stab at it first. The guarantee loan program, particularly the guarantee agencies and the lenders, have really started to clean up their act. Let me back up and say that for a 1995 audit, the audit of the Department's 1995 financial statements, we got a disclaimer of opinion. We, the Department of Education, got a disclaimer of opinion because of how bad the data was in the FFEL program, the old program.

Now, remember that's old information, that's 1995. But that is pretty dramatic. And those weren't the only problems in the FFEL program, but I think that it is kind of indicative of the data gathering problem that the guarantee agencies had and that the Department had to get that information.

Things have gotten much, much better. Competition is a wonderful thing sometimes, and in this case, the direct loan program has been a wake-up call for the banks and a wake-up call for the guarantee agencies. And part of that—because of that competition, I believe the programs are better today. Now, whether that's the best way to do it going forward, interesting debate.

Ms. BLANCHETTE. I would concur, and I will allow Mr. Eglin to add.

Mr. EGLIN. I think that I agree that the competition, I think, has been good because it has allowed the guaranteed program and the participants, the lenders and the agencies, to be much more efficient.

Also, as you know, the Congress has kind of tweaked some of the subsidies that were provided to the lenders and the guaranty agencies under the FFEL program, and what that has done, I think, is kind of more of a consolidation within that program to make it more efficient.

The question still remaining is which is the best, and I think there's a lot of interest in that. There are some studies under way. The Department has a major study under way that is looking at many elements of the direct program in comparison to the FFEL program to see which one is delivering—which have been more efficient.

Mr. SNOWBARGER. Again, I don't doubt the benefit of competition and what it's going to do. I just question who the competitor ought to be.

The other question I have is about the inefficiencies of the guarantee programs: do you have some feel for the reasons for the inefficiencies? Was it the regulations that were placed on either the lenders, the schools, whatever? Or did it come from the Department not being able to follow through and followup on compliance?

Mr. EGLIN. It's probably a little of both. As we point out in the high-risk report, part of it is the structure in which the program was established. And it was established almost 30 years ago and things are a lot different than they were then. And there is a lot more electronic information that can be processed much quicker. We don't need to have lenders as close to schools and students and parents as we did 30 years ago, so there are a lot of things that have changed.

And the fact that we depend on lenders and guaranty agencies to keep our books contributes to some of the problems with the financial statements. By the time it gets to the Department there is a lot of validation that needs to be done. Some of the agencies and some of the lenders, not necessarily deliberately, the information is tough to be validated and that has contributed to a lot of our problems.

So with that structure with thousands of lenders and 50 guaranty agencies, plus all the schools and students, that's a lot of folks participating in the FFEL program. There is a lot of money involved, and a lot of small transactions. A lot of $2- and $3,000 loans. It is not like $100- and $200,000 mortgages.

Ms. BLANCHETTE. To add to that, in that environment, as Mr. Bloom indicated and as we reported in our high-risk report and as I mentioned this morning, the data systems are horrendous. Not only do the different systems not communicate with each other or allow the Department to communicate across programs, in many instances there is no way to detect errors. And so with the many players and small-dollar transactions with different systems for different programs not communicating with one another, it just adds to the problem.

Mr. SNOWBARGER. Are there things that we need to do legislatively to change the way that the system operates or are those internal within the Department?

Mr. EGLIN. Well, it is probably a little of both. I think the Congress has provided a lot of guidance and made a lot of changes to the statute, almost annually. And it's—it probably has contributed to some of the structure that the Department operates within. And conversely, as I think we also point out in the high-risk report, the Department in how it manages it, the data systems, as Ms. Blanchette mentioned, as well as some of the other problems, contribute to this. So it is not an easy fix. And I think what the competition between the two programs has done has allowed efficiencies to surface because of the fact that they were competing with another program.

Ms. BLANCHETTE. And to add to that, with improvements in financial systems and the information systems, some of the problems would be reduced, if not eliminated. Now that's not an easy effort and it takes a long time.

Also, as we said in our statement for this hearing, with adherence to legislative mandates such as the CFO Act and the Clinger-

Cohen Act with respect to technology, and the Results Act, if the Department can garner the discipline that those acts require, and do the things that they should be doing under those acts, then it should be able to improve the financial aid program substantially.

Mr. BLOOM. Again, I agree with just about everything said there. You asked what you all might do, what Congress might do. I think we need to look at the role of the guaranty agencies. And I guess to draw the picture, you have thousands of financial institutions and banks making loans and they work through I think it is 37 or 39 guaranty agencies. And all the guaranty agencies have different systems, different ways to format the data. I think we have to look at what guaranty agencies do, whether we need so many of them.

Again, I'm a big believer in competition, but you know there are 37 of them. They don't really compete against each other. Maybe we need significantly fewer guaranty agencies. It is a pretty hot political issue, though.

And then you asked has the Department—could the Department have done a better job? I think the Department could have rode hard on the guaranty agencies much more than they have, particularly I think in the last 10 or 15 years to get the data, to force them to get the data. The interesting thing about the 1995 audit is that it really was a catalyst to get the guaranty agencies to work with the Department, and their association, NCHELP, has been very interested in working with us to make the data better because they now see that it is in their better interest. There hasn't been enough pressure put on by the administration and we do have somewhat of a flawed design that you in Congress could take care of.

Mr. SNOWBARGER. Let me follow up. Specific suggestions for legislation? You said that there are plenty of things that we could do, and that is nice, but I still haven't heard anything specific that we can do that you are proposing.

Mr. BLOOM. Well, I'll—I'll give you—there are three specific things in my testimony. They don't all relate directly to direct lending, but I'd like to get them to the record again. One is the IRS match. Give us the ability to get in and check our records with the IRS records. Very important to us.

The other is performance measures for schools. There are bad schools out there that aren't educating these kids. Let's legislate mandated performance measures. Seventy percent graduation rate. Seventy percent placement rate.

And the third thing would be separate regulations for the trade schools. The nondegree granting schools ought to be regulated differently than a 4-year university. Harvard shouldn't be regulated the same way as the Steve McNamara School of Beauty. They are different entities. I made that up. There is not——

Ms. BLANCHETTE. We were going to look into that, Steve.

Mr. SNOWBARGER. Let me go back to the IRS match. We have gone through the process of applying for student loans for a child.

Mr. SHAYS. You personally?

Mr. SNOWBARGER. Me, personally. Yes. Me personally on the line for these things, too. I know I had to give an awful lot of information, including at least 1 year's tax returns, if not two.

Are we assuming that people are giving fraudulent tax returns? I find it hard enough to fill out a form once, much less going back to fill out an IRS form the second time to defraud someone.

Mr. BLOOM. Well, they have. There are many people who have come up with fake 1040's. In fact, there have been "marketing companies out there that have been in the business of producing fraudulent tax returns." So that's a big issue.

The other thing is, and I don't know whether it's the regulations or the statute, we only ask for verification—it is a sample. It's 30 percent of the students actually have to bring their tax returns in for verification. It would just be so much easier if we could, we the Department, could send over the list with the adjusted gross income number, the social security number, and the name over to the IRS and the IRS could kick back those that don't match within a certain tolerance. We wouldn't want all the ones that are $1 off or $10 off, but they could send back the nonmatches so that the population that we would be looking at would be relatively small and there would be good reason for looking at it.

As I said in my oral testimony, I am a big believer in privacy, and the Privacy Act, and privacy of our tax returns. But I think it is different when you are asking for Federal money. We ought to take whatever steps we can to ensure as much privacy as possible. But I do believe that match ought to be made.

Mr. SNOWBARGER. Is that perhaps just as simple as having them sign a release?

Mr. BLOOM. This ends up being a fairly complicated question with the IRS. There are some folks that believe that the IRS could now do it, but there are folks at the IRS that believe that maybe they can't. It is a real tickling legal question. Steve.

Mr. MCNAMARA. We currently have a program called the Income Contingent Repayment Program in Direct Loans which makes people make payments on their loans according to their income and their ability to repay. To get into that program now you have to sign a waiver so that the IRS can tell us your income. So it would be probably something similar to what we currently have under ICR.

What we found was that a lot of people lied. We had several people, four or five or six, who made somewhere between $300,000 and $1.6 million and they said that they didn't file a tax return. And so in our audit we turned up a lot of folks that made a lot of money that said they didn't file or didn't make any money. This would protect us from that.

