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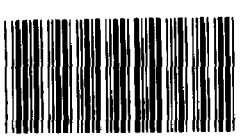
STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION

BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

ON
~~CERTAIN~~ ACTIVITIES OF THE VETERANS ADMINISTRATION'S
OFFICE OF THE INSPECTOR GENERAL

Mr. Chairman and Members of the Committee, we are pleased to be here today to discuss certain activities of the Veterans Administration's (VA's) Office of Inspector General (OIG). We have not made a detailed review of the operations of the OIG. However, we do have some limited observations based on work performed by our Task Force on Fraud and Abuse and the results of (1) our review of the OIG's investigation of allegations concerning the Palo Alto, California, VA Medical Center, which you requested by letter dated January 21, 1980, and (2) our inquiry into allegations made against the OIG relating to harassment of certain VA employees and the fabrication of charges and documents, requested in your letter dated May 27, 1980. We also have some observations concerning the recently proposed establishment of VA's Office of Medical Inspector which should be of interest to this Committee.



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BACKGROUND

The Inspector General Act of 1978 (Public Law 95-452), enacted on October 12, 1978, established the Office of Inspector General at VA and at eleven other Federal agencies.

By establishing IG offices the Congress intended to create independent and objective units to conduct and supervise audits and investigations of agency programs and operations; provide leadership and coordination and recommend policies to promote economy, efficiency and effectiveness; prevent and detect fraud and abuse; and keep the agency head and the Congress informed about problems with the administration of agency programs, and the necessity for and the progress of corrective action.

The OIG at VA consists of the Office of Audit (OA) and the Office of Investigation (OI), each under the direction of an Assistant Inspector General, and a smaller unit called the Risk Analysis Staff (RAS).

The OA conducts audits of VA programs, functions, activities and organizations and audits or arranges for audits of grants and contracts in accordance with Federal and VA regulations. The OA is authorized a staff of 271, including 235 professionals. The staff is divided fairly evenly among the headquarters planning and programming functions and four field offices located in Atlanta, Chicago, Los Angeles and Hyattsville, Maryland.

The OI conducts administrative investigations covering all activities of VA including individuals and organizations dealing with VA. The OI also conducts proactive investigative surveys to detect fraud and abuse.

The OI is authorized a staff of 72, including 53 professionals. The OI is currently decentralizing which will result in investigators being co-located with auditors in Los Angeles, Chicago, and Atlanta. In addition, an office has been established in New York City and the Washington field office has a suboffice in Puerto Rico.

The RAS assesses the vulnerability of VA's programs, functions and activities relating to fraud, abuse, waste, and mismanagement with a view toward recommending program improvements or areas for future audit and/or investigation. The RAS also reviews proposed legislation and regulations and operates the VA hotline. The RAS is authorized a staff of eight including six professionals.

WORK PERFORMED BY OUR TASK FORCE ON FRAUD AND ABUSE

In September 1978, we issued a report on what Federal agencies were doing to combat fraud in Government programs 1/. Subsequently, we established a Fraud and Abuse Task Force and a toll-free hot-line. The purpose of the task force was to undertake more detailed reviews at various Federal agencies, including VA, to determine (1) the extent of identified fraud in these agencies and (2) the procedures

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1/ "Federal Agencies Can, and Should Do More to Combat Fraud in Government Programs" (GGD-78-62, Sept. 19, 1978.)

used to detect and deter fraud. We expect to issue a report on this review in 1980. The purpose of the GAO hot-line is to permit any individual who has knowledge of or suspects fraud to call that information in to a central point for appropriate disposition.

Some of the information gathered in our review has no bearing on today's hearing. Other information relating to actual audits and investigations undertaken by the agencies reviewed, including VA, is now being processed for computer analyses but will not be available for a few months. We have, however, obtained some limited information from this review concerning the operation of VA's OIG that I believe will be of interest to the Committee.

