STATEMENT OF RICHARD J. GRIFFIN
DEPUTY INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 19, 2015

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG). I will focus on the OIG's recent activities related to wait times within the Veterans Health Administration (VHA) as well as other areas where we have identified the need for attention by VA and Congress. I am accompanied by John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections, Office of Healthcare Inspections, Office of Inspector General.

The OIG provides oversight over all VA programs and operations including the delivery of health care services and operations, benefits administration, financial management, and information technology and security. The surfacing of allegations in fiscal year (FY) 2014 related to wait times and poor care at the Phoenix VA Health Care System (PVAHCS) was a watershed event for VA and the OIG. Those allegations increased the scope of an ongoing healthcare inspection of the PVAHCS and generated a comprehensive audit effort to determine how the PVAHCS schedulers were managing appointments. We also launched investigations at 98 VA medical care facilities into allegations that scheduling was manipulated to make wait times for outpatient appointments appear to be shorter then the actual wait times experienced by veterans. The results of our investigative work for 44 of these sites have been referred to the VA Office of Accountability Review for whatever administrative action deemed appropriate by VA management. We have prioritized our investigative efforts to complete this work at the remaining 54 sites.

The national attention sparked by reporting on PVAHCS led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline, in the number of inquiries sent to us by Members of Congress, and by veterans and their families. In FY 2014, the OIG Hotline received almost 40,000 contacts which represents a 45 percent increase from FY 2013. Based on the number of contacts received to date, we project FY 2015 will yield a similar volume of contacts. Similarly, we saw a 38 percent increase in the number of inquiries from Members of Congress, and we expect this upward trend to continue.

Despite the tremendous number of OIG staff devoted to the Phoenix review, and the significant increases in our workload, in FY 2014, we issued 310 reports, closed 880 investigations, made 467 arrests, plus an additional 47 arrests in the Fugitive Felon

Program and information from the OIG led to another 25 arrests by other law enforcement agencies, and identified $2.3 billion in monetary benefits for a return on investment of $22 for every $1 in funding.

For FY 2015, the OIG is funded at $126,411,000. The President's Budget proposed $126,766,000 for FY 2016 which reflects a 0.3 percent increase above the 2015 enacted level. This level of funding will necessitate the equivalent of a 10 FTE reduction to cover a future pay raise and expected inflation in 2016.

VETERANS HEALTH ADMINISTRATION

VA needs to continue to rededicate itself to one of its core missions which is to deliver quality health care. The VA Secretary has taken steps to reorganize VA but much work remains. The greatest challenge facing VHA is the ability to meet the healthcare needs of an increasing and widely distributed veteran population with complex medical conditions. The passage of the *Veterans Access, Choice, and Accountability Act of 2014* to address demand creates a new set of challenges on the VA system, including paying for services, ensuring that veterans who seek care outside VA receive the appropriate care, and that medical records are updated and shared both with VA providers and outside providers.

OIG work routinely reports on clinical outcomes or performance that did not meet expectations. We routinely determine that there were opportunities by people and systems to prevent untoward outcomes. In addition to local issues at the facility, there are several organizational issues that impede the efficient and effective operation of VHA and place patients at risk of unexpected outcomes.

Since 2005, we have reported in 20 oversight reports on VA's wait time and scheduling practices. Many of these reports offered recommendations to improve access to health care services in VA. In addition, we provided testimony at 19 congressional hearing on patient wait times.

Phoenix VA Health Care System Reports

Since May 28, 2014, we have issued four reports on the Phoenix VA Health Care System (PVAHCS).[1] The initial two reports (May 2014 and August 2014) were the result of work by a multidisciplinary staff from the OIG's Office of Audits and Evaluations and Office of Healthcare Inspections. The OIG found patients at the PVAHCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them. Patients frequently encountered obstacles when patients or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while

[1] *Healthcare Inspection — Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona*, February 26, 2015; *Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona*, January 28, 2015; *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System,* August 26, 2014; *Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System*, May 28, 2014.

traveling or temporarily living in Phoenix. The problems in Phoenix were due to a failure by management to recognize the increased demands on the facility and to request and apply the resources to address those demands either through increased staffing or increased use of non-VA fee care.

