

**STATEMENT OF
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U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND
RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
“THE STATE OF THE DEPARTMENT OF VETERANS AFFAIRS”
MARCH 9, 2011**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the state of the Department of Veterans Affairs (VA) in the context of the work produced by the Office of Inspector General (OIG). Accompanying me today is Ms. Belinda Finn, Assistant Inspector General for Audits and Evaluations, Ms. Maureen Regan, Counselor to the Inspector General, and Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections.

The scope and complexity of VA services for our veterans and their families are staggering. The Veterans Health Administration (VHA) delivered clinical services to approximately 6 million veterans in fiscal year (FY) 2010 across a network of hospitals, clinics, nursing homes, counseling centers, and domiciliaries and is consistently rated favorably in comparison to other public and private facilities. While the number of claims received is at an all time high, the Veterans Benefits Administration (VBA) has also processed more claims than in previous years within an evolving environment characterized by legislative, regulatory, and technological change. The National Cemetery Administration (NCA) has been consistently recognized as a world-class leader in customer satisfaction. Further, the results of VA's FY 2010 financial statement audit identified information technology (IT) security controls as the only remaining material weakness, compared to four material weaknesses in the prior year that also included financial management systems, oversight, and compensation liabilities. These improvements are significant.

However, like all organizations, VA has opportunities to achieve savings, reduce risks, and improve performance. The OIG's oversight of the second largest Cabinet Department in Government is focused on helping VA improve the care and benefits delivered to veterans by identifying program weaknesses and making recommendations to VA program officials on what actions they can take to strengthen programs and correct deficiencies. This statement provides an overview of the OIG's oversight program and outlines those areas in need of attention by VA officials to ensure that veterans receive the care and benefits they have earned through their service to our Nation. We will address OIG initiatives, in addition to our regular oversight work that support VA programs to reduce fraud, train staff, and identify savings in VA contracts.

We will also briefly address current work in progress and areas of concern that we plan to allocate resources to in the future.

OVERVIEW OF THE OIG

The OIG is responsible for conducting audits, health care reviews, inspections, and investigations of VA operations. In FY 2010, the OIG was funded at \$109 million and is staffed at approximately 600 employees. In FY 2010, we produced a total of 263 reports, including 36 audits and other reviews, 116 health care related reports, 98 pre-award and post-award reports, opened 988 criminal investigations, closed 842 criminal investigations, with a total monetary impact of \$1,913,000,000. The OIG is a good investment with a return on investment for FY 2010 of \$20 to \$1.

The OIG is organized into three line elements: the Offices of Investigations, Audits and Evaluations, and Healthcare Inspections, plus a contract review office and a support element. The OIG's Office of Contract Review, funded at \$3.9 million through a reimbursable agreement with VA, performs pre-award and post-award contract reviews and other pricing reviews of Federal Supply Schedule (FSS), health care resources, and certain construction contracts. In addition to the Washington, DC, headquarters, the OIG has field offices located throughout the country.

Annually, the OIG is required by statute to conduct an audit of VA's Consolidated Financial Statements, an audit under the Federal Information Security Management Act, and a detailed accounting of VA's submission to the Office of National Drug Control and Policy. The OIG has a proactive program of cyclical reviews for VA Medical Centers (VAMCs), community based outpatient clinics (CBOCs), and VA Regional Offices (VAROs). We have a full program of national audits and health care reviews that are either planned in advance or in reaction to requests from the Secretary and other senior VA officials, Congress, or allegations reported through the VA OIG Hotline, which in FY 2010 received approximately 30,000 contacts from veterans, VA employees, and the public. Additionally, we conduct criminal and administrative investigations of wrongdoing in VA programs and operations by VA employees, contractors, and others, and seek prosecution, administrative action, and monetary recoveries when warranted.

VETERANS BENEFITS ADMINISTRATION

The OIG performs audits and evaluations of VBA programs, focusing on the effectiveness of benefits delivery to veterans, dependents, and survivors. Through our audits, evaluations, and inspections, we identify areas where VA can improve the management of program operations and provide VA with constructive recommendations to improve the delivery of benefits.

