



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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*BEFORE THE*  
COMMITTEE ON APPROPRIATIONS  
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS,  
AND RELATED AGENCIES  
U.S. HOUSE OF REPRESENTATIVES  
*ON*  
CHALLENGES FACING THE DEPARTMENT OF VETERANS AFFAIRS  
MARCH 13, 2019

Madam Chair, Judge Carter, and members of the Subcommittee, thank you for the opportunity to discuss with you some of the more significant work of the Department of Veterans Affairs (VA) Office of Inspector General (OIG). The mission of the OIG is to conduct effective oversight of VA's programs and operations through independent audits, inspections, reviews, and investigations. The OIG is intensely committed to improving services and benefits for veterans and their families, as well as promoting the appropriate use of taxpayer funds.

The OIG has nearly 900 staff to oversee a VA budget of over \$200 billion and the work of more than 380,000 VA employees. OIG staff are organized into five principal oversight directorates: Investigations (focusing on criminal matters); Audits and Evaluations; Healthcare Inspections; the Office of Contract Review (which conducts pre- and postaward reviews of VA proposals and contracts of significance); and a new Office of Special Reviews (which reviews emergent issues of critical concern that do not fall squarely within one of the other directorates). In addition, the Management and Administration directorate's operations include managing the OIG Hotline, which refers matters to the appropriate oversight directorates, and tracking the closing of recommendations implemented by VA.

The work of the OIG would not be possible without the support from Congress, including this Subcommittee and its Senate counterpart, in appropriating \$192 million for fiscal year (FY) 2019. With so many key VA leadership positions being held by those in an acting capacity over the past years, and numerous multibillion-dollar initiatives requiring careful planning and execution in the years ahead, effective OIG oversight is particularly critical.

For FY 2020, the OIG is requesting an appropriation of \$207 million. These resources would support an average of 1,000 full time equivalents (FTE) and sustain critical investments in facilities nationwide that began in 2015 as part of a multiyear effort to meet increased oversight needs of critical VA programs. In particular, appropriated funds will support a variety of impactful oversight work including conducting cyclical healthcare inspections, facility reviews, and benefits and procurement audits; responding to

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potential criminal activity; and evaluating risks and threats to VA infrastructure, such as investments in technology and procurement projects. This appropriation will also support a number of new or expanded initiatives that focus on high risk areas, including a predictive analytics program, the investigative development division, expanded healthcare inspections to include VISNs, and reviews of financial management at medical centers.

Among the major challenges that VA faces is implementation of legislation passed during the 115<sup>th</sup> Congress, notably the *VA MISSION Act*, the *Appeals Modernization Act*, the *VA Accountability and Whistleblower Protection Act of 2017*, and the *Forever GI Bill*. The OIG is monitoring, and in some cases conducting reviews of, these efforts given their impact on the services and benefits received by veterans and their families. OIG staff also is overseeing other complex and prodigious VA initiatives, such as the modernization of electronic health records.

In keeping with the OIG 2018–2022 Strategic Plan, staff will focus not only on the oversight of programmatic areas, such as VA health care and benefits, but also will examine key factors that cut across VA administrations and program offices to drive success or perpetuate deficiencies.<sup>1</sup> These include VA’s stewardship of taxpayer dollars, leadership and governance structures and practices, and VA’s capacity for careful planning and innovation.

The OIG’s strategic plan builds on a number of observed ongoing major management challenges and is responsive to issues identified by VA and the veteran community.<sup>2</sup> I would like to discuss the OIG’s five strategic goals and highlight recent impactful work that has resulted in recommendations for how VA can better meet its commitment to veterans, their families, and VA staff.

## **GOAL 1. IMPROVE ACCESS TO QUALITY AND TIMELY VA HEALTHCARE SERVICES**

*Improve veterans’ access to exemplary health care by identifying opportunities to enhance the quality, management, efficiency, and delivery of patient-centered care in VA facilities and in the community.*

VA’s Veterans Health Administration (VHA) runs the largest integrated healthcare system in the nation, and faces many of the same challenges as other public and private systems. Moreover, it must address the distinct needs of men and women who have served in the military. There are more than 140 VA medical centers (VAMCs) and 1,200 community-based outpatient clinics that provide services to approximately 7 million veterans.

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<sup>1</sup> [U.S. Department of Veterans Affairs Office of Inspector General Strategic Plan, 2018–2022.](#)

<sup>2</sup> [U.S. Department of Veterans Affairs Office of Inspector General Management and Performance Challenges](#), November 2018.

