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BEFORE THE SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 25, 2016

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the work of the VA Office of Inspector General (OIG) and our budget request for fiscal year (FY) 2017. I am accompanied by John D. Daigh, Jr., MD, CPA, Assistant Inspector General for Healthcare Inspections for the OIG's Office of Healthcare Inspections.

BACKGROUND

The OIG is responsible for conducting oversight of VA programs and operations including the delivery of health care services, benefits administration, financial management, and information technology and security. In the last several years, VA has grown significantly due to an increased demand for services by our Nation's veterans, and we expect this trend to continue. In fact, from 2009 through 2016, VA's budget has grown by more than 70 percent.[1] Such rapid growth presents increased risks of management and performance challenges that could result in poor financial stewardship of taxpayer dollars. It also creates a need for the OIG to be properly equipped to provide sufficient oversight of the new initiatives, revamped programs, and added services and functions resulting from this increased spending.

As we said last year, the national attention on VA has led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline and in the number of inquiries sent to us by Members of Congress. The OIG Hotline received over 39,000 contacts in FY 2014 and over 38,000 contacts in FY 2015. To date in FY 2016, the OIG Hotline has received 13,240 contacts. This is significant because every contact we receive obligates a certain amount of time and resources to be logged, analyzed, triaged, and processed by staff, regardless of whether the issue is one that the OIG can review or if another agency such as the Office of Special Counsel has legal authority over that matter. Moreover, the OIG does not get involved in veterans eligibility claims decisions so those individuals must be informed to contact VA and specifically the Veterans Benefits Administration (VBA). However, the triage process provides information to our managers regarding possible areas of concern that need to be reviewed.

Of particular concern to the OIG are those contacts alleging substandard quality of care. Because we are not in a position to open a formal inspection for every contact that

[1] http://www.va.gov/budget/docs/summary/Fy2017-FastFactsVAsBudgetHighlights.pdf

appears to warrant some level of additional review, we must have a sound process in place to ensure we are dedicating our limited resources to those allegations that in our professional judgment represent the greatest risk of harm to veterans. For example, to determine whether quality of care allegations should trigger a formal inspection, our team of physicians, nurses, and other clinicians consider multiple factors including risk to patients and resource availability. The risk assessment is particularly important and is informed by the relative scope (the number of patients affected) and severity (the actual or potential impact on patients' health or safety) of the alleged quality of care issues.

Because we contend with the stark contrast between our resources and the scope of our mission, we must continually evaluate our business practices to seek greater efficiencies, achieve larger economies, and ensure our actions are providing veterans and taxpayers with the necessary information. We have efforts underway to increase the number of reviews we complete annually. Over the next year, we will enhance our capabilities for tracking and trending Hotline complaints received to better identify issues meriting system-wide review and VA facilities that may benefit from focused OIG oversight.

Historically, we have recovered the costs of our operations many times over through a robust return on investment. In FY 2015 alone, we achieved a 20:1 return on investment, which amounts to $2.2 billion in monetary benefits. Actual dollar recoveries such as fines, penalties, restitutions, and civil judgments are eventually returned to the U.S. Treasury, and in some instances to VA's Revolving Supply Fund. The return of these funds, collected through the efforts of OIG, provide a considerable benefit to the taxpayer and VA. However, the OIG does not track VA's use of these funds as they are not directly available to support the OIG's requirements.

The OIG's budget for FY 2016 is $136,766,000 and we thank the Congress for the increase of $10 million over the President's request for FY 2016. That increase allows the OIG to increase our staff by 20 fulltime equivalents (FTEs) instead of a cut of 10 FTEs as the President's budget request would have necessitated. However, even with the increase in the FY 2016 budget, the OIG does not have the resources to allow for the needed oversight of VA's growing programs and operations. We view FY 2016 as the first step in right sizing the OIG's budget and staffing levels to an appropriate ratio given the size, scope, and complexity of VA's mission and organization.

