



Testimony  
Before the Committee on Veterans'  
Affairs, U.S. Senate

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# VETERANS AFFAIRS

## Sustained Management Attention Needed to Address Numerous IT Challenges

Statement of Valerie C. Melvin, Director  
Information Technology

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Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

I am pleased to be here today to testify on the Department of Veterans Affairs' (VA) efforts to modernize its information technology (IT). As you know, the use of IT is crucial to helping VA effectively serve the nation's veterans and, each year, the department expends billions of dollars on its information systems and assets.

However, over many years, VA has experienced challenges in managing its IT resources, raising questions about the effectiveness of its IT operations and its ability to deliver intended outcomes needed to help advance the department's mission. We have previously reported on a number of the department's IT initiatives.

As you requested, my testimony today summarizes results from a number of our key reports issued between 2010 and 2014 highlighting IT challenges that have contributed to our designation of VA health care as a high-risk area.<sup>1</sup> It also describes additional challenges that we more recently identified in 2015 and 2016 that are related to increasing the electronic exchange of VA's health records with those of the Department of Defense (DOD), development and use of the Veterans Benefits Management System (VBMS), and the department's modernization of its health care claims processing system.<sup>2</sup>

For this testimony, we relied on our body of work that led to our designation of VA health care as a high risk area in 2015. In addition, we relied on our more recent reports issued since the high risk designation. We also obtained and reviewed information on the department's actions in response to our previous recommendations and the current status of IT management activities. The reports cited throughout this statement

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<sup>1</sup>GAO, *High Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

<sup>2</sup>GAO, *Electronic Health Records: Outcome-Oriented Metrics and Goals Needed to Gauge DOD's and VA's Progress in Achieving Interoperability*, [GAO-15-530](#) (Washington, D.C.: Aug. 13, 2015); *Veterans Benefits Management System: Ongoing Development and Implementation Can be Improved; Goals Are Needed to Promote Increased User Satisfaction*, [GAO-15-582](#) (Washington, D.C.: Sept. 1, 2015); and *Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers*, [GAO-16-353](#) (Washington, D.C.: May 11, 2016).

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include detailed information on the scope and methodology for our reviews. The work upon which this statement is based was conducted 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.

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## Background

VA's mission is to promote the health, welfare, and dignity of all veterans in recognition of their service to the nation by ensuring that they receive medical care, benefits, social support, and lasting memorials. It is the second largest federal department and, in addition to its central office located in Washington, D.C., has field offices throughout the United States, as well as the U.S. territories and the Philippines.

The department's three major components—the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the National Cemetery Administration (NCA)—are primarily responsible for carrying out its mission. More specifically, VBA provides a variety of benefits to veterans and their families including disability compensation, educational opportunities, assistance with home ownership, and life insurance. VHA provides health care services, including primary care and specialized care, and it performs research and development to improve veterans' needs. Lastly, NCA provides burial and memorial benefits to veterans and their families.

Collectively, the three components rely on approximately 340,000 employees to provide services and benefits. These employees work in 167 VA medical centers, approximately 800 community-based outpatient clinics, 300 veterans centers, 56 regional offices, and 131 national and 90 state or tribal cemeteries situated throughout the nation.

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## VA Relies Extensively on IT

The use of IT is critically important to VA's efforts to provide benefits and services to veterans. As such, the department operates and maintains an IT infrastructure that is intended to provide the backbone necessary to meet the day-to-day operational needs of its medical centers, veteran-facing systems, benefits delivery systems, memorial services, and all other IT systems supporting the department's mission. The infrastructure is to provide for data storage, transmission, and communications requirements necessary to ensure the delivery of reliable, available, and

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responsive support to all VA staff offices and administration customers, as well as veterans.

Toward this end, the department operates approximately 240 information systems, manages 314,000 desktop computers and 30,000 laptops, and administers nearly 460,000 network user accounts for employees and contractors to facilitate providing benefits and health care to veterans. These systems are used for the determination of benefits, benefits claims processing, patient admission to hospitals and clinics, and access to health records, among other services.