Benefits Inspections Reviews

The Office of Audits and Evaluations' Benefits Inspection Program is part of our efforts to ensure our veterans received timely and accurate benefits and services. These independent inspections provide recurring oversight of VAROs focusing on disability compensation claims processing and performance of Veteran Service Center operations. The objectives are to evaluate how well VAROs are accomplishing their

mission of providing veterans with access to high quality benefits services; determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; minimize the risk of fraud, waste, and other abuses; and identify and report systemic trends in VARO operations. Benefits Inspections may also examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

In FY 2010, we issued 14 inspection reports and expanded our capacity to review the remaining VAROs and provide recurring oversight by adding a second field office in San Diego, California. The addition of this second field office enables the OIG to conduct inspections at all VAROs on a more frequent basis and perform follow-up visits to ensure continuous oversight. Key summary results from those inspections include:

- Claims processing – We project that 23 percent of 45,000 benefit claims requiring rating decisions that we reviewed, 23 percent were processed incorrectly. These errors involved claims related to Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), herbicide exposure-related disabilities, and temporary 100 percent evaluations. These errors either directly affected veterans' benefits or had the potential to affect benefits.
- Systematic Analyses of Operations (SAOs) – As part of VBA's internal quality management program, VAROs are required to conduct SAOs on an annual basis to identify existing or potential problems and propose corrective actions. VARO staff did not timely and accurately complete 24 (29 percent) of 82 SAOs. The inadequate SAOs represent missed opportunities for VAROs to identify existing or potential problems and take corrective actions.
- Mail Handling Procedures – Seventeen percent of search mail (i.e., claims-related mail waiting to be associated with a veteran's claim folder) was not properly controlled or associated with the claims files. Consequently, beneficiaries may not have received accurate and timely benefit payments.
- Incompetency Determinations – VARO staff unnecessarily delayed making final decisions in 54 (50 percent) of the 127 incompetency determinations reviewed at 5 VAROs. Delays increase the risk of an incompetent beneficiary receiving benefits payments without a fiduciary to manage those benefits and ensure the beneficiary's welfare.
- Veterans Appeals and Record Locator System (VACOLS) Compliance – Thirty-seven percent of Notice of Disagreements (NODs) from veterans were not timely input for workload management in VACOLS. Delays in establishing NODs in the system affect the integrity of VACOLS data, misrepresent performance and workload, and adversely affect the VBA National Call Center's ability to give accurate and timely customer service to veterans on their appeals. The VAROs nonetheless generally met VBA's timeliness goal of completing NODs within 182 days.

National Call Center

In another report in 2010, *Audit of National Call Centers and the Inquiry Routing and Information System* (May 13, 2010), we concluded that any one call placed by a unique

caller had a 49 percent chance of reaching an agent and getting the correct information. This occurred because VBA did not have a central entity to provide leadership and guidance, establish sufficient performance standards to evaluate timeliness and accuracy, provide adequate training, and implement an efficient call-routing system. VBA initiated some corrective measures by recruiting for a contact operations manager, adjusting the routing of calls, and increasing the number of telephone lines. In FY 2011, VBA plans to implement a new process to route calls more efficiently.

Temporary Disability Ratings

Despite numerous audit and inspection reports since FY 2004 stating that VARO staff were not consistently processing temporary 100 percent disability evaluations correctly, VBA has not fully corrected the problem. VBA staff did not adequately process 100 percent disability evaluations for about 27,550 (15 percent) of approximately 181,000 veterans. As a result, since January 1993 VBA paid veterans a net amount of about \$943 million in compensation benefits without adequate medical evidence. Without further action to adjust the benefits, the payments will continue and VBA will overpay these veterans a projected \$1.1 billion over the next 5 years. While VBA did not agree with our findings as they relate to the projected overpayment amounts, they agreed to implement the recommendations and provided an implementation plan. We stand firm on the statistical basis for the amount of projected overpayments. ([Veterans Benefits Administration – Audit of 100 Percent Disability Evaluations, January 24, 2011](#)).

