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Major Management Challenges and Program Risks

Department of Veterans Affairs





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Comptroller General of the United States

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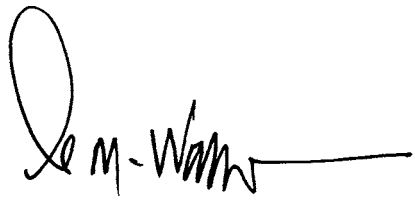
The President of the Senate
The Speaker of the House of Representatives

This report addresses the major performance and accountability challenges facing the Department of Veterans Affairs (VA) as it seeks "to care for him who shall have borne the battle and for his widow and his orphan"—stated in words VA adopted from Abraham Lincoln's Second Inaugural Address. It includes a summary of actions that VA has taken and that are under way to address these challenges. It also outlines further actions that GAO believes are needed. This analysis should help the new Congress and administration carry out their responsibilities and improve government for the benefit of the American people.

This report is part of a special series, first issued in January 1999, entitled the P*erformance and Accountability Series: Major Management Challenges and Program Risks*. In that series, GAO advised the Congress that it planned to reassess the methodologies and criteria used to determine which federal government operations and functions should be highlighted and which should be designated as "high risk." GAO completed the assessment, considered comments provided on a publicly available exposure draft, and published its guidance document, *Determining Performance and Accountability Challenges and High Risks* (GAO-01-159SP), in November 2000.

This *2001 Performance and Accountability Series* contains separate reports on 21 agencies—each cabinet department, most major independent agencies, and the U.S. Postal Service. The series also includes a

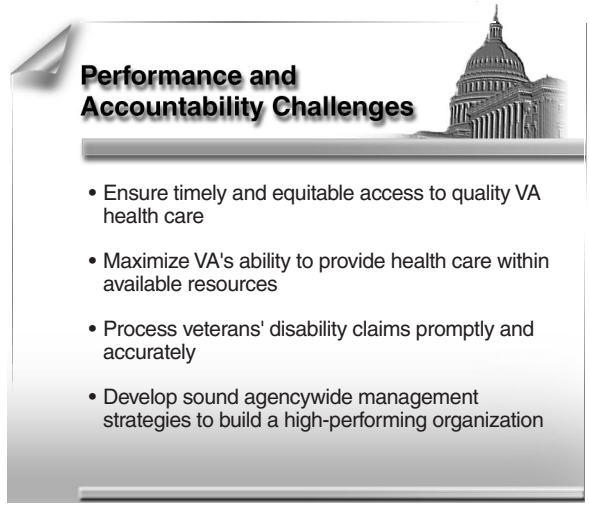
governmentwide perspective on performance and management challenges across the federal government. As a companion volume to this series, GAO is issuing an update on those government operations and programs that its work identified as "high risk" because of either their greater vulnerabilities to waste, fraud, abuse, and mismanagement or major challenges associated with their economy, efficiency, or effectiveness.



David M. Walker
Comptroller General
of the United States

Overview

The Department of Veterans Affairs' (VA) mission reflects the nation's historic commitment to care for veterans, their families, and their survivors. VA administers a variety of programs, including one of the world's largest health care systems. The Department estimates that, in fiscal year 2000, it spent about $42 billion—more than 80 percent of its total budget—to provide health care services to 3.6 million veterans and to pay disability compensation and pensions to over 2.5 million veterans and their families and survivors. In providing these services and benefits, VA faces several performance and accountability challenges.



Health Care Access

Over the past several years, VA has undertaken many initiatives to improve veterans' overall access to VA-provided health care, such as shifting its emphasis from inpatient to outpatient primary care and increasing the number of outpatient clinics it operates. VA has also undertaken efforts to improve the quality of the care it provides, including introducing patient safety initiatives.

However, several areas require continued emphasis if VA is to achieve its goals. For example, VA cannot ensure that veterans receive timely care at VA medical facilities. Nor can it ensure that it has maintained the capacity to provide veterans who have spinal cord injuries, serious mental illnesses, or other special needs the care that they require, as mandated by the Congress. VA must also assess its capacity to provide long-term care for its aging veteran population and respond to emerging health care needs, such as treating veterans for hepatitis C. At the same time, VA is facing a potential shortage of skilled nurses—if nationwide projections for the next several years bear out—which could have a significant effect on VA's quality of care initiatives.

To begin to respond to these concerns, VA must address long-standing weaknesses in the quality and reliability of its workload and cost data. Without good data, VA cannot link its strategic planning to areas that need improvement or emphasis, appropriately budget for and allocate funds and other resources, or measure its performance in providing care for all veterans enrolled in its health care system. We have made recommendations related to improving data on waiting times and services for disabled veterans. More specifically, we recommended that VA determine the extent and causes of waiting times and then develop a spending plan with initiatives that would solve the identified problems, as well as enhance monitoring of potential service delivery problems for veterans.

Health Care Resource Utilization

To expand care to more veterans and respond to emerging health care needs, VA must continue to aggressively pursue opportunities to use its health care resources—including its appropriation of about $20 billion—more wisely. VA has reduced its per-patient costs—one of its key performance measures—by 16 percent, but it could achieve additional efficiencies by realigning capital assets and human capital based on

changing demographics and veterans' health care needs. For example, VA needs to further modify its infrastructure to support its increased reliance on outpatient health care services and expand its use of alternative methods for acquiring support services, such as food and laundry. VA spends as much as one-quarter of its annual health care budget to operate and maintain about 4,700 buildings and 18,000 acres of property. VA also needs to pursue additional opportunities with the Department of Defense (DOD) to determine cost-effective ways to serve both veterans and military personnel, including sharing services and facilities. In addition, VA must ensure that it collects the money it is entitled to from third-party payers for health care services provided to veterans whose conditions are not service-connected.

To start to realize these efficiencies, VA has committed to systematically assessing its future infrastructure and health care services needs within its 22 Veterans Integrated Service Networks (VISN) as well as continuing to involve key officials in its strategic planning efforts and decision-making processes.[1] We have made several recommendations to VA that would help improve its infrastructure planning, provide more cost-effective support services, and enhance sharing with DOD.

[1]As part of its restructuring, VA decentralized basic budgetary, planning, and operating decisionmaking to its 22 VISNs. VISN directors are responsible for ensuring that the funds allocated to their networks are used as efficiently as possible and for identifying ways to provide health care services more efficiently. Also, VISN directors are responsible for assessing the future health care needs of veterans in their networks and planning their facilities and services accordingly—for example, proposing new outpatient clinics and consolidation of facilities.

Compensation and Pension Claims Processing

VA must also continue to seek ways to ensure that veterans are compensated for reduced earning capacity due to disabilities sustained or aggravated during military service. VA has had long-standing difficulties in ensuring timely and accurate decisions on veterans' claims for disability compensation. VA has improved its quality assurance system in response to our recommendations, but large and growing backlogs of pending claims and lengthy processing times persist. Moreover, veterans are raising concerns that claims decisions are inconsistent across VA's 57 regional offices. VA has taken steps to improve its information systems, performance measures, training strategies, and processes for reviewing claims accuracy.

