

# Major Management Challenges

## Identified By VA Office of Inspector General

The Office of Inspector General (OIG) has implemented a strategic planning process designed to identify and address the key issues facing VA. These issues, which include health care delivery, benefits processing, procurement, financial management, and information management, are presented in the OIG Strategic Plan 2001-2006. The following summarizes the most serious management problems facing VA in each of these areas, and assesses the Department's progress in addressing them. While these issues guide our oversight efforts, we continually reassess our goals and objectives to ensure that our focus remains relevant, timely, and responsive to changing priorities. (On these pages, the words "we" and "our" refer to the OIG.)

### OIG1. HEALTH CARE DELIVERY

In recent years, the Veterans Health Administration (VHA) restructured health care delivery to emphasize managed care through an extended network of community-based outpatient clinics and ambulatory care settings. This transition has raised new issues concerning the utilization of facilities and the allocation of resources. Providing safe, high quality medical care, reasonable waiting times, and accessibility to care are just some of the fundamental delivery of service issues that present challenges on a continuous basis.

*As we strive to provide the highest quality benefits and services to our Nation's veterans, we realize we have many program and management challenges to overcome. Following are descriptions of our major challenges as identified by the VA Office of Inspector General and the General Accounting Office along with the VA program's response. (In this report, years are fiscal years unless stated otherwise.)*

Opening VA health care to non-service-connected veterans created an unprecedented increase in demand for VHA, leading to inordinately high waiting times and insufficient resources. The political leadership in both the legislative and executive branches should confront this reality and codify the long-term health care benefits that will be provided to our Nation's veterans, and fund them accordingly. VHA needs to continue the trend of increasing revenue growth from non-appropriated sources and pursue every avenue possible to maximize the economy and efficiency of its programs and activities. The following issues present major challenges and opportunities to do just that.

### 1A. OIG ISSUE - VETERANS' EQUITABLE RESOURCE ALLOCATION (VERA)

In August 2001, OIG issued the report *Audit of Availability of Healthcare Services in the Florida/Puerto Rico Veterans Integrated Service Network 8* (Report No. 99-00057-55). We found that VHA did not include or consider the workload of Priority Group 7 (nonservice-connected/non-complex care) veterans in the VERA system. Accordingly, resource allocation decisions did not include all vet-

erans who are enrolled for care and treated. We recommended that VHA include this workload in the VERA model.

Although VHA stated that inclusion of Priority 7 veterans in the VERA model would be a step toward better alignment of VHA's actual enrollment experience, it decided in January 2003 not to include them in the VERA model for 2003. The VA Secretary sustained that decision, based on concerns that including Priority 7 veterans would create financial incentives to seek out more Priority 7 veterans instead of veterans who comprise VA's core health care mission: veterans with service-connected disabilities, incomes below the income threshold, or special needs (e.g., homelessness). VA did not want to encourage unmanageable growth. We believe the Department should reassess the decision to exclude this group of veterans from its resource model.

### VA'S PROGRAM RESPONSE

While the Secretary decided not to include basic care Priority Group 7 patients in the 2003 VERA allocations, other refinements to the VERA model addressed pressing issues identified by the GAO and the RAND

Corporation and improve the equity of resource allocation among VHA's networks. As such, VHA will continue allocation based on this decision.

### **1B. OIG ISSUE - CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)**

In October 2000, VHA implemented the CARES program to assess health care needs in VISNs and guide the realignment and allocation of capital assets supporting delivery of health care services. According to VHA, CARES will improve access and veteran satisfaction, and improve the delivery of health care in the most accessible and cost-effective manner while minimizing any adverse impacts on staffing. In doing this, VHA faces the dual challenges of ensuring access to world-class care as demographics change and converting VA's under-performing facilities into productive assets. In May 2003, GAO also reported on VA's large portfolio of aged, inefficient buildings, concluding that VA needs to find ways to minimize the resources devoted to these unneeded inpatient buildings.

#### **VA'S PROGRAM RESPONSE**

The CARES program is fully engaged in implementing the Secretary's programmatic goals and objectives outlined in the nine-step CARES process. The draft national CARES plan was delivered to the CARES Commission on August 4, 2003.

The Commission is expected to carefully consider the views and concerns of all stakeholders during a public review and comment period. In the draft plan, solutions are recommended to mitigate the

numerous infrastructure, patient care, and access to care issues identified by GAO and OIG. The majority of solutions resulted in realigning the current delivery of veterans' services to locations where they are projected to reside. Recommendations in the plan resulted in the following planning initiatives: capacity (workload); access (driving time precept); efficiency/quality (vacant space, small facilities, proximity, realignments, consolidations); and special disability programs (spinal cord injury and blind rehabilitation). To qualify as a planning initiative, solutions must be supported by a 2022 projected workload demand. When workload falls off after 2012 projections, solutions are to be considered temporary (contracting out, short-term leases).

### **1C. OIG ISSUE - PART-TIME PHYSICIAN TIME AND ATTENDANCE**

Since 2000, OIG substantiated 15 allegations received by the OIG Hotline regarding time and attendance violations by VA physicians. Additionally, our Combined Assessment Program (CAP) reviews<sup>1</sup> assessed physician time and attendance issues at 43 facilities and identified deficiencies at 24 locations. In 2003 we audited VHA's management of part-time physician time and attendance, physician productivity in meeting employment obligations, and physician-staffing requirements. Our April 2003 report, *Audit of VHA's Part-Time Physician Time and Attendance* (Report No. 02-01339-85), identified VA physicians who were not present during their scheduled tours of duty, were not providing VA the services obligated by their

employment agreement, or were "moonlighting" on VA time. We concluded that VA medical center (VAMC) managers did not ensure that part-time physicians met employment obligations, and that VAMCs did not perform workload analyses to determine the number of FTE needed or evaluate their hiring alternatives (such as part-time, full-time, intermittent, or fee-basis).

#### **VA'S PROGRAM RESPONSE**

The Deputy Under Secretary for Health for Operations and Management addressed this concern in a number of ways: October 2002, guidance was issued to field facilities on time and attendance best practices; December 2002, certification required that timekeepers had received refresher training and that part-time physicians understood VA's attendance policies and procedures; January 2003, directive issued outlining the responsibilities of employees and VHA management officials involved in ensuring compliance with time and attendance policies and procedures.

In addition, VHA is reviewing new policies and procedures to require part-time physicians on adjustable work hours to enter into service agreements that outline the level and type of service expected; approval is anticipated by December 31, 2003. The new requirements direct Facility Directors to review vacant positions to determine whether the appointment type is appropriate and to establish procedures for documenting the time and attendance of these physicians. Also, VHA is establishing monitors related to the supervision of time and attendance and developing an

<sup>1</sup> Through this program, auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VA health care systems and VA regional offices on a cyclical basis.

Intranet/Internet training course on time and attendance for employees, managers, and timekeepers. VHA is currently piloting a swipe card scanner technology as a possible means of monitoring part-time physician time and attendance. Results of the pilot will be assessed by the end of the first quarter of 2004. A physician staffing and productivity workgroup is finalizing proposed guidance on primary care (called the Primary Care Management Model). Approval is anticipated by November 2003. The group is currently reviewing specialty care.

#### **1D. OIG ISSUE - PHYSICIAN STAFFING GUIDELINES**

We performed an audit to evaluate management of physician staffing and the equity of the distribution of physician resources among VAMCs. The audit found significant staffing disparities among VAMCs with similar missions and levels of medical school affiliation. These disparities were not explained by the time physicians allocated to patient care, education, or research; the number of residents or physician extenders; or differences in acuity or complexity of care. These conditions occurred in part because VHA has not established physician-staffing guidelines. We recommended that VHA develop a benchmarking process for physician staffing and set goals to encourage VAMCs to adjust staffing levels based on the most efficient medical centers. This would have permitted the better use of about 2,000 physician full-time equivalent (FTE) employees with associated costs of \$181 million. VA did not concur with our recommendations or monetary estimate and has not yet established staffing standards required by Public Law 107-135. These issues remain unresolved.

#### **VA'S PROGRAM RESPONSE**

VHA is in the process of developing a physician productivity model for four key outpatient areas: primary care, urology, cardiology, and ophthalmology. The directive for primary care staffing and productivity model is in the concurrence process. The other clinic models will be ready for testing in the fall. Our objectives are to develop productivity standards and identify staffing levels that accurately address workload demands while reducing costs through productivity increases. The model will be applied to part-time as well as full-time physicians. In developing the model, VHA is carefully considering such factors as VA/private sector productivity comparisons, management style, relationships between patient complexity and staffing assignments, physician incentives, availability of capital assets, scope of physician activities, and costs. Although not all of these factors will be in the model for initial testing, they will be incorporated once additional information is obtained from surveys and data systems. From this work, VHA plans to develop productivity standards and identify staffing levels that accurately address workload demands. The model may be applied beyond the four areas at a future date.

#### **1E. OIG ISSUE - QUALITY MANAGEMENT (QM)**

Although VHA managers are vigorously addressing the Department's QM and patient safety procedures in an effort to strengthen patients' confidence, issues remain. OIG and General Accounting Office reviews in the 1990s found that managers needed to improve efforts for collecting, trending, and analyzing clinical data. From October 2001 through September 2002, we conducted QM reviews at 20 VA health care facilities

during CAP reviews. While we found improvements in QM programs, we also found that senior managers and QM program coordinators did not consistently compare their results with external standards, benchmarks, or national goals, and did not sufficiently ensure successful implementation of recommended QM actions in all areas reviewed. We made recommendations to the Department to address these issues.

We acknowledge that VHA has made progress and continues to focus on QM issues. However, our inspection results have shown that policies and procedures designed to safeguard patients are not always followed. The human factor disrupts the safeguards. For example, nursing employees have bypassed safeguards built into the Bar Code Medication Administration system, resulting in serious medication errors. The Computerized Patient Record System does not as yet contain all of the relevant clinical data needed, and providers may not enter clinical information. Since high-quality, safe patient care is VHA's primary objective, we believe that QM and patient safety should remain among VA's most significant management challenges.

#### **VA'S PROGRAM RESPONSE**

VHA has been working diligently to address all health care performance issues identified by the OIG. For all health care performance indicators where comparable data are available, VA outcomes exceed best-reported performance in 2002 of managed care organizations, governmental sources, and population-based surveys. In regard to VA's credentialing process, everyone who is currently practicing is fully credentialed by VA with 75 percent of those credentialed to be included in VetPro,

VHA's electronic credentialing process, by the end of 2003.

VHA continues to work with other relevant offices within VA Central Office, such as the Medical Inspector's Office and the Deputy Undersecretary for Operations and Management, to ensure quality and patient safety. Beginning in 2003, VHA, in concert with the National Center for Patient Safety, developed a new patient safety project to ensure that the software for VA's Bar Code Medication Administration, the Computerized Patient Record System, and Imaging are kept up-to-date. Reducing the incidence of system circumvention or workarounds either when scanning a patient's wristband or medications was identified as one of the goals of the VHA-sponsored Collaborative Breakthrough Series Project. The outcomes of this project will result in global lessons to be used throughout VHA. In addition, VHA established an official patient safety measure, which has demonstrated a dramatic improvement in the first two quarters of 2003 from the 2002 baseline data. Given VHA's progress and continued emphasis on quality management, we believe this issue should be reconsidered as a major management challenge.

### **1F. OIG ISSUE – LONG-TERM HEALTH CARE**

VHA established several programs to provide long-term health care to aging veterans. The OIG found that serious challenges continue to exist. For example, in 2003 we completed reviews of VHA's Community Nursing Home (CNH) Program and Homemaker/Home Health Aide (H/HHA) Program. We identified several issues warranting VHA's attention. While VHA has contracted with CNHs to provide care for aging veterans, it has taken years to imple-

ment standardized monitoring /inspection procedures, as noted in our December 2002 report *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program* (Report No. 02-00972-44). This has caused VA facilities to be inconsistent in overseeing the care and service provided to veterans residing in community facilities. We made recommendations to further clarify and strengthen the VHA CNH oversight process and to reduce the risk of veterans in CNHs from adverse incidents. The Under Secretary for Health is currently implementing an action plan that is responsive to our recommendations.

