IMPROVING THE DEPARTMENT OF VETERANS AFFAIRS EFFECTIVENESS: RESPONDING TO RECOMMENDATIONS FROM OVERSIGHT AGENCIES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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Wednesday, May 22, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:00 p.m., in Room 210, House Visitors Center, Hon. Chris Pappas, [Chairman of the Subcommittee] presiding.

Present: Representatives Rose, Cisneros, Takano, Bergman, Radewagen, Bost, Roy.

OPENING STATEMENT OF CHRIS PAPPAS, CHAIRMAN

Mr. PAPPAS. Today's hearing will come to order. Today's hearing of the Oversight and Investigation Subcommittee is entitled, "Improving the Department of Veterans Affairs Effectiveness: Responding to Recommendations from Oversight Agencies."

Both, the Government Accountability Office, the oversight arm of Congress, and the Department of Veterans Affairs Office of Inspector General, have made many recommendations for improving the Department.

Today, we will examine whether the VA is responding to these recommendations with effective and meaningful actions that better address the needs of our Nation's veterans. Today's hearing is the first during this congressional session for the Oversight and Investigation Subcommittee.

I, Ranking Member General Bergman, and all 7 of the other Members of this Subcommittee, are charged with conducting oversight across the programs and operations of the Department of Veterans Affairs, as well as those of other Federal agencies that serve our veterans. In carrying out its responsibilities, this Subcommittee will conduct hearings, site visits, and investigations nationwide. Oversight is a critical responsibility of Congress, as described by Article I of our Nation's constitution and the Subcommittee will not take our duties lightly.

During the coming months and through the remainder of the session, we will examine important topics that span the entire range of the Federal programs meant to serve our Nation's veterans. The Subcommittee will, at times, delve into some arcane topics and at other times, we may stir some controversy, even, but the Subcommittee will likely reveal failings of the Department of Veterans

Affairs and also show whether the VA is heading in the right direction.

We will also find examples where Congress must take action, whether to update and correct current laws, or require better accountability from Federal agencies and officials; however, all the Subcommittee's work will have a central goal: ensuring the Nation provides the support we need to give it to our veterans who earned it, the men and women who served our Nation at home and abroad.

Today's hearings will reveal the work of two independent and non-partisan government agencies that have a long history in oversight of the Department of Veterans Affairs. Both, the Government Accountability Office and the Department's Office of Inspector General, regularly identify key concerns about VA operations and each year, hundreds of reports are issued that recommend improvements. Their work is critical for the Department, for Congress, and for the public to understand the workings, the needs, and at times, the shortcomings of the VA.

Of course, it is ultimately up to the VA to implement the recommendations GAO and the IG make, but it does not always do so in a timely manner. For example, some of the GAO priority recommendations have remained unimplemented since 2012. The VA health care system has been on the GAO's high-risk list since 2015 and the Department still has not developed a viable action plan for getting off that list.

GAO has added a second VA operational area, acquisition management, to its high-risk list this year. The inspector general has more than 500 recommendations that VA still needs to implement and about a quarter of those have been awaiting implementation for more than a year.

Through their oversight work, GAO and the VA Inspector General repeatedly find systemic weaknesses at the VA, such as poor governance structures, a lack of leadership continuity, and failure to communicate effectively. These problems translate into real risks for veterans. For example, just last fall, GAO found that a lack of consistent program leadership resulted in VA spending only about 23 percent of $6.5 million allocated for suicide prevention outreach during fiscal year 2018.

As part of their testimony, the witnesses will describe the importance of strong and consistent leadership to ensure recommendations are implemented and major management challenges are addressed. Unfortunately, a key witness is missing and that is represented by the chair that is empty. Secretary Wilkie of the Department of Veterans Affairs declined our invitation, and he elected not to arrange for a representative of the Department to come in his place.

The secretary did not offer any scheduling conflicts or other credible reasons for why he decided not to participate; rather, he seemed to feel it would not be in his or the Department's best interests to share a panel with our two oversight witnesses who are here with us today.

Frankly, I find the VA's absence unacceptable. Contrary to what the secretary claimed in his communications with Chairman Takano and Ranking Member Roe when declining to participate in the hearing, House Veterans Affairs Committee has had a long his-

tory of seating the VA witnesses on panels with witness from the GAO and the IG. This is also quite common across other Congressional committees.

One question I had planned to ask the secretary today was whether he considers addressing the audits, the examinations, and the recommendations of the GAO and the IG to be a high priority and whether these findings have helped shape his leadership of the Department. The Department's refusal to participate in today's hearing speaks volumes about the degree to which it values the insights and recommendations that Mr. Dodaro and Mr. Missal have to offer.

It is my sincere hope that the secretary will soon come to the conclusion that the VA cannot go it alone. And to be clear, this Subcommittee invited the secretary to appear today in order to allow for greater dialogue and discussion on this critical path forward. Congress is at its best when it invites those of different views to share their analysis and opinions, even when they strongly disagree, so we can endeavor to find the best solutions to the problems faced by our Nation and our veterans.

With that, I would like to recognize Ranking Member Bergman for 5 minutes for any opening remarks he may wish to make here today.

General Bergman?

OPENING STATEMENT OF JACK BERGMAN, RANKING MEMBER

Mr. BERGMAN. Thank you, Mr. Chairman, and congratulations on holding your first hearing as Chairman of the O & I Subcommittee. Historically, and especially last term, it was a very bipartisan Subcommittee focused on asking tough questions and getting good results and dialogue, not only from the likes of, you know, GAO and the IG, but the VA, as well.

We are here today to understand how the Department of Veterans Affairs responds to recommendations of the VA Inspector General and the Government Accountability Office. In an organization as large and complex as VA, there will be challenges and there will be problems, and sometimes the people who are responsible need to be held accountable for the good of the organization. Other times, challenges and problems are more systemic.

In either case, a good measure of leadership and organizational health is an agency's response to these challenges. Unfortunately, VA is not participating in today's hearing. It has not been the recent past practice of the Committee to invite the secretary to testify at a Subcommittee hearing. Additionally, we generally place the secretary on a panel of his own out of deference. I understand that attempts were made to accommodate the Agency, but in the end, compromise could not be reached. I hope that in the future, we can overcome these issues because we need to hear from the VA to fully understand the issues.

We are fortunate, however, to have the comptroller general and the VA Inspector General here today representing their organizations, which are working day-in and day-out, to improve VA's effectiveness and efficiency. Comptroller General Dodaro, Inspector General Missal, thank you for being here. Your organizations pro-

vide a valuable service to VA and the men and women who rely on VA for benefits and health care.

My interest today is on what happens after the GAO or the IG issue recommendations in their reports. What procedures are in place at VA to ensure timely and proper implementation of recommendations and how does GAO and the IG help VA close recommendations.

I am also interested in understanding who at VA is accountable for monitoring implementation of GAO and IG recommendations across the department and what happens when the process foreclosing those recommendations stalls. As you know, the Department of Veterans Affairs Office Accountability and Whistleblower Protection Act of 2017 created the Office of Accountability and Whistleblower Protection and tasked it with the responsibility for recording, tracking, reviewing, and confirming implementation of recommendations. It is clear from VA's statement that the OAWP is not performing those functions as of yet, so I would appreciate our witnesses' ideas on how OAWP can improve the state of affairs.

I am also interested in hearing from the comptroller general what he sees as best practices and how other agencies developed and executed successful work plans to work their way off the high-risk list.

Again, it is unfortunate that VA is not here today, because it appears that there are good facts for VA to highlight. According to the data on the inspector general's website, VA has closed approximately 94 percent of the over 8,600 recommendations issued by the IG since October of 2012. Additionally, of the 510 open recommendations, only 123, or less than 1.5 percent of all recommendations are over one- year old.

Similarly, according to the GAO's priority open recommendation letter, dated March 28th, 2019, VA has implemented 90 percent of GAO's recommendations issued within the last 4 years, which is higher than the government-wide average of 77 percent and 10 percent above GAO's target of 80 percent. This is not to say that the VA is perfect, but it suggests that in recent years, VA is trending in the right direction. The question now is whether VA is properly addressing the highest priority recommendations and what barriers, if any, exist to closing them out. I look forward to a constructive hearing as we look for opportunities to improve how VA responds to GAO and IG recommendations.

With that, Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you very much, General Bergman. I look forward, as well, to working with you over this term.

I will now recognize our first witness, Mr. Gene Dodaro, Comptroller General of the United States, and Head of the Government Accountability Office. Mr. Dodaro was confirmed by the Senate in his role in 2010 and is serving a 15-year term, but his career at the GAO goes back 45 years. His agency produces hundreds of reports each year leading to billions of dollars of savings by Federal agencies and important improvement agencies and programs.

The Subcommittee thanks you for appearing today, and Mr. Dodaro, you have 5 minutes.

STATEMENT OF GENE L. DODARO

Mr. DODARO. Thank you very much, Mr. Chairman. Good afternoon to you, Ranking Member Bergman, Congressmen Bost, Cisneros, and Rose. It is very nice to see you all here this afternoon.

I want to highlight the fact that our work at the VA has shown that there are many dedicated and talented people there working very diligently to try to serve our veterans; however, the agency is seriously hobbled by underlying fundamental management weaknesses that make it very difficult for them to implement management reforms.

In order to highlight the attention of the administration and the Congress to these areas, I have placed a number of VA management issues on our high-risk list. In 2015, we added managing risk and improving health care to the list due to ambiguous policies and procedures, inadequate oversight and accountability, information technology challenges and inadequate training, and unclear resource needs and allocation priorities.

This past March, when we updated the high-risk list, which we do across government at the beginning of each new Congress, we added the acquisition management area at VA to the list, as well. Here, again, they had outdated policies and procedures. They hadn't been updated in over 10 years. There was not an effective strategy for medical and surgical procurements in place. Contract managers, management, and staff were overworked and in a lot of cases, there wasn't adequate training, and so these areas were problematic.

In 2003, we also added across the Federal Government, managing disability programs. One of the most significant disability programs, in addition to the Social Security Administration, is at VA. There were concerns with processing of initial claims, as well as appeals and backlogs and timeliness, as well as updating the eligibility criteria, which hasn't been updated in decades, despite efforts on the part of the Veterans Administration.

These are very serious management problems and I would make the point, though, that while implementation of our recommendations is an appropriate benchmark to use. It really is not going to be sufficient alone to solve VA's underlying management weaknesses and get off the high-risk list. The criteria for getting off the list is leadership commitment that is sustained, the fact that they have the capacity, the resources, and the people, and importantly, there needs to be a corrective-action plan that deals with the underlying root causes of the problems. And there needs to be a monitoring effort with milestones and metrics to be able to gauge progress, and there needs to be actually some demonstrated progress in fixing the problems.

The high-risk list includes the highest management risks across the Federal Government—there are 35 areas on the list—the reason I put VA on there is because while we can make recommendations, VA can address them, but then we make new recommendations that are still dealing with the same underlying problems. And that is the pattern we are in with the Veterans Administration.

Therefore, just addressing our recommendations isn't going to deal with the underlying management weaknesses there. I think

the Department recognizes this and is embarking at the VHA on a modernization program that has 10 lines of effort and is trying to put things in place. VA has come to the Congress requesting legislation to modernize its disability claims process and is implementing those reforms right now.

But in order for these reforms to be successful, VA leaders are going to have to energize an entrenched bureaucracy that is challenged in successfully implementing management reforms. GAO is dedicated to working with the Department in order to help it achieve success, and I am happy to share our experiences with other agencies in the Q&A portion. Twenty-six areas have come off the high-risk list over time. There is a prescription for success here. I have discussed this prescription with the Veterans Administration, and we are trying to work with them to implement it there, as well, but we are not there yet.

And so, I look forward to taking questions from you at the appropriate time.

[THE PREPARED STATEMENT OF GENE L. DODARO APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you, Mr. Dodaro.

I would now like to recognize Mr. Michael Missal, Inspector General of the Department of Veterans Affairs. Mr. Missal was confirmed by the Senate in his role in 2016. He had had previous experience in both, the private sector and in other government agencies, including the Securities and Exchange Commission.

The Office of Inspector General conducts investigations, audits, evaluations, and inspections of VA programs to eliminate waste and fraud, as well as to detect and prevent criminal activity.

The Subcommittee thanks you for appearing today Mr. Missal. You have 5 minutes.

STATEMENT OF MICHAEL J. MISSAL

Mr. MISSAL. Thank you. Chairman Pappas, Ranking Member Bergman, Chairman Takano, and Members of the Subcommittee, as we approach Memorial Day, the Office of Inspector General honors the men and women who have laid down their lives in defense of our country.

At the outset, I want to express our appreciation for the work of this Subcommittee on behalf of veterans. I thank you for the opportunity to discuss recommendations issued by the OIG that assist VA in improving services and benefits to veterans and their families and caregivers.

I also appreciate testifying with Mr. Dodaro, as we work closely together to ensure coordination and avoid duplication on our respective oversight responsibilities.

OIG recommendations are directed at every level of VA operations. They affect the quality and access to health care for veterans, and benefits for veterans with disabilities, their caregivers, and family members, and the effective stewardship of VA's approximately two-hundred-billion-dollar budget.

OIG reports focus not only on solutions to a defined problem, but also identify the underlying root causes of issues that negatively impact current programs and future initiatives. As a result, these

recommendations may also be a roadmap that other facilities, offices, or programs can follow to apply any lessons learned across VA and to take corrective actions applicable to other relevant VA operations.

Our critical work could not be accomplished without congressional support of OIG efforts through its appropriations and the attention given to OIG reports and recommendations. The OIG looks forward to working with our many stakeholders to advance recommendations for improvement in all VA programs, services, and systems. This includes recommendations proposed in the 100 reports issued during the first half of fiscal year 2019.

When developing recommendations, we focus on several key principles, including the following: first, recommendations are directed to the specific VA office or program official that has the responsibility and authority required to implement them. While our recommendations may be narrowly addressed to a particular VA facility or operation, VA should be disseminating information about identified problems and remediation plans to officials in all VA offices that could potentially have the same issues and are positioned to take positive action. We meet often with senior leaders and other VA staff to discuss specific issues and trends we identify in our work.

Second, recommendations are current with ongoing issues and except in rare circumstances, should not require more than 1 year to implement from the report's publication. This helps minimize the risk that OIG recommendations languish, become outdated, or lag behind VA policy and program changes.

Third, OIG recommendations are objective and driven by all documentation and other information collected and analyzed in accordance with audit, inspection, review, and investigative standards.

Finally, while we make recommendations, we do not direct how they are executed. It is important to note that OIG staff cannot mandate that VA accept OIG recommendations or pursuant to Federal law, direct specific action to carry them out. Consistent with this limitation, OIG reports may contain recommendations for VA to take appropriate administrative action against a specific VA employee for misconduct, but VA leaders and managers are then responsible for determining any appropriate administrative action.

As of the last reporting period, there were 84 OIG reports and 403 recommendations that had been open less than 1 year. The total monetary benefit associated with these recommendations is more than $2.7 billion. There were also 40 reports and 133 recommendations that remained open for more than 1 year. The total monetary benefit related to these reports is more than $329 million.

The OIG is deeply committed to serving veterans and the public by conducting effective oversight of VA programs and operations through independent audits, inspections, review, and investigations. That commitment can only be realized by making practical, meaningful recommendations that enhance VA's programs and operations, as well as prevent and address fraud, waste, and abuse.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you or other Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF MICHAEL J. MISSAL APPEARS IN THE APPENDIX]

Mr. PAPPAS. Well, thank you very much, Mr. Missal for your testimony.

I would now like to recognize the Chairman of the Full Committee, Chairman Takano, who has joined us for this first hearing of our Subcommittee. If there are no objections, I recognize Chairman Takano for 5 minutes.

OPENING STATEMENT OF MARK TAKANO, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. TAKANO. Thank you, Chairman Pappas and Ranking Member Bergman.

I came to today's hearing for two important reasons. First, I wanted to note that this is the first hearing of the session for the Subcommittee on Oversight and Investigations. The Subcommittee has a long and successful history of reviewing issues of great importance to our Nation's veterans. Past hearings have examined concerns with veteran's health care, delved into major problems with agency contracts, and reviewed whether the Department's money is well spent. I know that Chairman Pappas, Ranking Member Bergman, and the rest of the Subcommittee will move forward with sharp eyes and an even-handed approach, as it examines the gamut of issues and challenges facing the Department.

The best oversight is conducted with nonpartisan approach based on evidence and facts. The comptroller general and VA Inspector General are here today to help us understand the evidence and facts and I want to welcome them, too. Welcome, gentlemen.

However, I also must note that we have an empty chair at the witness table. The Department of Veterans Affairs decided not to show up for the hearing today. This is unacceptable. By not appearing today, the VA secretary is ignoring an opportunity to show that the Department cares about addressing the serious concerns GAO and the IG have identified.

The Veterans Health Administration and VA contracting are both at high risk, according to the Government Accountability Office. The comptroller general is here to testify about needed action by the Department. We need to hear from VA leadership about their plan to be removed from the Department's—from the high-risk list.

The VA Inspector General is here to testify about the 510 recommendations totaling approximately $3 billion that have not been yet implemented by the Department. These include recommendations to address medical-supply chain failures that have, at times, led to delayed procedures at the DC VA Medical Center. Other recommendations focus on inappropriate denial of claims for veterans who experienced military sexual trauma. The IG is also here to discuss its work on how VA is can and should improve its suicide prevention programs and the Veterans Crisis Line.

It is Congress' constitutional duty, and I say that again, it is Congress' constitutional duty to oversee the Federal Government. This Committee will not abandon its duty to protect the interests of veterans, their families, and taxpayers.

Now, the secretary wrote to me and Ranking Member Phil Roe, stating that participating on a panel with the Department's watchdogs was somehow a break with tradition or practice. Frankly, this is a terrible excuse. VA doesn't get to pick and choose which hearings they will attend. His refusal to show up sends Congress the wrong message.

Instead, we need to hear that VA will address the concerns identified by independent, credible investigators and auditors. The Department and the Committee have a history of working cooperatively with each other. I expect VA to show up and be accountable for the next hearings of the Committee.

I look forward to the hearings and other work that the Committee will undertake in this session of Congress, and with the remaining time, I do want to ask a question for Mr. Missal of the VA OIG.

Mr. Missal, your testimony discussed some important work by your office regarding the prevention of suicides. As you know, it is the number one priority for this Committee. It is a continuing tragedy that on average, 20 veterans commit suicide each day. I understand that the Office of Inspector General released a report on March 2017 that examined the VA's Veterans Crisis Line. The report revealed many serious problems with the crisis line, substantially impacting the quality of responses to veterans' needs. Sixty recommendations followed on a range of issues, such as improved crisis line staff training, more modern technology, and better cooperation with the VA Office of Suicide Prevention.

Mr. Missal, did VA implement all of those recommendations and how timely was VA's response?

Mr. MISSAL. Chairman Takano, I believe all of those recommendations are now closed out. We share the seriousness of suicide. We have a number of different active projects on it right now and with respect to the Veterans Crisis Line, we put out a report in 2016 and followed that up with one in 2017. We recently went back just to ensure that it is operating as effectively as possible, given how many veterans it touches.

Mr. TAKANO. Well, thank you very much.

And I yield back, Mr. Chairman.

Mr. PAPPAS. Thank you very much, Chair Takano.

And since we are on to the question portion of the Subcommittee hearing, I would like to recognize myself for 5 minutes.

It is noteworthy that both of our witnesses here today understand the importance of strong and consistent leadership for ensuring that major problems are addressed and that the recommendations are ultimately implemented. Unfortunately, the VA faces a major challenge. Currently, too many top positions remain unfilled at hospitals and within VA headquarters, itself; further, many of the leadership positions are filled with people serving in an acting capacity.

The Subcommittee staff has analyzed some data regarding leadership instability within the Veterans Health Administration, which is charged with taking care of the health care needs of more than 9 million veterans across this country.

I have a few charts here today. Chart number 1 here behind me shows that during the past 5 years, the Veterans Health Adminis-

tration has gone for a total of 824 days without a confirmed leader. Dr. Richard Stone is currently leading the VHA in an acting capacity.

Also behind me, we found that 48 percent of senior leadership positions within the Veterans Health Administration are currently held by individuals serving in an acting or interim role. In addition to that, the Veterans Health Administration has been affected by turnover in the position of the VA's chief information officer. Since January 2017 alone, 4 different individuals have led the VA's Office of Information Technology. With a significant number of major IT projects in the works for the VHA, this level of top-leadership turnover has presented numerous risks to the successful completion of those very projects.

I know that Dr. Stone and the vast majority of the VA and VHA leaders, even those serving in an acting capacity, are working really hard and are very dedicated to serving our veterans; however, a lack of permanence when leaders are, at times, wearing multiple hats within the agency, dividing their attention between key management responsibilities, is hardly the best situation for ensuring quality care.

So, for both witnesses, Inspector General Missal and Comptroller Dodaro, do these charts point to a major problem for the VA? And do these leadership problems challenge the ability for the Department to address your recommendations?

Mr. MISSAL. I agree that they present major challenges for VA. Continuity of leadership is a key issue. Leadership sets the tone at the top. VA is a very large, complex organization. It takes anyone a significant amount of time to really understand the programs, operations, and culture. In addition, when you have somebody in an acting position, they don't have the authority or the support of many of the staff that they are going to be able to move a program or initiative forward. We have found in many situations; leadership has been a key issue that has caused or resulted in some of the problems.

Mr. DODARO. I agree with Mr. Missal. And, actually, I was about ready to downgrade the Veterans Health Administration in the health care area in our rating on leadership commitment to not met, But I kept it at partially met, based upon a conversation I had with Secretary Wilkie—I am giving him the benefit of the doubt— and I have had a lot of follow-up with Dr. Stone, as well.

