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VETERANS AFFAIRS, AND RELATED AGENCIES
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Mr. Chairman, Ranking Member Wasserman Schultz, and Members of the Subcommittee, thank you for the opportunity to discuss the oversight the Office of Inspector General (OIG) provides to VA programs and operations. I have had the great honor and privilege of serving as the VA Inspector General since May 2016, and today is my first opportunity to testify before this Subcommittee. My statement will focus on the OIG's mission, some of the more significant enhancements we have recently made and our more meaningful oversight work that we reported on during the past fiscal year. I would first like to take this opportunity to thank the Congress for the increase to our fiscal year (FY) 2017 appropriation. Our FY 2017 appropriation of $159.6 million will greatly assist our ability to fulfill our mission of effective oversight of the programs and operations of VA in the face of the tremendous challenges and expanded growth of many mission critical programs in VA.

Although I did not come into the role of the VA IG with any preconceived notions of specific changes to make, I stated to the staff on my first day that we will always strictly adhere to the following three principles. First, we must maintain our independence and make sure that we do not even have the appearance of any impairment to our independence. Second, we must be fully transparent by promptly releasing reports of our work that are not otherwise prohibited from disclosure. Third, we must maintain the highest integrity of our work. This means that each of our reports must meet at least the following five standards: (i) they must be accurate; (ii) they must be timely; (iii) they must be fair; (iv) they must be objective; and (v) they must be thorough.

I wanted to learn as much as possible, in as short a time period as possible, about the OIG office, the Department and stakeholders. Since I began, I have visited 16 of my offices across the country, as well as a number of VA Medical Centers and Regional Offices. As part of my transition as IG, I also met with all of the senior leaders of VA, with the Comptroller General of the United States, with the Special Counsel of the United States, with members of Congress and their staff, and with the leadership of a number of VSOs. All of these meetings were productive and informative.

MISSION, VISION, AND VALUES

One of the first areas where I felt the OIG could improve was to restate our mission statement and articulate our vision and values. To this end, we published a Mission, Vision, and Values statement in September 2016, which is included at the end of the statement, and is available on our public website.[1] I have emphasized to my staff that we will strictly adhere to all tenets of our Mission, Vision, and Values statement and that it will be the guiding principle for all of the work we do going forward. Briefly, let me explain the more significant aspects of our mission, vision, and values.

Mission. Independent oversight is the core of every OIG's mission. We conduct effective oversight of VA programs and operations through independent audits, reviews, inspections, and investigations. Our work and recommendations identify opportunities to drive economy, efficiency, effectiveness, and integrity throughout VA programs and operations. Our ultimate goal is to help VA deliver quality and timely healthcare and benefits to our nation's veterans and their families, and to spend taxpayer money as appropriated.

Vision. With respect to our vision, which is how we accomplish our mission, there are a few items I would like to highlight. First, we are proactive in identifying potential issues. While we have more referrals than we can take, we also work on matters that we identify through proactive measures. We have a data analytics group and do other testing and analysis that identifies areas for us to inspect, audit or investigate. Second, most of our reports include meaningful recommendations that drive economy, efficiency, and effectiveness throughout VA programs and operations. Although we do not have authority to implement changes, we keep track of our open recommendations and the ones that are more than a year old are included in our Semi-Annual reports to the Secretary and Congress. Third, we promote accountability of VA employees if they fail to perform as expected. Individual accountability is something that we feel strongly about if it is deserved. Fourth, we treat whistleblowers and others who provide us with information with respect and dignity, and protect their identity if they desire. We rely heavily on information provided by whistleblowers, veterans, VA employees and others. We need to treat people who provide us information with the proper courtesies to encourage them and others to provide us with information.

Values. We also established values that govern how we conduct ourselves professionally. Among other values, we are going to meet the highest standards of professionalism, character, ethics and integrity. We know that we judge how other people act. Therefore, we need to act beyond reproach for us to have the necessary credibility. Moreover, we look to continually improve our performance. I am a strong believer that the most effective organizations are those that recognize and embrace the need for continuous self-examination, change and improvement. We will accomplish this through investing in our workforce and reflecting on lessons learned to determine how we can improve so that we can do even better the next time.

