

VA FINANCIAL MANAGEMENT: REDUCING FRAUD AND INCREASING COLLECTIONS

HEARING BEFORE THE SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTH CONGRESS

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THURSDAY, SEPTEMBER 23, 1999

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Brown and Hill.

Also Present: Representative Evans.

OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. This hearing will come to order. Good morning.

This Veterans' Affairs Oversight and Investigation Subcommittee hearing will examine two recent cases in which two employees of the Department of Veterans Affairs embezzled over \$1.2 million. This is money from the veterans' compensation fund.

We will also examine why the VA has had to refund over \$20 million to health insurance companies because its third-party collection program overbilled them for veterans' health care.

Finally, we will see how VA Inspector General contract audits are saving hundreds of millions of dollars in VA contracting and procurement activities. The subcommittee will hear what the VA Inspector General and the General Accounting Office have discovered in their respective investigations and reviews in these areas, and we will hear what the VA is doing to correct any deficiencies and improve financial management.

I want to make it clear that this subcommittee and the Veterans' Affairs Committee is interested only in protecting the funding for veterans' benefits and health care and to ensure this funding for veterans goes where Congress intended it to go. We strongly support a large increase in veterans' health care funding because it is justified by veterans' needs. The questions with the collection programs are how to get more money for veterans' health care and what the VA must do to collect the right amount.

At this time I now recognize Congresswoman Corrine Brown, our subcommittee Ranking Democrat member.

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman, for holding this hearing. I want to thank you for this opportunity to examine management issues on the VA that are disturbing. A VA claims supervisor at

the St. Pete regional office that serves veterans in my district was caught stealing over 600,000 through fraudulent claims. A similar case was uncovered in New York. Neither case was uncovered by VA internal safeguards.

VA Medical Care Collection Funds, MCCF, is supposed to bring in money from veterans' health insurance. It keeps falling short and has left VA with financial shortages. I worry that the Office of Management and Budget and the Budget Committee see MCCF as a money river, and then appropriate too little money to VA.

VA procurement contracts represent a great deal of money. We must be sure VA get the best price and that its contracts are honest.

I take this problem very seriously. The first issue is the loss of money VA cannot afford to lose. More important is the integrity of the system. Veterans wait a long time to have their benefits claims resolved, and they are not convinced that they are getting what they deserve.

I look forward to hearing the testimony before the subcommittee. Thank you, Mr. Chairman, for holding this hearing.

[The prepared statement of Congresswoman Brown appears on p. 31.]

Mr. EVERETT. Thank you very much, and I would now like to recognize the Ranking Member of the full veterans' committee, a real friend of veterans, Lane Evans.

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

Mr. EVANS. Thank you, Mr. Chairman. I appreciate the opportunity to speak and participate this morning. We have been watching over the past few years the drying up of funding for the Department of Veterans Affairs. We have been watching, and fighting for every dollar the VA can wrest from a Congress that won't discuss what it has done to our Nation's priorities in terms of veterans.

With the meager resources that have been allocated by Congress in the current VA-HUD appropriations bill, VA must practice the highest possible stewardship. I commend both Chairman Everett and Ranking Democratic Member Brown for holding this important subcommittee hearing.

Reducing fraud, making the best procurement contracts and increasing collections of money owed to the VA are methods of stewardship that can assure the application of badly needed dollars to the programs they were intended to support. Congress and the public were shocked to read last July the press accounts of two separate cases of claims fraud by VA employees, each netting the criminals over \$600,000 before they were brought to justice.

When the President's budget first appeared last February, both parties on the Veterans' Affairs Committee agreed that added funding was needed for at least 10 additional staff in the Office of Inspector General. It didn't happen. The better figure would have been at least 30, Mr. Chairman. Far too much work by the OIG goes undone because the office is understaffed.

Mr. Chairman, Ranking Member Brown, we must see that the VA gets the money it needs and uses it properly. The VA is trying

very hard to exercise its role of good stewardship. Possibly the overwhelming majority of VA employees are honest and capable, dedicated to their individual roles of providing the care and benefits this Nation has promised the men and women who have served in the uniform.

Thank you, Mr. Chairman, for holding this important hearing today.

[The prepared statement of Congressman Evans appears on p. 33.]

Mr. EVERETT. Thank you.

I would ask witnesses to limit their oral testimony to 5 minutes. The complete written statement will be made a part of the official hearing record. I ask that we hold all questions until each panel has testified.

I would now like to recognize Richard Griffin, the Inspector General for the VA, and if you will, Inspector General, if you would introduce your panel.

**STATEMENT OF RICHARD J. GRIFFIN, INSPECTOR GENERAL,
OFFICE OF INSPECTOR GENERAL, ACCOMPANIED BY MICHAEL SULLIVAN, ASSISTANT INSPECTOR GENERAL FOR AUDITING, OFFICE OF INSPECTOR GENERAL, AND MAUREEN REGAN, COUNSELOR TO THE INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL**

Mr. GRIFFIN. Thank you, Mr. Chairman. With me this morning is Mike Sullivan, who is the Assistant Inspector General for Audit in my office, and Maureen Regan, who is the counselor to the Inspector General. I have submitted my written statement for the record, and I do have an oral statement I would like to make.

Mr. EVERETT. Without objection, and you may proceed, please.

Mr. GRIFFIN. Mr. Chairman and members of the subcommittee, today I will present to you the Office of Inspector General's views on fraud and mismanagement in selected Veterans' Affairs programs and summaries of the OIG audits and investigations in those areas. I will focus on veterans' benefits, debt management, and procurement and contracting activities.

One of three principal missions assigned to my office by the Inspector General Act of 1978 is the duty to provide leadership in efforts to prevent and detect fraud and abuse in VA programs and operations. In recent months, we successfully completed two criminal investigations involving embezzlements from the VBA Compensation and Pension program totalling over \$1.2 million. In the first case, a former VBA employee created a fictitious veteran and arranged for the direct deposit over 12 years of \$620,000 in fraudulent payments. In the second case, a supervisor at the VA regional office in St. Petersburg stole \$615,000 by creating a fraudulent disability compensation award in the name of the employee's fiancé, a veteran who had served in the Persian Gulf War. After the initial fraudulent payment, the perpetrator used VBA's computer system on 10 occasions between March and October of 1997 to retroactively increase the fraudulent payments the employee was sending to their joint bank account.

As a result of these cases, the Under Secretary for Benefits asked us to evaluate vulnerabilities in the Compensation and Pension program.

This past June, I gave the Under Secretary our vulnerability assessment, reporting on 18 observed vulnerabilities. Some of the key observations identified in our report are the following: Operating procedures to promote separation of duties have been abandoned or circumvented; some employees have multiple target command authorities; large one-time payments are not always substantively reviewed, and third signature review does not always take place as required; long-running awards with no recent maintenance need to be reviewed; the need to verify continued entitlement when mail is returned undeliverable; and the failure to control and secure records regarding employee claims for VA benefits.

We are currently conducting an in-depth analysis to assess the scope and breadth of vulnerability in selected areas to try to determine if there is a systemic problem. This follow-up activity will require a substantial amount of time to complete, and our efforts to identify, investigate, and prosecute employee fraud in the Compensation and Pension program will continue indefinitely.

Poor controls and mismanagement can lead to extraordinary program losses unrelated to employee theft. Recent work done by our office in areas concerning improper payments to Federal and State prisoners, disability offsets from military pay, and payments to deceased beneficiaries have identified opportunities for the Department to save millions of dollars.

As part of our continuing oversight of the Veterans Health Administration, we have issued five reports on medical care cost recovery issues. Additionally, at the request of the Under Secretary for Health, we conducted an audit of insurance billing practices at one VA outpatient clinic. The purpose of our review was to determine the validity of allegations of improper or fraudulent billings by the VA outpatient clinic in Sepulveda to American Association of Retired Persons Health Care Options, administered by the United Healthcare Insurance Company, and to determine whether there were opportunities to improve billing practices.

Our review substantiated AARP's allegation of improper billing. We did not substantiate the allegation of fraudulent billings. We found that the outpatient clinic had agreed to refund over \$84,000, that is, 80 percent, of AARP insurance payments made in 1997. We also found that the outpatient clinic continued to improperly bill insurance carriers in 1998 for medical services not documented in medical records, for services incorrectly coded, for services involving upcoded bills to indicate a higher level of service than actually provided, and services not covered by insurance. Improper billing occurred primarily because facility staff were improperly using and inaccurately coding patient care encounter forms.

We have also devoted significant resources to detecting and preventing fraud in VA's procurement and contracting activities. This is a reimbursable activity that is done in partnership with the Department. As a result of our efforts, the Department has recovered over \$130 million since fiscal year 1994. We have also recommended \$250 million in cost avoidance.

We are currently conducting a general review of contracting practices within VA to assess the impact of procurement reform on the agency's buying practices. The review involves issues such as local procurements, the procurements of commercial items, the use of impact cards, local prime vendor programs and standardization of items, to mention a few.

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

[The prepared statement of Mr. Griffin appears on p. 35.]

Mr. EVERETT. Thank you very much.

I will tell Members that we will observe the 5-minute clock, but then we will have a second round.

Mr. Griffin, according to your testimony, it is VBA's policy that employee claim records be maintained at a designated office and held in special secured areas, and that this policy has not been implemented at all VBA regional offices. Now, it seems to me that this is pretty basic stuff. Why has there been no compliance? Why has there not been total compliance or halfway compliance even?

Mr. GRIFFIN. I think that is a fair question. When we completed our assessment, Under Secretary Thompson and I had a conversation. As a result of his concerns and the concerns raised in our report, he had a national teleconference with all of his staff and instructed that they do an inventory of all files, and if they were in possession of files in any regional office that did not belong in that office, that they should be packaged up and shipped to the designated office. To date, we have principally been focusing our efforts in one office, that being St. Petersburg, in order to thoroughly review the activity that has occurred there so that we might be able to then take the lessons learned from that facility and apply them on a national basis.

Mr. EVERETT. Of course, we know about St. Petersburg. Which other regional offices are not in compliance?

Mr. GRIFFIN. Well, we have not been to all 58 of the offices as of yet. As a result of these two criminal cases, we have incorporated this activity into our CFO audit work, and we have confirmed that Atlanta, St. Petersburg, New York and Houston, had files in their possession that they should not have had.

Mr. EVERETT. You know, if we don't understand why something happens, it is kind of hard to fix it. What reasons were given by the VBA for not following their own policies and internal controls?

Mr. GRIFFIN. I don't have the answer to that question at the moment. Perhaps in the subsequent panel that could be addressed by VBA.

Mr. EVERETT. Your testimony refers to the New York embezzlement case, that involved fraudulent payments of over \$5,000 a month for 12 years, and that was allowed to occur because VBA did not review long-running benefit records. How could this have been detected and prevented earlier?

Mr. GRIFFIN. Well, in that particular case, the fictitious veteran had a Social Security number assigned to the name that was used, along with the date of birth. A cross check, which is supposed to be done twice a year, matching Social Security records and compensation and pension records would have reflected that the Social Security number used to create the payment was different than the

actual Social Security number which goes with the name which was used to create the payment. This match is supposed to be performed on a recurring basis, and in this instance it didn't happen.

Mr. EVERETT. In other words, no one followed existing policy? In a nutshell is that what you are telling me?

Mr. GRIFFIN. If the policy was followed, the results were ignored.

Mr. EVERETT. We are talking about over \$600,000 of taxpayers' money, but more importantly veterans' money.

Was anybody ever disciplined for this? Somebody had to call the shot somewhere, and I want to tell you something, this subcommittee is getting increasingly disturbed about the fact that VA seems very reluctant to notice when upper-echelon employees, higher-ranking officials of VA don't do their work. Of course, that is something I should address to VA and not you, but was anybody ever disciplined?

Mr. GRIFFIN. From our perspective, a major ingredient of deterrence is the aggressive investigation and prosecution of any employee that violates the public trust, and we are committed to rooting out any and all employees that are defrauding VA of funds, as you say, that should go to the care for veterans.

Mr. EVERETT. You stated there were other problems that needed to be corrected. Could you explain some of these problems, what they are, and what actions you recommend to fix the problems?

Mr. GRIFFIN. One of the problems we have noticed in multiple offices involves separation of duties. When it comes to authorizing and approving compensation claims, if you have one person with multiple authorities establish the claim, approve the claim and authorize the payment you have tremendous vulnerability to fraud being perpetrated. If insiders operate with the realization that there is little or no oversight, then there is little deterrent for them from the standpoint of having a fear of being caught for perpetrating a crime.

Mr. EVERETT. Let me make sure I am clear on this. VA policy has been for one person to have complete control over the process. Is there no safeguard for a second person to have to check off?

Mr. GRIFFIN. There are safeguards that exist in policies depending on the size of awards. There are safeguards which, if followed, could accomplish the function of being an internal control. What we have seen is an indication that in instances where there is supposed to be a second approval, that it has become a perfunctory approval, one that is given without review of all of the facts in the file. It is just a sign-off without proper due diligence to examine whether or not a proper decision had been arrived at.

Mr. EVERETT. Rubber-stamping, if you will?

Mr. GRIFFIN. Yes, sir.

Mr. EVERETT. I will have additional questions, but my time is up, and I will recognize our Ranking Member.

Ms. BROWN. Thank you.

What was the response of VA to these fraud cases? What was their response?

Mr. GRIFFIN. The initial response was that the Under Secretary called me and expressed his concern about this, expressed a desire that we do a quick vulnerability assessment and work with his people to determine how we can tighten down the system.

Ms. BROWN. How soon will you know whether the New York and the St. Pete situations are unusual?

Mr. GRIFFIN. We will have a better handle on other activity in St. Pete within the next few months. When we will be in a position to express an opinion about the other 57 offices is difficult to predict, depending on what we find as we go along. We are doing a number of things in the area of computer matching to try to identify the most obvious cases that might be out there, and we will pursue those immediately, again, in part, for deterrent value so people realize that they can't do these things and expect to get away with it.

Ms. BROWN. How good is VA's arrangement to match claims record information by computers with the Social Security Administration? You touched on this a little bit, but how up to date are we on that?

