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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
HEARING ON
"THE GOVERNMENT ACCOUNTABILITY OFFICE'S HIGH RISK LIST AND THE VETERANS HEALTH ADMINISTRATION"

MARCH 15, 2017

Mr. Chairman, Ranking Member Tester, and Members of the Committee, thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG) and how the OIG provides effective oversight of VA programs and operations through independent audits, inspections, and investigations. The OIG seeks to prevent and detect fraud, waste, and abuse, and make meaningful recommendations to drive economy, efficiency, and effectiveness throughout VA programs and operations. Our goal is to undertake impactful work that will assist VA in providing the appropriate and timely services and benefits that veterans so deservedly earned, and ensuring the proper expenditure of taxpayer funds. I am accompanied by John D. Daigh, Jr., M.D., CPA, Assistant Inspector General for Healthcare Inspections.

I have had the great privilege of serving as the Inspector General since May 2, 2016. Since that time, I have fully immersed myself in the work, priorities, and policies of the OIG. We have made a number of enhancements since I started, including issuing a Mission, Vision, and Values statement; increasing transparency; creating a Rapid Response team in our Healthcare Inspections directorate; expanding our data analytics capabilities; and being more proactive in our review areas. I believe that these changes, as well as other enhancements we will make, will enable us to do additional impactful work in a more timely manner.

The OIG shares an analogous mission with the Government Accountability Office (GAO). It is important that the VA OIG has a strong relationship with GAO to ensure that we avoid duplication of effort as much as possible. To that end, one of the first things I did when I started was to meet with Comptroller General Dodaro and some of his senior staff. Our offices have communicated regularly since that time to promote coordination and more effective oversight of VA.

In February 2015, GAO added Managing Risks and Improving VA Health Care to its biannual High Risk list. It focused its concerns in five broad areas:

- Ambiguous policies and inconsistent processes,
- Inadequate oversight and accountability,
- Information technology challenges,
- Inadequate training for VA staff, and
- Unclear resource needs and allocation priorities.

While our work is determined by what we believe is the most effective oversight of VA, a number of our reports address concerns in these same five areas. I will highlight a sampling of OIG work in each of the areas that resulted in GAO placing VA Health Care on its High Risk list. However, it should be noted that many of the OIG's reports could fit in more than one area.

Ambiguous Policies and Inconsistent Processes

We have issued a number of reports in the past few years that include VA's ambiguous policies and inconsistent processes. Our recent report[1] on wait time in one specific Veteran Integrated Service Network (VISN), we assessed the reliability of wait time data and timely access within VISN 6 which includes VHA facilities in North Carolina and Virginia. The objective of the audit was to determine whether VISN 6 facilities provided new patients timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 facilities appropriately managed consults. We reported that veterans who were authorized Choice care in VISN 6 did not consistently receive the authorized health care within 30 days as required by Health Net's contract with VA.

We reviewed a statistical sample of 389 Choice authorizations provided to Health Net by VISN 6 medical facility staff during the first quarter of Fiscal Year (FY) 2016. Based on our sample results, we estimated that for the approximately 34,200 veterans who were authorized Choice care in VISN 6, approximately 22,500 veterans who received Choice care waited an average of 84 days to get their care through Health Net providers. We estimated it took VA medical facility staff an average of 42 days to provide the authorization to Health Net to begin the Choice process and an additional 42 days for veterans to receive the medical service through Health Net providers. We identified delays related to authorizations for primary care, mental health care, and specialty care. VHA's Chief Business Officer addressed a potential cause for delay in creating appointments by executing a contract modification effective November 1, 2015. This change allowed Health Net to initiate phone contact with a veteran to arrange a Choice appointment, rather than require the veteran to contact Health Net as previous required. Our analysis showed that, while still untimely, this change lowered the percentage of veterans who waited more than 5 days for Health Net to create an appointment from 86 percent to 69 percent.

The Under Secretary for Health concurred with our 10 recommendations and provided a responsive action plan and milestones to address the recommendations regarding monitoring controls over scheduling requirements, wait time data, and access to health care and consult management. Our recommendations will help ensure staff use clinically indicated and preferred appointment dates consistently, medical facilities conduct required scheduler audits, and staffing resources are adequate to ensure timely access to health care. The report's recommendations remain open.