Also, senior headquarters and facility leadership were not held responsible or accountable for implementing action plans that addressed compliance with scheduling procedures. The use of inappropriate scheduling practices caused reported wait times to be unreliable. The systemic underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA and PVAHCS's senior leadership ranks and mid-level managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible.

In our first two reports, we made 24 recommendations to VA to implement immediate and substantive changes to their policies and procedures. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans. In response to our work, VA reported it took immediate action to ensure 3,400 veterans who we identified needed health care services received medical appointments. Our review identified that use of unofficial wait lists and manipulation of wait time data were pervasive practices in VA. As a result, VA reported it took immediate actions to reach out to over 266,000 veterans to get them off wait lists and into clinics, made nearly 912,000 referrals to private health care providers for needed care, and scheduled approximately 200,000 new VA appointments nationwide for veterans. These reports brought much needed accountability over serious veteran access to care issues, led to changes in the highest level of VA leadership, and enactment of the *Veterans Access, Choice, and Accountability Act of 2014*, which expanded veterans' access to care outside the VA system and included a $16 billion increase in VA's funding. As of March 2, 2015, 18 recommendations from these reports remain open.

The most recent reports issued by the OIG's Office of Heathcare Inspections were the results of information received during the work conducted at the PVAHCS during the spring and summer of 2014. Our interim report on PVAHCS's Urology Services is concerning and requires VA's immediate attention.[2] It is also indicative of the challenges that VA faces in staffing and coordinating non-VA care. After experiencing a staffing shortage within the PVAHCS Urology Department, some patients were referred to a non-VA urologist via voucher or fee basis authorization. In 23 percent of cases reviewed, we found approved authorizations for care, notations that authorizations were sent to contracted providers, and scheduled dates and times of appointment with non-VA urologists but no scanned documents verifying that patients were seen for evaluations and, if seen, what the evaluations might have revealed. This finding suggests that PVAHCS has no accurate data on the clinical status of the patients who were referred for urologic care outside of the facility. Included in this group

[2] *Interim Report – Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona*, January 28, 2015.

are also patients who may have been followed routinely by the Urology Department prior to mid-2013 but, in the midst of the staffing crisis, were lost to follow-up.

The mismanagement of outside consults is not unique to Phoenix. In August 2013, we reported on problems at the Atlanta VA Medical Center (VAMC) regarding consults for mental health care.[3] In August 2014, we reported on the improper closing of non-VA care consults at the Carl Vinson VAMC in Dublin, Georgia.[4]

Opioid Management at VA Facilities

Of increasing concern in VA and in the Nation is the use of opioids to treat chronic pain and other conditions. In May 2014, we issued a national review, *Healthcare Inspections – VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy* (May 14, 2014), that described some of the issues facing patients on high dosages of opioids. In addition to this national review, we have issued nine reports detailing opioid prescription issues within VA since 2011.[5]

Opioid patients frequently have complex co-morbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications. A review of medications by a pharmacist or other health care professional can prevent harmful interactions between these medications. We found that 38.8 percent of the opioid patients received medication management or pharmacy reconciliation during FY 2012.

Increasing use of opioids has been associated with increasing rates of opioid-related serious adverse effects. We determined percentages of opioid patients with evidence of a serious adverse effect that may be reasonably expected to be related to opioid therapy for the following six serious adverse effects: (1) opioid overdose, (2) sedative overdose, (3) drug delirium, (4) drug detoxification, (5) acetaminophen overdose, and

---

[3] *Healthcare Inspection - Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia*, April 17, 2013; *Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia*, April 17, 2013.

[4] *Healthcare Inspection - Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, Georgia*, August 12, 2014.

