

**STATEMENT OF  
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BEFORE THE  
SUBCOMMITTEE ON MILITARY CONSTRUCTION  
VETERANS AFFAIRS, AND RELATED AGENCIES  
COMMITTEE ON APPROPRIATIONS  
UNITED STATES SENATE  
HEARING ON  
VA CHALLENGES IN FISCAL YEAR 2014  
APRIL 18, 2013**

**INTRODUCTION**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss VA Office of Inspector General (OIG) priorities in fiscal year (FY) 2014. I will focus on recent OIG work in claims processing and access to health care because they continue to be challenges for VA. In addition, I will briefly cover OIG work in VA's other programs and operations. I am accompanied by Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations, and Dr. John D. Daigh, Jr., Assistant Inspector General for Healthcare Inspections.

In FY 2012, the OIG issued 299 reports and our oversight produced a \$36 to \$1 return on investment<sup>1</sup>; as of March 31, 2013, we have issued 164 reports and realized a \$33 to \$1 return on investment. This return is realized by VA in terms of program savings, cost avoidance, questioned costs, and actual dollars recovered. The OIG's Office of Healthcare Inspections, whose mission results in improving the health care provided to veterans rather than saving dollars, is not included in the return on investment calculation.

**VETERANS BENEFITS ADMINISTRATION**

One of VA's core missions is to provide compensation benefits for those injured during their service in the military. The delivery of these benefits is a major challenge for VA and our reports indicate that much work continues to be needed in both technology initiatives and better training for staff to reduce the growing backlog of claims.

**Veterans Benefits Management System Development**

In February 2013, we issued a report on the Veterans Benefits Management System (VBMS)<sup>2</sup> that found VA had not fully tested VBMS yet continued to deploy it to VA Regional Offices. Due to the incremental development approach VA chose, the system had not been fully developed to the extent that its capability to process claims from

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<sup>1</sup> *Office of Inspector General Department of Veterans Affairs Semiannual Report to Congress April 1, 2012 - September 30, 2012*

<sup>2</sup> *Review of VBA's Transition to a Paperless Claims Processing Environment (February 4, 2013)*

initial application through review, rating, award, to benefits delivery could be sufficiently evaluated. However, we determined the partial VBMS capability deployed to date has experienced system performance issues. For example, on April 8, 2013, VBA performed an update to the portion of the VBMS system related to rating claims. As a result, the system was unexpectedly unavailable nationwide for 2 days.

As of the VBMS report date, VBA did not have a detailed plan for scanning and digitization of veterans' claims nor an analysis of requirements. We identified issues hindering VBA's efforts to convert hard-copy claims to electronic format for processing within VBMS, including disorganized electronic claims folders and inadequate management of hard-copy claims. As one of VBA's main transformation initiatives, the Under Secretary for Benefits indicated VBMS is designed to assist VA in eliminating the claims backlog. At the end of FY 2010, VBA's inventory of pending claims was just over 530,000 that took an average of 166 days to complete; as of March 2013, VBA's inventory of pending claims had grown to over 850,000 and is now taking an average 292 days to complete.

In our more recent inspections of the VA Regional Offices (VARO) in Houston, Texas; Newark, New Jersey; and Milwaukee, Wisconsin; 25 staff provided us a user's perspective of VBMS. Generally, staff expressed frustration with the system in part because of spontaneous system shut-downs, latency issues related to slow times to download documents such as medical evidence for review, longer times to review the electronic evidence, mislabeled electronic evidence, and mixing evidence from one veteran's electronic file to another veteran's file.

Further, as outlined in our April 2013 report<sup>3</sup> we found that claims processing inaccuracy at the Baltimore, Maryland, VARO had more than doubled for the types of medical disability claims we reviewed since our first inspection in June 2009. The error rates changed from 28 percent inaccurate to 68 percent inaccurate for the claims we reviewed. VBA's Systematic Technical Accuracy Review (STAR)<sup>4</sup> of a cross section of all claims found the Baltimore VARO went from 76.8 percent accuracy in 2009, down to 74.4 percent in 2013. The inventory of pending claims grew significantly from 7,000 in 2009 and about 19,000 in 2013, while the staffing level only increased slightly from 134 staff to 143 staff respectively. The average days to complete disability claims went from 210 days in 2009 to 342 days in 2013.