Mr. GRIFFIN. Well, any computer match is only as good as the data that is in the systems that you are matching. I know that there has been a problem with the quality of the data in some of the debt management activity that has occurred in the past. I think if you have good data, a straightforward match that can be run on a recurring cycle should identify those cases that we should be focusing on.

Ms. BROWN. I just have a follow-up about the St. Pete office because I am familiar with it because so many of my constituents use that office, and the waiting period is years. Could the problem relate to the volume of the number of people being served and to not having adequate staffing?

Mr. GRIFFIN. There is no question that the caseload in St. Pete has increased over the last 5 years. There are a lot of veterans who have moved to the Sun Belt, and there is no denying that there is a tremendous amount of work to be done, but you still need to have your controls in place.

Ms. BROWN. Without question.

Mr. Chairman, I will just wait for the next round. I yield back my time.

Mr. EVERETT. Thank you.

Your written testimony states that poor controls or mismanagement could lead to extraordinary program losses not related to employee theft. I was particularly interested in that because at some point a couple of years ago I was convinced that the VA was losing tens of millions of dollars a year because of the lack of good management. Today, I am convinced they are losing hundreds of millions of dollars a year because of the lack of good management. I think we have shown that. Could you expand on your statement, though, and estimate how many millions of dollars could be saved?

Mr. GRIFFIN. Yes. We recently concluded an audit involving incarcerated veterans, and our projected savings from that audit were \$170 million, \$100 million that had already been lost, and another \$70 million that would be lost over the next 4 years if the proper relationships weren't established with the Federal, State and local prisons around the country to alert the VA when a veteran becomes incarcerated. These prison contacts are critical because after 60 days, benefits payments are substantially reduced.

Mr. EVERETT. In the area of Medical Care Cost Fund or MCCF, the IG had three reports of debt collection issues that could increase medical care cost fund collections by tens of millions of dollars. Would you tell us a little bit about that?

Mr. GRIFFIN. Well, again, from our audit activity in the MCCF arena, we found that the local offices were not paying the type of attention that they should have paid to this opportunity to gain revenue for veterans' care. We found that there was insufficient training for people who were working in this area. There was insufficient management oversight. There were insufficient performance measures to ensure that there were follow-up attempts to claim money that was properly owed to the Department. And we felt that better coordination with regional counsel in those regions may have facilitated the collection activity and allowed them to capture some of these funds. Our audit report on this particular subject reflected potential increases of \$83 million in additional recoveries.

Mr. EVERETT. Is there a possibility there is as much underbilling as there is overbilling, or did you look at that?

Mr. GRIFFIN. Well, the \$83 million that we projected in our audit project was for \$83 million in underbilling.

Mr. EVERETT. Okay. Recommendations have been made to the VA to handle this problem. Have any of these recommendations been followed, to your knowledge?

Mr. GRIFFIN. Yes. I think subsequent to our most recent job, which was at the request of the former Under Secretary, when we looked at Sepulveda, I think that the VHA is very much on the case at this point. They had addressed some of these issues earlier and had sent out some tools to be used in the field to facilitate the collection, but I think there was not enough training and not enough follow-up to ensure that those tools were properly used. Indications now are that they have focused on this and that the situation should improve greatly in the future.

Mr. EVERETT. As a result of your efforts, you stated the Department has gained over \$130 million, as we discussed, and estimates over \$250 million in cost avoidance in the last 5 years. I think that is extraordinary. How many people are involved in these audits?

Mr. GRIFFIN. Those dollar figures pertain to a group of approximately 20 people that are in our contract review and evaluation division. It is a reimbursable activity that is paid for by the Department. It is an activity which we are extremely proud of as far as the results that they have been able to achieve in trying to work in partnership with the acquisition people in VA.

Mr. EVERETT. It appears to me it is an incredible return on investment, as our full committee Ranking Member said a little earlier. The Committee, both sides of the Committee, has recommended that you get additional help. If you had more bodies, I will put you on the spot, do you have any idea how much money you could possibly save?

Mr. GRIFFIN. With sufficient bodies we could cure world hunger. Our return on investment for the entire OIG organization for the past 2 years has been roughly \$20 for every dollar in our budget. I think that we can continue to do that. This is a huge Department. It is decentralized. There are, as you know, facilities all over the

country, and I think that there are significant opportunities for savings that we could pursue if we had additional staffing.

Mr. EVERETT. Well, I can guarantee you if we solve the problems within the VA, that we will ask you to solve world hunger. Thank you very much for your testimony.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Mr. EVERETT. I am sorry, excuse me.

Ms. BROWN. I want to follow up to that. How understaffed is your office based on the statutory floor?

Mr. GRIFFIN. The statutory floor would call for staffing of 417 FTE.

Ms. BROWN. Four hundred seventeen?

Mr. GRIFFIN. Yes.

Ms. BROWN. And what do you have?

Mr. GRIFFIN. We are presently at approximately 360.

Ms. BROWN. Three hundred sixty. So you are short how many?

Mr. GRIFFIN. Fifty-seven.

Ms. BROWN. Fifty-seven.

I have a couple of additional questions. VA has established a single-source contract for some pharmaceutical drug classes. Have savings been derived from these single source contracts?

Ms. REGAN. We haven't fully looked at that yet. That is one of the issues that we are looking at.

Mr. GRIFFIN. We expect to have a report done within 60 to 90 days on the contract side of the Department on a number of issues that we have been observing at various locations. We want to see if these are localized problems or if it is a systemic problem. My counselor and the people who work in contract review are preparing that document at this time, and we will certainly make sure that we get it to you when it is completed.

Ms. BROWN. Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. Thank you for your testimony and your good work. We appreciate it very much.

Mr. GRIFFIN. Thank you, Mr. Chairman.

Mr. EVERETT. I now would like to call Steve Backhus, Director of Veterans' Affairs and Military Health Care Issues, from the GAO, and, Steve, if you will introduce your staff, please.

STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE

Mr. BACKHUS. Good morning, Mr. Chairman. I am here by myself this morning.

Mr. EVERETT. Well, it should be easy to introduce yourself then.

Mr. BACKHUS. The folks that helped on this project are sitting here in the audience. Sheila Drake, Greg Whitney and Mark Scire are back here, but I thought I would see if I couldn't get through this myself this morning.

Mr. EVERETT. I am sure you can. If you will just please proceed.

Mr. BACKHUS. Okay. I am very pleased to be here today to discuss VA's efforts to increase its collections from private insurance companies for the medical care it provides to veterans with non-service-connected conditions. This revenue is a key source of funding that supplements VA's appropriations, and VA is relying in-

creasingly on its collections in order to expand and enhance services.

My remarks today address trends in collections and VA's efforts to increase its revenues. This work updates our 1997 report on this issue and is based on discussions with VA officials in headquarters, site visits to two medical centers, and a review of a 1998 report by Coopers and Lybrand and the VA Inspector General.

Regarding trends, VA's collections have declined in each of the past 3 fiscal years and will likely decline again in fiscal year 1999. Collections decreased from \$523 million in 1995 to \$442 million in 1998. Eleven months into this fiscal year VA had collected about \$388 million from third-party insurers. Unless VA collects \$54 million this month, or \$19 million more than it averages per month, VA collections will decline for the fourth year in a row.

Next year VA will implement regulations to change its billing from a cost to charge basis, which might increase revenues; however, data are insufficient to tell whether this will indeed reverse the declining collections trend. Our earlier work identified a number of factors that limit VA's ability to collect from insurers, and we believe these factors will continue to limit VA's collection potential, although quantifying the magnitude of this effect is also difficult without better data.

These factors include: One, a greater percentage of veterans aged 65 and over who have Medicare from which VA cannot collect; two, increasing enrollment in health maintenance organizations and other managed care plans which do not reimburse VA unless VA is a participating provider; and three, a shift in emphasis from hospital care to less costly outpatient care and thus revenue generating.

Nevertheless, VA can enhance its chances of increasing collections if it ensures that the management improvements that are being implemented at some facilities are implemented throughout VA. For example, as suggested by Coopers and Lybrand and the IG, VA medical facilities need to increase management involvement in the collection process, develop and measure progress against performance standards, and develop a single reporting structure for what is referred to as a business model to reduce fragmentation and improve communication among the various collection components. As of June 1999, though, only about half of VA medical facilities had implemented such a model.

VA also needs to obtain better information on veterans' health insurance coverage. VA is trying to educate staff and veterans through brochures and outreach about the need for such information. In addition, some facilities are pursuing veterans' insurance information more aggressively by contracting with private companies to identify veterans with insurance coverage. However, as of June 1999, little more than half of VA facilities reported that their collection of insurance information was thorough.

There are other areas where improvements are called for. VA needs to focus more on identifying whether the care it provides is nonservice-connected; obtaining approval from insurance companies for inpatient admissions prior to providing the care, called precertification; properly documenting the appropriateness and medical necessity of the care it provides; and of course, properly

billing for this care. While VA is training staff in order to improve its performance in these areas, as of June, 20 percent of the medical facilities did not report having procedures in place to validate whether the care for a nonservice-connected disability was being done, and over 30 percent had not trained their staff in some important steps necessary to accurately prepare a bill. Nearly all medical facilities had implemented precertification processes, though.

Lastly, VA needs to improve its efforts to collect overdue accounts receivable. As of May 1999, 75 percent of VA's delinquent accounts receivables were over 90 days old. In an effort to increase delinquent collections, in June 1998 VA contracted with a debt collection firm and has achieved additional collections of over \$9.7 million. As of June 1999, though, only about one-half of VA facilities reported using this firm to assist it in increasing its collections.

In conclusion, Mr. Chairman, VA has a number of initiatives under way aimed at improving its collection activities, but there remains significant room for improvement, and it is uncertain at this time whether VA will achieve its collection goals in the future.

Mr. Chairman, this concludes my statement. I will be glad to answer any questions that you or other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 40.]

Mr. EVERETT. Thank you very much.

Do you happen to know if the VA reached the goal for September?

Mr. BACKHUS. Well, the fiscal year is not over, so they have the balance of this month remaining.

Mr. EVERETT. Okay. Because it would be a fourth year of continuing decline.

Mr. BACKHUS. Yes, it will.

Mr. EVERETT. And, of course, the problem is that the Secretary himself, before this full committee, continued to increase their projections of how much they are going to collect, and they continue to collect less each of those 4 years. Let me mention that in your October 1997 GAO report it estimated that possibly \$600 million plus in overpayments of the VA. Today, GAO estimates that VA officials estimate that total repayment would not exceed over \$100 million. That is a half-billion-dollar, \$500 million, difference. Can you explain that?

Mr. BACKHUS. I can. At this time it seems reasonable to me that this adjustment be made. That original \$500 million estimate was based on—I am sorry, \$600 million was based on a 6-year projection of \$100 million a year in overpayments. Primarily as a result of the VA not informing the insurers, those people who are the beneficiaries over 65 and Medicare-eligible, VA, had not been informing the insurers that the insurers were only liable as a secondary payer; in other words, for the amount that Medicare wouldn't have paid if Medicare was the biller. Basically this means that those insurers were liable for approximately 20 percent of the costs of the care. Without informing those insurance companies of that limited liability, much of the payment that was potentially coming in was well in excess of the 20 percent that they owed, but what has happened are a couple of things.

A number of claims which have been submitted for refunds due to the overpayments has been very small. To date only \$19 million has been refunded, and the total value of the pending claims that are here in VA now are approximately \$29 million. So, combined, since 1997 when this estimate was produced, there is a maximum refund liability at this point of about \$48 million. So it is substantially less. The statute of limitations on these overpayments is 6 years, so time is beginning to expire on many of them. They are further reducing the potential liabilities. There has been some significant action on VA's part which is going to, I think, minimize or reduce the overbillings, and that is now they do notify the insurance companies that they are only liable for the residual amount that Medicare wouldn't pay or, in other words, approximately, as a secondary payer, approximately 20 percent. They shouldn't expect to see payments being made for the full amount of money that was the cost of the care. You should only expect to see payments coming in now for the proper amount, approximately 20 percent.

The third thing that is happening is that there is a conversion now the VA is making to a different basis for billing, based on reasonable charges and producing itemized bills. That should produce more accurate information so that the insurance companies will respond appropriately in the right amount. I do think the number is more reasonable at this time. Obviously, we are all interested in monitoring that and making sure it stays there, and if it changes, obviously let everybody know.

Mr. EVERETT. If I can understand, they overbill, the insurance company asks that money be paid back, and this could go back as far as 1993 or 1994. Does VA pay that money back, or does it come from the Treasury?

Mr. BACKHUS. Most of the refund up to this point has come from the Treasury.

Mr. EVERETT. In other words, the VA uses that money, which is excess money, and they have no liability to pay it back to the Treasury or pay it back to the third party?

Mr. BACKHUS. The way it has been working is that a couple of years ago VA got the authority to keep the money that they collect from the insurance companies. Prior to that, any refunds they collected went back to the Treasury. Thus far, the refunds from the overpayments that the VA has collected have been for time periods prior to the enactment of a law that permitted VA to keep the money. So, therefore, the refunds are coming out of the Treasury.

The refunds that are going to be paid now and in the future for periods of time where the VA was allowed to keep the money will come from the VA medical account.

Mr. EVERETT. Thank you.

There is a VHA memo dated March 8, 1999, stating that coding audits conducted by the IG, Price Waterhouse Coopers and AARP indicate that VA's coding and documentation was unacceptably inaccurate. It also stated that accurate coding is critical to the success of reasonable charges, and that facilities have failed every external audit. The coding audits have been shown to be up to a 90 percent inaccurate rate. My question is, how can the VA accurately collect with this magnitude of a problem?

Mr. BACKHUS. Well, clearly, unless things change, they won't be able to. It is probably the single biggest problem they encounter at this point. We have observed the same sort of thing. There is a lot of efforts under way to try to train these people in how to properly code, but there isn't yet the progress that needs to be made. Until it is made, the insurance companies will continue to reject bills and not pay them. There will be over and underpayments made, and the efficiency of this collection process as it should be won't occur.

Mr. EVERETT. Thank you very much. Ms. Brown.

Ms. BROWN. Thank you. The VA has consistently taken on targets that it does not reach. Does VA generally come up with the numbers, or do they originate with the Office of Management and Budget? And why are these figures always too high?