Another example, in September 2015, we reported in *Review of Alleged Mismanagement at the Health Eligibility Center* that VA's Chief Business Office (CBO)

[1] *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6*, March 2, 2017

had not effectively managed its business processes to ensure the consistent creation and maintenance of essential health care eligibility data. Due to the amount and age of the Enrollment System (ES) data, as well as lead times required to develop and implement software solutions, a multiyear project management plan was needed to address the accuracy of pending ES records and improve the usefulness of ES data. We offered 13 recommendations in the report including one focused on controls to ensure that future enrollment data are accurate and reliable before being entered into the Enrollment System. VA concurred with the recommendations and provided sufficient information to close all recommendations in October 2016. We have an ongoing review of the Health Eligibility Center focusing on the alleged lack of effective governance over the Veterans Health Administration's (VHA) execution of the health care enrollment program at its medical facilities. We expect to issue our report in late spring 2017.

Another program that operates nationwide also had issues related to inconsistent implementation of policies is the Homeless Grant Per Diem Program. In a June 2015 report, *Audit of Homeless Providers Grant and Per Diem Case Management Oversight*, we determined VA needed to clarify eligibility requirements across the program to ensure that all homeless veterans have equal access to case management services. Historically, homeless veterans ineligible for VA health care have not been excluded from the program. However, we questioned the application of the program's eligibility criteria, and found the criteria were unclear and inconsistently applied. This was confirmed in our interviews of VA's Office of General Counsel, program directors, network homeless coordinators, and liaisons, which revealed confusion occurred at all program levels. We made five recommendations, three of which involved establishing a definitive legal standard on program eligibility and ensuring that policies and controls matched that standard and were applied across the program. The recommendations dealing with policies and controls remain open.

Inadequate Oversight and Accountability

Proper oversight by management ensures that programs and operations would work effectively and efficiently. Our September 2016 report, *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System*, on the management of the construction of a new VA medical center in the Denver area, is an extremely costly example of the result of inadequate oversight. We confirmed the project to build a new medical center in the Denver area has experienced significant and unnecessary cost overruns and schedule slippages. Originally estimated for 2013 completion, it will not be ready before mid-to-late 2018, about 20 years after its need was identified.

Through all phases of the project, we identified various factors that significantly contributed to delays and rising costs, including:

- Inadequate planning and design,
- Initiation of the construction phase without adequate design plans,
- Changing the acquisition strategy mid-stream, and
- Untimely change request processing.

This occurred due to a series of questionable business decisions and mismanagement by VA senior officials. The report summarizes the significant management decisions and factors that resulted in a project years behind schedule and costing more than twice the initial budget of $800 million. We made five recommendations and VA management concurred with all recommendations. We recently requested information from VA on the implementation status of the recommendations and will keep them open until VA provides satisfactory evidence of implementation.

In June 2016, we issued a report on allegations related to appointment cancellations at the Houston VA Medical Center, titled *Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas*. We substantiated that two previous scheduling supervisors and a current director of two outpatient clinics instructed staff to input clinic cancellations incorrectly as canceled by the patient. We also confirmed that a current director of two CBOCs instructed staff, as recently as February 2016, to record an appointment as canceled by the patient if clinic staff at one CBOC offered to reschedule a veteran's appointment at a different CBOC situated about 17 miles away and the veteran declined the appointment. The CBOC Director noted this was appropriate since the CBOC was still offering the patient an appointment. However, when interviewed regarding these cancellations, the CBOC Director acknowledged she instructed staff to cancel appointments by the patient if the veteran declined an appointment in the alternate location. We made six recommendations, including referring the matter to VA's Office of Accountability Review (OAR), to determine what, if any, administrative actions should be taken based on the factual circumstances developed in our report.

In December 2014, we released an audit related to VA's National Call Center for homeless veterans, titled *Audit of The National Call Center for Homeless Veterans*. We reported that homeless and at-risk veterans who contacted the Call Center often experienced problems accessing a counselor and/or receiving a referral after completing the Call Center's intake process. We reported:

- Veterans could leave a message on an answering machine only 27 percent of the time period reviewed,
- Veteran messages were not referred to VA medical facilities due to inaudible messages or no contact information in 16 percent of the time period reviewed,
- Veterans were not referred to VA medical facilities despite providing all the necessary information in 4 percent of the time period we reviewed.

Moreover, the Call Center closed approximately 47 percent of referrals even though the VA medical facilities had not provided the Homeless veterans any support services. These missed opportunities occurred due to lapses in the Call Center's management and oversight. We made seven recommendations, including implementing effective performance metrics to ensure homeless veterans receive needed services. We closed our report in September 2015 based on information received that all recommendations had been implemented.

Information Technology Challenges

As we reported in our list of VA's Major Management Challenges within VA's Annual Financial Report, we have frequently identified VA's struggles to design, procure, and/or implement functional information technology (IT) systems. IT security is continually reported as a material weakness in the Consolidated Financial Statement audits that are conducted annually by the OIG's independent auditing firm, CliftonLarsonAllen (CLA).

