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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
HEARING ON
"GAO'S HIGH RISK LIST AND THE VETERANS HEALTH ADMINISTRATION"

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Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) health care reviews and audits of programs and performance of the Veterans' Health Administration (VHA). I am accompanied by Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations, Office of Inspector General.

VHA is at risk of not performing its mission as the result of several intersecting factors. VHA has several missions, and too often management decisions compromise the most important mission of providing veterans with quality health care. Leadership has too often compromised national VHA standards to meet short term goals. The Veterans Integrated Service Networks (VISN) do not consistently support local VA Medical Centers (VAMC) to encourage success and proactively address areas of risk. Resource management data gaps make the cost-effective delivery of a national benefit challenging. VHA's internal processes are inefficient and make the conduct of routine business unnecessarily burdensome.

Primary Mission Is Quality Health Care

VHA has many missions, the first of which should be the delivery of high quality health care. The first test of a management decision should be an assessment of its impact upon the delivery of quality health care. For example, veterans who receive their medical care through the VA need timely access to emergency care. The management of a possible myocardial infarction, stroke, or appendicitis requires not only a sophisticated emergency room and readily available imaging, but hospital specialty treatment rooms and dedicated teams to provide timely critical care. Many smaller hospitals cannot provide timely expert care for patients with these conditions. VHA's decision to operate an emergency room or urgent care center should have the quality delivery of this care as its most important standard. Arguments that veterans prefer to receive their care at VA or that this care creates contracting difficulties are secondary to the imperative that high quality care be provided. All medical care provided at each facility should be considered against this test.

VHA Leaders Must Set High Standards and Support Subordinates

The many OIG reports on the Phoenix VA Health Care System and problems with the VA appointment system highlight the challenges leaders must overcome if quality health care is to be provided.

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 they or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while 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 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 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. As of March 3, 2015, 18 recommendations from these reports remain open. In response to our work, VA reported it took immediate action to ensure that 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 access issues, led to changes in the highest level of VA leadership, and enactment of the *Veterans Access, Choice, and*

[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.

Accountability Act of 2014 (also known as *The Choice Act*), which expanded veterans' access to care outside the VA system and included a $16 billion increase in VA's funding.

The most recent reports issued by the OIG's Office of Healthcare Inspections were the results of information received during the work conducted at the PVAHCS during the spring and summer of 2014. Our January 28, 2015, interim report on PVAHCS's Urology Services requires VA's immediate attention. 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 non-VA urologists 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.

VHA Organizational Entities Must Be More Effective

The current VISN structure has not worked effectively to support and solve problems facing hospitals. A VISN contains medical facilities of varying size and capability. For example, one requirement for all medical facilities is that their providers be properly credentialed and privileged. One aspect of privileging providers is the presentation of physician performance data to the hospital privileging committee. In a forthcoming report on solo physicians' professional practice evaluations, we found that in hospitals where there are specialty units with small numbers of providers, it is difficult to obtain unbiased peer reviews of clinical cases and appropriate assessments of clinical performance by peers. The VISN structure has been inconsistently effective in addressing this issue.

Each VISN has a different internal organization and each medical facility has a different internal structure. This lack of standardization makes the dissemination of information and policy to facilities challenging and the acquisition of critical data from facilities more difficult. When we tested facility compliance with directives regarding the proper treatment of reusable medical equipment, we found significant non-compliance with initial policy statements.[2] When we looked at VA data on compliance with instructions to address shortcomings in the consult management process, there was wide variance across the VISNs in compliance with instructions.[3]

Resource Management

VHA's budget and execution data across the system does not permit ready analysis at the Department or clinic level across VHA. The cost of providers and support staff is

[2] *Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities*, June 16, 2009; *Follow-Up Colonoscope Reprocessing at VA Medical Facilities*, September 17, 2009.