Post 9/11 GI Bill

VA faced major challenges to ensure that veterans entitled to the new Post 9/11 GI Bill benefits received timely benefits because it lacked an automated IT solution to process these payments. As concerns regarding claims timeliness issues increased, VA issued 122,000 emergency payments worth \$356 million for students facing delayed education payments in the Fall 2009 school term. The emergency payment initiative offered effective relief to affected veterans; however, our review substantiated that VA inappropriately provided emergency payments totaling approximately \$103 million to ineligible military service members and veterans who did not participate in VA's education programs. VA also provided 2,700 emergency payments worth \$8 million to service members who did not meet VA criteria for emergency payments. We estimated a loss out of about \$87 million in unrecoverable debts out of the \$356 million in total emergency payments. As of February 2011, VBA had initiated collection actions with approximately 90 percent of the individuals who received these emergency payments and recovered 67 percent of the total payments, according to VBA senior officials. ([Veterans Benefits Administration Review of Alleged Improper Emergency Payments for Education Benefits, September 14, 2010](#)).

VBA Claims Backlog

Our oversight continues to identify opportunities for VBA to improve claims processing timeliness and reduce claim backlogs.

- In September 2009, our [Audit of VA Regional Office Rating Claims Processing Exceeding 365 Days \(September 23, 2009\)](#) made four recommendations to help

reduce claims processing times. To implement our recommendations, VBA established timeliness goals for each claims processing phase that are consistent with VBA's strategic target of completing rating claims within 125 days. VBA also revised policies to require VAROs to design and implement workload management plans that include these timeliness goals and prevent the inefficient claims processing practices discussed in our report. On April 12, 2010, to better align individual standards with organizational timeliness goals, VBA linked Veterans Service Representative (VSR) production credits and timeliness goals with VSR performance standards. On July 7, 2010, VBA's Office of Field Operations issued national and station-specific performance targets in an effort to reduce and eliminate the number of claims completed in excess of the 125-day strategic target.

- Notwithstanding recent hiring initiatives, VBA continues to experience difficulty in reducing claims inventories. In February 2010, our [Review of New Hire Productivity and the American Recovery and Reinvestment Act Hiring Initiative \(February 18, 2010\)](#) found that, although VBA met its FY 2008 hiring goals and filled almost all of its FY 2009 American Recovery and Reinvestment Act positions, VBA's rating and non-rating claims inventory was still expected to grow through at least FY 2011.

VETERANS HEALTH ADMINISTRATION

The OIG's oversight of VHA through health care inspections, reviews, and audits that focus on the effectiveness of health care delivery helps VHA maintain high-quality patient care and safety, safeguard against the occurrence of adverse events, and enhance the management of the delivery of services.

Combined Assessment Program Reviews

Every year we conduct approximately 50 combined assessment program (CAP) reviews that provide annual physical oversight of VHA's medical centers. Reviews are designed to focus on VHA's quality management program and selected clinical and administrative operations. We also conduct crime awareness briefings to increase VA employee awareness of the potential for fraud and requirement to report suspected criminal activity to the OIG. Topics reviewed through the CAP process are adjusted every 6 months. The current CAP topics include reviews designed to evaluate the credentialing and privileging of medical staff; the management of chemotherapy medications; efforts to reduce incidence of multidrug-resistant organisms; communication of test results to veterans; the medical center's efforts to maintain a clean and safe health care; and the facilities compliance with VA requirements for advance directives and discharge planning.

Quality Management

Recently, we published a roll-up report of the results of our CAPs in the area of quality management, [Combined Assessment Program Summary Report – Evaluation of Quality Management in Veterans Health Administration Facilities for Fiscal Year 2010' \(February 16, 2011\)](#). Although all 55 facilities had established comprehensive QM

programs and performed ongoing reviews and analyses of mandatory areas, 4 facilities had significant weaknesses (Memphis, Tennessee; El Paso., Texas; Dublin, Georgia; and Providence, Rhode Island). The CAP reports for each of these facilities provided recommendations and action plans to implement needed changes. To improve operations, we recommended that VHA reinforce requirements for comprehensive utilization management programs, thorough review of individual resuscitation episodes and trending of aggregate data, life support training policies, and reports.

Reusable Medical Equipment

We continue to be concerned about the processing of reusable medical equipment (RME) throughout the VA system. We have reported on this issue extensively finding that VA continues to struggle to ensure that equipment is properly cleaned.