But this is a serious problem and there needs to be sustained leadership at the VA. I have met with each of the last 4 secretaries. They have all had different priorities and initiatives that have taken the Department in somewhat different directions and kept it from having sustained leadership.

One of the reasons I put things on the high-risk list is that most of the problems need to be addressed across multiple administrations. These are the hardest management problems in the government, and in order to have them succeed, there have to be plans in place that sustain it across a period of time, and it is difficult to do it with a lot of turnover and lack of sustained leadership.

Mr. PAPPAS. Well, thank you for that response.

Mr. Comptroller, looking at a parallel example in a different agency, the Department of Homeland Security was unable to pass

a major financial audit. Among other things, this led it to be included on the Department's high-risk list. And I am wondering if you could talk a little bit about what happened in that case and what DHS has done to address its high-risk designation and what it might hold for the VA.

Mr. DODARO. Yes. We designated the Department of Homeland Security high risk the day it was stood up and created back in 2003. They have made a lot of progress over a period of time. We have met with a lot of secretaries, deputy secretaries, and other key officials there.

In the early days, it was difficult to see a lot of progress, but eventually they became more engaged with us. And several years ago we agreed on the 30 outcomes that we use to gauge whether or not they were going to be successful or not. So, we both agreed on what outcomes we were trying to achieve in this area.

I just reported in March, 17 of the 30 areas they have met now and are on their way. One of them is for 4 years running now. They received a clean opinion on their financial audit, which they hadn't for more years previously, and most of the other areas, they are on their way to make some progress.

They still have significant issues, particularly in getting more modern financial management systems and improving their acquisition procedures. They still have issues, which is why they are still on the list, but they have a plan. Now, that plan has remained the same with changes in administration over time, because we have agreed on it. We meet on a quarterly basis. The Department of Homeland Security rates themselves against the criteria we have for coming off the list, we review it, and then we respond to them and their efforts. So, we have a very constructive working relationship there.

Of course, they have some vacancies themselves, but I am hoping to continue to work with them. I just testified a few weeks ago, and Congressman Rose is on that Committee, on the management challenges at the Department of Homeland Security.

But I have mentioned to VA that DHS is a good model and that is what we are trying to work toward both, with VHA and VBA. And so, I am hopeful that we can take those success factors.

Now, the other important thing that I want to emphasize, is that hardly any area on the high-risk list gets off the list without sustained congressional oversight, as well, and action by the Congress. Engagement by the Congress is absolutely critical to the success of agencies coming off the high-risk list.

I would encourage this Committee to remain focused on that and continue to work to ensure VA is addressing these fundamental management weaknesses, because otherwise, the efforts will keep repeating themselves and there will be serious problems with any reform that needs to be implemented.

Mr. PAPPAS. Thank you, sir.

I would now like to turn it over to General Bergman, the Ranking Member, for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

And both, Mr. Dodaro and Mr. Missal, you used the terms symptoms versus root causes. I am glad to hear you say that, because we can waste a lot of time dealing with symptoms, and unless we

deal with the root causes and we are not going to get the results that we know we need.

And Mr. Dodaro, you said VA is hobbled by fundamental management weaknesses. Is one of those weaknesses the ability to identify root causes versus symptoms?

Mr. DODARO. That is part of it. We had a difficult time getting VA to do root-cause analysis a few years ago. For example, when we put the health care area on the list. But, eventually, they came to a list of root causes and I outlined what those were that they identified themselves and they comport with a lot of what we identified.

Mr. BERGMAN. Okay. So, actually, they were able to—

Mr. DODARO. They were able to come up with the root cause. What they haven't been able to do, though, is translate that into an action plan to deal with the root causes that have metrics and milestones and clear accountability and a lot of other fundamental—

Mr. BERGMAN. I have to—because I know we are on the same wavelength here, and Mr. Missal, you mentioned that GAO can recommend, but not require; is that correct?

Mr. MISSAL. Our office can recommend, but not require.

Mr. BERGMAN. Yeah, so the point is, as we then go back and forth in between what you both are articulating, this is pretty much the same question for both of you: Would you please explain how your office and the VA collaborate to close recommendations and who within VA is responsible for facilitating that collaboration.

Mr. MISSAL. We have a very active program on outstanding recommendations. Once a recommendation has been published in a report, we review them quarterly with VA to see what progress they are making. We expect to get in writing the progress that they have made, and we continue that throughout, until the recommendation is closed.

The responsible person would be the person to whom the recommendation is addressed. All of our recommendations are addressed to an individual, whether it is the secretary, deputy secretary, or on down from there.

Mr. BERGMAN. Okay. Mr. Dodaro?

Mr. DODARO. Yes, we coordinate through their Office of Congressional Liaison and that individual, then, has us work with the individual officials that are responsible for the area. For example, at the Veterans Health Administration, our people meet with them on a monthly basis. We go over their recommendations every 4 to 6 weeks and then we meet with the VBA separately.

So, we have regular meetings with them to help them understand what they need to do to implement the recommendation and very specifically answer any questions they have, and then make it clear that when we will recommend that something will be fixed. VA will come up with a plan to fix it and will want us to close the recommendation. We will say, No, no, no, no. It takes more than a plan. You actually have to implement the plan and you have to deal with this issue.

Those are the kinds of conversations that we have with them. I think we have an effective process working with them to close these recommendations.

Mr. BERGMAN. I see my time is running out here, but, Mr. Dodaro, I have one more here for you. Roughly 26 areas have been removed from the high-risk list. Some areas were removed in as little as 3 years, while one took 29 years. What are the top three, best practices that GAO has found effective in helping agencies address high-risk concerns?

Mr. DODARO. Number one is an effective action plan that deals with root causes, as well as the metrics, milestones. You need a roadmap and you need to evaluate how well you are getting there in achieving those objectives and dealing with the underlying root causes. That has not been done at VA in any of the areas that we have designated on the high- risk list yet.

Number two is sustained congressional leadership. There also needs to be buy-in from the agency leadership at the top and at all levels. And that leadership has to engage with GAO, but importantly, send the proper messages to their agencies.

Number three is congressional engagement in this process. Congress is a key stakeholder in the process, not only from an oversight standpoint, but also to make sure that whatever VA needs to implement these actions, that Congress is willing to provide.

Those are the top three.

Mr. BERGMAN. Okay. I yield back.

Mr. PAPPAS. Thank you, General Bergman.

I now recognize Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Good afternoon, gentlemen. Thank you for being here.

Mr. Dodaro, in adding VA's acquisition management to the high-risk list last year, the GAO cited evidence from its September 2018 report on the Veterans First program, which requires VA to give preference to veteran-owned small businesses when awarding contracts.

Among other things, the GAO found that VA training lacked clarity on how contracting officers should balance the preference for veteran-owned small businesses with fair and reasonable price determination when lower prices might be found on the open market. In addition, the GAO found that the VA's online training sessions on the Veterans First policy were not mandatory, so only about 52 percent of VA contracting officers had completed the training.

You recommended that the VA design more targeted training, considered making it mandatory. Can you tell me about the extent to which the VA has implemented this recommendation?

Mr. DODARO. First, VA has clarified the guidance to contracting officers to have them document the determinations that they make. They are actually doing some compliance checks now to make sure that the new policy is being implemented effectively. They are moving toward making the training mandatory and then providing it to all people. That hasn't fully happened yet, but they are on their way to having that accomplished.

Mr. CISNEROS. So, this is, I guess, some of the problems that we are seeing, right, when you talk about the management weakness. I mean, how difficult is it to make a mandatory training? It seems like it should be something that could be done with a simple letter.

Mr. DODARO. At GAO, I make that decision and I make it right away.

Mr. CISNEROS. Uh-huh.

Mr. DODARO. It is important. They should be able to do this, but they also have to work with their union and all the union bargaining agreements and how the training would be provided, and so that may take some time.

Mr. CISNEROS. You know, Mr. Missal, you said you could not implement—and this is just to kind of really follow up on some of General Bergman's questions—but you said you can make recommendations, but you can't make the VA implement these recommendations.

Mr. MISSAL. That is correct.

Mr. CISNEROS. Like you said, you will designate an individual as to who is responsible for this needs to handle it. I mean, some of these recommendations have been on the list for a long time. Are they being worked? Are they being ignored sometimes? Why aren't these recommendations being implemented if they are really trying to make change?

Mr. MISSAL. It really varies. About 85 to 90 percent of the recommendations we make are closed within a year. And just with respect to the recommendations, while we can't require them to implement them, what we do when we make the recommendation is ask VA if they are going to concur in it. VA concurs with almost all of our recommendations. We then ask them for an action plan: How are you going to implement it?

So, VA commits to the action plan, including the date when they think they will be finished with it. That gives us a structure to follow through. It is still VA's decision to do it. We can't require them, but by having an action plan, we can watch closely what they are doing.

Mr. CISNEROS. As you are going along, and like if a plan—let me ask you this: How often is a recommendation that you make, where they say, you know, we are not going to do this.

Mr. MISSAL. It is very rare. I think we have had a handful in the last few years.

Mr. CISNEROS. All right. So, they are working on all of these recommendations that you are saying, but when something is taking 29 years, what is the root cause of that? Is it really coming back down to management again?

Mr. MISSAL. It is a few that are open more than 5 years. It is typically a staffing issue, or we get the sense that it is not their priority.

But if we see recommendations that are open for a long time that we think really need to be closed out, I don't hesitate to escalate it. For instance, if it is at a mid- level person, I will escalate it at VA, and I typically get a very positive reaction when I bring it up. They explain that VA is committed to doing it, we think it is important, and it needs to have the right attention.

Mr. CISNEROS. And one last question for Mr. Dodaro, and you can probably give us this one for the record because I am running out of time, but there is always going to be turnover. We know that there is always, with each new administration, there is going to be new secretaries, there is going to be new assistant secretaries, but you talked about the weakness in management there at the VA.

Is it at the bureaucratic level or do we not have sustained professional managers there at the VA that can manage the day-to-day operations there? And I am out of time, so if you could just submit that for the record, I would appreciate that.

Mr. DODARO. I will do that.

Mr. CISNEROS. Thank you. I yield back my time.

Mr. PAPPAS. Thank you, Mr. Cisneros.

I now recognize Mr. Bost for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman.

Mr. Dodaro, I kind of want to go down that same path, and that is because a couple of years ago our office discovered, because we thought it was just the VA just adjacent to my district that was having this problem, but that was the fact that the management there at the individual VAs were—they had had, I think, 6 or 7 temporary managers over a 6-year period, because there was a rule that you could not be assigned a temporary management position for more than 280 days. If you continue down that path, what you have is—I was in small business. I couldn't memorize the names of the people I was even working within 280 days, let alone, figure out what the problems were and get them fixed.

So, we actually moved forward with a bill at that time to try to have them show us a plan where they would correct this problem. And what we also discovered was it wasn't just that VA; there were a total of about 20 we discovered that were in that same type situation.

Have you noticed any change at all and is that the type of management problem you are talking about?

Mr. DODARO. That is one of many, yes. That is definitely one of them. You know, for example, you can have somebody operate in an acting position longer than 210 days under the Federal Vacancies Act, but they can't carry out non-delegable functions, but most of the functions are delegable and should be in place.

But part of the problem here is that there are weaknesses at every level in lines of accountability. Sometimes at the medical center level, there are issues. The VISNs, do not have clear accountability. There are headquarters offices, and it is really not clear exactly what the line of accountability is.

What we find in health care, for example, there were 800 national policies. There were 55,000 local policies. And there was no alignment between the national policies and the local policies. If you don't have that, how are you going to train people to implement things? Nobody is really in charge.

What we have recommended in the past—and it may be something that this Committee should consider—is there needs to be a chief management officer in certain positions, and I have recommended in the past that this person be given a term appointment. So, they would be confirmed by the Congress. They wouldn't set policy, but they would make sure that the management infrastructure is there to work properly to implement whatever policy, that whatever administration it is, would want going forward.

We have successfully had that position installed at the Department of Defense. There is a position like that at the Department of Homeland Security. There is not, really, a management integra-

tion function at the VA right now, which I think is something that needs to be remedied.

We have not been able to succeed, though, in getting term positions. But some positions in the government, like the commissioner of the Internal Revenue Service, the Social Security Administration, FAA, they have 5-year terms that can be renewed for 5 years, and that has helped provide more management stability at those 3 entities.

So, I think this is something that the Committee should consider. I would be happy to work with the Committee on these types of structural changes.

Mr. BOST. One more question I have, and either one of you could possibly answer this, but another thing we discovered, also, is that there is not a set standard for certain jobs and I'm going to give one example. At one of our VA's, it was a personnel officer. There was no requirement of an education level. There was no requirement of anything of past experience in the field.

But then when we asked the VA about this, I mean, obviously if you are hiring a doctor, you are going to get a doctor, but in the position of management, there are no set standards or criteria that are met, and I think that is one of the problems why when we use the term "when you visit one VA, you visited one VA." Because we had in this case, a very inexperienced person in charge of personnel, and because of that, you got a lot of unique hires, to say.

Mr. DODARO. I would say—and I know Mr. Missal will say it, so I will be very brief on this—I would say VA is a large, decentralized organization, but it only works because of individual actions at levels. There is not a system in place that ensures these things are dealt with in a uniform matter on almost any issue.

Mr. BOST. Thank you. My time is up.

I yield back.

Mr. PAPPAS. Thank you. Mr. Rose is now recognized for 5 minutes.

Mr. ROSE. Mr. Missal—I am always very respectful of—I have a name that no one ever messes up—I want to talk very briefly about staff vacancies. You know, we have noted in the past the top-five shortages being psychiatrists, human resources professionals, primary care providers, psychologists, and med techs.

Do you find right now that there is enough of a sense of urgency, that there is enough resourcing around this? What is your perception of the ongoing work in this area?

Mr. MISSAL. I think it is due to a variety of reasons. We do a staffing report on a yearly basis pursuant to congressional mandate. And what we do is we actually survey the medical centers and say, "Tell us what your priorities are, where your important vacancies are."

As you correctly point out, psychiatrist was mentioned, I believe it was by 83 out of the 141 medical centers.

Mr. ROSE. Sure.

Mr. MISSAL. And when you think of suicide as being the number one clinical priority, psychiatrists play such an important role.

Number two is HR. How can they hire people if their HR function isn't fully staffed? We found a significant problem in our report on the Washington, D.C. Medical Center where there were vacan-

cies in many of the support areas that ensure quality health care, like sterilization, like housekeeping to clean rooms—

Mr. ROSE. Right.

Mr. MISSAL [continued]. —and they had a deficient HR—

Mr. ROSE. Well, what is interesting to me is that when you are sitting down with a four-star general, they never complain about the absence of colonels, right, because they grow them themselves. Do you think that it is time for the VA to start to consider ways in which we could actually—God forbid in this town, we think long term—and build a pipeline of medical professionals? Is it time to start thinking about that?

Mr. MISSAL. One of our recommendations on the staffing plan is for them to build staffing models to do precisely what you are talking about.

Mr. ROSE. What about a training model, though? What about starting to pay for people's education with a guaranteed time of service required on the back end?

Mr. MISSAL. VA has some of those programs. They do have it for physicians and other positions, as well.

Mr. ROSE. I am talking about dramatically expanding it. Is there something that we can do to guarantee a pipeline? Again, I have never heard a four-star or a two-star or whatever complain, Man, I don't have enough majors.

Mr. MISSAL. Well, we made a number of recommendations on how they can improve staffing. It is frustrating that they haven't implemented all of those, because to me, staffing one of the core functions of an organization.

Mr. ROSE. I agree.

Mr. MISSAL. If you can't get that right, it is hard to get the other things.

Mr. ROSE. I agree. I know that, Chairman Pappas, that is something that, you know, we would love to think about.

Mr. Dodaro, you mentioned that Congress needs to continue to assert its role in this. How, in the absence of—the fact that the VA is not even showing up right now, the secretary or a designee, leads me to believe that they don't care that much. Is it possible to have progression reports? Are there things—what is your recommendation for how, beyond oversight hearings, what can we do as a Committee to highlight the absence of any progress or some suitable progress on this matter and to push or shame or compel the VA leadership to do something?

Mr. DODARO. Yes. In the past, what I have recommended Congress has done is on several issues, they will ask for quarterly reports from the agencies on—

Mr. ROSE. And so your recommendation is to legislatively mandate quarterly reports?

Mr. DODARO. Well, if they are not coming to the hearings, I mean, you need to get the information.

Mr. ROSE. How do you do that?

Mr. DODARO. You have the power to—both, in the appropriation process, as well as authorization. You can compel them to provide regular reports.

Mr. ROSE. What are examples where there has been mandated quarterly reports in other departments?

Mr. DODARO. IRS is one example. I think you are going to really need it in the electronic health care record area.

Mr. ROSE. I agree.

Mr. DODARO. The IRS tried the big bang and the long- term effort on tax-system modernization and that didn't work well.

You need incremental reports. You are talking about anywhere from a $10–16 illion-dollar program being implemented over a ten-year period of time. You need incremental reports. You could have them report on how well they are responding to GAO and IG recommendations, how well they are dealing with the high-risk areas. You can have them do that.

They will complain it is onerous and whatever, but you need to get the information, and, particularly, if they are not appearing at hearings, that is a way to get it.

Mr. ROSE. That is very helpful.

Mr. DODARO. Yes. Also, through the appropriation process, we have worked with the Congress in the past to fence some of the money. In other words, like on some of these IT systems, you can only spend so much, and actually, there are quarterly reports required in some agencies before they can spend the money to go into the next tranche on IT.

Mr. ROSE. Cash and shame.

Mr. DODARO. Yes.

Mr. ROSE. Cash and shame.

Mr. DODARO. Yes, I would also say, if I might, on the graduate medical-education area, the Government spends about $16 billion a year right now on these—to pay for graduate medical education for doctors both, at VA and DoD, as well. And the part of the issue that we have identified, though, is that they have never evaluated the success of those programs. And if they could evaluate those programs, I think there would be a basis for supporting what you are suggesting.

Mr. ROSE. And just to close out, I mean, it seems that there is a crisis with staffing in the VA, but not a crisis in staffing at the DoD health care facilities and I am curious as to why that is when everyone is just trying to take care of soldiers and vets. So, we should look at that.

Mr. DODARO. Yes, one thing we could do is look at the two programs and compare. [GAO provided additional information for the record. See insert A.]

Mr. ROSE. That is great. Thank you.

Mr. PAPPAS. Thank you, Mr. Rose.

I now recognize Ms. Radewagen for 5 minutes.

Ms. RADEWAGEN. Thank you, Mr. Chairman, and Ranking Member. I want to welcome the panel.

So, my question is, the latest addition to the high-risk list, VA Acquisition Management, could you please describe how this area was identified for the high-risk list.

Mr. DODARO. Yes, we had been asked by the Congress to look at the functions that have been put in place; particularly, the surgical and medical procurement strategy they had in place. VA was hoping to achieve about $150 million of savings. We went in and found that they didn't really involve the clinicians in the development of that process. It was expected that 40 percent of all the procure-

ments would be made off of their master list on that area, but it was only about 20 percent. So, they weren't achieving the savings.

We found that they were still using a lot of emergency purchases, rather than going through a competitive process and having a better system. The regulations hadn't been updated since 2008. They have been working on an update since 2011. We talked to the contracting officers and they felt their workload was excessive and that they weren't getting necessary training.

There was a range of issues. We did a number of audits and that led us to the conclusion that there was a systemic problem here that needed to be addressed.

Ms. RADEWAGEN. Okay. So, also, it stands to reason that VA would close the easiest recommendations first. So, if we are talking about moving the needle in terms of closing recommendations with the greatest impact to solving the overarching problem, where would you—and it is a bit subjective—where would you say VA stands today?

Mr. MISSALMISSAL. VA closes anywhere between—or we close— so, we don't close a recommendation unless we get confidence that the solution that VA has agreed to is going to be sustainable. We close 85 to 90 percent of the recommendations we make within a year. And so, we watch it very carefully. We monitor what they are doing. We test it. We require everything in writing before we close out a recommendation.

And to make sure they are effective; it is really our responsibility to come up with recommendations that get to the root cause of the issue. Because when we do a report, we not only identify what went wrong, but why it went wrong, and our recommendations really have to focus on the fact that we want to address the issue, make sure it doesn't happen again, and that other VA facilities or programs that may have similar issues, can learn from that, as well.

Mr. DODARO. Yes, I would say that—

Ms. RADEWAGEN. Thank you, Mr. Chairman.

Oh, go ahead.

Mr. DODARO. Yes, I would say from my standpoint, they are doing a pretty good job of implementing our recommendations, working hard to do that. They are not doing such a good job in addressing the underlying root causes for the problems. And unless they do that, they will fix a set of recommendations and we will make a whole new set of recommendations and we will get into that kind of pattern.

I think addressing the underlying management weaknesses has to be done in order for all of us to say that our Government has the very best management operation at the VA to serve veterans.

Ms. RADEWAGEN. Thank you both.

Thank you, Mr. Chairman. I yield back.

Mr. PAPPAS. Thank you, Ms. Radewagen.

If the witnesses will oblige, General Bergman and I just want to take a few more minutes to get in a couple more questions. And I wanted to just follow up on a question that Chairman Takano referenced. He asked about the VA Office of Suicide Prevention.

And, Mr. Missal and Mr. Dodaro, is your office currently conducting any audits or examinations of any of the VA's suicide prevention programs?

Mr. MISSAL. Yes, we have a number of active projects going on right now. We have approximately 4 to 5 on individual suicides, including the one in the West Palm Beach medical facility where a veteran was in in-patient mental health and while there, committed suicide. And, we are also exploring other areas, as well.