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VHA continues to face significant obstacles in consistently delivering quality and timely health care to veterans. To provide VHA with practical and impactful recommendations for addressing these challenges, the OIG’s audit and healthcare work remains focused on

- Improving the quality of care delivered by VA and its community providers,
- Better coordinating patient care among various clinical providers,
- Enhancing veterans’ access to care (including reducing wait times), and
- Ensuring the availability of core services.

### Improving the Quality of Care

Among the reviews that the OIG conducts are those related to basic patient care, such as routine clinical evaluations. When simple screening tests or evaluations are improperly documented, disregarded, or delayed, the impact can be devastating. For example, the OIG has issued reports on concerns related to clinical blood pressure, prostate, and breast cancer testing and follow-up practices by both VA providers and providers under contract to VA.

- **Blood Pressure Evaluations:** The OIG received allegations that a healthcare provider was falsifying blood pressure readings at a VA community-based outpatient clinic in Lexington, Kentucky.<sup>3</sup> The OIG team’s review found that in 99.5 percent of more than 1,000 encounters, the primary care provider documented repeat blood pressure readings of 128/78. These falsified readings are below the threshold that would trigger electronic alerts to the provider to consider additional follow-up testing and potentially modify a patient’s treatment plan. In addition, the lower blood pressure values would also favorably impact a care provider’s performance metrics—metrics that could support year-end bonuses and evaluations. The OIG substantiated the allegation and noted the facility did not have processes in place to validate performance measures. These high-risk patients were put at unnecessary risk of harm of serious adverse outcomes such as acute cardiac events.

The OIG also identified a provider in the Danville community-based outpatient clinic of the Salem, Virginia, VA Medical Center who documented blood pressure readings of 139/89 at an unlikely frequency. After an initial review of the electronic health records of 40 patient encounters, OIG staff opened and expanded the review. In the final report, the OIG team determined that the care provider had falsified repeat blood pressure readings for hypertensive patients and failed to provide appropriate follow-up and management.<sup>4</sup> Also troubling is that

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<sup>3</sup> [Falsification of Blood Pressure Readings at the Berea Community Based Outpatient Clinic, Lexington, Kentucky](#), September 20, 2018.

<sup>4</sup> [Falsification of Blood Pressure Readings at the Danville Community Based Outpatient Clinic, Salem, Virginia](#), January 29, 2019.

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despite facility leaders being immediately informed of the preliminary findings, it was not until the OIG team made a follow-up call to the facility's chief of staff eight weeks later that the facility began an in-depth review of the care provider's practices. The Danville clinic is a contracted facility run by Valor Healthcare. The care provider in question has since been fired.

- **Prostate Tests:** The OIG conducted a review in response to allegations that a primary care provider at a VA clinic in Fort Benning, Georgia, did not follow up on elevated prostate-specific antigen (PSA) blood tests.<sup>5</sup> Elevated PSA values can indicate a variety of abnormalities, including infection and trauma, but may also indicate the presence of prostate cancer. The OIG team substantiated that the care provider did not consistently follow up on elevated prostate test results, which delayed a patient's prostate cancer diagnosis and treatment. Also, system leaders did not consistently monitor the care provider's performance or take adequate administrative action. The OIG notified system and Veterans Integrated Service Network (VISN) 7 leaders about this matter and the compromised quality of care.
- **Breast Cancer Screening:** While reviewing allegations related to a delay in care for one patient at the Atlanta VA Health Care System, the OIG broadened the scope of the inspection to examine 4,727 mammography orders and consults ordered from October 1, 2014, through June 22, 2017.<sup>6</sup> The OIG identified 42 patients whose diagnostic mammograms were not completed and referred them to the facility to ensure appropriate follow-up. The OIG also identified concerns related to the lack of a streamlined mammography scheduling process, delays in scheduling and retrieving imaging results, lack of consistent physician reviews for clinical appropriateness, large volumes of unscanned non-VA medical records, and deficiencies in the oversight of the Women Veterans Program, among others.

### Coordinating Patient Care

VA has had considerable challenges ensuring that patient care is coordinated both within a VA facility across practice areas as well as between VA facilities and community providers. Several reports illustrate the OIG's concerns with the impact on veterans when effective care coordination fails:

- The OIG conducted a review regarding care coordination within the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin.<sup>7</sup> Originally the allegation related to one patient who committed suicide less than 72 hours after having received care at the VA facility,

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<sup>5</sup> [\*Healthcare Inspection – Primary Care Provider's Clinical Practice Deficiencies and Security Concerns Fort Benning VA Clinic, Fort Benning, Georgia\*](#), January 30, 2018.