[5] *Healthcare Inspections – Alleged Inappropriate Opioid Prescribing Practices Chillicothe VA Medical Center, Chillicothe, Ohio,* December 9, 2014; *Healthcare Inspections – Quality of Care and Staff Safety Concerns at the Huntsville Community Based Outpatient Clinic, Huntsville, Alabama,* July 17, 2014; *Healthcare Inspection - Medication Management Issues in a High Risk Patient Tuscaloosa VA Medical Center, Tuscaloosa, Alabama,* June 25, 2014*; Healthcare Inspection – Quality of Care Concerns Hospice/Palliative Care Program Western New York Healthcare System, Buffalo, New York,* June 9, 2014; *Healthcare Inspections – Alleged Improper Opioid Prescription Renewal Practices San Francisco VA Medical Center, San Francisco, California,* November 7, 2013; *Healthcare Inspection – Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic,* August 21, 2012; *Healthcare Inspection – Alleged Improper Care and Prescribing Practices for a Veteran Tyler VA Primary Care Clinic, Tyler, Texas,* August 19, 2011; *Healthcare Inspection – Patient's Medication Management Lincoln Community Based Outpatient Clinic, Lincoln, Nebraska*, August 10, 2012; *Healthcare Inspection – Prescribing Practices in the Pain Management Clinic at John D. Dingell VA Medical Center, Detroit, Michigan*, June 15, 2011.

(6) possible and confirmed suicide attempts. We found that less than 1 percent of the population experienced any one of these adverse effects during the fiscal year, except for the adverse effect of possible and confirmed suicide attempts that was evident in 2 percent of the opioid patients.

The Veterans Access, Choice, and Accountability Act of 2014

Implementation of the *Veterans Access, Choice, and Accountability Act of 2014* is a considerable challenge for VA.[6] In addition to coordinating care for patients outside the VA system, VA also has to ensure that payments are made timely and accurately and that results of medical appointments are shared between VA and non-VA providers. These issues have been problematic in the past for VA. The OIG has provided significant oversight of billing issues in the non-VA Fee Care program over the last several years.[7]

Staffing Report

The Choice Act requires the OIG for the next 5 years to report on the staffing needs of VHA. Our first report was issued on January 30, 2015, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, in which we reported that the five occupations with the largest staffing shortages were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist. The access to care issues that VA continues to face as well as the results of this review illustrate the problems that VA faces in staffing its facilities to meet the increasing demand for services. We are working with VHA to improve data quality so that future reports will identify manpower needs based upon staffing standards.

VHA's National Call Center for Homeless Veterans

The OIG conducted a review to assess the effectiveness of VHA's National Call Center for homeless veterans in helping veterans obtain needed homeless services.[8] The call center is VA's primary vehicle for communicating the availability of VA homeless programs and services to veterans and community providers. Our oversight identified serious problems in the Call Center's intake and referral processes that were seriously hampering the Call Center's effectiveness and services to homeless veterans.

---

[6] Also referred to as the Choice Act.

[7] *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program,* August 3, 2009; *Veterans Health Administration – Review of Outpatient Fee Payments at the VA Pacific Islands Health Care System*, March 17, 2010; *Review of Veterans Health Administration's Fraud Management for the Non-VA Fee Care Program*, June 8, 2010; *Audit of Non-VA Inpatient Fee Care Program*, August 18, 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; *Review of Enterprise Technology Solutions, LLC, Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations*, August 20, 2012; *Veterans Health Administration – Review of South Texas Veterans Health Care System's Management of Fee Care Funds*, January 10, 2013.

[8] *Veterans Health Administration – Audit of The National Call Center for Homeless Veterans*, December 3, 2014.

We found that 27 percent of homeless veterans who contacted the Call Center in FY 2013 could only leave messages on an answering machine because counselors were unavailable to take calls. Additionally, 16 percent could not be referred to VA medical facilities because their messages were inaudible or lacked contact information, and approximately 4 percent were not referred to VA medical facilities because the Call Center did not follow up on referrals to medical facilities.

Of the approximately 51,500 referrals made in FY 2013, the Call Center provided no feedback or improvements to VAMCs to ensure the quality of the homeless services and closed 47 percent of referrals even though the VA medical facilities had not provided the homeless veterans any support services. In total, we identified 40,500 missed opportunities where the Call Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services from VA medical facilities.

We recommended the Interim Under Secretary for Health stop the use of the answering machine, implement effective Call Center performance metrics to ensure homeless veterans receive needed services, and establish controls to ensure the proper use of Call Center special purpose funds.