[3] *Healthcare Inspection – Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet,* December 15, 2014.

often a relevant cost in health care financial analysis. VHA does not have an adequate system to build the human requirements to provide health care appropriate for financial analysis. In recognition of this issue, Congress passed *The Choice Act* which requires the OIG for the next 5 years to report on the staffing needs of VHA and to audit the accuracy and timeliness of payments made under this law within 30 days after VHA has spent 75 percent of the $9.7 billion in funding authorized for patient care. Our first report was issued on January 30, 2015, in which we noted that the five occupations with the largest staffing shortages were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist.[4] The data presented is VHA's "wish" list for talent, not a requirement driven list. The requirement for VHA to develop a staffing methodology is not new. OIG assessed whether VHA has an effective methodology for determining physician staffing levels for 33 of VHA's specialty care services.[5] Audits and inspections continue to identify the need for VHA to improve its staffing methodology by implementing productivity standards. Public law mandates VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. We found VHA did not have an effective staffing methodology to ensure appropriate staffing levels for specialty care services. Specifically, VHA did not establish productivity standards for all specialties and VA medical facility management did not develop staffing plans. This occurred because there is a lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing medical facility staffing plans. Other essential personnel in a hospital, to include pharmacists, dieticians, physical therapists, also do not have staffing standards.

Each VISN and hospital has its own unique organizational chart. The combination of a lack of a robust capability to determine requirements and a lack of organizational standardization impedes the ability of managers to make effective financial decisions.

Operational Efficiency Must Improve

A number of VHA's internal operations and systems, which should be seamless to providers, do not function well. The appointment system inefficiencies have contributed to wait time problems. Medical consultation software was permitted to devolve such that information within the system was not standard and in many cases not reliable. This has resulted in patients who were lost to appropriate colon cancer screening. The process of hiring a new employee is extremely cumbersome and is but one element of the human resources management program that must improve. The work-arounds and lost productivity attributed to these "systems" makes the delivery of quality care much more difficult.

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. In addition to coordinating care for patients outside the VA system, VA also has to ensure that payments are made timely and accurately and

[4] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages,* January 30, 2015.

[5] *Audit of Physician Staffing Levels for Specialty Care Services*, December 27, 2012.

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.[6]

Non-VA Care

Non-VA medical care is care provided to eligible veterans outside of VA when VA facilities are not feasibly available. It consists of two major programs, Non-VA Care Inpatient and Outpatient programs and Patient-Centered Community Care (PC3).

The OIG has continued to report that VHA faces significant challenges to address serious nationwide weaknesses in its Non-VA Care Inpatient and Outpatient programs. Total annual Non-VA Care Program disbursements have grown from about $4.4 billion in fiscal year (FY) 2009 to about $5.6 billion in FY 2014.

As early as 2009, we reported that VHA improperly paid 37 percent of outpatient fee claims resulting in $225 million in overpayments and $52 million in underpayments. We estimated $1.1 billion in overpayments and $260 million in underpayments over the next 5-year period if VHA did not strengthen its processes for authorizing fee care services. In FY 2010, we reported that VHA improperly paid 28 percent of inpatient fee claims resulting in net overpayments of $120 million and estimated $600 million in improper payments could be processed over the next 5-year period.

In response to our August 2010 audit of Non-VA Inpatient Fee Care Program, VHA agreed there will be general cost savings and efficiencies realized with consolidating the fee program's claims processing system to achieve better economies of scale. Although specific cost savings depend on the actual consolidated strategy VA selects and on how well VA implements the chosen strategy, we conservatively estimated that current program inefficiencies cost VHA about $26.8 million in FY 2009, and could cost about $134 million through FY 2015. Today, we do not see VHA moving forward with an actual consolidation strategy for payment processing in the fee care program.

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

[6] *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.

established the PC3 contracts to provide veterans timely access to high-quality care from a comprehensive network of non-VA community providers.

This week we plan to publish the first of 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 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 the remaining four reports in FY 2015.