Activities of the OIG

In terms of resource allocation to defined objectives, the majority (56 percent) of staff effort of the OIG for fiscal year 1979 was spent performing cyclical audits of VA facilities, programs or systems and about 31 percent was spent performing special audits and investigations to actively seek out fraud, abuse, waste and mismanagement. The remainder of staff effort was directed at investigating complaints of significant administrative and/or suspected criminal irregularities; reviewing new legislation, regulations or major systems to identify and correct weaknesses which may affect future integrity, economy, or effectiveness; and performing vulnerability assessments of existing systems and programs.

For example, during the year the OA completed 114 internal audits of various VA facilities, programs or functions, and 77 external audits of contracts, State homes, or State approving agencies. An additional 181 external audits were conducted at the OA's request by other Federal agencies.

The OI completed 71 reactive investigations and 2 proactive surveys in fiscal year 1979. During one proactive OI review about 600 loan guaranty files were reviewed in an attempt to identify fraud in VA's loan guaranty program. The OI also reviewed a number of allegations of wrongdoing and handled complaint mail and security cases.

The RAS completed 3 vulnerability assessments; received, reviewed and processed 650 hotline contacts; and reviewed 77 legislative proposals and 25 VA-proposed regulations.

In fiscal year 1980 the OA plans to complete approximately 41 internal audits carried over from fiscal 1979 and start approximately 150 new audits. The OI plans to continue with reactive investigations and participate in joint efforts with other Federal agencies to identify fraud in specific Federal programs. The RAS plans to complete and issue reports on 12 risk analyses.

In the OIG's fiscal year 1980 audit plan, we noted only two new special initiatives to detect fraud and abuse. Most of the new audits planned by the OIG are routine cyclical audits of medical centers, regional offices, and cemeteries or audits of ADP systems as required by OMB Circular A-71.

In April 1979 during testimony before the House Veterans Affairs Subcommittee on Special Investigations, we stated that, in view of the size of VA's budget (then in excess of $20 billion), VA programs were inviting targets for fraud and abuse. We said that while VA had detected fraud and abuse, its efforts were limited and sporadic and were not the result of a systematic approach for identifying fraud and abuse. Although VA has identified individual cases of fraud or suspected fraud in all of its major programs, most of these resulted from cyclical audits which are not primarily designed to detect fraud or from activities conducted outside the OIG.

The April 30, 1980, Semi-Annual Report of the OIG states that, in comparison with the previous six months period, there was a reduction in excess of 50 percent in special initiatives to detect fraud, abuse and mismanagement.

According to the IG, the primary reasons for the limited number of audits specifically aimed at detecting fraud were declining resources, added workload, and efforts to audit medical centers on a 3-year cycle. In his May 5, 1980, letter to you, the IG expressed his concern regarding the OIG's ability to conduct audits of medical centers on a 3-year cycle and concluded that a better balance of OIG efforts would be obtained by generally going to a 5-year audit cycle.

While recognizing that the OIG may have a problem with staff resources, we believe that a more concentrated effort must be maintained to detect fraud and abuse.

Control over receipt and disposition of allegations

The OIG receives numerous allegations of fraud, abuse, waste or mismanagement from the VA hotline, complaint mail, department and staff offices in VA, other agencies, and from VA employees who contact auditors or investigators during field work. Presently there is no formal system in place in the OIG to account for the total number of allegations received or for the disposition of such allegations.

For example, if the OI staff determines that an allegation lacks investigative merit, they refer the allegation to the applicable VA department or office. In some cases the referral is made by transmittal memo with a copy retained in the OIG. Oftentimes, however, allegations perceived by the OIG as minor in nature are forwarded without a transmittal memo or any record of OIG receipt, review or referral action.

Without complete information, the OIG does not know the actual number of allegations received, who submitted them or what actions, if any, were taken.

An additional concern we have relates to the referral of allegations deemed to be minor or insignificant by the OIG to the various departments or offices for action. Employees probably refer complaints or make allegations to OIG units primarily because attempts to go through normal channels have failed or because they fear reprisal. The practice of the OIG of referring

certain allegations to the department or offices that may have been the cause for the complaint or allegation without keeping track of its receipt or resolution does not appear to be appropriate.