VA has a high number of legacy systems needing replacement including the Financial Management System; Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system; Veterans Health Information Systems and Technology Architecture, and the Benefits Delivery Network; After years of effort focused on replacement of VA's legacy scheduling software, a new scheduling system is still not in place. VA's issues with scheduling appointments are related to the inability to define its requirements and determine if a commercial solution is available or if it must design a system. Replacing systems has been a major challenge across the government and is not unique to VA. We have issued a number of reports outlining access issues and our work in this area is continuing.

While the difficulties between VA's electronic health record (EHR) and the Department of Defense's EHR are well documented, the increased utilization of care in the community will present further IT challenges. To ensure that medical providers both inside and outside VA have the most complete and up-to-date information, VA needs to find a more effective method for sharing patients' EHRs. We reported on the possibility of delays in care because of the difficulties in sharing medical records in the Urology Clinic at the Phoenix VA Health Care System in our October 2015 report, titled *Healthcare Inspection, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona*. Specifically, we identified approved authorizations for non-VA care coordination (NVCC) urological care and a notation that an authorization was sent to the non-VA provider. A scheduled date and time of an appointment with the non-VA urologist was often documented. However, we were unable to locate scanned documents from non-VA providers in these patients' EHRs verifying that the patients had been seen for evaluations, and if seen, what the evaluations might have revealed. This finding suggested that the Phoenix VA Health Care System (PVAHCS) did not have accurate data on the clinical status of the patients who were referred for the specialty care.

Further, with respect to scanning and reviewing outside clinical documents (for example, clinic notes, labs, or imaging results), when the services were provided by

TriWest Health Care Alliance (TriWest), the treating providers' office submitted this data to the TriWest Portal. To access that information, an NVCC staff member was required to log into the TriWest Portal to print and scan these records into the patients EHRs. This process was delayed because of the NVCC staffing shortages, which could have resulted in important clinical information not being reviewed for several months. We made three recommendations, including one specifically related to ensuring that non-VA care providers' clinical documentation is available in the EHRs in a timely manner for PVAHCS providers to review. We closed our report in June 2016 after VA provided information that addressed the recommendations.

In the area of IT security, VA uses personally identifiable information (PII), protected health information (PHI), and other sensitive information to deliver benefits to veterans and their dependents. Employees and contractors must safeguard this information. As we reported in our September 2015 report, *Review of Alleged Data Sharing Violations at VA's Palo Alto Health Care System*, the VA Palo Alto Health Care System (VAPAHCS) did not ensure that contract staff had the appropriate background investigations or proper security and privacy awareness training before being granted access to VA patient information. Additionally, facility Information Security Officers were not involved prior to the contractor placing its software on a VA server. We made three recommendations to VAPAHCS management and a fourth recommendation that VA's Office of Information Technology implement controls to ensure that unauthorized software is not procured or installed on VA networks without a formal risk assessment and approval to operate. We closed our report based on information provided that the recommendations were implemented.

Inadequate Training for VA Staff

One prevailing theme of the OIG's work related to wait times and scheduling issues was the inadequate, lack of, or incorrect training provided to VA staff responsible for scheduling appointments. We conducted extensive work related to allegations of wait time manipulation through FY 2015 and FY 2016 after the allegations at the PVAHCS surfaced in April 2014. As we have reported in more than 90 Administrative Summaries of Investigation and other reports that have been issued, the lack of training for schedulers and the lack of understanding of the process by their managers created a system in which long wait times were not accurately portrayed to management.

In October 2016, we reported again that some confusion persists regarding appointments. The focus for this report was on consult management. In our report, *Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System*, we substantiated that in 2015, PVAHCS staff inappropriately discontinued consults. We determined that staff inappropriately discontinued 24 percent of specialty care consults we reviewed. This occurred because staff were generally unclear about specific consult management procedures, and services varied in their procedures and consult management responsibilities. As a result, patients did not receive the requested care or they encountered delays in care. This report offered 14 recommendations including ensuring that staff are hired and trained appropriately. We are tracking VA's progress on implementing all the recommendations.

In January 2016, we determined that VHA did not provide medical facilities with adequate tools to reasonably estimate non-VA care (NVC) obligations in our report, *Audit of Non-VA Medical Care Obligations*. The facilities we visited used a combination of methods that were ineffective at ensuring NVC cost estimates were reasonable. The methods used to calculate estimated costs included Medicare or contract rates, historical costs, and the optional cost estimation tools provided by CBO. The accuracy of estimates varied widely among these methodologies. We made five recommendations including for VA to improve the cost estimate tools so that NVC cost estimates are produced consistently. The recommendations related to cost estimate tools remain open.