[1] See https://www.va.gov/oig/about/vaoig-mission-vision-values.pdf.

OPERATIONAL ENHANCEMENTS

In the past 10 months, we have made, or are in the process of implementing, a number of other enhancements to the OIG's operation. Several of these initiatives represent concerted efforts by the OIG to focus on high-risk areas throughout VA with the goal of being more proactive in our oversight. I believe that these changes will enable us to perform more impactful work in a timelier manner.

Rapid Response Team. We established a Rapid Response Team to more consistently and timely respond to the highest-risk clinical allegations we receive concerning Veterans Health Administration (VHA) facilities or programs.

Access to Care Division. We also established an Access to Care Division that will conduct focused oversight audits and reviews designed to evaluate wait times and other barriers to receiving care in VHA.

Comprehensive Healthcare Inspection Program (CHIP). We have enhanced our healthcare inspection program, formerly known as the Combined Assessment Program (CAP), to make it more extensive and risk-based. Among other changes, we are placing greater attention on the effectiveness of leadership of individual medical centers and presenting a narrative of our findings.

Construction Oversight. We are in the process of establishing a division that will provide much needed oversight of VA's major construction projects.

Expanded Data Analytics and Proactive Measures. We have established a Data Analytics Council, which will collaborate across OIG directorates to leverage existing VA data sources to strategically identify impactful and proactive oversight initiatives, particularly in high-risk procurement and information technology (IT) programs and operations.

Coordination with Other Government Entities. We have increased our interactions with the Government Accountability Office and the Office of Special Counsel to ensure coordination and transparency of work.

FISCAL OUTLOOK

VA is the second largest Federal employer, operating the Nation's largest integrated health care system. For FY 2017, VA is operating under a $180 billion budget, with over 378,000 employees serving an estimated 21.3 million living veterans. More than 9 million veterans are actively enrolled in the VA health care system and almost 4.5 million veterans receive disability compensation.[2]

The VA OIG is a relatively small office compared to other Federal OIGs as a percentage of both the agency's full-time equivalent staffing and budget. The OIG is comprised of approximately 725 full-time employee equivalents (FTE) organized into five major directorates: Investigations, Audits and Evaluations, Healthcare Inspections, Contract

[2] VA At-A-Glance Pocket Cards, Quarter 2, FY 2017. (Accessed February 28, 2017).

Review, and Management and Administration.[3] About 225 employees are based in Washington, DC, while the remaining 500 are dispersed throughout our approximately 40 field offices nationwide. Since FY 2014, we have received approximately 39,000 contacts to our Hotline annually. Each year, we average about 350 reports and other work products, 475 arrests, 330 convictions, and $3.125 billion in monetary benefits for a return on investment of $30 for every $1 expended on OIG oversight.[4] This is a strong return and supplements the inestimable value we bring by helping VA improve its health care and benefits services that impact so many lives.

The VA OIG FY 2017 appropriation of $159.6 million—an increase of approximately $22 million over FY 2016—was the largest on record for the OIG and served as an acknowledgement by the previous Administration and Congress that the OIG could not meet the growing and sustained demand for oversight of vulnerable, high risk VA programs in the near term without a significant investment in organizational strength. This increase was intended to support deployment of approximately 100 additional full time positions. We crafted our FY 2017 budget request with the intention that it would be the first of several tiered increases to "right size" the OIG over the next several years. The expansion plan would increase FTE to 1,160 by FY 2021, and bring the VA OIG to a level on par with staffing and resources at VA and comparably situated OIGs.

In consideration of the hiring freeze and the Administration's anticipated efforts to scale back the size of the Federal government, which is discussed in greater detail in the section that follows, we reduced our FY 2018 requirements by $27 million compared to the $197 million figure submitted as part of our 3-year expansion plan last year. Our budget request for FY 2018 is $170 million, and coupled with anticipated FY 2017 carryover, will cover the costs of normal inflation assumptions and at least 100 additional FTE over FY 2017. The Administration is proposing to straight-line funding for FY 2018 at FY 2017 enacted levels for a number of VA discretionary programs. Under this scenario, OIG's FY 2018 budget would be $159.6 million—the same as FY 2017. This funding level overlooks potential inflation costs of at least $3 million for civilian pay raises and infrastructure. Although we do not project that OIG operations would be adversely impacted at this funding level for FY 2018 because of available carryover funds, for subsequent years we would likely need to request a significant increase to the $159.6 million funding level to maintain current operations.