Given the incremental system development approach used and the complexity of the automation initiative, VA will continue to face challenges in meeting its goal of eliminating the backlog of disability claims processing by 2015. We are continuing our oversight of VA's ongoing VBMS system development efforts assessing the system's functionality, costs, and ability to establish and meet schedule milestones.

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<sup>3</sup> *Inspection of VA Regional Office, Baltimore, Maryland (April 11, 2013)*

<sup>4</sup> STAR is a key mechanism for evaluating regional office performance in processing accurate benefit claims for veterans and beneficiaries. The STAR process provides a comprehensive review and analysis of compensation rating processing associated with specific claims or issues.

## **Temporary 100 Disability Evaluations**

Our January 2011 report, *Audit of 100 Percent Disability Evaluations*, identified veterans receiving long-term payments to which they were not entitled. We projected that since January 1993 regional office staff overpaid veterans a net amount of about \$943 million. Without timely corrective action, we conservatively projected that VBA would overpay veterans \$1.1 billion over the period of calendar year 2011 through calendar year 2015. Over the last 3 years our VARO Inspections Program repeatedly reported systemic problems are continuing in VBA's processing of temporary 100 percent disability ratings. None of the 57 VAROs inspected fully followed VBA policy, which resulted in VARO staff not adequately processing temporary 100 percent ratings for approximately 66 percent of cases reviewed. These errors resulted in just under \$17,000,000 in overpayments and almost \$311,000 in underpayments.

In our inspections of three California VAROs<sup>5</sup>, we reported high errors rates, ranging from 53 to 97 percent, in processing temporary 100 percent disability evaluations. The magnitude of these and other claims processing errors caused VBA to temporarily cease operations at the Oakland and Los Angeles VAROs in order to provide training to staff.

In June 2011, and again in August 2012, VBA officials modified the electronic system to ensure suspense diary dates for medical re-examinations would automatically populate and remain in the system without manual entry. Currently, it appears these system corrections are working as we have observed that the diary dates remain in the system after being automatically populated. Although VBA has taken action to modify their electronic systems, these system fixes have not fully addressed the staff errors we frequently find. For example, during our FY 2012 inspection cycle and through March 2013, where we reviewed 29 VAROs, 524 (62 percent) of the total 848 temporary 100 percent disability evaluations contained processing errors. Within this group of 524 errors, 338 (approximately 65 percent) were attributed to human error. These errors include staff not scheduling medical reexaminations after receiving reminder notifications to do so, or staff not following up to reduce the temporary evaluations after notifying veterans of their intent to do so.

## **Medical Examinations and Disability Benefits Questionnaires**

Our VARO inspections continue to find claims processing errors associated with the use of medical examinations that do not contain the required information to render sound disability determinations. Further, we identified 30 of the 365 disability benefits questionnaires (DBQs) that did not contain adequate information to make accurate disability determinations.

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<sup>5</sup> *Inspection of the VA Regional Office Los Angeles, California* (May 10, 2012); *Inspection of the VA Regional Office Oakland, California* (May 10, 2012); *Inspection of the VA Regional Office San Diego, California* (May 10, 2012)

Our February 2012 report, *Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires*, reported VA began using DBQs in October 2010 as an initiative to help reduce the claims backlog. DBQs are condition-specific forms designed to capture medical information relevant to veterans' disability benefits claims. We reported that VA needed to strengthen internal controls over the use of DBQs in order to better prevent, detect, and minimize the risk of fraud and provide reasonable assurance that medical documentation used in the rating process is authentic and unaltered. Specifically, VBA had not developed adequate internal controls to ensure DBQs completed by private physicians were authentic and unaltered.

