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BEFORE THE
COMMITTEE ON HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE
HEARING ON
HIGH RISK: GOVERNMENT OPERATIONS SUSCEPTIBLE
TO WASTE, FRAUD, AND MISMANAGEMENT

FEBRUARY 15, 2017

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG) and how the OIG provides effective oversight of VA programs and operations through independent audits, inspections, and investigations. The OIG seeks to prevent and detect fraud, waste, and abuse, and make meaningful recommendations to drive economy, efficiency, and effectiveness throughout VA programs and operations. Our goal is to undertake impactful work that will assist VA in providing the appropriate and timely services and benefits that veterans so deservedly earned, and ensuring the proper expenditure of taxpayer funds.

I have had the great privilege of serving as the Inspector General since May 2, 2016. Since that time, I have fully immersed myself in the work, priorities, and policies of the OIG. We have made a number of enhancements since I started, including issuing a Mission, Vision, and Values statement; increasing transparency; creating a Rapid Response team in our Healthcare Inspections directorate; expanding our data analytics capabilities; and being more proactive in our review areas. I believe that these changes will enable us to do additional impactful work in a more timely manner.

The OIG shares an analogous mission with the Government Accountability Office (GAO). It is important that the VA OIG has a strong relationship with GAO to ensure that we avoid duplication of effort as much as possible. To that end, one of the first things I did when I started was to meet with Comptroller General Dodaro and some of his senior staff. Our offices have had a number of communications since that time to promote coordination and more effective oversight of VA.

In February 2015, GAO added Managing Risks and Improving VA Health Care to its biannual High Risk list. It focused its concerns in five broad areas:

- ambiguous policies and inconsistent processes,
- inadequate oversight and accountability,
- information technology challenges,
- inadequate training for VA staff, and
- unclear resource needs and allocation priorities.

While our work is determined by what we believe is the most effective oversight of VA, a number of our reports address concerns in these same five areas. As the Committee requested, I will highlight a sampling of OIG work in each of the areas that resulted in GAO placing VA Health Care on its High Risk list. It should be noted that many of the OIG's reports could fit in more than one area.

Ambiguous Policies and Inconsistent Processes

We have issued a number of reports in the past few years that include VA's ambiguous policies and inconsistent processes. For example, we reported in September 2015 in *Review of Alleged Mismanagement at the Health Eligibility Center* that VA's Chief Business Office (CBO) had not effectively managed its business processes to ensure the consistent creation and maintenance of essential health care eligibility data. Due to the amount and age of the Enrollment System (ES) data, as well as lead times required to develop and implement software solutions, a multiyear project management plan was needed to address the accuracy of pending ES records and improve the usefulness of ES data. We made 13 recommendations in the report including one focused on controls to ensure that future enrollment data are accurate and reliable before being entered into the Enrollment System. VA concurred with the recommendations and provided sufficient information to close all recommendations in October 2016. We have an ongoing review of the Health Eligibility Center focusing on the alleged lack of effective governance over the Veterans Health Administration's (VHA) execution of the health care enrollment program at its medical facilities. We expect to issue our report in late spring 2017.

In another example, of a one program that operates nationwide with issues related to inconsistent implementation of policies is the Homeless Grant Per Diem Program. In a June 2015 report, *Audit of Homeless Providers Grant and Per Diem Case Management Oversight*, we determined VA needed to clarify eligibility requirements across the program to ensure that all homeless veterans have equal access to case management services. Historically, homeless veterans ineligible for VA health care have not been excluded from the program. However, as we conducted our work and questioned the application of the program's eligibility criteria, we found the criteria were unclear and inconsistently applied. This was confirmed in our interviews of the VA's Office of General Counsel, program directors, network homeless coordinators, and liaisons, which revealed confusion occurred at all program levels. We made five recommendations, three of which involved establishing a definitive legal standard on program eligibility and ensuring that policies and controls matched that standard and were applied across the program. The recommendations dealing with policies and controls remain open.

Inadequate Oversight and Accountability

Proper oversight by management would ensure that programs and operations would work effectively and efficiently. Our September 2016 report, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System*, on the management of the construction of a new VA medical center in the Denver area, is

an extremely costly example of the result of inadequate oversight. We confirmed the project to build a new medical center in the Denver area has experienced significant and unnecessary cost overruns and schedule slippages. Originally estimated for 2013 completion, it will not be ready before mid-to-late 2018, about 20 years after its need was identified in the late 1990s. Through all phases of the project, we identified various factors that significantly contributed to delays and rising costs, including:

- Inadequate planning and design,
- Construction phase was initiated without adequate design plans,
- A change in acquisition strategy contributed to delays and increasing costs
- Change request processing was untimely.