<sup>6</sup> [\*Delays and Deficiencies in Obtaining and Documenting Mammography Services at the Atlanta VA Healthcare System, Decatur, Georgia\*](#), September 13, 2018.

<sup>7</sup> [\*Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin\*](#), August 1, 2018.

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which was later expanded to include concerns related to a second patient's mental healthcare management. Although facility managers correctly classified the patient's death as a sentinel event and completed VHA and Joint Commission reporting requirements, their root cause analysis process was deficient. Among the OIG team's findings was a failure by VA facility staff to inform a community monitoring agency that the patient violated a prior court settlement agreement that required 90 days of compliance with mental health treatment, failures to involve the family and the county human services department in the patient's discharge planning, and inadequate post-discharge follow-up.

The team also identified concerns related to the management of patients with complex mental health conditions by psychiatric clinical pharmacists without clear evidence of supervision or collaboration with licensed independent psychiatric providers. Recommendations in the report, and related conversations with VHA mental health and pharmacy leaders, focused on the need for better policy and guidance to ensure collaborations between clinical pharmacists and psychiatrists, particularly when a patient's condition changes or referrals to higher-level care are required.

- In December, the OIG reported on delays in care and care coordination at both the Cheyenne, Wyoming, VAMC and Iowa City, Iowa, VA Health Care System.<sup>8</sup> The subject patient was first seen in Cheyenne and later was seen by a primary care provider in Iowa City. The OIG team found that providers at the Cheyenne VAMC failed to conduct timely and proper follow-up for this patient who had a history of renal cell carcinoma. Additional findings included a lack of clear communications among providers through electronic health record documentation, inaccurate diagnostic coding on the patient's problem list, and limited patient evaluations. Additionally, an institutional disclosure and peer reviews were not initiated.

The OIG did not substantiate that Iowa City providers failed to deliver care and were unaware of the patient's cancer history, but failure to timely address the patient's urology e-consult resulted in a delay in care. Review of additional Iowa City patients' electronic health records similarly found that clinical care was provided and patients were not negatively impacted, but urology clinic providers did not always complete e-consult documentation as required, which puts patients at unnecessary risk for delayed treatment decisions.

### **Enhancing Access to Care**

For the last several years, access to health care has been a significant challenge for VHA. For more than a decade, the OIG, Government Accountability Office, and other organizations have issued numerous reports regarding concerns with delays or barriers for accessing VA health care. These included lengthy

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<sup>8</sup> [\*Delay in Care and Care Coordination Concerns at the Cheyenne VA Medical Center and the Iowa City VA Health Care System, Wyoming and Iowa\*](#), December 19, 2018.

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veteran wait times, inaccurate documentation, poor scheduling practices, consult backlogs, and problems associated with accessing community care such as the Choice Program. VA has made significant efforts to respond to criticisms and has taken additional steps by working to provide same-day services for veterans needing immediate mental health or primary care. Resolving timely access challenges is complicated and exacerbated by VA's need to implement the *VA MISSION Act* (including consolidating community healthcare programs into a single program that meets the needs of veterans, community providers, and VA staff) while providing uninterrupted services. An example of the ongoing monitoring of VA's progress on wait times includes the following:

- OIG reviews of facilities in VISN 15 and other VA medical facilities demonstrated that VHA wait times continue to be a problem for particular appointments, such as Choice patients who had not received care within 30 days.<sup>9</sup> Incorrectly recording wait times also persists. In VISN 15, the OIG estimated that during FY 2017, new patients waited an average of about 18 days for mental health and specialty care appointments, and 18 percent of the appointments for new patients at VISN 15 facilities had wait times longer than 30 days. This was higher than the estimated 10 percent that VHA's electronic scheduling system showed. VA staff did not correctly record clinically indicated dates for about 38 percent of the new patient appointments, which understated wait times by about 15 days. Inaccurate wait time data resulted in veterans not being identified as eligible for Choice. With respect to veterans in VISN 15 who received care through Choice, the OIG estimated that the overall average wait time was 32 days. The audit estimated that 41 percent of the appointments had wait times longer than 30 days, and those veterans waited an average of 58 days.

Regarding consults, facility staff discontinued or canceled an estimated 27 percent inappropriately, which led to veterans experiencing additional delays or not receiving the requested care. Despite VA having issued an updated national policy in 2016, clinicians and staff were still unclear on specific consult management procedures. The OIG team identified clinical concerns with six patients and determined that one patient likely had an adverse outcome as a result of a delay in care.