## **VETERANS HEALTH ADMINISTRATION**

For many years, the Veterans Health Administration (VHA) has been a national leader in the quality of care provided to patients when compared with other major U.S. health care providers. VHA's use of the electronic medical record, its National Patient Safety Program, and its commitment to use data to improve the quality of care has sustained VHA's quality of care performance. However, VHA faces particular challenges in managing its health care activities. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA.

### **Access to Mental Health Services**

The OIG conducted a review<sup>6</sup> at the request of the VA Secretary, Chairmen and Ranking Members of the U.S. Senate and U.S. House Committees on Veterans' Affairs, and the Chairman and Ranking Member of the House Veterans' Affairs Committee's Subcommittee on Health, after they expressed concerns that veterans may not be able to access the mental health care they need in a timely manner. In response, OIG reported VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services.

VHA did not provide first-time patients with timely mental health evaluations, and existing patients often waited more than 14 days past their desired date of care for their treatment appointments. In FY 2011, VHA had reported 95 percent of first-time patients received a full mental health evaluation within 14 days. Using the same data VHA used to calculate the 95 percent success rate, we selected a statistical sample of completed evaluations to review which supported only 49 percent of these evaluations occurred within 14 days. In fact, on average, for the remaining patients, it took VHA about 50 days to provide them with their full evaluations. Further, we reported approximately 1.2 million or 12 percent of patient follow-up appointments exceeded 14 days. We concluded that a series of timeliness and treatment engagement measures could provide decision-makers with a more comprehensive view of the ability with which new patients can access mental health treatment. We offered recommendations to the Under Secretary for Health to revise the full mental health evaluation measure to ensure the measurement is calculated to reflect a veterans' actual wait time experience.

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<sup>6</sup> *Review of Veterans' Access to Mental Health Care* (April 23, 2012)

This week we released two reports on the mental health care program at the Atlanta VA Medical Center in Decatur, Georgia. The first <sup>7</sup> was focused on allegations of an inpatient's death due to mental health service leadership's negligence and mismanagement of unit policies, patient monitoring, staffing, and lack of caring about patients. We did not substantiate the allegations of inadequate staffing, inappropriate staff assignments, or that leadership did not care about patients. However, we substantiated that the facility did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. We found inadequate program oversight including a lack of timely follow-up actions by leadership in response to patient incidents.

We recommended that the Under Secretary for Health ensure that VHA develops national policies to address contraband, visitation, urine drug screening, and escort services for inpatient mental health units. We also recommended that the Veterans Integrated Service Network (VISN) and Facility Directors ensure that the inpatient mental health unit develops these policies; strengthen program oversight and follow-up; improve communication with staff; and ensure functional and well-maintained life support equipment.

The second report<sup>8</sup> assessed the allegations of mismanagement and lack of oversight of a mental health contract. We substantiated mismanagement in the administration of the contract, and also substantiated additional allegations that there was inadequate coordination, monitoring, and staffing for oversight of contracted mental health patient care. Facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the contracted mental health program. Mental Health Service Line managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety.

The facility referred patients to the Community Service Boards (CSBs) for several years before they started to track the patients referred. The facility estimated that they referred between 4,000 and 5,000 patients since 2010, but did not know the status of those patients. The facility managers were aware that a large number of patients were, in the words of employees, "falling through the cracks" and estimated that the Mental Health Assessment Team continued to refer up to 60 new patients each week to the CSBs.

We reviewed 85 electronic health records from a list received from the facility of CSB-referred patients. We found that 21 percent of our random sample of CSB-referred patients were never provided care by the CSBs, with no follow up provided by the facility. VHA requires that an initial mental health appointment be scheduled within 14 days of referral. The contract did not have a time requirement, but only stated that the

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<sup>7</sup> *Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia* (April 17, 2013)

<sup>8</sup> *Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia* (April 17, 2013)

expectation was patients would be seen as soon as possible. We found that patients waited an average of 19 days for their initial assessment (range from 1 to 80 days). Seventy-four percent of CSB-referred patients had wait times greater than 14 days, with a wait time average of 92 days and a median range of 56 days (range from 5 to 432 days).

