



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
IMPROVING THE DEPARTMENT OF VETERANS AFFAIRS EFFECTIVENESS:
RESPONDING TO RECOMMENDATIONS FROM OVERSIGHT AGENCIES
MAY 22, 2019

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the operations of the Department of Veterans Affairs (VA). The mission of the OIG is to conduct effective oversight of VA's programs and operations through independent audits, inspections, reviews, and investigations.

This statement focuses on the processes the OIG uses to develop recommendations that will assist VA in improving services and benefits to veterans and their caregivers and families. Examples of critical recommendations are highlighted, as well as OIG-identified *Major Management Challenges* facing VA. OIG recommendations generally address specific allegations or concerns in particular VA facilities, offices, or programs. OIG reports focus not only on solutions to a defined problem, but also identify the underlying root causes of issues that negatively impact current programs and future initiatives whenever possible. As a result, these recommendations may also be a road map that other facilities, offices, or programs can follow to apply any lessons learned across VA and to take corrective actions applicable to other relevant VA operations.

In addition to using data to drive OIG oversight work, stakeholders within VA and the larger veteran community—as well as Congress and other oversight bodies—play an invaluable role in identifying problems and pushing for implementation of recommendations for positive change. This critical work would not be accomplished without congressional support of OIG efforts through its appropriations and the attention given to OIG reports and recommendations. The OIG looks forward to working with its many stakeholders to advance recommendations for improvement in all VA programs, services, and systems, including those proposed in the 100 reports issued during the first half of fiscal year (FY) 2019.

AUTHORITY AND PRINCIPLES GUIDING OIG RECOMMENDATIONS

The OIG was created by the Inspector General (IG) Act of 1978 and strengthened through amendments to the IG Act in 1988, the IG Reform Act of 2008, and the IG Empowerment Act of 2016. Pursuant to Section 4 of the United States Code Title 5 Appendix, the Inspector General is responsible for

- (1) conducting and supervising audits and investigations;
- (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and
- (3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action.

When developing recommendations, OIG staff focus on several key principles, including the following:

First, carefully articulated recommendations are directed to the specific VA office or program official that has the responsibility and authority required to satisfactorily implement them. Recommendations could be directed to anyone from the Secretary to a service line chief at a medical facility. Recommendations must be clear, be capable of execution, and specify who is accountable within VA for implementation. While the OIG's recommendations may be narrowly addressed to a particular VA facility or operation, VA should be disseminating information about identified problems and remediation plans to officials in all VA offices that could potentially have the same issues and are positioned to take positive action.

Second, recommendations are contemporaneous with ongoing issues and, except in rare circumstances, should not require more than one year to implement from the report's publication. As explained later, this helps align implementation with reporting requirements to Congress, while also minimizing the risk that OIG recommendations languish, become outdated, or lag behind VA policy and program changes. In the instance that a recommendation would require implementation over a longer period, VA and OIG staff work to develop implementation plans that have quarterly milestones to support tracking progress towards implementation.

Third, OIG recommendations are objective and nonpartisan—driven by data, evidence, and all documentation that are collected and analyzed in accordance with audit, inspection, and investigative standards. The OIG's statutory independence allows it to determine which VA programs, services, operations, and systems to examine that will have the greatest impact on veterans' lives and taxpayers' investments, and to then communicate those findings with Congress, VA's stakeholders, and the public.

Finally, the OIG makes recommendations, but does not direct how they are executed. It is important to note that OIG staff cannot mandate that VA accept OIG recommendations or direct specific action to carry them out. Consistent with this limitation, OIG reports may contain

recommendations for VA to “take appropriate administrative action” against a specific VA employee for misconduct, but under federal law, VA leaders and managers are then responsible for determining any appropriate administrative action. VA determines the level of disciplinary or adverse actions to be taken, if any. The OIG closes out these recommendations upon VA providing acceptable documentation that no action was deemed necessary, that specific administrative action was taken, or the individual left federal employment. VA leaders are solely responsible for managing VA and setting its policy, including determining how best to implement OIG recommendations. VA and the OIG may disagree about a specific recommendation, but those situations are rare and are noted in the published report.

