Department of Veterans Affairs

Office of Inspector General

September 2, 2015

A Statement from the Deputy Inspector General

VA OIG Substantiates Whistleblower's Claims of Extensive, Persistent Problems in Veterans Health Care Enrollment Records

Washington, DC – The Department of Veterans Affairs Office of Inspector General (OIG) received a request from the Chairman of the U.S House Committee on Veterans' Affairs to determine the merits of allegations made by a whistleblower about the Veterans Health Administration's (VHA) Health Eligibility Center (HEC). The OIG found the Chief Business Office has not effectively managed its business processes to ensure the consistent creation and maintenance of essential data and recommended a multiyear project management plan to address the accuracy of pending Enrollment System records to improve the usefulness of such data.

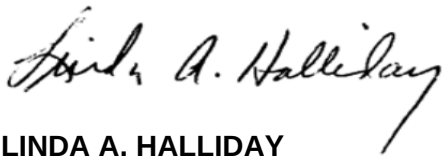
The OIG published a report http://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf on September 2, 2015, addressing the following four questions:

- Did the HEC have a backlog of 889,000 health care applications in a pending status?
- Did 47,000 veterans die while their health care applications were in a pending status?
- Were over 10,000 veteran health records purged or deleted at the HEC?
- Were 40,000 unprocessed applications, spanning a 3-year time period, discovered in January 2013?

We substantiated the first allegation that VHA's enrollment system had about 867,000 pending records as of September 30, 2014. However, due to serious enrollment data limitations, such as an estimated 477,000 pending records not having application dates, we could not reliably determine how many records were associated with actual applications for enrollment. OIG also substantiated that pending records included entries for over 307,000 individuals reported as deceased by the Social Security Administration. Again because of data limitations, we could not determine how many pending records represent veterans who applied for health care benefits. We also substantiated that employees incorrectly marked unprocessed applications as completed and possibly deleted 10,000 or more transactions over the past 5 years. Information security deficiencies, such as the lack of audit trails and system backups, limited our ability to review some issues fully and rule out data manipulation. Finally, we substantiated that the HEC identified over 11,000 unprocessed health care applications and about 28,000 other transactions in January 2013. This backlog developed because

the HEC did not adequately manage its workload and lacked controls to ensure entry of its workload into the enrollment system.

OIG recommended VHA assign and hold accountable a senior executive to develop and implement a project management plan to correct data integrity issues, to identify veterans whose applications have not been processed, enrollment program policy limitations, and access and security controls. We also provided recommendations to OI&T to implement adequate security controls and ensure the collection and retention of audit logs and system backups. OIG further recommended that VHA and OI&T officials confer with the Office of Human Resources and the Office of General Counsel to determine if administrative action should be taken against any VHA or OI&T senior officials involved, and ensure that appropriate action is taken. As this issue demonstrates, whistleblowers have proven to be a valuable information source to pursue accountability and corrective actions in VA programs.



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