### **Ensuring Availability of Effective Core Services**

As part of its overall goal to improve access to quality and timely VA health care, the OIG charts progress on particular improvement and patient care processes through its Comprehensive Healthcare Inspection Program (CHIP). One element of the CHIP review evaluates VHA's efforts related to Quality, Safety, and Value measures.<sup>10</sup> For the CHIP cycle in FY 2018, OIG inspectors found that facility managers overall had implemented improvement actions recommended by Peer Review

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<sup>9</sup> [Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 15](#), March 13, 2018.

<sup>10</sup> VHA requires its facilities operate a Quality, Safety, and Value program to monitor the quality of patient care and performance improvement activities.



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Committees. The OIG also observed consistent processes for required Root Cause Analyses for aggregate reviews (falls, missing patients, and adverse drug events) and individual reviews.

The OIG recognizes that hospital environments pose an intrinsic risk to patients as personnel are tasked with delivering effective treatment and support to a high volume of complex patients. Given the unpredictability of patient care management challenges, it is critical that hospitals have effective core services in place, including supply and equipment inventory controls that promote quality patient care and safety.

- Recent oversight reviews illustrate that when inappropriate demands are placed on front-line staff to deliver necessary care in a setting with inefficient or fractured core services, patients are placed at unnecessary risk. The most noteworthy of these examples was at the Washington, DC, VA Medical Center (where medical supplies and sterile instruments were not reaching patient care areas when needed).<sup>11</sup> During the DC VA Medical Center 2017 site visits and OIG team interviews with VA Central Office staff, a common theme emerged that leaders failed to respond to repeatedly identified significant deficiencies in core service operations. As a result of years of inaction, the lack of supplies and properly prepared instruments led to multiple delayed surgical procedures.

The DC VA Medical Center report has been a roadmap for other medical facilities nationwide to recognize the close relationship between nonclinical services and front-line delivery of quality care.

## **GOAL 2. ENSURE TIMELY AND ACCURATE BENEFITS FOR ELIGIBLE VETERANS**

*Help ensure that veterans and their families receive benefits in a timely manner, and superior services for which they are eligible, by making recommendations to advance expeditious and accurate VA decision-making and processes for delivering benefits.*

The Veterans Benefits Administration (VBA) is responsible for delivering approximately \$100 billion in federally authorized benefits and services to eligible veterans, their dependents, and survivors. In addition to compensation and pension benefits, the OIG conducts oversight of VBA's transitional assistance, home loans, training and education benefits, and fiduciary and caregiver support. OIG recommendations drive improvements in decision-making and accountability at every stage in the benefits process—from eligibility determinations through delivery and appeals.

In October 2017, the OIG implemented a new national inspection model for VBA oversight. 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

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<sup>11</sup> [Critical Deficiencies at the Washington DC VA Medical Center](#), March 7, 2018.

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

Since October 1, 2017, the OIG has published 17 oversight reports related to VBA.<sup>12</sup> VBA has generally concurred with the recommendations and provided acceptable action plans. VBA must now follow through with the difficult work of implementation to carry out their responsibilities effectively and be good stewards of taxpayer dollars.

I recently testified before the U.S. House of Representatives' Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs on VA's development and implementation of policy initiatives, with a particular focus on the challenges VBA has carrying out its benefits programs.<sup>13</sup>

Recent reports on systemic problems that VBA needs to address include the following often overlapping issues:

- Deficient controls
- Inadequate program leadership and monitoring
- Lack of information technology system functionality
- Unintended impacts of the National Work Queue

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<sup>12</sup> [\*Audit of the National Pension Call Center\*](#), November 1, 2017; [\*Review of Claims Processing Actions at Pension Management Centers\*](#), November 1, 2017; [\*Review of Alleged Appeals Data Manipulation at the VA Regional Office, Roanoke, Virginia\*](#), December 5, 2017; [\*Audit of Vocational Rehabilitation and Employment Program Subsistence Allowance Payments\*](#), March 15, 2018; [\*Review of Timeliness of the Appeals Process\*](#), March 28, 2018; [\*Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact\*](#), May 2, 2018; [\*VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017\*](#), May 15, 2018; [\*Unwarranted Medical Reexaminations for Disability Benefits\*](#), July 17, 2018; [\*Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma\*](#), August 21, 2018; [\*Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits\*](#), August 21, 2018; [\*Accuracy of Effective Dates for Reduced Evaluations Needs Improvement\*](#), August 29, 2018; [\*VA Policy for Administering Traumatic Brain Injury Examinations\*](#), September 10, 2018; [\*Review of Accuracy of Reported Pending Disability Claims Backlog Statistics\*](#), September 10, 2018; [\*Timeliness of Final Competency Determinations\*](#), September 28, 2018; [\*Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis\*](#), November 20, 2018; [\*VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students\*](#), December 3, 2018; [\*Delays in the Processing of Survivors' and Dependents' Education Assistance Program Benefits Led to Duplicate Payments\*](#), December 18, 2018.

