



## SECTION III: OTHER INFORMATION

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### SECTION A: SCHEDULE OF SPENDING (UNAUDITED)

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The Combined Schedule of Spending (SOS) presents an overview of how and where VA is obligating and spending money. The data used to populate this schedule is the same underlying data used to populate the SBR. The SOS presents total budgetary resources and year-to-date total obligations incurred for VA.

The budgetary information in this schedule is presented on a combined basis consistent with the account-level information presented in the SF 133, Report on Budget Execution and Budgetary Resources, and the SBR. Consolidation, which involves line-by-line elimination of inter-entity balances, is not permitted for this schedule.

Credit reform financing accounts are material to VA's financial statements; therefore, the budgetary accounts and non-budgetary credit reform accounts are presented separately similar to the presentation in the SBR.

USAspending.gov prime award financial data for VA contracts, grants, and insurance is a subset of the obligations incurred and is reported in VA's financial systems, but is based on and reported when amounts are paid not when obligations are incurred which creates timing and reconciliation requirements between the two sets of data. Additionally, the current USAspending.gov data is not integrated with or maintained in the same financial management and reporting system as the SBR. USAspending.gov does not track or report data by obligations incurred numbers as reported in the SBR and SOS financial management system. During FY16, VA began a financial management transformation initiative, in which the Department will migrate from its legacy financial systems environment to an integrated finance and acquisition system hosted by a Federal Shared Service Provider (FSSP). Successful completion of this transformation will result in new capabilities to address these issues.



**DEPARTMENT OF VETERANS AFFAIRS**  
**SCHEDULE OF SPENDING – UNAUDITED (dollars in millions)**  
**For the Years Ended September 30,**

	2016		2015	
	Budgetary	Non-Budgetary Credit Program	Budgetary	Non-Budgetary Credit Program
<b>What Money is Available to Spend?</b>				
Total Resources	\$ 203,368	\$ 13,507	\$ 199,137	\$ 11,919
Less Amount Available but Not Agreed to be Spent	(12,537)	-	(16,331)	-
Less Amount Not Available to be Spent	(8,514)	(10,534)	(12,220)	(8,829)
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 182,317</b>	<b>\$ 2,973</b>	<b>\$ 170,586</b>	<b>\$ 3,090</b>
<b>How was the Money Spent/Issued?</b>				
<i>Veterans Health Administration</i>				
Personnel Compensation and Benefits	\$ 35,062	\$ -	\$ 32,731	\$ -
Other Contractual Services	17,663	-	15,490	-
Supplies and Materials	11,688	-	11,542	-
Land and Structures	3,625	-	2,820	-
Equipment	2,563	-	2,976	-
Rent, Communications and Utilities	2,511	-	2,463	-
Grants, Subsidies and Contributions	1,897	-	1,848	-
Travel and Transportation of Persons	1,185	-	1,095	-
Other	1,987	-	-	-
<i>Veterans Benefits Administration (Including Veterans Benefits, Life Insurance, Housing Credit and Administration)</i>				
Insurance Claims and Indemnities*	81,804	756	77,940	511
Grants, Subsidies and Contributions**	15,354	333	14,976	736
Personnel Compensation and Benefits	2,149	-	2,126	-
Other Contractual Services	933	221	945	242
Rent, Communications and Utilities	186	-	165	-
Interest and Dividends	207	26	-	42
Land and Structures	2	1,591	1	1,517
Other	92	46	43	42
<i>National Cemetery Administration</i>				
Personnel Compensation and Benefits	151	-	142	-
Other Contractual Services	77	-	72	-
Grants, Subsidies and Contributions	49	-	47	-
Supplies and Materials	12	-	11	-
Rent, Communications and Utilities	13	-	12	-
Other	18	-	24	-
<i>Indirect Program Administration</i>				
Other Contractual Services	1,050	-	1,003	-
Personnel Compensation and Benefits	864	-	818	-
Equipment	522	-	617	-
Supplies and Materials	425	-	444	-
Rent, Communications and Utilities	159	-	156	-
Other	69	-	79	-
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 182,317</b>	<b>\$ 2,973</b>	<b>\$ 170,586</b>	<b>\$ 3,090</b>