Mr. SNOWBARGER. Well, I hear you saying that at least for some programs you ask for that waiver to be signed, and the IRS is not cooperating with that? Or——

Mr. MCNAMARA. No, they are cooperating with the Income Contingent Repayment match. But that's only for that program. We don't have the authority—IRS is very reluctant to give anybody any information.

Mr. SNOWBARGER. They may become a little more compliant here in a little bit if they're still around.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

I have a number of questions and I just want to preface it by saying that the purpose of this hearing really is to educate the staff and your testimonies give a lot more detail and we are going to followup on it. But I am just wrestling in general with a number of different issues. I would like both of you to tell me where the Department is most vulnerable to waste, fraud, and abuse.

Ms. BLANCHETTE. Where in terms of which programs?

Mr. SHAYS. Yes. Just emphasize again where you think it is most vulnerable to waste, fraud, and abuse.

Ms. BLANCHETTE. Well, of course the postsecondary financial aid programs as a general category.

Mr. SHAYS. That was the one that I really highlighted in my opening statement, because it seems to me, one, it is both in terms of process, but also in terms of the amount of dollars involved. Would you agree with that, Mr. Bloom?

Mr. BLOOM. Yes, absolutely. That's where we spend almost 75 percent of our time in the IG's office looking at student financial assistance.

Mr. SHAYS. How much of the total amount of the Department of Education's budget is in higher education loans and grants?

Mr. BLOOM. Well—half. Plus remember we have the guarantee portion—the guaranteed financial loans that are kind of above and beyond. That's a contingent liability and $40 billion a year goes out in that program, but of course we only pay out $2 billion a year in guarantees.

Mr. SHAYS. $2 billion, is that covering losses?

Mr. BLOOM. That's the losses. Not net of recoveries, but the gross loss number.

Mr. SHAYS. And then we recover some?

Mr. BLOOM. Yes. In fact, recently we have been recovering almost as much as we have been losing. But that's—remember, we are collecting——

Mr. SHAYS. You have a big pile.

Mr. BLOOM. You have a big pile from which you are collecting from and at some point that pile is going to dwindle.

Mr. SHAYS. Let's just take higher ed, loans and grants aside, and then tell me where the biggest area of potential waste, fraud, and abuse is.

Mr. BLOOM. I guess this probably relates to student financial aid to a certain extent but it really is the systems area. The other programs tend to be pretty straightforward grants out with pretty good controls in a lot of instances.

Mr. SHAYS. I will get back to the chief information officer, because I want to pursue that a second.

Ms. Blanchette.

Ms. BLANCHETTE. I'm hard pressed to identify a particular program, but I will say—and there are certainly lots of probably programs that we haven't looked at in detail but for the few that we have over the course of a number of years, the problem with accountability is the nature of the beast. So to speak, education. We have the Federal Government supporting education in this country, but the responsibility lies with States and the control is at a local level. So even when Federal funds are used to help disadvantaged populations——

Mr. SHAYS. You are not always sure how it is spent.

Ms. BLANCHETTE. We are not sure how it is spent and that is by design.

Mr. SHAYS. So what I am hearing you say is that if there is a grant application, you look at the grant, the grant makes sense, but there is a lot of flexibility in how the grant is spent and not necessarily tremendous oversight.

Ms. BLANCHETTE. Right, absolutely.

Mr. SHAYS. Isn't there another problem in the Department that you have a lot of small grants without any critical mass?

Ms. BLANCHETTE. That's right.

Mr. SHAYS. There are some grant programs that are not funded that are on the books. I remember we eliminated a number of them, and I remember the political heat that we took for it and they hadn't been funded for years. But it didn't matter because they had some great sounding names and it sounded like I had lost my mind in not wanting these programs to continue. So one would be a concept of critical mass, a lot of little programs and a lot of oversight.

Have we ever taken a look at some of these smaller programs and figured out the administrative costs versus how much actually gets out into the field?

Ms. BLANCHETTE. We looked in general in terms of the money that goes to SEAs, and I'll let Eleanor Johnson talk about that because she led that effort.

Mr. SHAYS. She is looking at you like she doesn't want to.

Ms. JOHNSON. I have my magic pin.

We did look on some very small studies at Chapter 1 several years ago and we looked how the money was spent on the local level. Seventy-three percent went right to the classroom directly. There was another, I believe, 18 percent that went for support services of various sorts and only 10 percent went to administration.

Generally, there is a specific amount, a specific percentage of the grant which is set aside for administrative purposes. To our knowledge, there has not been a case where more than that amount has actually been spent on administrative things and not gone to the classroom.

Mr. SHAYS. The Chief Financial Officer has been around for how long now?

Mr. BLOOM. The Chief Financial Officer Act was a 1990 act.

Mr. SHAYS. Right. But how long have we had a Chief Financial Officer?

Mr. BLOOM. Since 1991.

Mr. SHAYS. Some departments took a heck of a long time. Have you seen a positive impact of having a Chief Financial Officer?

Mr. BLOOM. Absolutely. Of course, I was a Chief Financial Officer at a department.

Mr. SHAYS. Well, you are disqualified.

Mr. BLOOM. I think it has been a tremendous impact. I think everyone would say the Chief Financial Officer Act has been a tremendous success.

Mr. SHAYS. Ms. Blanchette, would you say tremendous or just a success?

Ms. BLANCHETTE. Well, I am not within the group at GAO that looks at implication of the Chief Financial Officer Act, so I don't know that I would want to distinguish between the successful and tremendously successful.

Mr. SHAYS. Wouldn't you come in contact with the Chief Financial Officer in your work?

Ms. BLANCHETTE. GAO does, yes, and I would imagine—Mr. Eglin is over here saying yes.

Mr. SHAYS. And do you have any opinion whether it has been a good positive or strong positive?

Ms. BLANCHETTE. I will let Jay answer this, but of course it has been positive because you have someone focusing on the financial.

Mr. SHAYS. Not necessarily. I don't make that assumption nor do you actually, right? I mean, the intent is good and so on, and so it would be logical, but I don't know if it is really working.

Ms. BLANCHETTE. Right.

Mr. EGLIN. I think that in the student financial aid area it has made a significant impact on making some improvements. As we have talked, there were a lot of problems with data integrity and accuracy in the data systems, and I think the Office of the Chief Financial Officer has done a lot to build that organization up and build up the systems to complement that.

And as Mr. Bloom mentioned earlier, the Department has a set of financial statements together and however they may not have been able to get a clean opinion, that was pulled together. It has come a long way in the last couple of years, and I think we have seen the CFO has had a lot to do with that.

Mr. SHAYS. The Chief Information Officer does not yet exist in the Department of Education, correct?

Mr. BLOOM. Actually, there is an Office of Chief Information Officer. They had named an acting chief information officer. I think he took that position in July 1996. Now Leo Kornfeld was the fellow who occupied that chair. Leo left earlier this month. He resigned. He retired. That position is now vacant. It is a very important position.

Mr. SHAYS. We had one of the other departments that combined the CFO and the CIO, and I think that goes contrary to the intent of our legislation. I am not sure but I suspect that someone in that position in the private sector would be making a quarter of a million dollars.

Mr. BLOOM. At least.

Mr. SHAYS. And just imagine how amazing it is to think in terms of the Department, the Social Security Department, the incredible information systems they have there, and their inability to compensate someone in a way that would be commensurate with the kind of benefit they could provide to the entire Nation.

So I guess I am going to ask this question: Do you think that the Department is taking seriously the intent of our legislation that we really want a chief information officer and we want someone who is full time and who is going to be there a while?

Mr. BLOOM. Well, I believe they are certainly interested. I'd like to see them——

Mr. SHAYS. Interested? Everybody is interested.

Mr. BLOOM. I'd like to see that level of interest heightened on that part. I would like to see them—and it may cost a few dollars—to hire a recruiting firm or whatever circumstances you need to find that person who wants to do some good government service. Many of us have taken pay cuts to serve in these positions, and I'd like to see a concerted effort to find that chief scientist from IBM or someone from Apple that would see this as a challenge.

But you really have to have heightened interest to make it happen, and I think it takes secretarial involvement. When a secretary of a Department of Education calls you up and asks to you take a job, it's kind of hard to say no.

Mr. SHAYS. The Government Performance and Results Act? Is it being taken seriously by the Department of Education?

Mr. BLOOM. I think the short answer is yes. In certain parts, they are doing a really good job on that, particularly the strategic plan side. They came up with a strategic plan earlier than was called for in the legislation. Actually, they were one of the first to have a strategic plan.