Mr. BACKHUS. I can't say with certainty where the numbers originally are generated. What I do know is that they have a model that they use to try to estimate those numbers, and it is my understanding, my impression at least, that the model itself would provide a fairly accurate prediction of what is accomplishable, but the data that are entered into the model is bad and, therefore, it produces a bad result, and it is data that is obviously more optimistic or inflated, if you will, than what has actually been occurring, and therefore, it is producing numbers that at this point haven't been achievable.

Ms. BROWN. Thank you. I yield the rest of my time.

Mr. EVERETT. Mr. Hill.

Mr. HILL. Thank you, Mr. Chairman. Let me ask, has managed care penetration impacted VA's ability to collect from third-party providers or payers?

Mr. BACKHUS. Certainly has. More and more these days. Veterans who have other insurance have enrolled in either HMOs or other managed cares plans, preferred-provider-type organizations, and unless the VA is a participating provider in those plans, which they are not, except for a very few, these HMOs and managed care plans will not reimburse the VA. They will only pay for care to those providers which participate in their plans.

I don't have data on exactly how many veterans are now in such plans who have other insurance, but I could provide that for the record, and if I could find it in here, I know I have it with me, I do have data as far as the general population goes and how those trends have changed.

Mr. HILL. Okay. Are there steps Congress might take, such as making VA a preferred provider, to address this problem?

Mr. BACKHUS. I know that that is a recommendation that the VA has kicked around from time to time, and back in 1997 we wrote about that in our report as a possibility. I think that is still an idea that is worth thinking about, although I don't know at this time that I am prepared here to throw my weight behind that yet without having thought about it some more.

Mr. HILL. Okay. What about VA, would they be in favor of legislation making VA a preferred provider?

Mr. BACKHUS. Well, they are going to follow me here. My guess is yes.

Mr. HILL. Your guess is yes?

Mr. BACKHUS. Yes.

Mr. HILL. Okay. Thank you.

Mr. EVERETT. Thank you.

I want to go back to bean counting just a minute. Assuming the unlikely prospect that VA had all the collection policies up to snuff, that they were where they should be, are the internal audits good enough to tell if VA is charging enough for the services they are providing? Are they losing money on those services, or making money, or breaking even or what?

Mr. BACKHUS. I don't think there is anybody that can answer that question. The limitations of data that exist in trying to identify what their true costs are are such that I don't think it is determinable. However, this conversion that is taking place now, that is going to provide a different basis for billing where they are actually no longer limited to try to estimate their cost and charge only that cost, but they are allowed now to charge based on what the prevailing rates are in the market, the commercial sector. It should provide them the potential to increase some revenue. A question will still remain, though, as to whether that covers their cost or not.

Mr. EVERETT. The prevailing rate in the market may be one thing, but VA's actual cost could be something else, could it not?

Mr. BACKHUS. Absolutely.

Mr. EVERETT. Either high or low?

Mr. BACKHUS. Either way.

Mr. EVERETT. But the fact of the matter is, because of the lack of being able to audit, VA has no idea.

Mr. BACKHUS. That is my opinion, yes.

Mr. EVERETT. Okay. Ms. Brown. Mr. Hill?

Thank you very much for your testimony.

Mr. BACKHUS. You are welcome.

Mr. EVERETT. At this time I would like to recognize Ed Powell, Assistant Secretary for Financial Management, Department of VA, and, Ed, if you would please introduce your staff.

While the VA panel is being seated, let me make a statement. I ask unanimous consent that a July 13, 1999, letter to the Secretary of the Veterans Affairs Mr. West, from House Majority Leader Mr. Armev and myself, be made a part of the record. The letter expresses our concern about the fraud cases that have recently occurred in the VA. It is my understanding that the letter was referred to the Inspector General because it requested a document originating in the IG's office. Before the letter got to the IG, the IG had already supplied the document to the subcommittee.

The bottom line here is that neither the House Majority Leader nor I as Chairman have received a response to this letter after more than 2 months. We don't know if the Secretary saw the letter. We don't know if he knows about the fraud cases or thinks there is a problem about them.

I wouldn't mention this except that it is beginning to fit a pattern of congressional communications with the VA. Official letters are not being answered in a timely and responsive way.

Having said that, Mr. Powell, I enjoyed our meeting yesterday, and if you will, please proceed.

(The letter follows:)

CONGRESS OF THE UNITED STATES,
Washington, DC, July 13, 1999.

The Honorable Togo D. West, Jr.
Department of Veterans Affairs,
Washington, DC.

DEAR SECRETARY WEST: Recent news reports have highlighted disturbing examples of fraud within Veterans Department compensation and pension programs. Specifically, the Associated Press yesterday reported that two VA employees were successful in embezzling \$1.2 million in funds that were intended for our nation's veterans.

News reports show that Inspector General Griffin has drafted an internal office memorandum outlining at least 18 weaknesses in the program. We are confident you share our desire to remove waste, fraud and abuse from government. Therefore, in the best spirit of cooperation, we respectfully request that you forward us a copy of this internal memorandum so that we may read Inspector General Griffin's recommendations for ourselves. Congress is charged with programmatic oversight of federal programs and we believe seeing this memorandum in full will make us better able to work with you to correct deficiencies.

This incident is just the latest in what appears to be a pattern of waste, fraud and abuse within your department. In just the last few months, Inspector General Griffin publicly released information about other outrageous examples of fraud and abuse:

- A New Orleans man was able to conceal his mother's death so that he could continue to receive her VA benefit checks. He was able to abscond with \$78,160 before he was arrested.
- Although her husband died in 1983, a New York woman continued to illegally cast her deceased husband's monthly benefit checks. For over 15 years, she was able to collect up to \$243,044 before she was caught.

By working together we can help the VA benefits program run more effectively and efficiently. We need common sense solutions to these problems and look forward to working with you to reach them.

Sincerely,

DICK ARMEY,
House Majority Leader.

TERRY EVERETT,
Chairman, House Subcommittee on
Oversight and Investigations.

STATEMENT OF EDWARD A. POWELL, JR., ASSISTANT SECRETARY FOR FINANCIAL MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY NORA EGAN, DEPUTY UNDER SECRETARY FOR MANAGEMENT, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; TODD GRAMS, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; AND D. MARK CATLETT, DEPUTY ASSISTANT SECRETARY FOR BUDGET, DEPARTMENT OF VETERANS AFFAIRS

Mr. POWELL. Mr. Chairman, thank you. Members of the subcommittee, I am pleased to testify before you today to respond to your issues concerning the Medical Care Cost Fund overbillings and the internal control weaknesses recently uncovered at two of our regional offices.

Accompanying me this morning to my left, your right, Mark Catlett, who is the Deputy Assistant Secretary for Budget; my immediate left, Nora Egan, who is the Deputy Under Secretary for Management at the Veterans Benefits Administration; and to my right, Todd Grams, who is the Veterans Health Administration's Chief Financial Officer.

I have submitted my full statement to the subcommittee, and I request that that statement be made part of the hearing record.

As the Department's Chief Financial Officer, I work closely with management officials in VA's Administrations, supporting their efforts to provide benefits and services to our Nation's veterans, and providing strategic and operational leadership to improve the Department's financial management, stewardship and oversight.

Many of VA's management challenges are directly attributable to inadequate staffing levels, inadequate training and a reliance on outdated business processes and legacy IT systems. While there is no quick or easy solution to any of these, I can assure you we take these problems seriously, and we have plans in place to address them, and we are making significant progress.

Earlier this year, I initiated a Departmentwide effort to reexamine all of our business processes and systems with the objective of migrating our existing, independent and disparate financial systems to new, more integrated financial and logistic standards modeled on contemporary best practices as established by the Joint Financial Management Improvement Program, or what we will refer to as JFMIP. By taking this standards-based approach, we can significantly improve our management and operations, address weaknesses in our internal controls, reduce our operating costs, and maintain our focus on what is most important, providing benefits to our Nation's veterans.

This new approach, which is named the Integrated Financial/Logistics Management Standards, or IFMS, will bring consistent reporting standards, data and information to all Department components. It will also facilitate change throughout VA by providing the opportunity to abandon antiquated, inefficient ways of doing business, and incorporate the results of best practices through business process reengineering. Our goal with IFMS is to address weaknesses in VA's current financial management processes and systems and to provide VA the flexibility to adapt to internal and external changes.

IFMS is a major component of our plans for resolving problems and improving management decisionmaking; however, it is not a panacea. The Department is undertaking other management improvements which I wish to describe, specifically with regard to the two issues you have raised.

Almost any new program develops unforeseen problems during implementation. Similar to the experience of our health-care partners in the private sector, we are challenged with correcting and preventing inaccurate billings for health services in the Medical Care Cost Fund.

In 1997, when the concern about possible overpayments was brought to us, we took steps to correct billings to third-party payers. A series of handbooks, software and training programs were developed and provided on the coordination of benefits. This has been an agenda topic for numerous national meetings and conference calls. The Veterans Health Administration has issued several memoranda to network and medical center directors on the findings of AARP and the findings from other reviews conducted at the Department's request.

VHA has instructed its networks and medical centers to implement various actions, such as: conducting ongoing comparisons of a significant sample of bills to detect and correct any errors at the source of entry; providing coding training to all clinic support and coding staff on the appropriate use of certain common procedure and diagnostic codes; reviewing and updating all encounter forms to accurately reflect the level of care and procedures performed; make sure the clinical staff providing care are properly reported on those forms; and reviewing the administrative procedures for the proper handling of no-shows and cancellations.

In assessing these problems and developing corrective plans, VHA sought advice from a variety of sources such as the VA field office and headquarters staff, private sector contractors, the VA's Inspector General.

VHA also retained the American Hospital Association and Price Waterhouse Coopers to conduct a comprehensive compliance assessment, which was completed in April of 1999. The assessment recommended implementation of a comprehensive health care compliance program to help correct the integrity in the billing and collections program. In August, the VHA Compliance Office was established, and the task of staffing this office is now underway. Initially, MCCF staff have been reassigned to the new office, and several temporary contract employees have been employed to begin developing processes and policies to support compliance program efforts. In addition, compliance officers are being appointed throughout the networks and medical centers.

A special team has been appointed to develop a strategic training plan, and VHA will hold the first VA Compliance Conference next month. An infrastructure is also being developed to track compliance efforts electronically. We expect it to be fully implemented in fiscal year 2000.

We are confident the combination of these initiatives will correct the billing problems that surfaced in 1997.

Moving to our benefits program, the recently identified instances of employee fraud at the New York and St. Petersburg regional offices have reinforced the importance and value of institutionalizing systems of internal controls. The facts indicate the employees who committed the fraud were successful because internal control procedures were either missing, circumvented, or not followed.

Upon learning of these fraud cases last January, the Under Secretary of Benefits requested the IG's assistance in identifying internal control weaknesses and vulnerabilities in the Compensation and Pension program. At the end of the 6-month review, the IG reported 18 observations of internal control vulnerabilities. They fall into six general categories: reasonable assurance and safeguards; delegation of authority and organization; separation of duties and supervision; controls on ADP and claims records access; recording and documentation; and integrity, competence and attitude.

VBA has already begun addressing the IG's observations through policy changes, instructions and controls. Specific examples include issuing instructions that reinforce VBA's policy regarding the transfer of veteran-employee claims folders to the appropriate jurisdiction; reinstating regular reviews of security logs that identify each time an employee record is accessed; and reestablishing a Sys-

tem Security Office in headquarters with oversight of field violations.

Longer-term solutions are also being developed. Among these is the reinstatement of quality reviews of work products to determine the accuracy of claims processing. These reviews provide an excellent opportunity for assessing whether there are any improprieties in the actual claims themselves.

The administrations are not working alone in their efforts. My office's financial review staff in Austin, TX, continues to assist them in looking for weaknesses in financial management areas, including MCCF and internal controls. In addition, we are supporting the IG in their audit of the Compensation and Pension program's financial and internal controls.

None of the issues I have addressed can be resolved immediately. Our approach to these issues is deliberate and methodical. Our approach is also inclusive in that we will continue to seek out the Inspector General's participation in our assessments and plans. By working together, we will build and maintain a high level of confidence in our integrity and reliability in both of these areas.

Mr. Chairman, this concludes my statement. My colleagues and I are pleased to respond to your questions, and we look forward to that opportunity. Thank you.

[The prepared statement of Mr. Powell appears on p. 48.]

Mr. EVERETT. Thank you very much.

Mr. Catlett, the GAO has estimated potential possibilities for repayments are around a hundred million, with perhaps an additional 29 million. My first question is, did this happen on your watch?

Mr. CATLETT. The overpayment issue, it was identified, as they said, several years ago, and that is when it began. That is when we began to take the action, as Mr. Powell noted, to immediately notify the insurance companies and make efforts to correct this problem.

Mr. EVERETT. At what point were you advised of the problems in this collection system?

Mr. CATLETT. As soon as it was identified. We began our meetings within VA and with OMB to address how we were going to correct the problems that were identified.

Mr. EVERETT. Excuse me, one moment. We have votes on the floor which will probably keep us around 20 minutes, my best guess, and I am going to recess until we are able to make those votes, and we should be back, hopefully, around 11:30. Hearing is recessed.

[Recess.]

Mr. EVERETT. Mr. Catlett, I think the GAO stated that some of these overpayments go back beyond the statute of limitations. What is the statute of limitations in this case?

Mr. CATLETT. Sir, I will have to have that provided for the record by the General Counsel.

Mr. GRAMS. Mark, it is 6 years.

Mr. CATLETT. Mr. Chairman, could I follow up to the first question before we broke?

Mr. EVERETT. Sure.

Mr. CATLETT. I note that you used the term here now, overpayment versus an overbilling, which I think is more accurate. As you know, we were billing as we were required by law, a flat per diem. We bill everyone the same. The identification of this problem was by the companies who should have been paying us as a secondary payer rather than as a first payer. That was of interest not only to us in the financial operations of the Department, but also to the General Counsel. OMB also became involved. Our General Counsel coordinated with the Department of Justice in determining the liability and negotiating with settlements, which to date add up to \$21 million.

So the point I am making is this is a responsibility of the payer, the insurance companies, as much as it is an issue for us as the biller.