Because of the critical importance of this issue and the tragedy of the issue, we are expanding out to look at broader programs, with respect to suicide. And as I previously said, with respect to the VCL, we went out recently, again, to review that. That touches about 750,000 contacts a year.

Mr. PAPPAS. Thank you.

Mr. DODARO. Yes, we are, at the request of Chairman Takano, looking at the pattern that has emerged recently of veterans committing suicide on VA campuses and what is, perhaps, behind that issue.

Mr. PAPPAS. Well, thank you. I know the entire Committee looks forward to working with you on these matters.

I just wanted to call up one thing that Secretary Wilkie provided in his testimony. He said, "The Department is currently working on establishing a process to create functionality within the Office of Accountability and Whistleblower Protection, which would both, track and confirm, implementation of recommendations of both, the GAO and the IG."

Congress established this statutory requirement 2 years ago, however, the secretary did not provide a target deadline for following that particular law, and so I just wanted to make it clear that we will be following up with the Department on the timeline for ensuring that there is a clear and effective process to ensure implementation of that.

One final thing—and Congressman Rose had asked a bit about what can Congress do to ensure action on these recommendations—and one thing I wanted to ask you both if there is anything the Committee should be looking into to consider how we can empower you both and both of your agencies to do your job even better?

Mr. MISSAL. I think having hearings like this and shining a spotlight on the issue is one great way to do that. We publish semi-annually, the number of recommendations that have been outstanding for more than a year with details. So, we provided that information. We try to put as much transparency on our work as possible. And given the importance of recommendations, we feel that we can't do enough with respect to that.

Mr. DODARO. One of the things I was pleased to see last year is that Congress passed the GAO/IG legislation that will, in future years, require certain agencies, as part of their annual budget submission to the Congress, to identify actions that they are taking to implement open GAO recommendations. So, there'll be a systematic process to do that.

In the interim, every year I send a letter to each department agency head outlining the highest-priority recommendations from our standpoint, and you could ask what they are doing to imple-

ment those recommendations, to have them report to you on that, and we can help critique that submission and other reports.

But I agree with Mr. Missal that the most effective tool to Congress is to have hearings and to have people come up. The action that occurs, just because Congress holds a hearing is, has a cathartic effect on the agencies and prompts them to take action. And I have seen this not just at VA; it is across the government.

Mr. PAPPAS. Thank you. General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

And on the subject of oversight of the electronic health record modernization, I was the proud cosponsor of the Veterans EHR Modernization Oversight Act, which was enacted last December, and is one of the toughest pieces of reporting legislation to ever come out of this Committee. So, we know we have our work cut out for us on that, but we are going to be like a dog on a bone on that one.

Now, this question is for both of you. The Accountability and Whistleblower Protection Act, which I referenced earlier, of 2017, established the Office of Accountability and Whistleblower Protection and tasked it with recording, tracking, reviewing, and confirming implementation of recommendations from GAO and the IG.

From each of your organization's perspective, what are practices that OAWP could build into their policies and procedures that could help VA address recommendations and improve services?

Mr. MISSAL. We meet regularly with OAWP to talk about how they are going to be implementing a number of their policies, that they have not done so yet. I have a regular meeting with Dr. Bonzanto to do so. I know this is one area where they are working hard to try to implement it, to get it off the ground.

From our perspective, we coordinate from the OIG, all of the recommendations from VA. VA doesn't do the same thing. If it is a VHA recommendation, it goes to VHA. If it is VBA, VBA deals with it. If it is Office of Information and Technology, they take it.

So, I think having a practice where VA has the reservoir of all of the recommendations, will get greater attention, certainly, from the most senior leaders of VA. They really need to put that together to have a better indication of the number, types, and extent of recommendations that they have.

Mr. DODARO. I agree with Mr. Missal on that. That is a very good suggestion and a good potential outcome.

The head of that office came to visit with me, and I pledged to work with them, to coordinate with them on their responsibilities. I still think the Department is working out exactly how this is going to operate, because we are basically still operating as we have in the past, as I mentioned earlier, dealing with the Office of the Congressional Liaison and other things. And so, until we hear further from them on how they are going to work their internal coordination on the GAO recommendations, it is pretty much status quo.

But whatever they work out internally, I can pledge that we will work with them. It is to our benefit and everybody's benefit that our recommendations be implemented.

Mr. BERGMAN. Okay. And one final question. You know, in the military, we routinely change commanders, because you don't command a unit forever; you are there for a while and then you move on. But one of the things that we have is we have turnovers. Whether it be in the form of a brief, face-to-face, whether it be in the form of a folder or a binder or some record of what that unit is doing, where they have made their gains, where they have their challenges, et cetera, et cetera.

We talked about sustained leadership within the different levels of the VA. Do you sense, is there any corporate knowledge, if you will, that is passed along when someone is leaving a position of leadership and someone new coming in, is there a pass-down?

Mr. MISSAL. Again, it is going to depend on the situation, but if I could just generalize, I don't think they do as good of a job as they can. There has been an extraordinary number of senior leaders who have turned over—and I don't just mean at the very top, but at program offices, et cetera—and they don't frequently have a good sense of the history, what the priorities have been, and it takes them a long time to get up to speed.

And given all the critical issues facing VA now, that really does hamper implementing it, and that is why when we look at continuity of leadership, we think that is a really critical and important issue that VA just needs to get better at.

Mr. DODARO. Yes, I really don't know whether they do that or not, but I do know that if they do, it is not evident.

Mr. BERGMAN. Okay. Well, thank you very much.

Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you. I recognize Ms. Radewagen for 5 minutes.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

One last question here. DoD's supply chain management was removed from the high-risk list this year. Could you please share how that came around, what type of engagement GAO had with DoD to get off the list, and lessons learned from that engagement. And as a follow-up, would you please also explain what, if any, best practices from that successful removal are now being applied to VA offices on the high-risk list.

Mr. DODARO. Yes. The DoD supply chain management was one of the charter members of the high-risk list when we created the list in 1990. That was the one that has been on there for 29 years. And for many years, DoD ignored our recommendations and didn't make any movement until Congress required them to develop plans, on inventory management, and to report to the Congress. Then, they saw the benefit of those plans, which turned into the plans on asset visibility and material distribution. As a result, they have saved millions of dollars and they have a better system now to get the materials to the military at the right place and the right time and the right amounts.

That was a very good example of how Congress was the catalyst in that case, and then once DoD started implementing our recommendations and seeing the value of it, then it took over from there and we had a very constructive working relationship with them.

But it took too long. That could have been handled a long time ago and I am hoping at VA, we can take the lessons learned from DoD and help it to be a faster process. But so far, we don't have the plans. We are still lacking the plans that were lacking at DoD when we first put the area on the high-risk list. Until they have those plans and their reports against those plans, you aren't going to see any material change in our ratings.

Ms. RADEWAGEN. Thank you, Mr. Chairman.

I yield back.

Mr. PAPPAS. Well, thank you very much.

Before closing today's hearing, I just want to make a couple final points. I know that General Bergman and I share the same outlook, that we are really committed to ensuring that the work of this Subcommittee remains bipartisan, that there may be points in times where members disagree with one another, but we certainly have to move past the point where we are disagreeable and focus on the job that we are here to do, and I know that all the Members of this Subcommittee share that outlook.

I really want to thank our two witnesses, as well, for being here with us today. I want to express, you know, a real great appreciation to both, Comptroller Dodaro and General Missal, for their ongoing oversight work at the Department of Veterans Affairs. The audits, the inspections, the examinations, and reviews provide critical facts, analysis and recommendations for the Department, for Congress, certainly, and ultimately, for the general public.

And also please relay to your staff, you know, our thanks for the incredible work that they do. As was shown today, the impact on both, the GAO and the Office of the Inspector General, results in very real improvements to the Department of Veterans Affairs and our veterans are ultimately better served because of the work that they do and that you do.

General Bergman, I am happy to recognize you, if you would like to close.

Mr. BERGMAN. Well said, Mr. Chairman. My time is finite.

Mr. PAPPAS. Thank you. Members will have 5 legislative days to revise and extend their remarks and include extraneous material, and, without objection, the Subcommittee stands adjourned.

[Whereupon, at 3:13 p.m., the Subcommittee was adjourned.]

A P P E N D I X

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Prepared Statement of Gene L. Dodaro

Why GAO Did This Study

VA is responsible for providing benefits and services to veterans, including health care, disability compensation, and various types of financial assistance. In fiscal year 2019, VA received a total budget of $201.1 billion and a discretionary budget of $86.6 billion-the largest in VA's history-to carry out its mission. GAO, along with the VA Inspector General and other entities, continues to identify significant deficiencies in VA's governance structures and operations-all of which can affect the care provided to our nation's veterans.

This testimony focuses on the status of VA's efforts to address GAO's high-risk designations and open GAO recommendations in the following areas: VA health care, acquisition management, and disability claims workloads and benefit eligibility criteria, among other areas. It is primarily based on GAO's March 2019 high-risk update and a body of work that spans more than a decade.

What GAO Recommends

Since 2000, GAO has made more than 1,200 recommendations to reduce VA's high-risk challenges, and VA has implemented approximately 70 percent. GAO will continue to monitor VA's progress in implementing the remaining open recommendations.

Sustained Leadership Needed to Address High-Risk Issues

What GAO Found

The Department of Veterans Affairs (VA) has longstanding management challenges. As a result, GAO added several VA programs to its High-Risk List. This list focuses attention on government operations that are most vulnerable to fraud, waste, abuse, or mismanagement, or in need of transformation. These include managing risks and improving VA health care, VA acquisition management, and improving and modernizing VA disability programs, including managing claims and updating eligibility criteria.

March 2019 High-Risk Report Ratings for High-Risk Areas Related to the Department of Veterans Affairs (VA)
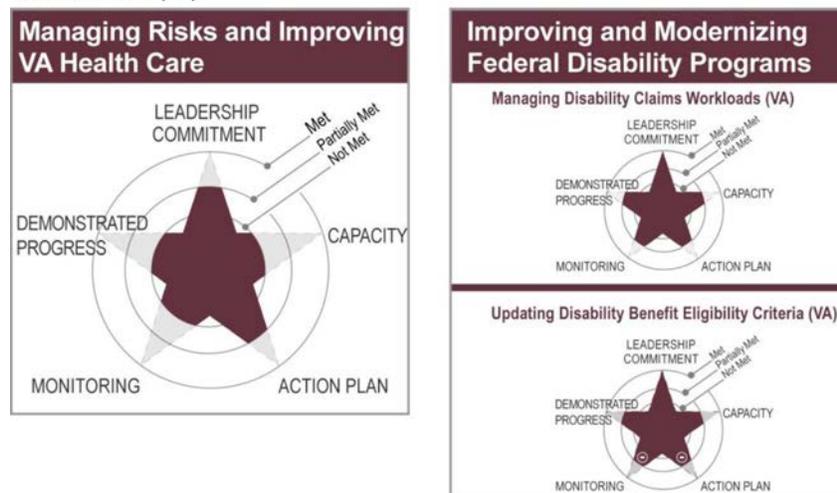
Source: GAO analysis. | GAO-19-571T

Note: VA acquisition management was a newly designated high-risk area in 2019. As such, it was not rated on the five criteria in March 2019.

VA health care was designated high risk in 2015 due to concerns about VA's ability to ensure the cost-effective and efficient use of resources to improve the timeliness, quality, and safety of health care for veterans. GAO identified five areas of concern: (1) ambiguous policies and inconsistent processes; (2) inadequate oversight and accountability; (3) information technology challenges; (4) inadequate training for VA staff; and (5) unclear resource needs and allocation priorities. VA's efforts to address each of these areas have been impeded by leadership instability. However, since his July 2018 confirmation, Secretary Wilkie has demonstrated his commitment to address the department's high-risk designations. His actions to date have allowed the department to maintain its leadership commitment rating of partially met in GAO's 2019 High- Risk update. VA also partially met the action plan criteria. As of March 2019, it did not meet the other three criteria for removal from the High-Risk List (agency capacity, monitoring, and demonstrated progress). This is, in part, because GAO continues to have audit findings that illustrate that the five areas of concern have not been fully addressed. For example:

- In a series of reports from 2012 through 2018, GAO found VA's wait time data unreliable for primary and specialty care as well as for care in the community. GAO also found that VA did not measure the full wait times that veterans experience in obtaining care across these settings.
- In November 2017, GAO reported that VA medical center officials did not always conduct or document timely required reviews of providers when allegations of wrongdoing were made against them.
- In April 2019, GAO found that VA's governance plan for modernizing its electronic health record system was not fully defined, potentially jeopardizing its fourth attempt at modernization.
- In April 2019, GAO reported that VA's appraisal process for assessing medical center director performance relies heavily on a system with long- identified deficiencies that remain unaddressed, thus diminishing VA's ability to hold officials accountable.

In its 2019 High-Risk Report, GAO added VA acquisition management as a high-risk area in light of the department's numerous contracting challenges and the significant Federal investment in serving veterans. To date, GAO has identified challenges in the following areas: (1) outdated acquisition regulations and policies; (2) lack of an effective medical supplies procurement strategy; (3) inadequate acquisition training; (4) contracting officer workload challenges; (5) lack of reliable data systems; (6) limited contract oversight and incomplete contract documentation; and (7) leadership instability. For example, as of May 2019, VA does not have updated

acquisition regulations and officials expect to have a full update by 2021; a process which has been in place since 2011.

GAO designated improving and modernizing Federal disability programs, including VA's program, as high risk in 2003. GAO identified two areas of concern related to VA: (1) managing disability claims workload and (2) updating disability benefit eligibility criteria. As a result of these concerns, veterans may not have their disability claims and appeals processed in a timely manner. GAO reported in March 2018 that VA is making a major effort to reform its appeals process by onboarding new staff and implementing new technology. However, its appeals planning process does not provide reasonable assurance that it will have the capacity to successfully implement the new process and manage risks. VA agreed with GAO's recommendation to better assess risks associated with appeals reform.

VA leadership has committed to addressing GAO's high-risk concerns and has launched several transformational efforts. For example, VA is currently implementing the Veterans Health Administration Plan for Modernization, a framework that aims to modernize the department, as well as the VA MISSION Act of 2018. This Act requires VA to consolidate programs that allow veterans to receive care outside VA. If successful, these efforts could be transformative for VA. However, such success will only be achieved through sustained leadership attention and detailed action plans that include metrics and milestones to monitor and demonstrate VA's progress. Sustained congressional oversight will also be essential.

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) efforts to address longstanding management challenges. As a result of these challenges, we added several VA programs to our High- Risk List.[1] This list focuses attention on government operations that are most vulnerable to fraud, waste, abuse, or mismanagement, or in need of transformation.

VA is in need of transformation. We, along with VA's Inspector General and other entities, continue to identify significant deficiencies in VA's governance structures and operations-all of which can affect the care provided to our nation's veterans.[2] To address these deficiencies, we have made over 1,200 recommendations to VA since 2000; VA has implemented approximately 70 percent of them. However, important recommendations remain unimplemented (open), and we continue to identify similar deficiencies in recent and ongoing work. In March 2019, we sent a letter to the Secretary of VA that detailed 30 open recommendations that we deem the highest priority for implementation (priority recommendations).[3] Fully addressing these open recommendations could significantly improve VA operations; however, the recommendations highlight issues that are symptomatic of broader, systemic management and oversight challenges that will only be addressed through transformative action. Our High-Risk Report provides VA a roadmap for this needed transformation.

Secretary Wilkie has said that VA is committed to addressing our high- risk concerns and has launched several transformational efforts. For example, VA is currently implementing its modernization plan, a framework through which the department intends to systemically overhaul its structure, culture, governance, and systems through organizational improvements. Congress has also acted to drive overarching change by, for example, passing the VA MISSION Act of 2018 (VA MISSION Act).[4] Among other things, this Act requires VA to consolidate several com-

[1] GAO, High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas, GAO–19–157SP (Washington, D.C.: Mar. 6, 2019).

[2] See VA Management Challenges: Actions Needed to Improve Management and Oversight of VA Operations, GAO–19–422R (Washington, D.C.: Apr. 10, 2019); Commission on Care, Final Report of the Commission on Care (Washington, D.C.: Jun. 30, 2016); The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, (Washington, D.C: Sep. 1, 2015); and Department of Veterans Affairs, Inspector General's Management and Performance Challenges, (Washington, D.C.: 2018).

[3] GAO, Priority Open Recommendations: Department of Veterans Affairs, GAO–19–358SP (Washington, D.C.: Mar. 28, 2019), GAO–19–157SP. Priority recommendations are those that GAO believes warrant priority attention from heads of key departments or agencies. They are highlighted because, upon implementation, they may significantly improve government operation, for example, by realizing large dollar savings; eliminating mismanagement, fraud, and abuse; or making progress toward addressing a high-risk or duplication issue.

[4] Pub. L. No. 115–182, 132 Stat. 1393 (2018).

munity care programs into a permanent program.[5] VA is currently implementing aspects of this Act.

My statement today focuses on the status of VA's efforts to address its high-risk designations and open GAO recommendations in the following areas: (1) managing risks and improving VA health care; (2) VA acquisition management; (3) improving and modernizing Federal disability programs; and (4) other government-wide high-risk areas that have direct implications for VA and its operations. This statement also describes VA's ongoing efforts to transform and modernize the department.

This statement is based on our 2019 high-risk update and our body of work that spans more than a decade.[6] For these products we analyzed VA's documents related to the department's efforts to address its high- risk areas and interviewed VA officials, among other things. More detailed information on the scope and methodology of our prior work can be found within each specific report. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA is responsible for providing benefits to veterans, including health care, disability compensation, and various types of financial assistance. In fiscal year 2019, VA received a total budget of $201.1 billion, and the largest discretionary budget in its history-$86.6 billion, about $20 billion higher than in 2015. The department operates one of the largest health care delivery systems in the nation through its Veterans Health Administration (VHA), with 172 medical centers and more than 1,000 outpatient facilities organized into regional networks. VA has faced growing demand by veterans for its health care services, with the total number of veterans enrolled in VA's health care system rising from 7.9 million to more than 9 million from fiscal year 2006 through fiscal year 2017. In fiscal year 2019, VHA received $73.1 billion of VA's $86.6 billion discretionary budget.

In addition to providing health care services, VA provides cash benefits to veterans for disabling conditions incurred in or aggravated by military service. To carry out its mission, VA spends tens of billions of dollars to procure a wide range of goods and services, including medical supplies; to construct hospitals, clinics, and other facilities; and to provide the information technology (IT) to support its operations.

We have made hundreds of recommendations to improve VA's management and oversight of the services it provides to veterans. Specifically, since 2000, we have made 1,225 recommendations to VA. While VA has implemented most of the recommendations, a number remain open, as of April 2019. Specifically,

- more than 125 recommendations related to VA health care remain open, including 17 recommendations that have remained open for 3 years or more;
- 15 recommendations related to improving VA acquisition management remain open, including 1 recommendation that has remained open for 3 years or more; and
- 12 recommendations related to management of disability claims workloads.

In 2017, we began sending letters to VA and appropriate congressional committees identifying priority recommendations for VA to implement in order to significantly improve its operations. We categorized these recommendations into nine areas: (1) veterans' access to timely health care; (2) veterans' community care program; (3) human capital management; (4) information technology; (5) appeals reform for disability benefits; (6) quality of care and patient safety; (7) national policy docu-

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[5] The Veterans Access, Choice, and Accountability Act of 2014 created the Veterans Choice Program as a temporary program to address problems with veterans' timely access to care at VA medical facilities. Under the Veterans Choice Program, when eligible veterans face long wait times, lengthy travel distances, or other challenges accessing care at VA medical facilities, they may obtain health care services from community providers- that is, providers who are not directly employed by VA. Pub. L. No. 113–146, 128 Stat. 1754 (2014). The Veterans Choice Program's authority sunsets on June 6, 2019.

[6] GAO–19–157SP. For more information on the GAO High-Risk List, see https://www.gao.gov/highrisk/overview, which we accessed May 16, 2019. For more information on our body of work on VA, see https://www.gao.gov/key—issues/managing—risks—improving—va—health—care/issue—summ ary?from, which we accessed May 16, 2019.

ments; (8) contracting policies and practices; and (9) veterans' access to burial options.[7]

Overall Rating for the Managing Risks and Improving VA Health Care High-Risk Area Remained Unchanged in 2019

Since we designated VA health care as a high-risk area in 2015, VA has begun to address each of the identified five areas of concern related to managing risks and improving VA health care: (1) ambiguous policies and inconsistent processes; (2) inadequate oversight and accountability; (3) IT challenges; (4) inadequate training for VA staff; and (5) unclear resource needs and allocation [8]priorities [9].

Figure 1: GAO's High-Risk Rating for Managing Risks and Improving VA Health Care in Fiscal Year 2019

Source: GAO analysis. | GAO-19-571T

Since our 2017 High-Risk Report, ratings for all five criteria remain unchanged as of March 2019. Specifically, the leadership commitment and action plan criteria remain partially met. Although VA has experienced leadership instability over the past 2 years in several senior positions, a new Secretary was confirmed in July 2018. Secretary Wilkie has demonstrated his commitment to addressing the department's high- risk designation by, among other things, creating an office to direct an integrated, focused high-risk approach and communicating to VA leaders the importance of addressing our recommendations and working with GAO. The Secretary's actions, to date, have allowed the department to maintain its leadership commitment rating as of March 2019.

The action plan criterion also remains partially met as of March 2019. In March 2018, VA submitted an action plan to address the underlying causes of its high-risk designation, but the plan did not clearly link actions to stated outcomes and goals or establish a framework to assess VA's progress. VA officials told us that instead of revising the March 2018 action plan, it will incorporate its plans to address the high-risk designation into the department's current initiatives. Specifically, VA is currently implementing the VHA Plan for Modernization, through which the department intends to modernize VA's structure, culture, governance, and systems through organizational improvements. VA officials have indicated that the VHA

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[7] GAO–19–358SP.