They are in the process of completing their performance measures. They've asked us to take a look at them, and they've asked us to use a critical eye to make sure they're measuring the right things and they are going to measure them in the right way.

You know, I think they've got a good start. Again, it is one of those things, we need to keep their interest, and we need to keep focused on it, and I think the Congress ought to continue to ask those questions and put the pressure on them. We are going to continue to ask those questions because, again, you have heard me say what you measure you get, and I really believe that we need to measure.

Mr. SHAYS. Now, I basically have a few more questions. Do you have any more, Vince? OK.

Getting to higher education loans—excuse me, let me just ask you about Head Start. There was a concern on the part of Congress that we were putting more money into the Head Start program than the communities were able to absorb. Did you have any sense that that was happening or a concern that that might be?

Mr. BLOOM. That's not anything that—I don't know the answer.

Mr. SHAYS. It is actually HHS. I'm sorry. It's HHS. Head Start is an HHS program, and you would not—even though I view it as education, this would not—you would not interface with this in any way.

Mr. BLOOM. We haven't in the past. It is a good question, whether we should or not.

Mr. SHAYS. One of the things we learned which was really shocking to us is that 49 percent of all the education programs in the Federal Government are outside the Department of Education. Which tells you that various chairmen of various committees wanted that education program and since they didn't oversee the Department of Education they just put it in their own department. But if we were really intending to have a Department of Education it would strike me that we would bring some of these education programs all in one area.

Let me conclude on this last point, and that is we had an amazing hearing—I thought it was amazing. But we had a hearing that

basically left me dumbfounded that we would have spent $750 million in 1 year for a school of cosmetology program. Are we finding that the money just goes where the proprietary schools manage to get students? If you told me we should be putting $750 million in student loans in cosmetology or to help fill the void of high-tech needs in the greater DC area, there is no contest to me. Considering that half the students in cosmetology never end up doing cosmetology.

Mr. BLOOM. That's an excellent point that really supports our saying if you put measurements on these schools for graduation rates and placement rates, then the job marketplace would determine where the students are.

Right now, it is whoever is out there—whoever has got the best rope to rope in the students. Stay home some afternoon and watch what's on TV. Who's got the commercials on TV? It's the proprietary schools. It's the trade schools, the cosmetology schools.

Mr. SHAYS. Your point to the committee is that if we want ultimately for it to go to where we might consider there are great national interests, that the mere fact requires that a certain percent have jobs will begin to kind of focus some money in those areas.

Mr. BLOOM. We believe that strongly.

Mr. SHAYS. Mr. McNamara, did you want to comment?

Mr. MCNAMARA. Absolutely. Mr. Chairman, we testified a couple of years ago when we put out what we call the Hair MIR or the Cosmetology MIR; and basically what that said is what Mr. Bloom just said. That, right now, we make money available to students to go wherever they want to go; and unscrupulous schools that don't offer an education can get them in their program, leave them with no education and no way to pay back their loan; and millions and millions of dollars can be going to places where it doesn't do any good.

What we recommended then is by simply putting measures on that that will require them, in effect, to be real schools, it should radically change the student aid program.

Mr. SHAYS. Is there a question that you wish we had asked?

And some of those who have accompanied the Inspector General and GAO, if you all would like to just make closing comment. I learn a lot from those who just sit and listen.

Ms. Johnson, do you have any closing comment you would want to make?

Ms. JOHNSON. We have been spending the last 3 or 4 years not really looking a lot, as far as elementary and secondary education is concerned, at the Department programs. We have spent most of our resources gathering basic information about some of the needs in education finance around the country.

The question that really comes to my mind, do we know that the programs are getting the money to the place where we intended it to go? When I looked at some of the very excellent strategic plans that the Department has put out and also what they're looking at in terms of analysis, they're looking at a lot of program effectiveness, but they aren't necessarily looking at the financial management that goes along with that, except in very specific instances like bad data. And because I am with GAO and, therefore, financial

management is close to my heart, that is one of the questions that I would ask.

Mr. EGLIN. I think most of the issues on the student financial aid side have pretty well been documented by the high-risk report that we issued, and that speaks for itself. I think those are issues that are still dear to our heart, also.

Ms. VAN RIPER. We say in investigations that our work begins when other people's work ends, and the majority of our work in investigation is centering on the trade and the technical schools with the short-term programs.

I would also second what has already been said about performance measures. We have a case inventory of about 325 major complex investigations, 67 percent of which are of the larger entities like banks, guaranty agencies and schools. All of the school investigations are trade and technical short-term programs. Performance measures would go a long way in handling some of the fraud and abuse that we are seeing in student aid programs.

Mr. MCNAMARA. I don't have anything. Thank you, Mr. Chairman.

Mr. SHAYS. Mr. Bloom or Ms. Blanchette, do you have any closing comments?

Ms. BLANCHETTE. I would just emphasize a point we made—great time for my voice to go out; right? I would like to emphasize a point we made in our statement and that I made in my summary of the statement.

The problems that the Department has in terms of its managing not only its higher ed programs but some of its elementary and secondary programs as well stem from I think a lack of discipline in management. It's not because there are people there necessarily who don't want to do a good job or who want to defraud anyone, but they come to work every day, and they probably spend their time putting out fires and taking care of problems rather than having systems in place that allow them to make sound, rational management decisions.

And with improved technology, as Mr. Bloom indicated, and with some of the processes that have come into place because of recent legislation that we have mentioned here today, that discipline is going to be imposed on the Department as well as other Federal agencies. And if those systems remain in place and if oversight continues and, therefore, gives the officials an incentive to keep things in place, then I think things will improve. But in the absence of processes and systems that allow competent people to do their jobs, things aren't going to get a whole lot better.

Harriet.

Ms. GANSON. Yes, just in terms of what you were saying about what the committee could do, I think that what you have done in terms of the Results Act and the Clinger-Cohen Act has provided the framework for improvement. Part of the GPRA is to have consultations with Congress.

This is a good opportunity for the committee to talk with the Department of Education about the strategic plan, about their performance measures, and about the financial management issues that Ms. Johnson talked about. I know that the Department has started the process of meeting with the committees and subcommit-

tees about their performance plans and getting input in terms of what those measures should be.

Mr. SHAYS. You just really triggered something that I was thinking that this committee should do and a number of us should go and meet, Mr. Towns, with the Secretary in an informal way, in their offices, and have them tell us where they're headed and get a sense that way of what they're doing, and then have a more formal hearing later on. I think that would be really interesting.

I thank you for your contribution, and I would say to you that the Department of Education did not get as much attention from our committee in the past years as I think it will get in the next 2, so we look forward to our paths crossing a little more often.

At this time, I am going to call our next and last panel. It is Beverly Sgro, secretary of education, Commonwealth of Virginia—please remain standing, and we will swear you in—and Paul Steidler, director of education reform project, the Alexis de Tocqueville Institution.

Do you have anyone accompanying you or are all on your own here?

Mr. STEIDLER. No, I do not.

Ms. SGRO. No, I am on my own also.

[Witnesses sworn.]

Mr. SHAYS. Thank you very much.

STATEMENTS OF BEVERLY SGRO, SECRETARY OF EDUCATION, COMMONWEALTH OF VIRGINIA; AND PAUL STEIDLER, DIRECTOR OF EDUCATION REFORM PROJECT, THE ALEXIS dE TOCQUEVILLE INSTITUTION

Mr. SHAYS. Why don't you, Mr. Steidler, just tell me what your institution is and where you're based; and then we will go with Ms. Sgro.

Mr. STEIDLER. Yes. We are a think-tank based in Arlington, VA, that focuses on a number of issues; but education is one of the largest.

Mr. SHAYS. OK. Welcome.

Ms. SGRO. Thank you.

Mr. SHAYS. You didn't have far to come, did you?

Ms. SGRO. No, I didn't. I came from Richmond and did a little other business while I was here this morning. No moss grows under our feet, sir.

It is a pleasure for me to be here with you, Mr. Chairman and members of the subcommittee. I want to start with giving you a little brief introduction of Virginia, because I think it is very pertinent to what you are attempting to do today.

In Virginia, we have seriously addressed the issue of educational reform to meet the needs of all of our students in the Commonwealth. We accomplished a great deal with the support of our citizens and without the interference of the Federal Government.

We believe, as do the citizens of this great country, that education is primarily a State function. The March 14, 1997, Wall Street Journal/NBC news poll reinforces this position. The poll indicates that almost half of Americans believe that the primary responsibility for education still rests with the States and local governments, a quarter see State government as having the primary

responsibility for education reform, and only 13 percent think the Federal Government should play a major role.