HIRING FREEZE IMPLICATIONS

We believe that the January 23, 2017 Presidential memorandum to freeze the hiring of Federal civilian employees, as well as the anticipated attrition plan to follow, will adversely affect the OIG's ability to recruit individuals for a number of the positions we need to fill. As a result, we expect to fall short of our original staffing target for FY 2017

[3] The Office of Contract Review, with 27 employees, operates under a reimbursable agreement with VA's Office of Acquisition, Logistics, and Construction to provide reviews of vendors' proposals and contracts. Our remaining workforce is funded through appropriations.

[4] Based on the 5-year average of reports issued, arrests and fugitive felon arrests, convictions, total dollar impact, and return on investment as reported in OIG semiannual reports for FYs 2012, 2013, 2014, 2015, and 2016.

and we will not be able to expand necessary resources. Guidance on the hiring freeze issued by the Office of Management and Budget (OMB) and the U.S. Office of Personnel Management (OPM) indicates that the Inspector General is the agency head for the purposes of determining which positions in the OIG are exempt from the freeze, as well as for the purposes of the agency-head review of job offers in the OIG that either do not have a start date or have a designated start date beyond February 22, 2017.[5] I have exempted several positions that are deemed necessary to meet "national security or public safety responsibilities," including essential activities to the extent that they protect life and property. These include positions that address patient safety and care, facility inspections, audits of programs with significant financial exposure, cybersecurity, and suspected criminal activity. In total, these exemptions account for approximately 50 percent of the vacancies that we intended to hire during FY 2017 based upon our appropriation and the projected attrition within our current workforce.[6]

The full impact of the hiring freeze remains unknown at this time. However, one foreseeable outcome is that it will limit the amount of work we can undertake due to the current number of vacancies within our organization. Furthermore, the freeze will negatively impact the OIG's ability to meet FY 2017 performance metrics, which were premised on an increase in staffing enabled by an increase in our budget. Although I made exemptions to the hiring freeze on a number of critical positions within the OIG based on OMB and OPM guidance, I did not exempt a number of open positions.

OVERSIGHT RESULTS

The OIG conducts strategic oversight of VA programs and operations in such areas as health care delivery, benefits processing, financial management, procurement practices, information management and security, and its workforce investment. Our work provides independent assessments of VA's operations and helps VA achieve its mission in critical areas while protecting the interests of veterans and taxpayers. Although we cannot accept all matters brought to our attention that appear to warrant some level of further review, it is important that we focus our efforts on mission-critical high risk areas we consider to be the most impactful work. When deciding whether to take on a matter, we consider a variety of factors, including but not limited to the scope of actual or potential impact to veterans and/or taxpayers; whether there is imminent harm to VA patients or employees; the pervasiveness of the problem; whether we have conducted prior related oversight; and whether the issue should be handled by VA or another agency. Following is a selection of our work that demonstrates a clear and urgent need for expanded oversight of VA.

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[5] OMB/OPM Memorandum M-17-18, *Federal Civilian Hiring Freeze Guidance* (January 31, 2017). https://www.whitehouse.gov/sites/whitehouse.gov/files/images/M-17-18-Federal-Civilian-Hiring-Freeze.pdf.

[6] Approximately 20 percent of all current OIG employees are eligible to retire through the end of calendar year 2017. By the end of calendar year 2020, that number will increase to nearly one-third of our workforce. These employees occupy positions throughout the OIG, to include healthcare and benefits inspectors, criminal investigators, auditors, Hotline analysts, and other support staff at both new and existing locations nationwide.