OIG RECOMMENDATIONS DEVELOPMENT

When OIG staff perform an audit, review, inspection, or administrative investigation, they conduct months of work that can involve on-site inspections, interviews, document and record reviews, data collection, and more. Using all information collected, staff prepare a draft report with findings that are based on thorough, objective, and balanced analyses. These reports usually include recommendations for VA corrective action or improvement. The draft report is typically sent to appropriate VA managers for review prior to publication to ensure accuracy. This process provides VA an opportunity to comment on the report’s factual content and findings. The comments also outline VA management’s position on implementing OIG recommendations and are included in the final OIG report. If management concurs with the recommendation, their response must include an implementation plan and a self-determined estimated date of completion. OIG staff will then review the implementation plan to determine if it satisfies the intent of the recommendation. In the event VA concurs with an OIG finding but not the recommendation, VA will need to provide an alternative action they believe will satisfy the intent of the recommendation. The VA workplan to carry out the recommendation and address the underlying finding is key to OIG staff’s follow-up process, as detailed later in this statement.

In some occasions, consistent with the OIG’s statutory independence from VA, a final report may be issued without VA’s response or concurrence of the findings and recommendations, or an acceptable implementation plan. However, it is rare for VA to not concur with OIG findings or recommendations, averaging just one percent of all responses over FYs 2017, 2018, and 2019 to date. OIG staff and leaders have open lines of communication with VA counterparts to resolve these situations. If VA does not concur with a finding or recommendation, and OIG staff cannot reach agreement with the VA office, OIG leaders will escalate the matter with VA managers up to the Deputy Secretary, who is the final VA deciding official, prior to publishing a report with nonconcurrence on recommendations.

In addition, VA may “concur in principle” or “partially concur” with a recommendation, but OIG requires VA to clearly explain the concern with the finding or recommendation (including a perceived inability to implement) that is cause for the qualified response. Overall, it is important for comments to make clear whether VA concurs or nonconcur with each finding, as well as with specific recommendations.

TRACKING OIG RECOMMENDATIONS

OIG recommendations can be accessed in several ways. The most up-to-date information can be found on the OIG website, www.va.gov/oig. The recommendations webpage provides live tracking on the status of OIG published reports and recommendations open for less than a year, open for more than a year, and closed as implemented.¹ This online dashboard also provides the realized and potential monetary impact of VA's implementation of OIG recommendations. The webpage search functionality allows users to isolate reports with open recommendations.

Pursuant to the IG Act of 1978, the Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the prior six-month reporting period.² Within the SAR, the OIG lists all open recommendations, including recommendations that have been open more than one year.

On January 3, 2019, the Good Accounting Obligation in Government Act (P. L. 115-414) was enacted, mandating each agency include in its annual budget justification submitted to Congress an explanation for the reasons why no final action has been taken regarding a Government Accountability Office or OIG recommendation open more than 12 months, as well as a timeline to implement the recommendation if the agency concurred. It is expected that the agency budget justification will include this information in the FY 2021 budget submission.

Current State of OIG Recommendations

As of March 31, 2019, there were 84 OIG reports and 403 recommendations that had been open less than one year. The total monetary benefit associated with these recommendations is more than \$2.7 billion. Also, as of March 31, 2019, there were 40 reports and 133 recommendations that remained open for more than one year. The total monetary benefit related to these reports is more than \$329 million.

FOLLOW-UP PROCESSES

While there have been instances in which VA has resolved an issue at the time of a report's publication, the vast majority of recommendations take time to implement fully. To ensure completion, the OIG engages its centralized follow-up staff to track the implementation of all report recommendations with the responsible VA office. This consolidated function helps ensure specially trained staff provide consistent management of OIG follow-up activities, frees report authors to work on other projects, and helps the OIG prepare timely and accurate status reporting for the website, SAR, and other products.