<sup>13</sup> [\*Statement of Michael J. Missal before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives\*](#), November 29, 2018.

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What is particularly troubling is that these deficiencies can have a significant impact on the lives of some of the most vulnerable veterans, including those living with posttraumatic stress disorder, Lou Gehrig's Disease (or ALS), military sexual trauma (MST), and other conditions.

- For example, in the report involving claims for Lou Gehrig's disease the OIG team found there were 71 errors in a sample of 100 decisions involving 45 veterans' ALS claims from April 2017 through September 2017. VBA staff made incorrect decisions regarding special monthly compensation benefits, used incorrect effective dates of claims, and gave inaccurate or conflicting information in decisions.
- The *Denied Military Sexual Trauma-Related Claims* report resulted from a nationwide review that revealed VBA staff did not properly process veterans' denied MST-related claims. The OIG estimated that VBA staff incorrectly processed approximately 1,300 of the 2,700 MST-related claims denied during the review period (49 percent). The OIG made six recommendations, including that VBA review all approximately 5,500 MST-related claims denied from October 2016 through September 2017, take corrective action, assign MST-related claims to a specialized group of claims processors, and improve oversight and training. VBA has already taken steps to address them. The Under Secretary stated that VBA was updating required training for claims processors, adding quality and accuracy reviews, and in FY 2019 will review every denied MST-related claim decided since the beginning of FY 2017.

Deficiencies with benefits programs and operations not only impact veterans, their caregivers, and family members, but also affect VBA's bottom line.

- For example, in December 2018 the OIG published a report focusing on whether VBA adjusted compensation benefits in the Survivors' and Dependents' Educational Assistance Program in a timely manner and accurately processed benefits payments. The audit team found that delays in the processing of these benefit adjustments led to overpayments totaling approximately \$4.5 million from August 1, 2016, through February 1, 2018. If the OIG's recommendations are not implemented, resulting in the same continued delays, there could be an estimated \$22.5 million in improper payments made over a five-year period. Causes include failure to routinely check a specially designated electronic mailbox at each regional office and at national levels, ineffective notification processes among VBA personnel, and the lack of system functionality to flag cases with duplicate benefits. In addition, some workload distribution rules that were put in place to facilitate the National Work Queue caused cases not to be distributed when ready for processing.

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### GOAL 3. HELP FACILITATE STRONG STEWARDSHIP OF TAXPAYER DOLLARS

*Identify procedures and strategies for making the most responsible use of VA appropriated funds, including sound and closely monitored procurement practices and financial systems that reduce the risk of fraud, waste, and misuse of resources.*

Sound financial management is integral not only to ensuring the best use of limited public resources, but also the ability to collect, analyze, and report reliable data to inform resource allocation decisions. The OIG has been making recommendations to help VA better identify savings and monetary recoveries through its reviews and audits of VA's financial management, controls, and high-risk programs.

- Each year as part of the oversight of VA appropriated funds management, the OIG is required to audit VA's consolidated financial statements under the *Chief Financial Officers Act*. The OIG contracts with an independent public accounting firm to conduct the audit and then OIG staff review those findings. For FY 2018, five material weaknesses were identified as well as two significant deficiencies. VA was found to be in substantial noncompliance with federal financial management systems requirements and the United States Standard General Ledger at the transaction level under the *Federal Financial Management Improvement Act*.<sup>14</sup> The OIG has been working with VA leaders to facilitate addressing these and other persistent noncompliance concerns, including with the *Improper Payments Elimination and Recovery Act*.