[8] GAO, High-Risk Series: An Update, GAO–15–290 (Washington, D.C.: Feb. 11, 2015).

[9] The five criteria for removal are the agency must have (1) a demonstrated strong commitment and top leadership support to address the risks; (2) the capacity-the people and other resources-to resolve the risks; (3) a corrective action plan that identifies the root causes, identifies effective solutions, and provides for substantially completing corrective measures in the near term, including but not limited to steps necessary to implement solutions we recommended; (4) a program instituted to monitor and independently validate the effectiveness and sustainability of corrective measures; and (5) the ability to demonstrate progress in implementing corrective measures. Each criterion is rated as met, partially met, or not met.

Plan for Modernization is intended, among other things, to address the high-risk areas for VA health care. VA officials also told us they are currently developing operational plans for the VHA Plan for Modernization, and these plans will include goals, time frames, and metrics, among other things. VA estimates that the operational plans will be complete by September 2019.

The monitoring, demonstrated progress, and capacity criteria remain unmet since our 2017 High-Risk Report. In order to address the monitoring and demonstrated progress criteria, VA's ongoing revisions to its action plan need to include the addition of certain essential components, including metrics, milestones, and mechanisms for monitoring and demonstrating progress in addressing the high-risk areas of concern. VA's capacity rating also remains not met. Though the department took steps to establish offices, workgroups, and initiatives to address its high-risk designation, many of these efforts are either in the initial stages of development or resources have not been allocated.

For each of the five identified areas of concern related to managing risks and improving VA health care, ratings reflect the level of progress VA has made to address them.

Ambiguous policies and inconsistent processes. Since our 2017 High-Risk Report, ratings for all five criteria remain unchanged for this area of concern as of March 2019.

- Leadership commitment: partially met. In September 2017, we reported that VHA had approximately 800 national policies, the majority of which were outdated. [10] VHA reported reducing the number of national policies by 26 percent, and work continues in this area. In addition, VHA established an inventory of approximately 55,000 local policies as of October 2017. In October 2018, VHA noted its plans to determine who is responsible for monitoring implementation of national and local policy, as well as the alignment between these levels of policy. At that time, VHA also discussed its future plans to monitor the implementation and alignment of national and local policy and update its national policy directive by the end of June 2019. Additionally, VA has implemented a structure for leadership input into the policy process, such as at the VHA Chief of Staff level. However, senior leadership has lacked the stability needed to ensure issued policy meets agency goals.

- Capacity: not met. Since 2017, VA has issued an updated directive on policy management, and put in place procedures to train staff and obtain input from all levels on policy development. However, VA continues to face challenges in this area because it is reliant on contracts and information technology resources, which if delayed, can impede progress toward meeting goals.
- Action plan: partially met. Since 2017, VA has further refined its root cause analysis for this area of concern. In June 2017, VA also identified the following as enterprise-wide root causes of its high-risk designation:

- disjointed strategic planning;
- poorly defined roles, responsibilities, and decision authorities;
- poor horizontal and vertical integration;
- lack of reliable data and analysis;
- ineffective human capital management; and
- inadequate change management.

VA relied on these root cause analyses as the foundational drivers for the VHA Plan for Modernization. However, VA has not used these analyses to develop and prioritize appropriate milestones and metrics in the action plan.

- Monitoring: not met. Since the March 2018 action plan lacked specific metrics and mechanisms for assessing and reporting progress, it is not clear how VA is monitoring its progress.
- Demonstrated progress: not met. Our work continues to indicate VA is not yet able to show progress in this area. Since its 2015 high-risk designation, we have made 50 new recommendations in this area of concern, 32 of which were made since our 2017 report was issued. For example,
- In November 2017, we reported that, due in part to misinterpretation or lack of awareness of VHA policy, VA medical center officials did not always conduct or document timely required reviews of providers when allegations were made against them. We also found that VHA was unable to reasonably ensure appropriate reporting of providers to oversight entities such as state licensing au-

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[10] GAO, Veterans Health Care: Additional Actions Could Further Improve Policy Management, GAO–17–748. (Washington, D.C.: Sept. 22, 2017).

thorities. As a result, VHA's ability to provide safe, high quality care to veterans is hindered because other VA medical centers, as well as non-VA health care entities, may be unaware of serious concerns raised about a provider's care.

We recommended that VHA direct medical centers to document and oversee reviews of providers' clinical care after concerns are raised, among other recommendations. All of our recommendations remain open. As of January 2019, VA estimated completing the recommended revisions to its policy and audit processes in August 2019 and August 2020, respectively. [11]

- In July 2018, we reported that VA collected data related to employee misconduct and disciplinary actions, but data fragmentation, reliability issues, and inadequate guidance impeded department-wide analysis of those data. Thus, VA management is hindered in making knowledgeable decisions regarding the extent of misconduct and how it was addressed.

We recommended that VA develop and implement guidance to collect complete and reliable misconduct and associated disciplinary-action data department-wide, whether through a single information system, or multiple interoperable systems. VA concurred with this priority recommendation, which remains open. VA reported that it expects to implement one or more information systems that will collect misconduct and associated disciplinary action data in January 2020. [12]

Inadequate oversight and accountability. Since our 2017 High-Risk Report, ratings for one criterion improved and four remain unchanged for this area of concern as of March 2019.

- Leadership commitment: partially met. VA has made organizational changes, including establishing the Office of Integrity, to standardize and streamline the agency's oversight of its programs and personnel. However, since 2017, the lack of stability in the Under Secretary for Health position has hindered its ability to demonstrate sustained commitment to improving this area of concern.
- Capacity: not met. VA has begun to implement capacity-building initiatives directed at improving oversight and accountability. For example, VHA's Office of Internal Audit and Risk Assessment, a key component of the department's oversight and accountability model, began conducting audits in 2018. However, according to VA's action plan, the department has yet to allocate resources for this office, such as sufficient staff to carry out its activities.
- Action plan: partially met. In March 2019, the rating for this criterion improved to partially met. In 2018, VA conducted an analysis of the root causes contributing to findings of inadequate oversight and accountability, an important step in identifying the underlying factors contributing to this area of concern.

However, the resulting action plan lacked key elements, including clear metrics to monitor and assess progress.

- Monitoring: not met. The March 2018 action plan lacked specific metrics and mechanisms for assessing and reporting progress in this area.
- Demonstrated progress: not met. Our work continues to indicate a lack of progress in this area. Since its 2015 designation, we made 89 new recommendations in this area of concern, 54 of which were made since our 2017 report was issued. For example:
- In October 2017, we reported that VHA is unable to accurately count the total number of physicians who provide care in its VA medical centers. VHA has data on the number of mission-critical physicians, which includes primary care and mental health physicians, it employs (more than 11,000) and who provide services on a fee-basis (about 2,800). [13] However, VHA lacks data on the number of contract physicians and physician trainees, and thus has no information on

[11] GAO, VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns, GAO–18–63 (Washington, D.C.: Nov. 15, 2017).
[12] GAO, Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability, GAO–18–137 (Washington, D.C.: July 19, 2018).

[13] VHA obtains data from its Veterans Integrated Service Networks and VA medical centers on which occupations are the highest priority for recruitment and retention based on known recruitment and retention concerns, among other factors. VHA then consolidates this data to identify the nationwide top 10 mission-critical occupations and top 5 mission-critical physician occupations. In fiscal year 2016, the ten mission-critical clinical occupations were physician, registered nurse, human resource manager, physical therapist, physician assistant, psychologist, medical technologist, occupational therapist, diagnostic radiologic technologist, and pharmacist. See U.S. Department of Veterans Affairs, Veterans Health Administration, Mission Critical Occupation Report (2016).

the extent to which medical centers nationwide use these arrangements and whether contract physicians are working in mission-critical occupations. As such, VHA cannot ensure that its workforce planning process sufficiently addresses gaps in physician staffing, including those for mental health providers, which may affect veterans' access to care, among other issues.

We recommended that VHA should develop and implement a process to accurately count all physicians providing care at each medical center, including physicians who are not employed by VHA. VHA did not concur with this recommendation, which we reiterated in our priority recommendation letter.[14]

- In a series of reports from 2012 through 2018, GAO found VA's wait time data unreliable for primary and specialty care, as well as for care in the community. GAO also found that VA did not measure the full wait times that veterans experience in obtaining care across these settings. Specifically, in December 2012, we made two recommendations to VA to improve the reliability and oversight of wait time measures, both of which are designated as priority, and remain open.[15]

Similarly, in June 2018, we reported that VHA could not systematically monitor the timeliness of veterans' access to Veterans Choice Program care because it lacked complete, reliable data to do so. Specifically, we found (1) a lack of data on the timeliness of accepting referrals and opting veterans in to the program, (2) inaccuracy of clinically indicated dates, which are used to measure the timeliness of care, and (3) unreliable data on the timeliness of urgent care.[16]

We recommended that VA take steps to improve the timeliness and accuracy of data on veterans' wait times for care and its oversight of the future community care program that will consolidate other community care programs with the Veterans Choice Program, whose authority sunsets on June 6, 2019. VA concurred with eight of the 10 recommendations related to these findings, all of which remain open.[17] VA reported that, in order to improve wait times data accuracy under the Veterans Community Care Program, it intends to implement several initiatives through September 2019.[18]

In September 2018, we reported on the timeliness of third-party administrators' payments to community providers under VA's largest community care program, the Veterans Choice Program. Although VA has taken steps to improve the timeliness of claim payments to these providers, VA is not collecting data or monitoring compliance with third-party administrators' customer service requirements for provider calls. This could adversely affect the timeliness with which community providers are paid, possibly making them less willing to participate and affecting veterans' access to care.

We recommended that VA collect data on and monitor compliance with its requirements pertaining to customer service for community providers. VA agreed with the recommendations, but has not yet implemented them.[19]

- In November 2018, we reported that VHA's suicide prevention media outreach activities declined in recent years due to leadership turnover and reorganization. Additionally, we found that VHA did not assign key leadership responsibilities or establish clear lines of reporting for its suicide prevention media outreach campaign, which hindered its ability to oversee the campaign.

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[14] GAO, Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies, GAO–18–124 (Washington, D.C.: Oct 19, 2017).

[15] GAO, VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, GAO–13–130. (Washington, D.C.: Dec 21, 2012).

[16] The Veterans Choice Program allows eligible veterans to obtain health care services from providers not directly employed by VA.

[17] In June 2018, we recommended that the Under Secretary for Health should implement a mechanism to separate clinically urgent referrals and authorizations from those for which the VA medical facility or the third-party administrator has decided to expedite appointment scheduling for administrative reasons. VA did not agree with this recommendation and stated there will no longer be a need to separate clinically urgent referrals for care from those that need expediting under the Veterans Community Care Program. However, we maintain that our recommendation is warranted. In particular, we found that VA's data did not always accurately reflect the timeliness of urgent care because both VA medical center and third-party administrator staff inappropriately re- categorized some routine care referrals and authorizations as urgent ones for reasons unrelated to the veterans' health conditions.

[18] GAO, Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of its Community Care Programs, GAO–18–281 (Washington, D.C.: June 4, 2018).

[19] See GAO, Veterans Choice Program: Further Improvements Needed to Help Ensure Timely Payments to Community Providers, GAO–18–671 (Washington, D.C.: Sep. 28, 2018).

In April 2019, VA implemented one of the recommendations by providing a new oversight plan for its suicide prevention media outreach campaign. It plans to implement the remaining recommendation by working with communications experts to develop metrics, targets, and an evaluation strategy to improve its outreach efforts.[20]

- In April 2019, we reported that VHA's appraisal process for assessing medical center director performance relies heavily on medical center performance information. VHA designed the Strategic Analytics for Improvement and Learning (SAIL) system to provide internal benchmarking of medical center performance and to promote high quality health care delivery across its system of regional networks and medical centers. SAIL was evaluated in 2014 and 2015 by VHA and an external contractor, respectively, but VHA has not assessed the recommendations from those evaluations, or taken action on them. The evaluations, which found issues related to the validity and reliability of SAIL and its ratings for measuring performance and fostering accountability, together included more than 40 recommendations for improvement.

Without ensuring that the recommendations resulting from these previous evaluations are assessed and implemented as appropriate, the identified deficiencies may not be adequately resolved, and VHA's ability to hold officials accountable for taking the necessary actions may be diminished. VA concurred with the two recommendations we made to address these findings, both of which remain open.[21]

Information technology challenges. Since our 2017 High-Risk Report, ratings for one criterion regressed, one improved, and three remain unchanged this area of concern as of March 2019.

- Leadership commitment: not met. In March 2019, the rating for this criterion declined to not met. In January 2019, the Senate confirmed a new VA Chief Information Officer (CIO). This is the fourth official to lead VA's IT organization since our 2017 High-Risk Report, and the frequent turnover in this position raises concerns about VA's ability to address the department's IT challenges.
- Capacity: not met. In May 2018, VA awarded a contract to acquire the same commercial electronic health record system as the Department of Defense (DoD). However, VA is early in the transition and its actions are ongoing. Additionally, VA has developed a strategy for decommissioning its legacy IT systems, which are tying up funds that could be reallocated for new technology to enable improved veteran care, but has made limited progress in implementing this effort.
- Action plan: partially met. In March 2019, the rating for this criterion improved to partially met. In 2018, VA conducted an analysis to identify the root causes of IT challenges, which informed the goals in its action plan. However, VA's action plan contained significant information gaps, including missing interim milestone dates. These information gaps raise questions about VA's commitment to addressing IT-related root causes and need to be addressed before we can consider this criterion met.
- Monitoring: not met. The March 2018 action plan lacked specific metrics and mechanisms for assessing and reporting progress.
- Demonstrating progress: not met. Our work continues to indicate VA is not yet able to show progress in this area. Since its 2015 high-risk designation, we have made 14 new recommendations in this area, 12 of which were made since our 2017 report was issued. For example:
- In June 2017, to address deficiencies we found related to VA's pharmacy system, we recommended that VA take six actions to provide clinicians and pharmacists with improved tools to support pharmacy services to veterans and reduce risks to patient safety. This included assessing the extent to which the interoperability of VA and DoD's pharmacy systems impacts transitioning service members. VA generally concurred with these recommendations, all of which remain open.[22]
- In April 2019, we testified that from 2001 through 2018, VA pursued three efforts to modernize its health information system- the Veterans Health Information Systems and Technology Architecture (VistA). (See Fig. 2.) However, these

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[20] GAO, VA Health Care: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation, GAO–19–66 (Washington, D.C.: Nov. 15, 2018).

[21] GAO, Veterans Health Administration: Past Performance System Recommendations Have Not Been Implemented GAO–19–350 (Washington, D.C.: Apr. 30, 2019).

[22] GAO, VA Information Technology: Pharmacy System Needs Additional Capabilities for Viewing, Exchanging, and Using Data to Better Serve Veterans, GAO–17–179 (Washington, D.C.: June 14, 2017).

efforts resulted in high costs, created challenges ensuring the interoperability of health data, and ultimately did not result in a modernized VistA. Specifically, in December 2017, we reported that VA obligated over $1.1 billion for contracts with 138 contractors during fiscal years 2011 through 2016 for two modernization initiatives, an Integrated Electronic Health Record program with the DoD and VistA Evolution. We have ongoing work that examines the cost to VA of VistA and the department's actions to transition from VistA to a new electronic health record system.[23]

Regarding the department's most recent effort, the Electronic Health Record Modernization, we testified in April 2019 that the governance plan for this program was not fully defined, which could jeopardize its fourth attempt to modernize its electronic health record system. VA plans to implement the same electronic health record system the DoD is currently deploying. The new system is intended to be the authoritative source of clinical data to support improved health, patient safety, and quality of care provided by VA.

VA has not fully implemented our priority recommendation calling for the department to define the role of the Interagency Program Office in the governance plans for acquisition of the department's new electronic health record system. VA concurred with this recommendation and reported that the Joint Executive Committee, a joint governance body, approved a role for the Interagency Program Office, but as of April 2019 VA has yet to provide us with documentation of this development.[24]

Figure 2: Timeline of the Department of Veterans Affairs (VA) Four Efforts to Modernize the Veterans Health Information Systems and Technology Architecture (VistA) Since 2001
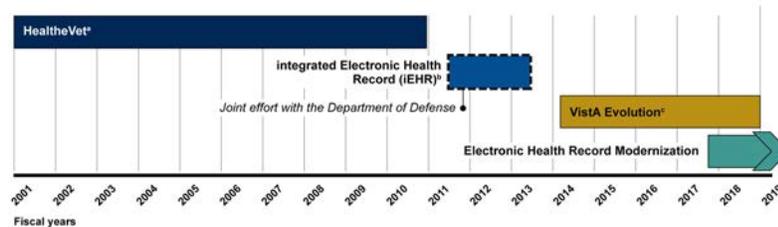
Source: GAO analysis of Department of Veterans Affairs data. | GAO-19-571T

(a) The HealtheVet initiative was VA's first VistA modernization project, which had the goals of standardizing the department's health care system and eliminating the approximately 130 different systems used by its field locations at that time.

(b) The integrated Electronic Health Record program was VA's second VistA modernization initiative, which it launched in conjunction with the Department of Defense (DoD). The program was intended to replace the two separate electronic health record systems used by the two departments with a single, shared system.

(c) The VistA Evolution program was a joint effort of the Veterans Health Administration and VA's Office of Information and Technology. The program was to be comprised of a collection of projects and efforts focused on improving the efficiency and quality of veterans' health care, modernizing the department's health information systems, increasing the department's data exchange and interoperability with DoD and private sector health care partners, and reducing the time it takes to deploy new health information management capabilities.

- We also testified in April 2019 that VA has not yet fully addressed the recommendation we made in September 2014 to expedite the process for identifying and implementing an IT system for the Family Caregiver Program. We reported in September 2014 that the Family Caregiver Program, which was established to support family caregivers of seriously injured post-9/11 veterans, has not been supported by an effective IT system. Specifically, we reported that, due to limitations with the system, the program office did not have ready access to the types of workload data that would allow it to routinely monitor workload problems created by the program. Without such information, the program's workload issues could persist and impact the quality and scope of caregiver services, and ultimately the services that veterans receive.

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[23] GAO, Veterans Affairs: Addressing IT Managements Challenges Is Essential to Effectively Supporting the Department's Mission, GAO–19–476T (Washington, D.C.: Apr. 2, 2019).
[24] GAO, Electronic Health Records: Clear Definition of the Interagency Program Office's Role in VA's New Modernization Effort Would Strengthen Accountability, GAO–18–696T (Washington, D.C.: Sept. 13, 2018).

VA concurred with our recommendation and subsequently began taking steps to implement a replacement system. However, the department has encountered delays and reported recently initiating an effort to implement a new IT system to support the program based on existing commercially available software. We have ongoing work to evaluate VA's effort to acquire a new IT system to support the Family Caregiver Program. [25]

Inadequate training for VA staff. Since our 2017 High-Risk Report, ratings for one criterion improved and four remain unchanged for this area of concern as of March 2019.

- Leadership commitment: not met. VA officials have reported progress in establishing a process to develop an enterprise-wide annual training plan to better ensure that VA staff are adequately trained to provide high-quality care to veterans. However, the actions necessary to complete and implement this training plan are not reflected in VA's March 2018 action plan for the training area of concern, raising questions about the process through which it will be developed. The lack of progress in setting clear goals for improving training demonstrates that VA lacks leadership commitment to address our concerns in this area.
- Capacity: not met. VA has created working groups and task forces- such as the Learning Organization Transformation Subcommittee in the National Leadership Council-with specific responsibilities. However, VA's ability to demonstrate capacity is limited because, according to VA's March 2018 action plan, the department relies on external contractor support services to meet training goals.
- Action plan: partially met. In March 2019, the rating for this criterion improved to partially met. VA completed a root cause analysis for training deficiencies, which informed the goals underlying its action plan. However, the action plan continues to have deficiencies identified in 2017. For example, not all goal descriptions correspond to planned actions and the action plan lacks detail about how and which data will be collected to assess progress.
- Monitoring: not met. The March 2018 action plan lacked specific metrics and mechanisms for assessing and reporting progress.
- Demonstrated progress: not met. Our work continues to indicate that VA is not yet able to show progress in this area. Since its 2015 designation, we have made 11 new recommendations in this area of concern, 3 of which were made since our 2017 report was issued. For example, in April 2018 we reported that, while the department has recommended training for patient advocates-staff members who receive and document feedback from veterans or their representatives-it has not developed an approach to routinely assess their training needs or monitored training completion. The failure to conduct these activities increases VA's risk that staff may not be adequately trained to advocate on behalf of veterans. As a result, we recommended VHA develop an approach to routinely assess training needs and monitor training completion. VA concurred with our recommendations, which remain open. [26]

Unclear resource needs and allocation priorities. Since our 2017 High-Risk Report, ratings for one criterion improved and four remain unchanged for this area of concern as of March 2019.

- Leadership commitment: partially met. In December 2017, a VA Chief Financial Officer (CFO) was confirmed after the department spent over 2.5 years under an interim CFO. In addition, VA is in the process of establishing a new office to estimate workforce resource requirements.
- Capacity: not met. VA has established functions intended to inform cost analyses of major VA initiatives, including a new financial management process to replace its outdated financial systems. However, it is unclear in its action plan the extent to which VA has identified the resources needed to establish and maintain these functions.
- Action plan: partially met. In March 2019, the rating for this criterion improved to partially met. Since our 2017 High-Risk Report, VA conducted a root cause analysis of this area of concern. However, VA's action plan lacks metrics for monitoring progress and does not include all of VA's ongoing actions, such as efforts to assess current and future regional demand for veterans' health care services.