However, VA also needs better analyses of its processes in order to target error-prone types of cases and identify processing bottlenecks—as well as determine if its performance goals are realistic. VA also needs to be vigilant in its human capital strategies to ensure that it maintains the necessary expertise to process claims as newly hired employees replace many experienced claims processors over the next 5 years. VA's human capital problems can be seen as part of a broader pattern of human capital shortcomings that have eroded mission capabilities across the federal government. (See our *High-Risk Series Update*, GAO-01-263, Jan. 2001, for a discussion of human capital as a newly designated governmentwide high-risk area.)

Management Capacity

Finally, VA has more work to do to become a high-performing organization and increase veterans' satisfaction with its services. It must revise its budgetary structure and develop long-term, agencywide strategies for ensuring an appropriate information technology (IT) infrastructure and sound financial management. If its budgetary structure linked funding to performance goals, rather than program operations, VA and the

Congress would be better positioned to determine the Department's funding needs. VA's IT strategy, which aims to provide veterans and their families coordinated services, must be successfully executed to ensure that VA can produce reliable performance and workload data and safeguard financial, health care, and benefits payment information. Last, similar to most other major agencies, VA's financial management strategies must ensure that its systems produce reliable cost data and address material internal control weaknesses and Federal Financial Management Improvement Act (FFMIA) requirements.

Major Performance and Accountability Challenges

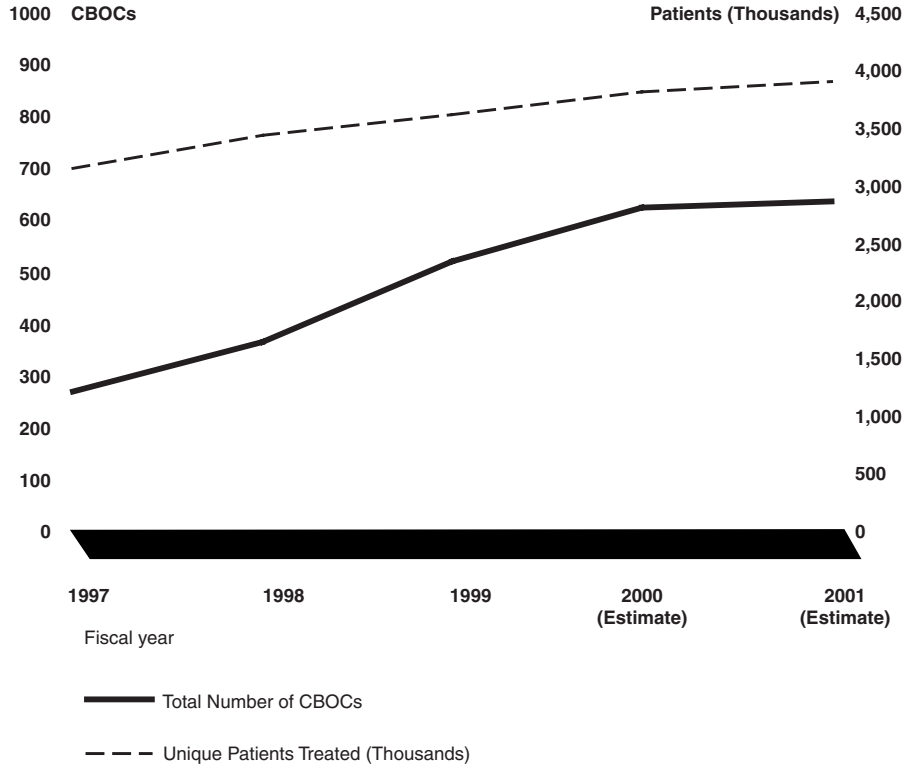
VA's mission is "to care for him who shall have borne the battle and for his widow and orphan"—stated in words VA adopted from Abraham Lincoln's Second Inagural Address. VA provides primary care, specialized care, and related medical and social support services to more than 4 million health care enrollees—about one-sixth of the total veteran population—through its more than 1,000 service delivery locations or by purchasing care from other providers. VA also supports medical education and research and serves as primary backup to other federal agencies during national emergencies. In addition, VA is responsible for providing compensation and pension benefits for disabled veterans.

These responsibilities are carried out primarily by the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) under numerous health care and compensation and benefits programs. In recent years, we have identified significant performance and accountability challenges in these programs that VA needs to address to ensure that it is effectively and efficiently achieving its mission to serve veterans and their families.

Ensure Timely and Equitable Access to Quality VA Health Care

As part of its effort to "honor and serve veterans in life" and "restore the capability of disabled veterans to the greatest extent possible"—two of VA's strategic goals—VA has taken significant steps to improve veterans' access to health care. Access to high-quality health care is critical to VA's accomplishing these goals. Over the past several years, VA has created hundreds of community-based outpatient clinics (CBOC) to provide care to veterans in outpatient settings rather than less efficient inpatient settings. VA expects that between fiscal years 1997 and 2001, the number of veterans who receive VA care will increase by 24 percent to 3.9 million (see fig. 1).

Figure 1: Increases in VA Patients and Community-Based Outpatient Clinics, Fiscal Years 1997-2001



Note: Figures for fiscal years 2000 and 2001 are goals and targets.

Source: VHA data.

VA is challenged to ensure that veterans receive the care they need, when they need it, and that the care provided meets standards of quality. However, the lack of adequate data often hampers VA's ability to determine the most appropriate use of its resources and to assess the quality and timeliness of the care it provides. This lack of data also limits VA's ability to identify

performance problems and measures to improve performance.

More Accurate Measures of Waiting Times and Health Outcomes Are Needed to Improve Timeliness and Quality of Care

Over the past decade, VA has taken steps to improve the timeliness and quality of VA-provided care. Since 1993, we have reported that veterans' waiting times to see providers were excessive. Veterans were waiting an average of 8 to 9 weeks to get an appointment in specialty clinics and frequently waiting up to 3 hours in certain types of emergency and screening clinics to see a provider. VA's Office of Inspector General (OIG) reported similar findings. Recent anecdotal information from VA and veteran service organization officials indicates that veterans continue to experience delays in obtaining care.

In response to these concerns and those of veterans' service organizations, VA has established strategic targets for the time it takes for veterans to get an appointment with a VA provider and the time they spend waiting in a provider's office. VA's target for obtaining initial, nonurgent appointments and specialty appointments is 30 days (average); its target for time spent in the waiting room to see a provider is within 20 minutes or less of the scheduled appointment time. VA intends to spend $400 million in fiscal year 2001 to begin meeting these waiting time targets. As part of its strategy to reduce waiting times, VA has entered into short-term contracts with consultants to help reduce the backlog of specialty appointments.