We believe a system of control over all allegations is necessary and should be adopted by the OIG. We understand that such a system is presently being considered.

Report concurrence procedures

According to the Assistant Inspector General for Audit, reports on reviews made by the OA are finalized in one of two ways depending on the requestor for the audit and subject matter of the report. Generally, reports dealing with field facilities (except the Department of Veterans Benefits (DVB)) may be finalized by the OA field office director if the facility director concurs in the recommendations and it is within his power to implement the recommended corrective actions. In this case the report may be finalized in the field and an information copy of the finalized report is provided to the OIG and appropriate staff at VA Central Office (VACO).

All other audit reports, including those considered sensitive and those specifically requested by the Congress, the Administrator, or others, are finalized by the OA in VACO. The finalization process includes initial review by the facility director, if necessary, and review by the appropriate departmental staff--DVB or Department of Medicine and Surgery (DM&S)--at VACO. If the department does not agree with audit report recommendations and the disagreement cannot be resolved between the OA and the department, the

report is submitted to the VA Administrator or Deputy Administrator for resolution. If the Administrator approves the recommendation, the report is finalized. If he does not approve the recommendation, the OA revises or deletes the contested recommendation. In other words, before a report is issued, all OA recommendations have to be accepted and/or approved and all concerned parties have to agree to implement the recommended actions.

The following example illustrates the concurrence process followed by the OIG and involves a report dealing with controls over drugs at VA medical centers prepared by the RAS.

In May 1980, the RAS staff issued a report on drug loss and accountability at VA medical centers. The study was performed to assess, among other things, controls over drugs as they flowed through the medical centers and prescription costs relating to the fee-basis pharmacy program. To a large extent, the study focused on VA's efforts to convert its ward stock pharmacy systems to unit dose systems.

In a September 1975 report, 1/ we had recommended that VA convert its pharmacy systems to unit dose in order to reduce medication errors and losses and strengthen VA's controls over drugs. As part

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1/"Potentially Dangerous Drugs Missing in VA Hospitals--Different Pharmacy System Needed (Sept. 30, 1975, MWD-75-103)

of a recent followup review on our earlier report, we reviewed a draft of the May 1980 OIG report. At that time the OIG estimated that VA's annual drug losses were a multimillion dollar problem and recommended, among other things, VA implement unit dose pharmacy systems system-wide within the next 5 years. However, as a result of meetings with officials of DM&S, the OIG revised its recommendation and offered several suggested alternative courses of action. The final report notes that the Administrator was briefed on the report, and he had asked DM&S to report on their progress in developing plans for implementing the option of their choice.

An example of a report that went to the Deputy Administrator for resolution was a report relating to VA employees receiving medical treatment for nonservice-connected conditions. This draft report was transmitted to DM&S for comment in April 1979. DM&S responded to the draft in July 1979, indicating a disagreement with the report's recommendations. The draft report was subsequently sent to the Deputy Administrator who concurred in the recommendations in May 1980--about 14 months after the draft report was initially submitted to DM&S for comment.

While we have no problems with discussing report recommendations with management officials and getting their considered views--we do it ourselves--we do have a problem with (1) reports being unduly delayed because of a lack of timely response by affected departments or offices, (2) report recommendations being revised or deleted because of a lack of concurrence, and (3) reports not

being issued without concurrence. As you know, in our reports, if the agency disagrees with our conclusions or recommendations, we consider its views in our final report, but do not drop a a recommendation unless after considering the agency's views we are convinced that the recommendation would not be appropriate.

The IG informed us that he follows the procedure of obtaining acceptance or approval of report recommendations because he believes that, if all concur, it is more likely that action will be taken to implement report recommendations.

It would appear that the procedure the OIG goes through in attempting to obtain concurrence on OA or RAS report recommendations tends to imply that report recommendations are not based on independent and unbiased review but rather on negotiations with all concerned parties.

We believe that after obtaining the department's position, the OIG should develop recommendations based on its independent views and go on record with these disclosing any areas of disagreement.