[25] GAO, VA Health Care: Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program, GAO–14–675 (Washington, D.C.: Sept. 18, 2014) and GAO, Veterans Affairs: Addressing IT Management Challenges Is Essential to Effectively Supporting the Department's Mission GAO–19–476T (Washington, D.C.: Apr 2, 2019).
[26] GAO, VA Health Care: Improved Guidance and Oversight Needed for the Patient Advocacy Program, GAO–18–356 (Washington, D.C.: Apr 12, 2018).

- Monitoring: not met. Since VA's action plan lacks specific metrics and mechanisms for assessing and reporting progress, it is not clear how VA is monitoring its progress.
- Demonstrating progress: not met. Our work continues to indicate VA is not yet able to show progress in this area. Since its 2015 designation, we have made 16 new recommendations in this area of concern, 10 of which were made since our 2017 report. For example:
- In May 2017, we reported identifying several limitations with VA's clinical productivity metrics and statistical models for tracking clinical efficiency; this limits VA's ability to assess whether resources are being used effectively to serve veterans. Specifically, we found that productivity metrics may not account for all providers or clinical services, reflect the intensity of clinical workload, and reflect providers' clinical staffing levels. Additionally, we found that efficiency models may also be adversely affected by inaccurate workload and staffing data. As a result, VA cannot systematically identify best practices to address low productivity and inefficiency as well as determine the factors VA medical centers commonly identify as contributing to low productivity and inefficiency.

We made four recommendations to address these findings; three of which VA implemented in the spring of 2018 by improving productivity metrics and staffing and workload data. To implement the remaining recommendation, VA should establish a process to oversee medical centers' plans for addressing low clinical productivity and inefficiency.[27]

- In August 2018 we reported that VA medical centers face challenges operating their Sterile Processing Services programs- notably, addressing workforce needs, such as lengthy hiring time frames and limited pay and professional growth potential. VHA's Sterile Processing Services workforce challenges pose a potential risk to VA medical centers' ability to ensure access to sterilized medical equipment. Until VHA examines these workforce needs, VHA won't know whether or to what extent the reported challenges adversely affect VA medical centers' ability to effectively operate their Sterile Processing Services programs and ensure access to safe care for veterans.

We recommended that VA examine workforce needs and take action based on this assessment, as appropriate. VA concurred with this recommendation, which remains open.[28]

VA Acquisition Management Was Added to GAO's High-Risk List in 2019

In light of numerous contracting challenges that we have identified, and given the significant investment in resources to fulfill its critical mission of serving veterans, we added VA acquisition management as a new high- risk area in 2019.[29] VA has one of the most significant acquisition functions in the Federal government, both in dollar amount of obligations and number of contract actions. Specifically, about a third of VA's discretionary budget in fiscal year 2018, or about $27 billion, has been used to contract for goods and services.

We have identified challenges in the following areas of concern related to VA's acquisition management: (1) outdated acquisition regulations and policies; (2) lack of an effective medical supplies procurement strategy;

(3) inadequate acquisition training; (4) contracting officer workload challenges; (5) lack of reliable data systems; (6) limited contract oversight and incomplete contract file documentation; and (7) leadership instability.

Outdated acquisition regulations and policies. VA's procurement policies have historically been outdated, disjointed, and difficult for contracting officers to use. In September 2016, we reported that (1) the acquisition regulations contracting officers currently follow have not been fully updated since 2008 and (2) VA had been working on completing a comprehensive revision of its acquisition regulations since 2011.[30]

VA's delay in updating this fundamental source of policy has impeded the ability of contracting officers to effectively carry out their duties. We recommended in September 2016 that VA identify measures to expedite the revision of its acquisition regulations and clarify what policies are currently in effect. VA concurred with this

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[27] GAO, VA Health Care: Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency, GAO–17–480 (Washington, D.C.: May 24, 2017).

[28] GAO, VA Health Care: Improved Oversight Needed for Reusable Medical Equipment, GAO–18–474 (Washington, D.C.: Aug. 3, 2018).

[29] GAO–19–157SP.

[30] GAO, Veterans Affairs Contracting: Improvements in Policies and Processes Could Yield Cost Savings and Efficiency, GAO–16–810 (Washington, D.C.: Sep. 16, 2016).

priority recommendation and, as of January 2019, had rescinded or re-issued updated policy memoranda for all information letters, which VA previously used to provide guidance that was temporary in nature.

VA has also made some progress in updating its acquisition regulations, but more work remains to be done over the next several years. As of April 2019, VA reports that 15 of the 41 parts in its acquisition regulations update were published as final rules, 10 were issued as proposed rules for public comment, and the remainder are at an earlier stage of the rulemaking process. All parts are scheduled to be out for public comment by March 2020, but the final rules are not expected to be published until April 2021.

Lack of an effective medical supplies procurement strategy. VA's program for purchasing medical supplies has not been effectively executed, nor is it in line with practices at leading hospitals. To support more efficient purchasing of medical supplies for its 172 medical centers that serve the needs of about 9 million veterans, VA launched the Medical Surgical Prime Vendor-Next Generation (MSPV–NG) program in December 2016. MSPV–NG was part of VA's overall effort to transform its supply chain and achieve $150 million in cost avoidance.

In November 2017, we reported that VA's approach to developing its catalog of supplies was rushed and lacked key stakeholder involvement and buy-in. It also relied on establishing non-competitive blanket purchase agreements for the overwhelming majority of products, resulting in low utilization by medical centers. VA had set a target that medical centers would order 40 percent of their supplies from the MSPV–NG catalog, but utilization rates were below this target with a nationwide average utilization rate across medical centers of about 24 percent as of May 2017. This low utilization adversely affected VA's ability to achieve its cost avoidance goal.

We recommended in November 2017 that VA develop, document, and communicate to stakeholders an overarching strategy for the program. VA concurred with this priority recommendation and is developing strategies to address it. First, in February 2019, VA developed and documented a new, overarching acquisition strategy for its Medical Surgical Prime Vendor (MSPV) program, and has begun the process of communicating it to key stakeholders, including clinical and logistics staff. Further, VA is developing a separate strategy to involve clinicians in developing requirements with plans to complete a pre-pilot of this strategy by September 2019. In response to a congressional request to assess these and other program changes, we recently began a review of VA's MSPV program. [31]

Inadequate acquisition training. VA acquisition training, at times, has not been comprehensive nor provided to staff that could benefit from it. A 2006 statute required, and a 2016 Supreme Court decision (Kingdomware Technologies, Inc. v. United States) reaffirmed, that VA is to give preference to veteran-owned small businesses when competitively awarding contracts-a program known as Veterans First. In September 2018, we reported that training on VA's Veterans First policy did not address some of its more challenging aspects. For example, many of the contracting officers we interviewed were uncertain about how to balance the preference for veteran-owned small businesses with fair and reasonable price determinations when lower prices might be found on the open market. [32]

In addition, VA provided several installments of online training sessions on the Veterans First policy to contracting officers but did not make them mandatory. As a result, only 52 percent of VA contacting officers completed the follow-up training by the spring of 2018. We recommended in September 2018 that VA provide more targeted training to contracting officers on how to implement the Veterans First policy, particularly in the area of making fair and reasonable price determinations, and assess whether this training should be designated as mandatory. VA concurred, and in April 2019, VA's Chief Acquisition Officer (CAO) stated that VA is taking steps to make this training mandatory. VA also reported that its Acquisition Academy will provide Veterans First training to all contracting staff on May 30, 2019.

Contracting officer workload challenges. The majority of our reviews since 2015 have highlighted workload as a contributing factor to the challenges that contracting officers face. Most recently, in September 2018, we reported that about 54 percent of surveyed VA contracting officers said their workload was not reasonable

[31] GAO, Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency, GAO–18–34 (Washington, D.C.: Nov 9, 2017).
[32] GAO, Veterans First Program: VA Needs to Address Implementation Challenges and Strengthen Oversight of Subcontracting Limitations, GAO–18–648 (Washington, D.C.: Sep. 24, 2018).

and found that workload stresses have exacerbated the struggles that they face implementing the department's Veterans First policy.[33]

In addition, in September 2016, we reported that VHA contracting officers processed a large number of small dollar-value actions to support medical center operations, many of which involve emergency procurements of routine items to support immediate patient care. Contracting officers and the department's Acting CAO told us that these frequent and urgent small-dollar transactions reduce contracting officers' efficiency and ability to take a strategic view of VHA's overarching procurement needs. We reported in November 2017 that emergency procurements accounted for approximately 20 percent-$1.9 billion-of VHA's overall contract actions in fiscal year 2016. Figure 3 shows the percent of VHA contract actions designated as emergencies in fiscal year 2016 by each network contracting office.[34]

Figure 3: Percent of Veterans Health Administration Contract Actions Designated as Emergencies, Fiscal Year 2016

Percentage of emergency contract actions

Veterans Integrated Service Network[a]
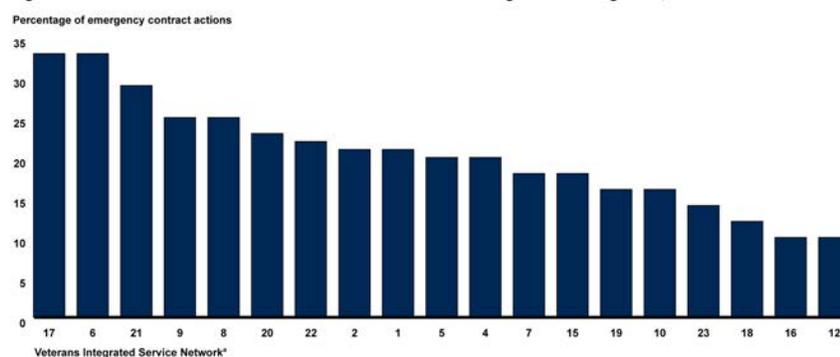
Source: GAO analysis of Veterans Affairs Electronic Contract Management System data. | GAO-19-571T

(a) Veterans Integrated Service Networks, organizations that manage medical centers and associated clinics across a given geographic area, are served by a corresponding network contracting office. Some Veterans Integrated Service Networks have been consolidated over time, and in fiscal year 2016, there were 19 Veterans Integrated Service Networks despite being numbered up to 23. As of fiscal year 2017, there were only 18 in total.

We recommended in November 2017 that VHA network contracting offices work with medical centers to identify opportunities to more strategically purchase goods and services frequently purchased on an emergency basis. VA concurred with this recommendation and recently offered to provide us with a demonstration of the supply chain dashboard that VA uses to track items purchased on an emergency basis, which we plan to attend by the end of May 2019. VA also agreed to conduct an analysis of its purchase card spending to identify items that should be purchased through its MSPV program. VA expects to complete this analysis by July 2019. If implemented, this would allow for both greater contracting officer efficiency and cost savings. For example, based on a similar recommendation we made in 2012, VA began more systematically employing strategic sourcing in FY 2013, and in subsequent fiscal years reported about $10 billion in savings over a 5-year period.

Lack of reliable data systems. The lack of accurate data has been a long-standing problem at VA. In September 2016, we reported that VA had not integrated its contract management and accounting systems, resulting in duplicative efforts on the part of contracting officers and increased risk of errors.[35] We and VA's Inspector General each recommended that VA perform data checks between the two systems. VA concurred with this recommendation and some VA contracting organizations have made efforts to address this risk. Further, VA reported in March 2019, that it plans to adopt a new integrated financial and contract management system, which it plans to install VA-wide over a 9- year period, with the final site receiving the system in 2027.

Limited contract oversight and incomplete contract file documentation. VA has had difficulty ensuring that its contracts are properly monitored and documented. In September 2018, we reported that, although VA obligated $3.9 billion

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[33] GAO–18–648.
[34] GAO–16–810.
[35] GAO–16–810.

to veteran-owned small businesses in fiscal year 2017, its contracting officers were not effectively monitoring compliance with key aspects of the department's Veterans First policy, such as limits on subcontracting (which ensure that the goal of the program-to promote opportunities for veteran-owned businesses-is not undermined). In many cases, we found that clauses requiring compliance were not included in the VA's contracts and orders with veteran businesses because the contracting officers either forgot to include them or were unaware of the requirement. [36]

The contracting officers we spoke with also said that they do not have sufficient time or knowledge to conduct oversight. Through limited reviews, VA has identified a number of violations that would warrant a broader assessment of the fraud risks to the program. We recommended in September 2018 that VA establish a mechanism to ensure that mandatory subcontracting-related clauses be consistently incorporated into set-aside contracts with veteran-owned businesses and that VA conduct a fraud risk assessment for the Veterans First program. VA concurred with these recommendations and is taking steps to implement them. For example, VA reported in April 2019 that it had made modifications to its electronic contract management system to ensure the clauses would be included in set-aside contracts and anticipated completing testing of the modifications in May 2019.

We also reported in September 2016 that a number of VA contract files we reviewed were missing key documents, increasing the risk that key processes and regulations were not followed. [37] We recommended that VA focus its internal compliance reviews to ensure that required contract documents are properly prepared and documented. VA concurred with this recommendation. Since then, VA has made policy changes that revised its processes for compliance reviews of contract documentation. We are currently following up with VA to obtain the results of its compliance reviews to determine if VA has fully implemented this recommendation.

Leadership instability. We have previously reported, most recently in September 2018, that procurement leadership instability has made it difficult for the VA to execute and monitor the implementation of key acquisition programs and policies. For example, changes in senior procurement leadership, including the CAO and VHA's Chief Procurement and Logistics Officer, occurred during the implementation of MSPV–NG and similar instability in leadership affected the MSPV–NG program office itself. Overall, the MSPV–NG program office has had four directors, two of whom served in an acting capacity, since its inception in 2014. [38]

To address this instability, we recommended in November 2017 that VA appoint a non-career employee as the CAO and prioritize the hiring of the MSPV–NG program office's director position on a permanent basis. VA concurred with these recommendations and implemented them in 2018. Stable leadership should help bring consistent and much needed direction to the MSPV–NG program, but we recently identified other areas within the VA where sustained leadership is also needed. For instance, in September 2018, we reported there have been six Acting Directors within the past 2 and a half years within an oversight office that helps assess whether VA is in compliance with aspects of its Veterans First policy.

Ratings for the VA Disability High-Risk Areas Either Remained Unchanged or Regressed in 2019

We designated improving and modernizing Federal disability programs as high risk in 2003. An estimated one in six working-age Americans reported a disability in 2010. Many of these Americans need help finding or retaining employment, or rely on cash benefits if they cannot work.

Three of the largest Federal disability programs-one run by VA- disbursed about $270 billion in cash benefits to 21 million people with disabilities in fiscal year 2017. However, Federal disability programs, including VA's, struggle to meet their needs. In particular, VA struggles to manage its disability claims workloads, and, when determining whether individuals qualify for disability benefits, VA relies on outdated eligibility criteria.

Managing disability claims workloads. Since our 2017 High-Risk Report, our assessment of ratings for all five criteria remains unchanged for this area of concern for VA as of March 2019.

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[36] GAO–18–648.
[37] GAO–16–810.
[38] GAO–18–648.

Figure 4: GAO's High-Risk Rating for Managing Disability Claims Workloads in Fiscal Year 2019

Source: GAO analysis. | GAO-19-571T

- Leadership commitment: met. VA has maintained leadership focus on managing initial disability claims and appeals workloads through various initiatives to improve benefits processing and reduce backlogs. Enhancing and modernizing VA's disability claims and appeals processes are goals in its 2018–2024 strategic plan.
- Capacity: partially met. VA has continued building the capacity to process initial disability claims, such as using an electronic system to distribute claims ready for decisions to available staff. On appeals, VA is reforming its process, onboarding hundreds of new staff, and implementing new technology. However, as we reported in March 2018, VA's appeals plan does not provide reasonable assurance that it will have the capacity to implement the new process and manage risks. VA agreed with our recommendation to better assess risks associated with appeals reform and took some steps to address risks, such as limited testing of the new process. However, as of April 2019 VA has not fully addressed this recommendation. For example, VA has not developed plans to fully address risks, such as veterans choosing more resource-intensive options at higher rates than expected. [39]
- Action plan: partially met. VA continues to implement plans to reduce the initial disability claims backlog. For appeals reform, VA submitted its appeals plan in November 2017 and provided several progress reports throughout 2018. In March 2018, we reported that VA's plan for implementing a new disability appeals process did not explain how VA would assess the new process compared to the legacy process, and did not fully address risks associated with implementing a new process.

We made two recommendations to improve VA's disability benefit appeals process, including that VA (1) clearly articulate in its appeals plan how it will monitor and assess the new appeals process compared to the legacy process, and (2) ensure that its appeals plan more fully addresses related risks, given the uncertainties associated with implementing a new process. As of April 2019, VA has taken actions to address our recommendations, although key steps remain. For example, VA has not fully articulated detailed steps and time frames for assessing the relative performance of the new and legacy appeals processes. Without this assessment, VA cannot determine the extent to which the new process will achieve final resolution of veterans' appeals sooner than the legacy process. [40]

- Monitoring: partially met. VA monitors the timeliness of initial disability claims and legacy appeals, and has set timeliness goals for some, but not all, of the appeal options under the new process. VA's plans also signal how it intends to monitor the allocation of staff for concurrent workloads in its legacy and new appeals processes. However, as of April 2019, VA has yet to specify a complete set of balanced goals for monitoring the new and legacy appeals processes (in-

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[39] GAO, VA Disability Benefits: Improved Planning Practices Would Better Ensure Successful Appeals Reform. GAO–18–352. (Washington, D.C.: Mar. 22, 2018).
[40] GAO–18–352.

cluding timely and accurate processing of appeals while ensuring veteran satisfaction).
- Demonstrated progress: partially met. VA reported it reduced the backlog of initial disability claims from 611,000 in March 2013 to about 81,000 at the end of fiscal year 2018. However, VA's Inspector General reported in September 2018 that VA overstated its performance by only reporting about 79 percent of the backlog. For appeals, VA addressed some gaps in its plan for implementing appeals reform, in accordance with our 2017 and 2018 recommendations, and has prioritized processing of legacy appeals. However, as of September 2018, VA still had a backlog of about 396,000 legacy appeals.

Updating disability benefit eligibility criteria. Since our 2017 High-Risk Report, VA's ratings for the action plan and monitoring criteria regressed while the other three remain unchanged as of March 2019.

Figure 5: GAO's High-Risk Rating for Updating Disability Benefit Eligibility Criteria in Fiscal Year 2019

Source: GAO analysis. | GAO-19-571T

- Leadership commitment: met. VA has sustained leadership focus on updating its Veterans Affairs Schedule for Rating Disabilities (VASRD)-used to assign degree of disability and compensation levels for veterans with military service-connected injuries or conditions-to reflect advances in medicine and labor market changes.
- Capacity: partially met. In August 2017, VA officials told us that it had taken actions to hire more staff for the regulations updates and leverage outside researchers to evaluate veterans' loss of earnings in the current economy. However, as of September 2018, the agency was still working to hire these staff. Moreover, VA's current earnings loss study covers only 8 of over 900 diagnostic codes and 2 of 15 body systems. VA needs to continue its current hiring and earnings loss planning efforts to ensure it has the capacity to comprehensively update the VASRD.
- Action plan: partially met. In March 2019, the rating for this criterion declined to partially met. As of April 2019, VA's efforts to update the VASRD included new plans to conduct earnings loss studies. Veterans Benefits Administration officials stated they completed a study for eight diagnostic codes under two body systems, and the agency is determining whether its current approach for evaluating earnings loss is applicable to updating other diagnostic codes. However, we lowered VA's prior rating of met to partially met because its latest August 2018 updated plan, issued since our 2017 High-Risk Report, provided limited detail on key planned activities, potentially jeopardizing its third attempt at modernization over the past decade. For example, VA's plans do not indicate how and when VA will assess the applicability of its current approach, and does not include plans for updating earnings loss information for the remaining diagnostic codes and body systems.
- Monitoring: partially met. In March 2019, the rating for this criterion declined to partially met. According to VA officials, VA continues to track its progress toward finishing the medical updates by fiscal year 2020 and has updated its project plan to reflect delayed time frames. However, we lowered VA's prior rating for this criterion from met to partially met because VA's plans have changed since our last update, and although it is conducting a study to update earnings loss information for some diagnostic codes and body systems, its plan does not

include timetables for monitoring these or future updates to earnings loss information.
- Demonstrated progress: partially met. VA reported that as of December 2018, it promulgated final regulations for 6 of 15 body systems, proposed regulations for 2, and is reviewing draft regulations for the remaining 7. However, VA has fallen about 4 years behind in its efforts to fully update the VASRD and has not completed earnings loss updates.

Other Government- Wide High-Risk Areas Have Implications for VA Operations

Several other government-wide high-risk areas include VA and its operations. These areas include (1) improving the management of IT acquisitions and operations, (2) strategic human capital management, (3) managing Federal real property, and (3) ensuring the cybersecurity of the nation.