While the Department has begun to systematically collect and improve the quality of waiting times data for its outpatient care, it currently does not have adequate data to identify the magnitude of waiting time problems or the facilities with the most serious problems. Nor does it have data to isolate the causes of problems or measure the effectiveness of its initiatives to reduce waiting times. In May 2000, we recommended that VA

first determine the extent of waiting times and their causes and then develop a spending plan with initiatives that will result in solving waiting time problems. We also recommended that VA develop a mechanism for monitoring and tracking expenditures for improving timeliness to evaluate how well targeted funds have reduced waiting times. Until these data are available, VA will not be able to (1) set realistic annual national and local performance goals and determine if its efforts to help veterans avoid unnecessary delays and inconvenience in obtaining care are successful or (2) target future spending on the most effective strategies to reduce waiting times. To identify how much money is needed and how it should be spent, VA needs to modify its budget formulation and execution practices.

VA also has a number of initiatives under way to improve the quality of VA-provided care, including developing or revising systems for detecting and preventing adverse events that could harm patients. Some VA systems are exemplary—such as those incorporating the use of bar code technology to prevent medical errors. However, VA is in the early stages of implementing its quality of care initiatives and, like other health care providers, has a long way to go. Improved strategic planning could help VA further its efforts. For example, while VA's strategic plan for fiscal years 2001 through 2006 lists improved patient safety as a goal, it does not include outcome measures for determining the effectiveness of its patient safety initiatives. We noted that VA could also better ensure that it meets its goals if it identified how and when VA's various patient safety initiatives will be implemented, how they are aligned to support improved patient safety, and what contribution each initiative can be expected to make toward the goal of improved patient safety.

Lack of Data and Decentralization Weaken VA's Ability to Ensure Adequate Capacity for Treating Veterans With Special Disabilities

Facing budget pressures as it reorganized its health care system, VA has been challenged to ensure that veterans with certain disabling conditions continue to have reasonable access to specialized treatment and rehabilitative services, as mandated by the Congress.[1] While VA has concluded that it has maintained the capacity to serve these veterans, it does not have sufficient data to support this conclusion. For example, VA does not have precise enough data to calculate workload and expenditure statistics for veterans with special disabilities. Moreover, VA based its conclusions on national statistics that indicated more disabled veterans were served with fewer resources. However, because VA has not yet fully developed outcome measures—which it committed to do by 1999—it cannot determine whether the quality of the care provided to veterans in special disability categories has been maintained, enhanced, or diminished.

Accountability is difficult to assign because responsibility for implementing the mandate to maintain capacity in special disability programs is divided among several headquarters units, including the Office of Policy and Planning, the Chief Network Office, and the Office of Patient Care Services. The Office of Policy and Planning is primarily responsible for coordinating the development of capacity statistics and program definitions; the Chief Network Officer is the primary contact for VISNs, providing operational direction and supervision; and the Office of Patient Care Services develops patient care policies and guidelines, acts as program consultant to the special disability programs, and provides advice and consultation to VISN and facility directors. However, none has responsibility for

[1]Six disabling conditions were identified by the Congress and VA: spinal cord dysfunction, blindness, amputation, serious mental illness, traumatic brain injury, and post-traumatic stress disorder.

monitoring field locations' capacity to serve special disability populations. We recommended that VA assign a lead office to be accountable for enhanced monitoring and follow-up to augment VA's current limited capacity measures and performance monitors. In addition to helping identify data reliability issues, such monitoring efforts could also identify locations with potential service delivery problems to special disability populations. Although VA appointed a Clinical Coordinator for Special Disability Programs, it has not specifically addressed developing employee performance standards.

VA Needs to Better Position Itself to Respond to Shifts in Veterans' Health Care Needs and Workforce Issues

VA officials estimate that as much as 10 percent of its approximately 4 million health care system enrollees are infected with the hepatitis C virus—a rate five times that of the general U.S. population. Over the past 2 years, VA has earmarked more than $260 million of its health care funding to screen all patients for hepatitis C risk factors, develop treatment protocols, and create a public health awareness campaign. VA projects that it will spend an additional $340 million in fiscal year 2001 for its hepatitis C efforts. However, VA has not provided clear guidance to its 22 VISNs on this initiative, nor has it developed basic procedures to capture accurate hepatitis C workload data. Moreover, only one-half of the funding reflected in VA's fiscal year 2000 budget for hepatitis C was spent on activities supporting the initiative. Consequently, VA cannot determine how many veterans with the hepatitis C virus have been identified, nor can it fully account for its fiscal year 2000 hepatitis C expenditures to ensure that these funds have been appropriately targeted.

VA must also position itself to be able to meet the changing health care needs of an aging veteran population. VA expects the number of veterans over age 85 to almost double between fiscal years 1998 and 2003 and double again over the following decade, peaking at

about 1.3 million by fiscal year 2013. This aging is likely to add to the demand for long-term care because the prevalence of chronic health conditions and disabilities increases markedly at advanced age. However, VA is not currently positioned to meet this demand, and the fiscal implications are uncertain. Ensuring the quality of the care provided will also pose a challenge. VA needs to explore alternatives, such as home- and community-based settings, for providing long-term care. VA nursing homes—the costliest long-term care settings—are the second most-used setting for long-term care. While recent legislation limits the extent to which VA can provide care through other long-term care settings and reduce its use of VA nursing homes, VA has other options. For example, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117), enacted in November 1999, authorizes VA to conduct a pilot program to evaluate the feasibility of using assisted living services as an alternative to nursing home care. A VA task force is reviewing the Department's options.

VA also faces workforce challenges. For example, between 1983 and 1998, the number of working nurses younger than 30 decreased by 41 percent compared to the number of all workers in the United States, which decreased less than 1 percent. Moreover, the number of new nursing graduates entering the profession is not keeping up with the number of nurses leaving the profession due to retirement or other reasons. A national nursing shortage could adversely affect VA's efforts to improve patient safety in VA facilities and put veterans at risk. According to the Institute of Medicine,[2] sufficient staffing, workloads, and patient care are directly related to safety. VA is assessing the adequacy of its current nursing workforce. Recent legislation

[2]Institute of Medicine, *To Err Is Human: Building a Safer Health System* (Washington, D.C.: National Academy Press, Nov. 1999).

authorizing higher salaries for VA nurses could help VA in these efforts.