We found VHA's H/HHA Program also needed improvements. Our summary evaluation of this program shows that 14 percent of patients receiving H/HHA services in our sample did not meet clinical eligibility requirements. Some patients were not in need of care. Other patients only needed supervision but were not dependent on assistance with their daily living requirements. Facilities were not using benchmark nursing home per diem rates as prescribed by policy. We met with VHA's Geriatrics and Extended Care group to discuss the draft report in September 2003. We estimate that had benchmark rates with Medicare/Medicaid been used, VHA could have saved an estimated \$10.7 million annually.

### **VA'S PROGRAM RESPONSE**

VHA has devised a new strategy to provide needed policy direction on reimbursement for skilled home care, homemaker/home health aide. VHA questions the \$10.7 million annual savings OIG calculated in regard to using Medicare/Medicaid rates. VHA requested to meet with

OIG during the fourth quarter of 2003 to recalculate the monetary benefits by reassessing the assumptions used in arriving at their data on this issue. The H/HHA directive and revised handbook are expected to be published in March 2004 to clarify clinical eligibility requirements and benchmarking rates. The Geriatrics and Extended Care Strategic Planning Group held a national conference call with managers to discuss the need to strengthen oversight of the long-term care programs and services. Follow-up from this call will be provided to the participants in writing in September 2003. Until the H/HHA policy for reimbursement for skilled home care is issued, the Office of Geriatrics and Extended Care in the VHA Central Office is coordinating with the Network directors to ensure that the payments for H/HHA are within the established Medicare and Medicaid-based ratio. This is being carried out through the geriatrics monthly conference calls to the Networks and alert messages to the Networks, informing them of any changes in benchmark rates or clinical eligibility.

In June 2002, VHA published a comprehensive oversight policy document that establishes a national standard for annual reviews of community nursing homes and monthly visits by VA staff to patients in these homes. This is being certified at a national level. By the end of 2003, VHA expects to complete the implementation of a 25-point plan to further refine VHA's oversight efforts of the community nursing home programs. VHA continues expanding the education and training of its staff related to the new policy on CNH oversight through weekly teleconferences to VA medical centers, satellite broadcasts, and Web-based training modules.

## **1G. OIG ISSUE - SECURITY AND SAFETY**

In the aftermath of the September 11 terrorist attacks, we reviewed the adequacy of security and inventory controls over selected biological, chemical, and radioactive agents owned by or controlled at VA facilities. In our March 2002 report, *Review of Security and Inventory Controls over Selected Biological, Chemical and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities* (Report No. 02-00266-76), we found that security measures to limit physical access to research facilities, clinical laboratories, and other high-risk or sensitive areas varied significantly. VHA's inventories of these substances were incomplete or inadequate. Some VA facilities needed to update their disaster preparedness plans. Although actions are in process, only one recommendation has been closed to date.

We continue to work with VHA, the Office of Policy, Planning, and Preparedness, and other VA officials regarding the recommendations that remain open. The following examples are some of the issues needing resolution before we can close the report's recommendations. Guidance concerning our recommendations to strengthen purchasing, inventories, transfer, and destruction processes was specifically addressed for research laboratories in VHA Directive 2002-075. However, VHA has not established formal policy applicable to clinical laboratories or other sites in facilities, beyond instructions and recommendations informally provided by Patient Care Services. Integration of guidance and direction provided by all VA officials on these security and safety issues would increase uniformity and reduce varying practices in the field.

We are seeking assurances that other facilities do not have additional, unaddressed and unfunded security vulnerabilities. We are following up to confirm that medical centers are in compliance with developing emergency management programs. VA directives or other formal policies are still needed to provide specific guidance to field facilities regarding non-citizens. Confirmation is needed that all non-citizens who have accessed facility areas with select agents or other sensitive materials (such as those outlined in the Attachment to VHA Directive 2002-075) have been determined to have legal status in this country, including regular reviews and updated processes for monitoring the status of non-citizens.

### **VA'S PROGRAM RESPONSE**

Significant progress has been made on all of the OIG recommendations, although they have not been closed by the OIG. VHA has completed its comprehensive inventory of all research laboratories. All VA research laboratories that use or store live organisms, with the exception of one for which the registration application is being processed, possess appropriate registration from the Centers for Disease Control and Prevention (CDC). In addition, VHA completed an extensive inventory of all clinical laboratories and pharmacies for select biological and chemical agents identified for potential use in terrorist activities. VHA Directive 2002-075, *Control of Hazardous Materials in VA Research Laboratories*, which was published in November 2002, directly addressed seven OIG recommendations, including improvements in physical security.

The Office of Research and Development (ORD) notified all research sites regarding the USA

Patriot Act of 2001. ORD has been educating research laboratories about the additional personnel security issues needed to comply with the USA Patriot Act and with the CDC Select Agent guidelines. The Office of Research Oversight and ORD met in October to discuss the responsibilities and procedures for the inspections of the annual program of unannounced inspections of sites with BSL-3 research laboratories that ORD initiated in April 2003. These are to ensure compliance with safety and security guidelines. OIG will not close this recommendation until all sites have completed their security upgrades.

VHA has a training program in development that will address the open recommendation of providing instruction on laboratory security. ORD has spent more than \$2 million to upgrade laboratory security. Sixty-four research sites have been identified as needing security upgrades. Fifty-five sites have received or been approved for funding. ORD will review the revised applications of the remaining nine sites by the end of 2003. In early 2003, OIG mandated VAMC directors to certify the implementation of directives and security requirements before OIG will close the recommendations. VHA and OIG have been meeting during 2003 to discuss how to best implement the open recommendations.

## **1H. OIG ISSUE - COMMUNICATING ABNORMAL TEST RESULTS**

In our November 2002 report, *Summary Review, Evaluation of VHA Procedures for Communicating Abnormal Test Results* (Report No. 01-01965-24), we reviewed the adequacy of VHA communication procedures for conveying abnormal test results to treatment providers and

patients. Managers at clinical laboratories that were visited had established provider notification guidelines; however, compliance varied. Collectively, laboratory, pathology, radiology, and primary care need a comprehensive national VHA policy on communicating abnormal test results to treatment providers and patients. Diagnostic clinicians and treatment providers must document notification, and managers must test their alert systems. One of our four recommendations has not yet been implemented.

### **VA'S PROGRAM RESPONSE**

VHA's Office of Information is working with the Office of Patient Care Services and field stakeholders to address both software usability and training issues to improve the use of automated alerts. These activities include, but are not limited to, system changes, such as enhancements to the CPRS Alert Processor within the CPRS Graphical User Interface and to VistA Care Management software; additional training in the area of alert management; and a business process review to address the recommendations noted by the OIG. An Alerts Management Sharing Web page on the VistA U Web site brings tools and best practices to the user's fingertips.

### **11. OIG ISSUE - MANAGING VIOLENT AND POTENTIALLY VIOLENT PATIENTS**

Our March 1996 report, *Evaluation of VHA's Policies and Practices for Managing Violent and Potentially Violent Psychiatric Patients* (Report No. 6HI-A28-038), recommended

that VHA managers explore network flagging systems that would ensure employees at all VAMCs are alerted when patients who have histories of violence arrive at a medical center for treatment. VHA concurred that Veterans Integrated Service Network (VISN)-level/national databases are needed to support information sharing; however, CAP reviews conducted in 2003 confirm that VHA still needs to address this safety concern.

### **VA'S PROGRAM RESPONSE**

The National Patient Record Flagging Directive, 2003-048, was released on August 28, 2003. The automated system-wide tracking software for Patient Record Flags was released to the field September 11, 2003 with activation at all sites by September 25, 2003. VHA instituted a training program on appropriate use of patient flags and Web-based support materials including best practices for clinical, administrative, and informatics field staff. A videotape for clinicians on Patient Record Flags is undergoing final review prior to release. A monthly call has been scheduled for the first Wednesday of each month at noon EST beginning October 1, 2003, to respond to any issues that may arise in the field concerning Patient Record Flags.

VA police officers receive 80 hours of initial entry training, designed to orient them to facility-specific and unique aspects of policing in a health care environment. Once completed, officers participate in a 200-hour basic police officer training course at the VA Law Enforcement Training Center, which prepares them to

effectively perform their duties relating to patient, employee, and visitor-related situations. Part of this course includes over 20 hours of classroom training on how to deal with violent behavior. VA Police Standard Operating Procedures has a section dedicated to the identification and management of assault and violent behavior.

### **OIG2. BENEFITS PROCESSING**

For the past quarter century, Veterans Benefits Administration (VBA) has struggled with timeliness of claims processing. Veterans wait too long for disability decisions, and improvement is needed in the quality and consistency of claims processing. OIG reviews continue to find that erroneous and improper payments to ineligible veterans and beneficiaries are a significant problem resulting from inadequate oversight and lack of internal controls. Because of the total dollar value of claims, the volume of transactions, the complexity of the criteria used to compute benefits payments, and the number of erroneous<sup>2</sup> and improper<sup>3</sup> payments already identified, we consider these issues high risk areas and major management challenges for VBA. Also, because VA must report erroneous and improper payments on four of its major programs<sup>4</sup> in its annual budget submissions and the performance and accountability report beginning in 2004, we believe VA needs to be more aggressive in identifying and eliminating erroneous and improper payments.

<sup>2</sup>The Office of Management and Budget defines erroneous payments as payments made that should not have been made or were made for incorrect amounts (including payments that do not necessarily involve cash disbursements).

<sup>3</sup>The Improper Payments Information Act of 2002 defines improper payments as any payment that should not have been made or that were made in incorrect amounts (including overpayments and underpayments).

<sup>4</sup>The four programs are Compensation, Dependency and Indemnity Compensation, Pension, and Insurance.

## VA PROGRAM RESPONSE

VBA continues to improve the quality, timeliness, and consistency of claims processing decisions:

	As of 9/30/2002	As of 9/30/2003
Completed rating actions	797,000	872,194
Rating claims pending	345,516	253,597
% claims pending >180 days	35.3%	18.5%
% of rating accuracy	81%	85.3%
% of authorization accuracy	80%	87%

Area directors also perform periodic site visits of regional offices to assess whether field station directors have developed an effective internal control process within regional offices. In addition, VBA has incorporated performance standards into regional office (RO) directors' performance plans to specifically address the concerns above. Each director is responsible for ensuring that program integrity initiatives and policies are implemented, assessed through an effective internal control process, and adjusted as necessary to achieve appropriate results for these areas:

- IT systems access and command authorities
- Proper storage of veteran-employee claims folders
- Security log reviews
- Access to sensitive files
- Third signature reviews for large one-time or retroactive payments
- Information Security

Senior VBA managers continue to review all one-time or "special" retroactive payments in excess of \$25,000. The Office of Performance Analysis and Integrity monitors and reports to RO managers on this process to ensure accuracy and timeliness. RO division managers use this information for training to preclude future errors.

VA acknowledges that additional progress needs to be made.

However, it is VBA's policy to hold managers responsible for the quality and timeliness of program performance, increasing productivity, controlling costs, and mitigating adverse aspects of agency operations.

### 2A. OIG ISSUE - COMPENSATION AND PENSION (C&P) TIMELINESS

VA reported its claims processing backlog peaked at about 601,000 outstanding claims. As of June 2003, VBA reports 418,000 total C&P claims pending, including 279,600 requiring rating action. C&P rating actions that once averaged 233.5 days currently average 195.4 days. VA credits these improvements to the reforms recommended by the Secretary's Claims Processing Task Force, which was charged with identifying ways to expedite claims and deliver benefits to veterans more timely. In October 2001, the Task Force recommended measures to increase the efficiency and productivity of VBA operations, shrink the backlog of claims, reduce the time it takes to decide a claim, and improve the accuracy of decisions. The Task Force made 34 recommendations (20 short-term and 14 medium-term), and VBA defined 63 actions to accomplish the 34 recommendations. CAP reviews performed at VA regional offices (VAROs) since 2001 found that C&P claims processing failed to achieve prescribed timeliness goals at 13 facilities. VBA needs to address recommendations

made in the CAP reviews and fully implement the Task Force recommendations.