We recommended that the Under Secretary for Health rectify the deficiencies described in this report with respect to the provision of quality mental health care and contract management, with the goal that veterans receive the highest quality medical care from either the VA or its partners. The Under Secretary for Health and the VISN and Facility Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

These reports are particularly troublesome because in July 2011, we reported<sup>9</sup> on problems with the management of the electronic wait list for several mental health clinics at the same facility. Among the findings of that report, we substantiated that several mental health clinics had significantly high numbers of patients on their electronic wait lists over a period of months in FY 2010, and we substantiated that facility managers were aware of the wait lists but were slow in taking actions to address the condition. Large mental health electronic wait lists are inherently problematic as they represent impaired access to critically needed care.

These new findings stand in contrast to our findings<sup>10</sup> in March 2009 regarding mental health care for veterans in Montana. In that report, we found that VA leverages community resources, VA resources, and fee care to provide mental health care for rural veterans.

### **Non-VA Fee Care Programs**

The OIG has reported that VHA faced significant challenges to address serious nationwide weaknesses in its Non-VA Inpatient and Outpatient Fee Care Programs.<sup>11</sup> Specifically, our audits disclosed serious weaknesses in the pre-authorization of fee service. The cost of fee care rose from \$1.6 billion in FY 2005 to almost \$4.3 billion in 2013. As early as 2009, we reported that VHA improperly paid 37 percent of outpatient fee claims resulting in \$225 million in overpayments and \$52 million in underpayments. We estimated \$1.1 billion in overpayments and \$260 million in underpayments over the next 5-year period if VHA did not strengthen its processes for authorizing fee care

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<sup>9</sup> *Healthcare Inspection - Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia* (July 12, 2011)

<sup>10</sup> *Healthcare Inspection - Access to VA Mental Health Care for Montana Veterans* (March 31, 2009)

<sup>11</sup> *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program* (August 3, 2009); *Audit of Non-VA Inpatient Fee Care Program* (August 18, 2010); *Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program* (June 8, 2010); *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* (November 8, 2011); *Administrative Investigation - Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado* (April 12, 2012); and *Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations* (August 20, 2012)

services. In FY 2010, we reported that VHA improperly paid 28 percent of inpatient fee claims resulting in net overpayments of \$120 million and estimated \$600 million in improper payments could be processed over the next 5-year period. Weak authorization procedures resulted in VA health care facilities not having reasonable assurance that requests for services are medically necessary.

Approximately 5 years have passed since we issued our first report on the fee care program, yet we continue to have concerns that the authorization of fee care services is still too weak to ensure sufficient funds for these services are available to pay for the services veterans receive. In January 2013, our review<sup>12</sup> of the South Texas Veterans Healthcare Systems' management of fee care funds substantiated an allegation that the healthcare system authorized \$29 million in fee care without sufficient funds to pay for the services received by veterans. We found management at the South Texas Healthcare System and the VISN lacked effective oversight mechanisms to ensure the financial management and stewardship of these funds.

In response to our August 2010 audit of Non-VA Inpatient Fee Care Program, VHA and OIG agreed there will be general cost savings and efficiencies realized with consolidating the fee program's claims processing system to achieve better economies of scale. Although specific cost savings depend on the actual consolidated strategy VA selects and on how well VA implements the chosen strategy, we conservatively estimated that current program inefficiencies cost VHA about \$26.8 million in FY 2009, and could cost about \$134 million over the next 5 years. We recommended the Under Secretary for Health evaluate alternative payment processing options to identify mechanisms to improve payment processing costs and timeliness. Today, we do not see VHA moving forward with an actual consolidation strategy for payment processing in the fee care program.