In 2009, after instances in Murfreesboro, Tennessee; Miami, Florida; and Augusta, Georgia, involving the improper processing of endoscopes and colonoscopes, we published two reports including the results of unscheduled inspections at all VAMCs that performed these procedures. To improve compliance with VHA policy, VHA asked us to include RME issues in CAP reviews for the period of January 1 through September 30, 2010, which covered 45 VHA medical facilities. While VHA facilities recognized the importance of maintaining consistent RME practices to ensure veterans' safety, we identified six areas where compliance with RME requirements still needs to improve. We made the following recommendations that:

- Standard Operating Procedures (SOPs) be current, consistent with manufacturers' instructions, and located within the reprocessing areas.
- Employees consistently follow SOPs, supervisors monitor compliance, and annual training and competency assessments be completed and documented.
- Flash sterilization be used only in emergent situations, supervisors monitor compliance, and managers annually assess and document competencies for employees who perform flash sterilization.
- Appropriate personal protective equipment be donned before entering and worn in decontamination areas.
- Ventilation systems be inspected and filters changed quarterly in all reprocessing areas, and that temperature and humidity levels be monitored and maintained within acceptable ranges in sterile storage areas.
- Processes for consistent internal oversight of RME activities be established to ensure senior management involvement.

Just this week, we released a report requested by members of Congress on improperly cleaned and sterilized dental equipment at the John Cochran Division (JCD) of the St. Louis VA Medical Center. The dental RME reprocessing issues at the JCD were a long-standing problem that went unrecognized and unaddressed by Veterans Integrated Service Network (VISN) and VAMC managers. While VHA identified the deficiencies and took actions to correct them, those actions did not always resolve the issues. Responsible managers did not verify the adequacy of RME reprocessing practices, nor did they assure that corrective actions were consistently implemented in response to

VHA guidance and a VA Infectious Disease Program Office (IDPO) report. As a result, SOPs were not developed in a timely manner for the reprocessing of dental RME, SOPs did not always match manufacturers' instructions, and Dental Clinic staff had not received training on dental RME pre-treatment or reprocessing.

VA issued notices of disclosure to 1,812 patients potentially affected by the breaches in the cleaning and sterilization processes, as required by VHA policy. We concluded that the VAMC promptly set-up and staffed its Dental Review Clinic, made appropriate efforts to contact identified patients, and provided adequate support and follow-up to patients.

The VISN Director agreed to monitor the facility's compliance with all appropriate elements of RME reprocessing; ensure that the VISN Supply, Processing, and Distribution Management Board ensure that SOPs based on manufacturer's instructions are in place and that staff training and competencies are current; and take appropriate administrative actions based on the findings of the Administrative Board of Investigation and IDPO report. ([Healthcare Inspection – Reprocessing of Dental Instruments, John Cochran Division of the St. Louis, VA Medical Center, St. Louis, Missouri, March 7, 2011](#)).

Community Based Outpatient Clinic Reviews

In addition to the health care provided at VAMCs, VA also provides care to veterans at over 800 community based outpatient clinics (CBOCs). With the support of this Subcommittee, the OIG initiated a systematic review of CBOCs in FY 2009 to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures. In FY 2010, our reviews revealed that the quality of medical care provided in VA-owned CBOCs and contracted CBOCs was similar. However, we routinely found poor contract planning and administration that resulted in overpayments by VA. We plan to visit 85 CBOCs in FY 2011 to continue to evaluate the quality of clinical care provided as well as the management of contracts.

Our Office of Audits and Evaluations also reviewed CBOC operations. We found that VHA lacks a comprehensive CBOC management control system with which to evaluate and manage CBOC performance and address operational problems. Our audit results show that CBOC data relied upon to make VHA budgetary and resource management decisions contained significant inaccuracies. The Under Secretary for Health accepted our recommendations and indicated that corrective actions would be completed by January 2011. However, as of February 28, 2011, four of six recommendations remain open. As VA's network of CBOCs grows and VHA strives to balance quality, access, and patient services, we were pleased to see that the Under Secretary for Health is focusing a review to identify gaps in the provision of health care and determining how to monitor contractor and VA-managed CBOC performance. ([Audit of CBOC Management Oversight, July 28, 2010](#)).

Non-VA Fee Care Program

In FY 2010, VA spent approximately \$4.4 billion for the care of veterans at non-VA facilities and costs are expected to increase in future years due to increased demand for care and increased health care costs. VA faces ongoing challenges in addressing the financial vulnerabilities and the inefficiencies in processing medical fee claims associated with both the inpatient and outpatient aspects of the Non-VA Fee Care Program.