### VA'S PROGRAM RESPONSE

Since the Claims Processing Task Force Report was released to the VA Secretary in October 2001, significant improvement has been shown in the area of claims processing timeliness. The backlog of the total number of claims and claims pending over 6 months continues to diminish as VBA continues to implement each of the 34 recommendations outlined in the report.

VBA recognizes that continued improvement in the area of claims processing needs to be shown. All offices have been operating under the new Specialized Claims Processing Teams since September 30, 2002. The new claims processing model has already significantly improved claims processing through uniformity in decision-making, specialization, and standardization in regional office organization structure, and VBA believes the improvements will continue. VBA has completed all recommendations with the exception of four that the Secretary determined needed no further action.

### 2B. OIG ISSUE - COMPENSATION AND PENSION PROGRAM'S INTERNAL CONTROLS

In 1999, the former Under Secretary for Benefits asked OIG for assistance

to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. In June 1999, we issued a vulnerability assessment on the management implications of employee thefts from the C&P system. We identified 18 internal control vulnerabilities.

Our July 2000 report, *Audit of the C&P Program's Internal Controls at VARO St. Petersburg, FL* (Report No. 99-00169-97), confirmed that 16 of the 18 categories of vulnerability reported in our 1999 vulnerability assessment were present at VA's largest VARO. We made 15 recommendations for improvement. As of June 2003, 5 of the 15 recommendations were unimplemented, including controlling adjudication of employee claims, use of a third-person authorization control in the Benefits Delivery Network, and verification of continued entitlement of certain beneficiaries.

In February 2002, we issued our report, *Follow Up Evaluation of the Causes of C&P Overpayments* (Report Number 01-00263-53). Our recommendation to reduce C&P benefit overpayments by revising processing procedures and clarifying VA policy has not been resolved or implemented. VBA should implement procedures to suspend benefits when bad addresses cannot be resolved.

#### **VA'S PROGRAM RESPONSE**

VBA has placed an increased emphasis on oversight and accountability through program reviews that are used to highlight best practices and correct out-of-line situations. The results are shared with all regional offices to improve operations. In addition, the Network Support Centers continue to perform annual information security reviews of all regional offices. VBA established an information security position at each

regional office to monitor system access and establish safeguards to protect veterans' information and privacy. These mechanisms have increased the level of accountability while providing an increased focus on internal controls and program integrity.

VBA has made good progress in addressing the St. Petersburg audit findings. Nineteen of the 26 action items contained in the 15 recommendations identified in the St. Petersburg audit (10 of the 15 recommendations) have been closed by the OIG. Most of the outstanding recommendations are contingent upon full deployment of VBA's Modern Award Processing (MAP) system scheduled for completion by the fourth quarter of 2004. However, many interim measures have been taken to mitigate the vulnerabilities until the permanent system fix is implemented.

While one recommendation from the C&P overpayments audit remains open, VBA is pursuing a nationwide address locator service available to all regional offices to obtain better addresses for beneficiaries that will resolve this outstanding issue. Once in place, we will finalize procedures for managing non-essential returned mail including, as the final step, suspending benefits if a better address cannot be found. We anticipate having these procedures in place by the end of 2003.

#### **2C. OIG ISSUE - BENEFIT OVERPAYMENTS DUE TO UNREPORTED BENEFICIARY INCOME**

Our November 2000 report, *Audit of VBA's Income Verification Match Results* (Report No. 99-00054-1), found that VA's beneficiary income verification process with the Internal Revenue Service resulted in a large

number of unresolved cases. We estimated potential overpayments of \$773 million associated with benefit claims that contained fraud indicators such as fictitious Social Security Numbers (SSNs) or inaccuracies in key data elements. We also estimated an additional \$33 million in potential overpayments was related to inappropriate waiver decisions, failure to establish accounts receivable, and other processing shortcomings. VBA has implemented seven of the eight report recommendations. The recommendation to complete data validation to reduce the number of unmatched records with the Social Security Administration remains unimplemented. This was a repeat recommendation from a 1990 OIG report.

#### **VA'S PROGRAM RESPONSE**

The one remaining unimplemented recommendation from Report No. 99-0054-1 pertains to the SSN Verification Project described in M21-1, part IV, chapter 31, subchapter VIII. After reviewing and analyzing data, VBA was able to modify the process to ensure better output and matching results. VA has resumed the SSN Verification Project, and a change to M21-1, part IV, chapter 31, subchapter VIII is in process that will revise procedures for working the SSN verification lists.

Based on a sample run in April 2003, VA expects around 23,000 line items per month for at least the first 4 months. After the initial 4 months, the numbers should decline but it is difficult to predict the rate of reductions. Regional offices are required to annotate the SSN verification lists as they work them and retain a copy of the annotated list for 2 years from the date of the list. These lists will be available for review during site visits by C&P Service staff.

## **2D. OIG ISSUE - OVERPAYMENTS INVOLVING UNREIMBURSED MEDICAL EXPENSE CLAIMS**

At the request of the former Under Secretary for Benefits, OIG conducted an audit of VBA's benefit payments to beneficiaries receiving increased benefits because of unreimbursed medical expense (UME) claims. In September 2002, we issued our report, *Audit of VBA Payments Involving Unreimbursed Medical Expense Claims* (Report No. 00-0061-169). We found that some beneficiaries were submitting unsupported or fraudulent UME claims and identified beneficiary overpayments of \$125 million and underpayments of \$20 million annually.

These improper payments occurred because VAROs were not effectively managing the processing of UME claims. VBA needs to enhance verification of UME claims and ensure that claims greater than \$15,000 are verified. VBA reports it has implemented procedures to verify claims greater than \$15,000 and other recommendations.

Following discussions with VBA and after further review, we believe that a fair representation of the projected annual overpayments associated with claims processing error would be \$43.8 million. The VBA estimate of \$8.4 million is wholly inconsistent with the claims processing error results and does not consider at all the additional erroneous payments associated with beneficiary fraud.

### **VA'S PROGRAM RESPONSE**

After collaborating with the OIG on the seven recommendations, VBA resolved the vulnerabilities and the IG closed the *Audit of VBA Payments Involving Unreimbursed Medical Expense Claims* on July 9, 2003 (10

months from the date of the final report). We appreciate the OIG's efforts identifying improper payments and feel that program management is more effective as a result of this audit.

However, after reviewing some of the OIG findings, there is a significant difference between VBA's estimated annual cost avoidance of \$8,415,152 and the OIG's estimate in the final report. It is particularly important to resolve this issue as we aggressively pursue quantifying erroneous and improper payments in accordance with the 2002 Improper Payment Act.

## **2E. OIG ISSUE - FUGITIVE FELON PROGRAM**

The Veterans Education and Benefits Expansion Act of 2001 prohibits veterans who are fugitive felons, or their dependents, from receiving specified veterans' benefits. OIG has established a program to identify VA benefits recipients and employees who are fugitives from justice. The program involves computerized matches between fugitive felon files of law enforcement organizations and VA records. Once a veteran or employee is identified as a fugitive, information on the individual is provided to the law enforcement organization responsible for serving the warrant. Information is also provided to VA so that benefits may be suspended and overpayments may be recovered. In light of VBA's current claims processing work, we believe that adding the workload that this Act generates presents a major challenge for VA.

To date, OIG has completed agreements with the U.S. Marshals Service, the States of California and New York, and the National Crime Information Center. We have already identified more than 11,000 potential fugitive beneficiaries and employees.

OIG anticipates that 1–2 percent of all fugitive felony warrants submitted will involve VA beneficiaries; savings are projected to exceed approximately \$209 million.

### **VA'S Program Response**

VBA began collaborating with the OIG in March 2002 to develop a plan addressing the Veterans Education and Benefits Expansion Act of 2001, P.L. 107-103. Based on information and guidance provided by the OIG, VBA has devised internal procedures that will both comply with the law and provide accurate information on suspended benefits with as limited an impact on regional offices as possible.

VBA is implementing these procedures. C&P established and issued guidance to field personnel including a standard "due process" letter to veterans in a fugitive felon status. Guidance and field procedures for Vocational Rehabilitation & Employment and Education are currently being developed. The credit underwriting guidelines for VA-guaranteed loans require loan applicants to disclose employment, residence, and credit information. The underwriting process provides for public records searches by credit bureaus that provide credit information. We believe that VA's credit underwriting process effectively excludes fugitive felons from obtaining loan guaranty benefits, except for the possibility of such individuals seeking benefits under an assumed identity.

In May 2003, VBA received 1,000 warrants from the OIG, originating from California and the U.S. Marshals Service. The warrants were sorted and sent to the appropriate regional offices. Of the 1,000, about 20 percent have been adjusted and the rest are pending final

action. We will send additional warrants out to regional offices when we receive them from OIG. VBA staff continues to meet with OIG to discuss and refine the process, and we rely on their expertise with law enforcement to achieve the most accurate actions necessary.

## **2F. OIG ISSUE – INCARCERATED VETERANS**

In February 1999, OIG published a report titled *Evaluation of Benefit Payments to Incarcerated Veterans* (Report No. 9R3-B01-031). The review found that VBA officials did not implement a systematic approach to identify incarcerated veterans and adjust their benefits as required by Public Law 96-385. The evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in 6 states. Projecting the sample results nationwide, we estimated that about 13,700 incarcerated veterans had been, or will be, overpaid about \$100 million.

VBA has implemented the recommendations in the report. VBA reached an agreement with the Social Security Administration (SSA) to use the State Verification and Exchange System (SVES) to identify claimants incarcerated in State and local facilities. VBA is now processing both a Bureau of Prisons match and SSA prison match cases on a monthly basis. By September 6, 2002, over 18,500 veterans were identified who received VA benefits and were potentially incarcerated. Additional potentially incarcerated veterans are being identified at the rate of 700-800 monthly. However, at this time, VBA does not have procedures in place to track the disposition of these cases and quantify the results of the matching program. VA should set up a database for tracking

the total dollar value of incarcerated overpayments, which VA is required to report annually with other erroneous payments.

## **VA'S PROGRAM RESPONSE**

Over the past year, VA has focused many resources on identifying incarcerated beneficiaries and, when appropriate, adjusted their compensation and pension benefits as provided by 38 U.S.C. § 5313 and 38 U.S.C. § 1505. In June 2002, VA started a computer match with SSA through which one-fourth of the entire VA Compensation and Pension file is run against SSA's prisoner database each month. The initial 4 monthly runs each produced over 4,000 matches. Subsequent monthly matches have each produced approximately 800 matches. Since the start of the prison match with SSA, nearly 30,000 matches have been generated. VBA is currently tracking a sample of just under 20 percent of the 700-800 monthly SSA prison match cases. It is VBA's opinion that tracking 100 percent of these cases would not be cost beneficial.

In addition to the computer match with SSA, which primarily identifies individuals in the custody of state and local authorities, VA continues to conduct a computer match program with the Federal Bureau of Prisons. Monthly runs average 30 to 40 matches.

Before VA can reduce a beneficiary's award, it must establish that the beneficiary was incarcerated for conviction of a crime. Many of the beneficiaries identified on the SSA prison match have not yet been convicted of a crime or were determined incompetent to stand trial and are confined in mental health facilities. If the beneficiary receives disability compensation or Dependency and

Indemnity Compensation, VA must establish that the beneficiary was convicted of a felony. Finally, VA must establish that the individual has been incarcerated for at least 61 consecutive days after conviction.

In regard to the reporting requirements for erroneous payments, VBA has been working diligently with OMB and the Department to comply with the Improper Payment Act of 2002. A database is being developed that will maintain annual improper payment rates on Compensation, DIC, and pension benefits.