Veterans Health Administration

Providing timely and high quality health care to our nation's veterans is one of VA's key responsibilities. Historically, VHA has been a national leader in the quality of care provided to patients when compared with other major U.S. health care providers. However, in recent years, VHA has experienced significant challenges in delivering high-quality, timely health care—whether that care is provided within VHA or through VHA's ability to arrange for the delivery of services in the community. Factors such as increased demand, operational inefficiencies, and inadequate information systems to manage health care resources efficiently and effectively impact VHA's ability to ensure the quality and timeliness of the services it provides. In some cases, veterans do not receive the services they need. For more than a decade, the OIG and other organizations have issued numerous reports regarding issues with access to VA health care such as veteran wait times, scheduling practices, consult management, and the Non-VA care program. Since the nationwide scandal on patient wait times in 2014, we have continued to identify problems with VHA managing access to health care.

One of our most recent reports on the topic of health care access found that Veterans Integrated Service Network (VISN) 6 did not consistently provide timely access to health care for new patients at its VA medical facilities and through the Veterans Choice Program (Choice) in FY 2016.[7] It also did not have accurate wait time data. Our assessment of wait times for new patient appointments shows a significant difference when compared to wait time data captured in VHA's electronic scheduling system. As a result, we concluded that VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. Among other consequences, the inaccurate wait time data resulted in a significant number of veterans not being eligible for treatment through Choice. VISN 6 also did not consistently manage the timeliness of specialty care consults. This audit demonstrates that many of the same access to care conditions reported over the last decade continued to exist within VISN 6 medical facilities in FY 2016.

Our work also noted opportunities for improving continuity of care between VHA and community care providers with respect to obtaining and scanning non-VA clinical records. Complete and accurate documentation in patient electronic health records (EHRs) is essential for sound, fully-informed clinical decision making. Gaps in non-VA documentation, such as those found during our review of a delay in care for a lung cancer patient, put patients at risk and make continuity of care between various providers and specialties more difficult to achieve.[8] This review also discovered examples of consults[9] placed during the course of the patient's treatment with routine

[7] *Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6* (March 2, 2017). VISN 6 includes seven VA Medical Centers and over twenty-five Community Outpatient Clinics located in North Carolina and Virginia.

[8] *Healthcare Inspection, Delay in Care of a Lung Cancer Patient Phoenix VA Health Care System Phoenix, Arizona* (September 30, 2016).

[9] VHA policy states that consults are a mechanism for physicians and other health care providers to create templated notes to request an opinion, advice, or expertise regarding evaluation or management of specific problems in the care of individual patients. There are certain timeliness standards for completing consults based on three urgency designations: routine, urgent, and STAT.

urgency even though the clinical expectation and actual need was for a more urgent response.

Our audit of VA's FY 2016 Consolidated Financial Statements also identified VHA's 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, VHA's Office of Community Care (OCC) did not have adequate policies and procedures for its own monitoring activities. OCC's activities also were not integrated with VA and VHA Chief Financial Officer (CFO) responsibilities under 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 the costs of non-VA provider care, VA has 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.

We have issued a number of reports since 2013 that evaluated consult timeliness and the impact of consult delays on patient outcomes. For example, our recent review into alleged consult delays and management concerns at the VA Montana Healthcare System (VA Montana), Fort Harrison, Montana, found that a large percentage (between 42 and 61 percent) of patients with consults ordered in FY 2015 experienced a delay in obtaining a clinical in-house consult, non-VA care consult, and/or Choice consult.[10] We found that delays among consults ordered in FY 2015 may have harmed four patients. Beginning in July 2015, the system initiated a focused effort to identify and resolve factors that contributed to consult delays and reduce outstanding consults. Despite this effort, we found evidence of persistent issues with completing consults timely in FY 2016 (through late August 2016). Efforts are ongoing to address those factors within the VA Montana Healthcare System's control that contribute to consult delays, including hiring additional staff to process non-VA care and Choice consults and reducing the number of unnecessary consults. 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

[10] *Healthcare Inspection, Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana* (March 10, 2017).

ongoing efforts to improve consult timeliness. VA Montana's Director and the VISN 19 Director concurred with our three recommendations and provided a responsive action plan and milestones to address the recommendations.