Timelines

In addition to VA's comments on a draft report, the responsible VA office provides a workplan describing the process and timeline for each recommendation to be implemented. After the report is issued, the OIG follow-up group is responsible for entering all this information into a tracking

¹ <https://www.va.gov/oig/recommendation-dashboard.asp>.

² An archive of SARs is available at <https://www.va.gov/oig/publications/semiannual-reports.asp>.

system, analyzing the report's recommendations and VA comments, and then preparing the appropriate documentation request to the responsible VA office.

At quarterly intervals starting 90 days after report issuance, the follow-up group requests the VA office provide an accounting of actions taken to implement open recommendations, as well as whether the VA office believes a recommendation may be closed. Each VA administration and staff office maintains a point of contact for this process, which helps with consistency in addressing implementation issues, tracking progress, and coordinating the response of the VA office assigned the recommendation. After receiving the VA office's report, the follow-up staff draft a preliminary assessment to the responsible OIG office, which wrote the report, as to whether any recommendations appear ready to close. The responsible OIG office then reviews the materials and provides a final determination whether any recommendations have been satisfactorily implemented and can be closed. If the VA office does not provide any response, follow-up staff can escalate the issue for resolution by connecting OIG leaders to the appropriate VA leaders.

Recommendation Closure or Suspension

The responsible OIG office has the subject-matter expertise related to the recommendation at issue, and no recommendation may be closed without that office's approval. The decision to close a recommendation is based on a review of VA's supporting documentation or independent information obtained by OIG that indicates the corrective action has occurred or progressed enough to show recommendation implementation. For example, a recommendation to train employees on a particular issue is not closed if the VA office says it will conduct the training, but rather if the VA provides syllabus and scheduling documentation showing adequately developed training is underway and will continue in a systematic fashion.

In a very few cases, there may be a need for OIG leadership to temporarily suspend follow-up activities or close recommendations as "not able to be implemented." For example, suspension may be warranted when a planned corrective action has gone stagnant due to circumstances beyond the control of the VA office (such as the need for a technology solution) and no viable alternatives exist, or if the program materially changes or is terminated and so the recommendation no longer applies. As mentioned earlier, if VA does not concur with a recommendation following OIG outreach at report publication or during follow-up, that nonconcurrency is noted and reported publicly and to Congress. If a new report is issued that repeats not-yet-implemented recommendations from a prior report, follow-up staff would close out the initial recommendations and consolidate all recommendations related to unresolved concerns into the new report.

Aligned with the schedule for preparing the SAR, follow-up staff work with responsible OIG staff every six months to review open recommendations to determine whether any problems exist in implementation or whether circumstances would allow closure of any recommendations. As needed, OIG staff can confer with VA offices to examine the issues preventing implementation and work to revise related implementation plans.

IMPACTFUL RECOMMENDATIONS AFFECT A RANGE OF VA PROGRAMS

OIG recommendations are directed at every level of VA operations, affecting the quality and access to health care for more than 7 million veterans; benefits for veterans with disabilities, their caregivers, and family members; and the effective stewardship of appropriated funds. They can be directed at individual facilities, regional networks, or national program or administrative offices. The following reports are highlighted to demonstrate how OIG staff perform sustained follow-up on identified areas of weakness to ensure meaningful improvement within VA.

Veterans Health Administration Examples

Critical Deficiencies at the Washington DC VA Medical Center. In March 2017, the OIG received a confidential complaint and additional subsequent allegations that the Washington DC VA Medical Center had equipment and supply issues that could be putting patients at risk for harm. The OIG conducted an inspection, issuing an interim report in April 2017, and a final report in March 2018.³ The final report provided findings in four areas: (1) risk of harm to patients, (2) hospital service deficiencies affecting patient care, (3) lack of financial controls, and (4) failures in leadership. These deficiencies spanned many years, impacting the core medical center functions that healthcare providers need to effectively provide quality care. In particular, the report detailed the failure to ensure supplies and equipment reached patient care areas when needed, in part due to the facility's failure to use its inventory management IT system. The OIG made 40 recommendations, and VA concurred with each one. While VA provided detailed action plans on how the recommendations would be implemented and identified progress made, of the 40 recommendations, 13 are still open as of May 14, 2019.