The report published this week was requested by the House Appropriations Committee to review VA's FY 2014 PC3 costs and VA's FY 2014 budget submission that stated PC3 contracts would save $13 million in FY 2014. Our analysis of available PC3 data determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate in FY 2014. VA paid the PC3 contractors approximately $18.9 million in FY 2014:

- $15.1 million (80 percent) for implementation and administrative fees
- $3.8 million (20 percent) for health care services

These same health care services would have cost about $4.0 million if they had been purchased under the non-VA care program. Thus, PC3 cost about $14.9 million more than if VA had used the non-VA care program to purchase the same health care services. This occurred because VA did not conduct adequate price analyses to support its cost-savings estimate. Further, VA lacked an implementation plan to ensure the utilization of PC3. Thus, VA could not ensure it achieved the estimated cost savings and recouped the fees paid to the PC3 contractors. VA simply assumed that the PC3 contractors would develop adequate provider networks; VA medical facilities would achieve the desired 25 to 50 percent contract utilization rates; and the accrued PC3 cost savings for health care services would more than offset the contractors' fees. These flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent utilization rate in FY 2014.

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*, 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.[7] Patients prescribed opioids frequently have

[7] *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*

complex co-morbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications even leading to death. These patients remain a high risk population.

VHA's Homeless Program

In FY 2015 we reported that VHA missed 40,500 opportunities where the National Call Center for Homeless Veterans 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 assessed 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. 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.

VA Procurement Practices

We have continually reported in VA's Performance and Accountability Report the challenges VA faces in the area of procurement, to include planning, solicitation, negotiation, award, and administration. Many of our reports have identified weaknesses in procurement actions that did not provide assurance that VHA obtained fair and reasonable prices or that competition requirements were met.[9] Today VHA still needs a modern inventory system. In FY 2012, we reported VHA needs to strengthen VAMC management of prosthetic supply inventories to avoid spending funds on excess supplies and to minimize risks related to supply shortages. VAMCs spent about $35.5 million to buy prosthetic supplies in excess of current needs. Also, VAMCs increased the risks of supply expiration and disruptions to patient care due to supply shortages.[10] We recommended VHA implement a modern inventory system and strengthen management of prosthetic supply inventories. As an interim measure to address

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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.

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

[9] *Audit of VHA's Support Service Contracts*, November 19, 2014; *Audit of VHA Acquisition and Management of Prosthetic Limbs*, March 30, 2012.

[10] *Audit of VHA's Prosthetics Supply Inventory Management,* March 30, 2012.

recommendation from our 2012 report, VHA implemented system patches while a new system is in development.

In FY 2012, the Office of Management and Budget stated Government spending for support service functions quadrupled over the past decade. Previous OIG audits identified recurring systemic deficiencies in virtually all phases of VHA's contracting processes. In our November 2014 audit report, we noted that VHA's support service contract costs increased 60 percent from approximately $503 million for about 5,100 contracts in FY 2012 to just over $805 million for about 4,700 support service contracts in FY 2014. VHA did not have effective internal controls or follow existing controls to ensure adequate development, award, monitoring, and documentation of support service contracts. The contract deficiencies included insufficient documentation of key contract development and award decisions, assurance that paid invoice amounts were correct and funds were de-obligated following the contract completion, and a complete history of contract actions in VA's mandatory Electronic Contract Management System.

During FYs 2012 and 2013, we estimated VA made about 15,600 potential unauthorized commitments valued at approximately $85.6 million, which require ratification actions. Unauthorized commitments are agreements that are not binding solely because the Government representative who made them lacked the authority to enter into that agreement on behalf of the Government. Unauthorized commitments include commitments made by individuals who do not have valid warrants or exceed the limitations of their warrant authority. The significant number of unauthorized commitments we identified exemplifies persistent weaknesses in VA procurement practices and especially using purchase cards. Further, the practice of institutional ratifications does not hold individuals accountable for this serious offense.

VA Construction Program

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.[11] 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.[12] 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 facility maintenance backlog.

In FY 2013 we reported VHA did not adequately review individual projects to ensure proper use of minor construction funds.[13] Specifically, VA medical facilities integrated

[11] *Review of VA's Management of Health Care Center Leases*, October 22, 2013.
[12] *Audit of Non-Recurring Maintenance Program*, May 7, 2014.
[13] *Review of Minor Construction Program*, December 17, 2012.

design and construction work for 7 of 30 minor construction projects into 3 combined projects that exceeded the $10 million minor construction spending limit. This occurred because VHA did not effectively oversee project execution after funding was distributed to individual project accounts. As a result, VHA violated the Antideficiency Act by integrating design and construction work for five minor construction projects into two combined projects by exceeding the $10 million minor construction threshold. VHA would have likely committed a third Antideficiency Act violation if we had not identified two other minor construction projects that integrated design and construction work into a single contract solicitation, which VHA suspended while in the award process.