Adequate staffing is essential to providing timely health care access to patients. As required by Public Law (P.L.) 113-146, the *Veterans Access, Choice, and Accountability Act of 2014,* we have completed the third of five required determinations of staffing shortages in VHA.[11] We determined that the top five critical need occupations for FY 2016 are Medical Officer, Nurse, Psychologist, Physician Assistant, Physical Therapist, and Medical Technologist. Because of a tie for fifth place, we had six occupations in our determination. In looking at the gains, losses, and changes in onboard staffing for critical need occupations, we found that in the past year, VHA continued to increase the absolute number of staff in critical need occupations. However the net gains are still significantly reduced by high loss rates. We noted in our prior reports that because of the relatively long onboarding process and challenges in finding suitable candidates, staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and FTE allocation at the individual facility level. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures to address the above concerns. In our initial (January 30, 2015) determination, we recommended that VHA continue to develop and implement staffing plans for critical need occupations. In the second report, we found VHA was in the early stages of developing staffing models. In this third report, we found that VHA had developed draft reports on staffing models for certain medical specialties and regrettable losses. While VHA had made progress in developing and implementing staffing models, we did not identify a plan that included a set of milestones and timelines for further staffing model development to achieve full implementation. We made four recommendations, two of which are repeat recommendations, to address this finding.

While filling these critical staffing shortages is essential to patient care, VA, and in particular VHA, must remain cognizant of the need to strategically and prudently use taxpayer dollars in the recruitment and retention of highly qualified employees in hard-to-fill positions. Our recent report of VA's use of recruitment, relocation, and retention (3R) incentives found that VA needs to improve controls over its use of these pay authorities to ensure they are applied strategically and prudently.[12] VHA accounted for at least 99 percent of VA's 3R incentive spending in FYs 2012 through 2015. We identified ineffective oversight processes to ensure compliance with VA's 3R incentive requirements, inadequate oversight of how 3R incentives are used to address known and expected workforce gaps, and ineffective procedures to recoup funds from individuals with outstanding recruitment and relocation incentive service obligations. As a result, VA has limited assurance that it is using 3R incentives effectively and strategically to acquire and retain talent, yet these tools are vital to VHA's success for recruiting and retaining qualified staff. Considering that VA anticipates about 31 percent

[11] *Healthcare Inspection, OIG Determination of VHA Occupational Staffing Shortages* (September 28, 2016).
[12] *Audit of Recruitment, Relocation, and Retention Incentives* (January 5, 2017).

of its employees will be eligible for retirement by 2020, including about 58 percent of the SES workforce, it is imperative that VA take timely action to ensure its use of 3R incentives aligns with its immediate and long-term human capital goals. Without stronger internal controls, we projected that VA risks an estimated $158.7 million in unsupported 3R incentive spending, in addition to about $3.9 million in estimated repayment liabilities projected for FYs 2015 through 2019.

The OIG routinely investigates and arrests individuals who steal and/or sell controlled and non-controlled substances from and at VA facilities. During FY 2016, we opened 49 investigations resulting in 55 individuals being charged with various crimes relating to illicit drug activity. 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; employees who diverted or stole pharmaceuticals for the purpose of illegal sale; employees of non-VA delivery services who stole prescription drugs intended for VA patients; patients who sold their prescribed drugs to other VA patients; and individuals who sold contraband drugs such as heroin at VA facilities. As a result of one such investigation, a former Murfreesboro, Tennessee, VA Medical Center (VAMC) nurse was arrested after being indicted for obtaining a controlled substance by fraud and theft of property. That OIG investigation revealed that on at least 18 occasions between April 2014 and March 2015, the defendant diverted oxycodone, hydrocodone, morphine, and lorazepam intended for Community Living Center geriatric patients. The defendant admitted to stealing the drugs for personal use and subsequently resigned from her position at VA. In another example, an investigation at the Little Rock, Arkansas, VAMC led to two pharmacy technicians and a pharmacy technician student trainee being indicted for charges to include conspiracy, theft, and possession with intent to distribute. The OIG investigation resulted in the defendants being charged with diverting and distributing 4,000 oxycodone tablets, 3,300 hydrocodone tablets, 308 ounces of promethazine with codeine syrup, and over 14,000 Viagra and Cialis tablets. Three additional VA employees were identified as part of the drug diversion, resulting in a resignation and reassignments. The monetary loss to VA was over $77,000.[13] Drug theft is a serious issue that the OIG will continue to pursue diligently. Not only is it illegal, it is an issue of patient safety if the provider is ingesting controlled substances while on duty, if false entries are placed in patient files to cover up the diversion, or if patients are given another substance in place of the diverted drug.