This report was meant to not only improve conditions at the DC VA Medical Center, but also to serve as a guide for other VA medical facilities' logistical services and to improve integrated reviews and oversight by Veterans Integrated Service Networks (VISNs) and VA central offices.

Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package. As a result of the inventory management issues identified at the DC VA Medical Center, the OIG conducted a national audit in which the audit team surveyed 21 medical centers and conducted unannounced on-site visits to 11 of those 21. They found other medical centers also encountered challenges as part of the migration to a new inventory management system and that significant discrepancies existed between actual inventory and the data for tracking expendable medical supplies.⁴ Also, they found proper inventory monitoring and management practices were lacking. Some of the issues stemmed from the failure to provide adequate oversight of the migration at the Veterans Health Administration (VHA) level, while others stemmed from a lack of oversight from the VISN. The OIG's May 1, 2019, report

³ [Interim Summary Report](#), April 17, 2017; [Critical Deficiencies at the Washington DC VA Medical Center](#), March 7, 2018.

⁴ [Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package](#), May 1, 2019.

included six recommendations to the Executive in Charge for the Office of the Under Secretary for Health regarding inventory distribution and controls, which VA is now implementing.

Veterans Crisis Line. The OIG is monitoring VA's delivery of mental health care and the operations of its suicide prevention programs. The OIG conducted a review of the Veterans Crisis Line (VCL) in 2016 and again in 2017 because of VHA's inability to implement OIG recommendations for this critical program in a timely manner, as well as the receipt of additional allegations.

On March 20, 2017, the OIG issued *Evaluation of the Veterans Health Administration Veterans Crisis Line*, reporting deficiencies in multiple areas of the VCL's administration.⁵ Although the OIG was impressed with the dedication of VCL staff assisting veterans and loved ones, the OIG staff found VCL's management team faced significant obstacles providing suicide prevention and crisis intervention services to veterans, service members, and their families. The VCL's biggest challenges included meeting the operational and business demands of responding to over 500,000 calls per year, and training staff to assess and respond to the needs of individual contacts with veterans and family members under stressful, time-sensitive conditions.

The OIG staff found deficiencies in the governance and oversight of VCL operations following its realignment under VHA's Office of Member Services, a business operations group with expertise in call center operations. While VA leaders stated that Member Services and the Office of Mental Health Operations would work closely together to manage VCL services, the review found decisions were made with insufficient clinical input. The OIG also identified internal quality assurance deficiencies, including that there was an inadequate process to collect, analyze, and effectively review relevant quality management data to improve outcomes for callers. OIG staff made 16 recommendations to VA to improve crisis intervention services for veterans in distress. Among other weaknesses, the OIG identified in response to a complaint that there was a failure to properly respond to a veteran during multiple calls, resulting in missed opportunities to provide crisis intervention services. The OIG closed out the report recommendations on March 28, 2018, after accepting VA's implementation plan for the final open recommendation.

It is important to note that the March 2017 report resulted, in part, from VA's failure to implement prior OIG recommendations made in a February 2016 report, *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York*.⁶ The OIG's seven recommendations from the 2016 report remained open for more than a year. OIG staff conducted the subsequent review because the failure to implement previous recommendations was impairing the VCL's ability to increase the quality of crisis intervention services to callers. The OIG's February 2016 report recommendations were eventually closed out on July 31, 2017.

⁵ [Evaluation of the Veterans Health Administration Veterans Crisis Line](#), March 20, 2017.

⁶ [Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York](#), February 11, 2016.