For example, VBA relies on VBMS to collect and store information such as military service records, medical examinations, and treatment records from VA, DOD, and private medical service providers. IT also is widely used and critically important to supporting the department in delivering health care to veterans. VHA's systems provide capabilities to establish and maintain electronic health records that health care providers and other clinical staff use to view patient information in inpatient, outpatient, and long-term care settings. Specifically, the Veterans Health Information Systems and Technology Architecture, known as VistA, consists of many computer applications and modules that collect, among other things, information about a veteran's demographics, allergies, procedures, immunizations, and medical diagnoses.

However, a number of VA's systems are old. For example, our recent report on legacy systems used by federal agencies identified 2 of the department's systems as being over 50 years old and among the 10 oldest investments and/or systems that were reported by 12 selected agencies.<sup>3</sup>

- Personnel and Accounting Integrated Data (PAID)—This 53-year old system automates time and attendance for employees, timekeepers, payroll, and supervisors. It is written in Common Business Oriented Language (COBOL), a programming language developed in the late 1950s and early 1960s, and runs on IBM mainframes. VA plans to replace PAID with a project called Human Resources Information System Shared Service Center in 2017.

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<sup>3</sup>GAO, *Information Technology: Federal Agencies Need to Address Aging Legacy Systems*, [GAO-16-468](#) (Washington, D.C.: May 25, 2016).

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- **Benefits Delivery Network (BDN)**—This 51-year old system tracks claims filed by veterans for benefits, eligibility, and dates of death. It is a suite of COBOL mainframe applications. VA has general plans to roll the capabilities of BDN into another system, but there is no firm date associated with this transition.

To address these obsolete systems that are in need of modernization or replacement, we recommended that the Secretary of Veterans Affairs direct the department's Chief Information Officer (CIO) to identify and plan to modernize or replace legacy systems, as needed, and consistent with draft OMB guidance, including time frames, activities to be performed, and functions to be replaced or enhanced. VA concurred with our recommendation and stated that it is planning to retire PAID and BDN in 2017 and 2018, respectively.

In 2014, VA issued its 6-year strategic plan, which emphasizes the department's goal of increasing veterans' access to benefits and services, eliminating the disability claims backlog, and ending veteran homelessness. According to the plan, the department intends to improve access to benefits and services through the use of improved technology to provide veterans with access to more effective care management. The plan also calls for VA to eliminate the disability claims backlog by fully implementing an electronic claims process that is intended to reduce processing time and increase accuracy. Further, the department has an initiative under way that provides services, such as health care, housing assistance, and job training, to end veteran homelessness. Toward this end, VA is working with other agencies, such as the Department of Health and Human Services, to implement more coordinated data entry systems to streamline and facilitate access to appropriate housing and services.

VA reported spending about \$3.9 billion to improve and maintain its IT resources in fiscal year 2015. Specifically, the department reported spending approximately \$548 million on new systems development efforts, approximately \$2.3 billion on maintaining existing systems, and approximately \$1 billion on payroll and administration. For fiscal year 2016, the department received appropriations of about \$4.1 billion for IT.

Further, for fiscal year 2017, the department's budget request included nearly \$4.3 billion for IT. The department requested approximately \$471 million for new systems development efforts, approximately \$2.5 billion for maintaining existing systems, and approximately \$1.3 billion for payroll and administration. In addition, in its 2017 budget submission, the

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department requested appropriations to make improvements in a number of areas, including:

- veterans' access to health care, to include enhancing health care-related systems, standardizing immunization data, and expanding telehealth services (\$186.7 million);
- veterans' access to benefits by modernizing systems supporting benefits delivery, such as VBMS and the Veterans Services Network (\$236.3 million);
- veterans' experiences with VA by focusing on integrated service delivery and streamlined identification processes (\$171.3 million);
- VA employees' experiences by enhancing internal IT systems (\$13 million); and
- information security, including implementing strong authentication, ensuring repeatable processes and procedures, adopting modern technology, and enhancing the detection of cyber vulnerabilities and protection from cyber threats (\$370.1 million).