- **Improving the management of IT acquisitions and operations.** The executive branch has undertaken numerous initiatives to better manage the more than $90 billion that is annually invested in IT across the government. However, our work shows that Federal IT investments, including those made by VA, too frequently fail or incur cost overruns and schedule slippages while contributing little to mission-related outcomes. Thus, in 2015, we added improving the management of IT acquisitions and operations to the High-Risk List.[41] To address the portion of the high-risk area for which it is responsible, VA should, among other things, implement our past recommendations on improving IT workforce planning practices and establishing action plans to modernize or replace obsolete IT investments.[42]

In August 2018, for example, we found that VA's policies did not fully address the role of its CIO consistent with Federal laws and guidance in the areas of IT workforce, IT strategic plan, IT budgeting, and IT investment management. Until VA fully addresses the role of the CIO in all of its policies, it will be limited in addressing longstanding IT management challenges. We recommended that VA's IT management policies address the role of the CIO for key responsibilities in the four areas we identified. VA concurred with this recommendation, which remains open.[43]

- **Strategic human capital management.** This area was added to our High-Risk List in 2001 and continues to be at risk today because mission-critical skills gaps both within Federal agencies and across the Federal workforce are impeding the government from cost-effectively serving the public and achieving results.[44] As of December 2018, VA reported an overall vacancy rate of 11 percent at VHA medical facilities, including vacancies of over 24,000 medical and dental positions and around 900 human resource positions. Also, with 32 percent of the VA workforce eligible to retire in the next 5 fiscal years, VA must address these mission-critical skill gaps and vacancies that we continue to identify in our work.[45]

In December 2016, for example, we found that VHA's limited human resources capacity combined with weak internal control practices has undermined VHA's human resources operations and its ability to improve delivery of health care services to veterans. Further, VHA is challenged by inefficiencies in its performance management processes, including the lack of a performance appraisal IT system, which prevents it from identifying trends and opportunities for improvement. VHA can better support medical centers by establishing clear lines of accountability for engagement efforts, collecting and leveraging leading practices, and addressing barriers to improving engagement. We made three recommendations to VA to improve its performance management system. VA partially concurred with these recommendations, which remain open.[46]

- **Managing Federal real property.** Since Federal real property management was placed on the High-Risk List in 2003, the Federal government has given high-level attention to this issue. However, Federal agencies, including VA, continue to face long-standing challenges, including (1) effectively disposing of ex-

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[41] GAO–15–290.

[42] GAO–19–157SP.

[43] GAO, Federal Chief Information Officers: Critical Actions Needed to Address Shortcomings and Challenges in Implementing Responsibilities, GAO–18–93 (Washington, D.C.: Aug. 2, 2018).

[44] GAO, High-Risk Series: An Update, GAO–01–263 (Washington, D.C.: Jan. 1, 2001).

[45] Percentage based on VA employees on board at the start of fiscal year 2017.

[46] GAO, Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges, GAO–17–30 (Washington, D.C.: Dec. 23, 2016).

cess and underutilized property, (2) relying too heavily on leasing, (3) collecting reliable real property data for decision making, and (4) protecting Federal facilities.

In January 2019, for example, we reported that VA has enhanced its data collection on vacant properties, but the agency does not collect information needed to track and monitor disposal projects at the headquarters level. Without information on the status of disposal projects, VA cannot readily track and monitor its progress and identify areas where facilities' managers may need additional assistance. As a result, we recommended that VA improve its procedures related to disposal of excess and underutilized property to help local facility managers plan, implement, and execute projects to dispose of those properties. In addition, VA should collect key information on the status of these disposal projects to help manage the process and identify areas where management attention is needed. VA concurred with the three recommendations we made related to these findings, all of which remain open. [47]

- **Ensuring the cybersecurity of the nation.** We have designated information security as a government-wide high-risk area since 1997. We expanded this high-risk area in 2003 to include protection of critical cyber infrastructure and, in 2015, to include protecting the privacy of personally identifiable information. Federal agencies and our nation's critical infrastructures are dependent on IT systems and electronic data to carry out operations and to process, maintain, and report essential information. The security of these systems and data is vital to public confidence and national security, prosperity, and well- being. Because many of these systems contain vast amounts of personally identifiable information, agencies must protect the confidentiality, integrity, and availability of this information. In addition, they must effectively respond to data breaches and security incidents when they occur.

In May 2016, for example, we found that VA had developed a risk assessment for their selected high-risk systems, but had not always effectively implemented access controls. These control weaknesses included those protecting system boundaries, identifying and authenticating users, authorizing access needed to perform job duties, and auditing and monitoring system activities. Weaknesses also existed in patching known software vulnerabilities and planning for contingencies. An underlying reason for these weaknesses is that the key elements of information security programs had not been fully implemented. VA concurred with all of our five recommendations related to improving its cybersecurity controls. However, two recommendations-which specifically call for the department to conduct security control assessments and develop a continuous monitoring strategy-remain open. [48]

In November 2018, the department's inspector general reported that VA had made progress in developing, documenting, and distributing policies and procedures to support its security program, but identified IT security as a major management challenge due to the persistence of deficiencies. [49] For example, the inspector general identified significant deficiencies related to access, configuration management, change management, and service continuity. In addition, VA's financial statement auditor reported deficiencies in the department's IT security controls as a material weakness for financial reporting purposes. [50] The auditor has reported IT security controls as a material weakness for more than 10 years.

VA's Transformational Efforts Are Ongoing

Since his confirmation in July 2018, Secretary Wilkie has demonstrated his commitment to addressing the department's high-risk designations by, among other things, creating an office to direct an integrated approach for high-risk concerns and communicating to VA leaders the importance of addressing our recommendations. Additionally, VA leadership has also encouraged senior leaders to meet with GAO subject matter experts from acquisition, performance, human capital, and financial management, among other areas, to discuss leading practices and VA's modernization efforts. In addition, senior leaders from GAO and VA meet regularly to identify and address the root causes of high-risk issues, and discuss the status of our recommendations and VA's efforts to address them.

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[47] GAO, VA Real Property: Clear Procedures and Improved Data Collection Could Facilitate Property Disposals, GAO–19–148 (Washington, D.C.: Jan. 9, 2019).

[48] GAO, Information Security: Agencies Need to Improve Controls over Selected High- Impact Systems, GAO–16–501. (Washington, D.C.: May 18, 2016).

[49] Department of Veterans Affairs, Agency Financial Report Fiscal Year 2018. (Washington, D.C.: November 26, 2018).

[50] A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected in a timely basis.

Fully addressing these issues will require sustained leadership attention on these issues as well as leadership stability-something that VA has not had in recent years. In particular, in the 2 years prior to Secretary Wilkie's confirmation, VA experienced leadership instability with senior- level vacancies in key positions, including the Under Secretary for Health, CIO, and Deputy Under Secretary for Health for Community Care.

In addition to sustained leadership, VA must develop action plans for addressing the high-risk issues.[51] As noted earlier, VA officials have stated that they are currently working to address our high-risk concerns through the implementation of the VHA Plan for Modernization. The plan, which identifies high-level implementation targets through 2020, provides a framework to address the Secretary's four priorities: (1) improving training and customer service; (2) implementing the VA MISSION Act and improving veterans' access to care; (3) connecting the VA's electronic health records system to the DoD's to ensure a continuum of care for transitioning service members; and (4) transforming VA's business systems. As part of this effort, VA is focused on "10 lanes of effort," including transitioning to the same electronic health record system the DoD is currently deploying, and transforming its business systems- including its human resource management, finance and acquisition management, and supply chain functions-to improve the quality and availability of services at VA medical centers.[52]

In closing, VA has launched several significant efforts to address many of the underlying management challenges it faces, including transforming its electronic health record and financial management systems, updating its medical surgical prime vendor program, and implementing the VA MISSION Act. Any one of these efforts would be a significant undertaking for an agency given their scope, time frames, and costs, and VA is attempting to concurrently implement them. If successful, these efforts could be transformative for VA. Sustained congressional oversight of VA's efforts will also be needed. We stand ready to support this oversight through continued monitoring of VA's efforts as it ensures that the modernization efforts integrate and address many of the concerns that led to the designation of various VA areas as high risk.

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you may have.

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Obtaining Copies of GAO Reports and Testimony

[51] GAO–19–157SP.
[52] The 10 lanes of effort for the VHA Plan for Modernization are (1) Commit to Zero Harm; (2) Streamline VHA Central Office; (3) Develop Responsive Shared Services; (4) Reduce Unwarranted Variation Across Integrated Clinical and Operational Service lines; (5) Engage Veterans in Lifelong Health, Well-Being and Resilience; (6) Revise Governance Processes and Align Decision Rights; (7) VA MISSION Act: Improving Access to Care; (8) Modernize Electronic Health Records; (9) Transform Financial Management System; and (10) Transform Supply Chain.

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Prepared Statement of Michael J. Missal

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the operations of the Department of Veterans Affairs (VA). The mission of the OIG is to conduct effective oversight of VA's programs and operations through independent audits, inspections, reviews, and investigations.

This statement focuses on the processes the OIG uses to develop recommendations that will assist VA in improving services and benefits to veterans and their caregivers and families. Examples of critical recommendations are highlighted, as well as OIG-identified Major Management Challenges facing VA. OIG recommendations generally address specific allegations or concerns in particular VA facilities, offices, or programs. OIG reports focus not only on solutions to a defined problem, but also identify the underlying root causes of issues that negatively impact current programs and future initiatives whenever possible. As a result, these recommendations may also be a road map that other facilities, offices, or programs can follow to apply any lessons learned across VA and to take corrective actions applicable to other relevant VA operations.

In addition to using data to drive OIG oversight work, stakeholders within VA and the larger veteran community-as well as Congress and other oversight bodies-play an invaluable role in identifying problems and pushing for implementation of recommendations for positive change. This critical work would not be accomplished without congressional support of OIG efforts through its appropriations and the attention given to OIG reports and recommendations. The OIG looks forward to working with its many stakeholders to advance recommendations for improvement in all

VA programs, services, and systems, including those proposed in the 100 reports issued during the first half of fiscal year (FY) 2019.

AUTHORITY AND PRINCIPLES GUIDING OIG RECOMMENDATIONS

The OIG was created by the Inspector General (IG) Act of 1978 and strengthened through amendments to the IG Act in 1988, the IG Reform Act of 2008, and the IG Empowerment Act of 2016. Pursuant to Section 4 of the United States Code Title 5 Appendix, the Inspector General is responsible for

(1) conducting and supervising audits and investigations;

(2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and

(3) keeping the Secretary and Congress fully and currently informed about significant problems and deficiencies in VA programs and operations and the need for corrective action.

When developing recommendations, OIG staff focus on several key principles, including the following:

First, carefully articulated recommendations are directed to the specific VA office or program official that has the responsibility and authority required to satisfactorily implement them. Recommendations could be directed to anyone from the Secretary to a service line chief at a medical facility. Recommendations must be clear, be capable of execution, and specify who is accountable within VA for implementation. While the OIG's recommendations may be narrowly addressed to a particular VA facility or operation, VA should be disseminating information about identified problems and remediation plans to officials in all VA offices that could potentially have the same issues and are positioned to take positive action.

Second, recommendations are contemporaneous with ongoing issues and, except in rare circumstances, should not require more than one year to implement from the report's publication. As explained later, this helps align implementation with reporting requirements to Congress, while also minimizing the risk that OIG recommendations languish, become outdated, or lag behind VA policy and program changes. In the instance that a recommendation would require implementation over a longer period, VA and OIG staff work to develop implementation plans that have quarterly milestones to support tracking progress towards implementation.

Third, OIG recommendations are objective and nonpartisan-driven by data, evidence, and all documentation that are collected and analyzed in accordance with audit, inspection, and investigative standards. The OIG's statutory independence allows it to determine which VA programs, services, operations, and systems to examine that will have the greatest impact on veterans' lives and taxpayers' investments, and to then communicate those findings with Congress, VA's stakeholders, and the public.

Finally, the OIG makes recommendations, but does not direct how they are executed. It is important to note that OIG staff cannot mandate that VA accept OIG recommendations or direct specific action to carry them out. Consistent with this limitation, OIG reports may contain recommendations for VA to "take appropriate administrative action" against a specific VA employee for misconduct, but under Federal law, VA leaders and managers are then responsible for determining any appropriate administrative action. VA determines the level of disciplinary or adverse actions to be taken, if any. The OIG closes out these recommendations upon VA providing acceptable documentation that no action was deemed necessary, that specific administrative action was taken, or the individual left Federal employment. VA leaders are solely responsible for managing VA and setting its policy, including determining how best to implement OIG recommendations. VA and the OIG may disagree about a specific recommendation, but those situations are rare and are noted in the published report.

OIG RECOMMENDATIONS DEVELOPMENT

When OIG staff perform an audit, review, inspection, or administrative investigation, they conduct months of work that can involve on-site inspections, interviews, document and record reviews, data collection, and more. Using all information collected, staff prepare a draft report with findings that are based on thorough, objective, and balanced analyses. These reports usually include recommendations for VA corrective action or improvement. The draft report is typically sent to appropriate VA managers for review prior to publication to ensure accuracy. This process provides VA an opportunity to comment on the report's factual content and findings. The comments also outline VA management's position on implementing OIG recommendations and are included in the final OIG report. If management concurs

with the recommendation, their response must include an implementation plan and a self-determined estimated date of completion. OIG staff will then review the implementation plan to determine if it satisfies the intent of the recommendation. In the event VA concurs with an OIG finding but not the recommendation, VA will need to provide an alternative action they believe will satisfy the intent of the recommendation. The VA workplan to carry out the recommendation and address the underlying finding is key to OIG staff's follow-up process, as detailed later in this statement.

In some occasions, consistent with the OIG's statutory independence from VA, a final report may be issued without VA's response or concurrence of the findings and recommendations, or an acceptable implementation plan. However, it is rare for VA to not concur with OIG findings or recommendations, averaging just one percent of all responses over FYs 2017, 2018, and 2019 to date. OIG staff and leaders have open lines of communication with VA counterparts to resolve these situations. If VA does not concur with a finding or recommendation, and OIG staff cannot reach agreement with the VA office, OIG leaders will escalate the matter with VA managers up to the Deputy Secretary, who is the final VA deciding official, prior to publishing a report with nonconcurrence on recommendations.

In addition, VA may "concur in principle" or "partially concur" with a recommendation, but OIG requires VA to clearly explain the concern with the finding or recommendation (including a perceived inability to implement) that is cause for the qualified response. Overall, it is important for comments to make clear whether VA concurs or nonconcurs with each finding, as well as with specific recommendations.

TRACKING OIG RECOMMENDATIONS

OIG recommendations can be accessed in several ways. The most up-to-date information can be found on the OIG website, www.va.gov/oig. The recommendations webpage provides live tracking on the status of OIG published reports and recommendations open for less than a year, open for more than a year, and closed as implemented.[1] This online dashboard also provides the realized and potential monetary impact of VA's implementation of OIG recommendations. The webpage search functionality allows users to isolate reports with open recommendations.

Pursuant to the IG Act of 1978, the Semiannual Report (SAR) to Congress presents the OIG's accomplishments during the prior six-month reporting period.[2] Within the SAR, the OIG lists all open recommendations, including recommendations that have been open more than one year.

On January 3, 2019, the Good Accounting Obligation in Government Act (P. L. 115–414) was enacted, mandating each agency include in its annual budget justification submitted to Congress an explanation for the reasons why no final action has been taken regarding a Government Accountability Office or OIG recommendation open more than 12 months, as well as a timeline to implement the recommendation if the agency concurred. It is expected that the agency budget justification will include this information in the FY 2021 budget submission.

Current State of OIG Recommendations

As of March 31, 2019, there were 84 OIG reports and 403 recommendations that had been open less than one year. The total monetary benefit associated with these recommendations is more than $2.7 billion. Also, as of March 31, 2019, there were 40 reports and 133 recommendations that remained open for more than one year. The total monetary benefit related to these reports is more than $329 million.

FOLLOW–UP PROCESSES

While there have been instances in which VA has resolved an issue at the time of a report's publication, the vast majority of recommendations take time to implement fully. To ensure completion, the OIG engages its centralized follow-up staff to track the implementation of all report recommendations with the responsible VA office. This consolidated function helps ensure specially trained staff provide consistent management of OIG follow-up activities, frees report authors to work on other projects, and helps the OIG prepare timely and accurate status reporting for the website, SAR, and other products.

Timelines

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[1] https://www.va.gov/oig/recommendation-dashboard.asp.
[2] An archive of SARs is available at https://www.va.gov/oig/publications/semiannual-reports.asp.

In addition to VA's comments on a draft report, the responsible VA office provides a workplan describing the process and timeline for each recommendation to be implemented. After the report is issued, the OIG follow-up group is responsible for entering all this information into a tracking system, analyzing the report's recommendations and VA comments, and then preparing the appropriate documentation request to the responsible VA office.

At quarterly intervals starting 90 days after report issuance, the follow-up group requests the VA office provide an accounting of actions taken to implement open recommendations, as well as whether the VA office believes a recommendation may be closed. Each VA administration and staff office maintains a point of contact for this process, which helps with consistency in addressing implementation issues, tracking progress, and coordinating the response of the VA office assigned the recommendation. After receiving the VA office's report, the follow-up staff draft a preliminary assessment to the responsible OIG office, which wrote the report, as to whether any recommendations appear ready to close. The responsible OIG office then reviews the materials and provides a final determination whether any recommendations have been satisfactorily implemented and can be closed. If the VA office does not provide any response, follow-up staff can escalate the issue for resolution by connecting OIG leaders to the appropriate VA leaders.

Recommendation Closure or Suspension

The responsible OIG office has the subject-matter expertise related to the recommendation at issue, and no recommendation may be closed without that office's approval. The decision to close a recommendation is based on a review of VA's supporting documentation or independent information obtained by OIG that indicates the corrective action has occurred or progressed enough to show recommendation implementation. For example, a recommendation to train employees on a particular issue is not closed if the VA office says it will conduct the training, but rather if the VA provides syllabus and scheduling documentation showing adequately developed training is underway and will continue in a systematic fashion.

In a very few cases, there may be a need for OIG leadership to temporarily suspend follow-up activities or close recommendations as "not able to be implemented." For example, suspension may be warranted when a planned corrective action has gone stagnant due to circumstances beyond the control of the VA office (such as the need for a technology solution) and no viable alternatives exist, or if the program materially changes or is terminated and so the recommendation no longer applies. As mentioned earlier, if VA does not concur with a recommendation following OIG outreach at report publication or during follow-up, that nonconcurrence is noted and reported publicly and to Congress. If a new report is issued that repeats not-yet-implemented recommendations from a prior report, follow-up staff would close out the initial recommendations and consolidate all recommendations related to unresolved concerns into the new report.

Aligned with the schedule for preparing the SAR, follow-up staff work with responsible OIG staff every six months to review open recommendations to determine whether any problems exist in implementation or whether circumstances would allow closure of any recommendations. As needed, OIG staff can confer with VA offices to examine the issues preventing implementation and work to revise related implementation plans.

IMPACTFUL RECOMMENDATIONS AFFECT A RANGE OF VA PROGRAMS

OIG recommendations are directed at every level of VA operations, affecting the quality and access to health care for more than 7 million veterans; benefits for veterans with disabilities, their caregivers, and family members; and the effective stewardship of appropriated funds. They can be directed at individual facilities, regional networks, or national program or administrative offices. The following reports are highlighted to demonstrate how OIG staff perform sustained follow-up on identified areas of weakness to ensure meaningful improvement within VA.

Veterans Health Administration Examples

Critical Deficiencies at the Washington DC VA Medical Center. In March 2017, the OIG received a confidential complaint and additional subsequent allegations that the Washington DC VA Medical Center had equipment and supply issues that could be putting patients at risk for harm. The OIG conducted an inspection, issuing an interim report in April 2017, and a final report in March 2018.[3] The final report provided findings in four areas: (1) risk of harm to patients, (2) hospital serv-

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[3] Interim Summary Report, April 17, 2017; Critical Deficiencies at the Washington DC VA Medical Center, March 7, 2018.

ice deficiencies affecting patient care, (3) lack of financial controls, and (4) failures in leadership. These deficiencies spanned many years, impacting the core medical center functions that health care providers need to effectively provide quality care. In particular, the report detailed the failure to ensure supplies and equipment reached patient care areas when needed, in part due to the facility's failure to use its inventory management IT system. The OIG made 40 recommendations, and VA concurred with each one. While VA provided detailed action plans on how the recommendations would be implemented and identified progress made, of the 40 recommendations, 13 are still open as of May 14, 2019.

This report was meant to not only improve conditions at the DC VA Medical Center, but also to serve as a guide for other VA medical facilities' logistical services and to improve integrated reviews and oversight by Veterans Integrated Service Networks (VISNs) and VA central offices.

Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package. As a result of the inventory management issues identified at the DC VA Medical Center, the OIG conducted a national audit in which the audit team surveyed 21 medical centers and conducted unannounced on-site visits to 11 of those 21. They found other medical centers also encountered challenges as part of the migration to a new inventory management system and that significant discrepancies existed between actual inventory and the data for tracking expendable medical supplies.[4] Also, they found proper inventory monitoring and management practices were lacking. Some of the issues stemmed from the failure to provide adequate oversight of the migration at the Veterans Health Administration (VHA) level, while others stemmed from a lack of oversight from the VISN. The OIG's May 1, 2019, report included six recommendations to the Executive in Charge for the Office of the Under Secretary for Health regarding inventory distribution and controls, which VA is now implementing.

Veterans Crisis Line. The OIG is monitoring VA's delivery of mental health care and the operations of its suicide prevention programs. The OIG conducted a review of the Veterans Crisis Line (VCL) in 2016 and again in 2017 because of VHA's inability to implement OIG recommendations for this critical program in a timely manner, as well as the receipt of additional allegations.

On March 20, 2017, the OIG issued Evaluation of the Veterans Health Administration Veterans Crisis Line, reporting deficiencies in multiple areas of the VCL's administration.[5] Although the OIG was impressed with the dedication of VCL staff assisting veterans and loved ones, the OIG staff found VCL's management team faced significant obstacles providing suicide prevention and crisis intervention services to veterans, service members, and their families. The VCL's biggest challenges included meeting the operational and business demands of responding to over 500,000 calls per year, and training staff to assess and respond to the needs of individual contacts with veterans and family members under stressful, time-sensitive conditions.