### **Physician Staffing Standards for Specialty Care Services**

In December 2012, we issued a report on *VHA's Physician Staffing Levels for Specialty Care Services*. We found VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. The need for VHA to develop a staffing methodology is not a recent issue. As early as 1981, we recommended that VHA develop a methodology to measure physician productivity. VHA has not established productivity standards for 31 of 33 specialty care services we reviewed, and VA medical facility management did not develop adequate staffing plans. VHA's lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs.

To determine an approximate measure of current physician specialty productivity, we established a rudimentary standard by identifying VHA's relative value unit median for each specialty care service. The national median is the middle value among each specialty care service. Using that median, we analyzed the collective group of specialty

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<sup>12</sup> *Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds* (January 10, 2013)

physicians at all medical facilities and determined that 12 percent of physician full-time equivalents did not perform to the standard, and represented \$221 million in physician salaries during FY year 2011. Although we did not analyze the productivity of individual physicians, our results support the need for an in-depth evaluation of staffing. The primary message of this report is that VHA needs to implement productivity standards to measure and compare the collective productivity of physicians within a specialty care service at VA medical facilities. This information is necessary and fundamental to planning and building appropriate budgets to meet veteran's needs and ensuring timely access to care.

### **Women's Health Issues**

VA must provide care to a growing number of women veterans, currently 10 percent of the veteran population. In FY 2009, VA spent \$180 million on gender-specific medical care. In FY 2014, the President's budget plans on spending \$422 million, a change of approximately 134 percent from FY 2009.

In December 2012,<sup>13</sup> we issued a report on VHA services available to women veterans who have experienced military sexual trauma (MST). We conducted the review at the request of the Senate Committee on Veterans' Affairs. VHA policy states that veterans and eligible individuals who report experiences of MST, but who are deemed ineligible for other VA health care benefits or enrollment, may be provided MST-related care only. VHA also requires that veterans and eligible individuals must have access to residential or inpatient programs able to provide specialized MST-related mental health care, when clinically needed, for conditions resulting from MST. VHA requires that all facilities screen veterans for MST.

We reviewed inpatient and residential programs identified by VHA as resources for female veterans who have experienced military sexual trauma. We conducted site visits and reviewed the electronic health records of female veterans with MST discharged from these programs between October 1, 2011, and March 31, 2012. We found:

- Nearly all the women in our review had more than one mental health diagnosis. Ninety-six percent were diagnosed with PTSD. Major depression and substance use disorders were also common. Almost 90 percent of the women in the review were receiving outpatient mental health services in the 3 months prior to admission to the inpatient or residential program.
- Gender-specific care and same gender therapists were available. Treatments utilized varied by site, but all programs employed one or more evidence-based psychotherapies.
- Women were often admitted to programs outside their VISN. Some of these veterans travel across the country to VA residential programs that consider themselves national resources. Obtaining authorization for travel funding was frequently cited as a problem for patients and staff. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits

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<sup>13</sup> *Healthcare Inspection - Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma* (December 5, 2012)



and payment is only authorized to the closest facility providing a comparable service. This is not aligned with the MST policy, which states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location.

- We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

In a report<sup>14</sup> from December 2010 on VA health care and compensation benefits for combat stress in women veterans, we found:

- 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 post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI).
- Higher proportions of female veterans generally were receiving disability benefits for mental health conditions, but 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 affect a full assessment of some outcomes.
- VBA has guidance and training for evaluating MST claims, but sensitivity training is needed for claims processors and women veterans coordinators.
- VBA has not assessed the feasibility of requiring MST-specific training and testing.

### **Prosthetics Management**

As a result of our oversight reports,<sup>15</sup> VHA acknowledged that improvements in prosthetics inventory management are necessary. In March 2012, we reported VHA needs to strengthen VA Medical Center (VAMC) management of prosthetic supply inventories to avoid spending funds on excess supplies and to minimize risks related to supply shortages. We estimated during April through October 2011 that VAMCs maintained inventories of approximately 93,000 specific prosthetic items worth about \$70 million. Further, we estimated that VAMC inventories exceeded current needs for almost 43,500 items (47 percent) and were too low for nearly 10,000 items (11 percent).