Under the Non-VA Fee Care Program, VA facilities may authorize veterans to receive treatment from non-VA health care providers when certain services are unavailable at VA facilities, when services cannot be economically provided due to geographic inaccessibility or in emergencies when delays may be hazardous to life or health. We have issued four reports on the Fee Program in the past 2 years addressing inpatient fee care, the lack of a program fraud management program, outpatient fee care and medical fee claim processing, and the quality of care at one facility. In these reports, we identified opportunities for VA to achieve significant cost savings, improve its management of the Non-VA Fee Care Program, and better coordinate care.

- We estimated that VA improperly paid 28 percent of pre-authorized inpatient medical fee claims by not properly authorizing fee care, and not correctly determining payment rates in FY 2009. This resulted in VA making overpayments of \$120 million related to inpatient medical fee claims. Without timely corrective actions, we estimated VA could make \$600 million in improper payments over the next 5 years. Additionally, we identified medical fee claims processing inefficiencies estimated to cost \$26.8 million or \$134 million over the same 5-year period that could be avoided by consolidating the Fee Program's claims processing system. The Under Secretary for Health agreed to implement our recommendations and concurred economies of scale can be achieved by consolidating medical fee claims processing activities. Recently, the Chief Business Office entered into an agreement with VA's Financial Services Center in Austin, Texas, to develop a pilot program to process all medical fee claims for one VISN. The Financial Services Center is developing the project in phases and plans to have the project fully implemented by August 2012. Additionally, the Chief Business Office has contracted for a national risk assessment of their business oversight of the Fee Program and for an external organization to audit claims to determine if fee payment locations are complying with VA pricing and payment methodologies and procedures. ([Veterans Health Administration – Audit of Non-VA Inpatient Fee Care Program, August 18, 2010](#)).
- In June 2010, we reported that VA had not established controls designed to prevent and detect fraud primarily because it had not identified fraud as a significant risk to the Fee Program. We estimated that the Fee Program could be paying between \$114 million and \$380 million annually for fraudulent health care claims. The Under Secretary agreed with our recommendation to establish a fraud management program and is moving forward with plans. ([Veterans Health Administration – Review of Fraud Management for the Non-VA Fee Care Program, June 8, 2010](#)).

- In August 2009, we reported that VA improperly paid 37 percent of outpatient medical fee claims, resulting in an estimated \$1.1 billion in overpayments and \$260 million in underpayments over a 5-year period. VA health care facilities did not properly justify or authorize services as required by VHA policy, increasing the risk of improper payments. Further, we found that VHA had not developed procedures suitable for fee staff to use as their day-to-day instructions for processing medical fee claims and meeting policy requirements. The Acting Under Secretary for Health accepted our recommendations to establish policies, standardize business procedures, provide training to maintain staff competence, and develop an oversight program. (*Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program, August 3, 2009*).
- In a report dealing with the care provided at the Orlando VAMC, in Orlando, Florida, we determined that the medical center lacks an adequate care management system to coordinate care between VA providers and fee basis providers which led to delays in care. We found instances where medical care was affected or delayed due to communication breakdowns between VA and non-VA providers. For example, a patient had to undergo a second biopsy because the original non-VA pathology results could not be located; another veteran arranged for care at a different VA facility outside of his geographic region due to fee basis delays; and general delays in finding fee basis services in the community. (*Healthcare Inspection Inadequate Coordination of Care, Orlando, VA Medical Center, Orlando, Florida, June 24, 2010*).

Medical Licensing Issues

VHA regulations require that physicians maintain one State medical license that is active and in good standing in order to practice medicine in VHA facilities. Physicians hold primary responsibility for renewing their medical license(s) timely and clinical privileges will be revoked if a physician does not maintain at least one active medical license.