Mr. EVERETT. Well, you know, Mark, one of the problems I have in 5 years of chairing subcommittees is I can never find out which donkey to pin the tail on. Everybody has always got an excuse, and it is really difficult to find somebody who will take responsibility. We are talking about hundreds of millions of dollars across the VA system.

Let me just continue. In 1997, the GAO report stated that the VA did not know how many veterans in their 2.9 million patient base have insurance or how many insured veterans received billable care. Have you done anything to correct that, or are there procedures in process to correct that so we know exactly who we can bill and how much money we are losing by not billing?

Mr. CATLETT. Sir, I would ask—Todd Grams to respond, who I know is ready to provide the detailed information. Clearly the issues you are raising here are ones that we have taken seriously, and, as noted in Mr. Powell's statement, are something that won't be fixed overnight, and we have been taking steps to address these issues. Todd would be glad to provide some details for the record now and more if necessary in terms of steps that have been taken.

Mr. GRAMS. Thanks, Mark.

Mr. Chairman, of all the initiatives we have, three are directly related to identifying which veterans have insurance. First is an initiative called preregistration. In that initiative we actually call veterans before they come in for their appointments to our facilities. We ask them a series of questions which allows us to update our information so we don't have to slow the veteran down when they come in that day of care.

Mr. EVERETT. Is this something that has been in existence for a while, or has this just been started?

Mr. GRAMS. This is something that we piloted a couple of years ago, and we mandated it this year to the field.

Mr. EVERETT. Please continue.

Mr. GRAMS. We also have an initiative that we have worked out with one of HCFA's fiscal intermediaries in the State of Texas, which I call an insurance match program, which allows us to send a veteran's name to that fiscal intermediary, and they will tell us out of the database that is kept for the Medicare program whether or not that veteran has primary health insurance.

The third and final and new way that we are identifying health insurance, as you are well aware, Mr. Chairman, we have an en-

rollment process now in the VA, and one of the questions we ask when veterans enroll is whether or not they have health insurance.

Mr. EVERETT. Well, I appreciate the fact that you are moving forward on this. That really was not my question, though. My question, I am trying to find out who let the horse out of the barn, not the fact that you are putting the horse back in the barn, and I am having a devil of a time in almost all my hearings finding somebody that is responsible to the Congress and to the taxpayer and to the veterans in ensuring this money is spent well. Somewhere somebody has got to be held responsible.

I said earlier, at one time I didn't know how much money I felt was being wasted within the VA, and then I finally decided it must be tens of millions of dollars, but more recently I am convinced it is hundreds of millions of dollars, and I would point out to you that at one of my recent hearings where the VA had millions of square feet of unneeded building space and was spending \$400 million each year for upkeep and maintenance of unneeded buildings. Many of these buildings need to be closed down, by VA's own admission. There's also \$27,000 spent by a director for a fish tank; \$250,000 by a director to refurbish government housing and put gold-plated bathroom fixtures in it; \$97,000 for a director to waterproof a basement, which the IG tells me couldn't have cost more than \$4,500. And yet in all these cases that I have mentioned, nobody has been held responsible. This is tons of money. As I said earlier, it is hundreds of millions of dollars.

And if I sound like I am impatient, I am, and I am getting more so because we can always get an idea that you guys, and I appreciate that, are going to fix the problem, but nobody ever gets held responsible for the problem. Until we start holding people responsible for the problem, and I mean firing people as they would be in the private sector, this thing is going to continue. At some point the taxpayers are going to get mighty tired of it, and that is a discredit the VA is doing towards the veterans, not just the taxpayers, but towards the veterans.

Now, I understand what we have just been through, and this is just really one part of the overall situation that concerns me with the way the VA spends its money.

Mr. GRAMS. I can't address a lot of what you have raised there, Mr. Chairman, but I will tell you, if you want someone to come back up here in 3 months, 6 months or a year to hold them accountable for what is going on in the revenue program, I am that person, and I will be glad to come up whenever you need me.

Mr. EVERETT. As I told others, including Deputy Secretary Gober, I would hold you to that.

Mr. Powell, or whoever should answer this, maybe Mark, the situation where we had this guy getting \$5,000 a month for 12 years, should that not have been detected earlier by some sort of internal controls? Are there no internal controls that would prevent this from happening?

Ms. EGAN. Mr. Chairman, I am the person who should address that question.

Mr. EVERETT. Please.

Ms. EGAN. Yes, sir, we should have caught it. I think in Mr. Powell's testimony he did mention that over the past 7 or 8 years, as

we suffered reductions in staff, and increased complexity of cases, we moved a lot of people who used to do that kind of checking into production. We also streamlined processes in an effort to respond to very justifiable criticism that we were not processing claims as expeditiously and responsively as we could. As we moved people out of the functions, either in administration or in finance or in the compensation area that would normally have performed those kinds of safeguards, we lost sight of that. In my own personal opinion, we focused on timeliness in trying to be responsive to claims, in this particular case new claims, at the expense of some of the internal controls and safeguards that were in the system.

In this instance, there were two issues. One would be doing a kind of maintenance review of running awards that had not been ongoing for 20 years or more. VBA stopped doing that because, given how many cases came to their attention that did need some modification, it was determined that it wasn't the best use of productive time.

Somewhere between that and where we are today, we are going to be working with the Inspector General on how to do a better review and trigger certain things in the system that will cause us to do that kind of review.

The second issue is the mail issue. Clearly, this person had a fictitious address. Over the years, we got numerous pieces of correspondence back from this individual with "no addressee" or "no such address." At the same time as we experienced this with this individual, we were also trying to focus on direct deposit for veterans and their beneficiaries. We get some 15,000 pieces of mail a day into ROs. My understanding of what happened was, that because so many veterans were having their checks direct deposited, there was no need to let us know when they changed addresses. And, because we do have a requirement of some due process to notify people if we are going to suspend a payment, when we had mail of the kind called drop file letters, ones that we couldn't find a folder for, or whatever, they just went into a box for folks to look at when they got the time to do it. That, in retrospect, was not a good decision. But in terms of the volume of mail that comes in, and, again, shifting the resources, while I am not defending it, I understand probably why the regional office focused on other things besides the mail.

One of the things we are going to do and we are in the process right now, is negotiate a Memorandum of Understanding with the United States Postal Service to do a match on addresses. We think this will clear up a lot of the issues where we just simply don't have a current address on a veteran who is entitled to benefits.

Then we need to look at what is left where we have no claims file or the claims file can't be found. We are going to be working with the IG to come up with a way to track those so that hopefully in the future we can do a better job.

Mr. EVERETT. Well, I appreciate locking the barn door again. I just can't imagine all that mail that the post office says we can't find an address for being just simply stuck in a file and nobody being responsible enough to find out what was going on. This happened year after year. And it goes back to my recurring question: Do you know in either the Florida or the New York situation of any

employee that was either disciplined or given a bad performance rating in either of these cases?

Ms. EGAN. Not at this time, sir. I don't have the final and complete IG investigation. I think the issue with the mail, while, it happened at New York, was probably endemic to the system. I think part of the problem that you have discussed became a system problem.

Mr. EVERETT. A system problem is a personnel problem. Somebody is behind a system problem.

Ms. EGAN. I think it was a decision made over a number of years, sir, to try and respond to some of the other demands in terms of timeliness, to try and deal with the staffing shortages we have by moving people into production that evolved over a period of time. Less and less time was spent on doing the kind of internal controls and oversight. And if that is a systems problem, I am responsible for that.

Mr. EVERETT. I heard that. With all due respect let me tell you that the VA has a reluctance to punish, or not a reluctance, a refusal to punish and discipline people who need to be punished and disciplined, and I will go back as far as my hearings on EEOC where directors, at least 12 directors who were guilty of sexual harassment, were allowed to retire, and not only allowed to retire, but given \$25,000 buyouts.

I am getting a little tired of hearing about the barn door being locked after all this, and no one is ever held accountable. In the real world, let me tell you, there are some people that are involved in the VA that wouldn't last 2 seconds, and rightly so, and shouldn't last 2 seconds in the VA. It is a discredit to our veterans. This is important money, and as long as the VA continues to refuse to discipline people, my guess is you can put all the safeguards in that you want, but we have got a saying down home, you know, you don't lock your door to keep an honest person out. You lock your door to keep a crook out, and even when you lock your door, a crook will find a way in.

Ms. EGAN. Mr. Chairman.

Mr. EVERETT. Yes.

Ms. EGAN. I mentioned earlier that when we receive the complete and full investigation from the Office of the Inspector General on both St. Petersburg and the New York regional offices, and if it is evident in that information that there are individuals who are responsible for this, we will take appropriate action.

Mr. EVERETT. Would you give this committee a report on that?

Ms. EGAN. Absolutely, sir.

Mr. EVERETT. I appreciate it.

Mr. POWELL, do you agree with GAO's estimate of your repayment liability?

Mr. POWELL. At this time, sir, I don't have any reason to think their methodology was inappropriate in reducing the repayment liability down to the hundred million dollar range. As previously stated, we are finding the fall-off of the claims resulting from the statute of limitations and ongoing negotiations with AARP and others when they come up. We are not just accepting claims as presented. As I understand from Todd, and he may want to address this in more detail, if someone comes and says they have a claim

against us, we are also auditing it from our point of view, using outside consultants, to ensure claim is not just one-sided.

As I mentioned when we met with your staff, the IFMS program which we are undertaking is a very significant change in the way this Department does its bookkeeping. As you and I talked, we have never had a cost accounting system in VA that even remotely came close to what you would find in the private sector for this type of an activity. The new system we are looking at will give us first and foremost a consistent methodology across the entire VA system. We will have consistent charts of accounts at all of the VA's facilities meaning all the hospitals will have the same chart of accounts. We don't currently have that. We would have one travel system for the whole VA versus the myriad of different operations we currently have. We will be able to roll up costs in a way that has been only dreamt of within the context of our operation.

It is a very important effort, and it will take a great deal of energy and effort to get it done. It will require extensive reengineering of our processes. I hope that you will stay behind it because it will take 3 to 5 years to complete.

I also would like you to know, because it has come up on the procurement issues in the IG. Pre- and post-award audits generated approximately \$390,000 a year in recovery prior to our office funding and participating in the audits. Once we became involved, the IG was able to devote approximately 40 FTE to these efforts. The General Counsel and our office negotiate the actual settlements. Working together, this current fiscal year the recoveries have exceeded \$12.5 million as of the end of August.

This is an ongoing effort which we take very seriously and fully support. It is a normal and ordinary business practice that is probably one of the better things we do in terms of making sure we are getting good value for our dollar.

Mr. EVERETT. I appreciate that, Mr. Powell, and I was very encouraged after our conversation yesterday.

Ms. Egan, is VBA on board with the IFMS system that Mr. Powell just finished telling us about?

Ms. EGAN. Yes, sir, we are supportive of it. There are some issues regarding our payment systems as we are migrating from our current benefits delivery system to a replacement system, and how they interface with the replacement finance system that is going to be built under IFMS. Whether it is an integration or an interface, is an issue that is under discussion right now because of the scope, but in general we are very supportive of it.

Mr. EVERETT. These are issues that can be resolved?

Ms. EGAN. Absolutely.

Mr. POWELL. Yes, sir.

Mr. EVERETT. I will have additional questions. Let me give my Ranking Member a chance, please.

Ms. BROWN. Thank you.

I just want to follow up on how soon will you know whether the New York or the St. Pete situations are unusual; what systemwide correction action have you taken, and what are you planning to take.

Ms. EGAN. In terms of whether it is systemwide or not, I think the Inspector General mentioned that they had so far discovered

some potential similar issues at our regional offices in New York, Houston, Atlanta, as well as St. Pete, but I also know that the IG and Mr. Powell's office did some reviews at Waco, Cleveland, and Phoenix and did not find those kinds of issues.

One of the immediate things we are doing, and I should have it this week, is a run of all VBA, or VA actually, but particularly VBA employees who are veterans who have claims. We are going to do a match against the regional offices. If we find repeated instances of where there are a large number of employee folders being maintained at the regional office where they are employed, that is a flag for us, and we are going to go in and take a look at that. That is one of the immediate steps that we will be taking in conjunction with the Inspector General's office.

There are some legitimate reasons why an employee's folder could be in an RO—they have a hearing coming up and their power of attorney wants to review the file or the folder has gone back to set up an exam with VHA or one of the contract providers. But other than that, they should not be there, and if we find significant numbers, that will be a bellwether for us to go in and take a look at it.

In addition, we have put out some directives in the last several weeks reminding folks of their responsibilities on internal controls with regard to the jurisdiction of those folders and the maintenance of the folders. We have been ensuring we have second or third signature where appropriate. Many of these systems were in place, apparently just not followed. We are reminding the directors of their responsibility and accountability for these systems, reinstating the target security review to make sure no employee tries to access their own files or other protected files, that is flagged to us, and to follow up on that.

Long term, we are working with the IG on a number of other initiatives. Even if we do a better job enforcing those safeguards that are the front end part of the system, it is not foolproof. We will do the best we can, but there are always some other things, as the Chairman pointed out.

One of the other things we are going to do on oversight is when we get the Treasury tapes back on payments, our finance folks in headquarters are going to be looking at very large payments. Those are not sometimes unusual these days because of cases that have been pending before the Board or the Court. We do have a significant number of fairly large retroactive or one-time payments, but we will be reviewing those as a double-check oversight.

As far as the audit goes, as you know, they had 18 recommendations, and we are working with them on each and every single one. The Under Secretary is very determined that we do what we can to reinstitute the credibility.

I don't believe that fraud is widespread. I do believe we have significant quality issues. I think that as a result of our training, our lack thereof in the last several years, that we have people who, with the best intentions, are making bad decisions, either paying people who shouldn't be paid, not paying people who should be paid. Training would help prevent this kind of fraud. But when fraud happens, it is not only a violation of the law, it is a violation

of our trust, for the public and the veteran, and that bothers us tremendously.

Ms. BROWN. Did you say it is not a violation of the law?

Ms. EGAN. No. It is not only a violation of the law. To me the bigger issue is it is a violation of the trust, the public trust, that all civil servants, in my mind, people who work for VA and VBA, have to have with the veterans and the beneficiaries whom we serve. So it is very troubling, and it is not going to be left unattended.