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## VA's CIO Has Initiated a Transformation of the IT Organization

VA's CIO has recently initiated an effort to transform the focus and functions of the Office of Information and Technology (OI&T),<sup>4</sup> in response to the Secretary's goal of achieving a more veteran-focused organization. The CIO's transformation strategy, initiated in January 2016, calls for OI&T to focus on stabilizing and streamlining processes, mitigating weaknesses highlighted in GAO assessments, and improving outcomes by institutionalizing a new set of IT management capabilities.

As part of this transformation, the CIO began transitioning the oversight and accountability of IT projects to a new project management process called the Veteran-focused Integration Process in January 2016, in an effort to streamline systems development and the delivery of new IT capabilities. The CIO also intends to establish five new functions within OI&T:

- The enterprise program management office is to serve as OI&T's portfolio management and project tracking organization.

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<sup>4</sup>OI&T provides IT services across VA and manages the department's IT assets and resources. The office is headed by VA's CIO.

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- The account management function is to be responsible for managing the IT needs of VA's major components.
  - The quality and compliance function is to be responsible for establishing policy governance and standards and ensuring adherence to them.
  - The data management organization is expected to improve both service delivery and the veteran experience by engaging with data stewards to ensure the accuracy and security of the information collected by VA.
  - The strategic sourcing function is to be responsible for establishing an approach to fulfilling the agency's requirements with vendors that provide solutions to those requirements, managing vendor selection, tracking vendor performance and contract deliverables, and sharing insights on new technologies and capabilities to improve the workforce knowledge base.

According to the CIO, the transformation strategy is expected to be completed by the first quarter of fiscal year 2017, although the vast majority of the plan, including establishing the five new functions, is to be executed by the end of fiscal year 2016.

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## IT Challenges Contributed to Designation of VA Health Care as High Risk

In February 2015, we designated VA health care as a high-risk area. Among the five broad areas contributing to our determination was the department's IT challenges.<sup>5</sup> Of particular concern was the failed modernization of a system, suspended development of another system, and the extent of system interoperability—the ability to exchange information—with DOD, which present risks to the timeliness, quality, and safety of VA health care.

We have reported on the department's failed attempts to modernize its outpatient appointment scheduling system, which is about 30 years old. Among the problems cited by VA staff responsible for scheduling appointments are that the system requires them to use commands requiring many keystrokes and that it does not allow them to view multiple

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<sup>5</sup>The remaining four areas are ambiguous policies and inconsistent processes, inadequate oversight and accountability, inadequate training for VA staff, and unclear resource needs and allocation priorities.

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screens at once. Schedulers must open and close multiple screens to check a provider's or a clinic's full availability when scheduling a medical appointment, which is time-consuming and can lead to errors.

In addition, we reported in May 2010 that after spending an estimated \$127 million over 9 years on its outpatient scheduling system project, VA had not implemented any of the planned system's capabilities and was essentially starting over by beginning a new initiative to build or purchase another scheduling system.<sup>6</sup> We also noted that VA had not developed a project plan or schedule for the new initiative, stating that it intended to do so after determining whether to build or purchase the new application. We recommended that the department take six actions to improve key systems development and acquisition processes essential to the second outpatient scheduling system effort. The department generally concurred with our recommendations, but as of May 2016, had not addressed four of the six recommendations.

Further, in January 2014, we reported that the inability to electronically share data across facilities had led VA to suspend the development of a system that would have allowed it to electronically store and retrieve information about surgical implants (including tissue products) and the veterans who receive them nationwide.<sup>7</sup> Having this capability would be particularly important in the event that a manufacturer or the Food and Drug Administration ordered a recall on a medical device or tissue product because of safety concerns. In the absence of a centralized system, at the time of our report, VA clinicians tracked information about implanted items using stand-alone systems or spreadsheets that were not shared across VA facilities, which made it difficult for the department to quickly determine which patients may have received an implant that was subject to a safety recall.

Additionally, we reported in February 2014 that VA and DOD lacked electronic health record systems that permit the efficient electronic

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<sup>6</sup>GAO, *Information Technology: Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System*, [GAO-10-579](#) (Washington, D.C.: May 27, 2010).