- Based on earlier work, we were concerned about the comprehensiveness of systems and processes that track and follow up on expiring medical licenses at VA medical facilities. We conducted a national review to evaluate the interconnecting systems that provide data on medical license status and found that license expiration dates were inconsistent and fragmented across VHA medical facilities. Because VHA guidance lacked defined and specific requirements for monitoring expiration dates and following up on renewals, individual VHA medical facilities employed a variety of different approaches to track and manage licensure data. Further, VetPro (VHA's electronic credentialing and privileging database) reports were not always considered trustworthy, user-friendly, or adaptable to local needs. In addition, we confirmed that the license expiration date automatically updates in the Personnel and Accounting Integrated Data system after the notification of the impending expiration is sent to the facility. We recommended that the Under Secretary for

Health require VHA to outline the requirements and responsibilities for collecting, validating, and monitoring medical license expirations; assuring communication and coordination among involved Services; and following up to promote timely renewal of licenses. We also recommended that VHA medical facilities evaluate and refine local practices and policies to conform to VHA's requirements. ([Healthcare Inspection – Tracking of Medical License Expiration Dates, November 29, 2010](#)).

- In response to allegations received in our Hotline, we conducted an inspection of the Nuclear Medicine Service at the Northport VAMC in Northport, New York. We substantiated that the VAMC was operating an unaccredited residency training program in nuclear medicine that fell outside established VA residency training policies and VA personnel policies, which led to the Chief of the Nuclear Medicine Service allowing unqualified individuals who were not licensed to practice medicine in the United States to work in the Service. As a result of our work, the VAMC Director discontinued the nuclear medicine residency training program and removed two unlicensed trainee physicians, and VHA's Office of Academic Affiliations discontinued funding nuclear medicine resident positions at the facility. ([Healthcare Inspection - Alleged Residency Training Issues in Nuclear Medicine Service, Northport VA Medical Center, Northport, New York, November 12, 2010](#)).

JOINT REVIEW OF WOMEN VETERANS ISSUES AT VBA AND VHA

At the direction of the Joint Statement of Managers in the Conference Report to Accompany the Consolidated Appropriations Act of 2010 (Public Law 111-117), we conducted a review to assess VA's capacity to address combat stress in women veterans. This review was a joint project by our Office of Healthcare Inspections and our Office of Audits and Evaluations. ([Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits, December 16, 2010](#)).

We assessed women veterans use of VA health care for traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and other mental health conditions and whether VBA properly adjudicated women veterans disability claims for these conditions. After analyzing integrated data from VA and the Department of Defense for almost 500,000 male and female veterans who separated from the military from July 1, 2005 to September 30, 2006, for the experience transitioning to VA and using VA healthcare and compensation benefits through March 31, 2010, we reported the following:

- Female veterans generally were more likely to transition to and continue to use VA health care services.
- Higher proportions of female veterans generally were diagnosed with mental health conditions by VA after separation but lower proportions were diagnosed with PTSD and TBI.
- Higher proportions of female veterans generally were receiving disability benefits for mental health conditions, but at a lower proportion for PTSD and TBI.

- Gender-based biases were not identified in VBA's adjudication of male and female disability claims but data limitations affected a full assessment of some outcomes.
- VBA has guidance and training for evaluating military sexual trauma (MST) claims, but sensitivity training is needed for claims processors and Women Veterans' Coordinators to better prepare them to effectively communicate with veterans who may be distressed during interactions regarding their MST-related disability claim.
- VBA has not assessed the feasibility of requiring MST-specific training and testing for claims processors who work on MST-related claims because it has not analyzed available data on its MST-related workload and how consistently these claims are adjudicated.

DEPARTMENT-WIDE ISSUES

VA continues to experience difficulties in its management of contracts, especially in the area of IT contracts. Historically, VA has struggled to manage IT developments that deliver desired results within cost and schedule objectives. The Office of Information Technology (OI T) has implemented the Program Management Accountability System (PMAS) to strengthen IT project management and improve the rate of success of VA's IT projects. We are currently conducting an audit to determine how well OI T has planned and implemented PMAS and its effectiveness in managing VA's IT capital investments; we will report on our findings this summer

Information Technology Project Management

Over the past 2 years, our audit work on several IT system development projects has identified themes as to why VA has continued to fall short in its IT project management. These issues include inadequate project and contract management, staffing shortages, lack of guidance, and poor risk management—issues that have repeatedly hindered the success of IT major development projects undertaken by OI T.