The importance of appropriately, consistently, and transparently executing appropriations cannot be overstated, as this helps to ensure that VA programs, services, and benefits are supported in the manner that Congress intended. However, in FY 2018, the OIG documented several instances of mismanagement of appropriated funds that include the following:

- VA misused approximately \$9.6 million from the General Operating Expense appropriation, \$3.1 million from the Medical Support and Compliance appropriation, and \$5.2 million from the Medical Services appropriation to finance information technology development costs.<sup>15</sup>
- VA was delinquent in reimbursing the Department of Treasury Bureau of Fiscal Service's Judgment Fund in accordance with applicable regulations for claims arising out of major contract disputes. Payments made on behalf of VA totaled over \$240,000,000, but VA reimbursed the Judgment Fund only approximately \$21,400,000. By not reimbursing the Judgment Fund

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<sup>14</sup> [Audit of VA's Financial Statements for Fiscal Year 2018 and 2017](#), November 26, 2018.

<sup>15</sup> [Alleged Contracting and Appropriations Irregularities at the Office of Transition, Employment, and Economic Impact](#), May 2, 2018; [Review of Alleged Funding Security Issues of the Veterans Services Adaptable Network at the VA Medical Center Orlando, Florida](#), January 31, 2018; [Audit of VHA's Use of Appropriations to Develop a System Enhancement and Mobile Health Applications](#), January 17, 2018.

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promptly, VA has continued to maintain significant liabilities not covered by budgetary resources.<sup>16</sup>

OIG audit reports and reviews include identified cost savings and better use of funds. More information about the monetary impact of OIG work is included in the OIG's *Semiannual Report to Congress*.<sup>17</sup> The OIG's Office of Investigations also focuses on a wide range of cases that can have significant impact on the lives of veterans and VA operations. Investigations often target individuals and entities that use fraud schemes, thefts, or other criminal means to divert taxpayer dollars from deserving veterans. Examples include the following:

- **VA Choice Contractor Paid \$40.8 Million in Reimbursements for Overpayments:** A contractor that acted as a third-party payer for the VA Choice Program reimbursed VA more than \$40 million for overpayments that it received as a result of improperly submitting duplicate invoices. An OIG and VA investigation revealed that errors in the contractor's billing practices led to multiple overpayments.
- **Business Owner Pled Guilty to Conspiracy to Commit Wire Fraud:** An individual pled guilty to conspiracy to commit wire fraud related to her co-ownership of a company providing services to the Houston, Texas, VA Medical Center Prosthetics Department. An OIG investigation resulted in charges that allege from January 2011 through December 2014, the defendants conspired to bill VA for false and fraudulent claims for services and then split the proceeds. The overall loss to VA is approximately \$499,000.
- **Nonveteran Pled Guilty to Theft of Government Funds:** A nonveteran pled guilty to theft of government funds following an OIG investigation that revealed he forged the certificate of release or discharge from active duty he submitted to VA, falsely claiming to have served in the U.S. Marine Corps during the Korean War and to have received the Purple Heart for being shot during a battle. The defendant received approximately \$219,700 in VA pension and healthcare benefits over a 12-year period, to include attending a residential VA Blind Rehabilitation program with limited admissions.

#### **GOAL 4. IDENTIFY WEAKNESSES IN LEADERSHIP AND GOVERNANCE**

*Address emergent, pervasive, and persistent problems within VA that have arisen or gone unremediated because of failures in leadership, including lack of accountability, poor governance, staffing deficits, and misconduct by individuals in positions of trust.*

The OIG has made VA leadership and governance issues a top priority, in recognition that weaknesses in these areas ultimately affect the care and services provided to veterans and allow significant problems

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<sup>16</sup> [Review of the VA's Reimbursements to the Treasury Judgment Fund](#), November 28, 2017.

<sup>17</sup> [Semiannual Report to Congress, Issue 80, April 1 – September 30, 2018](#).

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to persist unresolved for years. In all OIG work, staff focus on identifying the root causes of identified deficiencies or wrongdoing—including who is accountable.

Areas of review include violations of ethical standards and lack of policies and guidance, or nonadherence to them. The OIG also focuses on unstable, ineffective, or vacancies in leadership. Currently, there is an Acting Deputy Secretary and numerous acting leaders at the VHA Central Office, VISN, and VAMC levels. Vacancies in leadership positions present obstacles to changing the culture of a facility or organization. Many oversight authorities have commented that VA's culture needs to improve, but without permanent leadership and a functional governance structure, reforms cannot take hold.

- As mentioned earlier, the OIG March 2018 report on the Washington, DC, VA Medical Center detailed that many of the identified problems and disfunction could be attributed to the lack of effective leadership at multiple levels and an acceptance by many personnel that poor conditions will never change.<sup>18</sup> In the OIG's interim follow-up conducted at the same time as a Comprehensive Healthcare Inspection in May 2018, the facility was still without a permanent director and associate director, which likely contributed to the facility's modest transformation efforts.<sup>19</sup> A permanent director was hired and began working in October 2018.