The OIG staff found deficiencies in the governance and oversight of VCL operations following its realignment under VHA's Office of Member Services, a business operations group with expertise in call center operations. While VA leaders stated that Member Services and the Office of Mental Health Operations would work closely together to manage VCL services, the review found decisions were made with insufficient clinical input. The OIG also identified internal quality assurance deficiencies, including that there was an inadequate process to collect, analyze, and effectively review relevant quality management data to improve outcomes for callers. OIG staff made 16 recommendations to VA to improve crisis intervention services for veterans in distress. Among other weaknesses, the OIG identified in response to a complaint that there was a failure to properly respond to a veteran during multiple calls, resulting in missed opportunities to provide crisis intervention services. The OIG closed out the report recommendations on March 28, 2018, after accepting VA's implementation plan for the final open recommendation.

It is important to note that the March 2017 report resulted, in part, from VA's failure to implement prior OIG recommendations made in a February 2016 report, Healthcare Inspection-Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York.[6] The OIG's seven recommendations from the 2016 report remained open for more than a year. OIG staff conducted the subsequent review because the failure to implement previous recommendations was im-

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[4] Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package, May 1, 2019.

[5] Evaluation of the Veterans Health Administration Veterans Crisis Line, March 20, 2017.

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

pairing the VCL's ability to increase the quality of crisis intervention services to callers. The OIG's February 2016 report recommendations were eventually closed out on July 31, 2017.

Suicide Prevention. Many OIG reports also provide recommendations for facilities after reviewing the care provided to individual patients. The recommendations often can be used as guidance for other facilities within the VA system as well. For example, a September 2018 Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide Minneapolis VA Health Care System, Minnesota examined the care of a patient who died from a self-inflicted gunshot wound less than 24 hours after being discharged from an inpatient mental health unit.[7] Even though the action plans had target implementation dates no later than January 31, 2019, six of the seven recommendations remain open. The recommendations for corrective action relate to care provider coordination, accuracy of documentation, inclusion of family members in a veteran's health care and discharge, and completion of analyses after a tragic event.

The OIG previously reported on the performance of multiple VHA facilities by conducting a trends analysis of suicide prevention programs. In an Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities, the OIG examined suicide prevention efforts in VHA facilities to assess facility compliance with relevant VHA guidelines.[8] OIG conducted this review at 28 VHA medical facilities during its comprehensive assessment program reviews from October 1, 2015, through March 31, 2016. The OIG found that most facilities had a process for responding to referrals from the VCL and a process to follow up on high-risk patients who missed appointments. However, the OIG identified system weaknesses in areas such as outreach activities; suicide prevention safety plan completion, content, and distribution; flagging records of high-risk inpatients and notifying the Suicide Coordinator of the admission; and evaluating high-risk inpatients during the 30 days following discharge. The OIG's six recommendations to the then-Acting Under Secretary for Health are now closed.

Routine Inspections. The OIG continues to conduct unannounced cyclical assessments of operations and quality control programs at VHA medical facilities, now known as Comprehensive Healthcare Inspection Program (CHIP) reports. These reports focus on leadership within a facility and key factors that affect patient care, such as quality, safety, and value; the credentialing and privileging process; environment of care; and medication management. Additionally, the OIG annually rotates high-interest topics in these fields, such as posttraumatic stress disorder care, mammography results and follow-up, and controlled substances inspection programs.[9] OIG staff may also conduct more frequent follow-ups to assess VA's progress in implementing recommendations when a facility appears unable to address OIG findings. These additional inspections help ensure issues do not remain unresolved over long periods of time.

For example, in May 2015, an OIG assessment of the VA St. Louis Health Care System in Missouri identified 45 recommendations to address concerns across the facility's operations.[10] Due to the wide-ranging issues, in November of the same year, OIG staff conducted another review of the facility to assess progress on the action plans, with a particular focus on quality and environment of care.[11] While some progress was noted, OIG staff made additional recommendations in those areas of focus. OIG staff returned to the facility yet again in June 2016. In that report, the OIG made one recommendation related to the environment of care.[12] Finally, OIG staff conducted an inspection of the facility in 2018 that resulted in seven recommendations, which have all been closed.[13]

VISN Reviews. To augment oversight of VHA-related recommendations, the OIG is launching routine reviews of VISNs. There is limited utility to having medical facilities implement recommendations if those corrective actions are not supported by the VISN. This expanded focus on VISNs is meant to address the oversight and

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[7] Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide Minneapolis VA Health Care System, Minnesota, September 25, 2018.

[8] Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities, May 18, 2017.

[9] Semiannual Report to Congress, Issue 80.

[10] Combined Assessment Program Review of the VA St. Louis Health Care System, St. Louis, Missouri, May 18, 2015.

[11] Combined Assessment Program Follow-Up Review of the VA St. Louis Health Care System, St. Louis, Missouri, January 20, 2016.

[12] Combined Assessment Program Follow-Up Review of Environment of Care at the VA St. Louis Health Care System, St. Louis, Missouri, January 18, 2017.

[13] Comprehensive Healthcare Inspection Program Review of the VA St. Louis Health Care System, Missouri, August 23, 2018.

services that VISNs provide all medical centers within their network that affect efficient operations and quality patient care. After completing several successful pilot visits, the OIG will be conducting unannounced reviews for four VISNs during the remainder of FY 2019. OIG staff conducting facility- and VISN-level inspections are engaging in coordination efforts to ensure reports regarding medical facilities make relevant connections to their VISN responsible for leadership, support, and oversight. The reports will include recommendations to improve accountability for the provision of high-quality health care.

Veterans Benefits Administration Examples

In October 2017, the OIG implemented a new national inspection model for oversight of the Veterans Benefits Administration (VBA). Previously, the OIG largely conducted oversight through inspections of VBA's 56 regional offices. Under the new model, the OIG conducts nationwide audits and reviews of high-impact programs and operations within VBA to accomplish the following objectives:

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

Since October 1, 2017, the OIG has published 19 VBA-related oversight reports. VBA has generally concurred with the recommendations and provided acceptable action plans, with the closure of most recommendations that have been open for over one year.

Two recent OIG reports regarding VBA claims processing for complex claims related amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and to military sexual trauma (MST) demonstrate the value of OIG recommendations. In 2016, VBA moved to a National Work Queue (NWQ) for the processing of disability compensation claims. Previously, VBA used Segmented Lanes to process claims. Under that approach, specialized claims, like those for MST and ALS, were routed to staff experienced with those claims. Under the NWQ, VBA no longer directed complex claims to specialized teams, but rather distributed daily to each VA regional office (VARO) new claims, which the VARO then assigned to processors by workload. These OIG reports detail how national policy changes have had negative impacts on claims processing. While well-intentioned efforts to expedite overall benefits processes were carried out, there was an unintended impact on VBA's ability to review and process certain claims accurately.

Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis. In November 2018, the OIG examined whether VBA accurately decided veterans' claims involving service-connected ALS. [14] VA describes ALS as a rapidly progressive neurological disease that attacks the nerve cells responsible for directly controlling voluntary muscles. Because a statistical correlation was found between military service activities and the development of ALS, VA established a presumption of service connection for this disease in 2008. Thus, veterans who develop the disease during service, or any time after separation from military service, generally receive benefits if they had active and continuous service of 90 days or more. Although VBA prioritizes these claims, staff must also accurately decide these claims because it is a serious condition that often causes death within three to five years from the onset of symptoms.

OIG staff reviewed a statistical sample of 100 veterans' cases involving service-connected ALS from April through September 2017. The team found that VBA staff made 71 errors involving 45 veterans' ALS claims, projecting that 430 of 960 total ALS veterans' cases had erroneous decisions. For example, rating personnel incorrectly decided ALS claims related to one or more of the following categories:

- Special monthly compensation benefits
- Evaluations of medical complications of ALS
- Effective dates
- Additional benefits related to adapted housing or automobiles
- Inaccurate or conflicting information in decisions
- Proposals to discontinue service connection

These errors resulted in estimated underpayments of about $750,000 and overpayments of about $649,000 over a six-month period, for a potential $7.5 million in underpayments and $6.5 million in overpayments over a five year period. Also, VBA staff generally did not tell veterans about available special monthly compensation benefits. Most rating personnel indicated that they do not often receive claims in-

[14] Accuracy of Claims Involving Service-Connected Amyotrophic Lateral Sclerosis, November 20, 2018.

volving ALS or higher levels of special monthly compensation, which makes these claims more difficult to evaluate. The Under Secretary for Benefits concurred with the OIG's two recommendations to implement a plan to improve and monitor decisions involving service-connected ALS and to provide notice regarding additional special monthly compensation benefits that may be available. These recommendations are still open.

Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma. In August 2018, the OIG reviewed VBA's denied PTSD claims related to veterans' MST to determine whether staff correctly processed the claims.[15] Some service members are understandably reluctant to submit a report of MST, particularly when the perpetrator is a superior officer. Service members may also have concerns about the potential for negative performance reports or punishment for collateral misconduct. There is also sometimes the perception of an unresponsive military chain of command. If the MST leads to PTSD, it is often difficult for victims to produce evidence to support the assault's occurrence. VBA policy correctly requires staff to follow additional steps for processing MST-related claims so veterans have further opportunities to provide adequate evidence.

VBA reported that it processed approximately 12,000 claims per year over the last three years for PTSD related to MST. In FY 2017, VBA denied about 5,500 of those claims (46 percent). The OIG review team assessed a sample of 169 MST-related claims that VBA staff denied from April through September 2017. The review team found that VBA staff did not properly process veterans' denied MST-related claims in 82 of 169 cases. As a result, the OIG estimated that VBA staff incorrectly processed approximately 1,300 of the 2,700 MST-related claims denied during that time (49 percent). The OIG found that multiple factors led to the improper processing and denial of MST-related claims. Included among these factors were the lack of reviewer specialization, lack of an additional level of review, discontinued special focused reviews, and inadequate training.

The OIG made six recommendations to the Under Secretary for Benefits including that VBA review all approximately 5,500 MST-related claims denied from October 2016 through September 2017, take corrective action on those claims in which VBA staff did not follow all required steps, assign MST-related claims to a specialized group of claims processors, and improve oversight and training on addressing MST-related claims. The Under Secretary concurred with the recommendations and has already taken steps to address them, particularly in the area of training, with four recommendations currently still open. The Under Secretary also stated that, in FY 2019, VBA will review every denied MST-related claim decided since the beginning of FY 2017.

STEWARDSHIP OF APPROPRIATED FUNDS EXAMPLES

While some OIG recommendations focus primarily on improving quality of care for veterans, or program effectiveness, others emphasize deficiencies in the efficient use of taxpayer dollars or misusing appropriated funds. Several examples follow demonstrating the need for more effective controls, stronger oversight practices, and greater accountability so that VA funding is put to the most efficient and effective use to the benefit of veterans, their caregivers, and families.

VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students. A December 2018 OIG report examined the effectiveness of VA and State Approving Agencies' (SAAs') monitoring of participating educational programs, which identified serious concerns, including gaps in approval practices that led to ineligible and potentially ineligible schools participating in the program.[16] The OIG conducted this audit to determine if VA and SAAs were effectively reviewing and monitoring education and training programs that enrolled Post-9/11 GI Bill students to ensure only eligible programs participated. Prior OIG reports noted financial risks for these programs.[17] Based on its review, the OIG estimated that 86 percent of SAAs did not adequately oversee the education and training programs to make certain only eligible programs participated. In total, the audit team projected that VBA annually issues an estimated $585 million in related improper Post-9/11 GI Bill tuition and fee payments to ineligible or potentially ineligible schools and that $473.8 million of this amount will be paid to for-profit schools.[18]

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[15] Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma, August 21, 2018.

[16] VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students, December 3, 2018.

[17] Id. at 49–50.

[18] "Under OMB Circular A–123, App. C, Pt. I–A, Risk Assessing, Estimating, and Reporting Improper Payments, (October 20, 2014), improper payments are payments that should not have

Oversight deficiencies occurred, in part, because VBA maintained it has a limited role for oversight of SAAs. The OIG recommended clarifying requirements for approvals, requiring periodic re-approval of programs, reporting schools with misleading advertising, strengthening compliance surveys for program eligibility, revising program assessment standards, and confirming that SAA funding can support the recommended steps. Of those, one recommendation has been closed as implemented, and OIG staff are monitoring VBA's progress on the remaining five.

Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans. On occasion, OIG staff audit programs and monitor recommendation implementation, but continue to receive allegations of specific acts of wrongdoing through the OIG Hotline. In June 2016, the OIG audited whether VBA was adjusting compensation and pension (C&P) benefit payments for veterans incarcerated in federal, state, and local correctional institutions in a timely manner and as required by Federal law.[19] The OIG identified program weaknesses and determined that VBA did not consistently take action to adjust C&P benefits for incarcerated veterans as legally required. VBA's ineffective actions in processing incarceration adjustments resulted in significant improper benefit payments totaling more than $100 million. If conditions remained the same and improvements were not made, VBA could have made additional inaccurate payments (improper payments) of more than $200 million over a 5-year period from FY 2016 through FY 2020. The report's six recommendations are now closed.

However, this was not the first time OIG reported on problems with C&P benefit payments adjustments. In 1986 and 1999, OIG identified similar issues with C&P benefit payments to incarcerated veterans, and VA provided remediation plans.[20] Because problems in this area have tended to reoccur or new problems emerge, the OIG continues to identify and follow up on similar improper payments reported through the OIG Hotline. One recent example involves a veteran improperly receiving $46,200.[21]

MAJOR MANAGEMENT CHALLENGES

Each year, pursuant to Section 3516 of United States Code Title 31, the OIG provides Congress with an update summarizing the most serious management and performance challenges identified by OIG work as well as an assessment of VA's progress in addressing them.[22] These challenges are aligned with the OIG's six areas of focus outlined in its strategic plan: (1) leadership and workforce investment, (2) health care delivery, (3) benefits delivery, (4) financial management, (5) procurement practices, and (6) information management.

The OIG has made VA leadership and governance a top priority in recognition that deficiencies in these areas ultimately affect the care and services provided to veterans and allow significant problems to persist unresolved for years. And, as in prior years, access to health care remains a significant challenge for VA. This is a particular concern as prodigious changes are underway for expanding community care and enhancing access to care in VA facilities and as VA implements changes to its benefit appeals process. The OIG has noted specific progress in quality improvement and patient care processes during CHIP inspections and other work in individual facilities, yet deficiencies remain in other areas affected by inadequate staffing and IT systems.

The OIG has also focused on problems identified VA-wide regarding information management, financial management, and procurement practices that, while critical to VA carrying out its missions, have been at the heart of failures in providing medical care and a range of benefits and services to veterans and their families. OIG audits and reviews, such as the audit of VA's consolidated financial statements, as required under the Chief Financial Officer's Act and the review of VA's compliance with the Improper Payments Elimination and Recovery Act, establish that elimi-

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been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements; payments made to ineligible recipients; and payments where an agency's review is unable to discern it is proper due to insufficient documentation." Id. at 3.

[19] Audit of Compensation and Pension Benefit Payments to Incarcerated Veterans, June 28, 2016.

[20] Evaluation of Benefit Payments to Incarcerated Veterans, February 5, 1999.

[21] Semiannual Report to Congress, Issue 80.

[22] U.S. Department of Veterans Affairs Office of Inspector General Management and Performance Challenges, November 2018.

nating continued shortfalls in VA's financial management systems would improve VA's effectiveness at using appropriated funds to benefit veterans.[23]

CONCLUSION

A strength of the OIG's oversight work is the commitment to identifying underlying causes, which is the foundation for developing meaningful and comprehensive recommendations. By addressing these causes, VA can more effectively address not only the symptoms but prevent future occurrences. The OIG has commonly found the following through its oversight work:

- Poor governance structures
- Lack of continuity of leadership
- Failure to communicate effectively
- Failure to ensure accountability
- Poor financial management
- IT failures and not using IT effectively
- Poor planning and forecasting
- Failure to anticipate the consequences of policy changes
- HR and staffing issues
- Poor training
- Poor quality assurance
- Inadequate, outdated, conflicting, or absent policies
- Culture of complacency
- Bureaucracy ahead of veterans

The OIG is committed to serving veterans and the public by conducting effective oversight of VA programs and operations through independent audits, inspections, reviews, and investigations. That commitment can only be realized by making practical, meaningful recommendations that enhance VA's programs and operations as well as prevent and address fraud, waste, and abuse.

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

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STATEMENTS FOR THE RECORD

ROBERT WILKIE

The Department of Veterans Affairs (VA) appreciates the work of the U.S Government Accountability Office (GAO) and the VA Office of Inspector General (OIG) to help the Department make improvements to programs throughout our enterprise that facilitate more effective and efficient services and benefits to our Nation's Veterans. VA has a strong collaborative relationship with both GAO and OIG. VA treats all recommendations seriously and strives to implement the concurred upon recommendations in a timely manner.

The Department would have liked to participate in this hearing; unfortunately, to do so would have been contrary to the longstanding practice of prior Administrations and this Administration by allowing Executive Branch officials to testify at a Congressional hearing on a panel that includes non-Executive Branch witnesses.

According to GAO, VA leads the Federal government with a 90 percent recommendation implementation rate. In March 2019, GAO issued its biennial high-risk report in which GAO added VA Acquisition Management as a high-risk area. This is the third high-risk area for VA–Managing Risks and Improving VA Health Care was added in 2015, and Improving and Modernizing Federal Disability Programs was added in 2003. The Department is committed to implementing all concurred upon GAO recommendations and moving off of GAO's high-risk list. In November, Secretary Wilkie met with the Comptroller General to discuss the high-risk report areas and high priority recommendations. During that meeting, Secretary Wilkie assured the Comptroller General that the Department appreciates GAO's work and that VA is working on taking corrective action on all open GAO recommendations.

With regard to the GAO high priority recommendations, in 2018, GAO identified 26 priority recommendations. Since that time, VA implemented 5 of the 26 open priority recommendations and GAO closed 1 priority recommendation on a program

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[23] Audit of VA's Financial Statements for Fiscal Years 2018 and 2017, November 26, 2018; VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017, May 15, 2018.

that recently underwent significant statutory changes. When GAO issued its March 2019 priority open recommendations report, VA had 20 open priority recommendations and GAO added 10 new priority recommendations bringing the total to 30 priority recommendations. VA provides GAO with updates on all open priority recommendations. Within the Department, several initiatives are underway to more directly focus administrations and staff offices on the development of milestones and metrics and demonstrated progress on implementing GAO recommendations. VA leaders and staff meet periodically with GAO to discuss VA's efforts to implement action plans related to open recommendations and receive feedback from GAO on the progress being made.

The VA OIG is the independent oversight entity within VA that conducts reviews and recommends improvements that are designed to promote economy, efficiency, and effectiveness throughout VA programs and operations. The VA OIG issues hundreds of reports and recommendations each year involving programs throughout the VA enterprise. During the last 12 months, OIG issued 128 reports with 715 recommendations on VA programs and operations. The administrations and staff offices work with OIG inspectors and investigators to come to agreed upon corrective action plans to resolve audit recommendations. The Department strives to complete OIG recommendations with the same urgency as all oversight recommendations.

In June 2017, the Department of Veterans Affairs Accountability and Whistleblower Protection Act was enacted. The Act, among other things, statutorily established the Office of Accountability and Whistleblower Protection (OAWP) and codified its establishment under section 323 of title 38 of the United States Code (U.S.C.). As prescribed by Congress under 38 U.S.C. § 323(c)(1)(F), one of OAWP's core functions is to record, track, review, and confirm "implementation of recommendations from audits and investigations carried out by [VA OIG], the Medical Inspector of the Department, the Special Counsel, and the Comptroller General of the United States, including the imposition of disciplinary actions and other corrective actions contained in such recommendations." The Department is currently working on establishing processes to create this functionality within OAWP which would enhance oversight on the implementation of recommendations issued by, among other entities, GAO and VA OIG. The Department looks forward to updating the Committee on its implementation.

Conclusion

Our mission is to serve our Veterans. We are committed to taking corrective action on all oversight recommendations to ensure that VA is the most efficient and effective organization possible for our Veterans. Your continued support is essential to providing the best services and benefits for Veterans and their families.

Overview and Comparison of the Department of Veterans Affairs (VA) and the Department of Defense (DOD) Graduate Medical Education (GME) Programs

Key Points of Comparison between VA and DOD GME Programs

- In contrast with DOD, which administers its own residency programs, VA generally does not sponsor or administer residency programs. Instead, the VA physician training program is administered through affiliations with academic institutions and teaching hospitals.
- VA does not directly pay salaries to the medical residents that rotate through its facilities. Instead, VA uses disbursement agreements to reimburse affiliated institutions for the health care services provided at VA medicals centers (VAMC) by medical residents. The affiliate institutions are ultimately responsible for administering salaries to their GME participants that are completing rotations at VAMCs.
- Medical residents who participate in VA's GME program have no service obligation to VA after the completion of their residency programs.

VA GME Program Overview

The Veterans Health Administration (VHA) GME program is carried out through coordinated programs and activities in partnership with affiliated U.S. academic institutions (affiliates), such as medical schools and teaching hospitals.

- While VHA's GME program is administered by its Office of Academic Affiliation (OAA), VAMCs enter into separate affiliation agreements with each affiliate-

under which the VA medical center and the affiliate agree to share responsibility for the academic program.

- In the vast majority of cases, VAMCs do not serve as the primary sponsor and training site for medical residents. VA reports that 99 percent of its GME programs are sponsored by an affiliate.
- Residents complete service rotations at VAMCs that are affiliated with their academic institution.
- VAMCs enter into disbursement agreements with the affiliates in order to reimburse them for services provided by residents rotating through the VA medical centers. VA reports that its GME program is affiliated with 144 of the 152 accredited allopathic medical schools and all 34 of the accredited osteopathic medical schools in the United States.