<sup>7</sup>GAO, *VA Surgical Implants: Purchase Requirements Were Not Always Followed at Selected Medical Centers and Oversight Needs Improvement*, [GAO-14-146](#) (Washington, D.C.: Jan. 13, 2014).



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exchange of patient health information as military service members transition from DOD to VA health care systems.<sup>8</sup> Since 1998, VA and DOD have undertaken a patchwork of initiatives intended to allow their health information systems to exchange information and increase interoperability. Among others, these have included initiatives to share viewable data in existing (legacy) systems, link and share computable data between the departments' updated health data repositories, and jointly develop a single integrated system.

In March 2011, the secretaries of the two departments announced that they would develop a new, joint integrated electronic health record system (referred to as iEHR). This was intended to replace the departments' separate systems with a single common system, thus sidestepping many of the challenges they had previously encountered in trying to achieve interoperability. However, in February 2013, about 2 years after initiating iEHR, the secretaries announced that the departments were abandoning plans to develop a joint system, due to concerns about the program's cost, schedule, and ability to meet deadlines. The Interagency Program Office (IPO) reported spending about \$564 million on iEHR between October 2011 and June 2013.

In place of the iEHR initiative, VA stated that it would modernize VistA, while DOD planned to buy a commercially available system. The departments stated that they would ensure interoperability between these updated systems, as well as with other public and private health care providers. Our February 2014 report noted that the departments did not substantiate their claims that it would be less expensive and faster than developing a single, joint system.<sup>9</sup> We have also noted that the departments' plans to modernize their two separate systems were duplicative and stressed that their decisions should be justified by comparing the costs and schedules of alternate approaches.<sup>10</sup> We

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<sup>8</sup>GAO, *Electronic Health Records: VA and DOD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration*, [GAO-14-302](#) (Washington, D.C.: Feb. 27, 2014).

<sup>9</sup>[GAO-14-302](#).

<sup>10</sup>See GAO's Action Tracker, a publicly available website that includes progress updates and assessments of the actions from GAO's annual reports on reducing fragmentation, overlap, and duplication.

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therefore recommended that the departments should develop cost and schedule estimates that would include all elements of their approach (i.e., modernizing both departments' health information systems and establishing interoperability between them) and compare them with estimates of the cost and schedule for the single-system approach. If the planned approach were projected to cost more or take longer, we recommended that they provide a rationale for pursuing such an approach.

VA and DOD agreed with our prior recommendations and stated that initial comparison indicated that the current approach would be more cost effective. However, as of June 2016, the departments have not provided us with a comparison of the estimated costs of their current and previous approaches. Moreover, with respect to their assertions that separate systems could be achieved faster, both departments have developed schedules that indicate their separate modernizations are not expected to be completed until after the 2017 planned completion date for the previous single-system approach.

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## Recent Evaluations Have Identified Additional IT Challenges

To further highlight the department's IT challenges, our most recent report in August 2015 on VA's efforts to achieve electronic health record interoperability with DOD noted that the departments have engaged in several near-term efforts focused on expanding interoperability between their existing electronic health record systems.<sup>11</sup> For example, the departments analyzed data related to 25 "domains" identified by the Interagency Clinical Informatics Board and mapped health data in their existing systems to standards identified by the IPO. The departments also expanded the functionality of their Joint Legacy Viewer—a tool that allows clinicians to view certain health care data from both departments in a single interface.<sup>12</sup>

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<sup>11</sup>[GAO-15-530](#).

<sup>12</sup>The Joint Legacy Viewer provides a real-time, integrated, categorized, and chronological view of electronic health record information contained in existing VA and DOD systems. For example, it allows both departments to share certain healthcare data (e.g., patient demographics, allergies, medications) in a viewable interface that is available to clinicians.