Suicide Prevention. Many OIG reports also provide recommendations for facilities after reviewing the care provided to individual patients. The recommendations often can be used as guidance for other facilities within the VA system as well. For example, a September 2018 *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide Minneapolis VA Health Care System, Minnesota* examined the care of a patient who died from a self-inflicted gunshot wound less than 24 hours after being discharged from an inpatient mental health unit.⁷ Even though the action plans had target implementation dates no later than January 31, 2019, six of the seven recommendations remain open. The recommendations for corrective action relate to care provider coordination, accuracy of documentation, inclusion of family members in a veteran's health care and discharge, and completion of analyses after a tragic event.

The OIG previously reported on the performance of multiple VHA facilities by conducting a trends analysis of suicide prevention programs. In an *Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities*, the OIG examined suicide prevention efforts in VHA facilities to assess facility compliance with relevant VHA guidelines.⁸ OIG conducted this review at 28 VHA medical facilities during its comprehensive assessment program reviews from October 1, 2015, through March 31, 2016. The OIG found that most facilities had a process for responding to referrals from the VCL and a process to follow up on high-risk patients who missed appointments. However, the OIG identified system weaknesses in areas such as outreach activities; suicide prevention safety plan completion, content, and distribution; flagging records of high-risk inpatients and notifying the Suicide Coordinator of the admission; and evaluating high-risk inpatients during the 30 days following discharge. The OIG's six recommendations to the then-Acting Under Secretary for Health are now closed.

Routine Inspections. The OIG continues to conduct unannounced cyclical assessments of operations and quality control programs at VHA medical facilities, now known as Comprehensive Healthcare Inspection Program (CHIP) reports. These reports focus on leadership within a facility and key factors that affect patient care, such as quality, safety, and value; the credentialing and privileging process; environment of care; and medication management. Additionally, the OIG annually rotates high-interest topics in these fields, such as posttraumatic stress disorder care, mammography results and follow-up, and controlled substances inspection programs.⁹ OIG staff may also conduct more frequent follow-ups to assess VA's progress in implementing recommendations when a facility appears unable to address OIG findings. These additional inspections help ensure issues do not remain unresolved over long periods of time.

⁷ [Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide Minneapolis VA Health Care System, Minnesota](#), September 25, 2018.

⁸ [Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities](#), May 18, 2017.

⁹ [Semiannual Report to Congress, Issue 80](#).

For example, in May 2015, an OIG assessment of the VA St. Louis Health Care System in Missouri identified 45 recommendations to address concerns across the facility's operations.¹⁰ Due to the wide-ranging issues, in November of the same year, OIG staff conducted another review of the facility to assess progress on the action plans, with a particular focus on quality and environment of care.¹¹ While some progress was noted, OIG staff made additional recommendations in those areas of focus. OIG staff returned to the facility yet again in June 2016. In that report, the OIG made one recommendation related to the environment of care.¹² Finally, OIG staff conducted an inspection of the facility in 2018 that resulted in seven recommendations, which have all been closed.¹³

VISN Reviews. To augment oversight of VHA-related recommendations, the OIG is launching routine reviews of VISNs. There is limited utility to having medical facilities implement recommendations if those corrective actions are not supported by the VISN. This expanded focus on VISNs is meant to address the oversight and services that VISNs provide all medical centers within their network that affect efficient operations and quality patient care. After completing several successful pilot visits, the OIG will be conducting unannounced reviews for four VISNs during the remainder of FY 2019. OIG staff conducting facility- and VISN-level inspections are engaging in coordination efforts to ensure reports regarding medical facilities make relevant connections to their VISN responsible for leadership, support, and oversight. The reports will include recommendations to improve accountability for the provision of high-quality health care.

Veterans Benefits Administration Examples

In October 2017, the OIG implemented a new national inspection model for oversight of the Veterans Benefits Administration (VBA). Previously, the OIG largely conducted oversight through inspections of VBA's 56 regional offices. Under the new model, the OIG conducts nationwide audits and reviews of high-impact programs and operations within VBA to accomplish the following objectives:

- Identify systemic issues that affect veterans' benefits and services
- Determine the root causes of identified problems
- Make useful recommendations to drive positive change across VBA

¹⁰ [*Combined Assessment Program Review of the VA St. Louis Health Care System, St. Louis, Missouri*](#), May 18, 2015.