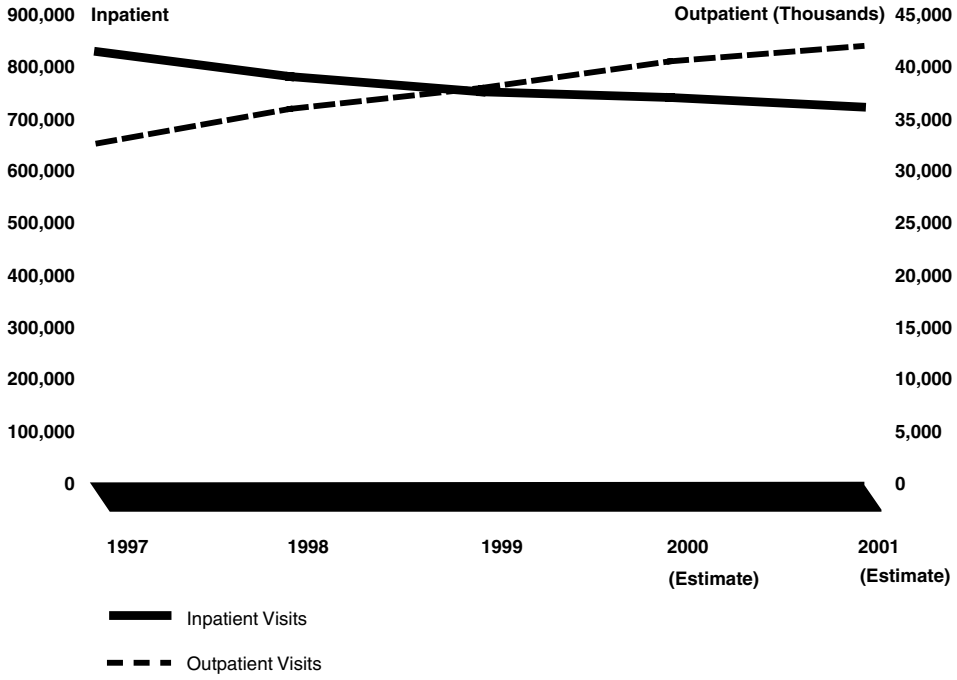
Key Contact

Cynthia A. Bascetta, Director
Health Care, Veterans Health and Benefit Issues
(202) 512-7101
bascettac@gao.gov

Maximize VA's Ability to Provide Health Care Within Available Resources

Over the past several years, VA has made much more efficient use of its available health care resources—a critical element to VA achieving its strategic goals. The Department is serving more patients, providing more care in less costly outpatient settings, and achieving some health care efficiency improvements (see fig. 2). VA estimates that between fiscal years 1997 and 2001, it will have reduced its per-patient costs—one of its key performance goals—by 16 percent.

Figure 2: Inpatient and Outpatient Care, Fiscal Years 1997-2001



Source: VHA data.

However, these significant accomplishments now introduce additional challenges to VA because many of the facilities it owns, which cost vast sums of money to maintain, are unoccupied or underused. To ensure progress in both increasing access and improving quality of care, VA must (1) realign its capital assets to ensure the best use of its resources; (2) continue to expand the use of cost-effective alternatives to providing support services, such as food and laundry; and (3) pursue additional opportunities to share health care services and facilities with DOD. In addition, VA needs to take steps to reverse the decline in collections from third-party insurers.

Further Realignment of VA's Infrastructure Could Better Meet Veterans' Health Care Needs

As much as 25 percent of VA's annual health care budget could be spent to operate, maintain, and improve roughly 4,700 buildings and 18,000 acres of property—including unused and underused hospitals and other facilities. While VA has closed several underused inpatient facilities as it increased its use of CBOCs, further realignment of its capital assets could free up significant funds for patient treatment. In the Chicago area alone, we found that as much as $20 million could be freed up annually through capital asset realignment if VA served this population with three instead of four hospitals.

Realigning VA's infrastructure to achieve efficiencies and effectively meet veterans' current and future needs—while mitigating the potential effects on staffing, communities, and other VA missions—will require skilled capital asset management. VA's realignment decisions have largely been made ad hoc and based on subjective criteria without proactive senior management involvement. In addition, realignment decisions have often met with public opposition and concerns of medical schools affiliated with VA facilities. Realignment in the Chicago area, for example, involves affiliation agreements among four medical schools and four VA hospitals. As a result, VA's decisions about how to realign its assets—especially those aimed at consolidating administrative and clinical services across two or more nearby medical centers—have often been delayed.

In August 1999, we recommended that VA develop asset-restructuring plans for its 106 health care markets to guide its planning and management of health care assets. In response, VA established the Capital Asset Realignment for Enhanced Services (CARES) program, which is designed to provide objective criteria and give senior management a more proactive leadership role. The program calls for assessments of veterans' health

care needs and available service delivery options to meet those needs in each health care market.[3] VA has developed specific criteria for making these assessments. In addition, current testing of CARES in Chicago will provide valuable information on the feasibility and credibility of the program. Ultimately, the success of this program depends on good strategic planning and appropriate organizational realignment.

Expanded Use of Alternative Methods for Support Services Could Realize Additional Savings

VA facilities have initiated management efficiencies in a variety of nonpatient care support services. For example, some VA facilities consolidated inpatient food and laundry services. Over the past several decades, VA has consolidated 28 food production locations into 10, used lower-cost Veterans Canteen Service (VCS) workers instead of higher-paid Nutrition and Food Service workers in 9 locations, and contracted out food services at 2 locations. VA has also consolidated 116 laundries into 67; contracted for labor to operate 2 VA laundries; and contracted out laundry at 15 facilities to 10 commercial laundries.

However, VA needs to systematically explore, through strategic planning, further use of such options across its health care system. We have identified another 63 food production locations that could be consolidated into 29, saving an estimated $12 million annually, after an initial $11 million investment in one-time equipment purchases. Using lower-cost VCS employees at all VA food production locations could save an additional $67 million annually. We similarly found the potential for savings in laundry services. We estimated that an additional $2 million could be saved by consolidating 13 laundries, plus avoiding an estimated $9 million in one-time equipment and renovation costs. VA may also be

[3]These assessments are expected to be completed over the next 3 years.

able to reduce its food and laundry service costs at some facilities through competitive outsourcing—where VA would determine whether it would be more cost-effective to contract out these services or provide them inhouse. In November 2000, we recommended that VA conduct studies at all of its food preparation and laundry locations to identify and implement the most cost-effective way to provide these services at each location. However, VA must ensure that contract terms on payments and service quality standards are met. For example, we found that weaknesses in the monitoring of VA's Albany, New York, laundry contract appear to have resulted in overpayments, reducing potential savings.

VA and DOD Need to Increase Joint Activities to Maximize Federal Health Care Resources

In an effort to save federal dollars, VA and DOD have sought ways to share excess health care resources. For example, local VA medical centers and military treatment facilities have entered into agreements to exchange inpatient, outpatient, and specialty care services, as well as support services. Some local VA and DOD facilities have entered into joint ventures, pooling resources to build a joint medical facility or capitalize on an existing facility. Local facilities have also arranged to jointly purchase pharmaceuticals, laboratory services, medical supplies, and equipment.