Number of residents in the pipeline. VA is the largest provider of medical training in the United States.

- VHA statistics for the 2017–18 academic year show that 45,296 medical residents trained at VAMCs.
- Physician residents represent approximately 50 percent of the total number of physicians working in VA facilities.
- The Veterans Access, Choice, & Accountability Act of 2014 authorized the addition of up to 1,500 additional physician residency positions over a ten year period, with a focus on medical specialties and geographic locations of high priority for VA. Through the first five years of this effort, VHA had approved 1,055 additional physician resident positions.

Recruitment of VA Physicians through GME

Lack of a service requirement. Medical residents who participate in VA's GME program have no service obligation to VA after the completion of their residency programs. However, VA sees its GME program as having a major impact on developing the VA health care workforce.

- In our 2017 report on VHA physician staffing and recruitment, agency officials noted that access to the GME pool of potential hires serves as an important recruitment resource. [1]

- Additionally, officials reported that physician training programs provide current physicians with teaching opportunities that also bolster recruitment and retention.
- VA reports that about 60 percent of its physicians participated in VA training programs prior to employment.
- According to the VA Trainee Satisfaction Survey completed by more than 23,000 trainees during the 2016–17 academic year, 73 percent of respondents indicated a willingness to work at VA after their VA clinical training experience.

Recruitment challenges. Despite VHA's large and expanding graduate medical training program, VAMCs experience difficulties hiring physicians who receive training through its residency programs. We have reported on some of these difficulties in physician recruitment, including barriers to recruiting VA GME participants for permanent employment after the completion of their residency programs.

- In October 2017, we reported that VHA did not track the number of physician trainees who were hired following graduation, but VA officials stated that the number was small in comparison to the almost 44,000 physician trainees educated at VAMCs each year. [2]
- We found that VAMCs faced challenges hiring physician trainees, in part, because VHA did not share information on graduating physician trainees for recruitment purposes with VAMCs across the system.
- Our October 2017 report also described delays in VAMCs' hiring offers to graduates. Agency officials noted that VAMCs could not make employment offers to medical resident trainees until they had completed their training programs. Competitors often make hiring offers as early as trainees' second year of residency, according to VAMC officials.
- VHA officials said some VAMCs use existing policy flexibilities to recruit trainees more proactively by making early hiring offers that are contingent on the

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[1] See GAO, Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies, GAO–18–124 (Washington, D.C.: Oct 19, 2017).
[2] See GAO–18–124.

trainee meeting certain conditions, such as completing training, and that these actions improve the likelihood of successful recruitment.

Other Recruitment and Retention Efforts-National Recruitment Service and Financial Incentives

VHA has a National Recruitment Service within VHA's Workforce Management and Consulting Office.

- In fiscal year 2016, the National Recruitment Service, comprised of 19 VHA physicians, referred 2,200 candidates to VAMCs, which resulted in 325 physicians hired, according to VHA officials.

VHA uses a variety of financial incentives to recruit new physicians.

- Financial incentives include market-based salaries, an education debt reduction program, bonus pay for recruitment, retention, and relocation, and continuing medical education funding.
- The VA MISSION Act of 2018 created two new scholarship opportunities and a loan repayment program to recruit medical students and residents.
- The Veterans Healing Veterans Medical Access and Scholarship Program provides four years of tuition, fees, and stipend support for two veterans at nine medical schools in exchange for four years of clinical practice at a VA facility after completion of a residency and/or fellowship.
- The VA Health Professions Scholarship Program provides annual medical or dental school scholarships (tuition, fees, and stipend) in exchange for 18 months of service at a VA facility for each year of support.
- The Specialty Education Loan Repayment Program is a loan repayment program targeted towards physician residents. Its purpose is to provide VA with needed medical specialists in geographic areas and VA facilities where VA needs those specialists. Applicants can apply right after the residency match or up to two years before completion of the residency. The program can repay up to $160,000 of education loans total; each year of service at a VA facility qualifies for $40,000 in loan repayment, with a minimum of two years of service required.
- In our October 2017 report, we recommended that VHA conduct a comprehensive, system-wide evaluation of the physician recruitment and retention strategies used by VAMCs to determine their overall effectiveness, identify and implement improvements, ensure coordination across VHA offices, and establish an ongoing monitoring process.
- VHA concurred with our recommendation, and in May 2019, VHA submitted an evaluation of its physician recruitment and retention programs. The report covered the use of the Education Debt Reduction Program, physician pay tables, and recruitment, retention, and relocation incentives. One result of the evaluation is that VHA provided Veterans Integrated Service Networks with recommendations on how to efficiently allocate their recruitment, retention, and relocation incentives.

Other health professions: VAMCs serves as training sites for other health professions, including dentistry, nursing, and social work, among others. VA statistics from the 2017–18 academic year indicate that 49,958 individuals participated in dental, nursing, or associated health profession training at VAMCs.

For more information about VHA's GME program contact Sharon M. Silas at (202) 512–7114 or silass@gao.gov, and for more information about VHA physician staffing and recruitment, contact Debra A. Draper at (202) 512–7114 or draperd@gao.gov.

DOD GME Programs

Military Residency Programs

The military services' GME programs provide specialty training to medical school graduates who agree to an active duty service obligation. Through GME programs, military medical officers acclimate to the military while developing core competencies and critical wartime medical readiness skills, such as combat casualty care and treatment of injuries from explosive or biological incidents. According to military service officials, specialty training through GME programs is an important recruitment and retention tool because it may encourage continued service beyond the fulfillment of the initial active duty service obligation. Programs are accredited by and follow the standards of the Accreditation Council for Graduate Medical Education, a civilian organization, and managed by each respective military services. The military services generally partner with civilian teaching hospitals, where residents rotate for training in areas or populations not seen at a DOD hospital.

- **Service requirement:** While in a military residency program, participants incur an additional 6 months of active duty service obligation for each 6 months in training, with a minimum of 2 years active duty service obligation.
- **Number of residents:** In fiscal year 2018, there were 3,189 residents and fellows enrolled in DOD GME programs, training in 70 specialties, at military treatment facilities.[3]

The National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017) directed the Secretary of Defense to establish and implement a process to oversee GME programs, and transferred administrative and management responsibility for military treatment facilities from the military services to the Defense Health Agency and requires the agency to assume responsibility for the policy, procedures, and direction of GME programs. However, each military service's medical command remains responsible for recruiting, organizing, training, and equipping their medical personnel.

While we have done recent work on DOD's proposed plan for oversight of GME programs, we have not done work on DOD's GME/residency programs. The following is related work specific to medical students.

DOD Programs for Medical Students

In addition to recruiting medical school graduates, DOD's two primary programs for creating a pipeline of future military physicians are its scholarship program, managed by the services-the Armed Forces Health Professions Scholarship Program (AFHPSP)-and DOD's sponsored medical school-the Uniformed Services University of the Health Sciences (USUHS).[4]

- **Benefits and service requirement:** AFHPSP medical students receive a monthly stipend and incur an obligation to serve 6 months of active duty service for each 6 months of benefits received, with a 2-year minimum obligation.[5] In addition, DOD pays for all qualified educational expenses, including tuition, books, and fees. USUHS medical students receive the pay and benefits of an officer at the O–1 level and incur a minimum 7-year service obligation. Most AFHPSP and USUHS participants go on active duty and perform their GME training at military hospitals, although some AFHPSP participants are granted deferments while they pursue civilian GME.
- **Number of medical students:** The services reported that they generally met their recruitment goals for AFHPSP, and that the program enabled DOD to successfully recruit approximately 800 to 850 medical students per year from fiscal years 2011 to 2016. Further, USUHS successfully recruits an additional 170 medical students per year.
- **Recruitment challenges:** However, although the services report that they are generally meeting their AFHPSP recruitment goals, we found that they are not recruiting the maximum number of participants (that is, 2,100) they are allowed. Instead, for fiscal years 2011 through 2015, the Army enrolled in its program approximately 71 percent to 85 percent of the maximum allowed; the Navy about 59 percent to 63 percent; and the Air Force approximately 70 percent to 79 percent.
- Officials from these services cited various factors that limit their ability to recruit the maximum number of participants they are allowed-such as restrictions on the number of physicians they are authorized to bring into the military in any given year; concern that increasing AFHPSP goals could reduce the overall quality of medical student recruits; and the limited number of slots available in military GME programs-making it difficult to place an increased number of AFHPSP participants in these residency programs.
- **Medical students who do not meet their service requirement:** In 2008, we examined the number of participants in two DOD programs who do not enter active duty following completion of the program of studies for which they

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[3] An additional 23 specialties did not have any residents in fiscal year 2018. The count of students only includes residents and fellows at military treatment facilities, although residents and fellows may be trained in civilian GME programs as well. See GAO, Defense Health Care: DOD's Proposed Plan for Oversight of Graduate Medical Education Programs, GAO–19–338 (Washington, D.C.: Mar. 28, 2019).

[4] For more information about these programs and the data that follow, see GAO, Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties, GAO–18–77 (Washington, D.C.: Feb 28, 2018).

[5] There are some exceptions to active duty service obligation incurred. For example, Department of Defense Instruction 6000.13 states that an AFHPSP participant may serve his or her service obligation in a component of the Selected Reserve for a period twice as long as the participant's remaining active duty obligation.

were enrolled, including the extent to which the military services have sought and received reimbursement for stipends or annual grants paid. [6]

- Our analyses of service and Defense Finance and Accounting Service data showed that, for fiscal years 2003 through 2007, fewer than 1 percent (171) of the total number of participants (19,921) withdrew from the programs or, alternatively, graduated but did not go on to active duty service.
- Upon withdrawal or release from the program, participants are obligated to reimburse the government for all or some portion of their medical education expenses unless relieved of that obligation by their respective service secretary. We found that DOD has procedures in place to recoup medical education expenditures from participants who fail to complete their education or serve their active duty obligation, and many cases we reviewed were processed in a timely manner. However, in some cases, it took more than 5 years from the time recoupment actions on individuals' debts were initiated until the time the Defense Finance and Accounting Service established an official debt account and began collection efforts.
- At that time, we made five recommendations to strengthen DOD's debt collection efforts, all of which DOD has since implemented.
- **Retention challenges:** Nonetheless, we also found that retaining fully qualified physicians is challenging for the military services, and that the added stresses of deployments and the general perceptions of war, along with the potential for health care providers to earn significantly more money in the private sector, have caused some physicians to separate from military service once they have fulfilled their service obligations. [7]

Examples of Other Military Physician Recruitment Programs

- **Financial Assistance Program (FAP).** Provides annual grants of up to $45,000 and monthly stipends of more than $2,000 for physicians accepted or enrolled in a residency program. Participants incur a minimum 2-year active duty obligation or 6-month active duty obligation for every 6 months or portion thereof of FAP sponsorship, whichever is greater. FAP participants will serve on active duty in a grade commensurate with their educational experience. Participants receive full pay and allowances for their respective grades for a period of 14 days active duty for annual training performed for each year of participation.
- **Health Professions Loan Repayment Program.** Provides repayment of educational loans for fully qualified health professionals. Participants incur a 2-year active duty obligation or 1 year of active duty obligation for each year of repayment, whichever is greater.
- **Specialized Training Assistance Program.** Provides a monthly stipend of more than $2,000 for physicians in designated specialties currently accepted or enrolled in a residency program. Participants incur a 1-year obligation in the Army Selected Reserve for every 6 months or portion thereof of financial assistance.

For more information about DOD's GME programs or physician recruitment, contact Brenda S. Farrell, (202) 512–3604 or farrellb@gao.gov.

Succession Planning

The most recent work we have on succession planning is Human Capital: Selected Agencies Have Opportunities to Enhance Existing Succession Planning and Management Efforts, GAO–05–585. This work included a review of how four agencies including the Census Bureau, Department of Labor (DOL), Environmental Protection Agency (EPA) and Veterans Health Administration (VHA) are implementing succession planning and management efforts. Key findings include:

- All four agencies had implemented succession planning and management efforts that collectively are intended to strengthen organizational capacity. However, in light of governmentwide fiscal challenges, we found that the agencies had opportunities to enhance some of their succession efforts.
- While all of the agencies assigned responsibility for their succession planning and management efforts to councils or boards, VHA had established a Sub-

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[6] See GAO, Military Personnel: Better Debt Management Procedures and Resolution of Stipend Recoupment Issues Are Needed for Improved Collection of Medical Education Debts, GAO–08–612R (Washington, D.C.: Apr. 1, 2008).

[7] See GAO–08–612R, and GAO, Military Personnel: Status of Accession, Retention, and End Strength for Military Medical Officers and Preliminary Observations Regarding Accession and Retention Challenges, GAO–09–469R (Washington, D.C.: Apr. 16, 2009).

committee and high-level positions that are directly responsible for its succession efforts.

- The four agencies had begun to link succession efforts to strategic planning. DOL, EPA, and VHA had identified gaps in occupations or competencies, undertaken strategies to address these gaps, and were planning or taking steps to monitor their progress in closing these gaps.
- All of the agencies' succession efforts included training and development programs at all organizational levels. However, there were opportunities to coordinate and share these programs and create synergies through benchmarking with others, achieving economies of scale, limiting duplication of efforts, and enhancing the effectiveness of programs, among other things.

In the report we made eight recommendations, including two recommendations to VA. All eight recommendations have been closed and implemented. For more information on this work and the recommendations: https://www.gao.gov/products/GAO–05–585.

In addition to this work, GAO is currently looking at whether VA's succession planning policies and procedures are consistent with OPM's guidance for succession planning. For additional information on this work contact Robert Goldenkoff, GoldenkoffR@gao.gov.

Examples of Quarterly Reporting Requirements for GAO

Authority	GAO Section(s)/Title	Summary
P.L 115–141 Consolidated Appropriations Act, 2018	Explanatory Statement. Div. J. Military Construction, VA and Related Agencies Appropriations Act, 2018. Veterans Electronic Health Records	Requires VA to submit quarterly reports on implementation of VA's electronic health records. Report to include detailed obligations, expenditures, and deployment strategy by VA facility. Directs GAO to perform quarterly performance reviews of the VA electronic health record deployment. GAO reporting date not specified.
P.L 115–55 Veterans Appeals Improvement and Modernization Act of 2017.	Sec. 3 Comprehensive Plan for Processing of Legacy Appeals and Implementing New Appeals System. (a) Plan Required. (b) Elements. (c) Review by Comptroller General of the United States. (1) In General. (A). (B). (2) Elements. (A). (B). (C).	Requires VA to submit to Congress and GAO, no later than 90 days after enactment, a comprehensive plan for processing legacy appeals and for implementing a modernized appeals system. VA to report quarterly until the modernized appeals system is implemented and semiannually for 7 years following implementation. Requires GAO to (1) assess VA's initial plan, including whether the plan comports with sound planning practices, (2) identify any gaps in the plan, and (3) provide recommendations for improvement as appropriate. Report no later than 90 days after VA submits the initial plan.

QUESTION FOR THE RECORD

U.S. GOVERNMENT ACCOUNTABILITY OFFICE (GAO)

July 1, 2019

The Honorable Chris Pappas
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman

This letter responds to your request that we address questions submitted for the record related to the May 22, 2019, hearing entitled Improving the Department of Veterans Affairs Effectiveness: Responding to Recommendations from Oversight Agencies. GAO's responses to these questions are enclosed.

If you have any questions about this response or need additional information, please contact please contact Debra A. Draper at (202) 512–7114 or draperd@gao.gov or Sharon M. M. Silas at (202) 512–7114 or silass@gao.gov for VHA health care issues; Shelby S. Oakley at (202) 512–4841 or oakleys@gao.gov for VA acquisition management issues; or Elizabeth H. Curda at (202) 512–7215 or curdae@gao.gov for VA disability claims issues.

Sincerely yours,

Debra Draper
Director, Health Care

Sharon Silas
Acting Director, Health Care

Shelby Oakley
Director, Contracting and National Security Acquisitions

Elizabeth Curda
Director, Education, Workforce, and Income Security

Enclosure

Attachment - Additional Questions for the Record

The Honorable Gil Cisneros

1. At the hearing, Rep. Cisneros asked GAO to provide a response for the record on VA turnover and management weaknesses. Specifically, Rep. Cisneros asked GAO's thoughts about whether the issue is primarily among career employees or political appointees or both.

In recent years, VA's workforce has experienced instability among both career employees and political appointees.

First, VA has experienced mission-critical skill gaps and vacancies throughout the department, which includes career employees. As of December 2018, VA reported an overall vacancy rate of 11 percent at Veterans Health Administration (VHA) medical facilities, including vacancies of over 24,000 medical and dental positions and around 900 human resource positions. With 32 percent of the VA workforce eligible to retire in the next 5 fiscal years, VA must address these mission-critical skill gaps and vacancies that we continue to identify in our work.[1] For example:

- In December 2016, we found that VHA's limited human resources capacity combined with weak internal control practices has undermined VHA's human resources operations and its ability to improve delivery of health care services to veterans.[2] Further, VHA is challenged by inefficiencies in its performance management processes, including the lack of a performance appraisal IT system, which prevents it from identifying trends and opportunities for improvement. VHA can better support medical centers by establishing clear lines of accountability for engagement efforts, collecting and leveraging leading practices, and addressing barriers to improving engagement. We made three recommendations to VA to improve its performance management system. VA partially concurred with these recommendations, which remain open.
- In October 2017, we reported that VHA is unable to accurately count the total number of physicians who provide care in its VA medical centers.[3] VHA has data on the number of mission-critical physicians, which includes primary care and mental health physicians, it employs (more than 11,000) and who provide services on a fee-basis (about 2,800).[4] However, VHA lacks data on the number

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[1] Percentage based on VA employees on board at the start of fiscal year 2017.

[2] GAO, Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges, GAO–17–30 (Washington, D.C.: Dec. 23, 2016).

[3] GAO, Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies, GAO–18–124 (Washington, D.C.: Oct. 19, 2017).

[4] VHA obtains data from its Veterans Integrated Service Networks and VA medical centers on which occupations are the highest priority for recruitment and retention based on known recruitment and retention concerns, among other factors. VHA then consolidates this data to identify the nationwide top 10 mission-critical occupations and top 5 mission-critical physician occupations. In fiscal year 2016, the ten mission-critical clinical occupations were physician, registered nurse, human resource manager, physical therapist, physician assistant, psychologist, medical technologist, occupational therapist, diagnostic radiologic technologist, and pharmacist.

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of contract physicians and physician trainees, and thus has no information on the extent to which medical centers nationwide use these arrangements and whether contract physicians are working in mission-critical occupations. As such, VHA cannot ensure that its workforce planning process sufficiently addresses gaps in physician staffing, including those for mental health providers, which may affect veterans' access to care, among other issues. Additionally, we found that VHA has not evaluated the effectiveness of its physician recruitment and retention strategies. One such strategy-hiring physician trainees-is weakened by ineffectual hiring practices, such as delaying employment offers until graduation. VHA could strengthen its strategies by comprehensively evaluating the causes of recruitment and retention difficulties and identifying effective solutions.

As a result of these findings, we made five recommendations, including that VA develop a process to count all physicians, provide guidance on productivity measurement, and evaluate its physician recruitment and retention strategies. VA concurred with four of the five recommendations, but did not concur with the one to accurately count all physicians, stating that its workforce assessment tools are sufficient. However, GAO maintains that this is essential for effective workforce planning.

VA has implemented two of the five recommendations. For example, in May 2019, VA submitted an evaluation of its physician recruitment and retention programs. The report covered use of the Education Debt Reduction Program, physician pay tables, and recruitment, retention, and relocation incentives. One result of the evaluation is that VHA provided Veterans Integrated Service Networks (VISNs) with recommendations on how to efficiently allocate their recruitment, retention, and relocation incentives. Evaluating physician recruitment and retention programs will allow VHA to ensure that funds for these activities are effective and efficient.

Also since the 2017 High-Risk Report was issued in February 2017, VA experienced leadership instability in several senior positions, some of which are political appointments. For example, there was notable turnover in critical politically appointed positions including the VA Secretary, Chief Information Officer, and Chief Financial Officer. Secretary Robert Wilkie was confirmed in July 2018. As a result, in our 2019 High-Risk Report, GAO determined that VA partially met the leadership commitment criterion for managing risks and improving VA health care high-risk area, as it did in 2017. As of June 2019, key leadership vacancies remain, including the political appointments for VA Deputy Secretary and Under Secretary for Health positions; according to the Partnership for Public Service, VA is second among Federal departments in terms of Senate confirmations with 83 percent of key positions filled.[5]

Fully addressing GAO's open recommendations could significantly improve VA operations; however, the recommendations highlight issues that are symptomatic of broader, systemic management and oversight challenges that will only be addressed through transformative action. As the Comptroller General testified during the hearing, the reason that VA was added to the High-Risk List in 2015 was due, in part, to underlying management weaknesses. As a result, VHA is embarking on an administration-wide modernization program, and VBA is implementing reforms to modernize its disability claims process. Per the statements of the Comptroller General during the hearing, in order for these efforts to be successful, VA leaders are going to have to energize an entrenched bureaucracy that is challenged in implementing management reforms. Successfully implementing these reforms and fully addressing the issues that led to VA's high-risk designations will require sustained leadership attention on high-risk related issues as well as leadership stability.

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See U.S. Department of Veterans Affairs, Veterans Health Administration, Mission Critical Occupation Report (2016).

[5] See https://ourpublicservice.org/political-appointee-tracker/, which we accessed on June 17, 2019.