¹¹ [*Combined Assessment Program Follow-Up Review of the VA St. Louis Health Care System, St. Louis, Missouri*](#), January 20, 2016.

¹² [*Combined Assessment Program Follow-Up Review of Environment of Care at the VA St. Louis Health Care System, St. Louis, Missouri*](#), January 18, 2017.

¹³ [*Comprehensive Healthcare Inspection Program Review of the VA St. Louis Health Care System, Missouri*](#), August 23, 2018.

Since October 1, 2017, the OIG has published 19 VBA-related oversight reports. VBA has generally concurred with the recommendations and provided acceptable action plans, with the closure of most recommendations that have been open for over one year.

Two recent OIG reports regarding VBA claims processing for complex claims related amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and to military sexual trauma (MST) demonstrate the value of OIG recommendations. In 2016, VBA moved to a National Work Queue (NWQ) for the processing of disability compensation claims. Previously, VBA used Segmented Lanes to process claims. Under that approach, specialized claims, like those for MST and ALS, were routed to staff experienced with those claims. Under the NWQ, VBA no longer directed complex claims to specialized teams, but rather distributed daily to each VA regional office (VARO) new claims, which the VARO then assigned to processors by workload. These OIG reports detail how national policy changes have had negative impacts on claims processing. While well-intentioned efforts to expedite overall benefits processes were carried out, there was an unintended impact on VBA's ability to review and process certain claims accurately.

Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis. In November 2018, the OIG examined whether VBA accurately decided veterans' claims involving service-connected ALS.¹⁴ VA describes ALS as a rapidly progressive neurological disease that attacks the nerve cells responsible for directly controlling voluntary muscles. Because a statistical correlation was found between military service activities and the development of ALS, VA established a presumption of service connection for this disease in 2008. Thus, veterans who develop the disease during service, or any time after separation from military service, generally receive benefits if they had active and continuous service of 90 days or more. Although VBA prioritizes these claims, staff must also accurately decide these claims because it is a serious condition that often causes death within three to five years from the onset of symptoms.

OIG staff reviewed a statistical sample of 100 veterans' cases involving service-connected ALS from April through September 2017. The team found that VBA staff made 71 errors involving 45 veterans' ALS claims, projecting that 430 of 960 total ALS veterans' cases had erroneous decisions. For example, rating personnel incorrectly decided ALS claims related to one or more of the following categories:

- Special monthly compensation benefits
- Evaluations of medical complications of ALS
- Effective dates
- Additional benefits related to adapted housing or automobiles
- Inaccurate or conflicting information in decisions
- Proposals to discontinue service connection

¹⁴ [*Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis*](#), November 20, 2018.

These errors resulted in estimated underpayments of about \$750,000 and overpayments of about \$649,000 over a six-month period, for a potential \$7.5 million in underpayments and \$6.5 million in overpayments over a five-year period. Also, VBA staff generally did not tell veterans about available special monthly compensation benefits. Most rating personnel indicated that they do not often receive claims involving ALS or higher levels of special monthly compensation, which makes these claims more difficult to evaluate. The Under Secretary for Benefits concurred with the OIG's two recommendations to implement a plan to improve and monitor decisions involving service-connected ALS and to provide notice regarding additional special monthly compensation benefits that may be available. These recommendations are still open.

Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma. In August 2018, the OIG reviewed VBA's denied PTSD claims related to veterans' MST to determine whether staff correctly processed the claims.¹⁵ Some service members are understandably reluctant to submit a report of MST, particularly when the perpetrator is a superior officer. Service members may also have concerns about the potential for negative performance reports or punishment for collateral misconduct. There is also sometimes the perception of an unresponsive military chain of command. If the MST leads to PTSD, it is often difficult for victims to produce evidence to support the assault's occurrence. VBA policy correctly requires staff to follow additional steps for processing MST-related claims so veterans have further opportunities to provide adequate evidence.