In 2017, the OIG's VA medical center inspection program was revamped to include a stronger focus on leadership during the unannounced cyclical review. During these inspections for FYs 2017 and 2018, the OIG often found key leadership issues:

- At the Samuel S. Stratton VA Medical Center in Albany, New York, two of four executive leadership positions were filled by interim staff.<sup>20</sup>
- At the Roseburg VA Health Care System in Oregon, of four leadership positions, three were new to their positions and two of the four were in temporary positions during the OIG inspection.<sup>21</sup> Some members of the prior leadership team and multiple key senior managers exited suddenly amid internal and external concerns.
- The inspection of the Robley Rex VA Medical Center in Louisville, Kentucky, noted that an interim director was assigned in August 2018 after two other interim directors were in the

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<sup>18</sup> [Critical Deficiencies at the Washington DC VA Medical Center](#), March 7, 2018.

<sup>19</sup> [Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center](#), January 28, 2019.

<sup>20</sup> [Comprehensive Healthcare Inspection Program Review of the Samuel S. Stratton VA Medical Center, Albany, New York](#), March 29, 2018.

<sup>21</sup> [Comprehensive Healthcare Inspection Program Review of the Roseburg VA Health Care System, Oregon](#), September 17, 2018.

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position, which was vacated in February 2018.<sup>22</sup> The associate director position was filled in January 2018, but had five prior interim appointees since July 2017.

Governance structures continue to be a problem for carrying out VA programs and operations, as well as for promoting accountability. Deficiencies also often undermine effective reporting and information sharing:

- The OIG report, *Inadequate Governance of the VA Police Program at Medical Facilities*, illustrates such problems.<sup>23</sup> That report highlighted confusion about police program oversight roles and authority, as well as lack of a centralized management authority within VHA to manage and oversee the police deployed at VHA locations. According to VA policy, VHA leaders maintained primary responsibility for ensuring police program requirements are achieved. The Office of Security and Law Enforcement (OS&LE), a VA staff office outside VHA, had program oversight responsibilities limited to national policy development, inspections of compliance with particular standards, and training. OS&LE did not, however, have program authority to manage VA police operations at local facilities. In addition, OS&LE reported to the Assistant Secretary for Operations, Security, and Preparedness (OSP), however that position was eliminated and OSP was reassigned as of September 2018 to the Assistant Secretary for Human Resources and Administration.
- Leadership and governance issues were also significant factors in the OIG findings on a review of VA's Executive Protection Division (EPD).<sup>24</sup> The OIG received several allegations of mismanagement and misuse of the EPD, including ineffective procedures, scheduling and overtime abuses, pay administration issues, time card fraud, and various policy violations. The OIG substantiated VA's mismanagement of the EPD since at least 2015. There were no published operational policies or procedures on critical executive protection functions and a lack of adequate threat assessments. There were also security vulnerabilities caused by EPD staff, as well as financial abuses by agents who claimed to be performing official duties when they were not. In looking at how this misconduct persisted, VA commented that EPD personnel were going directly to the former VA Secretary and his staff to curtail reforms.
- Failures in leadership or governance are affected by the loss of agents of change at every level of VA and the overall lack of key personnel to carry out leaders' goals. The OIG has issued a series of reports on occupational staffing shortages within VHA that illustrate these concerns. In FY 2018, the OIG reported on both clinical and nonclinical shortages identified by VA medical

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<sup>22</sup> [Comprehensive Healthcare Inspection Program Review of the Robley Rex VA Medical Center, Louisville, Kentucky](#), December 19, 2018.

<sup>23</sup> [Inadequate Governance of the VA Police Program at Medical Facilities](#), December 13, 2018.

<sup>24</sup> [Mismanagement of the VA Executive Protection Division](#), January 17, 2019.

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facility directors.<sup>25</sup> Staffing is extremely complex—requiring hiring in anticipation of future losses, changes in clinical demand, staffing productivity, and staff allocations. The OIG recognizes that VHA has made progress in implementing staffing models in specific areas such as primary care and inpatient nursing, and has expanded the occupations covered by such models. However, VHA still lacks operational staffing models as recommended by the OIG that comprehensively cover critical occupations and can be tailored to local needs.