BUDGET REQUEST FOR FISCAL YEAR 2017

We appreciate the recognition by the President that the OIG's budget needed to continue to grow in FY 2017 and would like to acknowledge the support that the Secretary gave during the budget formulation process. For FY 2017, the President requested and we hope the Congress will approve $160,106,000. This will enable the OIG to staff up to 790 FTEs.

This budget request will begin to increase our oversight of critical VA programs and services. It will support deployment of additional positions including healthcare and

benefits inspectors, criminal and administrative investigators, auditors, and other support staff at both new and existing locations nationwide, especially areas of the country where there is no permanent OIG presence and has a growing veteran population. This funding will support increased oversight activities related to mental health care, patient safety, facility inspections, major and minor construction projects, Choice Act programs, transformational initiatives related to claims processing, emergent criminal activity and threats to physical and information security, along with providing increased oversight for the expansion of VA programs in general.

Veterans Benefits Administration

Our goal each fiscal year is to issue inspection reports for 20 VA Regional Offices (VAROs) as part of our cyclical benefits inspection program. However in FY 2016, that number will drop to 10 due to reviews associated with several of the over 40 initiatives that VBA rolled out as part of its transformation plan. Two initiatives that we will review in FY 2016 and continue our oversight into FY 2017 are related to centralized mail processing and the national work queue—the system VBA will rely upon to track and manage its workload moving forward. An expansion of the OIG budget provides for more benefits inspectors to return to a 3-year oversight plan of performing 20 inspections of VAROs per year but also enable special reviews to be planned in order to examine the effectiveness of VBA's mission-critical processes and support systems.

We remain concerned about the accuracy of VBA's continued reporting on reducing the backlog and improvement in accuracy. In FY 2015, we conducted 13 reviews at 11 VAROs on allegations of data manipulation.[2] We are also concerned that due to the focus on rating claims processing, there is a growing workload associated with non-rating claims as well as an increase in workload in the appeals area.[3] Additional oversight is needed in these areas.

In June 2014, we issued a report in which we substantiated allegations that the Oakland VARO had not processed or properly stored information claims for benefits.[4] Based on requests from several Members of Congress, we conducted another review in 2015, specifically focusing on an allegation that VARO management had a list of over 13,000 unprocessed informal claims for benefits. In January 2016, we reported that we could not find evidence of the existence of a list even after interviews with current and former VARO staff, whistleblowers, and members of a previous VBA management team.[5] We did obtain a list of 1,308 informal claims that contained veterans' names and file numbers, and appeared to represent a working list compiled during the time of the special informal claim review project in 2013. Both VBA and the OIG examined this

[2] VA Regional Offices: Baltimore, MD; Boston, MA; Denver, CO; Honolulu, HI; Houston, TX*; Little Rock, AR; Los Angeles, CA*; New York, NY; Oakland, CA; San Diego, CA; St. Paul, MN (*denotes two separate reviews).

[3] In the Benefit Inspections reports for FY 2015, we have consistently reported our concerns related to the lack of focus on non-rating claims.

[4] *Review of Alleged Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California*, February 18, 2015.

[5] *Follow-Up Review on Mismanagement of Informal Claims Processing at VARO Oakland, California*, January 8, 2016.

information to ensure veterans claim information was accountable to the extent physical evidence existed. We did find errors in effective dates as well as the VARO having significant delays in processing claims. VBA took timely action to address our concerns and also reviewed 100 percent of approximately 1,300 informal claims.

Veterans Health Administration

The Veterans Health Administration (VHA) is under considerable stress to provide timely and quality care for veterans both inside VA and outside of VA. An increase in the OIG's budget provides for increased oversight of the risks that VHA faces in implementing the Choice Act including risks associated with the delivery of care and the payment of that care. This is especially important for veterans in rural settings as they face unique challenges to obtain care then those veterans living in more urban areas.

These risks are evident in the OIG's reports on urology issues at the Phoenix VA Health Care System.[6] The system was overwhelmed with requests for outside appointments due to a lack of VA staff. Problems occurred with referrals, outside appointments being scheduled, veterans knowing and keeping the appointments, bills being paid, and most importantly, the outside medical information being inputted into the veteran's medical record. This was just one clinic in one facility. The enormous task ahead of VHA needs and requires OIG oversight to ensure that processes are in place to protect not only the veteran's health but also their tax dollars.