VBA reported that it processed approximately 12,000 claims per year over the last three years for PTSD related to MST. In FY 2017, VBA denied about 5,500 of those claims (46 percent). The OIG review team assessed a sample of 169 MST-related claims that VBA staff denied from April through September 2017. The review team found that VBA staff did not properly process veterans' denied MST-related claims in 82 of 169 cases. As a result, the OIG estimated that VBA staff incorrectly processed approximately 1,300 of the 2,700 MST-related claims denied during that time (49 percent). The OIG found that multiple factors led to the improper processing and denial of MST-related claims. Included among these factors were the lack of reviewer specialization, lack of an additional level of review, discontinued special focused reviews, and inadequate training.

The OIG made six recommendations to the Under Secretary for Benefits including that VBA review all approximately 5,500 MST-related claims denied from October 2016 through September 2017, take corrective action on those claims in which VBA staff did not follow all required steps, assign MST-related claims to a specialized group of claims processors, and improve oversight and training on addressing MST-related claims. The Under Secretary concurred with the recommendations and has already taken steps to address them, particularly in the area of training, with four recommendations currently still open. The Under Secretary also

¹⁵ [*Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*](#), August 21, 2018.

stated that, in FY 2019, VBA will review every denied MST-related claim decided since the beginning of FY 2017.

STEWARDSHIP OF APPROPRIATED FUNDS EXAMPLES

While some OIG recommendations focus primarily on improving quality of care for veterans, or program effectiveness, others emphasize deficiencies in the efficient use of taxpayer dollars or misusing appropriated funds. Several examples follow demonstrating the need for more effective controls, stronger oversight practices, and greater accountability so that VA funding is put to the most efficient and effective use to the benefit of veterans, their caregivers, and families.

VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill

Students. A December 2018 OIG report examined the effectiveness of VA and State Approving Agencies' (SAAs') monitoring of participating educational programs, which identified serious concerns, including gaps in approval practices that led to ineligible and potentially ineligible schools participating in the program.¹⁶ The OIG conducted this audit to determine if VA and SAAs were effectively reviewing and monitoring education and training programs that enrolled Post-9/11 GI Bill students to ensure only eligible programs participated. Prior OIG reports noted financial risks for these programs.¹⁷ Based on its review, the OIG estimated that 86 percent of SAAs did not adequately oversee the education and training programs to make certain only eligible programs participated. In total, the audit team projected that VBA annually issues an estimated \$585 million in related improper Post-9/11 GI Bill tuition and fee payments to ineligible or potentially ineligible schools and that \$473.8 million of this amount will be paid to for-profit schools.¹⁸ Oversight deficiencies occurred, in part, because VBA maintained it has a limited role for oversight of SAAs. The OIG recommended clarifying requirements for approvals, requiring periodic re-approval of programs, reporting schools with misleading advertising, strengthening compliance surveys for program eligibility, revising program assessment standards, and confirming that SAA funding can support the recommended steps. Of those, one recommendation has been closed as implemented, and OIG staff are monitoring VBA's progress on the remaining five.

Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans. On occasion, OIG staff audit programs and monitor recommendation implementation, but continue to receive allegations of specific acts of wrongdoing through the OIG Hotline. In June 2016, the OIG audited whether VBA was adjusting compensation and pension (C&P) benefit payments for veterans incarcerated in federal, state, and local correctional institutions in a timely manner and

¹⁶ [*VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students*](#), December 3, 2018.

¹⁷ *Id.* at 49-50.