Virginia has established high academic standards that are measurable and understandable; Statewide tests that assess student performance on those standards; a system of accountability that ties school accreditation to student performance; and a system of public reporting that will provide the public with information on how we are progressing toward those standards at the school, school division, and Statewide level.

The American Federation of Teachers recently reported that Virginia, and Virginia alone, received an exemplary rating for its standards in the four academic subjects of English, math, science and history. We involved over 5,000 citizens representing teachers, school administrators, parents, business persons, the State Board of Education and educational experts in this community effort by civic-minded individuals who volunteered their time. This process is in stark contrast to the failed efforts of the Federal Government that contracted with revisionist historians at the University of California at Los Angeles to produce a set of national history standards at a cost of $2.2 million.

Virginia has accomplished these important educational reforms in 3½ years with no Federal funding. Governor George Allen and the citizens of Virginia believe that education is one of the most important responsibilities of State government, and we believe that we can continue to make progress without the excessive and sometimes inappropriate involvement of the Federal Government.

I believe the role of the Federal Government should be limited primarily to two areas.

The first is funding and coordinating the collection and dissemination of useful data that can be used by State policymakers to compare their State relative to other States. The U.S. Department of Education and other Federal agencies are in a unique position to collect, collate and distribute data relative to education and demographics that are helpful to policymakers. While this is an important function of the U.S. Department of Education, often the data is not published in a timely manner. Its usefulness is greatly decreased. If the Department were not attempting so many other programs, it could produce these reports in a more timely fashion.

Second issue I think is important for the Federal Government is one that's kind of interesting since you have just had a very lengthy discussion on student financial aid. But I am still going to say that thing is a role that the Federal Government should be playing. However, I will add the caveat that I think it can be done much more efficiently and certainly in a more effective manner as well.

College student financial aid has been relatively successful for students because these programs are established to provide loans and grants directly to students. In fact, these programs should be and probably are a good example of vouchers to students. It is important to have these programs administered from the Federal level since it gives students greater flexibility and greater choice.

Attending out-of-State institutions is possible because the money can follow the student. In fact, it would be advantageous if Federal aid to public education were distributed in much the same way for

students—a specific amount per student could be allocated to each State. And the money would follow the student no matter where the student attended school—be it a charter school, a public school, or other type of facility.

But all of us know, the reach of the Federal Government extends well beyond these two functions. Its role extends well beyond its contribution.

Since inception, the budget of the U.S. Department of Education has doubled; and, at the present time, there are 760 Federal education programs in 39 different departments and agencies.

A compelling example of the disproportionate role of the U.S. Department of Education is illustrated by its involvement in special education programs. When the Education of the Handicapped Act—now the Individuals with Disabilities Education Act—was passed initially, the Federal Government indicated that it intended to fund 40 percent of the costs associated with the legislation. Currently, however, Federal funding covers only 8 to 9 percent of the mandates in special education. States and local governments cover more than 90 percent of those costs. In Virginia, the State contributed $158 million to its special education requirements. Localities spend another $520 million. The Federal Government contributes only $57 million. Yet the regulations that are forced on local school systems by the U.S. Department of Education for special education programs are the most intrusive, pervasive and time consuming that school administrators face in any school year.

Just recently, the Fourth Circuit Court ruled in favor of Virginia and against the U.S. Department of Education which argued that students in special education could not be suspended from school or expelled even when their dangerous or egregiously inappropriate behavior was in no way related to their disability. The U.S. Department of Education position defies logic and common sense.

According to the U.S. Department of Education, a student with a minor reading disability could not be disciplined for striking a teacher, for bringing a loaded handgun to school or for selling drugs. Imagine the message this policy sent to our students. One student bragged to teachers and students that he could do anything he wanted because school administrators could not discipline him for any reason.

Despite our best efforts to reason with the U.S. Department of Education, this agency threatened to withhold Virginia's allocation for special education even after our policy of disciplining special education students only when it could be established that their behavior was not related to their disability had been in existence for years.

This type of interference in the rights of States to develop and administer policies is an usurpation of the State's role in education by the Federal Government. This particular case has been in litigation for more than 3 years.

The role of the Federal Government should be reduced substantially, and the block granting of funds should be implemented. Similar to the model that Congress adopted in welfare reform, education matters should be turned over to the States so that each State can establish its own model for education reform.

Some programs will be emulated by others, much like our own academic standards in English, math, science and history. Our standards of learning are being studied, and in some cases adopted, by more than 30 States at this time. Other programs that are less successful will be discarded. Thus, national success in educational reform will grow out of individual State efforts. Adopting this model will result in the decrease of the hundreds of programs at the U.S. DOE that are ineffective. The money saved by reducing the Federal bureaucracy should be returned to the States and sent directly to the classroom, where students will benefit from these tax dollars.

I hope that you will act now to strengthen and increase the flexibility that is presently purported and which was originally claimed. If you set general priorities, give us "true" block grants and the room to work, States will produce results.

There will always be a local, State and Federal partnership in education. However, in a true partnership, everyone has something to give, and none of the partners are perceived as intruders.

Thank you very much for allowing me to address, and I would be glad to answer any questions.

[The prepared statement of Ms. Sgro follows:]

Testimony Before the U.S. House of Representatives
Committee on Government Reform and Oversight
Subcommittee on Human Resources

Remarks By
The Honorable Beverly H. Sgro
Secretary of Education
Commonwealth of Virginia

March 20, 1997

Good morning, Mr. Chairman and Members of the Subcommittee, and thank you for this opportunity to speak with you about the role of the federal government in education.

In Virginia, we have seriously addressed the issue of educational reform to meet the needs of all of our students in the Commonwealth. We accomplished a great deal with the support of our citizens and without the interference of the federal government. We believe, as do the citizens of this great country, that education is primarily a state function. The March 14, 1997, Wall Street Journal/NBC News poll reinforces this position. The poll indicates that almost half of Americans believe that the primary responsibility for education still rests with state and local governments. A quarter see state government as having the primary responsibility for education reform and only 13% think the federal government should play a major role.

Virginia has established high academic standards that are measurable and understandable; statewide tests that assess student performance on those standards; a system of accountability that ties school accreditation to student performance; and a system of public reporting that will provide the public with information on how we are progressing toward those standards at the school, school division, and statewide level.

The American Federation of Teachers recently reported that Virginia, and Virginia alone, received an exemplary rating for its standards in the four academic subjects of English, math, science and history. We involved over 5,000 citizens representing

teachers, school administrators, parents, business persons, the State Board of Education and educational experts in this community effort by civic-minded individuals who volunteered their time. This process is in stark contrast to the failed efforts of the federal government that contracted with revisionist historians at the University of California at Los Angeles (UCLA) to produce a set of national history standards at a cost of $2.2 million.

Virginia has accomplished these important educational reforms in just three and one half years with no federal funding. Governor George Allen and the citizens of Virginia believe that education is one of the most important responsibilities of state government. And we believe that we can continue to make progress without the excessive and sometimes inappropriate involvement of the federal government.

I believe the role of the federal government should be limited primarily to:

- Funding and coordinating the collection and dissemination of useful data that can be used by state policy makers to compare their state relative to other states. The U.S. Department of Education and other federal agencies are in a unique position to collect, collate, and distribute data relative to education and demographics that are helpful to policy makers. While this is an important function of the U.S. Department of Education, often the data is not published in a timely manner. Its usefulness is greatly decreased. If the department were not attempting so many other programs, it could produce these reports in a more timely fashion.

- Providing funds for student financial aid is critical if we are to provide access to higher education. College student financial aid has been successful because these programs are established to provide loans and grants directly to students. In fact these programs are simply good examples of vouchers. It is important to have these programs administered from the federal level since it gives students greater flexibility and greater choice. Attending out-of-state institutions is possible because the money can follow the student. In fact, it would be advantageous if federal aid to public education were distributed in much the same way to states for students - a specific amount per student could be allocated to each state. And the money would follow the student no matter where the student attended school - be it a charter school, a public school, or other type of facility.

But all of us know, the reach of the federal government extends well beyond these two functions. Its role extends well beyond its contribution.

In 1945-46 the federal government provided only 1.4% of the dollars for education while states provided 34.7% and localities provided 63.9%. Today, by contrast, the federal government provides 7.2% of the tab for education, while the states provide 44.8% and the localities pay 48.0%. Since its inception, the budget of the U.S. Department of Education has doubled, and at the present time there are 760 federal education programs in 39 different departments and agencies. The cost to the U.S. taxpayer - $121 billion each year.