Veterans Benefits Administration

Delivering timely and accurate benefits is central to VA's mission. The Veterans Benefits Administration (VBA) is responsible for oversight of the nationwide network of VA Regional Offices (VARO) that administer a range of veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs are estimated to pay out over $104 billion in mandatory benefit programs to veterans and their beneficiaries in FY 2017.[14]

[13] *Veterans Affairs Employees Charged with Stealing and Selling Prescription Drugs*. Department of Justice, U.S. Attorney's Office, Eastern District of Arkansas (February 8, 2017).
[14] VA's FY 2017 Budget Submission in Brief.

While we have continuously reported the need for enhanced policies and procedures, training, oversight, quality reviews, and other management controls to improve the timeliness and accuracy of claims decisions, we also remain concerned that VBA's aggressive focus on reducing the backlog of compensation claims occurred at the expense of delaying the processing of other VBA workload such as its non-rating and appealed claims workload. For example, our June 2016 audit found that VBA staff did not consistently take action to adjust compensation and pension benefits for incarcerated veterans, which resulted in improper payments valued at approximately $104.1 million.[15] Without improvements, we estimated VBA could make additional improper benefits payments totaling about $203.8 million from FY 2016 through FY 2020. In general, VBA did not place priority on processing incarceration adjustments because VBA did not consider these non-rating claims to be part of the disability claims backlog. Both VBA Central Office and VARO staff consistently reported that incarceration adjustments were not a high priority. As a result of our work, VBA agreed to increase the priority of processing its incarceration adjustment workload.

In another example, in September 2016, we reported that veterans entitled to statutory housebound benefits did not consistently receive correct benefits decisions because VBA staff overlooked the issue, and VBA's electronic reminder was ineffective. Based on our sample projections, we estimated that these errors resulted in some veterans being underpaid $110.1 million while others were overpaid $44.3 million. As a result of our work, VBA will conduct annual reviews of housebound benefits and tighten controls over this program and we are providing increased oversight of this issue as part of our FY 2017 benefits inspection program.

Our work has also identified improper payments with respect to Post-9/11 G.I. Bill education benefits. Our September 2016 audit projected that, of the more than $5.2 billion in payments made in academic year 2013-2014, VBA made about $247.6 million in improper payments and $205.5 million in missed recoupments annually.[16] As a result, VBA may have an estimated $2.3 billion in improper tuition and fee payments and missed recoupments over the next five academic school years if it does not strengthen program controls. To help reduce improper payments and missed recoupments, VBA needs to:

- Improve the School Certifying Officials' awareness of program requirements related to the submission of accurate and complete enrollment certifications;
- Refine the school selection process and ensure the completion of required compliance surveys to improve the verification and monitoring of tuition and fee certifications;
- Develop adequate guidance regarding allowable book fees and repeated classes; and
- Verify and obtain supporting documentation for mitigating circumstances.

[15] *Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans* (June 28, 2016)
[16] *Audit of Post-9/11 G.I. Bill Tuition and Fee Payments* (September 30, 2016)

Our work also uncovered fraud schemes related to education benefits. For example, a husband and wife who co-owned a beauty school in Chesapeake, Virginia, pled guilty to fraud and related charges after an investigation determined that they provided information to VBA falsely representing that they provided full-time schooling to hundreds of veteran students.[17] In reality, the school was a sham. Most veterans enrolled in courses received few, if any, hours of instruction, and there were no tests, exams, or practical exercises given. Rather, students were directed to simply sign in and out of the school each day so that the owners could report to VBA that they were enrolled and attending. In exchange, the owners received Post-9/11 GI Bill tuition payments for each veteran totaling more than $4.5 million between October 2011 and September 2016. The husband and wife were each sentenced to 5 years' imprisonment and community service.