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In addition, VA and DOD have moved forward with plans to modernize their respective electronic health record systems. For its part, VA has developed a number of plans for its VistA modernization effort (known as VistA Evolution), including an interoperability plan and a road map describing functional capabilities to be deployed through fiscal year 2018. According to the road map, the first set of capabilities was to be delivered in September 2014, and was to include access to the Joint Legacy Viewer, among other things. VA's CIO has asserted that the department has continued to improve VistA. However, the CIO also recently indicated that the department is taking a step back in reconsidering how best to meet VA's future electronic health record system needs and has not determined whether to modernize VistA or to replace it with an off-the-shelf system.

Nevertheless, a significant concern that we identified is that VA (and DOD) had not identified outcome-oriented goals and metrics that would more clearly define what they aim to achieve from their interoperability efforts and the value and benefits these efforts are intended to yield. As we have stressed in our prior work, assessing the performance of a program should include measuring its outcomes in terms of the results of products or services. In this case, such outcomes could include improvements in the quality of health care or clinician satisfaction. Establishing outcome-oriented goals and metrics is essential to determining whether a program is delivering value.

In our August 2015 report, we stressed that using an effective outcome-based approach could provide VA with a more accurate picture of its progress toward achieving interoperability with DOD and the value and benefits generated. Accordingly, we recommended that the departments, working with the IPO, establish a time frame for identifying outcome-oriented metrics, define related goals as a basis for determining the extent to which the departments' modernized electronic health record systems are achieving interoperability, and update IPO guidance accordingly. VA concurred with our recommendations and has told us that it has initiated actions in response to them.

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## Efforts to Develop and Use the Veterans Benefits Management System Can Be Improved

In September 2015, we reported that VBA had made progress in developing and implementing VBMS, its system that is to be used for processing disability benefit claims.<sup>13</sup> Specifically, it had deployed the initial version of the system to all of its regional offices as of June 2013. Further, after initial deployment, VBA continued developing and implementing additional system functionality and enhancements to support the electronic processing of disability compensation claims. As a result, 95 percent of records related to veterans' disability claims are electronic and reside in the system.

Nevertheless, we found that VBMS was not able to fully support disability and pension claims, as well as appeals processing. Specifically, while the Under Secretary for Benefits stated in March 2013 that the development of the system was expected to be completed in 2015, implementation of functionality to fully support electronic claims processing was delayed beyond 2015. In addition, VBA had not produced a plan that identified when the system will be completed. Accordingly, holding VA management accountable for meeting a time frame and for demonstrating progress was difficult.

As VA continues its efforts to complete the development and implementation of VBMS, we reported in September 2015 that three areas could benefit from increased management attention.

- **Cost estimating:** The program office did not have a reliable estimate of the cost for completing the system. Without such an estimate, VA management and the department's stakeholders had a limited view of the system's future resource needs, and the program risked not having sufficient funding to complete development and implementation of the system.
- **System availability:** Although VBA had improved its performance regarding system availability to users, it had not established system response time goals. Without such goals, users did not have an expectation of the system response times they could anticipate and management did not have an indication of how well the system performs relative to performance goals.

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<sup>13</sup>[GAO-15-582](#).

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- System defects: While the program had actively managed system defects, a recent system release included unresolved defects that impacted system performance and users' experiences. Continuing to deploy releases with large numbers of defects that reduce system functionality could adversely affect users' ability to process disability claims in an efficient manner.

We also found in our September 2015 report that VA had not conducted a customer satisfaction survey that would allow the department to compile data on how users view the system's performance, and ultimately, to develop goals for improving the system. GAO's 2014 survey of VBMS users found that a majority of them were satisfied with the system, but decision review officers were considerably less satisfied. Although the results of our survey provided VBA with data about users' satisfaction with VBMS, the absence of user satisfaction goals limited the utility of survey results. Specifically, without having established goals to define user satisfaction, VBA did not have a basis for gauging the success of its efforts to promote satisfaction with the system, or for identifying areas where its efforts to complete development and implementation of the system might need attention.

In our September 2015 report, we recommended that VA develop a plan with a time frame and a reliable cost estimate for completing VBMS, establish goals for system response time, minimize the incidence of high and medium severity system defects for future VBMS releases, assess user satisfaction, and establish satisfaction goals to promote improvement. As we stressed in our report, attention to these issues can improve VA's efforts to effectively complete the development and implementation of VBMS. Fully addressing our recommendations, as VA agreed to do, should help the department give appropriate attention to these issues.