The authority and control the federal government has in education is clearly disproportionate. This is especially disturbing when one looks at the outcomes of some of these federal programs. Remember, only 13% of our citizens think that the federal government should play a major role in education reform.

A compelling example of the disproportionate role of the U.S. Department of Education is illustrated by its involvement in special education programs. When the Education of the Handicapped Act (now the Individuals with Disabilities Education Act) was passed initially, the federal government indicated that it intended to fund 40% of the costs associated with the legislation. Currently, however, federal funding covers only 8% to 9% of the federal mandates in special education. States and local governments cover more than 90% of the costs! In Virginia, the state contributes $158 million to its special education requirements. Localities expend $520 million. The federal government contributes only $57 million. Yet, the regulations that are forced on local school systems by the U.S. Department of Education for special education programs are the most intrusive, pervasive, and time consuming that school administrators face in any school year.

Just recently the Fourth Circuit Court ruled in favor of Virginia and against the U.S. Department of Education which argued that students in special education could not be suspended from school or expelled even when their dangerous or egregiously inappropriate behavior was in no way related to their disability. The U.S. Department of Education position defies logic and common sense. According to the U.S. Department of Education, a student with a minor reading disability could not be disciplined for striking a teacher, for bringing a loaded hand gun to school, or for selling drugs. Imagine the message this policy sent to our students. One student bragged to teachers and students that he could do anything he wanted, because school administrators could not discipline him for any reason. Despite our efforts to reason with the U.S. Department of Education, this agency threatened to withhold Virginia's allocation for special education even after our policy of disciplining special education students only when it could be established that their behavior was <u>not</u> related to their disability had been in existence for years.

This type of interference in the rights of states to develop and administer policies is an usurpation of the state role in education by the federal government. This particular case has been in litigation for more than three years. It has caused a great deal of distress in our schools and a large expenditure of time and money that could have been better spent on educating students; not fighting the federal government.

The role of the federal government should be reduced substantially and the block granting of funds should be implemented. Similar to the model that Congress adopted in welfare reform, education matters should be turned over to the states so that each state can establish its own model for education reform. Some programs will be emulated by others, much like our own academic standards in English, math, science and history. Our Standards of Learning are being studied and, in some cases adopted, by more than 30 states at this time. Other programs that are less successful will be discarded. Thus, national success in educational reform will grow out of individual state efforts. Adopting this model will result in the decrease of the hundreds of programs at the US DOE that are ineffective. The money saved by reducing the federal bureaucracy should be returned to the states and sent directly to the classroom where students will benefit from these tax dollars.

I hope that you will act now to strengthen and increase the flexibility that is presently purported and which was originally claimed. If you set general priorities, give us "true" block grants and the "room to work", states will produce results.

There will always be a local, state, and federal partnership in education; however, in a true partnership everyone has something to give, and none of the partners are perceived as intruders.

Thank you for the opportunity to share my thoughts on this most important matter with you.

Mr. STEIDLER. Mr. Shays, Congressman Towns, thank you for the opportunity to testify today about the U.S. Department of Education's mission, management and purpose.

One of the most critical education problems we face today is the quality of elementary and secondary schools in the inner cities. Yet, there are a plethora of Department of Education programs that are of questionable value to students in these schools as the programs in large part benefit bureaucracies, teachers, and students that are not poor.

The array of these trickle-down programs include a literacy program for prisoners, Goals 2000, professional development assistance for teachers, and even something called parent training.

It is, however, the primary Federal education program for the poor, Title I, that should be examined most closely. Title I has a mixed history at best.

Since its inception in 1965, Title I has been reauthorized eight times, most recently in 1994. The program, which has spent roughly $100 billion, was envisioned as a way to help disadvantaged children. Many studies have questioned its effectiveness. For example: In 1980, noted education scholar Jonathan Kozol observed, "If Title I were not a mere expanded version of the errors of the past, we would not have more illiterate adults today than in the year in which that legislation took effect."

A 1987 Phi Delta Kappan report found, "The children who are tutored under Chapter 1—now Title I—do somewhat better on the average in the basic skills in the early grades than similarly disadvantaged pupils who have not been tutored. But by the middle grades this advantage disappears."

In 1992, the Commission on Chapter 1, a group of 28 education leaders, criticized the $6.1 billion program—then in 52,000 schools—particularly for its practice of pulling out students from regular classes for extra help, thus stigmatizing them.

The U.S. Department of Education's Final Report on the National Assessment of the Title I Program, released in February 1993, stated, "The program today does not appear to be helping to close the learning gap."

Is Title I now meeting its purpose of improving educational opportunities for low-achieving children living in low-income areas? Currently, an area is eligible to receive Title I funds if it has at least 10 low-income children and these children represent just 2 percent of the student population. At the risk of stating the obvious, many areas that are not poor now can and do receive significant amounts of Title I funds.

Title I funds are now increasingly being used for school-wide programs which allow schools to, "upgrade the entire educational program in the school to support systemic reform." As a result, this may lead Title I grants to serve 10 million children in 1998 versus approximately 7 million in 1996. This raises questions about the dilution of Title I aid to the neediest children.

Indeed, there are other indications that the aid is not going to those who need it most. Research by the Alexis de Tocqueville Institution found that the 15 wealthiest counties in the U.S. received $56 million in Title I aid in fiscal year 1996.

Education Week, a highly respected publication in the education field, has also found disturbing signs about the program. It recently noted that Marin County, America's wealthiest county, will have 20 school districts sharing $1.2 million in Title I money in the current fiscal year. In nearby San Francisco, Jefferson Elementary School, in a neighborhood with a 14 percent poverty rate, receives no Title I money.

At a time of continued deterioration among inner-city schools and concern about the focus and effectiveness of Department of Education programs, there are three steps that Congress can take to bring education decisionmaking closer to the people who need assistance.

First, Title I money could be provided in the form of a block grant so that States will direct the funds to the areas that need them most.

Another alternative would be to allow States to use Title I and other Federal education funds in combination with State, local and private money to provide scholarship/voucher opportunities for students in problem-plagued schools. Here, low-income parents would have an opportunity to decide what is best for their children. The scholarship/voucher plans would immediately enable many of our most disadvantaged children to obtain a much better education.

Third, Congress could reduce or eliminate many trickle-down programs to finance scholarships/vouchers. Modest savings of $500 million, for example, would provide enough money for over 165,000 poor children to have a $3,000 voucher to attend a private or parochial school of their choice. Bolder measures, of course, would have more of an impact.

I thank you for your time and look forward to your questions.

Mr. SHAYS. Thank you very much.

[The prepared statement of Mr. Steidler follows:]

U.S. House of Representatives
Subcommittee on Human Resources of the
Committee on Government Reform and Oversight

Statement of Paul F. Steidler
Senior Fellow, Alexis de Tocqueville Institution
March 20, 1997

Mr. Chairman, Mr. Vice Chairman, Members of the Subcommittee, thank you for the opportunity to testify today about the U.S. Department of Education's (DoEd's) mission, management, and purpose.

One of the most critical education problems we face today is the quality of elementary and secondary schools in the inner cities. Yet, there are a plethora of Department of Education programs that are of questionable value to students in these schools as the programs in large part benefit bureaucracies, teachers, and students that are not poor.

The array of these trickle-down programs include a literacy program for prisoners, Goals 2000, professional development assistance for teachers and even "parent training."

It is however the primary federal education program for the poor, Title I, that should be examined most closely. Title I has a mixed history at best.

Since its inception in 1965, Title I has been reauthorized eight times, most recently in 1994. The program, which has spent roughly $100 billion, was envisioned as a way to help disadvantaged children. Many studies have questioned its effectiveness. Consider:

- In 1980, noted education scholar Jonathan Kozol observed, "If Title I were not a mere expanded version of the errors of the past, we would not have more illiterate adults today than in the year in which that legislation took effect."

- A 1987 Phi Delta Kappan report found, "The children who are tutored under Chapter I [now Title I] do somewhat better on the average in the basic skills in the early grades than similarly disadvantaged pupils who have not been tutored. But by the middle grades this advantage disappears."

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- In 1992, the Commission on Chapter 1, a group of 28 education leaders, criticized the $6.1 billion program -- then in 52,000 schools -- particularly for its practice of 'pulling out' students from regular classes for extra help, thus stigmatizing them.