Ms. BROWN. Is it possible to make the system crook-proof, I mean?

Ms. EGAN. I don't think so. I think no matter what kind of system you develop, someone will find their way around it if they truly want to. We depend on a lot of expertise in our systems, and I hope we have the safeguard to either catch it ahead of time or catch it after the fact.

I think to the extent that we want to try and build a system that is foolproof, the money spent may be more money than the fraud, and I am also concerned that by putting in a lot more safeguards and stopgaps, we have to balance that with our efforts to try and improve our timeliness in response to people. People file claims for pension or compensation, they are waiting for that answer, and there is always a struggle to balance between trying to make the right decision and getting them the decision they need in a timely manner. And, as you well pointed out, we are struggling with that with putting the kind of appropriate safeguards both in the front end part of the process and the review process.

Ms. BROWN. Chairman Everett mentioned earlier, it seems as if the VA has the good old boy system, and that when you catch a person, or a person is identified, what happens? I mean \$600,000 is a significant amount of dollars.

Ms. EGAN. Well, in the case of the individuals who perpetrated the fraud, they, of course, have not only been fired, they are incarcerated or in the process of being. But I think the real issue is swift and sure punishment for those who violate it—and Mr. Thompson, I don't know if you had a chance to see the videotape of Mr. Thompson's presentation, but it was when we received the IG report, he went within a week or two to all employees. We had a live telecast, and talked about that and talked about where fraud has occurred, punishment will be swift and severe.

I think what the Chairman was referring to also is who in management is responsible. I mean, you have employees, and we will deal with those, but the larger context to which I think the Chairman was speaking was that somehow when these systems failures happen or there are issues that happen under your nose, when is management held accountable for this? As I said to the Chairman, I think that there has been systems degradation over the years for which it is my watch now, so I am responsible, but in the specific instance of New York and St. Pete or any other regional office in which we may do an investigation, if the results of that investigation show that there are employees who acted inappropriately, we will take appropriate action.

Ms. BROWN. I have one final question for Mr. Powell. Why are some of the VA health care costs higher than that of the private

sector? I deal with a lot of veterans, I want you to know, when I have my town meetings or discussions back in the district. They have a lot of issues pertaining to the quality of care, waiting periods, getting appointments. I am just inundated with those kinds of issues, and in addition, with issues as far as how long it takes to processed or get a person in the system; denials. I mean, it takes years and years, and it is very frustrating to the veterans. Sometimes I would like for someone to go to some of those town meetings with me because they beat me up pretty badly, and I feel when they come to me, something has failed the system.

Mr. POWELL. I am not entirely sure how to give you some comfort on that because I am not really in a position to do that. I think I can address nominally the issue why is our health care a bit more expensive.

By and large, a large component of our—well, actually, as I recall, about 80 percent plus of our component or rather our cohort are sicker or poorer, which is why we are treating them, and the private sector won't touch them. In many cases these are folks that are very expensive to care for. That was also our mission from the very beginning was to deal with those individuals. That causes us to have to have facilities, have care that some private hospitals just don't do. And I have some familiarity with some of the larger teaching institutions in Virginia, where I am from. I know that they are, in fact, and we have all heard of this, a virtual dumping ground for those individuals who don't have insurance. Those hospitals incur a higher cost because they have to treat these individuals. I don't want to imply that we are a dumping ground by any stretch of the imagination. Caring for veterans is our mission. However, in some cases they do cost a good deal more because they have more complex medical needs.

Now, as to your other issues, I think that is a bit beyond the scope of what we are doing this morning, but I am sure we would be happy to get with you and try to address it the best we can, or perhaps Todd could add some more to it.

Mr. GRAMS. I would just like to add to your discussion about costs. I think you have to be careful about what data you have and what that data reflects. People who don't understand our system well will throw around numbers that reflect average cost per patient, and built into that are things like long-term nursing home care and pharmaceuticals and other items that aren't covered by Medicare or private health insurance plans. When you strip those costs out of our average cost per patient, we actually compare quite favorably to the private sector and the Medicare plans. As a matter of fact, the price that we pay for our basic care patients in VA is actually below the annual Medicare capitated price that they pay in their managed care plans.

I would like to conclude by pointing out, if the committee is not aware, that over the past 5 years, VHA has reduced its patient cost by 23 percent in constant dollars. I know the Chairman is always looking for what value you are getting for your taxpayer dollar that you give to the VA. I think anyone in this room would be hard-pressed to find another government agency that has actually reduced its cost per unit of workload by 23 percent in a 5-year period.

Ms. BROWN. You all have recently single-sourced out your pharmaceutical contracts. VA has established a single-source contract for some pharmaceutical drug classes. Have savings been derived from these contracts?

Mr. POWELL. I think it is probably better to say the Pharmacy Prime Vendor Program has been a significant cost avoidance type of program. I don't have the amount of savings off the top of my head. However, I remember Dr. Kizer very pointedly saying one time, if it weren't for the savings, our budget would really have gone through the roof.

Ms. BROWN. I have some written questions that I will submit to you on the contractual arrangements that I would like to have followed up with. I am looking forward to meeting with you. I hope we can arrange that Friday.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. EVERETT. Thank you.

Ms. Egan, you said you didn't think there was a great deal of fraud out there in the system. Has electronic transfer of these payments increased over the years?

Ms. EGAN. Payments to veterans?

Mr. EVERETT. Yes.

Ms. EGAN. Yes, sir. We probably have the highest rate in the government. I think we are at about 93 percent for employees. It is 70 percent for veterans and beneficiaries, electing electronic deposits.

Mr. EVERETT. For each of those transfers, do you have a real address for people other than the bank?

Ms. EGAN. No, sir. That is one of the problems. We have an address of record, which is their address at the time they filed the claim. We periodically ask them to update it. Sometimes we put reminders in the checks, if they get a check, to do it. We are working with the banks to try and do that. This was an initiative we undertook as part of Y2K to make sure we had addresses. It is a struggle for us. That is one of the reasons we are doing the match with the Postal Service because we do have difficulty when people move—they can move all over the country and leave their bank the same and the deposits go to that bank. We have to depend periodically on them volunteering to update their addresses.

Mr. EVERETT. Neither of us want to imply that the electronic transfers directly to the banks, that there is an awful lot of fraud in there, but how can you be so sure that there is not fraud in there? I mean, you stated very clearly that you didn't think there was a great deal of fraud out there. How do we know that? That is really what I would like to know. How do we know that there is not a great deal of fraud out there?

Ms. EGAN. Based on the information that we have, which was based on two regional offices, I don't want to necessarily make an extrapolation that there is a lot of fraud out there, Mr. Chairman. You know, one of the reasons we are undertaking some of the issues we are doing, particularly first doing the match on employees, is to determine if this is a widespread problem.

Mr. EVERETT. Is it fair to say we don't know what the magnitude of fraud is? Is that a fair way to put it, we don't know how much fraud is out there?

Ms. EGAN. No, sir, we don't.

Mr. EVERETT. Okay. Mr. Powell, let us go back to bean counting a little bit. Which of the VA's most inefficient collecting processes do you intend to contract out to increase your intake or revenue and collection rate, and, you know, do you have a timetable for doing this? By the information I have, unless September collections are very great, the VA will be in their fourth year of declining collections. What concerns this subcommittee and the full Committee is that every time you guys give us a budget, you say you are going to collect more every year, and you count that towards the budget the VA has to serve veterans, and, of course, it doesn't materialize.

Mr. POWELL. If you will allow me, I will defer to Todd.

Mr. EVERETT. Absolutely.

Mr. GRAMS. Some of our processes we already have contracted out, for the reasons that you just cited; it's where we are doing a lousy job. We figure after we give the field a certain amount of time to try something, if they don't deliver, then it is fair game for contracting out. One area for that is third-party debt that is over 90 days old, and we did not do well. We looked at the statistics on that, and once a debt hit 90 days or greater, we did a very bad job of following up and collecting. We now have a nationwide contract with a company called TransWorld, and that is proving to deliver, I think if I am remembering it right, if not I will change it in the record—I think it is about \$13 we are collecting for every dollar we spend. So that has turned out to be quite a profitable endeavor.

In the bigger picture, given the fact that our collections have been falling and not reaching goals the last few years, we contracted with Systems Flow Incorporated, SFI, to do a study of our whole revenue process and come back and recommend to us what would be right for contracting out given all the factors that they took into account. Right now we are going to go forward with a pilot program for contracting out at several of our networks the activities of preregistration, insurance verification, billing collection and some of customer service. Those functions will be taken out of the specific facilities in that network, and a central unit will be created, and these functions then in that central unit will be turned over to a contractor. And we are going to pilot that and see how well they do versus how well our internal activities are, and if it comes out favorably, then we will want to roll this out on a nationwide basis.

Mr. EVERETT. I am glad to hear that you are contracting out your ARs, your accounts receivables, that are over 90 days. The private sector's figures on that are about 28 percent. VA's is 92 percent. So it makes sense, according to the figures I have. So it makes sense that you would contract it out. In addition to that, based on accounts receivables from discharge date of the patient, the private sector is 60 days. VHA is 244 days. Bill lag time, private sector, is 9 days. VHA is 83 days. You know, when I was in business many years ago I learned if you didn't send the bills out, people just don't pay you, and probably for good reason.

Mr. GRAMS. Can I just point out for the record, Mr. Chairman, I believe your staff got those numbers from the contractor study that our office contracted for. So we could find that information out, and since we found that information out, we have put several initiatives in place to get those numbers down.

I would like to point out that when the study was done, our inpatient date from discharged to the day we actually closed the account was 300 days. That is ridiculous. It is down now to 119. Now, are we happy with 119? No. Are we extremely pleased with the progress we have made in the last several months? Yes. I can walk you through some more statistics, or I can put them in the record, that show that favorable direction.

So while I would agree with you the numbers still don't look good, I would say our employees are responding very positively and are moving in the right direction. I think one of the things that has helped drive that—and I know the IG and GAO both has cited us in the past for not doing well in terms of performance measurement or holding people accountable. One thing you and your staff may want to look at is we have something called a tier three report that we publish every month, and what that report shows is how well the facilities and the networks are doing in terms of their collections versus their goals versus what they did last year, their productivity in terms of how many bills did they generate this year versus last year and what is that collection percentage as compared to the previous year, as well as our benchmarks.

And the final tier of the report deals with process, and it is simple questions like are you using software that we sent out to you, are you asking the veterans the right questions. Each section of this report contains not only numbers, but for those of us who like visuals, it contains graphs for every network, and myself and the chief network officer every month are able to sit down and go through this and see how the networks are going. The chief network officer then discusses problems with a specific network director one on one. In addition to that, I share the collection data every month with every network director at our national leadership board meetings.

Mr. EVERETT. Well, I think my point is this: The VA's core business is taking care of veterans, the health of veterans, and it seems to me the VA not only has done a poor job as bill collectors, but that they ought not to be bill collectors. They ought to concentrate on their core mission, and that is the health care of veterans.

Let me just say before adjourning this hearing, I have some closing remarks. I want to express my appreciation for the many thousands of honest and dedicated employees who daily fulfill the mission of the Veterans Benefits Administration for our veterans. They do a wonderful job. These fraud cases are highly unfortunate because nearly all VBA employees are devoted to seeing that veterans receive their benefits. I know that they want the few dishonest ones in their midst discovered and brought to justice and will help in any way they can.

And I include to that those who are enablers, and in my mind, the people who do not enforce the policies within the VA that are set forth to prevent this from happening are enablers. As far as I am concerned, there is no question about that.

The VA has its work cut out for it in improving financial management. I think the Department has a pretty good understanding of what the problems are in internal controls and the MCCF program. The steps necessary to correct these problems have begun, but we have got a long way to go. The subcommittee will continue to hold oversight hearings on these issues.

Finally, I really don't see any real accountability in management at the VA that is evident from today's hearing, something I have said before. No one is being held accountable for any of the problems or failures that we have heard about. That must change, or the Department will not become the world-class organization that it aspires to be and that it should be to serve our veterans. Please understand, I am not pointing fingers at any particular person, but there are enablers in here because the VA has, as I said earlier, not just a reluctance, but a refusal to hold people responsible for being enablers, allowing people to break the law and steal from our veterans.

The hearing is adjourned.

[Whereupon, at 12:25 p.m., the subcommittee was adjourned.]

A P P E N D I X

REMARKS of HON. CORRINE BROWN **VA Management Issues Hearing** *September 23, 1999*

Mr. Chairman and Mr. Evans, I want to thank you for this opportunity to examine several management issues within the Department of Veterans Affairs (VA) that have been disturbing in recent months.

1. Questions of the security of the Veterans Benefits Administration (VBA) claims system have risen in the light of major fraud cases. The theft through fraudulent claims of over \$600,000 at the Saint Petersburg Regional Office that regularly serves veterans from my District, and of a similar amount in New York, is troubling in itself. Of greater concern, it seems to me, is that neither case was uncovered by VA's internal safeguards.
2. The ongoing inability of VA's Medical Care Collections Fund (MCCF) efforts to bring in as much money through seeking health care reimbursements from third party insurers as has been budgeted over recent years has left VA with financial shortages. While VA's collection efforts seem to be improving, I am concerned that the budget process is far too willing to plan on MCCF as a money river, and then to appropriate too little funding to VA in reliance on MCCF.
3. The Veterans Health Administration (VHA) lets an enormous volume of procurement contracts nationally, regionally, and through its many facilities. We must always make certain that VA gets the best price possible, and that its contracts are honest.

Today we are here to receive the testimony of the General Accounting Office (GAO) and VA's own Office of the Inspector General (OIG) with regard to these issues. This committee's staff has been working for several months with GAO and Office of the Inspector General (OIG) to develop these topics for review at this hearing. We will also hear from both VBA and VHA on what it is doing to address these problems.

I take these problems very seriously. The first issue is the loss of money VA cannot afford to lose. More important is the integrity of the system. Veterans wait a long time to have their benefits claims resolved, and they are not always convinced they get what they deserve. The idea that the same VA employees who are minimizing payments to real veterans with legitimate service-connected claims might at the same time be diverting VA funds into bogus claims payments to themselves and their relatives or friends is maddening. Likewise, when veterans receive bills for health care because their insurer finds a way not to pay, it feels unfair to many of our veterans.