VA and DOD officials have found that, by sharing resources, better use has been made of their local facilities, staff, and equipment; in some cases, beneficiary access and patient satisfaction have improved. However, most sharing activity is occurring through a relatively small number of sharing agreements and joint ventures. Overall, 75 percent of direct medical care episodes provided under the sharing program occurred under just 12 agreements for inpatient care, 19 agreements for outpatient care, and 12 agreements for ancillary care. Most joint venture activity occurred in Albuquerque, New Mexico, and in southern Nevada. In addition, relatively few VA facilities

are participating in national sharing initiatives being developed by the VA/DOD Executive Council.

To ensure sharing occurs to the fullest extent possible, VA needs to continue to work with DOD to address a number of barriers. For example, some VA and DOD facilities try to shift responsibility to each other for treatment and payment of dual eligible beneficiaries—retired military who are also veterans—making it difficult to reach agreements for treating these beneficiaries.

It is particularly critical that VA take a long-term approach to improving the sharing database, which it administers. While the database captures information on the number of agreements and the range of services covered, these data are inadequate to assess progress. VA and DOD need to collect data on the volume of services provided, the amounts of reimbursements collected, and the costs avoided through the use of sharing agreements. Further, improvements are needed in the accuracy of information in the joint VA-DOD database. Without a baseline of activity or complete and accurate data, VA and DOD—and the Congress—cannot assess the progress of VA and DOD sharing. We made several recommendations aimed at removing barriers to sharing and for improving information on the results of sharing agreements in the joint VA/DOD sharing database.

Additional opportunities also exist for VA and DOD to jointly purchase pharmaceuticals and exact higher discounts from manufacturers. VA and DOD's combined annual spending for pharmaceuticals is more than $2.4 billion. In fiscal year 2000, the two Departments saved an estimated $51 million from jointly awarded national committed-use contracts with suppliers to purchase 4 percent of their total drug requirements. While these savings are impressive, our analysis of

actual purchases has shown that significantly more federal health care dollars could be saved if VA and DOD expanded the use of national committed-use contracts. However, officials from VA and DOD indicated that the prospects for further joint contracting are limited because their patient populations and drug formularies[4] differ. VA needs to continue to work with DOD to take advantage of recent legislation encouraging the two Departments to increase their cooperation in the procurement of pharmaceuticals to the maximum extent possible.

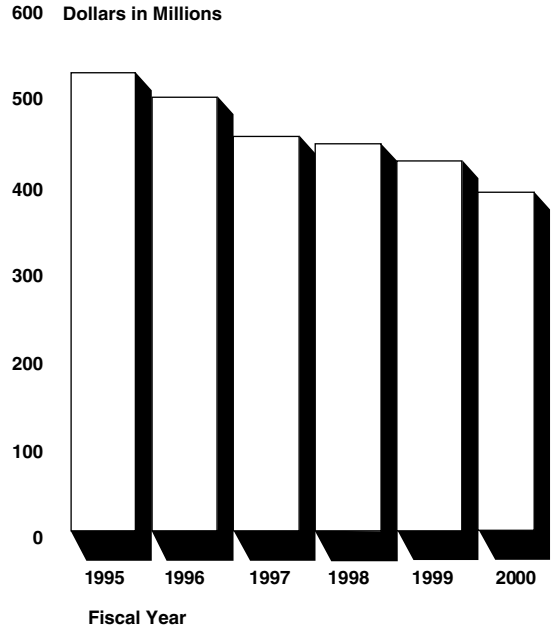
VA Efforts May Not Reverse Declining Third-Party Collections

Over the past 5 fiscal years, collections from third-party insurers, which VA relies on to supplement its medical care appropriations, have declined.[5] In fiscal year 2000, VA collected $387 million from third-party insurers—$35 million less than collected the year before (see fig. 3).

[4]A formulary is a list of drugs, grouped by therapeutic class, that a health care organization prefers that its physicians prescribe.

[5]VA can bill insurers for care it provides to veterans for medical conditions not related to service-connected disabilities. Because VA cannot bill Medicare without legislative action giving it authority to do so, VA reduced its third-party collection goals. Historically, these collections have determined, in part, VA's appropriations.

Figure 3: VA Third-Party Collections, Fiscal Years 1995-2000



Source: VHA data.

Several factors contributing to this decline are outside VA's control. For example, an increasing percentage of veterans are becoming eligible for Medicare—which, by law, cannot pay for VA-provided care. More veterans are also enrolling in managed care organizations, from which VA cannot typically collect because it is not a participating provider. In addition, the net effect that VA's shift to less expensive outpatient care will have on collections is uncertain.

In September 1999, VA began to bill insurers based on "reasonable charges" for actual care provided, rather than charging rates based on average cost of care. While VA expects its new billing to increase collections, reverses in declining third-party collections will not

occur until VA implements its improved billing processes. For example, information on veterans' insurance coverage that VA has collected has been inadequate to identify opportunities to bill insurers or to avoid billing insurers inappropriately for care not covered. VA's processes for following up on outstanding bills have also been inadequate to guarantee timely payments from insurers. Weaknesses such as these affect collections under VA's reasonable charges billing. For example, to meet the strict standards placed on private providers who bill the Medicare program, VA must accurately and completely document the care provided.

VA has begun to update its billing and records systems and bring them in line with industry standards and needs to continue these efforts. VA has also undertaken several initiatives to address collections weaknesses. First, VA has contracted with a collection agency to assist facilities in collecting third-party bills that are outstanding for more than 90 days. VA has also distributed brochures to veterans and VA collections staff explaining the need for information on veterans' insurance coverage. Finally, VA has begun to develop training for medical records staff in documenting and coding of care provided to patients and has provided training to staff responsible for obtaining precertifications from insurers.

Key Contact

Stephen P. Backhus, Director
Health Care, Veterans and Military Health Care Issues
(202) 512-7101
backhuss@gao.gov