## **OIG3. PROCUREMENT**

VA faces major challenges in implementing a more efficient, effective, and coordinated acquisition program. The Department spends about \$6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction, and services. High-level management support and oversight are needed to ensure VA leverages its full buying power, maximizes the benefits of competition, and improves contract administration.

In May 2002, the VA Secretary's Procurement Reform Task Force recommended improvements to better leverage VA's substantial purchasing power and to improve the overall effectiveness of procurement operations. By June 2002, VA began implementing Task Force recommendations. For example, VHA issued a new policy on national standardization of supplies and equipment and has established 40 user groups with responsibilities for evaluating 80 classes of supply commodities for potential standardization.

OIG reviews continue to identify problems with Federal Supply

Schedule (FSS)<sup>5</sup> contracts and blanket purchase agreements (BPAs)<sup>6</sup>, along with procurements for health care items, scarce medical services, and construction. We also continue to identify weaknesses in the management of purchase cards and problems with inventory management, as discussed below.

### **3A. OIG ISSUE - FEDERAL SUPPLY SCHEDULE (FSS) CONTRACTS**

OIG is currently conducting a national audit to evaluate the effectiveness of VA medical supply procurement practices. Preliminary results show that VAMC purchasers often paid higher prices than necessary because they did not make purchases from VA national or FSS contracts or because they established duplicative, expensive local contracts. Furthermore, we found that some existing VA national and FSS contracts did not cover products purchased, so that facilities paid a wide range of prices for the same products. Many products have potential for greater standardization, and using national contracts could better leverage the Department's buying power, yielding significant cost savings.

#### **VA'S PROGRAM RESPONSE**

The VHA Clinical Logistics Office is the lead office for the implementation of the National Item File at field facilities. Implementation will begin during October 2003. This initiative will standardize nomenclature so that supplies can be consistently tracked with nationally accepted descriptions. Secondly, under the purview of the

VHA Acquisition Board, the Acquisition Planning Workgroup is developing a 5-year National Acquisition Plan. This plan will provide a basis for identifying requirements at the local level that represent opportunities for standardization and national contracts. Finally, the VHA Clinical Logistics Office recently hired a Director of Standardization to expand this nationwide effort. The standardization process has been reengineered into 14 product lines and 39 user groups that include a VISN Chief Medical Officer as the Chair. All groups have been issued charters and timelines for completion of the nationally identified Top 50 items. Web-based applications are under development to accelerate the expansion of the program. As the program matures, measures are being implemented to track compliance at the local level and accelerate the program efforts.

The VA Office of Acquisition and Materiel Management (OA&MM) National Acquisition Center continues to encourage potential offerors and current contractors to offer their complete product line for the FSS and national contracts. OA&MM also continues to work with VHA in identifying items for standardization.

### **3B. OIG ISSUE - CONTRACTING FOR HEALTH CARE SERVICES**

OIG reviews have identified conflicts of interest in the request for approval of contracts, preparation of solicitations, contract negotiations, and contract administration efforts. Also, we

continue to see that legal, technical, and pre-award price reasonableness reviews are not always performed on non-competitive contract awards. Some contracts and solicitations do not contain terms and conditions that adequately protect the Department's interests. Lastly, we have found instances where VA has allowed the affiliated medical schools to dictate the terms and conditions of contracts, including the services to be provided.

#### **VA'S PROGRAM RESPONSE**

For nearly a year, VHA has been in the process of drafting new health care procurement policy under 8153 sharing authority. During this time, we have been building consensus among all interested parties on methods to improve our justification of a fair and reasonable price, compliance with existing VA conflict of interest policy, and appropriate quality assurance and performance monitoring. Some of the interested parties include the Center for Medicare and Medicaid Services, the American Academy of Medical Colleges, and the Counsel of Teaching Hospitals. This policy has been sent to the Department for concurrence.

OA&MM will continue to educate and disseminate to the field information regarding VA's Federal Supply Schedule Program for Professional and Allied Health Care Services.

### **3C. OIG ISSUE - GOVERNMENT PURCHASE CARD ACTIVITIES**

OIG reviews identified systemic management weaknesses in the oversight

<sup>5</sup>General Services Administration (GSA) provides Federal agencies with a simplified process for obtaining commonly used commercial supplies and services at prices associated with volume buying. GSA issues Federal Supply Schedules containing the information necessary for placing delivery orders with schedule contractors. GSA has delegated authority to VA to award and administer schedules for pharmaceuticals and medical/surgical supplies and equipment.

<sup>6</sup>BPAs are a simplified method of filling anticipated repetitive needs for services and supplies. Contractual terms and conditions are contained in a GSA Schedule contract and do not need to be re-negotiated for each use.

and use of Government purchase cards. We found instances of wasteful spending (buying without regard to need or price), purchases that exceeded the cardholder's authority, and purchases that were inappropriately split to avoid competition requirements. Some cardholders did not use existing contracts, which has resulted in paying higher prices for the same items.

VA management controls over purchase card transactions need to be strengthened so that VA buying power is leveraged to the maximum extent possible and discounts are not lost. Increased visibility and oversight over procurements are needed to ensure price reasonableness so

that VA procurement needs are met effectively and economically.

**VA'S PROGRAM RESPONSE**

The Office of Management, in partnership with the VA administrations and OIG, has taken many steps to improve oversight and use of purchase cards in the Department. VA and administration-level policies and procedures have been disseminated to clearly identify responsibilities, recurring controls, restrictions and sanctions. Management controls and oversight are continuously emphasized through mandatory training for purchase cardholders, liaisons, and approving officials. Controls such as restrictions on where cards can be used, what can be purchased, and

dollar limitations on single and cumulative purchases have been implemented with the purchase card-issuing bank. Price reasonableness and effective use of sources, including contracts that provide for maximum discounts and variety of providers, are emphasized. VA's Office of Management and OIG are also cooperating in a detection program to determine where purchase cards may have been improperly used. In addition, purchase card audits are being conducted at the field station level. Refresher training has been mandated for cardholders and approving officials at least every 2 years to ensure they are aware of all program requirements.

**3D. OIG ISSUE - INVENTORY MANAGEMENT**

Since 1999, we have issued six national audits of inventory management practices for various supply categories, identifying potential cost savings of about \$388.5 million. We noted potential savings (\$ in millions) could be achieved in the management of the following inventories.

• Medical Supply Inventories	\$ 75.6
• Prosthetic Supply Inventories	\$ 31.4
• Pharmaceutical Inventories	\$ 30.6
• Engineering Supply Inventories	\$168.4
• Miscellaneous Supply Inventories	\$ 53.7
• Consolidated Mail Outpatient Pharmacy (CMOP) Inventories	\$ 28.8
<b>Total</b>	<b><u>\$388.5</u></b>

For example, in May 2002, we issued *Audit of VA Consolidated Mail Outpatient Pharmacy Inventory Management* (Report No. 00-01088-97). We reviewed seven CMOP operations and found that they could significantly reduce their pharmaceutical inventories. CMOPs maintained supplies on hand that exceeded the applicable benchmarks for 60 percent of their inventory items. We estimate that of the \$63.5 million in total inventory at the CMOPs reviewed, \$28.8 million (45 percent) exceeded current operating needs.

Recommendations included eliminating excess inventories, improving inventory management, and developing criteria for adding new items to product lines. Recent CAP reviews continue to find VA has funds tied up in excess inventories. VA needs to develop and implement an effective method to control inventories and free up funds for other uses.

**VA'S PROGRAM RESPONSE**

The VA Office of Management established performance monitors for medical center inventory manage-

ment shortly after the audits. Medical centers are required to report data quarterly and compile information into a "report card," with indices displayed in red, yellow, and green -- depending on the level of compliance. Collection and monitoring of this data is now conducted by the VHA Clinical Logistics Office and regularly reported to the VHA Acquisition Board and to the Deputy Secretary at the Monthly Performance Review. In addition, OA&MM assisted the VHA Logistics Office in writing VHA Directive and Handbook 1761.2, VHA

Inventory Management. OA&MM also includes inventory management training at its training events that are presented to over 500 participants per year. In addition to the OIG CAP reviews, the Office of Acquisition and Materiel Management (OA&MM) also reviews inventory management during business site reviews at more than 30 medical centers annually. On-site training is provided when out-of-line situations are discovered.

We plan several initiatives in 2004 to improve CMOP management. VHA, in partnership with OA&MM, is developing a Generic Inventory Package training program for all new hands-on users, which is scheduled to begin during the second quarter of 2004. Policy and procedures on the management of infrequently used medical and surgical supplies that must be kept on hand for management of life-threatening emergencies are being developed. The VHA Clinical Logistics Office has also been identified as being responsible for the implementation and maintenance of the National Item File. This will facilitate better inventory management processes and provide compliance data for standardization monitoring. In 2005, we plan to develop inventory and standardization utilization reports that will facilitate cost reductions.

### **3E. OIG ISSUE - CONTROLS OVER THE FEE-BASIS PROGRAM**

We conducted an audit to determine if VHA had effective internal controls to ensure that payments for fee-basis treatment were appropriate. Fee-basis treatment is inpatient care, outpatient care, or home health care provided by non-VA health care providers at VA expense. In June 1997, the *Audit of Internal Controls*

*over the Fee-Basis Program* (Report No. 7R3-A05-099) concluded VHA could reduce fee-basis home health care expenditures by at least \$1.8 million annually and improve cost effectiveness by establishing contracting guidelines for such services and providing contracting officers with benchmark rates to determine the reasonableness of charges. VHA has not implemented two of seven recommendations.

### **VA'S PROGRAM RESPONSE**

VHA devised a new strategy to provide needed policy direction on reimbursement for skilled home care, homemaker/home health aide, and hospice services. VHA's Business Office and VA's General Counsel are currently exploring reimbursement policy based upon payments made by the Centers for Medicare and Medicaid Services (CMS) for similar care.

### **OIG4. FINANCIAL MANAGEMENT**

Since 1999, VA has achieved unqualified audit opinions on its Consolidated Financial Statements. The Department has made improvements in the areas of: (i) reliance on independent specialists, (ii) management of legal representations, and (iii) management ownership of financial data. However, material weaknesses continue, and corrective actions to address non-compliance with financial system requirements are expected to take several years to complete. VA needs to establish an integrated financial management system.

Over the last few years, OIG reported that VHA needs to: (i) strengthen procedures and controls for means testing, billings, and collections; (ii) reduce the rate of coding and billing

errors; (iii) decrease the time it takes to bill for services; and (iv) improve medical record documentation for billing purposes. In addition, VA reported last year that VHA's Revenue Office believes that significant amounts of revenue have yet to be collected. While VA has addressed many of the concerns we reported over the last few years, our most recent audits continue to identify major challenges where VHA could improve debt management, financial reporting, and data validity.

### **4A. OIG ISSUE - FINANCIAL MANAGEMENT AND REPORTING**

VA program, financial management, and audit staffs perform certain manual compilations and labor-intensive processes in order to attain auditable Consolidated Financial Statements. These manual compilations and processes should be automated and performed by VA's financial management system. In the meantime, we consider the risk of materially misstating financial information as high.

Last year, VA responded that the new CoreFLS<sup>7</sup> would resolve many OIG concerns. A November 2002 CoreFLS document, "*Resolving OIG Concerns*," noted CoreFLS alone may not be a remedy and that some issues are clearly outside the scope of this system. As an example, gaps in VA's Standard General Ledger compliance may continue to be observed in some feeder systems that are not being replaced by CoreFLS. Thus, if VBA continues operating a separate General Ledger, VA's Standard General Ledger compliance will need to be reassessed annually. In addition, CoreFLS gains will not be evident until full system implementation, now scheduled for 2006.

<sup>7</sup>Core Financial and Logistics System - An integrated commercial "off-the-shelf" financial and logistics software system.