VHA cannot accurately account for these inventories and because inventory management practices are weak, inventory losses associated with diversion can go undetected at VAMCs. To avoid spending taxpayer dollars on excess prosthetic supply inventories and risking the disruption of patient care by experiencing supply shortages, VHA must ensure VAMCs properly manage prosthetic inventories. By strengthening

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<sup>14</sup> *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits* (December 16, 2010)

<sup>15</sup> *Audit of VHA Acquisition and Management of Prosthetic Limbs* (March 8, 2012); *Audit of VHA's Prosthetics Supply Inventory Management* (March 30, 2012)

VAMC management of prosthetic supply inventories and using supplies stocked in excess inventories instead of purchasing additional supplies, VHA can reduce prosthetic supply costs by approximately \$35.5 million. VA cannot afford to use valuable financial resources to purchase, maintain, and store more prosthetic supplies than necessary. In response to our work, VHA now has a plan to replace its inventory systems with a comprehensive inventory management system. Completion of the new system is projected for FY 2015, pending the availability of funds.

In addition to the management of prosthetics, we conducted a review<sup>16</sup> to evaluate VA's capacity to deliver prosthetic care. We assessed VA credentialing requirements for prosthetists and orthotists; the demand for health care services; and psychosocial adjustments and activity limitations of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans with amputations and their satisfaction with VA prosthetic services. We found:

- All required prosthetist and orthotist staff in VA Regional Amputation Centers and Polytrauma Amputation Network Sites and all their prosthetic laboratories were certified.
- Veterans with amputations are a complex population with a variety of medical conditions and are significant users of VA health care services and not just prosthetic services.
- OEF/OIF/OND veterans with amputations were generally adapting to living with their amputations. While some veterans reported receiving excellent care at VA facilities, many veterans indicated that VA needed to improve care. Concerns with VA prosthetic services were centered on the VA approval process for fee basis or VA contract care, prosthetic expertise, and difficulty with accessing VA services.

### **VISN Management**

In March 2012,<sup>17</sup> OIG assessed Veterans Integrated Service Network (VISN) office management controls and fiscal operations to determine if funds and resources, accountability and transparency, effective oversight of VHA health care facilities, were in compliance with VA policies. Since their establishment 16 years ago, the VISN organizational office expenses had increased over 500 percent above the original estimates. OIG reported VISN offices lacked adequate financial controls and accurate information for areas such as travel, leased office space, and performance awards. The growth in operational costs and the fiscal issues identified supported that VHA needed to strengthen VISN office financial management and fiscal controls. VHA lacked fundamental management controls and quality data needed to ensure that VISN offices effectively and efficiently use staffing resources that might otherwise be used for direct patient care.

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<sup>16</sup> *Healthcare Inspection - Prosthetic Limb Care in VA Facilities* (March 8, 2012)

<sup>17</sup> *Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices* (March 27, 2012); *Audit of VHA's Financial Management and Fiscal Controls for Veterans Integrated Service Network Offices* (March 27, 2012)

The Under Secretary for Health agreed with the findings and recommendations and put plans in place to establish a more uniform organizational structure. VHA established work teams to analyze the VISN office operations and to address the VISN offices' lack of a clear consistent definition of purpose that links to a standard structure and function capability. VHA now has agreement on a clear plan to streamline and standardize VISN organizational structure and staffing and is in the process of implementing this plan for more effective oversight of its health care facilities and related community-based outpatient clinics, nursing homes, and veterans' centers.

### **VISN Procurement Practices**

Since FY 2000, the OIG has identified procurement practices as a major management challenge. VA made major changes intended to strengthen its procurement process including establishing an integrated oversight process that replaced traditional, technical, and legal reviews. In a review of VISN contracts,<sup>18</sup> the OIG assessed whether VHA implemented the new controls effectively and provided the oversight and resources needed to ensure VISN contracting officers award and manage contracts in accordance with acquisition laws, regulations, and VA policy. We reported that required integrated oversight reviews were not conducted on about 68 percent of contracts, when required. In fact, we estimated almost 3,000 contracts valued at just under \$1.6 billion were at risk because systemic contracting deficiencies associated with acquisition planning, contract award, and administration were not effectively addressed.