Financial Management

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 has continued to deteriorate over time and no longer meets the increasingly stringent and demanding financial management and reporting requirements mandated by the Department of the Treasury and OMB.[18] 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 had 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 system replacement will be a major advancement for VA in modernizing its system architecture for improved financial management and stewardship.

VA struggles with improper payments, including accurately reporting on them as well as working to eliminate them. Our work on VA's compliance with the Improper Payments Elimination and Recovery Act (IPERA) for FY 2016 continues. However, we reported in May 2016 that VA did not fully comply with IPERA for FY 2015. Two programs exceeded the improper payment threshold of 10 percent—VHA Community Care and Purchased Long Term Care Support and Services. Eight programs, including those two programs, also did not meet reduction targets. More important, OMB designated the VHA Community Care, Purchased Long Term Services and Support, and Compensation programs as high-priority in November 2015. For high-priority programs, agencies must establish semi-annual or quarterly actions for reducing improper payments, as required by the Improper Payment Elimination and Recovery Improvement Act of 2012 (IPERIA) and OMB Circular A-123, Appendix C.

[17] *Owner of Chesapeake Barber College Pleads Guilty to $4.5 Million GI Bill Fraud.* Department of Justice, U.S. Attorney's Office, Eastern District of Virginia (December 14, 2016).
[18] *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015* (November 15, 2016).

Procurement
For several years, OIG audits and reviews have identified systemic deficiencies in all phases of the procurement process, including planning, solicitation, negotiation, award, and administration. We attribute these deficiencies largely to inadequate oversight and accountability. The replacement of the Denver VAMC is an extremely costly example of the result of inadequate oversight.[19] 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 in the late 1990s. 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 poor business decisions and mismanagement by VA senior officials. Our 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.

Lack of sufficient oversight also increases the risk that VA will award sole source and set-aside contracts intended for eligible Veteran-Owned and Service-Disabled Veteran-Owned Small Businesses (VOSB and SDVOSB) to ineligible parties and that contractual performance requirements will not be met. The VOSB and SDVOSB contracting programs increase contracting and subcontracting opportunities for veterans and service-disabled veterans and ensure these businesses receive fair consideration when VA purchases goods and services. However, the program's set-aside advantage makes it a target of abuse and fraud by ineligible contractors using various deceptive schemes to acquire lucrative VA contracts.

Many of our investigations involve "pass-through" schemes whereby the VOSB or SDVOSB win a contract, perform little to none of the work, and passes through the contract or large portions of the contract to the ineligible company for a fee or percentage of the award. The VOSB or SDVOSB simply functions as a shell business and "passes through" the work to the ineligible business. This defeats the socio-economic goals that were intended under the set-aside program. Similarly, "Rent-A-Vet" schemes occur when an otherwise ineligible business uses a veteran as a front to try to establish VOSB or SDVOSB eligibility. In this scheme, the true owner of a company conspires with a veteran to have the veteran assume ownership of the

[19] *Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System* (September 21, 2016).

company, but in name only. The true owner maintains control over the company, and the veteran receives either a flat fee or a percentage of any contracts awarded and does not perform any functions associated with owning or operating the company. A variation of this scheme involves the establishment of a new firm for the sole purpose of set-aside acquisition. The new firm is not actively managed or controlled by the veteran, who acts only as a figurehead.

For example, a non-veteran owner of a purported SDVOSB was sentenced to 30 months' incarceration, 12 months' supervised release, and was ordered to pay a $1 million fine after previously being found guilty of fraud charges stemming from an investigation that revealed the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two service-disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those service-disabled veterans, the company was awarded more than $112 million in Federal contracts between 2006 and November 2010, of which $110 million were VA contracts. The case involved over 200 VA construction contracts that occurred in at least 7 states. Of note, prosecutions of this type were rare until the VA OIG started championing this type of fraud case to the Department of Justice. Through this collaboration, we have been successful in obtaining many convictions. Although these types of investigations are resource intensive, our work helps ensure that SDVOSBs and VOSBs can compete for business.