- Our FY 2009 report on Financial and Logistics Integrated Technology Enterprise (FLITE) determined that program managers did not fully incorporate lessons learned from the earlier failed Core Financial and Logistics System (CoreFLS) program to increase the probability of success in FLITE development. We found deficiencies similar to those identified in CoreFLS reviews also occurred within FLITE. For example, critical FLITE program functions were not fully staffed, non-FLITE expenditures were improperly funded through the FLITE program, and contract awards did not comply with competition requirements. ([Audit of FLITE Program Management's Implementation of Lessons Learned, September 16, 2009](#)).
- Our FY 2010 report on the FLITE Strategic Asset Management (SAM) pilot project disclosed that FLITE program managers did not take well-timed actions to ensure VA achieved cost, schedule, and performance goals. Further, the contractor did not provide acceptable deliverables in a timely manner. Once

again, we identified instances where FLITE program managers could have avoided mistakes by paying closer attention to lessons learned.

Specifically, we found that FLITE program managers awarded a task order for implementation of the SAM pilot project, even though the FLITE program suffered from known staffing shortages. FLITE program managers did not clearly define FLITE Program and SAM pilot project roles and responsibilities, resulting in contractor personnel receiving directions and guidance from multiple sources. FLITE program managers did not ensure that the solicitation for the SAM pilot project clearly described VA's requirements for SAM end-user training resulting in a more than a 300 percent increase from the original training cost. Finally, FLITE program managers did not always effectively identify and manage risks associated with the SAM pilot project even though inadequate risk management had also been a problem with the failed CoreFLS. Because of such issues, VA was considering extending the SAM pilot project by 17 months (from 12 to 29 months), potentially more than doubling the original contract cost. Following our audit report, VA in fact extended the SAM pilot only to ultimately suspend it in March 2011 to reexamine its development approach and has terminated the contracts for convenience. ([Audit of the FLITE Strategic Asset Management Pilot Project, September 14, 2010](#)).

Procurement

Procurement continues to be a major management challenge for VA. Our oversight of VA's procurement activities is through audits, investigations, reviews, inspections, and the work of the Office of Contract Review which conducts pre- and post-award reviews of contracts awarded by VA's National Acquisition Center, pre-award reviews of proposals for health care resources to be awarded to VA affiliated universities and medical centers on a sole-source basis, and this fiscal year has begun conducting pre-award reviews of certain construction proposals. This work provides us with a unique nationwide perspective on VA's procurement practices. It also provides us with insight into the commercial practices of the various industries that VA contracts with, in particular the health care industry. Since 2005, Office of Contract Review has issued 560 reports with a total monetary impact of \$2.2 billion.

Across the board, our body of work has identified systemic issues that cause or contribute to procurement failures, overpayments, and misuse of funds, including poor acquisition planning, poorly written contracts, inadequate competition, no price reasonableness determinations, and poor contract administration. We believe the decentralized organizational structure for procurement activities in VA as well as inadequate oversight and accountability are primary factors contributing to these problems.

Our work has provided VA with information needed to identify and establish plans to correct systemic deficiencies in the acquisition processes. For example, VA has established the Acquisition Academy in Frederick, Maryland, which has implemented rigorous training programs for contracting officers and contracting officer's technical

representatives. VA also has implemented processes, such as Contract Review Boards, to provide better oversight of large dollar procurements prior to award. In 2007, VA implemented an Electronic Contract Management System (eCMS) to better manage, increase visibility, and provide improved oversight of VA contracting processes. In July 2009, we reported that eCMS was incomplete and unreliable and therefore ineffective. Until VA enforces compliance for the mandatory use of the system, VA cannot benefit from the full capabilities of the system. (*Audit of VA Electronic Contract Management System*, July 30, 2009) In FY 2010 as part of our oversight of funding provided under the American Recovery and Reinvestment Act (ARRA), we reported that despite VA's efforts to monitor ARRA data in eCMS, data reliability and system problems limited VA's ability to oversee ARRA related procurements. (*Review of VHA's Efforts to Meet Competition Requirements and Monitor Recovery Act Awards*, September 17, 2010).

CURRENT AND FUTURE WORK

In addition to the OIG's recurring mandatory, proactive, and reactive work already described, the Office of Audits and Evaluations is currently either working on or planning work to address areas of concern including rural health; the structure of Veteran Integrated Service Networks; service-disabled veteran-owned small business programs; the Medical Care Collection Fund, the security of VA's IT connections with university affiliates; the Fee Care program for dental care; and management of VA foreclosed properties.