### **Veteran Homelessness**

In November 2009, the VA Secretary announced a goal to end homelessness among veterans by 2015. OIG performed an audit<sup>19</sup> to determine whether community agencies receiving funds from the Grant and Per Diem Program are providing services to homeless veterans as agreed upon in their grant agreements in FY 2012. Further, we examined whether program funding was effectively aligned with program priorities. This program provides transitional housing for homeless veterans through partnerships with non-profit and local government agencies. Serious female veterans' housing, safety, security and privacy issues were discovered during the course of our audit that required immediate management attention by VHA.

We reported the placement of homeless females in a male-only approved provider facility. The seriousness of the issues supported a need for VHA to perform a nationwide assessment to identify other inappropriate housing situations placing veterans at risk under the grant program. VHA officials took immediate action to conduct an inventory to ascertain the gender-mix identified in each funded grant proposal and the appropriateness of the services available relative to the veterans currently served. Housing situations were assessed to better ensure the privacy, safety and security of homeless veterans. We also reported VHA lacked an effective mechanism to assess and measure bed capacity, procedures to monitor the liability of

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<sup>18</sup> *Audit of VHA's Veterans Integrated System Network Contracts* (December 1, 2011)

<sup>19</sup> *Audit of VHA's Homeless Providers Grant and Per Diem Program* (March 12, 2012); *VHA's Safety, Security, and Privacy for Female Veterans at a Chicago, IL Homeless Grant Provider Facility* (September 6, 2011)

reported information, and sufficient training on program eligibility. A weak grant application process created uncertainties on the abilities of some providers to deliver the supportive services described in their grant proposals. To minimize the risks to homeless veterans in this program, VHA agreed to implement standards to ensure providers have the capability and mechanisms to deliver proposed services to homeless veterans prior to awarding grant funds.

### **VA CONFERENCES**

In September 2012,<sup>20</sup> OIG reported that VA processes and oversight were too weak, ineffective, and in some instances non-existent, to ensure conference costs were accurate, appropriate, necessary, and reasonably priced. Simply put, accountability and controls were inadequate to ensure effective management and reporting of dollars spent for two human resources conferences. We questioned about \$762,000 as unauthorized, unnecessary, and/or wasteful expenses. More than a year after the conferences, VA was unable to provide an accurate and complete accounting of costs associated with two of its conferences. Further, significant expenditures were authorized by VA staff lacking authority to make the purchases, resulting in unauthorized commitments. Transparency was lacking for what services VA purchased and paid for. Sound conference management processes and practices were needed to gain assurance that future business could be conducted in an economical manner in order to ensure proper fiscal stewardship of taxpayer funds. This work is important since VA conference management spending had reached almost \$100 million annually.

### **OIG INVESTIGATIVE WORK**

From April 1, 2012, through March 31, 2013, the Office of Investigations opened 1,028 and closed 1,046 investigations, arrested 493 individuals for a wide variety of criminal offenses, and completed judicial actions resulting in more than \$1.8 billion in fines, penalties, restitutions, and civil judgments.

### **Service-Disabled Veteran-Owned Small Business Program**

We arrested 13 individuals who defrauded VA's Service-Disabled Veteran-Owned Small Business Program. Those sentenced during this time frame received 142 months' imprisonment and were ordered to pay \$8.7 million in fines, restitution, and forfeiture. Additionally, the 13 individuals and companies involved have been referred to the VA committee for suspension and debarment. During this time frame, seven individuals and four companies were suspended, and four individuals and one company were debarred from contracting with other Federal agencies.

### **Fiduciary Fraud**

We arrested 19 individuals who stole money from VA beneficiaries who were not competent to handle their financial affairs. In addition to the 266 months' imprisonment imposed this past year, restitution ordered exceeded \$3.5 million.