### **VA'S PROGRAM RESPONSE**

VA's Core Financial and Logistics System will address many of the issues identified by the OIG. Implementation is on schedule. VA continues to move forward with additional improvements in financial management and reporting. Due to the size and complexity of VA's financial systems, changes require significant resources and time to implement. In support of the President's Management Agenda, VA submitted the audited Consolidated Financial Statements for 2002, 2 months earlier than the previous year and is planning to complete the 2003 financial audit statements by November 11, 2003. VA will achieve these improvements through changes and enhancements to financial management systems and reporting, incorporating best practices in estimation methodologies, early month-end closes, and continued refinement to existing systems and interfaces.

### **4B. OIG ISSUE – DEBT MANAGEMENT**

Our March 1999 report, *Evaluation of VHA's Income Verification Match Program* (Report No. 9R1-G01-054), found that VHA could increase opportunities to enhance Medical Care Collection Fund (MCCF) collections. This 1999 audit found the recommendations made in a 1996 OIG report on VHA's income verification match program were not fully implemented. Furthermore, VHA has not implemented 3 of the 13 recommendations made in the 1999 report.

In our February 2002 report, *Audit of the Medical Care Collection Fund Program* (Report No. 01-00046-65), we found that VHA could enhance MCCF collections by requiring VISN and VA medical facility directors to better manage MCCF program activities. We made recommendations to

improve medical record documentation, establish performance standards, and monitor results. We recognize that progress has been made, but VHA has not fully implemented these recommendations. Opportunities exist to ensure aggressive follow-up on unpaid bills and appeals of denied insurance claims that would increase future collections. We recommend that VHA continue to pursue improvements aggressively.

### **VA'S PROGRAM RESPONSE**

Three recommendations are pending from the *Evaluation of VHA's Income Verification Match Program*, as of September 2003. The Income Verification Match (IVM) process was successfully restarted in March 2003 when VA facilities initiated billing of converted cases. Billing activity reports were completed and shared with facilities in September 2003. Software enhancements to automatically bill all pending cases on the 61st day after referral will be installed by November 2003. Multi-year income verification processing will begin in October 2003 when VA's Health Eligibility Center (HEC) begins processing 2002 income year cases.

OIG has agreed to a revised financial assessment process based on the IVM Program to meet the intent of the Centralized Means Test Program. Full implementation of the revised financial assessment process based upon the IVM Program is dependent upon substantial modification to VHA's information system and will be implemented with 12 to 18 months.

Actions have been taken to close the remaining two recommendations from the *Audit of the Medical Care Collection Fund* report. On July 8, 2003, a memorandum issued to VISN directors implemented the

Compliance and Business Integrity Program's Supporting Indicators. These indicators monitor the accuracy of medical record coding and medical care billing. In addition, in 2003, the Chief Business Officer implemented industry-based performance metrics and reporting capabilities to identify and compare overall VA revenue performance. These metrics and associated performance targets were incorporated in VISN and medical center directors' performance contracts for 2003. As analysis of these enhancements and metrics occur, they will be refined and expanded over time as appropriate. VHA is piloting centralized coding pools in two VISNs to improve coding accuracy, and developing point-of-care coding at outpatient clinics and a charge description master that will eliminate the review and coding of non-billable events. In September 2003, to ensure follow-up with insurance carriers on delinquent receivables, VHA, with the Financial Quality Assurance Service, will be completing a review of outstanding third-party receivables and preparing a plan to reduce the receivable amounts.

### **4C. OIG ISSUE – DATA VALIDITY**

The Government Performance and Results Act (GPRA) requires agencies to develop measurable performance goals and report results against those goals. Successful implementation requires that information be accurate and complete. VA has made progress in implementing GPRA, but additional improvement is needed to ensure that stakeholders have useful and accurate performance data. In 1998, we initiated a series of audits assessing the quality of data used to compute the Department's key performance measures. In the eight

audits so far, we validated the underlying data in only two of the nine key measures reviewed. While VA has corrected the deficiencies cited in our reports involving the 7 measures that had validity problems, we are concerned that the remaining 17 performance measures identified in the 2002 performance and accountability report that have not been reviewed may have similar problems. Until the remaining 17 measures are reviewed, this issue will remain a major management challenge. VA should do a thorough review of the remaining measures and provide us assurance that data validity problems do not exist or have been corrected.

#### **VA'S PROGRAM RESPONSE**

Efforts are ongoing across VA to improve accuracy and validity of data. VHA has taken corrective action where necessary, to ensure that the validity of all data elements is adequate. The new Office of Performance Analysis and Integrity, established in 2003, consolidates data quality functions for all of VBA. This office will conduct data analyses to improve the value and quality of data VBA collects. VBA also created a Data Warehouse and Operational Data Store, which will facilitate the ability to have reliable, timely, accurate, and integrated data across the organization.

#### **OIG5. INFORMATION MANAGEMENT**

VA faces significant challenges addressing federal information security program requirements and establishing a comprehensive, integrated VA security program. Information security is critical to the confidentiality, integrity, and availability of VA data, and to protect the assets required to support health care and benefits delivery. Lack of management oversight contributes

to inefficient practices and weaknesses in electronic information and physical security. We continue to identify serious Department-wide vulnerabilities.

#### **5A. OIG ISSUE - INFORMATION SECURITY**

In our December 2002 report, *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 01-02719-27), we concluded VA had not effectively implemented a number of information security remediation efforts and had not ensured compliance with established policies, procedures, and guidelines. As a result, VA is at risk of attacks on, or disruption of, mission-critical systems, unauthorized access to financial and Privacy Act data, and fraudulent payment of benefits. In our 2003 work, we have found that many information system security vulnerabilities reported in our 2001 and 2002 national audits are unresolved, and we have identified additional vulnerabilities. VA needs to devote sufficient resources to ensure effective security management, oversight, and protection of critical Department operations.

CAP reviews from October 2002 through March 2003 continued to identify security weaknesses at all 11 VAMCs where we reviewed information security management. We made recommendations to improve contingency planning, background checks, systems certification, and other internal controls. VA has not implemented all planned security measures and has not ensured compliance with established security policies, procedures, and controls requirements.

#### **VA'S PROGRAM RESPONSE**

The Office of Cyber and Information Security and OIG have identified the lack of role-based training for

Information Security Officers as the primary cause for continual recurrence of previously identified security deficiencies at facilities. To improve this situation, a Cyber Security Practitioner Professionalization Program has been established to ensure that VA personnel have access to adequate training in areas of IT security. VA employees who meet stringent qualifications through combinations of training, testing, and experience will be credentialed. Pertinent information will be maintained on individual cyber security practitioner certification status and periodically re-evaluated.

As an additional control, the Office of Cyber and Information Security has committed to establishing an independent compliance capability to better ensure that established policies and procedures are effectively implemented as well as tested, through the newly created Review and Inspection Division (RID). RID staff has been providing security management assistance and will conduct independent testing and verification of implemented security practices.

#### **5B. OIG ISSUE - MEDICAL RECORD PRIVACY AND SECURITY**

A December 2002 review evaluated VAMC compliance with VA's medical record privacy policies and security practices. The report, *Healthcare Inspection - Evaluation of VHA Medical Record Security and Privacy Practices* (Report No. 01-01968-41), made recommendations—two of seven are not yet implemented—to secure patient information and improve internal controls.

#### **VA'S PROGRAM RESPONSE**

VA Directive and Handbook 6500 address these issues in addition to

the Office of Cyber Security Review and Inspection Division site assessments. A revision of VHA M1, part 1, chapter 5, Medical Records, is in final concurrence and will provide guidance on locked containers or shredders in employee work areas. All VA employees completed privacy training by April 2003 and all new VA employ-

ees must complete the Web-based training within 30 days of employment. The Office of Cyber Security has instituted a Web-based privacy reporting mechanism, Privacy Violation Tracking System, for use throughout VA to document potential privacy complaints and violations received or observed by VA/VHA

Privacy Officers. It also provides statistical data for national oversight of VA's privacy program. A directive and handbook on VA's cyber security program is in the concurrence process, as well as interim guidance for VA Information Security Officers. The Cyber Security Practitioner Training Program has been implemented.

## Major Management Challenges

### Identified By The General Accounting Office (GAO)

In January 2003, GAO issued its special series of reports entitled the *Performance and Accountability Series: Major Management Challenges and Program Risks*, (GAO-03-110). One of the reports described major management challenges and high-risk areas facing the Department of Veterans Affairs. The following is excerpted from the report in which GAO discusses the actions that VA has taken and that are underway to address the challenges GAO identified in its Performance and Accountability Series 2 years ago, and major events that have significantly influenced the environment in which the Department carries out its mission. The report on VA can be viewed in its entirety at the GAO Web site: <http://www.gao.gov/cgi-bin/getrpt?GAO-03-110>.

#### **GAO1. ENSURE ACCESS TO QUALITY HEALTH CARE**

Although VA has opened hundreds of outpatient clinics, waiting times are still a significant problem. To help

address this, VA has taken several actions including the introduction of an automated system to schedule appointments. Over the past several years, VA has done much to ensure that veterans have greater access to care and that the care they receive is appropriate and of high quality. Yet VA remains challenged to ensure that veterans receive the care they need, when they need it -- a challenge that has become even greater with the recent expansion of benefits.

VA must also better position itself to meet the changing needs of an aging veteran population by improving nursing home inspections and increasing access to non-institutional long-term care services. In fiscal year 2001, VA spent 92 percent of its long-term care dollars in institutional settings, such as nursing homes -- the costliest long-term care setting. However, VA's oversight of community nursing homes -- where about 4,000 veterans received care each day in fiscal year 2001 -- as not been adequate to ensure acceptable quality of care. While VA has begun to implement certain policies to improve oversight of these homes, as GAO recommended in July 2001, VA has yet to develop a uniform oversight policy for all community nurs-

ing homes under VA contract. Further, VA plans to rely increasingly on the results of state inspections of community nursing homes rather than conducting its own inspections, but it has not developed plans for systematically reviewing the quality of state inspections.

#### **VA'S PROGRAM RESPONSE**

In June 2002, VHA published a comprehensive policy on oversight of community nursing homes (CNH), implementing long-standing OIG recommendations in this area. This policy will provide national standards for annual reviews of CNHs and monthly visits by VA staff to patients in those homes. In 2002, VA established national community-based outpatient clinic (CBOC) planning criteria and standards to ensure that clinics are located in areas with greatest needs and that veterans receive the same minimum set of services and standard of care system-wide. During 2002, VA also launched a long-term strategic planning process called CARES. CARES, an acronym for Capital Asset Realignment for Enhanced Services, is designed to streamline the system's capital assets to meet the changing health care needs and demographics of America's veterans.

Future need for CBOCs to improve access will be identified through the CARES process. In 2002, all VISNs achieved full Network-wide implementation of 24/7 telephone access.

By the end of 2003, a State Veterans Home (SVH) handbook on patient safety will be issued, and training materials will follow. Points of contact have been identified at VHA facilities and the VA Central Office (VACO) Geriatrics and Extended Care (G & E) office. Electronic reporting of inspection findings and payment claims has been established. Ongoing communication forums between SVH officials, VHA facilities, and VACO G & E staff have been established. Training focused on patient safety in SVHs is ongoing. A pilot project to electronically transmit quality data from the Resident Assessment Instrument/Minimum Data Set on SVH patients is currently underway. Interpretive guidelines for the nursing home program are currently under revision and will continue to be reviewed to ensure they remain up to date. Regulations regarding SVH Day Health Care have been issued, and associated interpretive guidelines are being developed. Training on clinical privileging is planned for early 2004.

**Hepatitis C** - Since 1999, VA included a total of \$700 million in its budgets submitted to the Congress to screen, test, and provide veterans who test positive for hepatitis C with a recommended course of treatment. In June 2001, GAO testified that VA missed opportunities to screen as many as 3 million veterans who visited medical facilities during fiscal years 1999 and 2000, potentially leaving as many as 200,000 veterans unaware that they have hepatitis C. In response to our testimony, VA has begun to improve screening and test-

ing procedures. In 2002, VA established a process to monitor screening and testing performance. In addition to monitoring VA's progress in screening and testing veterans for hepatitis C, GAO is assessing its efforts to notify veterans who test positive and to evaluate veterans' medical conditions regarding potential treatment options.