But at the same time, it is important that Congress keep these problems in perspective. Most VA claims supervisors and rating specialists know enough about the system to rig fraudulent claims. The fact that VA cannot quantify fraud does not mean the system is shot through with criminals.

Can more be done? Yes, and it should be. Can VA devote all its attention to preventing fraud? No, it cannot – neither with the level of staffing Congress has allocated nor if it wants to pay honest claims on time.

I believe our veterans will always deserve care from the federal government. We must make certain the tight money for that care is neither pilfered nor wasted.

I look forward to your testimony this morning. Thank you, Mr. Chairman.

**Remarks of the Honorable Lane Evans
Subcommittee on Oversight & Investigations
VA Financial Management Hearing
September 23, 1999**

We have been watching, over the past few years, the drying up of funding for the Department of Veterans Affairs (VA). We have been watching this, and fighting for every dollar we can wrench for VA from a Congress that doesn't want to discuss what it has done to veterans' place in our Nation's priorities.

With the meager resources that have been allocated by Congress in the current VA-HUD Appropriations Bill, VA must practice the highest possible grade of stewardship. I want to commend both Chairman Terry Everett and Ranking Democratic Member Corrine Brown for holding this Subcommittee on Oversight and Investigations hearing on VA financial management.

Reducing fraud, making the best procurement contracts and increasing collections of money owed to VA are methods of stewardship that can assure the application of badly-needed dollars to the programs they were intended to support. Congress and the public were shocked to read last July the press accounts of two separate cases of claims fraud by VA employees, each netting the criminals over \$600,000 before they were brought to justice.

It is intensely important that we learn what measures need to be taken and are being taken to keep such crimes at a minimum. While nobody believes any system is totally crime-proof, VA must re-establish in the public's awareness the integrity of the benefits system. We pay decent, not especially generous, benefits to our veterans for service-connected disabilities – workers compensation, if you will, for limbs and minds and health damaged or shattered by war or readiness for war. This high purpose must never be seen as tarnished either by the public or by VA employees.

Likewise, hard-won VA funds must not be lost through procurement contracts that fail to get the best price possible. I am particularly pleased to note that the efforts of VA's Office of the Inspector General since 1994 have recouped \$130 million. OIG's auditors have recommended procedures that could result in an additional \$250 million in costs VA can avoid. That is a quarter-billion dollars that veterans and their advocates would not need to wrest from the congressional leadership.

It must be noted that when the President's budget first appeared last February, both parties on the House Veterans' Affairs Committee agreed that added funding was needed for at least 10 additional FTEE in OIG. A better figure would be 30.

The amount of money either saved or recouped by OIG with inadequate staffing is quite impressive, but far too much work they should do goes undone because the office is understaffed.

I am glad to see improvements in MCCF, VA's program for billing third-party private health care insurers for non-service-connected health care for veterans above certain income levels. It concerns me, however, that collections have declined in the past three years, and may decline again in 1999.

The 1997 Balanced Budget Act gave VA authority collect "reasonable charges," rather than mere "reasonable costs," and to retain the money MCCF brings in, rather than refund it to the U.S. Treasury. The incentive, then, is for VA to do this task well – to at least recoup costs of medical care.

MCCF must recapture every dollar rightfully owed VA for treating veterans' non-service-connected health problems. The service-connected problems are rightly the federal government's responsibility.

My concern is that VA – with the concordance of the Office of Management and Budget (OMB) – keeps falling short of its targets. That means not only that there are problems with methodology and collections, but that the goals set year after year are unrealistically high. GAO, in its 1997 report on MCCR (as MCCF was then called), identified eight factors that could lead to decreased recoveries. Yet year after year Congress and OMB imagine VA will recover larger sums than it actually can, and then reduce VA's appropriations in reliance on monies that nobody truly believes will fully materialize.

Mr. Chairman and Ranking Member Brown, there are few assignments in Washington tougher than seeing to it VA gets the money it needs for its vital mission and uses it properly. I believe VA is trying very hard to do its part in good stewardship. I also believe the overwhelming majority of VA employees are honest and capable, dedicated to their individual roles in providing the care and benefits this Nation has promised the men and women who have served it so faithfully.

Thank you, Mr. Chairman.

STATEMENT OF
THE HONORABLE RICHARD J. GRIFFIN
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HEARING ON FRAUD AND MISMANAGEMENT IN VA
SEPTEMBER 23, 1999

Mr. Chairman and Members of the Subcommittee, today I will present to you the Office of Inspector General's (OIG) views on fraud and mismanagement in selected Veterans Affairs (VA) programs and summaries of the OIG audits and investigations in those areas. I will focus on veterans benefits, debt management, and procurement and contracting activities.

Veterans Benefits

One of three principal missions assigned to my office by the Inspector General Act of 1978 is the duty to provide leadership in efforts to prevent and detect fraud and abuse in VA programs and operations. Recently, the Under Secretary for Benefits asked us to evaluate vulnerabilities in the Compensation and Pension (C&P) program that might facilitate fraud or abuse, particularly fraud committed by VA employees.

The request came about after two successful criminal investigations of thefts from the C&P program totaling over \$1.2 million. Two Veterans Benefits Administration (VBA) claims examination employees, at separate VBA Regional Offices, each embezzled over \$600,000 in unconnected schemes. A brief description of each follows.

In April 1998, a man was arrested in New Jersey on drug possession charges. The arresting officers found a fictitious identification card on his person and records relating to a savings account in the name shown on the identification card. Our joint investigation led to the discovery that fraudulent VA disability compensation benefits were paid into the savings account monthly since August 1986. At the time the fraud was discovered, the payments were made at the rate of \$5,011 monthly, the maximum VA compensation rate.

The man arrested turned out to be a former VA employee who had worked as a disability rating specialist at VBA's New York Regional Office from January 1986 to May 1987. The former employee was ultimately convicted of having

fraudulently received VA compensation benefits to which he was not entitled. The scheme was perpetrated using another person's Social Security Number (SSN). The name and date of birth used were not those of the person whose SSN was used. Therefore, even though technology offers the opportunity and ability to verify entitlement by computer matching VA claim records with Department of Defense (DoD) and Social Security Administration (SSA) records, a totally fictitious identity was successfully used to perpetrate a fraud.

The fraudulent payments continued monthly for 12 years, totaling over \$620,000. Based on what we have learned, VA controls and procedures were not followed. As a result, the fraud was not discovered and could have continued indefinitely were it not for the perpetrator's arrest on drug charges.

In the second case, a supervisor at VA Regional Office St. Petersburg stole \$615,451 by creating a fraudulent disability compensation award in the name of the employee's fiancé, a veteran who had served in the Persian Gulf War. The fraud began in March 1997 and continued until the employee's arrest in January 1999.

After the initial fraudulent payment, the perpetrator used VBA's computer system on 10 occasions between March and October 1997, to retroactively increase the fraudulent payments she was sending to their bank account. These actions generated a series of one-time payments totaling about \$520,000, and incrementally increased the recurring benefit payments to \$5,011 monthly. At the time of her arrest, the perpetrator was a Veterans Service Center Section Chief, a mid-level managerial position. We are continuing to investigate related matters.

As a result of the discovery of these thefts, the Under Secretary for Benefits requested that my office review internal controls in the C&P program to determine what vulnerabilities existed that may have facilitated these frauds. This past June, I provided the Under Secretary our vulnerability assessment, reporting on 18 observed vulnerabilities in 6 general internal control categories. We then began an initiative to assess the scope and breadth of vulnerability in selected areas and to try to determine if there is a systemic problem.

This follow-up activity will require a substantial amount of time to complete and our efforts to identify, investigate, and prosecute employee fraud in the C&P program will continue indefinitely.

Vulnerabilities that Diminish Quality Control and Facilitate the Ability to Commit Fraud

Separation-of-duty controls intended to prevent fraud had been abandoned or circumvented. The objective of separation-of-duty is to prevent fraud by precluding any one person from having the ability to both authorize and release payments. With appropriate separation-of-duty controls in place, complicity of two or more employees is generally needed to commit a theft, thereby reducing the opportunity and vulnerability for crime.

As a means to speed up claims processing at VARO St. Petersburg:

- Some VBA payment authorizers routinely approved award actions of peers and subordinates, and released payment, without actually reviewing the evidence that supported the action or verifying that the claim was adjudicated in accordance with law.

- Payment authorization authority, previously reserved to senior experienced claims examination staff, had been delegated to less experienced employees. Accordingly, less experienced employees could trade casework among themselves, rather than refer the casework to a few senior officials, to obtain payment authorization. This practice expanded the overall production capability of the work unit, but quality assurance was reduced and vulnerability to employee fraud increased.

At some VBA regions, employees were authorized duplicative computer command authorities, in violation of VA policy, apparently to increase overall production capability. This gave the employees the ability to circumvent separation-of-duty controls and computer edits to create a benefit account and approve payment, without the need to refer the case to another employee for authorization. Employees with these extraordinary authorities could also create a fictitious benefit payment account and generate payments, or fraudulently upgrade the benefit payments of otherwise entitled beneficiaries, without the knowledge of other VBA employees. We also found other significant computer access vulnerabilities that could be exploited to perpetrate a fraud, such as by acquiring and using the computer access authorities of others to conceal the perpetrator's involvement.

Large one-time payments were not always substantively reviewed before payment was released. VBA policy required that claims payments exceeding prescribed amounts (\$15,000 for disability compensation payments) be reviewed and approved by the payment authorizer and the manager of the Adjudication Division (Adjudication Officer), before payment was released. We found that such third signature reviews were not always performed as required or, in some cases, may have been perfunctory. Additionally, the third review was only a paper review and there was no computer edit to prevent release of a payment absent the third review. This was a critical internal control vulnerability that facilitated the VARO St. Petersburg fraud.

Another issue relates to failure to control and secure records regarding employee claims for VA benefits. VBA policy requires that employee claims be adjudicated at another designated Regional Office, not the Office where the employee works. Additionally, policy requires that employee claims records be maintained at the designated office and held in special secure areas. We have learned that this policy has not been implemented at all VBA regions.

Vulnerabilities that Need to be Corrected to Help Identify Potential Ongoing But As Yet Undetected Fraud Or Abuse

Long running benefit payments need to be reviewed for continuing entitlement. At present, running awards of benefits are reviewed only if a claims examiner or rating specialist establishes a future suspense date control. For example, a control might be established for a future medical examination if the claimant's medical condition is expected to improve, or some other future event is anticipated. In most cases, no control exists for future review of static conditions.

Lack of control for future review creates vulnerability that can facilitate a fraud such as in the VARO New York embezzlement. In that case the fraud continued for many years during which time monthly payments exceeding \$5,000 continued. No control existed that would have triggered a review for continuing entitlement.

Continued entitlement should also be verified when mail is returned undeliverable. The investigation of the VARO New York embezzlement found that the crime may have been detected years earlier, preventing years of inappropriate payments,

had returned mail been properly handled. In this case, as in most VA benefit cases, payments were deposited by electronic funds transfer directly to the perpetrator's bank account. During the investigation we noted that the VARO was holding returned mail related to the fraudulent award that dated back several years. Because the mailing address was that of an abandoned building, the Postal Service returned the VBA computer generated informational mail as undeliverable. Employees at the Regional Office filed the mail without action to determine a correct address and payments continued until 1998 when the perpetrator was arrested on the drug charge.

VBA managers have stated that the volume of returned mail has increased substantially since the advent of electronic funds transfer, to the point that many regions have given up on routine attempts to obtain current mailing addresses on returned mail. This incident serves as a red flag highlighting the potential consequences of not acting on returned mail.

Vulnerabilities That Need To Be Corrected To Improve the Ability to Investigate and Prosecute Crime

To improve the ability to investigate and prosecute crime involving the C&P program, we have asked the Under Secretary to give priority attention to the recording and documentation issues cited in our assessment, particularly the lack of a comprehensive audit trail for rating and authorization actions. As I previously indicated, this documentation shortcoming has inhibited our investigations, necessitating that we undertake highly labor-intensive efforts to reconstruct events.

While I find these employee thefts to be a matter of great concern, there is more at risk from a poor internal control environment than just vulnerability to employee theft. Poor controls and mismanagement can lead to extraordinary program losses unrelated to employee theft. In the last several years, work done by our office in areas concerning improper payments to Federal and State prisoners, disability offsets from military pay, and payments to deceased beneficiaries have identified opportunities for the Department to save millions of dollars. Recommendations related to these issues remain to be fully implemented.

Debt Management Issues

As part of our continuing oversight of the Veterans Health Administration, the OIG issued five reports over the last 4 years on medical care cost recovery issues. Additionally, at the request of the Under Secretary for Health, we conducted an audit of insurance billing practices at one VA outpatient clinic. The issues identified in these reports are recognized by VA top management as being at high risk, and if not corrected could significantly reduce future revenue streams and adversely impact the public trust.

Three reports on debt collection surfaced a recurring issue that demonstrated that VHA could increase its medical care cost fund collections by tens of millions of dollars each year. The audits found that VHA management had not closely monitored or actively managed the Medical Care Cost Fund (MCCF) billing and collection process. Additionally, one of these reports found that management action was needed to correct and prevent improper billings of VA pensioners and service-connected veterans.

Two other reports focused on debt establishment, demonstrating that VHA needed to improve procedures to prevent unnecessary income verification, ensure compliance with Privacy Act requirements, and increase MCCF revenues. Management had not established performance measures and monitors to

effectively oversee and enforce compliance with established debt management policy, procedures, and laws.

AARP Billing Practices

In 1999, at the request of the Under Secretary for Health, the OIG conducted a review of medical insurance billing practices at VA Outpatient Clinic (OPC), Sepulveda, CA. The purpose of our review was to determine the validity of allegations of improper/fraudulent billings to American Association of Retired Persons (AARP) Health Care Options, administered by the United Healthcare Insurance Company, and to determine whether there were opportunities to improve billing practices.