Information Technology

Further, the OIG has frequently identified examples where VA has struggled to design, procure, and/or implement functional IT systems. Further, for the past 17 years, IT security has been reported as a material weakness in the Consolidated Financial Statement audits that are conducted annually by the OIG's contracted independent auditors, CliftonLarsonAllen.[20]

VA has a high number of legacy systems needing replacement: 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 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

[20] *Audit of VA's Financial Statements for Fiscal Years 2016 and 2015* (November 15, 2016).

complete and up-to-date information, VA needs to find a more effective method for sharing patients' EHRs.

While OIG's audit of VA's information security program for FY 2015 noted some improvements, we 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.[21] Weaknesses in access and configuration management controls resulted from VA not fully implementing security standards on all servers, databases, and network devices. VA also has not effectively implemented procedures to identify and remediate system security vulnerabilities on network devices, databases, and server platforms VA-wide. Further our in-process audit work for FY 2016 has found VA has not remediated over 7,000 outstanding system security risks in its corresponding Plans of Action and Milestones, the control designed to improve its information security posture.

RECOMMENDATION FOLLOW-UP

Follow-up is an important component of OIG oversight work. OMB requires a process to follow up and report on the status of OIG report recommendations. The OIG is also required to report in its Semiannual Report to Congress on the status of report recommendations, with an added emphasis on those recommendations pending over 1 year. As of the conclusion of February 2017, there were 138 total open reports and 448 total open recommendations. 65 (47 percent) of these reports and 154 (34 percent) of these recommendations are greater than 1 year old.

OIG staff take great care in developing recommendations for improvement that are clear and specific, provide a yardstick to measure improvement and gauge full implementation. We develop recommendations for corrective action that can be realistically implemented within a year. As such, the OIG generally does not accept VA implementation plans that take more than a year to complete, except under the rarest of circumstances and only when measurable timelines are provided. Over the last year, approximately 80 percent of recommendations have been closed within 1 year.

CONCLUSION

VA is a massive and decentralized enterprise with significant vulnerabilities to fraud, waste, abuse, and mismanagement in its programs and operations; the consequences of which can have a dramatic effect on veterans and taxpayers. Regardless of hiring restrictions, the OIG must be positioned to provide effective oversight especially in the high-risk areas related to patient care provided by VA and community providers. With continued support from Congress, we look forward to increasing our ability to conduct impactful oversight of VA programs and operations for the betterment of our veterans, their families, and American taxpayers.

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

[21] *Federal Information Security Modernization Act Audit for Fiscal Year 2015* (March 15, 2016).

OIG MISSION

To serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs (VA) through independent audits, inspections, and investigations.

VISION

To meet our mission and enhance the trust and confidence of veterans and their families, Veterans Service Organizations, Congress, VA employees, and the public, we must:

- Ensure that our work is independent and avoid any appearance of impairment to our independence.
- Prevent and detect fraud, waste, and abuse in VA programs and operations.
- Be proactive and strategic in identifying impactful issues.
- Produce reports that are:
    - Accurate
    - Timely
    - Fair
    - Objective
    - Thorough
- Make meaningful recommendations that drive economy, efficiency, and effectiveness throughout VA programs and operations.
- Be fully transparent by promptly releasing reports that are not otherwise prohibited from disclosure.
- Promote accountability of VA employees if they fail to perform as expected.
- Attract, develop, and retain the highest quality staff in the Office of Inspector General (OIG).
- Treat whistleblowers and others who provide information to the OIG with respect and dignity and protect their identities if they so desire.

VALUES

Our conduct will be guided and informed by adherence to the following values:

- Meet the highest standards of professionalism, character, ethics, and integrity.
- Work as one organization by encouraging teamwork and collaboration across directorates and offices.
- Establish a positive and engaging work environment.
- Promote diversity, individual perspectives, and equal opportunity throughout the OIG.
- Respect the role and expertise that each staff member brings to the OIG.
- Continually improve our performance.
- Ensure equitable opportunities for professional growth and development.
- Accept responsibility for our behavior and performance.