  As Commission Chair David Hornbeck noted, "The program helps disadvantaged students with special instruction, but also hurts them by drilling them in low-level skills . . . the program also has 'perverse incentives' because schools lose money if students improve."

- The U.S. Department of Education's Final Report of the National Assessment of the Title I Program, released in February 1993, stated, "The program today does not appear to be helping to close the learning gap."

Is Title I now meeting its purpose of improving educational opportunities for low-achieving children living in low-income areas? Currently, an area is eligible to receive Title I funds if it has at least ten low-income children and these children represent just two percent of the student population. At the risk of stating the obvious, many areas that are not poor now can and do receive significant amounts of Title I funds.

A change providing that funds can be used for "schoolwide" programs allows schools to now use Title I funds "to upgrade the entire educational program in the school to support systemic reform." As a result, this may lead Title I grants to serve 10 million children in 1998 versus approximately seven million in 1996. This raises questions about the dilution of Title I aide to the neediest children.

Indeed, there are other indications the aide is not going to those who need it most. Research by the Alexis de Tocqueville Institution found that the 15 wealthiest counties in the U.S. received $56 million in Title I aide in fiscal year 1996 (copy attached).

Education Week, a highly respected publication in the education field, has also found disturbing signs about the program (David J. Hoff, "Title I Quirks Pit Well-to-do, Poor Schools; Critics Worry Money is Spread Too Thin," February 5, 1997, p. 1 -- copy attached). The publication notes that Marin County -- America's wealthiest county -- will have 20 school districts sharing $1.2 million in Title I money in the current fiscal year. In nearby San Francisco, Jefferson Elementary School, in a neighborhood with a 14 percent poverty rate, receives no Title I money.

At a time of continued deterioration among inner-city schools, and concern about the focus and effectiveness of DoEd programs, there are three steps that Congress can take to bring education decision-making closer to the people who need assistance.

First, Title I money could be provided in the form of a block grant so that states will direct the funds to the areas that need them most.

Another alternative would be to allow states to use Title I and other federal education funds -- in combination with state, local, and private money -- to provide scholarship/voucher opportunities for students in problem-plagued schools. Here, low-income parents would have an opportunity to decide what is best for their children. The scholarship/voucher plans would immediately enable many of our most disadvantaged children to obtain a much better education.

Third, Congress could reduce or eliminate many trickle-down programs to finance scholarships/vouchers. Modest savings of $500 million, for example, would provide enough money for over 165,000 poor children to have a $3,000 voucher to attend an inner-city private or parochial school. Bolder measures, of course, would have more of an impact.

I thank you for your time and look forward to your questions.

The views expressed in this testimony are those of Mr. Steidler and not necessarily those of the Alexis de Tocqueville Institution or its Board or Directors.

Helping Those in Need?
How the U.S. Department of Education Spends $56 Million

The 15 wealthiest counties in the U.S. will receive over $56 million this year from a federal program that is suppose to be targeted to poor children. Through its Title I program, the U.S. Department of Education channels money to local educational agencies based "primarily" on the number of poor children in each county.

Given these counties' significant resources, it is highly questionable whether they truly need these funds.

A list of the counties, in order of per capita income, and the amount they will receive in Fiscal Year 1996 follows.

	County/State	Amount Receiving	Average Per Capita Income
1.	Marin, California	$ 1,209,739	$33,175
2.	San Mateo, California	$ 5,399,096	$32,660
3.	Araphahoe, Colorado	$ 3,602,275	$32,569
4.	Eagle, Colorado	$ 207,850	$32,335
5.	Pitkin, Colorado	$ 67,001	$32,104
6.	Fairfield, Connecticut	$11,821,568	$31,840
7.	Martin, Florida	$ 1,098,411	$30,654
8.	Blaine, Idaho	$ 118,252	$30,508
9.	DuPage, Illinois	$ 3,439,843	$30,418
10.	Lake, Illinois	$ 5,674,750	$28,963
11.	Hamilton, Indiana	$ 608,165	$28,547
12.	Johnson, Kansas	$ 1,932,029	$28,440
13.	Howard, Maryland	$ 1,068,792	$27,991
14.	Montgomery, Maryland	$ 5,483,329	$27,978
15.	Oakland, Michigan	$14,323,604	$27,796

Total: $56,054,704

Average U.S. Per Capita Income: $18,415

This table comes from a larger report by the Alexis de Tocqueville Institution on financing options for the Dole school choice proposal. For additional information, contact Paul Steidler, 703-527-5021.

August 28, 1996

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Title I Quirks Pit Well-to-do, Poor Schools

Critics Worry Money Is Spread Too Thin

By David J. Hoff
San Rafael, Calif.

The federal program intended to counteract poverty's effects on student performance is hard at work here in the wealthiest county in America, just down the road from the Fidelity Investments branch office.

Meanwhile, across the Golden Gate Bridge in the heart of San Francisco, neighborhoods with three times the poverty rate—and no investment brokers in sight—don't get any help from the $6.7 billion Title I program.

"We have the poverty, and we should not be having to compete with suburbs," said Mary Welsh Byrd, the director of state and federal programs for the 64,000-student San Francisco Unified School District.

But Congress' method for distributing money under the huge Title I program does force poor schools to compete—against those in affluent areas like California's Marin County and against each other.

Continued on Page 24

Fred Mertz

Title I money pays for Kathy Weichman's position as an aide at Vallecito Elementary School in Marin County, Calif. Despite the county's distinction as the nation's wealthiest, officials say the area has hidden pockets of poverty.

Title I Quirks Pit Poor and Well-to-do Schools

Continued from Page 1

Despite the remedial education program's stated purpose of helping schools in poor areas boost achievement, critics contend the money is spread among too many districts to have a real impact in the places where poverty is most prevalent.

The nation's 20 wealthiest jurisdictions receive Title I grants ranging from $31,714 in Falls Church, Va., to $69.9 million in the Manhattan borough of New York City. Together, the top 20 get $138.7 million from Title I—about 2 percent of the total, according to federal census records and data from the U.S. Department of Education. *(See box, page 19.)*

School officials here in Marin County, where per-capita income tops $28,000, say the area has hidden pockets of poverty and the student needs that go with them. For example, officials here point out, half the children in the tony waterfront town of Sausalito are on welfare.

Some of Title I's quirks are the result of political calculation. The rest spring from the complex mathematics written into the law's funding formula.

Marin County's 20 school districts will share $1.2 million in Title I money this year to serve the districts' 34,000 students. Just over 5 percent of the county's students come from families officially deemed to be living in poverty. San Francisco receives $11.9 million from Title I.

In Marin County, Title I provides an average of $663 for each student whose family is classified as poor. In San Francisco, the district averages $817 for each student living below the poverty line.

But the 1994 Title I law does not allow districts to simply assign the average amount to each poor student. The money runs out before all students are helped because the law stipulates that students in schools receiving Title I money get the district average plus 25 percent more. To decide which schools are worthy of the federal help, districts must rank buildings by poverty level. Then they start at the top of that list and stretch the money as far as they can.

In the end, some poor urban schools lose out. And when they do, they often complain about the well-to-do suburban schools that are winners.

In the Dixie school district in Marin County, the federal rules mean that one elementary school gets all of the district's federal aid. In San Francisco, meanwhile, the money runs out before all of the schools in poor neighborhoods can get a piece of the pie.

Pockets of Poverty

Marin County's Vallecito Elementary School is tucked in a neighborhood about a half mile from the Fidelity Investment branch here. Just over 4 percent of the children in the school come from families on welfare.

While that figure seems paltry compared with rates that hover around 20 percent in parts of San Francisco and nearby Oakland, poor children at Vallecito still struggle to keep up with their peers, according to officials in the 2,900-student, K-8 Dixie district.

"When you have a lot of high-end achievers, it's incumbent on a district to focus on kids that aren't doing so well," Thomas J. Lohwasser, the district's superintendent, said.

But critics say districts like Mr. Lohwasser's should be able to find their own way to pay for the remedial reading and mathematics instruction that Title I provides for about 7 million students throughout the country.

Photos by Paul Merritz

At E.R. Taylor Elementary, Christine W. Hirschhorn, far right, receives Title I money to pay for Reading Recovery teachers like Shirley Perkins, left, but 23 other San Francisco elementary schools don't.

"There are a lot of places getting Title I money that could meet their own educational needs without this program," said Paul Steidler, a senior fellow at the Alexis de Tocqueville Institution, an Arlington, Va., think tank that promotes free market solutions in public policy.