### **VA'S PROGRAM RESPONSE**

The External Peer Review System collects data on evidence of systematic screening of veterans for hepatitis C through patient chart reviews. The results show steady improvement in rates of screening during every quarter. In the first quarter of 2003, over 93 percent of 8,000 charts that were reviewed contained evidence of screening for hepatitis C risk factors.

VA's efforts to enhance notification and evaluation of veterans who test positive for hepatitis C involve several strategies. An information letter from the Under Secretary for Health was circulated to all facilities in December 2002, outlining systems for ensuring that diagnostic testing is efficient and accurate and that clinicians are aware of positive test results promptly. A VA Hepatitis C Case Registry has been implemented that captures all veterans with positive hepatitis C antibody tests and related diagnostic codes and enables each site to identify and track the patients who need to be notified. A newly developed query tool for the Computerized Patient Record System (CPRS) allows clinicians to access a broad array of data in the electronic medical record. An application of the CPRS query tool will enable clinicians to search for abnormal test results such as positive hepatitis C tests. Systems such as My HealthVet are being developed to give patients better access to test results and other

information in the electronic medical record. Although there are significant concerns about relaying sensitive, personal medical information by mail or telephone, several VA sites are working on ways to notify patients without loss of confidentiality. Best practices will be identified and disseminated based on this work. Further data on timeliness of notification are being collected through the External Peer Review Program to guide future performance improvement activities.

## **GAO2. MANAGE RESOURCES AND WORKLOAD TO ENHANCE HEALTH CARE DELIVERY**

### **2A. CARES**

VA has begun to make more efficient use of its health care resources to serve its growing patient base. However, to meet the growing demand for care, VA must carry out its plan to realign its capital assets and acquire support services more efficiently. At the same time, VA needs to improve its process for allocating resources to its 21 health care networks to ensure more equitable funding. VA must also seek additional efficiencies with the Department of Defense (DoD), including more joint purchasing of drugs and medical supplies.

VA is one of many federal agencies facing challenges in managing problems with excess and underutilized real property, deteriorating facilities, and unreliable property data. In 1998, GAO reported that in the Chicago area alone, as much as \$20 million could be freed up annually if VA served area veterans with three instead of four hospitals. In response, in October 2000, VA established the Capital Asset Realignment for Enhanced Services (CARES) program,

which calls for assessments of veterans' health care needs and available service delivery options to meet those needs in each health care market—a geographic area with a high concentration of enrolled veterans. VA needs to build and sustain the momentum necessary to achieve efficiencies and effectively meet veterans' current and future needs. The challenge is to do this while mitigating the impact on staffing, communities, and other VA missions. Successfully completing this capital asset realignment will depend on VA's ability to strategically and expeditiously complete the implementation of CARES.

#### **VA'S PROGRAM RESPONSE**

See discussion under OIG Challenge, 1B on page 146.

#### **2B. ALTERNATIVE METHODS FOR PATIENT CARE SUPPORT SERVICES**

VA's transformation from an inpatient- to an outpatient-based health care system has significantly reduced the need for certain patient care support services such as food and laundry. In November 2000, GAO recommended that VA conduct studies at all of its food and laundry service locations to identify and implement the most cost-effective way to provide these services at each location. In August 2002, VA issued a directive establishing policy and responsibilities for its networks to follow in implementing a competitive sourcing analysis to compare the cost of contracting and the cost of in-house performance to determine who should do the work. VA needs to follow through on its commitment to ensure that the most cost-effective, quality service options are applied throughout its health care system and to conduct system wide feasibility assessments for consolidation and competitive sourcing.

#### **VA'S PROGRAM RESPONSE**

Since the GAO recommendation was made, VA has implemented an infrastructure and plan to take advantage of competitive sourcing opportunities. VA established the Competitive Sourcing and Management Analysis Service (CSMAS) to lead activities across VA. OMB approved VA's plan to study 55,000 FTE across 19 ancillary functions within VA, including food and laundry service. The CSMAS established a Web-based communication tool and a detailed competitive sourcing handbook and training course, and made various other tools available across VA. In mid-2003, VA's General Counsel (GC) opined that 38 U.S.C. 8110(a)(5) prohibited VA from doing cost comparisons with any personnel paid from VA's medical care accounts. In August 2003, after GC clarification of the ruling, all competitive sourcing studies in VHA were terminated. VA is now seeking remedies to the prohibition through either a separate appropriation or revision to title 38. In the meantime, VA is examining other alternatives that do not violate the prohibition of title 38 while potentially yielding cost savings that would be obtained if VHA was permitted to continue with competitive sourcing studies.

#### **2C. VETERANS' EQUITABLE RESOURCE ALLOCATION (VERA)**

In fiscal year 1997, VA began allocating most of its medical care appropriations under the Veterans Equitable Resource Allocation (VERA) system, which aims to provide VA networks comparable resources for comparable workloads. In response to recommendations GAO made in February 2002 regarding VERA's case-mix categories and Priority 7 workload, VA said that further study was needed to determine how and

whether to change VERA. VA announced in November 2002 that it plans to make changes to VERA for the 2003 fiscal year when VA's appropriation is finalized. Some of the planned changes, if implemented, could address recommendations GAO made. Delaying these improvements to VERA means that VA will continue to allocate funds in a manner that does not align workload and resources as well as it could.

#### **VA'S PROGRAM RESPONSE**

In 2003, VERA expanded from 3 to 10 price groups. There are six (1 through 6) Basic Care price groups and four (7 through 10) Complex Care price groups. This change is consistent with the recommendations in the 2002 GAO and RAND reports and improves the equity of resource allocation among networks. This change also modified the initial funding split between Basic Care and Complex Care to reflect the current base year cost experience rather than continuing to use the fixed 1995 cost split ratio.

Based on a careful assessment of all policy options, the Secretary decided to continue the past practice of excluding nonservice-connected Priority 7 Basic Care patients from the VERA allocation model for 2003. Although the inclusion of nonservice-connected Priority 7 veterans in the VERA Basic Care category would be a step toward better aligning the VERA allocation model with VA's actual enrollment experience, including these veterans in the VERA model would create financial incentives to seek out more of these veterans instead of those with service-connected disabilities, with incomes below the current income threshold, or with special needs (e.g., spinal cord injury) -- veterans who comprise VA's core health care mission.

## 2D. VA/DoD SHARING

In an effort to save federal health care dollars, VA and DoD have sought ways to work together to gain efficiencies. To ensure sharing occurs to the fullest extent possible, VA needs to continue to work with DoD to address remaining barriers, as GAO recommended in our 2000 report. It is particularly critical that VA take a long-term approach to improving the VA/DoD sharing database, which VA administers. Currently, VA and DoD do not collect data on the volume of services provided, the amount of reimbursements collected, and the costs avoided through the use of sharing agreements. 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.

### VA'S PROGRAM RESPONSE

Through the VA/DoD Executive Council structure, the Departments are institutionalizing sharing and collaboration through a joint strategic planning process. In April 2003, the VA/DoD Joint Executive Council approved a joint strategic plan to improve the quality, efficiency, and effectiveness of benefits and service delivery. Each of the six strategic goals is accompanied by performance expectations, measurements, and timelines. To monitor and facilitate implementation of high-priority joint projects, processes have been or are being established for capital asset planning, adoption of a national item (coding) file in logistics, conversion of Distribution and Pricing Agreements to VA Federal Supply Schedules, implementation of interoperable electronic health records, joint separation physicals and compensation and pension examinations, and expansion of joint Consolidated Mail Outpatient Pharmacies.

VHA's Medical Sharing Office and Office of Information are discussing how to collect data on the volume of services provided to DoD and how to integrate this data with reimbursements collected. The Office of Information is analyzing possible short- and long-term improvements to the VA/DoD database to capture the volume and types of service provided and tie these services to reimbursements collected. Recommendations for short-term improvements are expected in several months and will include modifications to existing software. Long-term improvements must be integrated into planned major changes that will modernize VA's current VISTA medical record system, and are at least 2 years away. To improve the timeliness and upgrade the current VA/DoD database, the Medical Sharing Office has dedicated an information technology specialist whose primary responsibility is managing the database.

The VHA Handbook, "*VA-DoD Health Care Resource Sharing*" (1660.1-section 7, "Reimbursements and Billing" - soon-to-be revised), requires an evaluation of costs in developing agreements with DoD. The Medical Sharing Office believes that requiring facilities to submit cost avoidance data would be unnecessarily burdensome for facilities and would act as a disincentive to developing agreements. Several years ago, DoD imposed a cost avoidance requirement and found that compliance was sporadic and that frequently the information provided was incomplete. DoD's requirement was eliminated after a short period.

As a small part of the VA/DoD Sharing initiative, requirements have been and will continue to be identified for joint contracting under the pharmaceutical and medical/surgical

arenas. The number of joint contracts, pending procurements, estimated award values, actual sales, and cost avoidance will continue to be reported periodically to the appropriate VHA office.

The VA/DoD Health Executive Council has made significant progress with deploying the Federal Health Information Exchange nationwide; implementing a new standardized national reimbursement rate structure for VA/DoD clinical sharing agreements; utilization of VA's Consolidated Mail Outpatient Pharmacies at three sites to provide refill prescriptions for DoD military treatment facilities; increased cooperation in facility and capital asset planning, including DoD representation in the CARES process; and VA's enhanced role as a direct sharing partner in TRICARE.

Similarly, the VA/DoD Benefits Executive Council is working on the Benefits Delivery at Discharge initiative that 1) assists separating service members in accessing their benefits by providing information, education, and claims assistance at the time of discharge; 2) includes a single physical examination that meets the requirements of both the military separation exam and the VA compensation and pension exam; and 3) is based on interoperable information systems to facilitate the exchange of information and expedite claims processing.

### 2E. THIRD-PARTY COLLECTIONS

VA's third-party collections increased in fiscal year 2001—reversing a trend of declining collections—and again in fiscal year 2002. However, over the past several years, GAO has reported on persistent collections process

weaknesses—such as lack of information on patient insurance, inadequate documentation of care, a shortage of qualified billing coders, and insufficient automation—that have diminished VA's collections. VA has taken several steps to improve its collections performance, including developing the *Veterans Health Administration Revenue Cycle Improvement Plan* in 2001, which aims to address its long-standing collections problems. More recently, in May 2002, VA created a Chief Business Office that is planning additional initiatives to improve collections. However, by the end of fiscal year 2002, VA was still working to implement proposed initiatives for resolving its long-standing collection problems. To ensure it maximizes its third-party collections, VA will need to be vigilant in implementing its plan and initiatives.

### **VA'S PROGRAM RESPONSE**

In 2003, VHA implemented performance measures for the revenue program including collections, gross days revenue outstanding, days to bill, and accounts receivable greater than 90 days. VISNs and medical centers are encouraged to utilize existing contracts to outsource Accounts Receivable follow-up. The electronic data interchange for insurance claims has expedited this process by reducing pay receipt times from health plans that accept electronic claims. Employee training programs on the core revenue business processes have been developed to increase awareness of the revenue process. By October 2003, a denial management capability at VISN and facility levels will require establishment of audit-appeal business processes and claims development quality controls. At the same time, we will be issuing policies related to mandated pre-certification, continued stay review, and

procedural authorization for all health-insured veterans consistent with payer requirements, as well as standardizing the utilization review procedures at every facility.

Planned for 2004 are projects to improve the medical care collection fund processes and include the development of an insurance lockbox for processing electronic transactions; implementation of software to quicken the electronic transmission of claims, allowing for faster payment and increased billing productivity; and the completion of a joint VA and Centers for Medicare/Medicaid Services project in November 2003. This joint project will enable VA to provide Medicare supplemental payers with Medicare deductible and coinsurance amounts used to determine reimbursements to VA for health care provided to veterans. The redesigned VHA enrollment database will be deployed during December 2003. It will help ensure that consistent and reliable demographic and eligibility data are shared across VHA. We are actively pursuing enhanced VHA/VBA data sharing with an initial focus on expanded access to veterans' service-connected disability rating information. An initiative that will automate the identification and verification of health insurance benefits is being implemented in September 2003.