INVESTIGATION OF CERTAIN ALLEGATIONS INVOLVING THE VA PALO ALTO MEDICAL CENTER

In your letter of Jaunuary 21, 1980, you asked us to monitor the OIG's investigation of allegations made concerning the Palo Alto VA Medical Center. These allegations appeared in a series of newspaper articles in the Peninsula Times Tribune and correspondence from several VA police officers, and there has been significant congressional concern in this matter.

The major allegations at the Palo Alto Medical Center include charges of:

--significant increases in the rate of crime,

--widespread illegal drug use,

--inadequate support from local and Federal law enforcement agencies,

--interference by medical center officials in criminal investigations, and

--reprisals and threats against VA police officers making the allegations.

In addition, other allegations concerning employee wrongdoing and questionable medical center activities were made during the OIG's on-site investigation which began in December 1979.

The OIG has completed its investigation and has prepared a report of its findings. Based on our review of that report and its supporting documentation, we found that most of the major allegations were only pursued in part by the OIG. While specific incidents brought to the attention of the OIG were addressed, the OIG did not attempt to resolve the broader allegations. One example is the allegation that the crime rate at Palo Alto has been increasing. The OIG collected information indicating that the number of reported crimes had increased; however, the OIG did not attempt to determine the extent to which the increase resulted from more crimes being reported, an increase in patient population, or a real increase in the rate of crime.

In addition, the allegation we considered most serious and certainly the one receiving most of the media coverage--widespread illegal drug use--was only briefly mentioned in the OIG report. Specifically, the allegation was addressed only as it related to two specific incidents at Palo Alto. However, the OIG was aware that the Drug Enforcement Administration (DEA) was also investigating the issue of illegal drug activity at Palo Alto. Following its investigation, the DEA was unable to conclude that any significant or widespread drug activity existed at Palo Alto primarily because the VA police officers who had made the allegations could not provide the DEA investigators any documented evidence to substantiate their allegations. We believe the OIG report should have disclosed the findings and conclusions resulting from the DEA investigation.

Because the OIG report did not reach conclusions for many of the allegations, we attempted to do so based on the report and supporting documents. We designated certain allegations as "sustained" if they were confirmed or corroborated in part or full by the testimony of witnesses and/or documentation. Other allegations were designated "not sustained" if available information indicated that the allegation had no basis in fact. We designated some allegations as "unresolved" if there was not sufficient evidence to make a determination on the veracity of the allegation.

In our judgment, 8 of the 37 allegations addressed by the OIG were sustained, 17 were not, and 12 were unresolved. Of those that were unresolved, we believe further investigation for three of the allegations is warranted, namely

--the increasing rate of crime at Palo Alto;

--an alleged $7 million cover-up in the records of the Center's supply section; and

--the harassment of a VA police officer.

In addition, we noted that a number of allegations were not addressed in the OIG report or its supporting documentation. We were told that the OIG did not address all of the allegations because (1) some were considered not in the purview of the OIG or (2) some were not specifically brought to the attention of the OIG. We agree that several were not within the OIG's jurisdiction such as the adequacy of other Federal agencies' recent investigations into the allegations at Palo Alto. However, we believe that the OIG should have pursued the allegations of reprisals and threats against VA police officers making allegations, inadequate law enforcement support from Federal agencies, VA's failure to pursue legal action against employees and patients suspected of being involved in criminal activities, and VA police officers being assigned nonsecurity duties.

At the time we prepared our testimony, the OIG had not made any recommendations for corrective action. We understand that any recommendations resulting from the OIG investigation will be transmitted separately to the Chief Medical Director.

ALLEGATIONS OF HARASSMENT BY THE OIG

Your May 27, 1980, letter requested that we investigate charges of unwarranted harassment by the OIG of certain VA employees and the fabrication of charges and documents. Specifically, you requested

that we interview each VA central office employee of the OIG to determine whether there was any substance to these allegations.

From May 29 to June 6, 1980, we interviewed 135 employees of the OIG. While we perceived a certain amount of employee unrest due to recent reorganizations within the OIG, we have not encountered any knowledge of the allegations on the part of OIG employees nor any documentation to substantiate them. We plan to continue our efforts on this matter and report back to you shortly.