Our review substantiated AARP's allegation of improper billing. We did not substantiate the allegation of fraudulent billings. We found that VAOPC Sepulveda had agreed to refund over \$84,000 or 80 percent of AARP insurance payments made in 1997. We also found that VAOPC Sepulveda continued to improperly bill insurance carriers in 1998 for (a) medical services not documented in medical records, (b) services incorrectly coded, (c) services involving "upcoded" bills to indicate a higher level of service than actually provided, and (d) services not covered by insurance. Improper billing occurred primarily because facility staff were improperly using and inaccurately coding Patient Care Encounter Forms. Staff were completing Encounter Forms for purposes of counting workload without considering the impact their entries had on MCCF billings. We also believe that improper billing for medical services could occur at other medical facilities. In response to our briefing and proposed recommendations VHA management took immediate action and developed a detailed strategy to correct and prevent inappropriate billing by VHA facilities.

Procurement and Contracting Activities

We have devoted significant resources to detecting and preventing fraud in VA's procurement and contracting activities. As a result of our efforts, the Department has recouped over \$130 million dollars since FY 1994. OIG has also recommended \$250 million in cost avoidance. Our efforts in this area have involved issues such as defective pricing, price reduction and Trade Agreement Act violations on VA's Federal Supply Schedule contracts, overcharging, product substitution, defective products, defective workmanship, non-compliance with contract terms and conditions, the submission of false claims for payment, and credit card fraud. Our efforts in the contract area have also resulted in a steady increase in the number of companies who have come forward voluntarily to disclose contract problems and make restitution to the Government.

We are currently conducting a general review of contracting practices within VA to assess the impact of procurement reform on the agency's buying practices. The review involves issues such as local procurements, the procurement of commercial items, the use of impact cards, local prime vendor programs, standardization of items, etc.

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

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations,
Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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VA HEALTH CARE

Collections Fall Short
of Expectations

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) efforts to increase revenues from alternative sources as a way to supplement its medical care appropriations. My remarks today will focus on VA's management of its efforts to increase collections from third-party insurers, because this area represents the largest source of alternative revenue. Specifically, I will discuss trends in third-party collections and VA's efforts to increase its collections.

My testimony is based on an update of our 1997 report on VA's third-party program.¹ To update that report, we reviewed (1) reports on VA's medical care collections program by VA's Inspector General and Coopers and Lybrand and (2) VA's internal reports, including its Three Tier report, regarding implementation of medical care collections activities. We also interviewed officials at VA's Central Office and at two VA facilities—the New Jersey Health Care System (NJHCS), which includes the VA Medical Centers in East Orange and Lyons, New Jersey, and the Houston, Texas, VA Medical Center.² We selected NJHCS because it had the highest medical care collections from October 1998 through July 1999 and the Houston Medical Center because it had a greater workload than NJHCS but had collected considerably less money during the same period.

In summary, VA's third-party collections have declined in each of the past 3 fiscal years and may decline again by the end of fiscal year 1999. In fiscal year 1998, VA collected \$442 million from third-party insurers for care provided to veterans for non-service-connected conditions, down from \$523 million in fiscal year 1995. In fiscal year 1999, as of August 31, VA had collected about \$388 million from third-party insurers. Unless VA's September collections exceed by \$19 million its average monthly collections of \$35 million, the annual decline in third-party collections will continue for the fourth year in a row. Next fiscal year, VA will experience its first full year of billing insurers on a reasonable-charges basis rather than a reasonable-cost basis. However, data are insufficient to predict whether this will reverse the declining collections trend.

VA has tried to reverse the decline in its collections from third-party insurers. Three factors limit VA's ability to increase the amount it collects from private insurers—the increasing number of veterans whose primary insurance is Medicare, increasing health maintenance organization (HMO) penetration, and its own efforts to increase the emphasis on outpatient care. Nevertheless, VA can enhance its chances of increasing collections if it ensures that the management improvements that are being implemented at some facilities are implemented throughout VA. These include overall improvements in VA medical facilities' use of good business management practices, as well as specific improvements in how facilities collect insurance information, document the appropriateness and medical necessity of care being billed, and pursue unpaid bills.

BACKGROUND

VA's health care system—the nation's largest direct health care provider—serves about 15 percent of the nation's 25 million veterans. VA has more than 600 delivery

¹VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult (GAO/HEHS-98-4, Oct. 17, 1997).

²The New Jersey Health Care System is part of Veterans Integrated Service Network (VISN) 3, based in the Bronx, New York. The Houston Medical Center is part of VISN 16, based in Jackson, Mississippi.

locations to provide services such as primary care, specialized medical care, mental health care, geriatrics care, and extended care.

In 1986, the Congress gave VA authority to bill private insurers for care provided to insured veterans who did not have service-connected disabilities. In 1990, this authority was expanded to allow VA to collect for the treatment of veterans with service-connected disabilities, if the treatment was for a non-service-connected medical condition. With the enactment of the Balanced Budget Act of 1997 (BBA), the Congress changed the third-party program into one designed to supplement VA's medical care appropriations by allowing VA to retain all third-party collections. The law established the Medical Care Collections Fund (MCCF) to receive third-party collections and some other revenues (such as veterans' copayments and deductibles). VA can use these funds to provide medical care to veterans and to pay for its medical care collection expenses. Before the MCCF was established, VA was allowed to keep enough collections to fund its collection activities but deposited the remainder in the U.S. Treasury.

BBA also gave VA authority to change its basis for billing third-party insurers from "reasonable costs" to "reasonable charges." Under reasonable costs, VA based its billing of insurers on its average cost to provide care—for example, a flat fee of \$229 for veterans' outpatient visits in fiscal year 1999. For inpatient visits, VA billed insurers a per diem based on patients' locations in the hospital. For example, VA charged \$2,079 per day of care in a surgical bed section in fiscal year 1999. Under reasonable charges, VA will base its bills to insurers on market prices. VA expects that it will help increase third-party collections. However, we concluded that the effect of reasonable charges on VA's collections could not be accurately determined.³

In January 1997, VA proposed a 5-year plan to operate within an appropriation of \$17 billion per year through fiscal year 2002. By the end of fiscal year 2002, VA planned to reduce its average health care costs per patient by 30 percent, serve 20 percent more veterans, and obtain 10 percent of its funding from "alternative revenue streams." These revenue streams were to include, in addition to third-party insurance collections, collections of veterans' copayments and deductibles, collections from the Medicare program, and proceeds from sharing agreements under which VA would sell services to other providers such as the Department of Defense and private hospitals. VA's fiscal year 2000 budget acknowledges that it will not meet the 10-percent goal, in part because the Congress has not authorized Medicare payments to VA. VA estimates that it will have obtained 4.3 percent (\$772 million) of its medical care funding from "alternative" sources by the end of fiscal year 1999, increasing to 7.6 percent (about \$1.4 billion) in fiscal year 2002.

COLLECTIONS FROM THIRD-PARTY INSURERS ARE DECLINING

To help serve more veterans and enhance services, VA had planned on increasing collections from third-party insurers to supplement its medical care appropriations but has been unable to achieve projected amounts. In fact, VA's collections have decreased in each of the past 3 fiscal years and may decrease again by the end of fiscal year 1999. In our 1997 report, we identified a number of factors that limit VA's ability to collect from insurers. We believe these factors will continue to limit VA's collections potential, although quantifying the magnitude of the effect is difficult because the necessary data are not available. However, one factor that we identified—refunds of overpayments by private insurers—has not had a major effect on VA's ability to increase collections. Such refunds could affect future collections if

³VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain (GAO/HEHS-99-124, June 11, 1999).

private insurers continue to discover more instances of overpayments for care provided after July 1997 and request refunds from VA.

Third-party Collections
Continue to Decline

In fiscal year 1995, VA collected \$523 million from third-party insurers. Since then, the amount collected has declined every fiscal year and may decline again in the current fiscal year. Collections declined from \$523 million in fiscal year 1995 to \$495 million in fiscal year 1996, \$450 million in fiscal year 1997, and \$442 million in fiscal year 1998. As of August 31, 1999, VA had collected \$388 million during fiscal year 1999. VA's average collections are about \$35 million per month, but it will have to collect \$54 million in September to equal fiscal year 1998's collections.

In our 1997 report, we analyzed several factors that limit VA's potential to collect more from private insurers. First, an increasing percentage of veterans are older than 65 and eligible for Medicare, which by law does not pay for care furnished by VA. VA has estimated that in 1999, 38 percent of the veteran population is older than 65, up from 32 percent in 1994. Second, more veterans are enrolling in HMOs and other managed care plans. For example, according to data provided by VA, total HMO enrollment in the general population increased from 25.8 million in December 1986 to 58.8 million in January 1997. Because VA is not a participating provider, it typically cannot collect from such plans. Third, VA's shift in emphasis from hospital care to outpatient care has resulted in more episodes of less expensive outpatient care and fewer episodes of more expensive inpatient care. This in turn has a tendency to decrease the amount that can be billed to insurers. Between fiscal years 1995 and 1998, the annual number of VA inpatient episodes dropped from 879,000 to 617,000, while outpatient episodes rose from 26.5 million to 33.4 million.

Overpayment Refunds Are Still a Potential
Problem, Although Current Collections
Have Not Been Significantly Affected

In 1997, we reported that VA might have to refund as much as \$600 million in overpayments to some insurers. These overpayments were made by insurers whose policies contain provisions making their coverage secondary to Medicare when policyholders become eligible for Medicare. VA's bills did not specify that these insurers were expected to pay as a secondary, rather than a primary, payer. Thus, some insurers whose policies contain such provisions have paid VA as the primary payer. Some of these insurers are seeking refunds of previous payments to VA or are reducing current payments. VA's position is that it will refund overpayments to insurers whose claims are timely and well grounded.

Based on data provided by VA's Office of General Counsel, actual refunds to insurers have been relatively small compared with potential liabilities. Specifically, at the time of our review, VA officials estimated that total repayments would probably not exceed \$100 million and told us that they had repaid approximately \$19 million. However, unknown refunds have been paid by individual medical facilities, and claims for about an additional \$29 million are pending. For example, NJHCS recently agreed to pay an insurer approximately \$286,000 after the insurer audited NJHCS bills. At the Houston Medical Center, we found one repayment in fiscal year 1999 for about \$35,000.

Most of VA's refunds have come from an account in the Treasury, not from VA's medical care funds, because most overpayments occurred before July 1997, when VA was still required to deposit excess collections in the Treasury. Of the \$19 million in refunds reported by VA's Office of General Counsel, all but about \$800,000 was paid from the Treasury account. Also, all but about \$86,000 of the \$286,000 refund by

NJHCS came from the Treasury account. All the \$35,000 refund by the Houston Medical Center came from its current medical care account.

To prevent this type of overpayment in the future, VA is working with the Health Care Financing Administration (HCFA) to develop a facsimile of the Medicare remittance advice that would provide information on the secondary payer's share of billed charges for VA's use in billing insurers.⁴ However, according to a VA official, HCFA has delayed this because of higher-priority computer programming needs. In the interim, VA has instructed medical facilities to annotate bills, when applicable, to state that the insurer is billed as a secondary, not primary, payer. VA expects that this interim step will help ensure that insurers who should be paying VA as secondary payers are not paying as first-party payers. VA also expects that its ability to provide HCFA Medicare remittance advice documents will help overcome VA's difficulty in collecting from some Medicare supplemental insurers. These insurers refuse to pay VA because it neither bills such insurers the way HCFA does for non-VA patients nor provides them with Medicare remittance advices along with each bill. VA is currently in litigation with some Medicare supplemental insurers over this issue.

VA HAS TAKEN INITIATIVES
TO IMPROVE COLLECTIONS,
BUT COULD DO MORE

VA has several initiatives under way to improve its third-party collections. These initiatives address the entire process of collecting from insurers—from the initial identification of an insured veteran through the identification of billable care to the payment by the insurer. The initiatives are intended to address problems identified in the past by VA's Inspector General, Coopers and Lybrand, and us that adversely affect collections such as ineffective management, inadequate information on veterans' insurance coverage, inaccurate billing, and inadequate follow-up of outstanding bills. The initiatives are a step in the right direction but must be effectively implemented throughout VA to improve its potential for increasing collections from third-party insurers.

The Business Model Concept
Has Not Been Fully Implemented

In its 1998 report, Coopers and Lybrand pointed out that only 25 percent of the 24 VA sites it visited incorporated the various functions of the medical care collections program under a centralized management structure—what it calls the “business model.” According to Coopers and Lybrand, this type of organization is characteristic of successful private-sector hospital operations. As of June 30, 1999, about half of VA's facilities had implemented this concept. In our site visits, VA officials supported moving to this concept because it enables them to better control the quality of their medical documentation. For example, NJHCS is considering reorganizing under such a structure so that all coders and billers would come under the system's Medical Administration Service instead of being in several different sections.

Better Identification and Accuracy
of Veterans' Insurance Are Needed

Having accurate information on third-party insurance, such as the type of policy and the types of services covered, patient copayments and deductibles, and preadmission certification requirements, is key to VA's medical care collections program. Yet only 54 percent of VA facilities reported that their collection of health insurance

⁴HCFA produces these statements, which provide an explanation of the Medicare allowable charges and the portion of the billed charges Medicare will pay. The statements are provided to insurers who pay secondary to Medicare.

information was thorough by June 1999. Without adequate information on veterans with insurance and the provisions of that insurance, VA could miss opportunities to bill insurers for non-service-connected care provided to veterans or inappropriately bill insurers when a veteran's policy did not cover the care provided. Sixty-five percent of VA's facilities reported that they periodically verified and maintained their insurance files.

Because veterans have little incentive to provide insurance information, VA is trying to educate both veterans and staff about the importance of obtaining such information.⁵ Specifically, VA has brochures explaining the need for this information. In addition, some VA facilities have emphasized the need for facility staff to obtain insurance information when veterans enroll in the VA health care system. NJHCS officials stressed that their goal is to ensure that all required information—including employment and insurance information—is obtained when a veteran first comes in contact with NJHCS. This contact may occur during one of NJHCS' enrollment outreach events or when the veteran first visits one of its medical facilities. NJHCS' medical care collections coordinator told us that his office focuses a lot of attention on obtaining accurate insurance information and trying to obtain this information during enrollment rather than during preregistration. NJHCS staff told us that in instances in which a veteran or spouse is employed but does not report having insurance, staff contact the employer to verify whether the veteran has insurance. Also, VISN 3 has contracted with a company that has an insurance information database and has identified additional insured veterans for NJHCS. This has led to additional billings of and collections from insurers. The Houston VA Medical Center has recently contracted with the same company to provide similar services, but results are not yet available.