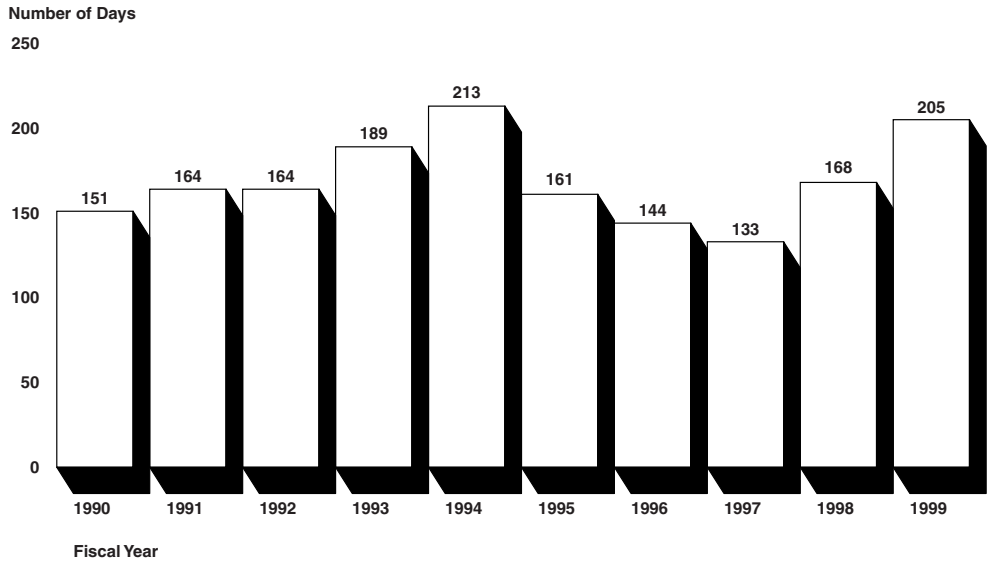
Cynthia A. Bascetta, Director
Health Care, Veterans Health and Benefit Issues
(202) 512-7101
bascettac@gao.gov

Process Veterans' Disability Claims Promptly and Accurately

As part of its effort to "restore the capability of disabled veterans to the greatest extent possible and improve the quality of their lives," VA provides over $20 billion a year in disability compensation and pension benefits to more than 2.5 million veterans, family members, and survivors. However, long-standing processing delays have resulted in an increasing backlog of veterans' initial and repeat claims for disability compensation.[6] Between fiscal years 1995 and 1999, the average time for processing initial compensation claims jumped from 161 days to 205 days (see fig. 4), and the average time to resolve veterans' appeals of VA's claims decisions continued to exceed 2 years.

[6]VA reviews veterans' initial claims to establish eligibility for disability benefits and reviews repeat claims to increase the amount compensated.

Figure 4: Average Number of Days for Processing of VA Initial Compensation Claims, Fiscal Years 1990-1999



Source: VBA data.

By the end of fiscal year 1999, about 69,000 initial compensation claims were pending—34 percent of which had been pending for more than 6 months—and VA had a backlog of about 138,000 repeat claims by veterans who already received compensation. In addition to these delays and backlogs, there were concerns about the high rate of claims errors and about the consistency of decisions among VA's 57 regional offices. Under its current quality measurement system, VA found that nearly one-third of decisions are incorrect or have technical or procedural errors. Delays and errors also affect veterans' eligibility and priority for other VA benefits and services, such as health care and vocational rehabilitation, since they are based in part on VA's assigned disability ratings.

VA has addressed a number of key management issues—such as implementing new performance measures, modernizing its information technology systems, and developing training. However, it is unclear to what extent these measures will improve the timeliness and accuracy of its claims processing because the underlying causes of the problems have not yet been identified. At the same time, many experienced staff are expected to retire and veterans are seeking compensation for more service-connected disabilities per claim. Many of these problems stem from the growing complexity of claims processing caused by increased procedural and documentation requirements.

Effectiveness of VA's Efforts to Improve Claims Processing Performance Not Yet Known

Addressing the problems that weaken its claims processing performance—including improving the quality of its data and ensuring sufficient staff to process claims—are major management challenges for VA. While VA has taken a number of steps to address these problems, it has not identified their underlying causes. Without such information, VA cannot ensure that its corrective actions will improve its claims processing performance. In addition, VA's training and recruitment programs may not be adequate to ensure a sufficient workforce of competent claims processors. Consequently, existing problems of claims backlogs and errors will likely persist, delaying outcomes to provide veterans and their families with timely and accurate disability payments.

In September 1998, VA's Inspector General reported that, due to data entry errors, VA's claims processing database overstated claims processing timeliness. In March 1999, we found that while VA has taken significant steps to measure the accuracy of its claims processing decisions, additional measures are needed to ensure that error-prone cases are identified and processes for reviewing the accuracy of claims meet the government's internal

control standards. In light of these findings and our recommendations, VA is implementing

- a system to identify regional offices with accuracy problems, so that more detailed reviews can be done at these offices to identify the underlying causes of inaccuracies, corrective actions, and needs for additional staff training;
- a case management approach to claims processing to hold individuals and teams accountable for every aspect of the claims process and to establish a case manager contact to keep the veteran informed of the status of the claim; and
- a major IT effort to replace its existing compensation and pension payment systems with a new state-of-the-art system expected to manage claims development processes, establish veterans' records, compute the award or payment amount based on the results of the rating process, develop the payment record, and handle all accounting functions.

However, until VBA identifies the underlying causes of its claims processing problems and measures its progress, the effectiveness of these initiatives cannot be determined. Moreover, VA's top management has yet to approve a complete IT management plan and schedule or an approved strategy to convert data from the existing systems into the new system. VBA officials acknowledged these issues and informed us that efforts are under way to address them.

VA has also been faced with the challenge of ensuring an adequate workforce to process claims. VA estimates that by 2005, 1,100 of its claims processing workforce will retire. To prepare for this loss of experienced staff, VA planned to add more than 400 new staff to its compensation and pension programs in fiscal year 2000. VA plans to redirect or hire an additional 400 staff for fiscal year 2001. While VA plans to provide training to

new staff, their lack of experience will likely limit VA's ability to ensure that the benefits and pension claims process will be timely and accurate. According to VA, it takes 2 to 3 years on the job for claims processors to achieve a full level of decision-making expertise, making it critical that an effective training program be in place. VBA has begun to implement a centralized training program. However, the comprehensiveness and effectiveness of this program are unknown at this time.

External Challenges May Constrain VA's Ability to Improve Its Claims Processing Performance

Prior to 1989, veterans dissatisfied with their claims determinations could ask for a review of their case by the Board of Veterans' Appeals, whose decisions were final. Veterans now have the option to appeal the Board's decision to an independent Court of Veterans Appeals.[7] Further, both veterans and VA may appeal these decisions to the Court of Appeals for the Federal Circuit. The establishment of the Court of Veterans Appeals introduced a number of complex procedural and documentation requirements with which VA must comply. Before 1989, the rationale for VA's determination—including the degree of the rating for each disability claimed—was summarized in a brief statement for each claim. Under the new requirements, VA claims processing staff must describe for each disability issue the evidence and rationale leading to the decision. While this initial investment may improve veteran satisfaction—and increase understanding of the factors that led to the decision—providing this rationale adds up-front time to process cases. In the long run, however, time may be saved if this effort results in a decrease in remands.

Individual veteran's cases are also becoming more complex, complicating the claims process. For example,

[7]The court was established under the Veterans' Judicial Review Act of 1988 (P.L. 100-687).

in fiscal year 1998, VA found that a sample of about 69,000 veterans filed claims for a total of about 316,000 disabilities. Each of these disabilities requires a separate rating. In addition, veterans can file repeat claims to include new evidence or to respond to changes in regulations that occur after a case has been sent to the Appeals Board. Veterans can also file as many repeat claims for disability compensation as they desire if their condition worsens or if they develop a new disability. In fiscal year 1998, repeat claims outnumbered initial claims by about three to one, further burdening regional office workloads.