PROPOSED ESTABLISHMENT OF THE OFFICE OF MEDICAL INSPECTOR

DM&S has recently proposed establishing an Office of Medical Inspector (OMI). The proposed OMI will be responsible to the Chief Medical Director for monitoring and reporting on the quality of patient care and other medical determinations. In fulfilling these responsibilities, the OMI will conduct special investigations of health care facilities as requested by the Chief Medical Director; receive, review, and evaluate reports dealing with professional conduct and competency issues; make site visits to review quality of care rendered; and, based on information gathered and/or developed, make recommendations to the Chief Medical Director for corrective action.

The OIG has been a prime mover in the establishment of this office. In a memo to the Chief Medical Director, dated July 11, 1979, the IG stated that his office has been experiencing problems in investigating allegations involving the quality of

patient care and related medical matters. The IG stated that his office lacks the expertise and DM&S lacks the perceived independence because at times doctors who had been assigned to look at quality of care allegations lacked the objectivity or willingness to delve into the facts. The IG has stated that the OIG lacks the "authority" to prevent medical professionals under investigation from using their positions to interfere with testimony of subordinates and using professional and political contacts, including affiliation relationships, to disrupt investigations or implementation of recommendations.

In his memo he also expressed his concern with one of the existing groups in DM&S--the Systematic External Review Program group (SERP)--that undertakes reviews which address quality of care and the other DM&S issues. The IG stated that the SERP inquiries have been "uneven in depth and quality." Moreover, he said that SERP reviews do not seem to go far enough into direct patient care issues. For example, there is no review of patient complaints. Also, he said that SERP reviews follow no rigid standards and review comments are generally based on limited observations and discussions.

In his July 11, 1979, memo, the IG cited the investigation of allegations relating to improper surgical procedures at the Manhattan VA Medical Center. In this investigation, the OIG was criticized for failure to conduct a thorough and objective in-house investigation. Specific criticism of the OIG's investigation included (1) attempts were made to minimize and obscure charges rather than explore them, (2) quality of care issues were not fully explored, and (3) recommended

changes were inadequate. During this investigation, the OIG had referred a number of medical records to DM&S for review. Although this referral is generally a normal procedure when quality of care issues are involved, the OIG and DM&S were criticized for whitewashing the investigation.

Although recognizing problems with independence and the quality of reviews conducted by DM&S either on its own or in assisting the OIG, the IG has nevertheless agreed to the establishment of the OMI. It does not appear that the establishment of another group within DM&S will address the IG's concerns over the objectivity or thoroughness of quality of care inquiries conducted by DM&S.

We understand that the Administrator has not yet approved the establishment of the OMI. If it is approved, we believe that the OIG must take measures to assure itself that proper standards and guidelines are developed and rigidly followed by OMI in the conduct of its reviews. If the OIG lacks the expertise to adequately review the activities of the OMI, then he should take steps to obtain under his control and direction the expertise as needed to better insure the integrity of all VA audits and investigations.

In this statement, we have only cited areas of concern relating to the OIG's operations. We do not mean to imply that the OIG has accomplished little since its establishment. Quite the opposite, when we reviewed VA's internal audit operations in 1977, we pointed out that on a comparative basis with 49 major and minor audit organizations in the Government, VA ranked last in both the ratio of auditors to agency employees and the ratio of auditors to agency appropriations.

Our report 1/ on this matter was instrumental in the Congress adding a significant number of positions to that office. Since the establishment of the OIG, staffing has increased to over 300 authorized positions. Numerous audits and investigations have been undertaken and corrective actions have been taken on report recommendations as evidenced by the OIG's semi-annual reports. I am sure the IG will adequately address the OIG's accomplishments.

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Mr. Chairman, this concludes our statement. We will be happy to respond to any questions you or other Members of the Committee may have.

1/"Greater Audit Coverage of Internal Financial Operations Is Needed" (FGMSD-77-3, Nov. 19, 1976)