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## Modernization of Health Care Claims Processing System Requires Additional Planning to Ensure Weaknesses Are Addressed

As we reported in May 2016, VA's expenditures for its care in the community programs, the number of veterans for whom VA has purchased care, and the number of claims processed by VHA have all grown considerably in recent years.<sup>14</sup> The substantial increase in utilization of VA care in the community programs poses staffing and workload challenges for VHA, which has had ongoing difficulty processing claims from community providers in a timely manner.

VHA officials and staff at three of the four claims processing locations we visited told us that limitations of the existing IT systems, including the Fee Basis Claims System (FBCS) that VHA uses for claims processing, have delayed processing and payment of claims for VA care in the community services. Officials at the sites we visited described the following limitations.

- VHA cannot accept medical documentation electronically.
- Authorizations for VA care in the community services are not always readily available in FBCS.
- FBCS cannot automatically adjudicate claims.
- System weaknesses have delayed claims payments.

The officials we interviewed said that if the agency is to dramatically improve its claims processing timeliness, comprehensive and technologically advanced solutions must be developed and implemented, such as modernizing and upgrading VHA's existing claims processing system or contracting out the claims processing function. In October 2015, VHA submitted a plan to address these issues as part of a broader effort to consolidate VA care in the community programs.<sup>15</sup> The agency estimated that it would take at least 2 years to implement solutions that would fully address all of the challenges now faced by its claims processing staff and by providers of VA care in the community services.

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<sup>14</sup>[GAO-16-353](#).

<sup>15</sup>Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, (Washington, D.C.: Oct. 30, 2015). The VA Budget and Choice Improvement Act required VA to develop a plan for consolidating its existing VA care in the community programs. The plan was due to Congress no later than November 1, 2015. Pub. L. No. 114-41, § 4002, 129 Stat. 443, 461 (2015).

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However, VHA has not yet provided to Congress or other external stakeholders a plan for modernizing its claims processing system. In particular, VHA has not provided (1) a detailed schedule for developing and implementing each aspect of its new claims processing system; (2) the estimated costs for developing and implementing each aspect of the system; and (3) performance goals, measures, and interim milestones that VHA will use to evaluate progress, hold staff accountable for achieving desired results, and report to stakeholders the agency's progress in modernizing its claims processing system.

That VHA has not yet provided a detailed plan but has stated that it expects to deploy a modernized claims processing system as early as fiscal year 2018 is cause for concern. Thus, to help provide reasonable assurance that VHA achieves its long-term goal of modernizing its claims processing system, we recommended in May 2016 that the Secretary of Veterans Affairs direct the Under Secretary for Health to ensure that the agency develops a sound written plan that includes:

- a detailed schedule for when VHA intends to complete development and implementation of each major aspect of its new claims processing system;
- the estimated costs for implementing each major aspect of the system; and
- the performance goals, measures, and interim milestones that VHA will use to evaluate progress, hold staff accountable for achieving desired results, and report to stakeholders the agency's progress in modernizing its claims processing system.

The department concurred with our recommendation and said that VHA plans to address the recommendation when the agency develops an implementation strategy for the future consolidation of its VA care in the community programs.

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In conclusion, effective IT management is critical to the performance of VA's mission. The department faces challenges in key areas, including the development of new systems, modernization of existing systems, and increasing interoperability with DOD. While we recognize that the transformation of VA's IT organization is intended, among other things, to mitigate the IT weaknesses we have identified, sustained management attention and organizational commitment will be essential to ensuring that the transformation is successful and that the weaknesses are fully addressed.

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Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have.

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## GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Valerie C. Melvin at (202) 512-6304 or [melvinv@gao.gov](mailto:melvinv@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony statement. GAO staff who made key contributions to this statement are Mark T. Bird (Assistant Director), Jennifer Stavros-Turner (Analyst in Charge), Kara Epperson, Rebecca Eyler, and Jacqueline Mai.



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