Recent OIG reports have identified issues related to the various call centers operated by VA, including the Veterans Crisis Line (VCL).[7] In a report issued earlier this month, we substantiated allegations that:

- Some calls routed to backup crisis centers were answered by voicemail.
- Callers did not always receive immediate assistance from VCL and/or backup center staff.
- VCL management did not provide social service assistants with adequate orientation and ongoing training.

We identified gaps in the VCL quality assurance process including an insufficient number of required staff supervision reviews, inconsistent tracking and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data.

In December 2014, we reported on issues related to the National Call Center for Homeless Veterans.[8] In that audit, we identified 40,500 missed opportunities when the

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[6] *Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ*, January 28, 2015; and *Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ,* October 15, 2015.

[7] *Healthcare Inspection – Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York*, February 11, 2016.

[8] *Audit of VHA's National Call Center for Homeless Veterans* December 3, 2014.

Call Center either did not refer the homeless veterans' calls to medical facilities or it closed referrals without ensuring homeless veterans had received needed services. We also found problems for homeless veterans with leaving messages on answering machines when counselors were unavailable, referrals that could not be made due to problems with the messages, and a lack of documentation that veterans had received needed support services.

VA manages a number of call centers, and these centers face some unique and similar challenges. For example, during our work at the Philadelphia VARO, we found unacceptable working conditions and received feedback from staff that their performance standards did not provide sufficient time to enter notes and review emails. We are pleased to note that the problem with the site conditions has been addressed and the call centers have been relocated into the main building housing the Philadelphia VARO employees.

As was mentioned earlier, the OIG continues to receive requests from Members of Congress regarding the operations of VA facilities that serve their district and states. Often these requests require reviews of multiple clinical areas and address a broad range of quality of care issues. These reviews are resource intensive both with staff and time. For example in the last two weeks, we have been requested to review three VA Medical Centers. An increase in FY 2017 to better manage the increased volume of health care related requests, would allow for the expansion of staff within the Office of Healthcare Inspections.

Other VA Programs and Operations

VA has many other challenges in the programs and operations outside of VBA and VHA: construction, information technology (IT) and security, and contracting for vital goods and services. Each of these areas need vigorous oversight to ensure that taxpayer money is spent correctly and appropriately.

The issues related to the replacement facility in Denver need to be addressed. We are completing work on a review and plan to issue a final report in early Spring. This work is examining issues specific to the site conditions and taking a broader look at how VA manages its construction projects. It will be important, that as VA moves forward, we increase our oversight of both major and minor construction projects especially because VA has an increasing number of older facilities and decisions need to be made on how to spend construction money in an effective and efficient manner.

IT related issues have long been reported by the OIG as a challenge. VA has struggled with the planning, deployment, and security of systems. As was noted in the FY 2015 Consolidated Financial Statements audit, information security was once again rated as a material weakness.[9] VA continues to rely on legacy systems for mission critical items. Our work with regards to the contract for development of the Veteran Benefits Management System (VBMS) further demonstrates VA's difficulties in planning for new

[9] *Audit of VA's Financial Statements for Fiscal Years 2015 and 2014*, November 16, 2015. IT security has been a material weakness for over 10 years.

IT systems.[10] In this report, we focused on whether VA had improved its schedule, cost, and performance supporting VBMS development to meet its claims processing accuracy and backlog elimination goals. We noted that VA remained partially effective in managing VBMS development to help meet claims processing accuracy and backlog elimination goals. We also found that VA stayed on schedule in deploying planned VBMS functionality to all VAROs in 2013. However, since September 2009, total estimated VBMS costs increased significantly from about $579.2 million to approximately $1.3 billion in January 2015. The increases were due to inadequate cost control, unplanned changes in system and business requirements, and inefficient contracting practices.