Looking beyond 2004, VHA is planning to implement several software upgrades to add new functionality to the billing processes. For example, a Patient Financial Services System project will implement a commercial off-the-shelf health care billing and accounts software system that will replace the VistA Integrated Billing and Accounts Receivable applications. VHA will continue working closely with the

Department's CIO to ensure that all new technological developments are compatible with VA's technology and processing environment.

### **GAO3. PREPARE FOR BIOLOGICAL AND CHEMICAL ACTS OF TERRORISM**

Following the attacks of September 11, 2001, VA determined that it needed to stockpile pharmaceuticals and improve its decontamination and security capabilities. VA also has new responsibilities to establish four medical emergency preparedness centers and carry out other activities to prepare for potential terrorist attacks.

### **VA'S PROGRAM RESPONSE**

VHA has progressed significantly in the areas of establishing VAMC-based pharmaceutical caches and in essential decontamination training and equipment for VAMC facilities and personnel. Both are becoming integral components of VHA's comprehensive emergency management system.

The four proposed Medical Emergency Preparedness Centers would build on VA's expertise in health care, infectious disease, nuclear medicine, education, research, patient and staff health and safety, and other areas vital to emergency preparedness. The centers would enhance the readiness in the event of terrorist acts posing threats to public health and safety. The final language enacted by Congress did not support funding of the four centers. Thus, VA's appropriations act specifically prohibits any funds provided for 2003 from being spent on these centers. VA continues to work with other agencies such as the Departments of Defense, Health and Human Services, and Homeland Security in the emergency preparedness role.

VA's Office of Policy, Planning, and Preparedness developed criteria for identifying VA's critical infrastructure, a 12-threat scenario risk matrix, and a detailed inspection checklist. The prototypes were delivered in October 2002. By the summer of 2004, 14 full assessments of VA's most critical facilities and preliminary assessments of an additional 100 highly critical facilities will be completed.

An electronic database is being developed that will capture vulnerability assessment data and link it with existing VA space and building databases as well as law enforcement databases. It will be operable by the end of 2003. This system will be delivered to VA as a turnkey operation to coincide with the completion of the vulnerability assessments performed in the project described above. A separate project to assess the Department's ability to secure or reconstitute its essential business papers is scheduled for completion in October 2003.

VA is also studying the preparedness of VA personnel during and after a catastrophic event, determining if the Department has a sufficient number of personnel with the requisite skills for rapid deployment in the event of an emergency, and reviewing the standards for evacuation and/or shelter-in-place activities. The study is also evaluating practices regarding security clearance and treatment of foreign nationals. Additionally, a review of employee personnel files will be completed in November 2003 determining if there is sufficient information available in case of grave emergency or death of employees.

In December 2003, a review of selected VA emergency preparedness planning documents will be completed. This review is being conducted

for relevancy, currency, and the degree to which all pertinent planning considerations have been addressed. This review is being undertaken in a context of existing operational standards and best practices for developing emergency preparedness planning, including responding to acts of terrorism.

#### **GAO4. IMPROVE VETERANS' DISABILITY PROGRAM**

VA acted to improve its timeliness and quality of claims processing, but is far from achieving its goals. Of greater concern are VA's outmoded criteria for determining disability and its capacity to handle the increasing number and complexity of claims. VA will need to seek solutions to provide meaningful and timely support to veterans with disabilities. While the Department is taking actions to address these problems in the short term, longer-term solutions may require more fundamental changes to the program including those that require legislative actions. For these reasons, GAO has added VA's disability benefits program, along with other federal disability programs, to the 2003 high-risk list.

The Secretary has made the improvement of claims processing performance one of VA's top management priorities, setting a 100-day goal for VA to make accurate decisions on rating-related compensation and pension claims, and a reduction in the rating-related inventory to about 250,000 claims by the end of fiscal year 2003. While VA has made some progress in improving production and reducing inventory, it is far from achieving the Secretary's goals. Improving timeliness, both in the short and long term, requires more than just increasing production and reducing inventory. VA must also continue addressing delays in obtain-

ing evidence to support claims, ensuring that it has experienced staff for the long term, and implementing information systems to help improve productivity.

To help improve decision accuracy and consistency across regional offices, VA established the Training and Performance Support System (TPSS), a computer-assisted system designed to provide standardized training for staff at all regional offices. However, many of the modules were not available to help train the new claims processing staff VA hired during fiscal years 2001 and 2002, and, in May 2001, GAO reported that VA had pushed back its completion of all TPSS modules until sometime in 2004. Until VA completes TPSS implementation, it will not be able to evaluate the program's impact on claims processing accuracy and consistency. More recently, GAO recommended in August 2002 that VA establish a system to regularly assess and measure the degree of consistency across all levels of VA claims adjudication and to improve the quality of decisions made by VA's Board of Veterans' Appeals.

Of greater concern is VA's use of outmoded criteria for determining disability. In 1997, GAO reported that VA's disability rating schedule is still primarily based on physicians' and lawyers' judgments made in 1945 about the effect service-connected conditions had on the average individual's ability to perform jobs requiring manual or physical labor.

More recently, GAO reported that the criteria used by VA and other federal programs to determine disability have not been fully updated to reflect medical and technological advances and have not incorporated labor

market changes. GAO recommended that VA use its annual performance plan to delineate strategies for and progress in periodically updating its disability criteria. GAO also recommended that VA study and report to the Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on VA disability programs' eligibility criteria and benefit

package. VA did not concur with our recommendations. The Secretary of Veterans Affairs stated that the current medically based criteria are an equitable method for determining disability and that VA is in the process of updating its criteria to account for advances in medicine. However, GAO believes that until VA aligns its disability criteria with medical and technological advances and

holds itself accountable for ensuring that disability ratings are based on current information, future decisions affecting its disability program will not be adequately informed. This fundamental problem and sustained challenges in processing disability claims put the VA disability program at high risk of poor performance.

### VA'S PROGRAM RESPONSE

VBA continues to improve the quality, timeliness, and consistency of claims processing decisions:

	As of 9/30/2002	As of 9/30/2003
<b>Completed rating actions</b>	<b>797,000</b>	<b>827,194</b>
<b>Rating claims pending</b>	<b>345,516</b>	<b>253,597</b>
<b>% claims pending &gt;180 days</b>	<b>35.3%</b>	<b>18.5%</b>
<b>% of rating accuracy</b>	<b>81%</b>	<b>85.3%</b>
<b>% of authorization accuracy</b>	<b>80%</b>	<b>87%</b>

VA continues to address delays in obtaining evidence to support claims, ensuring that it has experienced staff for the long-term, and implementing information systems to help improve productivity. Extensive progress between VA and DoD sharing efforts are underway that will reduce the time and resources it takes to process claims. We are working with DoD to develop a medical examination protocol that would satisfy requirements for a proper discharge exam as well as a comprehensive C&P examination. In addition, we are collaborating with DoD's Joint Requirements and Integration Office to obtain limited access to active-duty personnel data maintained in the Defense Integrated Military Human Resources System database. VA also continues to electronically request and receive imaged records from the Army, Navy, and Marine Corps through an interface between the

Personnel Information Exchange System and the Defense Personnel Records Imaging System. Approximately 2,700 requests for records are processed through this interface each month, which expedites the evidence-gathering portion of claims processing improving VA's timeliness by 3 to 6 months.

Succession planning and maintaining a well-trained workforce are of utmost importance. VBA was pleased with GAO's final report, *Better Collection and Analysis of Attrition Data Needed to Enhance Workforce Planning* (GAO-03-491) and concurred with GAO's recommendation that will help VBA ensure it has experienced staff for the long term. Beginning in July 2003, VBA implemented an exit interview survey process to capture data regarding employee turnover. Data analysis will be conducted cen-

trally and will include a review of overall attrition and stratification by grade and/or tenure. At a later time, training on retention will be offered to human resources staff in the field. In addition, VBA recently completed its initial workforce plan, which analyzed workforce needs and trends, including retirement and non-retirement losses in the aggregate and by key occupations.

VBA did not concur with GAO's contention that the criterion for determining disability is outmoded. The Schedule for Rating Disabilities that VA uses is continuously reviewed and revised based upon medical advances. Among the changes to the schedule is the replacement of fixed convalescence periods with periods based upon medical evidence in the individual veteran's claim. An example of this is the convalescence period for most cancers that has been

shortened from 1 year to, in most cases, 6 months.

We believe that GAO's recommendation does not take full consideration of the fact that the rating schedule evaluation scheme is not based solely on occupational considerations and their impacts on earnings. The study of the President's Commission on Veterans' Pensions (the Bradley Commission), referenced by GAO in its 1997 report, concluded that the basic purpose of disability compensation for VA was not to strictly adhere to the basic standard of assigning percentages based on average impairment of earning capacity. Furthermore, VA's standard has been primarily a physical disability standard that also takes into consideration pain, suffering, disfigurement, and social inconvenience. It should be noted that in developing rating schedule changes, we do consult and/or receive comments from professional and advocacy groups concerned with issues related to the change currently being recommended. Court decisions also play a role in the development of the schedule.

VA will initiate an evaluation of the disability compensation program in 2004. The evaluation will examine whether the program improves the quality of life of veterans and is more than an income replacement program. The evaluation would compare the income of disabled veterans who receive compensation with those who do not. The evaluation will encompass the full array of federal benefit programs that are available to disabled veterans with emphasis on VA health care; VA vocational rehabilitation, education, and pension programs; and other programs such as Social Security and Medicare. Research questions and outcome measures will be developed

that address concerns about the current disability rating scale and the impact a service-connected disability has on a veteran's earnings potential and quality of life. The evaluation team will also examine advances in medical treatment and the use of support technology. While the study will require approximately 36 months to complete, periodic interim reports will ensure that the most current information is made available to the Secretary for decisions affecting the disability compensation program.

#### **GAO5. DEVELOP SOUND DEPARTMENTWIDE MANAGEMENT STRATEGIES TO BUILD A HIGH-PERFORMING ORGANIZATION**

Since 1997, VA has spent about \$1 billion annually on its information technology. VA has established executive support and is making strides in developing an integrated Departmentwide enterprise architecture. To safeguard financial, health care, and benefits payment information and produce reliable performance and workload data, VA must sustain its commitment.

#### **5A. LINK BUDGETING AND PLANNING**

Establishing a close link between budgeting and planning is essential to instilling a greater focus on results. While VA's health care budget formulation and planning processes are centrally managed, they are not closely linked. VA's annual performance plan describes the Department's goals, strategies, and performance measures. However, the relationship between its performance plan and its health care budget formulation is unclear.

VA officials noted that steps are being taken to better integrate their health

care budget formulation and planning processes. However, VA continues to face challenges in further integrating these processes and in defining areas for improvement.

#### **VA'S PROGRAM RESPONSE**

VA has made a number of advancements toward integrating budget and performance. Ongoing Monthly Performance Review meetings involving VA senior leadership have created a continuous review of program performance in the areas of financial management, performance measurement, workload, and major construction, and information technology projects. The purpose of this regularly scheduled meeting, chaired by the Deputy Secretary, is to inform while identifying issues through a detailed review of Department resources. Because all programs are represented at this meeting, the resulting management decisions are immediately communicated and incorporated to maximize resource utilization. As of 2003, VA completed Program Assessment Rating Tool reviews on 5 of 9 programs in collaboration with OMB. This information will be incorporated in subsequent budget requests and will address areas that need performance improvement and describe how resources relate to program effectiveness. Two VA programs are participating in Common Measures exercises: Medical Care and Vocational Rehabilitation and Employment (VR&E). Common measures are meant to evaluate the effectiveness of government programs that have similar goals. The Veterans Health Administration is working with the Department of Defense, Indian Health Service, and Community Health Centers programs to quantify the resources spent on direct federal health care programs. VR&E is developing measures with the Departments of Labor, Housing

and Urban Development, Education, and Interior to evaluate the effectiveness of federal employment programs. With the 2005 budget, VA is providing a more complete picture of our resource needs by better integrating legislative proposals with the budget request.