VETERANS BENEFITS ADMINISTRATION

The Veterans Benefits Administration (VBA) is charged with providing compensation benefits for those injured during their service in the military. The accurate and timely delivery of these benefits has continued to be a major challenge for VA. Our oversight indicates that much work continues to be needed before VA can consistently deliver earned and needed benefits to our veterans timely and accurately. Further, VBA needs to improve its financial stewardship of taxpayer funds, data integrity and overall claims management, and focus more efforts on addressing the timeliness and accuracy associated with processing veterans' claims. The OIG's recent reviews of allegations of VA Regional Office (VARO) mismanaged operations are identifying troubling breakdowns in the processing controls for claims, data manipulation of claims information, and inadequate storage of claims.

We have reviewed two of VBA's initiatives to address the claims backlog—the initiative to address claims over 2 years old and the Quick Start Program.[9] With both we found significant areas of concern.

- *Special Initiative* - In April 2013, VBA began a Special Initiative to process all claims pending over 2 years. VBA staff were to issue provisional ratings for cases awaiting required evidence and complete these older claims within 60 days. For our review, we focused on whether (1) provisional ratings resulted in veterans receiving benefits more quickly and helped eliminate the backlog, and (2) older claims were accurately processed under the Special Initiative.

[9] *Review of VBA's Special Initiative To Process Rating Claims Pending Over 2 Years*, June 14, 2014; *Audit of the Quick Start Program*, May 20, 2014.

We found that the Special Initiative rating process was less effective than VBA's existing rating process in providing benefits to veterans quickly. With the implementation of the Special Initiative, VBA instituted two changes that misrepresented its reported progress toward eliminating the backlog as well as other claims processing statistics. First, VBA normally defines claims as pending until all required actions are completed. Under this initiative, VBA considered claims to be complete upon issuance of provisional ratings, even though final decisions had not been made. VBA removed these provisionally-rated claims from the backlog while veterans were still awaiting final decisions. This made the backlog appear lower as provisional ratings were issued. Second, VBA normally measures the number of days a claim is pending from the date of claim, defined as the earliest date VA received the claim in any of its facilities. However, following receipt of additional evidence on a provisional rating, staff were to establish a new rating claim using the date of receipt of that evidence as the new date of claim. This policy change kept the newly established claims from immediately becoming part of the backlog, making the claims appear more recent than they actually were. This also made VBA's workload statistics on average days claims were pending appear even smaller. Then, once staff issued final ratings, it appeared that VBA completed these claims twice, calculating the average days to complete claims to be even lower.

We estimated VBA staff inaccurately processed 17,600 of 56,500 claims, resulting in $40.4 million in improper payments during the Special Initiative period. We recommended the Under Secretary for Benefits establish controls for all provisionally-rated claims, reflect these claims in VBA's pending workload statistics, expedite finalization of provisional ratings, and review for accuracy all claims that received provisional ratings under the Special Initiative.

- *Audit of the Quick Start Program* – The OIG evaluated the Quick Start Program to determine if VBA's timeliness and accuracy of claims processing improved between 2011 and 2013. The Quick Start Program was initiated to improve claims processing and eliminate the claims' backlog by offering service members a seamless transition from the Department of Defense (DoD) to VA. We found while there were improvements in the average days to complete the claim and the accuracy of the claim, the timeliness of processing these claims and the accuracy remains a challenge. This occurs because of insufficient oversight and training, and conflicting guidance on granting service connection for medical disabilities. We also projected that inaccurate claims processing resulted in some veterans being underpaid and others overpaid. We reported that veterans using this program experienced an average delay of 99 days in receiving benefits valued at almost $20 million in FY 2013.

Several of our national audits have raised concerns about VBA's financial stewardship including, our audit work dealing with VA benefits and military drill pay, payments under the GI Bill, the management of mail at the Eastern Area Fiduciary Hub, and our continuing work related to temporary 100 percent disability ratings. [10]

- *Concurrent VA and Military Drill Pay* – This audit determined that VBA did not timely process VA benefits offsets when drill pay was earned concurrently and projected that if VBA improved their controls, VBA could recover approximately $478 million from FY 2013 through FY 2017. In total, we identified that VBA could recover approximately $623 million in improper payments.