VA operations require the efficient procurement of a broad spectrum of services, supplies, and equipment at national and local levels. OIG audits and reviews of support service contracts, Patient Centered-Community contracts, and allegations regarding other contracts identified systemic deficiencies in all phases of the procurement process including planning, solicitation, negotiation, award, and administration. The OIG attributes these deficiencies to inadequate planning, oversight and accountability.

Recurring systemic deficiencies in the procurement process, including the failure to comply with the Federal Acquisition Regulation and VA Acquisition Regulation, and the lack of effective oversight increase the risk that VA may award contracts that are not in its best interest. Further, VA risks paying more than fair and reasonable prices for supplies and services and making overpayments to contractors. VA must improve its acquisition processes and oversight to ensure the efficient use of VA funds and compliance with applicable acquisition laws, rules, regulations, and policies.

The OIG continues to be successful in its criminal investigations of businesses that receive contracts for work under false pretense under the Service-Disabled Veteran-Owned Small Business program. Our oversight helps to ensure the right firms and eligible veterans receive this work. In June 2015, a former VA employee who worked as a supervisory engineer at the East Orange, New Jersey, medical campus of the VA New Jersey Health Care System was sentenced to 46 months in prison for accepting more than $1.2 million in kickback payments in connection with VA contracts awarded to companies with which he had relationships, and to engaging in a scheme to defraud the VA by claiming one of those companies was owned by a service-disabled veteran when it was not. As a supervisory engineer, the former employee had the authority and influence to direct certain VA construction contracts to particular companies. He partnered with another individual, who was not a veteran, to set up three companies that could be used to obtain VA work under set-aside SDVOSB contracts. He then directed more than $6 million worth of VA construction projects to those companies. The defendant admitted he accepted $1,277,205 in kickbacks in exchange for his official action and influence between 2007 and July 2012. He also admitted that for many of the projects awarded to the other individual's companies, he recruited other contractors to perform the work so the companies were able to keep the money paid to them without having to incur the expense of actually completing the projects.

[10] *Follow-up Review of the Veterans Benefits Management System*, September 14, 2015.

OIG's Office of Investigations

The OIG's Office of Investigations reaches into all areas of VA consistent with our mission to detect and stop fraud, waste, and abuse. After the allegations wait time manipulations surfaced, we devoted a significant amount of resources to reviewing these allegations.

As we stated in other testimony to Congress, the OIG has completed 77 investigations and provided the results to the VA's Office of Accountability Review (OAR) for appropriate action. We are working diligently on the remaining investigations. We are preparing a final report that will be issued for each facility that we investigated, but we must ensure we fulfill our responsibility to comply with applicable statutes governing the release of information, including an individual's right to privacy and the protection of veterans, whistleblowers, witnesses, and other sources that may be identified in the information transferred to OAR. This is an extensive, meticulous, and time-consuming process.

The OIG's Office of Investigations has been leading on the issue of allegations of wait time manipulation with assists from other OIG offices as needed. However, based on lessons we have learned through the completed 77 investigations, going forward, we will do more triaging of the allegations and determine which OIG office would be better situated to review allegations related to wait time manipulation.

With the proposed increase in FY 2017, we would increase the number of investigators to address criminal and inappropriate administrative activity related to procurement, fiduciary issues, workers compensation, drug diversion, and identity theft.

CONCLUSION

The OIG needs to have the appropriate level of funding to provide for the necessary oversight of VA programs and operations that the Congress, VA, and most importantly, the veteran expect. Congress began that process in FY 2016 and the request for FY 2017 continues this effort. We continue to base our work on those areas in VA with the highest risk either to patient care, employee safety, or other financial and contractual risks.

We are currently waiting and excited for the Senate to confirm the nominee to be the Inspector General. It is my privilege to serve as the Deputy Inspector General and the last 8 months have been filled with many professional challenges for me and the organization. However, on behalf of the OIG staff, I can say we are committed to the OIG mission of providing independent oversight of the programs and operations of the VA. When the nominee is confirmed, the staff and I are committed to assisting him as he leads and shapes the organization in dedicating resources to provide oversight to improve VA operations and programs to better serve veterans.

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