## **GOAL 5. IDENTIFY WAYS TO ENHANCE INFORMATION SYSTEMS AND INNOVATION**

*Assess and recommend enhancements to VA's infrastructure systems, including information technology, data security, and financial management that support VA operations. Through findings and report recommendations, highlight practices that promote quality standards that can be implemented throughout VA, particularly those that effectively use program planning, budget forecasting, and other predictive tools.*

VA Information Technology (IT) infrastructure is essential to its delivery of medical care and benefits to veterans. Secure IT systems and networks for safeguarding that information and supporting the range of VA mission-critical programs and operations is critical. It is concerning, therefore, that VA's financial management system does not comply with the *Federal Financial Management Improvement Act* or the *Federal Managers' Financial Integrity Act*.

Although VA has made progress producing, documenting, and distributing policies and procedures as part of its IT security program, VA continues to face hurdles implementing components of its agencywide information security risk management program to meet Federal Information Security Management Act requirements.<sup>26</sup> Significant deficiencies persist related to access, configuration management, and change management controls, as well as service continuity practices designed to protect mission-critical systems from unauthorized access, alteration, or destruction. VA must prioritize remediation of these deficiencies, as ongoing delays in implementing effective corrective actions may contribute to the continued reporting of an IT material weakness in VA's financial statements.

OIG teams that focus on healthcare and benefits programs and processes also report on limitations with information management systems and technology that have an impact on veterans and the most efficient use of appropriated funds. It is a common theme in OIG findings that data and other information system deficiencies contribute to systemic issues that must be corrected:

- For example, the OIG has recommended that VBA could add features to its Veterans Benefit Management System (VBMS) to help prevent the scheduling of needless reexaminations for veterans with disabilities (cases that meet the exemption criteria).<sup>27</sup> Specifically, VBMS could

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<sup>25</sup> [OIG Determination of Veterans Health Administration's Occupational Staffing Shortages, FY 2018](#), June 14, 2018.

<sup>26</sup> [Federal Information Security Modernization Act, Fiscal Year 2017](#), April 11, 2018.

<sup>27</sup> [Unwarranted Medical Reexaminations for Disability Benefits](#), July 17, 2018.



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program an alert if a claims processor tries to request a reexamination that meets exemption criteria. This would help prevent errors and provide immediate feedback to claims processing staff. As a result, veterans would not be subjected to unnecessary exams and VBA would save reexamination costs.

- It took more than two years after the implementation of the Intent to File (ITF) process (in which a claim date can be activated but information can be provided for up to a year) for VBA to update the computer software. VBMS contains Intent to File data, yet initially lacked the functionality to assist rating personnel when assigning effective dates for benefits based on these submissions.<sup>28</sup> Additional functionality upgrades within VBMS could further improve accuracy of assigning effective dates related to ITF submissions. The OIG recommended that VBA prioritize the design and implementation of system automation reasonably designed to minimize inaccuracies.

## HIGHLIGHTS OF UPCOMING OIG INITIATIVES

The OIG has a number of new initiatives for FY 2019 to increase oversight of VA. Among these efforts are the following:

- The Office of Special Reviews is examining issues related to allegations of senior employee misconduct, violations of ethical conduct, and operations and practices. Ongoing reviews include those of VA's Office of Accountability and Whistleblower Protection, community care financial tracking, and improprieties relating to procurement of leadership development contracts.
- The Office of Investigations has expanded a new Investigative Development Division to intensify its identification and investigation of complex fraud cases related to construction, acquisition/procurement, community care, and grants and education.
- The OIG is expanding its CHIP reviews to focus on VISN-level leadership in a more systematic way. These reviews will evaluate the stability of leadership positions within a VISN and their ability to support its medical facilities in reducing risks that could lead to quality of care issues and unfavorable experiences and outcomes. VISN inspections will begin in April 2019.
- Reviews are planned to assess the financial management and logistics processes within VAMCs to ensure VHA is implementing prudent financial practices and effectively managing its funds, programs, and resources. These financial reviews are intended to assist VHA in their efforts to identify potential high-risk issues/areas and mitigate the likelihood that those risks will occur. OIG staff will provide the VAMCs with recommendations designed to help improve operations and provide timely and quality care to veterans.

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<sup>28</sup> [Processing Inaccuracies Involving Veterans' Intent to File Submissions for Benefits](#), August 21, 2018.

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## **CONCLUSION**

The OIG is committed to serving veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, reviews, and investigations. All staff are focused on making meaningful recommendations that enhance VA's programs and operations as well as prevent and address fraud, waste, and abuse. We appreciate congressional support of OIG efforts through our appropriations and we remain committed to transparency by providing full and timely reports on our significant activities.

Madam Chair, this concludes my statement. I would be happy to answer any questions that you and other members of the Subcommittee may have.