- *Payments Under the G.I. Bill* – We evaluated VBA's management of the Post-9/11 G.I. Bill monthly housing allowance and book stipend payments. Our review found that 92 percent of student records that we sampled experienced processing delays in the approval of their original claims, and 18 percent experienced payment processing delays in their housing allowance and book stipends. Based on these results, we estimated that 77,800 students annually experience delays in the processing of about $60.8 million in housing allowances and book stipends. We also reported that VBA's controls need to be strengthened to reduce improper payments and estimated that they could save $35 million over the next 5 years with improved controls.

- *Eastern Area Fiduciary Hub* – In response to allegations received in the OIG's Hotline, we reviewed the Eastern Area Fiduciary Hub in Indianapolis, Indiana; activities related to merit reviews; field examinations; and mail management. We found that the office had over 11,000 pending field examinations that exceeded VBA timeliness standards, failed to take appropriate action when a misuse determination was made involving fiduciary accounts, and that over 3,000 pieces of mail were not processed within its timeliness standards.

- *Temporary 100 Percent Disability Rating* – Our work in the area of temporary 100 percent ratings began when we issued an audit report in January 2011.[11] In that report, we projected that without improved management, VBA could overpay veterans $1.1 billion in the next 5 years. In our June 2014 report, we followed-up that original work, and while VBA made some progress, they did not take sufficient action to ensure that improper payments were not issued. In the 2014 report, we projected a loss of approximately $222 million to the Government if veterans were not scheduled for follow-up appointments. Both of these audits demonstrated a compelling need for improved management of temporary rating decisions to ensure disability ratings are supported with appropriate medical evidence.

[10] *VBA's Management of Concurrent VA and Military Drill Pay Compensation*, June 3, 2014; *Audit of Post- 9/11 G.I. Bill Monthly Housing Allowances and Book Stipend Payments*, June 11, 2014; *Review of Alleged Mismanagement of VBA's Eastern Area Fiduciary Hub*, May 28, 2014; *Follow-up Audit of 100 Percent Disability Evaluation*, June 6, 2014.
[11] *Audit of VBA's 100 Percent Disability Evaluations*, January 24, 2011.

In addition to conducting our cyclical inspections of VAROs, since June 2014, we have received allegations of improper mail management, mail storage, and data manipulation at 11 VAROs that necessitated a reprioritization of our work. This increase in allegations resulted in a decrease of the annual inspections in FY 2014 from the projected 20 to 10. If we continue to receive allegations about specific VARO operations, we may need to further reduce the number of planned inspections in FY 2015. The issues that we have reviewed and reported on include improper storage of claims and supporting information, data manipulation, identification of unprocessed workload, and mail mismanagement. As of March 13th, we have issued six benefits inspections reports.

OTHER AREAS OF CONCERN

VA's procurement practices and management of information technology continue to be areas of concern and challenge to VA. We have issued reports dealing with construction contracts, contracts for information technology (IT) needs, and IT security.

Construction Contracts

In FY 2014, we issued a report on VA's management of several health care center leases that found that VA's process was not effective and did not fully account for expenditures.[12] Among our recommendations was to establish adequate guidance for management of the procurement process of large-scale build-to-lease facilities and establish central cost tracking to ensure transparency and accurate reporting on Health Care Center expenditures.

We also reviewed VHA's non-recurring maintenance program where expenditures increased from $824 million in FY 2008 to $1.8 billion in FY 2013. We reported that VHA did not have an adequate process to track how much of the over $1.8 billion in non-recurring maintenance funds medical facilities spent to address its nearly $10.7 billion identified facility maintenance backlog.

Information Technology Management

In our audit of the Office of Information and Technology's (OIT) management of the Pharmacy Reengineering program (PRE), we reported that OIT needed stronger accountability over cost, schedule, and scope.[13] We recommended the Executive in Charge and Chief Information Officer ensure all of the time used, including the time on the initial operating capability phase, to complete each remaining PRE increment is reported and monitored; ensure adequate oversight and controls, including the planning guidance, staffing, and cost and schedule tracking needed to deliver functionality on time and within budget; and establish a plan for future funding of PRE until a decision on an integrated Electronic Health Record is made. The CIO agreed and provided an acceptable corrective action plan. We will continue to assess OIT's corrective actions in the future and review the effectiveness of VA's efforts to implement other IT investments in system development and redesign.

[12] *Review of VA's Management of Health Care Center Leases*, October 22, 2013.
[13] *Audit of VA's Pharmacy Reengineering Software Development Project*, December 23, 2013.