Key Contact

Cynthia A. Bascetta, Director
Health Care, Veterans Health and Benefit Issues
(202) 512-7101
bascettac@gao.gov

Develop Sound Agencywide Management Strategies to Build a High-Performing Organization

VA faces additional challenges in several areas critical to building a high-performing organization: budget formulation and execution, information technology, and financial management. To meet its strategic goal to create an environment that fosters the delivery of "One VA" world-class service to veterans and their families, VA has begun to address some of these issues through its plans to implement an information technology framework that supports the integration of information across the Department and to continue to achieve unqualified audit opinions on its annual financial statements.

VA's Budget Systems Need to Be Aligned to Link Funding to Performance

A significant management challenge for VA is to develop budget formulation and execution systems that allow it to link the funds it spends, or proposes to spend, to its performance—as required by the Government Performance and Results Act. However, VA's current budget structure—like those of other federal agencies—

does not allow such linkages. Most of VA's budget accounts are organized around program elements rather than strategic goals and objectives. For example, VA's medical care budget account is organized according to program activities based on types of health care provided—such as acute hospital care and outpatient care. VA's compensation and pension account breaks out compensation and pension funding according to the veterans' periods of military service. Instead, VA needs its budget request to show the amount of funding it requires to meet the levels of performance it expects to achieve.

VA is working with the Office of Management and Budget on developing a performance-based budget. VA's fiscal year 2001 budget request included some improvement in presenting budget information linked to performance measurement. VBA's request included a business plan, with information on the amounts of funding requested for specific initiatives. These initiatives were, in turn, tied to specific performance goals to improve VBA's program operations—notably, claims processing timeliness and accuracy. For example, VBA's request identified the funding and staffing increases requested to implement its Systematic Technical Accuracy Review (STAR) system, which is designed to identify VBA regional offices with claims processing problems, so VBA can target training for claims processing staff to these offices. Another improvement is in the National Cemetery Administration's (NCA) budget request. In addition to providing information on funding needs to address specific performance improvement initiatives, NCA provided a summary of VA's requests and prior-year funding data for seven accounts that help fund VA's burial program, including accounts that fund national cemetery operations, grants to states for construction of state veterans' cemeteries, funding for construction and expansion of VA national cemeteries, and other

memorial activities such as the acquisition of headstones and grave markers.

Another budget formulation and execution challenge for VA is to implement systems that provide adequate workload and cost data. Such data are needed so VA can determine the levels of performance it can expect from different levels of funding and to ensure that funds are allocated to VA facilities in ways that ensure that veterans receive equitable VA services nationwide. For example, to ensure equitable access to health care for veterans across the country, VA needs adequate data to identify the locations and causes of access problems. Because VA lacks such data, it cannot target funds earmarked for improving equity of access to the facilities where they are needed most.

VA has implemented a health care workload and cost information system—the Decision Support System (DSS)—for VISNs and individual facilities to use to help prepare budgets, allocate resources, and generate productivity analyses and patient-specific costs. However, only one VISN has reported using DSS for resource allocation, and only eight reported using it for budget formulation. To ensure that all of its health care networks and facilities are using this system, VA has required that fiscal year 2002 funding allocations be based on DSS data and that VISNs' applications for new CBOCs include data on VA health care users with and without reasonable access to care.

VA's Efforts to Use Information Technology to Help Serve Veterans Need Improvement

Since 1996, VA has spent an estimated $5 billion on IT initiatives to help realize its vision of providing seamless service to veterans and their families. VA expects its IT expenditures to increase over the next 5 years from about $1.5 billion in fiscal year 2001 to more than $2.1 billion by fiscal year 2005. VA's IT strategy must be successfully executed to ensure that VA can produce reliable performance and workload data, as well as

safeguard financial, health care, and benefits payment information.

In 1999, we noted that VA had made progress in addressing year 2000 challenges but still had some issues to address. The Department addressed these issues and made a successful transition to the year 2000 without any significant incidents, disruption of benefits to veterans, or risk to patient health and safety. In August 2000, we recommended that VA take certain actions to improve its IT investment decision-making process and fully implement key provisions of the Clinger-Cohen Act of 1996, which aims to strengthen IT leadership and management at federal agencies. However, the Department is struggling with how to integrate complex technologies and management processes so that they are aligned with VA's missions, goals, strategies, programs, and business processes. VA has yet to sufficiently address seven challenges to strengthen the leadership and management of its IT initiatives. Table 1 summarizes these challenges and VA's status in responding to each.

Table 1: Status of IT Challenges Facing VA

Challenge	Status
Appointment of Chief Information Officer (CIO)	
CIOs provide leadership and partner with senior officials to develop strategic plans and policies, build credible information management organizations, and develop and organize information management capabilities to meet agency mission needs.	In 1998, VA established the position of assistant secretary for information and technology to serve as VA's CIO. However, the President did not nominate someone to the position until September 19, 2000; the position remains unfilled.

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Challenge	Status
IT investment management	
VA needs to maximize the value and return on its IT investments and mitigate associated risks.	In 1999, VA established a process for selecting, controlling, and evaluating its IT capital investments. VA has efforts under way to implement the improvements we recommended: (1) establish and monitor deadlines for completing formal in-process reviews at key project milestones, (2) provide data to decisionmakers on lessons learned from post-implementation reviews, and (3) develop guidance to better manage projects below thresholds established by VA's Capital Investment Board.[a]
Integrated business process reengineering	
Before making major IT investments, agencies are required under the Clinger-Cohen Act to analyze their missions and revise and improve mission-related and administrative processes accordingly. To do this, agencies should have an overall business process improvement strategy—one that coordinates and integrates ongoing reengineering and improvement projects, sets priorities, and makes appropriate departmentwide budget decisions.	VA has not developed a departmentwide strategy specifying needed reengineering and improvement projects or their relation and priority. VA did not concur with our August 2000 recommendation to reassess its decision to delegate business process reengineering to individual administrations and still plans to rely on VHA, VBA, and its other administrations to pursue their own reengineering initiatives, believing they best understand the means to achieve their missions. However, until VA develops a departmentwide reengineering strategy, it is unlikely to achieve its "One VA" vision.
Integrated IT architecture	
In achieving the agency's strategic and IT goals, CIOs are charged with implementing a two-component architecture that will provide a framework for maintaining existing IT and for acquiring new IT.[b]	To date, VA has completed only the technical component of its architecture. For the second component, the logical architecture, VA plans to implement a strategy that will likely result in at least three separate architectures. To help achieve its "One VA" vision—and comply with requirements of the Clinger-Cohen Act—VA needs to reassess this strategy and work with VBA and VHA to develop an integrated, departmentwide logical architecture.
Tracking IT expenditures	
VA needs to establish a uniform mechanism for tracking IT expenditures to make informed decisions about whether to modify, accelerate, or discontinue projects.	Although VA Directive 6000[c] and VA's capital investment guide require it to maintain complete and accurate cost data for IT projects, there is no uniform mechanism for tracking IT expenditures across the department. VA has delegated this responsibility to managers in VA's administrations and offices, resulting in varying tracking approaches and difficulty in identifying VA's total IT costs.
Assessing IT performance	
The Clinger-Cohen Act requires executive branch agencies to establish performance measures that relate to how well IT supports their programs.	While VA's FY 2001 performance plan identified IT initiatives for improving claims processing accuracy and timeliness, it did not include performance goals. Without such goals, it will be difficult to assess the performance of these initiatives.