### **Threats and Assaults**

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<sup>20</sup> *Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida* (September 30, 2012)

The OIG received 561 threat referrals, resulting in 57 full investigations. We open a referral on every threat allegation that is reported by VA, VA Police Service, or others. The vast majority involve preliminary investigations that normally include an interview of the subject and results in the subject admitting that they were not serious about the threat and were only trying to get VA to act on their particular issue. Full investigative cases are opened for cases that involve the arrest, involuntary committal, or result in a substantial amount of investigative work. These full investigations resulted in 36 arrests. Although many threat referrals do not result in judicial action, we take all threats against VA employees and VA property seriously.

We also conducted 35 non-sexual assault investigations resulting in 27 arrests, and 25 sexual assault investigations resulting in 11 arrests. These involved veteran assaults on VA employees, VA employee assaults on veterans, employee on employee assaults, and veteran on veteran assaults.

### **Beneficiary Travel Fraud**

We recently prioritized the deterrence of fraud associated with VA's beneficiary travel reimbursement program, which was funded at approximately \$861 million in FY 2012. Typically, this type of fraud involves veterans grossly inflating the number of miles driven to and from VA facilities by providing a false home address on the claim form. During the last 12 months, we conducted 201 of these investigations, resulting in the arrest of 63 individuals. In each of these prosecutions, we encouraged prosecutors to issue press releases to deter this type of fraud. In addition to developing our own data analytic tool to proactively identify potential fraud, we have worked closely with VHA program officials to significantly enhance their data mining efforts and design new warning posters to be placed where veterans file claims.

### **NEW OIG INITIATIVES**

We are currently performing an audit to assess whether VHA is effectively managing purchased home care services to ensure veterans receive appropriate services. OIG's current work in VHA includes examining the management of hearing aids, as hearing loss is the most common service-connected disability. We are also assessing whether VHA is effectively managing the allocation of Home Telehealth Program funds to improve access to care and to reduce patient treatment. Work in VBA includes projects that are examining the accuracy and timeliness of GI Bill payments and assessing the effectiveness of VBA's processing of Quick Start Claims. While it is too early to report results on the GI Bill project, our preliminary results support that the processing of Quick Start Program claims is taking longer to process than the average time for all disability claims. In addition, our preliminary results are that VBA needs to improve the Quick Start claims-processing accuracy rate.

As President Obama's administration has placed emphasis on reducing spending on management support service contracts, we are examining if VHA ensured support service contract requirements were justified, and assessing how well contract performance is monitored. As we continue to focus our efforts to help VA improve the weaknesses in contract awards and administration, we have teams examining whether

the Technology Acquisition Center (TAC) is effectively awarding and administering information technology service contracts. From October 2010 to June 2012, the TAC awarded almost 4,475 contracts valued at \$8.8 billion. We also have two active projects reviewing purchase card activity. One project is identifying opportunities for VHA to realize savings annually by leveraging purchase card use while the other project is examining the extent that VA personnel are making unauthorized commitments using purchase cards. Lastly, we plan follow-up work to assess the effectiveness of VA's controls over conference management expenditures, to determine whether VA is demonstrating effective controls in spending.

## **CONCLUSION**

At a time of unprecedented demand for VA benefits and service, the OIG has directed its oversight efforts on VA's most formidable challenges, including disability claims processing and mental health care. We will continue to provide VA with recommendations on how to improve benefits and services to veterans, and the information technology, financial, and acquisition systems that support VBA and VHA's delivery of these services. We are committed to these efforts both because it is good government and because it honors our Nation's commitment to those who served. With increased attention to the areas outlined in this statement, we believe that VA can improve performance, achieve savings, and reduce risks.

Mr. Chairman, thank you for the opportunity to discuss the results of the work of the OIG. We appreciate the continued steadfast support and interest you and the Subcommittee have demonstrated for our mission. We welcome any questions that you or other members of the Subcommittee may have.