Based on information received through the OIG Hotline, we conducted a review of allegations that VHA's Chief Business Office (CBO) violated appropriations law by improperly obligating a total of $96 million of medical support and compliance funds to finance the development of the Health Care Claims Processing System (HCCPS).[14] We substantiated that $92.5 million was improperly obligated, The CBO spent approximately $73.8 million and $18.7 million remains obligated. Medical support and care appropriations are only authorized for administering medical, construction, supply, and research activities.

We recommended the Interim Under Secretary for Health establish oversight mechanisms, seek the return of all medical support and compliance appropriations, de-obligate all current medical supply and compliance funds, and obtain appropriate funding for HCCPS development. We also recommended that the Interim Under Secretary determine if appropriate administrative action should be taken against senior officials in the Purchased Care organization's chain of command.

Information Technology Security

In May 2014, we published our annual assessment of VA compliance with the Federal Information Security Management Act (FISMA) and applicable National Institute of Standards and Technology guidelines.[15] We contracted with the independent accounting firm, CliftonLarsonAllen LLP, to perform this audit. We found that VA had made progress developing policies and procedures but still faced challenges implementing components of its agency-wide information security risk management program to meet FISMA requirements. While some improvements were noted, FISMA audits continued to identify significant deficiencies related to access controls, configuration management controls, continuous monitoring controls, and service continuity practices designed to protect mission-critical systems.

Weaknesses in access and configuration management controls resulted from VA not fully implementing security control standards on all servers and network devices. VA has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, database and server platforms, and Web applications VA-wide. Further, VA has not remediated approximately 6,000 outstanding system security risks in its corresponding Plans of Action and Milestones to improve its overall information security posture.

As a result of the FY 2013 consolidated financial statement audit, CliftonLarsonAllen LLP, concluded a material weakness still exists in VA's information security program. We recommended the Executive in Charge for Information and Technology implement comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems. We plan to issue the FY 2014 FISMA audit results shortly.

[14] *Report Highlights: Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System*, March 2, 2015.
[15] *VA's Federal Information Security Management Act Audit for Fiscal Year 2013*, May 29, 2014.

OIG INVESTIGATIVE WORK

From October 1, 2013, through March 6, 2015, the OIG's Office of Investigations opened 1,812 investigations and worked 630 investigations to closure, resulting in the arrest of 691 individuals for a wide variety of criminal offenses. Criminal fines, penalties, restitutions, civil judgments, and administrative recoveries exceeded $70.5 million. We additionally opened and closed another 3,000 preliminary inquiries regarding alleged crimes and/or serious misconduct.

Eligibility Fraud in Service-Disabled Veteran-Owned Small Business (SDVOSB) Program

We continue to aggressively pursue allegations of eligibility fraud involving companies and individuals taking advantage of set-aside contracting in VA's SDVOSB program. To date, our investigations have resulted in the indictment of 45 individuals and 5 companies. Defendants have been sentenced to a cumulative total of imprisonment exceeding 26 years and fines and restitution exceeding $14 million. Sixty individuals and companies deemed culpable of committing this type of fraud have been referred to VA for suspension and debarment action to exclude them from receiving future contracts.

Fiduciary Fraud

The Fiduciary program's mission is to protect VA beneficiaries who, due to injury, disease, or age, are unable to manage their VA benefits. Under the program, VA appoints a fiduciary (an individual or entity) to receive and disburse VA benefits on behalf of the beneficiary. As of July 2014, VBA reported providing fiduciary services to more than 147,000 beneficiaries in FY 2013 who received more than $2.6 billion in VA benefits. Since October 1, 2013, we have arrested 17 individuals who stole money from VA beneficiaries who were unable to handle their financial affairs. In addition to terms of imprisonment, restitution of nearly $1 million was ordered. Among them was a fiduciary in Minnesota who stole nearly $300,000 from veterans and Social Security beneficiaries entrusted to her care.