Some facilities are taking additional steps to verify the accuracy of insurance information. For example, the Houston Medical Center has two staff members whose primary task is to verify insurance coverage. They receive lists of veterans identified as having insurance and then contact insurers to verify coverage. Also, Houston has a system in which each patient's insurance must be reverified every 90 days.

Documentation and Billing of VA Medical Care Needs Improvement

VA's ability to accurately document the non-service-connected care provided to insured veterans and assign the appropriate codes for billing purposes is essential to Veterans Health Administration's (VHA) third-party collections program. VA can bill only for non-service-connected care, and VA staff told us that sometimes the explanations provided for veterans' service-connected disabilities are not specific enough to help physicians determine whether the care they provide is related to service-connected conditions. About 20 percent of medical facilities did not report having procedures to validate whether treatment was for a non-service-connected disability, and less than 70 percent had reported that they trained their staffs in converting the explanation of care provided into codes used to bill insurers.

Failure to properly document care can lead to missed opportunities to bill for care, overpayments by insurers, or denials of VA bills. Also, with the implementation of reasonable charge billing, VA will have to meet the stringent documentation standards imposed on private sector providers by HCFA and private insurers.⁶

⁵VA is currently working against the perceptions of average veterans that they are entitled to "free" health care and therefore do not need to provide private insurance information. In January 1998, Coopers and Lybrand reported that many veterans are unaware of or unable or unwilling to provide insurance information.

⁶VA required that reasonable charge rates be used to bill insurers for care provided on or after September 1, 1999.

VA is trying to improve its medical documentation and billing practices to meet HCFA and private insurer standards. Both of the VA medical facilities we visited are training clinical staff and coders in documenting and coding medical care by HCFA's standards. For example, the Houston Medical Center has obtained assistance from the Baylor College of Medicine to train clinical staff in this area.

Many insurers require that care be precertified (that is, the insurer's approval must be obtained before care is rendered). One of the important services that utilization review staff at medical facilities perform is to obtain in advance from insurers the type and amount of care for which they will pay. Doing this helps increase VA's likelihood of collecting from insurers. VA has trained utilization review staff—many of whom are nurses—on obtaining precertifications from insurers. For example, VA held a national conference for utilization review staff in August 1999. Ninety-eight percent of VA medical facilities reported that they had a precertification process by the third quarter of fiscal year 1999.

More Aggressive Action Is Needed
to Follow Up on Debt Collection

Experience suggests that, in general, the longer VA waits to follow up on delinquent bills, the less likely it is to collect on them. As of May 1999, about 75 percent of its delinquent receivables for billed care were more than 90 days old. In June 1998, VA contracted with a collection agency, Transworld Systems, Inc., to assist facilities in collecting third-party bills that are outstanding for more than 90 days. By the third quarter of fiscal year 1999, 48 percent of VA facilities were using the Transworld contract. The facilities send delinquent third-party bills to Transworld, which sends out letters to the insurers on VA's behalf, requesting payment. Both of the facilities we visited use VA's contract with Transworld Systems (the Houston VAMC was a pilot facility for this initiative), which costs VA \$4.75 per bill. VA reported collections of more than \$9.7 million as a result of this contract at a cost of less than \$800,000.

RELATED GAO PRODUCTS

Veterans' Affairs: Progress and Challenges in Providing Care to Veterans (GAO/T-HEHS-99-158, July 15, 1999).

VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain (GAO/HEHS-99-124, June 11, 1999).

Veterans' Affairs: Progress and Challenges in Transforming Health Care (GAO/T-HEHS-99-109, Apr. 15, 1999).

VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult (GAO/HEHS-98-4, Oct. 17, 1997).

(406175)

**STATEMENT OF
THE HONORABLE EDWARD A. POWELL, JR.
ASSISTANT SECRETARY FOR FINANCIAL MANAGEMENT AND
CHIEF FINANCIAL OFFICER
DEPARTMENT OF VETERANS AFFAIRS**

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

OVERSIGHT HEARING TO EVALUATE FRAUD AND MISMANAGEMENT

SEPTEMBER 23, 1999

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the issues you have raised concerning Medical Care Cost Fund (MCCF) overbillings, and internal control weaknesses uncovered at two Department of Veterans Affairs' (VA) regional offices. I am accompanied today by Nora Egan, Deputy Under Secretary for Management in the Veterans Benefits Administration, Todd Grams, Chief Financial Officer in the Veterans Health Administration, and Mark Catlett, Deputy Assistant Secretary for Budget.

As the Department's Chief Financial Officer, I work closely with management officials in VA's Administrations to support them as they provide benefits and services to our Nation's veterans, and to provide strategic and operational leadership for improving the Department's financial management stewardship and oversight.

Many of VA's management challenges are directly attributable to problems with our existing business processes and our legacy systems. As a result, earlier this year I initiated a Department-wide effort to reexamine all of our business processes and systems with the objective of migrating our existing, independent and disparate financial systems to new, more integrated financial and logistics standards modeled on contemporary business, financial, and logistics

management best practices. By taking this standards-based approach, we can significantly improve our management and operations, address the weaknesses in our internal controls, reduce our operating costs, and maintain our focus on what is most important - - providing benefits to our Nation's veterans.

This initiative, which we have named the Integrated Financial/Logistics Management Standards or IFMS, has been approved by both VA's Information Technology and Capital Investment Boards. IFMS will involve extensive field and central office staff participation from all three of VA's Administrations and VA staff offices. IFMS is about bringing consistent reporting standards, data, and information to all Department components. It will also provide us leverage to speed change throughout VA by providing us the opportunity to abandon our old inefficient ways of doing business and incorporate the results of best practices through business process re-engineering. Our goal with IFMS is to address weaknesses in VA's current financial management processes and systems and provide VA the flexibility to adapt to internal and external changes. IFMS will also help us better support and facilitate VA's strategic business and technology plans.

Consistent and reliable data will assist us in resolving problems and improving management decisionmaking. Ultimately, improved business practices through better management information will help us prevent future problems.

I wish to focus on the two issues you raised concerning VA's revenue program and internal control weaknesses uncovered at two of VA's regional offices.

VA's Revenue Program

VA's revenue programs encompass a broad range of issues and initiatives. It is my understanding you want to discuss specific issues and initiatives concerning the overpayment of VA by health insurance companies.

Regarding overpayments, we have sought advice from a variety of sources, all of which have proven useful. These sources include VA field and headquarters staff, private sector contractors, and the VA Inspector General. Before discussing the steps taken to address this problem, it should be recognized that producing accurate bills for health services is not a challenge unique to VA. I say this, not to make excuses for our shortcomings, but simply to recognize that this is an industry-wide challenge.

In 1997, when the concern about possible overpayments was brought to us, we took several steps to correct billing to third-party payers. A series of handbooks outlining procedures to implement coordination of benefits was developed along with the software to assist in the coordination of benefit procedures. A series of audio training calls and two satellite video-training programs was conducted on coordination of benefits. In addition, these issues have been addressed at numerous national meetings and on national conference calls. The Veterans Health Administration (VHA) has issued several memoranda to Network Directors and medical center directors regarding the findings of the American Association of Retired Persons and the findings of other reviews that were conducted at VA's request. Networks and medical centers have been instructed on several actions facilities must initiate locally to prevent similar problems and improve their processes. Some of these actions are:

- ◆ conduct an ongoing review of a significant sample of bills to compare these to medical records and correct any errors at the source of entry;

- ◆ provide coding training to all clinic support and coding staff on the appropriate use of CPT-4 (Common Procedure Terminology – 4th version/edition) codes and ICD-9 (International Classification of Diseases – 9th version/edition) codes;

- ◆ provide training to all clinical staff on the appropriate use of the CPT-4 evaluation and management codes;
- ◆ review and update all encounter forms to accurately reflect the level of care and those procedures performed in specific clinics;
- ◆ review the administrative procedures for the proper handling of clinic no-shows or cancellations; and
- ◆ assure that clinical staff providing care are properly reported on the encounter forms.

VHA also retained the American Hospital Association (AHA) and PriceWaterhouse Coopers to conduct a comprehensive compliance assessment in January 1999. That assessment, completed in April 1999, recommended implementation of a comprehensive health-care compliance program to help correct the integrity in the billing and collections program. The VHA Compliance Office was officially established on August 6, 1999. Recruitment of staff is currently underway. In the interim, MCCF staff have been reassigned to the Compliance Office, and several temporary contract employees have been employed to develop processes and policies and to begin the work of the new office.

Some Veterans Integrated Service Networks (VISNs) and medical centers have already appointed compliance officers. Other VISNs and medical centers have appointed a compliance "contact" until recruitment of their compliance officers can be accomplished.

A multi-disciplinary team was constituted from staff of medical centers and VISNs to develop a strategic plan for training VHA employees regarding compliance functions. Training in the technical areas of coding, medical documentation and

billing is presently occurring at the medical centers. Plans include training on the ethical framework of the compliance program for all employees including top management, and periodic training for health care providers, coders, billers, compliance officers, and other appropriate staff. Bi-weekly conference calls with VISNs and field facilities provide a forum for sharing progress and approaches, and to discuss issues so all can move forward expeditiously.

The first VA Compliance Conference for compliance officers and leaders in VHA will be held in Chicago, October 27-28, 1999, in conjunction with the Health Care Compliance Association's (HCCA) National Annual Compliance Institute. The HCCA conference attendance is open to Chief Executive Officers, Chief Financial Officers, compliance officers, health law attorneys, health administration faculty, physicians, managed care managers, and others.

Infrastructure is being developed to track compliance efforts electronically. A nationwide compliance line to report compliance issues, via a toll-free telephone number, is planned for full implementation in fiscal year 2000.

Additionally, each VISN has a "Reasonable Charges Action Plan" for implementing the Department's new methodology for computing charges for medical care, which became effective September 1, 1999. These plans include educational efforts for both health-care providers and administrative staff, and they require coding data validation on a bi-weekly basis. A series of reports from the field has been required and national-level coding data validation is conducted. These efforts were taken to ensure all field facilities are taking the necessary steps to insure accurate bills will be produced under the reasonable charges system.

Mr. Chairman, the MCCF Revenue Program is contributing significant funding for VA health care. We are confident the initiatives currently underway will correct the billing problems that surfaced in 1997. Through these and other efforts we

will be able to continue to increase the revenues generated by this program in future years.

Internal Control Weaknesses at Regional Offices

There have been three recent instances of employee fraud at two regional offices in the Veterans Benefits Administration (VBA). One case involved an employee creating a false benefits award for himself; another concerned a supervisor creating a false benefits award for her close friend; and the third involved an employee creating a false benefits award for another employee at the regional office. From what we now know, it appears the employees were able to carry out these fraudulent activities because procedures and checks and balances either have not been developed, were circumvented, or were not being utilized within the regional offices.

We believe violations of the law, such as these, are deplorable. However, they are also violations of trust, which makes them even worse. Our employees have been entrusted by the public to conduct its business. When they engage in fraudulent activities the trust is violated, not only with the public, but with their fellow employees as well. It impacts on honest employees, not just the few engaged in criminal activity, and such loss of trust may not be recoverable. The Under Secretary for Benefits addressed these issues and discussed internal controls in a broadcast to all field stations on July 22, 1999.

Having said this, I would like to briefly address the root causes that have diminished the VBA's internal controls over time. The VBA workload has dramatically increased in recent years, despite the fact there are fewer veterans overall.

There has been an increase in the number of issues per individual claim, coupled with the increasing legal and medical complexity of the work. To meet these

increasing demands with diminishing resources, VBA has shifted staffing resources into processing claims, and away from oversight/review functions. VBA's efforts have been focused on restoring quality and timeliness, not addressing the potential for fraud. Clearly, not enough attention has been placed on ensuring that appropriate controls are in place to detect and prevent fraud, and to enforce those controls that do exist.

When the Under Secretary for Benefits learned of these fraud instances in January 1999, he immediately called upon the VA's Inspector General's (IG) office to assist in identifying internal control weaknesses and vulnerabilities in the Compensation and Pension Program. Working with members of the VBA, the IG's office spent six months reviewing and assessing this program, and issued a report to the Under Secretary with 18 separate observations of internal control vulnerabilities. These observations fall into six general categories:

- ◆ reasonable assurance and safeguards;
- ◆ delegation of authority and organization;
- ◆ separation of duties and supervision;
- ◆ ADP access controls/access to claims records;
- ◆ recording and documentation; and
- ◆ integrity, competence, and attitude.

VBA has already begun addressing these 18 observations, and has identified specific policy changes, instructions, or controls which have been or immediately can be implemented to reduce the internal control vulnerabilities. Specific examples include: issuing instructions to the field reinforcing the policy regarding the transfer of veteran-employee claims folders to the appropriate jurisdiction; reinstating regular reviews of security logs that identify each time an employee record is accessed; and re-establishing a System Security Office in headquarters with oversight of field violations. Wherever VBA can institute immediate and lasting solutions to these vulnerabilities, they have already begun to take action and will continue to do so. Longer-term solutions are also being outlined, with

timeframes for completion. One of these solutions is the re-institution of quality reviews of work products for the purposes of determining the accuracy of claims processing. Those reviews provide an excellent opportunity for assessing whether there are any improprieties in the actual claims themselves.

In conclusion, my office's financial review staff in Austin, Texas, continues to assist VA Administrations in looking at financial management areas, including MCCF and internal controls, for weaknesses. Though they were not part of any review of the internal control problems found at the two regional offices, they were contacted early in 1999 by VBA's Compensation and Pension Service Director and Acting Chief Financial Officer to provide financial review assistance from an internal control perspective. At their request, my staff visited three other regional offices to gain a better understanding of the Compensation and Pension Program and the potential vulnerabilities inherent in its processes. In addition, we are supporting the IG in their audit of the Compensation and Pension Program's financial and internal controls. We anticipate conducting eight to ten site visits during FY 2000 to follow up on problem/fraud indicators and evaluate procedures and controls in this Program.

Mr. Chairman, this concludes my statement. My colleagues and I will be pleased to respond to any questions you or other members of the subcommittee may have.

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