VA is submitting its 2005 budget using the same account structure proposed in the 2004 budget. The structure focuses on nine major programs – medical care, research, compensation, pension, education, housing, vocational rehabilitation and employment, insurance, and burial. The 2004 budget is pending congressional action. The Administration is negotiating with Congress on what features of the proposed account structure will be implemented.

### **5B. INFORMATION TECHNOLOGY CHALLENGES**

Over the past 2 years, VA's commitment to addressing critical weaknesses in the Department's IT management has been evident. Nonetheless, challenges to improve key areas of IT performance remain. Specifically, VA's success in developing, implementing, and using a complete and enforceable enterprise architecture hinges upon continued attention to putting in place a sound program management structure. In addition, VA's computer security management program requires further actions to ensure that the Department can protect its computer systems, networks, and sensitive health and benefits data from vulnerabilities and risks.

VA is also challenged to develop an effective IT strategy for sharing information on patients who are both VA and DoD beneficiaries or who seek care from DoD under a VA/DoD sharing agreement. The lack of com-

plete, accurate, and accessible data is particularly problematic for veterans who are prescribed drugs under both systems. While each department has established safeguards to mitigate the risk of medication errors, these safeguards are not necessarily effective in a shared environment—in part because VA's and DoD's IT systems are separate. Consequently, DoD providers and pharmacists cannot electronically access health information captured in VA's system to aid in making medication decisions for veterans, nor can they take advantage of electronic safeguards such as computerized checks for drug allergies and interactions.

### **VA'S PROGRAM RESPONSE**

In June 2003, the VA CIO signed and published the "*VA Enterprise Architecture Program Management Plan*." It defines the processes and approach that allow the One VA Enterprise Architecture to be integrated with the VA capital planning, budgeting, and project management oversight processes. The plan serves as the mechanism for formalizing the execution of the One VA Enterprise Architecture Management Program as a change agent and continuous improvement process, aligning integrated technology solutions with the business needs of the Department.

The Office of Cyber and Information Security (OCIS) is charged with implementation and oversight of the Department IT Security Program and is developing policies, procedures, and practices that ensure the protection of VA information systems. In accordance with a GAO recommendation to further identify risks and associated vulnerabilities, OCIS is establishing an IT risk management capability for the Department. This capability will include a central risk management focal point in OCIS; a

program for promoting awareness of risk-related IT security issues; and identification and implementation of practical risk assessment procedures and tools that link security policies to business needs. Additionally, the OCIS risk focal point will assist business managers in conducting risk assessments; establish risk management policies and procedures; and continually monitor and evaluate the effectiveness of these activities, thereby ensuring the timely identification and effective mitigation of risks associated with emerging vulnerabilities.

Additionally, OCIS has enhanced the capabilities of a key technical project targeted toward identification of vulnerabilities and mitigation of risk. This program, the Enterprise Cyber Security Infrastructure Project (ECSIP), merges VA's actions to implement a Departmentwide intrusion detection system (IDS) and, concurrently, upgrade external connections. ECSIP activities will systematically collapse the more than 200 existing Internet gateways and other external network connections in VA into a more manageable number and efficient structure. Concurrent with this effort, Departmentwide IDS capability will be incrementally deployed on a strategic basis to provide significantly increased security protections for the remaining gateways.

To enhance VA's ability to protect its information systems, OCIS revised the ECSIP schedule to provide more rapid deployment of IDS technology throughout the Department. Additionally, concurrent with the IDS effort, the capabilities of the existing VA Central Incident Response Capability will be expanded to include establishment of a Network and Security Operations Center that will provide real-time technical mon-

itoring of VA's internal network, analytical incident support, and information sharing capabilities regarding emerging threats and vulnerabilities with appropriate public and private organizations. These combined activities will enhance capabilities to protect sensitive VA information systems and data from existing and emerging vulnerabilities, thereby mitigating risk.

VA is closely collaborating with DoD on a strategy to improve sharing of complete and accurate electronic medical information. The VA/DoD Joint Executive Council and VA/DoD Health Executive Council have approved the adoption of the joint VA/DoD electronic health records plan -- HealthePeople (federal). This plan provides the exchange of health data and development of a common health information infrastructure and architecture supported by common data, communications, security and software standards, and high performance health information systems. The plan will directly address and mitigate risks of medication errors, drug allergies, and adverse drug reactions. It also includes the Federal Health Information Exchange, which will provide VA historical data on separated and retired military personnel from the DoD's Composite Health Care System. VA and DoD are also developing interoperable (and bi-directional) data repositories, which will provide real-time health data on veterans who receive care from both systems.

### **5C. FINANCIAL MANAGEMENT MATERIAL WEAKNESSES**

In December 2002, VA's independent auditor issued an unqualified audit opinion on VA's consolidated financial statements for fiscal years 2002 and 2001. However, the unqualified

opinion was achieved, for the most part, through extensive efforts of both program and financial management staff and the auditors to overcome material internal control weaknesses to produce auditable information after year-end. The auditor reported two long-standing systems and control problems that remain unresolved. In addition, VA's accounting systems--similar to those of most 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 has demonstrated management commitment to addressing material internal control weaknesses previously reported, and has made significant improvements in financial management. For example, in February 2001, the auditor reported that VA had improved on its reporting and reconciling of fund balances with Treasury--removing this as a material weakness. VA also continued to make progress in implementing recommendations from our March 1999 report that resulted in improved control and accountability over VA's direct loan and loan sale activities and compliance with credit reform requirements.

However, during its audit of VA's fiscal year 2002 financial statements, the auditor reported that two previously reported material weaknesses still exist in the areas of information systems security and financial management system integration.

Departmentwide weaknesses in security controls over automated data

processing continue to make VA's sensitive financial and veteran medical and benefit information at risk of inadvertent or deliberate misuse or fraudulent use.

Material weaknesses continue to hamper timely completion of financial statements. Specifically, VA continues to have difficulty related to the preparation, processing, and analysis of financial information to support the efficient and effective preparation of its financial statements.

### **VA'S PROGRAM RESPONSE**

VA's Office of Information and Technology has developed and monitors a Departmentwide information technology security controls plan that details actions through March 2005 to correct identified risks of inadvertent or deliberate misuse or fraudulent use of data.

The Department continues to move toward implementing CoreFLS, an integrated commercial off-the-shelf software financial and logistics system solution. Deployment of CoreFLS represents a major step in VA's effort to implement a centralized system where policies, processes, procedures, and data classification rules are consistently applied. The CoreFLS system will be the basis for a more comprehensive solution across all VA systems. CoreFLS will assist VA by addressing internal controls and financial reporting deficiencies in many significant ways and provide the following features/capabilities to support VA's obtaining an unqualified audit opinion:

- Integration of many disparate systems into a single system to improve the Department's ability to track, reconcile, and report VA-wide financial and logistics activities automatically.

- Improved management of financial and logistical activities as "One VA" by streamlining operations, standardizing best practices, and providing timely information for management decisions.
- Better alignment of resources with program activities, tracking of program performance against full cost, improved automated reconciliation, and improved ad hoc analytical tools.

CoreFLS will greatly simplify the process of generating VA's consolidated financial statements by combining the financial activities of all VA administrations and reporting them from a single system of records. CoreFLS will also provide the capability to reopen closed periods in a controlled manner (or perform multiple preliminary year-end closings) so that revised financial statements can be prepared. Further, CoreFLS will reduce manual compilations and streamline extraneous processes, thus reducing vulnerability to error and fraud.

**GAO6. FEDERAL REAL PROPERTY: A HIGH RISK AREA**

There is a need for a comprehensive and integrated real property transformation strategy that could identify how best to realign and rationalize federal real property and dispose of unneeded assets; address significant real property repair and restoration needs; develop reliable, useful real property data; resolve the problem of heavy reliance on costly leasing; and minimize the impact of terrorism on real property.

VA has struggled to respond to asset realignment challenges due to its mission shift to outpatient, community-based services. GAO reported in

1999 that VA had 5 million square feet of vacant space and that utilization will continue to decline. VA has recognized that it has excess capacity and has an effort under way known as the Capital Asset Realignment for Enhanced Services (CARES) that is intended to address this issue. VA's environment contains a diverse group of competing stakeholders who could oppose realignment plans that they feel are not in their best interests, even when such changes would benefit veterans.

Improvements in capital planning are needed. For example, GAO reported in 1999 that VA's capital asset decision-making process appeared to be driven more by the availability of resources within VA's different appropriations than by the overall soundness of investments. This resulted in VA spending millions more on leasing property instead of ownership because funds were more readily available in the appropriation that funds leases than in the construction appropriation.

In recent years, VA has also developed legislative proposals to establish a capital asset fund, which would, among other things, be aimed at improving its capability to dispose of unneeded real property by helping to fund related costs such as demolition, environmental cleanup, and repairs.

**VA'S PROGRAM RESPONSE**

VA concurs with GAO's recommendation. The Secretary has taken steps to significantly improve the Department's management of capital assets, including the establishment of the Office of Asset Enterprise Management (OAEM) in 2001. OAEM promotes capital programming strategies including the development of integrated approaches to

transform underutilized or unneeded capital assets from liabilities to potential capital resources through the use of existing authorities (enhanced use leasing and enhanced sharing) and legislative and policy changes when necessary.

VA is committed to a comprehensive, corporate-level approach to capital asset management to more closely link asset decisions with its strategic goals, elevate awareness of assets, and employ performance management techniques to monitor asset performance on a regular basis. At the core of VA's capital asset business strategy is value management – striving to return value to VA's business and managing existing value for greater return.

VA is conducting a comprehensive planning process, Capital Asset Realignment for Enhanced Services (CARES), to align capital assets to meet veterans' future needs for accessible, quality health care. Preliminary recommendations indicate that VA's enhanced-use lease authority will play a major role in the realignment of VHA's capital assets by transforming underutilized space from a liability to an important component of the VA's overall capital portfolio.

Each year VA re-evaluates the capital investment methodology and planning process and adapts capital strategies to ensure alignment with the administration's management agenda, and strategic plan, goals and objectives.

In 2003, VA continued to develop a Capital Asset Management System (CAMS) that functions as a portfolio management tool for all of its significant capital assets. CAMS will be structured to extract valid, reliable,

useful, real property data from existing corporate data systems. Each significant investment will be tracked through its entire lifecycle from formulation, execution, steady state, and disposal. Investment protocols and standards are being developed to provide guidelines for each major phase or milestone in the life cycle of a capital asset decision. These assets will be monitored and evaluated against a set of performance measures (including capital assets that are underutilized and/or vacant) and capital goals to maximize highest return on the dollar to support veteran needs. The following portfolio metrics have been established:

- Decrease operational costs;
- Reduce energy utilization;
- Decrease underutilized capacity;

- Increase intra/inter-agency and community-based sharing;
- Increase revenue opportunities;
- Maximize highest and best use;
- Safeguard assets

In 2004, VA requested authority to restructure its appropriations in order to bring them more in line with the Department's business lines. The accounts were also restructured to allow VA officials more flexibility and accountability when acquiring capital assets. This includes basing leasing versus construction decisions on sound business principles instead of funding availability.

For 2004, VA again introduced legislation that would allow the Department to dispose of, sell,

transfer and/or exchange excess properties and retain the proceeds by establishing a Capital Asset Fund. This latter incentive will allow VA to better manage its underutilized or excess real property by improving its capability to dispose of unneeded property. Funds may also be used to pay for related significant costs such as environmental clean up and demolition. A majority of the proceeds received will be used to fund CARES capital needs. The improvements to VA's infrastructure will also allow dollars currently being spent on maintenance and operations to be diverted to enhance veterans' health care delivery.