Threats and Assaults

Since October 1, 2013, we conducted more than 1,000 preliminary inquiries and full investigations relating to threats made against VA employees and facilities resulting in 44 arrests and/or involuntary commitments. Although most threat-related investigations do not result in judicial action, we take all threats against VA employees and VA property seriously. We also conducted 17 assault investigations resulting in 24 arrests, and 9 sexual assault investigations resulting in 4 arrests. These investigations involved veterans assaulting VA employees and other veterans, as well as VA employees assaulting veterans and other VA employees. In one investigation, a veteran was sentenced to 2 years' incarceration after pleading guilty to threatening to kill Atlanta, Georgia, VAMC medical staff by going to his residence to get a weapon, return, and shoot them in the head if he was not granted a 100 percent disability pension rating. The veteran left the VAMC and before he could return he became engaged in a shootout with local police at his residence after the officers responded to a domestic disturbance call.

Identity Theft, Procurement Fraud, and Improper Payments

We have recently added headquarters staff to focus our national efforts to combat identity theft, procurement fraud, and improper payments resulting from criminal conspiracy. During this time period, we arrested 16 individuals who stole veterans' personally identifiable information (PII) for a variety of criminal schemes, but primarily to facilitate Federal income tax refund fraud exceeding $6 million. In one investigation, a former VAMC clerk and a VA volunteer were sentenced to 72 months' and 48 months' respectively for exchanging VA patients' PII for money and illicit drugs.

As a result of an OIG investigation, 14 individuals were prosecuted on bribery charges, including an engineer at the East Orange, New Jersey, VAMC who was convicted of conspiring with a contractor to defraud VA of more than $6 million. In another investigation, we convicted a former VA contracting officer in Palo Alto, California, VAMC for accepting more than $100,000 in cash, vacations, and other items of value in exchange for her influence in awarding contracts. To date, this investigation has resulted in criminal charges against two other VA employees and one contractor. In a third investigation, we convicted the former Director of the Cleveland, Ohio, and Dayton, Ohio, VAMCs on 64 corruption-related charges related to the sale of confidential information about VA contracts and projects to multiple contractors; one of the contractors used the inside information to obtain an advantage in securing a contract valued at approximately $20 million.

Our 14-year proactive program to identify VA monetary payments made to deceased payees has resulted in 691 arrests and the recovery of nearly $80 million. We have recently initiated efforts to identify and thwart national criminal schemes to redirect VA benefits by defrauding the multi-agency *eBenefits* system, as well as to detect billing fraud in fee basis and overseas medical care programs. One of our investigations, resulted in the conviction of a DoD employee living in Germany for defrauding VA and the Office of Personnel Management of more than $2.2 million in medical reimbursements, which exposed considerable vulnerabilities in VA's overseas medical care program.

Drug Diversion

Since October 1, 2013, we have arrested 184 individuals who diverted and/or sold controlled and non-controlled substances from and at VA facilities. Among them were VA health care providers who stole pain medications intended for specific patients and consumed them while on-duty and delivering patient care; patients who sold their prescribed drugs to other VA patients; individuals who sold contraband drugs such as heroin at VA facilities; and employees of delivery services, including the U.S. Postal Service, who stole prescription drugs intended for VA patients. As a result of one such investigation, a Long Beach, California, VAMC pharmacist, three pharmacy technicians, and a distribution supervisor pled guilty to stealing more than 16,000 tablets of prescription medications.

Beneficiary Travel Fraud

We have worked closely with VA to identify, investigate, prosecute, and deter fraud associated with VA's beneficiary travel reimbursement program, whose expenditures approached $797 million in FY 2014. We believe our efforts with VA to enhance VA's data mining efforts and develop more effective warning posters to be placed where veterans submit claims for these beneficiary travel benefits, coupled with increased media attention resulting from DOJ press releases, have played a significant role in deterring such crime. VA reports expending nearly $43 million fewer dollars in this program in FY 2014 than in FY 2012.

OIG INITIATIVES

In FY 2015, we have initiated projects in several high priority areas—contracts for VA's Patient-Centered Community Care (PC3) initiative; allegations of mismanagement at VHA's Health Eligibility Center; oversight of VBA's fiduciary program; the interaction between the DoD and VA with regard to providing for care for victims of military sexual trauma; VA's formulary issues; and credentialing and privileging issues.