This occurred due to a series of questionable business decisions and mismanagement by VA senior officials. The report summarizes the significant management decisions and factors that resulted in a project years behind schedule and costing more than twice the initial budget of $800 million. We made five recommendations and VA management concurred with all recommendations. We recently requested information from VA on the implementation status of the recommendations and will keep them open until VA provides satisfactory evidence of implementation.

In June 2016, we issued a report on allegations related to appointment cancellations at the Houston VA Medical Center, *Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas*. We substantiated that two previous scheduling supervisors and a current director of two outpatient clinics instructed staff to input clinic cancellations incorrectly as canceled by the patient. We also confirmed that a current director of two CBOCs instructed staff, as recently as February 2016, to record an appointment as canceled by the patient if clinic staff at one CBOC offered to reschedule a veteran's appointment at a different CBOC situated about 17 miles away and the veteran declined the appointment. The CBOC Director believed this was appropriate since the CBOC was still offering the patient an appointment. When interviewed regarding these cancellations, the CBOC Director acknowledged she instructed staff to cancel appointments by the patient if the veteran declined an appointment in the alternate location. We made six recommendations, including referring the matter to VA's Office of Accountability Review (OAR) to determine what, if any, administrative actions should be taken based on the factual circumstances developed in our report.

In December 2014, we released an audit related to the VA National Call Center for homeless veterans, *Audit of The National Call Center for Homeless Veterans*. We reported that homeless and at-risk veterans who contacted the Call Center often experienced problems accessing a counselor and/or receiving a referral after completing the Call Center's intake process. Referred veterans did not always receive the services needed because the Call Center did not follow-up on referrals to medical centers. These missed opportunities occurred due to lapses in the Call Center's management and oversight. We made seven recommendations, including

implementing effective performance metrics to ensure homeless veterans receive needed services. We closed our report in September 2015 based on information received that all recommendations had been implemented.

Information Technology Challenges

As we have reported in our list of VA's Major Management Challenges within VA's Annual Financial Report we have frequently identified VA's struggles to design, procure, and/or implement functional information technology (IT) systems. IT security is continually reported as a material weakness in the Consolidated Financial Statement audits that are conducted annually by the OIG's independent auditing firm, CliftonLarsonAllen (CLA).

VA has a high number of legacy systems needing replacement: the Financial Management System; Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system; Veterans Health Information Systems and Technology Architecture, Benefits Delivery Network; and the electronic Contract Managing System. After years of effort focused on replacement of VA's legacy scheduling software, a new scheduling system is not in place. VA's issues with scheduling appointments are related to the inability to define its requirements and determine if a commercial solution is available or if it must design a system. Replacing systems has been a major challenge across the government and is not unique to VA. We have issued a number of reports outlining access issues and our work in this area is continuing.

While the difficulties between VA's electronic health record (EHR) and the Department of Defense's EHR are well documented, the increased utilization of care in the community will present further IT challenges. To ensure that medical providers both inside and outside VA have the most complete and up-to-date information, VA needs to find a more effective method for sharing patients' EHRs. We reported on the possibility of delays in care because of the difficulties in sharing medical records in the Urology Clinic at the Phoenix VA Health Care System in our October 2015 report, *Healthcare Inspection, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona*. Specifically, we identified approved authorizations for non-VA care coordination (NVCC) urological care and a notation that an authorization was sent to the non-VA provider. A scheduled date and time of an appointment with the non-VA urologist was often documented. However, we were unable to locate scanned documents from non-VA providers in these patients' EHRs verifying that the patients had been seen for evaluations, and if seen, what the evaluations might have revealed. This finding suggested that the Phoenix VA Health Care System (PVAHCS) did not have accurate data on the clinical status of the patients who were referred for the specialty care.

Further, with respect to scanning and reviewing outside clinical documents (for example, clinic notes, labs, or imaging results), when the services were provided by TriWest Health Care Alliance (TriWest), the treating providers' office submitted this data to the TriWest Portal. To access that information, an NVCC staff member was required to log into the TriWest Portal to print and scan these records into the patients EHRs.

This process was delayed because of the NVCC staffing shortages, which could have resulted in important clinical information not being reviewed for several months. We made three recommendations, including one specifically related to ensuring that non-VA care providers' clinical documentation is available in the EHRs in a timely manner for PVAHCS providers to review. We closed our report in June 2016 after VA provided information that addressed the recommendations.

In the area of IT security, VA uses personally identifiable information (PII), protected health information (PHI), and other sensitive information to deliver benefits to veterans and their dependents. Employees and contractors must safeguard this information. As we reported in our September 2015 report, *Review of Alleged Data Sharing Violations at VA's Palo Alto Health Care System*, the VA Palo Alto Health Care System (VAPAHCS) did not ensure that contract staff had the appropriate background investigations or proper security and privacy awareness training before being granted access to VA patient information. Additionally, facility Information Security Officers were not involved prior to the contractor placing its software on a VA server. We made three recommendations to VAPAHCS management and a fourth recommendation that VA's Office of Information Technology implement controls to ensure that unauthorized software is not procured or installed on VA networks without a formal risk assessment and approval to operate. We closed our report based on information provided that the recommendations were implemented.