Others point out that students' learning problems in schools like the ones here in San Rafael are not as pervasive as in high-poverty cities.

"It's the predominance of poverty in a school that impacts achievement, rather than the individual poverty," said Mary Jean LeTendre, the Education Department's Title I director. "The poor kid who is attending a school that has very little poverty is going to do better than a rich kid who goes to a high-poverty school."

But when Congress tries to take away schools' funding—even schools in wealthy areas like Marin County—federal lawmakers quickly hear protests from local officials.

> Critics worry money is spread too thin to have real impact.

The 1994 law that reauthorized the Title I program forced Mr. Lohwasser of the Dixie district to spend his entire $36,561 grant at Vallecito Elementary, the school with the district's highest poverty rate. That meant he had to cut the after-school program in the dis-

tricts other two elementary schools, which had been funded with Title I money. The superintendent said he could not find enough local or state money in his $10 million budget to continue the after-school services. "The program has really been missed," he said.

If the federal government permanently withdrew its $36,561 grant, the district would have to lay off the three part-time aides who work in Vallecito Elementary's classrooms, Mr. Lohwasser said.

S.F. Funds Fall Short

San Francisco school officials also consider the money necessary. Sixty-three of the city's 110 schools get Title I money.

Because the city's $11.9 million grant is not enough to cover all schools, some buildings where 14 percent of children's families subsist on welfare and 70 percent of the children qualify for free or reduced-priced meals are shut out of the program, according to district records.

At the E.R. Taylor Elementary School—where 77 percent of the students eat free or reduced-priced meals and nearly 19 percent are on the welfare rolls—the $209,000 Title I grant pays for a Reading Recovery program throughout the school, according to Christine W. Hiroshima, the school's principal.

While the school's Title I funding has been steady over the years, fluctuations in state and local budgets have forced Ms. Hiroshima to find creative ways to continue the reading program and still offer other services such as a school nurse.

"It's a struggle just to maintain your program every year," Ms. Hiroshima said. "It's really a dilemma ... whether we'll be able to provide the extra services."

But while Taylor Elementary has a thriving reading program because of Title I, Jefferson Elementary School in the Sunset neighborhood near Golden Gate Park, with a 14 percent poverty rate, gets no money from Title I.

Mission High School—where 515 of the 1,547 students are from families on welfare—doesn't get any money because the per-pupil grant would have taken away too much money from the lower grades, according to Ms. Byrd, the district's state and federal programs director.

As it is, 23 San Francisco elementary schools don't see any Title I money.

That scenario is common throughout inner city districts, a lobbyist for big-city schools said.

"It's kind of ludicrous that a school district with [low] poverty is getting money, and you have school districts with [high] poverty and they're not able to reach all their schools," said Jeff Simering, the legislative director for the Council of the Great City Schools, a Washington-based group that represents the nation's large urban districts.

Gathering Votes

Whether schools like Marin County's Vallecito Elementary should continue to receive Title I money while some San Francisco schools go without has been the subject of intense debate in Washington for more than three years.

Plans to target the federal money on the poorest of the poor school districts may advance the goal of helping more poor children but it doesn't get votes needed for approval, especially in the House, where members closely track the federal money that flows into their home districts.

When House members voted on the bill to reauthorize Title I in 1994, they could check one of several computer printouts detailing how much money was due to go to their districts under the formula proposed in the bill.

If too many districts came up with zeros, the measure never would have passed, House aides said.

Instead, lawmakers passed the new formula, which includes a plan intended to target money toward urban areas like San Francisco and poor rural areas for appropriations that surpass the fiscal 1995 spending level. Even though Congress has raised Title I spending by more than $500 million since 1994, none of the cash has gone into the targeted formula.

Other changes barred from the program any district with fewer than 10 poor children or less than 2 percent of its enrollment in poverty.

Because well-off school districts receive so little money, the impact of those changes is "marginal," the Congressional Research Service said in an analysis of the 1994 law.

But in Marin County, the change, which took effect this school year, disqualified five districts that received about $10,000 last year.

In California's $706 million Title I grant, the changes kept about $1 million from wealthy districts.

Congress is making other small steps to steer more Title I money toward the poorest schools. Last year, lawmakers boosted the appropriation for the "concentration grant" portion of the formula from $684 million to almost $1 billion. Officials in Washington also raised the biggest part of Title I, the basic grants, by 2.5 percent.

Mr. Simering, who knows the realities of winning votes in Congress, said it is almost inevitable that districts in places like Marin County will continue to get a portion of Title I money.

"The hope is that you don't shower those that are substantially less needy with too much money," he said.

Rich Areas Get Richer

The federal Title I program, which was intended to help schools deal with the effects of poverty on their students' academic performance, will grant $138.7 million this year to the 20 richest local jurisdictions in the country. The list of these cities and counties comes from the 1990 census ranking based on per-capita income.

Jurisdiction	Per Capita Income	Population	Title I Aid
Marin County, Calif.	$28,381	230,096	$1,209,738
Manhattan, N.Y.	27,862	1,487,536	69,913,742
Pitkin County, Colo.	26,755	12,661	67,001
Falls Church, Va.	26,709	9,578	31,714
Fairfield County, Conn.	26,161	827,645	11,821,568
Arlington County, Va.	25,633	170,936	943,332
Montgomery County, Md.	25,591	757,027	5,483,328
Westchester County, N.Y.	25,584	874,866	14,147,610
Alexandria, Va.	25,509	111,183	873,376
Morris County, N.J.	25,177	421,353	2,037,748
Somerset County, N.J.	25,111	240,279	965,623
Fairfax County, Va.	24,833	818,584	3,515,528
Bergen County, N.J.	24,080	825,380	4,699,611
Nassau County, N.Y.	23,352	1,287,348	10,440,857
Hunterdon County, N.J.	23,238	107,776	478,024
Los Alamos County, N.M.	22,900	18,115	83,259
Valdez-Cordova, Alaska	22,772	9,952	195,666
Howard County, Md.	22,704	187,328	1,068,792
San Mateo County, Calif.	22,430	649,623	5,339,098
Montgomery County, Pa.	21,990	678,111	4,007,292

Mr. SHAYS. Basically, two messages are coming through loud and clear. Some of it gets more into an ideological debate than a debate on, say, financial or data information.

The general message I'm hearing from the Education Secretary of Virginia is that you believe that the Government's role should be limited and primarily in two areas. The message I'm getting from you, Mr. Steidler, is that you believe that the money is misdirected to wealthier areas primarily—and what?

Mr. STEIDLER. I believe that we are not getting the maximum bang for the buck of money that's going out there. There are a lot of places that are getting money that clearly do not need it as much as other areas do.

Mr. SHAYS. The report—no one can accuse me of self-interest, since Fairfield County, which I represent, is one of your targeted 15 communities. But what would be helpful is to, say, take Bridgeport, which is one of those communities in Fairfield which is 1 of the 10 poorest in terms of the number of students who are poor per capita in the country. So you have a Fairfield, CT—not the county, the town of Fairfield—which has a 3-percent minority population and a very wealthy community next door to Bridgeport, CT, which has an 85-percent minority population.

I would generally agree with you that, for instance, one reason why we tried to change the school lunch program was that we subsidize all children 30 cents for school lunches—all students. And given my congressional salary of $133,000 and my wife's salary as a teacher, we make approximately $200,000. I am dumbfounded to know why my daughter should be subsidized.

What we allowed in our bill last year, 2 years now, was to allow State and local governments to direct money away from New Canaan, CT, for students who could afford lunches and direct it to the Bridgeports and the Stanfords in my district that couldn't.

Which really leads me to a question: Isn't the real issue with the State departments, local departments, that they would just like a little more flexibility on how they spend the money? Could you elaborate on that?

Ms. SGRO. Yes, that is one of the most difficult things for us, is that we have the opportunity to acquire Federal money, so to speak, and then it comes with so many regulations with it that it becomes, in some cases, very, very difficult for us to manage the money and to put it exactly where we want it, which is in the desk with those little children in the classroom. We want to get all of that money there, but sometimes we don't have the flexibility, and a program that might be wonderful for California might not be very advantageous for Virginia.

So the greater flexibility that we can have, the less tentacles that come with the dollars, the more likely we are to have real education reform and to have children who really are learning and are prepared for the work force.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

Madam Secretary, what are your views on vouchers?