To continue our oversight of VBA initiatives to improve claims processing timeliness and reducing claim inventory backlogs, we are currently following VBA's efforts related to the Disability Benefits Questionnaire, an on-line tool designed to streamline the submission of medical examinations by VHA and veterans' private physicians to VAROs. We plan to begin an audit of VBA's paperless claims processing initiative—the Veterans Benefits Management System (VBMS). VBA expects VBMS to reengineer claims processing by automating the assembly of claim evidence. VBA anticipates VBMS will reduce claims backlog, lower claim cycle times, and increase transparency.

Our Office of Healthcare Inspections plans to review the quality of VA purchased care; study the allocations of provider and staff time; and review the effectiveness of programs for homeless veterans. The Office of Contract Review will issue reports on VA's medical and surgical prime vendor program and a roll-up of issues identified during review of health care resources proposals.

The OIG will also continue to provide support to VA through two fraud programs. The Office of Investigations uses several computer matching initiatives to detect and deter criminal activity.

- The Death Match Project – This program compares the Social Security Administration's "Death File" with a database of VA beneficiaries, which enables us to identify instances of benefits continuing to be paid out to deceased veterans. Our work in this area focuses on investigating and prosecuting those

individuals taking advantage of a beneficiary's death for personal gain. This

program has resulted in 446 arrests, recovery of more than \$47 million, and a 5-year cost avoidance of more than \$126 million.

- Fugitive Felon Program – This program involves computerized matches between fugitive felon files of Federal and State law enforcement organizations and VA benefit files. When a veteran fugitive felon is identified, VA can suspend benefits and initiate recovery of any benefit payments made while the veteran was in fugitive status. Since its inception in 2002, this program has resulted in 2,092 arrests and identified \$753.3 million in estimated overpayments with an estimated cost avoidance of \$868.5 million.

The OIG also assists VA through various outreach and liaison efforts, and by training VA leaders and employees through the following efforts:

- Monthly Meetings with VHA, VBA, and OIG Senior Management – The Assistant Inspectors General for Audits and Evaluations, Healthcare Inspections, and Investigations meet on a monthly basis with the Chief Information Officer, VHA, and VBA senior officials to discuss recent results of OIG oversight work and to identify risks, vulnerabilities, and areas that can benefit from future OIG oversight work. We coordinate issues that will help improve program performance and operations, reduce costs, facilitate decision-making by responsible officials, and contribute to public accountability.
- VA Acquisition Academy – The Counselor to the Inspector General and Office of Investigations staff provide instruction to VA contracting officers at advanced contracting courses at the VA Acquisition Academy in Frederick, Maryland. The training covers the role of the OIG, criminal conduct relating to procurement, audit issues relating to procurement, and how to avoid or prevail in contract disputes.
- The Counselor and the Office of Contract Review are working with VA on a General Services Administration (GSA) task group to improve the efficiency of the GSA FSS Program.
- Drug Diversion Liaison – Each VA medical center has an assigned OIG criminal investigator responsible for sharing information with the VA Police Chief and Pharmacy Service Chief to deter, detect, and investigate potential drug diversion.
- Fiduciary Fraud Liaison – Each VA Regional Office has an assigned OIG criminal investigator responsible for sharing information with the lead fiduciary coach to deter, detect, and investigate potential fiduciary fraud.
- Major Construction Liaison – Each VA major construction project with a value greater than \$10 million has an assigned OIG criminal investigator responsible for sharing information with contracting officers, COTRs, program managers, and prime and sub-contractor staff to deter, detect, and investigate potential construction fraud.

CONCLUSION

VA faces formidable challenges in delivering high-quality medical care and benefits to our Nation's veterans in a cost-efficient and effective manner. With increased attention to the areas outlined above, we believe that VA can achieve savings, reduce risks, and improve performance. Through the OIG's oversight work, we will continue to provide VA with recommendations on how to improve services to veterans by VBA and VHA, and through better contract planning and oversight, and IT system development. We are committed to these efforts both because it is good government and because it honors our Nation's commitment to those who served.

Mr. Chairman, thank you for the opportunity to discuss the results of the work of the OIG and we welcome any questions that you or other members of the Subcommittee may have.