Unclear Resource Needs and Allocations Priorities

In March 2017, we published *Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, MT*. We assessed the extent that patients experienced delays in obtaining consults, and the impact of any delays on patient outcomes. We reported that, for system consults ordered through VA Montana Healthcare System in FY 2015, there were apparent delays[2] for:

- 11,073 of 26,293 patients (42 percent) with at least one in-house consult;
- 11,863 of 21,221 patients (56 percent) with at least one non-VA care consult; and
- 2,683 of 4,427 patients (61 percent) with at least one Choice consult.

We found that delays among consults ordered in FY 2015 may have harmed four patients. Beginning in July 2015, system leadership initiated a focused effort to identify and resolve factors that contributed to consult delays, including hiring additional support staff to process consults. Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). We also noted that system leadership initiated ongoing reviews to determine if patient harm occurred due to delays in care.

We made two recommendations to the VA Montana Director to ensure that an external (non-system) source review the care of patients we identified who were potentially harmed by consult delays and that VA staff provide institutional disclosures, as appropriate. We also made a recommendation regarding ongoing efforts to improve consult timeliness. The VA Montana Director and the VISN 19 Director concurred with our three recommendations and provided a responsive action plan and milestones to address the recommendations.

The OIG has repeatedly reported on VA's legacy systems and how they impair VA operations. A key element to accurate planning is a financial system that provides timely information to VA leadership. As was reported in *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015*, VA's complex, disjointed, and legacy financial management system architecture continues to deteriorate over time and no longer meets the increasingly stringent and demanding financial management and

[2] We considered delayed consults to be those that were not completed, canceled or discontinued within the expected timeframe.

reporting requirements mandated by the Department of the Treasury and the Office of Management Budget. VA continues to be challenged in its efforts to apply consistent and proactive enforcement of established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems. VA announced in October 2016 that it selected the Department of Agriculture as its Federal shared service provider to deliver a modern financial management solution to replace its existing core financial management system. When completed, this will be a major and critical effort for VA in modernizing its system architecture for financial management.

The audit of VA's FY 2016 Consolidated Financial Statements also identified Community Care obligations, reconciliations, and accrued expenses as a material weakness. Lack of tools to estimate non-VA Care costs, lack of controls to ensure timely deobligations, and the difficulty in reconciling non-VA Care authorizations to obligations in VA's Financial Management System, make the accurate and timely management of purchased care funds challenging. In addition, the Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities were not integrated with VA and VHA Chief Financial Officer (CFO) responsibilities under Public Law (P.L.) 101-576, the *Chief Financial Officers Act of 1990*, to develop and maintain integrated accounting and financial management systems and provide policy guidance and oversight of all Community Care financial management personnel, activities, and operations.

To address the difficulties in estimating costs, VA requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone—i.e., obligating funds at the time of payment—would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls to monitor accounting, reconciliation, and management information processes to ensure they effectively manage funds appropriated by Congress.

VA needs to accurately forecast the demand for health care services in both the near term and the long term. The OIG is required by Section 301 of P.L. 113-146, the *Veterans Access, Choice, and Accountability Act of 2014,* to review VHA occupations with the largest staffing shortages. We have issued three reports at this time and under the statute we will report for another two years. In our most recent report issued in September 2016,[3] we identified (i) medical officer; (ii) nurse; (iii) psychologist; (iv) physician assistant; and (v) physical therapist/medical technician as five critical occupations with the largest staffing shortages. In our initial review[4] and our

[3] https://www.va.gov/oig/pubs/VAOIG-16-00351-453.pdf, September 28, 2016
[4] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, January 30, 2015

subsequent reviews[5], we continue to recommend VHA create a staffing model that considers demand and complexity, and matches that to budget requests and allocations. While VHA has continually concurred with the recommendation, their planned completion date is September 2017. Further delay will potentially result in missed opportunities to request appropriate funding when planning for the FY 2019 budget.

CONCLUSION

The OIG is committed to providing effective oversight of the programs and operations of VA. A number of our reports address the five broad areas noted by GAO in placing VA Health Care on its High Risk list. We will continue to produce reports that provide VA, Congress, and the public with recommendations that we believe will help VA operate its programs and services in a manner that will effectively and timely deliver services and benefits to veterans and spend taxpayer money appropriately.

Mr. Chairman, this concludes my statement and we would be happy to answer any questions that you or other Members of the Committee may have.

[5] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages,* September 1, 2015