Ms. SGRO. Virginia has not discussed vouchers in any formal setting at all. We have attempted for the last 4 years in the general assembly to institute—implement—get a bill passed for charter

schools. We were unsuccessful in this last general assembly session. But Virginia, at this point, is not interested in vouchers per se.

Mr. TOWNS. Thank you. Why do you think that vouchers are the solution? What happens to those children that are not lucky enough to get a voucher?

Mr. STEIDLER. The first thing I would say, Congressman, is that providing vouchers and looking for systemic public school reform are by no means mutually exclusive issues. And I think one of the unfortunate things about the debate that has gone on is that, by saying that you support vouchers, you are somehow deemed not to support those changes that are going to affect public school reform.

Again, I would just make that point that those two issues are by no means mutually exclusive; and whether one favors or opposes vouchers, that this should be recognized.

I think another thing that is quite telling about the need for vouchers is that while hopefully the education system as a whole in many troubled areas will be fixed in the next couple of years, that is often scant comfort for the mother of a 7th or 8th grade child who is looking for an immediate way in which their child's education can be improved. And by providing a voucher or scholarship program to them, they are immediately able to get into a much better school and out of a school that might be chronically troubled and take a number of years to get fixed.

I would also add that I think it's the option aspect that should be very important here for States and localities. By giving them the flexibility about how to deploy these funds, that that is something where they are going to be able to make the decisions that will be most appropriate for their communities.

Mr. TOWNS. If the State does not assume, say, a certain academic level of excellence, then the Federal Government should not be involved in that at all?

Mr. STEIDLER. I think——

Mr. TOWNS. I want to make it very clear. And, of course, block grants do the kind of things that you are saying and then all of a sudden we realize that nothing is really happening. What role should the Federal Government play? After all, that is our money?

Mr. STEIDLER. I'm not sure what role the Federal Government should play in that case.

I would make the observation that I think one of the difficult things that we have now is that many people in communities feel very frustrated about pushing for education change because they perceive that there are controls in Washington that are in effect and that it is much more difficult to effect that change. And I think that by block granting money, you put the money closer to the people who are affected by it and you give them more possibility to petition those who can make change and who can institute meaningful reforms.

Just getting back to the Title I situation, I would also make the observation that when Congress reauthorized the measure back in 1994, it has taken a stab at improving the program. Hopefully, the program will be improved and function much better than it has over the past 29 years or so since its initial inception.

But I think that if you allow States and localities to find ways in which to deploy that money and make it much more effective, you are going to have more opportunity for getting the right deployment of funds and the right programs in place.

Ms. SGRO. Mr. Towns, may I respond to that also?

Mr. TOWNS. I was going to ask you to.

Ms. SGRO. Thank you. I will jump in first.

In Virginia, one of the aspects of our reform that we believe is critically important, first step was establishing standards.

The second was to establish a testing assessment program in which the test is really designed to test the standards, which is kind of a unique idea and not very prominent idea across our Nation.

The third part is probably the piece that you're asking for, and that is a report card. We are going to publicize how each school—how the children perform in each of those schools across the State, so that parents can actually see how well their children are doing compared with the other children in the State.

We also have a component in our test that will allow us to compare our students with other students across the United States. That's an important mechanism.

I believe that if Congress were to grant block grants to the States then States can be held accountable by the public, by the taxpayers, the people who are sending the money up here. They will have every opportunity to vote in, vote out those local school boards and influence the people who are running their schools; and I think people will be very intolerant if they see that one school is not performing well and another school is performing well.

We have several measures on that report card, not just a single test. Let me assure you of that.

I would not be a proponent of that. But looking at retention rates, looking at dropout rates, looking at attendance records of students and teachers and how many special education students are receiving services, those kinds of measures—what is the behavior of the children? How many serious disciplinary incidences have occurred in a school? And you want to see a school that is always improving, and a school that is not should be held accountable.

Mr. TOWNS. Thank you.

On that note, let me go into something else which I am certain you have heard it and this will not be brand new to you when I say it.

One of the major criticisms of the Virginia new educational standards is that you rely too heavily on rote memory and not enough on critical thinking skills. How would you respond to that? I know it is not new. You have heard it.

Ms. SGRO. I have heard it a few times, just once or twice in the last several years. Quite honestly, I would——

Mr. SHAYS. Would you repeat your answer? Because he needs to hear it twice.

Ms. SGRO. I would be so bold to say, Mr. Towns, that that really is a specious argument, that in fact our standards provide the academic basic skills, knowledge that a student needs to have in order to, in fact, do critical thinking, if you want to separate it. I do not think that you can separate critical thinking from what is taught.

Clearly, if you don't know how to—you don't have the basics of fixing a car, you don't have any idea how those pieces go together, you are not going to be able, as a wonderful car mechanic, be able to hear it go down the street and do a diagnosis as so many of our best people do. The same is true in the academic arena as well. You have to know when certain wars were fought and who are major leaders for this Nation and be able to create the framework that goes with that. So I think that really and truly is a specious argument.

Mr. TOWNS. Well, let me thank you for your comments and to say to you, Mr. Steidler, I am still concerned about those youngsters who, for some reason, that will not be able to get a voucher and be left out there, because something has to be done for them. And I am not sure I understand what you would do for them. That's not clear to me. I just wanted to say that important part.

I understand in terms of—but the point is that those who are not fortunate enough, what would happen to them, that's the part that troubles me. And we might be leaving out somebody who has a cure for cancer.

Mr. STEIDLER. Yes. I would just emphasize again that I do not believe that the two issues are mutually exclusive. We should have high standards and we should be willing to spend what needs to be spent to improve the quality of education in the public school system.

I think another thing that is very critically important is that schools need to be freed up of regulations, but I think they also need greater flexibility in terms of how they operate. They need more ability to be able to reward those teachers who are the best and the brightest to pay them what they need, and they need the flexibility to get rid of those teachers who are incompetent or who are just not doing the job. And that involves making some fundamental changes in terms of how the schools interact with the teacher unions.

You know, I'm not saying that a voucher program for a few children is going to be the silver bullet out there, but it does provide—it does provide a mechanism for many children to immediately get a much better education. I think it would also help put pressure on some systems that have been very unresponsive to change to undertake those changes that are appropriate.

I would just like to make the final observation that it strikes me as very mindboggling that right now the administration has proposed what is, in effect, a voucher program for college students where somebody—someone who is making $95,000 a year can send their child to Notre Dame and get a substantial tax break on that or any private and parochial school of their choice; and we are not providing that same opportunity to those parents of secondary and elementary schoolchildren that are in areas that are quite troubled and need to get some immediate help.

Mr. SHAYS. I am going to weigh in a quick second. May I?

Mr. TOWNS. Sure.

Mr. SHAYS. I would love to experiment, say, in the city of DC, with a voucher system; and I would love then to see its impact. But, right now, what we have done is we have imprisoned some students in some schools that are in pathetic conditions.

Having said that, I haven't been to some of these schools. I have read about them. One of the things that may be interesting as a committee is to use DC, as kind of our testing area and also, just in terms of our information area, is really see how good or bad the DC schools are. And then just see what possible alternatives.

I would quickly like to know why charter schools failed, because they seem to me to be a happy compromise between the voucher. Why did they fail in Virginia? Was it a partisan debate?

Ms. SGRO. It was a partisan debate. Yes, it failed on a partisan vote.

Mr. SHAYS. Was the VEA—do you call it the VEA there?

Ms. SGRO. Yes, VEA. They weighed in very heavily against charters. They have been against charters since the outset of this debate.

It was interesting, because Secretary Riley was there at the very closing week of our general assembly, and I certainly wrote him a letter. He was the guest speaker at the Democratic Caucus fundraiser, and I personally wrote him a letter and requested that he speak with the Democratic members of the general assembly to explain the benefits of vouchers, the fact that Virginia would be eligible to compete for additional funding to get them started. I think he was quite—of course, he is very much in favor of them but was not able to carry the day for really partisan reasons, unfortunately.

Mr. SHAYS. But the administration here in DC, does it support the concept of charter schools?

Ms. SGRO. Yes, very much so. It was an interesting week, because the President had just made his very strong endorsement of charter schools, Secretary Riley had, and just our Democratic Members in Congress were still reticent to pass a charter school law. And, in honesty, that is probably the very weakest charter school bill that has been put forward across the United States.

Mr. TOWNS. I thank both of you for your testimony.

Mr. SHAYS. Thank you both for being here. We appreciate you being here.

Ms. SGRO. Thank you very much. We appreciate the opportunity.

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

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