Information Technology Management

VA launched the Project Management Accountability System (PMAS) in June 2009. We followed-up to assess whether the Office of Information and Technology (OIT) took effective actions to address recommendations we made to strengthen PMAS in two prior audit reports.[14] We reported in 2015 that OIT has taken steps to improve PMAS, but more than 5 years after its launch, OIT has not fully infused PMAS with the discipline and accountability necessary for effective oversight of IT development projects. Two OIT offices did not adequately perform planning and compliance reviews. The PMAS Business Office (PBO) still had Federal employee vacancies and the PMAS Dashboard lacked a complete audit trail of baseline data. Project managers continued to struggle with capturing increment costs and project teams were not reporting costs related to enhancements on the PMAS Dashboard.

These conditions occurred because OIT did not provide adequate oversight to ensure our prior recommendations were sufficiently addressed and that controls were operating as intended. OIT also did not adequately define enhancements in the PMAS Guide. As a result, VA's portfolio of IT development projects was potentially being managed at an unnecessarily high risk.

Since approximately 2000, VA has made a number of unsuccessful efforts to replace VHA's Veterans Health Information Systems and Technology Architecture. VA canceled the Replacement Scheduling Application (RSA) project.[15] A March 2009 memo from the Under Secretary for Health to the Acting Assistant Secretary for Information and Technology stated that the RSA project had not developed a single scheduling capability it could provide to the field nor was there any expectation of delivering a capability in the near future. The memo also stated that after more than 5 years and a cost of more than $75 million, the RSA failed to deliver a useable product because of ineffective planning and oversight.

We reported that because the RSA project lacked defined requirements, an information technology architecture, and a properly executed acquisition plan, RSA was at

[14] *Follow-Up Audit of the Information Technology Project Management Accountability System*, January 22, 2015; *Audit of the Project Management and Accountability System Implementation*, August 29, 2011.

[15] *Review of the Award and Administration of Task Orders Issued by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, August 26, 2009

significant risk of failure from the start. We suggested that VA needed experienced personnel to plan and manage the development and implementation of complex information technology projects effectively. We also suggested that a system to monitor and identify problems affecting the progress of projects could support VA's leadership in making effective and timely decisions to either redirect or terminate troubled projects. Since the cancelation of the RSA project, VA has continued to seek solutions to replace its current scheduling system.

In another OIG audit we assessed OIT's management of VHA's Pharmacy Reengineering program (PRE), and reported that OIT needed stronger accountability over cost, schedule, and scope.[16] We also reviewed 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).[17] 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. By using MS&C appropriations, VHA avoided competing with other VA projects for IT appropriations.

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.[18] 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 2014 consolidated financial statement audit, CliftonLarsonAllen LLP concluded a material weakness still exists in VA's information security program.

[16] *Audit of Pharmacy Reengineering Software Development Project*, December 23, 2013.
[17] *Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System*, March 2, 2015.
[18] *VA's Federal Information Security Management Act Audit for Fiscal Year 2013*, May 29, 2014.

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.

Criminal Activity

Threats and Assaults - Since October 1, 2013, we conducted more than 1,000 preliminary inquiries and full investigations relating to threats made against or by VA employees and against facilities resulting in 44 arrests and/or involuntary commitments. Although most threat-related investigations do not result in judicial action, we take all threats 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.

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.

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, a former VA contracting officer in Palo Alto, California, VAMC, was convicted 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.

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 non-VA fee care and overseas medical care programs. One of our investigations, resulted in the conviction of a Department of Defense 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.

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 supporting VHA healthcare delivery requirements. 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.

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.

Conclusion

The issues confronting VHA 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.

Mr. Chairman and Members of the Committee, Mr. Abe and I will be pleased to answer your questions.