Patient-Centered Community Care

In September 2013, VA awarded Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corporation PC3 contracts totaling $5 billion and $4.4 billion, respectively. The expected life of the contracts is a base year plus 4 option years. VHA established the PC3 contracts to provide veterans timely access to high-quality care from a comprehensive network of non-VA community providers.

We currently have five projects that are reviewing various aspects of VA's PC3 contract and the effectiveness of its implementation. All five focus on the operational risk areas that directly affect veterans' waiting times, access to services, and continuity of care. The first review that we expect to complete is this Committee's request to determine whether VA's PC3 contracts would save $13 million in FYs 2014 as VA stated in its budget submission.

The remaining four projects are reviewing whether PC3 contracted care issues are causing delays in patient care; whether PC3 networks are providing adequate veteran access to care; whether PC3 contractors are providing VHA with timely medical documentation; and the effectiveness of PC3 contract pricing. We plan to issue all of these reports in FY 2015.

Review of Alleged Mismanagement at VHA's Health Eligibility Center

The OIG expanded an ongoing project at the Health Eligibility Center (HEC) in Atlanta, Georgia, at the request of the Chairman of the U.S. House Committee on Veterans' Affairs. Specifically, we are reviewing whether there is a backlog of applications for health benefits in a pending status; whether veterans died while their applications were in a pending status; whether HEC staff purged and deleted veterans' applications; and whether the HEC had discovered about 40,000 unprocessed applications covering a 3-year time period. A major obstacle in completing our work is the serious data integrity issues with the HEC information system. This condition has limited our ability

to determine the extent of issues being reviewed; however, we expect to publish our report in FY 2015.

VBA Fiduciary Program

We are currently working on two audits addressing the management of VBA's fiduciary program field examinations and managements of accounts when misuse had been identified. This work is important because it addresses the effectiveness of vital support service to veterans who cannot perform these services for themselves. We plan to publish reports in FY 2015.

Review of Care for Military Sexual Trauma

We are working with the DoD to obtain data so that we can examine VA medical care delivered to veterans with a history of military sexual trauma from DoD. Once a Memorandum of Agreement for data sharing is signed, we will brief Members of Congress who have expressed an interest in this topic.

Low Volume Physicians' Professional Practice Evaluations in VHA Facilities

To ensure that physicians are both competent when hired and remain competent during the course of their employment, VHA credentials and privileges providers on a regular basis. In the credentialing process, the facility verifies the physician's education, licensure, and formal training. In the privileging process, the facility decides which procedures or services a physician can provide at their facility based on their licensure, training, and experience. Facilities are required to monitor individual physician performance over time and re-privilege them every 2 years, to make sure they maintain their competence to perform specific procedures or services. The re-privileging of specialists at facilities with small staff levels is an area of concern because re-privileging needs to be completed by staff with experience in that specialty. When a facility only has one physician in a particular specialty, they should be seeking assistance from staff outside of that facility during the re-privileging process. We expect to publish a report in FY 2015.

Review of Non-Formulary Drug Requests in VHA

Formulary management is an integral part of VA's comprehensive health care delivery process. VA National Formulary (VANF) is a listing of products (drugs and supplies) that must be available for prescription at all VA facilities, and cannot be made non-formulary by a VISN or individual medical center. The VANF is the only drug formulary authorized for use in VHA. The formulary management process must provide pharmaceutical and supply products of the highest quality and best value, while ensuring the portability and standardization of this benefit to all eligible veterans. "Non Formulary" refers to drugs or supplies that are defined as commercially available products, but are not included on the VANF. Our review will focus on the management of non-formulary drugs or supplies and the process for obtaining them. We expect to publish a report in calendar year 2015.

CONCLUSION

The issues confronting VA are issues that the OIG has long reported as serious and in need of attention at the VA Central Office, at the Veteran Integrated Service Network, and at the facility levels. The rededication by senior leadership and renewed commitment by employees to meet the expectations of veterans and the Nation is a step in the right direction. The OIG will continue to report on these issues until we see that change has occurred and that it is not just a temporary adjustment. However, the OIG's ability to continue its important mission, hinges upon having the resources necessary to accomplish President Lincoln's call "To care for him who shall have borne the battle and for his widow and his orphan."

Mr. Chairman and Members of the Subcommittee, Dr. Daigh and I will be pleased to answer any questions.