Inadequate Training for VA Staff

One prevailing theme of the OIG's work related to wait times and scheduling issues was the inadequate, lack of, or incorrect training provided to VA staff responsible for scheduling appointments. We conducted extensive work related to allegations of wait time manipulation through fiscal years (FY) 2015 and 2016 after the allegations at the PVAHCS surfaced in April 2014. As we have reported in more than 90 Administrative Summaries of Investigation and other reports that have been issued, the lack of training for schedulers and the lack of understanding of the process by their managers created a system in which long wait times were not accurately portrayed to management.

In October 2016, we reported again that there was still confusion regarding appointments. The focus for this report was on consult management. In our report, *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, we substantiated that in 2015, PVAHCS staff inappropriately discontinued consults. We determined that staff inappropriately discontinued 24 percent of specialty care consults we reviewed. This occurred because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result, patients did not receive the requested care or they encountered delays in care. This report has 14 recommendations including ensuring that staff is hired and trained appropriately. We are tracking VA's progress on implementing all the recommendations.

In January 2016, we determined that VHA did not provide medical facilities with adequate tools to reasonably estimate non-VA care (NVC) obligations in our report, *Audit of Non-VA Medical Care Obligations*. The facilities we visited used a

combination of methods that were ineffective at ensuring NVC cost estimates were reasonable. The methods used to calculate estimated costs included Medicare or contract rates, historical costs, and the optional cost estimation tools provided by CBO. The accuracy of estimates varied widely among these methodologies. We made five recommendations including for VA to improve the cost estimate tools so that NVC cost estimates are produced consistently. The recommendations related to cost estimate tools remain open.

Unclear Resource Needs and Allocations Priorities

The OIG has repeatedly reported on VA's legacy systems and how they impair VA operations. A key element to accurate planning is a financial system that provides timely information to VA leadership. As was reported in *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015*, VA's complex, disjointed, and legacy financial management system architecture has continued to deteriorate over time and no longer meets the increasingly stringent and demanding financial management and reporting requirements mandated by the Department of the Treasury and the Office of Management Budget. VA continues to be challenged in its efforts to apply consistent and proactive enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems. VA announced in October 2016 that it had selected the Department of Agriculture as its Federal shared service provider to deliver a modern financial management solution to replace its existing core financial management system. When completed, this will be a major and critical event for VA in modernizing its system architecture for financial management.

The audit of VA's FY 2016 Financial Statements also identified Community Care obligations, reconciliations, and accrued expenses as a material weakness. Lack of tools to estimate non-VA Care costs, lack of controls to ensure timely deobligations, and the difficulty in reconciling non-VA Care authorizations to obligations in VA's Financial Management System, make the accurate and timely management of purchased care funds challenging. In addition, the Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities also were not integrated with VA and VHA Chief Financial Officer (CFO) responsibilities under Public Law (P.L.) 101-576, the *Chief Financial Officers Act of 1990*, to develop and maintain integrated accounting and financial management systems and provide policy guidance and oversight of all Community Care financial management personnel, activities, and operations.

To address the difficulties in estimating costs, VA has requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone—i.e., obligating funds at the time of payment—would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls to monitor accounting, reconciliation, and

management information processes to ensure they effectively manage funds appropriated by Congress.

VA needs to accurately forecast the demand for health care services in both the near term and the long term. The OIG is required by Section 301 of P.L. 113-146, the *Veterans Access, Choice, and Accountability Act of 2014* to review VHA occupations with the largest staffing shortages. We have issued three reports at this time and under the statute we will report for another two years. In our most recent report issued in September 2016,[1] we identified (i) medical officer; (ii) nurse; (iii) psychologist; (iv) physician assistant; and (v) physical therapist/medical therapist as the five critical occupations with the largest staffing shortages. In our initial review[2] and our subsequent reviews[3], we continue to recommend VHA create a staffing model that considers demand and complexity, and matches that to budget requests and allocations. While VHA has continually concurred with the recommendation, their planned completion date is September 2017. A further delay will result in missed opportunities to request appropriate funding when planning for the FY 2019 budget.

CONCLUSION

The OIG is committed to providing effective oversight of the programs and operations of VA. A number of our reports address the five broad areas noted by GAO in placing VA Health Care on its High Risk list. We will continue to produce reports that provide VA, Congress, and the public with recommendations that we believe will help VA operate its programs and services in a manner that will effectively and timely deliver services and benefits to veterans and spend taxpayer money appropriately.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions that you or other Members of the Committee may have.

[1] *OIG Determination of VHA Occupational Staffing Shortages*, September 28, 2016.
[2] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, January 30, 2015.
[3] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, September 1, 2015.