¹⁸ "Under OMB Circular A-123, App. C, Pt. I-A, Risk Assessing, Estimating, and Reporting Improper Payments, (October 20, 2014), improper payments are payments that should not have been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements; payments made to ineligible recipients; and payments where an agency's review is unable to discern it is proper due to insufficient documentation." *Id.* at 3.

as required by federal law.¹⁹ The OIG identified program weaknesses and determined that VBA did not consistently take action to adjust C&P benefits for incarcerated veterans as legally required. VBA's ineffective actions in processing incarceration adjustments resulted in significant improper benefit payments totaling more than \$100 million. If conditions remained the same and improvements were not made, VBA could have made additional inaccurate payments (improper payments) of more than \$200 million over a 5-year period from FY 2016 through FY 2020. The report's six recommendations are now closed.

However, this was not the first time OIG reported on problems with C&P benefit payments adjustments. In 1986 and 1999, OIG identified similar issues with C&P benefit payments to incarcerated veterans, and VA provided remediation plans.²⁰ Because problems in this area have tended to reoccur or new problems emerge, the OIG continues to identify and follow up on similar improper payments reported through the OIG Hotline. One recent example involves a veteran improperly receiving \$46,200.²¹

MAJOR MANAGEMENT CHALLENGES

Each year, pursuant to Section 3516 of United States Code Title 31, the OIG provides Congress with an update summarizing the most serious management and performance challenges identified by OIG work as well as an assessment of VA's progress in addressing them.²² These challenges are aligned with the OIG's six areas of focus outlined in its strategic plan:

(1) leadership and workforce investment, (2) healthcare delivery, (3) benefits delivery, (4) financial management, (5) procurement practices, and (6) information management.

The OIG has made VA leadership and governance a top priority in recognition that deficiencies in these areas ultimately affect the care and services provided to veterans and allow significant problems to persist unresolved for years. And, as in prior years, access to health care remains a significant challenge for VA. This is a particular concern as prodigious changes are underway for expanding community care and enhancing access to care in VA facilities and as VA implements changes to its benefit appeals process. The OIG has noted specific progress in quality improvement and patient care processes during CHIP inspections and other work in individual facilities, yet deficiencies remain in other areas affected by inadequate staffing and IT systems.

The OIG has also focused on problems identified VA-wide regarding information management, financial management, and procurement practices that, while critical to VA carrying out its missions, have been at the heart of failures in providing medical care and a range of benefits and services to veterans and their families. OIG audits and reviews, such as the audit of VA's consolidated financial statements, as required under the Chief Financial Officer's Act and the

¹⁹ [Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans](#), June 28, 2016.

²⁰ [Evaluation of Benefit Payments to Incarcerated Veterans](#), February 5, 1999.

²¹ [Semiannual Report to Congress, Issue 80](#).

²² [U.S. Department of Veterans Affairs Office of Inspector General Management and Performance Challenges](#), November 2018.

review of VA's compliance with the Improper Payments Elimination and Recovery Act, establish that eliminating continued shortfalls in VA's financial management systems would improve VA's effectiveness at using appropriated funds to benefit veterans.²³

CONCLUSION

A strength of the OIG's oversight work is the commitment to identifying underlying causes, which is the foundation for developing meaningful and comprehensive recommendations. By addressing these causes, VA can more effectively address not only the symptoms but prevent future occurrences. The OIG has commonly found the following through its oversight work:

- Poor governance structures
- Lack of continuity of leadership
- Failure to communicate effectively
- Failure to ensure accountability
- Poor financial management
- IT failures and not using IT effectively
- Poor planning and forecasting
- Failure to anticipate the consequences of policy changes
- HR and staffing issues
- Poor training
- Poor quality assurance
- Inadequate, outdated, conflicting, or absent policies
- Culture of complacency
- Bureaucracy ahead of veterans

The OIG is committed to serving veterans and the public by conducting effective oversight of VA programs and operations through independent audits, inspections, reviews, and investigations. That commitment can only be realized by making practical, meaningful recommendations that enhance VA's programs and operations as well as prevent and address fraud, waste, and abuse.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.

²³ [Audit of VA's Financial Statements for Fiscal Years 2018 and 2017](#), November 26, 2018; [VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017](#), May 15, 2018.