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Challenge	Status
Computer security	
VA also needs to implement appropriate security measures to ensure that financial, health care, and benefits payment information are not at risk of inadvertent or deliberate misuse, fraud, improper disclosure, or destruction.	Since September 1998, we have reported on VA's computer security weaknesses, which have placed financial, health care, and benefits payment information at risk of misuse, fraud, improper disclosure, or destruction—possibly occurring without detection. VA has not adequately limited access granted to authorized users, segregated incompatible duties among computer personnel, managed user identification and passwords, or monitored access activity. As of September 2000, VA had not yet fully implemented an integrated security management program and VHA had not effectively managed computer security at its medical facilities. Agreeing with our recommendation to create a comprehensive, coordinated security management program that would encompass VHA and other VA organizations, VA intends to develop an accelerated plan to improve information security at its facilities. VA also plans to develop departmentwide policy, guidance, and processes.

[a]The Capital Investment Board reviews projects that exceed specific dollar thresholds set for each of VA's administrations or that are seen as high risk or high visibility.

[b]An integrated IT architecture is a blueprint, consisting of logical and technical components, to guide and constrain the development and evolution of a collection of related systems. At the logical level, the architecture provides a high-level description of an organization's mission, the business functions performed and the relationships among them, the information needed to perform the functions, and the flow of information among functions. At the technical level, the architecture provides the rules and standards needed to ensure that the interrelated systems are built to be interoperable and maintainable. These include specifications of critical aspects of component systems' hardware, software, communication, data, security, and performance characteristics.

[c]*VA Information Resources Management Framework*, VA Directive 6000, Sept. 17, 1997.

Many Financial Management Weaknesses Remain Despite Unqualified Audit Opinion

In March 2000, VA's Office of Inspector General (OIG) issued an unqualified audit opinion on VA's consolidated financial statements for fiscal years 1999 and 1998.[8] However, many systems and control problems, as reported by VA's OIG and by GAO, remain unresolved. For example, VA's accounting systems still require

updating, and several material internal control weaknesses have not yet been corrected. In addition, VA's accounting systems—similar to those of most other major agencies—did not comply substantially with Federal Financial Management Improvement Act (FFMIA) requirements. These weaknesses continue to make VA's program and financial data vulnerable to error and fraud and limit the Department's ability to monitor programs through timely internal financial reports throughout the fiscal year.

VA's unqualified opinion was achieved by reconciling medical accounts receivable balances and correcting a number of material credit reform and loan guaranty accounting deficiencies. While this was a major accomplishment for VA, the OIG's audit report also points out a number of material internal control weaknesses related to information security controls, Housing Credit Assistance (HCA) program accounting, and fund balance with Treasury reconciliations. Specifically, VA's OIG found that

- departmentwide weaknesses in general controls over automated data processing continue to make VA's program and financial data vulnerable to error or fraud;
- material weaknesses continue to impede timely completion of financial statements and reduce the use and value of internal financial reports for management control and program monitoring of its direct loans and related foreclosed properties[9]; and

[8]See *Report of Audit of the Department of Veterans Affairs Consolidated Financial Statements for Fiscal Years 1999 and 1998*, (Report No. 99.00006.46, Mar. 14, 2000).

[9]The Department reported information systems security controls and HCA program accounting issues as material weaknesses in their FFMIA reports for fiscal years 1999 and 1998.

- the Austin Finance Service Center's reconciliations were incomplete due to cumbersome, labor-intensive processes, and weaknesses in the existing accounting system and Treasury reporting and reconciliation processes.

The VA OIG's audit report also discusses VA noncompliance with several FFMIA requirements, impeding VA's ability to provide reliable, useful, and timely information needed to manage day-to-day operations. First, VA's HCA financial management systems were not in substantial compliance with federal financial system requirements. Specifically, VA's HCA general ledger and subsidiary program systems did not interface with VA's core financial system, and processes were not in place for reconciling general ledger and subsidiary foreclosed property data and for providing reliable financial information that could be used to monitor HCA programs. Additionally, the HCA systems did not provide the timely data necessary for preparing VA's Consolidated Financial Statements. Second, VA's OIG reported that, with the exception of the Austin Automation Center, VA lacked sufficient information system security, making VA's program and financial data vulnerable to error or fraud. Finally, VA's systems did not accumulate and report cost data at the activity level. Reliable cost information is needed for VA to assess its operating performance. However, in preparing the fiscal year 1999 financial statements, VA was able to develop and allocate costs on a reasonable basis to the lines of business defined in the Statement of Net Cost.

In 1999, we reported that VA's management and operational controls were insufficient to maintain accountability over its direct loan and loan sale activities and did not comply with credit reform accounting requirements. For example, when VA transferred the servicing of its direct loan portfolio to a contractor in fiscal year 1997, it shut down its automated direct loan system and surrendered to the contractor

almost all hard copy loan records needed to manage its loans.[10] As a result, VA was unable to determine the composition and value of its loan portfolio, reconcile cash flows, or properly monitor the contractor's work. We also found that VA's failure to monitor in a timely manner the contractors that service loans that VA sold allowed inefficiencies and improper actions to go unchecked, costing VA more than $6 million.

VA has made substantial progress in implementing our recommendations for gaining accountability and control over its direct loan and loan sale activities and for complying with credit reform accounting requirements. However, it still needs to develop a direct loan database that includes a complete inventory of all loans originated and a database to record all loans being assumed by VA to provide a basis for monitoring and controlling loan and foreclosed property assets.

Key Contacts

Cynthia A. Bascetta, Director
Health Care, Veterans Health and Benefit Issues
(202) 512-7101
bascettac@gao.gov

Joel Willemssen, Managing Director
Information Technology Issues
(202) 512-6408
willemsenj@gao.gov

McCoy Williams, Acting Director
Financial Management and Assurance
(202) 512-6906
williamsml@gao.gov

[10]The data transferred to the contractor were also incomplete and inconsistent.

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