<b>DEPARTMENT OF VETERANS AFFAIRS</b>				
<b>SCHEDULE OF SPENDING – UNAUDITED (dollars in millions)</b>				
<b>For the Years Ended September 30,</b>				
	<b>2016</b>		<b>2015</b>	
	<b>Budgetary</b>	<b>Non-Budgetary Credit Program</b>	<b>Budgetary</b>	<b>Non-Budgetary Credit Program</b>
<b>Where did the Money go to?</b>				
<i>Veterans Health Administration</i>				
Federal	\$ 11,506	\$ -	\$ 10,238	\$ -
Non-Federal	66,675	-	60,727	-
<i>Veterans Benefits Administration (Including Veterans Benefits, Life Insurance, Housing Credit and Administration)</i>				
Federal	1,947	348	1,749	319
Non-Federal	98,780	2,625	94,447	2,771
<i>National Cemetery Administration</i>				
Federal	50	-	51	-
Non-Federal	270	-	257	-
<i>Indirect Program Administration</i>				
Federal	511	-	553	-
Non-Federal	2,578	-	2,564	-
<b>Total Amounts Agreed to be Spent</b>	<b>\$ 182,317</b>	<b>\$ 2,973</b>	<b>\$ 170,586</b>	<b>\$ 3,090</b>

\*Primarily Veterans' pension and disability compensation costs, insurance program costs and loan guaranty program losses.

\*\*Primarily Veterans' educational readjustment benefit programs, special adaptive housing costs and loan subsidy and reestimate costs.



## SECTION B: SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

The following tables provide a summary of audit-related or management-identified material weaknesses and the noncompliance with FFMIA and Federal financial management system requirements outlined in the 2016 Agency Financial Report.

**Table 1 - Summary of Financial Statement Audit**

Audit Opinion	Unmodified				
	Yes				
Restatement	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Material Weaknesses					
IT Security Controls	1	0	0	0	1
Education Benefits Accrued Liability	0	1	0	0	1
Control Environment Surrounding the Compensation, Pension, and Burial Actuarial Estimates	0	1	0	0	1
Community Care Obligations, Reconciliations, and Accrued Expenses	1	0	0	0	1
Financial Reporting	1	0	0	0	1
CFO Organizational Structure for VA and VHA	0	1	0	0	1
Procurement, Undelivered Orders and Reconciliations	1	0	1	0	0
<b>Total Material Weaknesses</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>0</b>	<b>6</b>

**Table 2 - Summary of Management Assurances**

Effectiveness of Internal Control over Financial Reporting (FMFIA § 2)						
Statement of Assurance	Qualified					
	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Material Weaknesses						
Financial Reporting	1	0	0	0	0	1
Education Benefits Accrued Liability	0	1	0	0	0	1
Control Environment Surrounding the Compensation, Pension and Burial Actuarial Estimates	0	1	0	0	0	1
<b>Total Material Weaknesses</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3</b>
Effectiveness of Internal Control over Operations (FMFIA § 2)						
Statement of Assurance	Qualified					
	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Material Weaknesses						
Community Care Obligations, Reconciliations, and Accrued Expenses	1	0	0	0	0	1
CFO Organizational Structure for VA and VHA	0	1	0	0	0	1
Procurement, Undelivered Orders and Reconciliations	1	0	1	0	0	0
<b>Total Material Weaknesses</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>



<b>Conformance with Federal Financial Management System Requirements (FMFIA § 4)</b>						
Statement of Assurance	<b>Systems conform, except for the below non-conformance</b>					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
IT Security Controls	1	0	0	0	0	1
<b>Total Non-Conformances</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>
<b>Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA)</b>						
	<b>Agency</b>			<b>Auditor</b>		
1. System Requirements	Lack of compliance noted			Lack of compliance noted		
2. Accounting Standards	No lack of compliance noted			No lack of compliance noted		
3. USSGL at Transaction Level	Lack of compliance noted			Lack of compliance noted		



## SECTION C: FREEZE THE FOOTPRINT

Section 3 of OMB Memorandum 12-12, *Promoting Efficient Spending to Support Agency Operations* established the “Freeze the Footprint” (FTF) policy intended to control utilization and spending associated with real property. OMB Management Procedures Memorandum 2013-02, Freeze the Footprint policy implementation guidance requires that all CFO Act Executive Branch Departments and agencies shall not increase the total square footage (sq. ft.) of their domestic office and warehouse inventory compared to the FY 2012 baseline, unless increased footage is offset through consolidation, colocation, or disposal of space from the inventory of that agency.

### Baseline Comparison

	FY 2012 Baseline	FY 2015 Reported	Change
<b>Square Footage</b> (in millions)	28.87	29.82	0.95

### Reporting of Operation and Maintenance Costs – Owned and Direct Lease Buildings

	FY 2012 Reported Cost	FY 2015 Reported Cost	Change
<b>Operation and Maintenance Cost</b> (in millions)	\$99.57	\$143.80	\$44.23

VA’s total sq. ft. subject to FTF for FY 2015 was 29.82 million, which represents a 3.3 percent increase over the FY 2012 baseline of 28.87 million.

VA anticipated footprint growth from FY 2013 to FY 2015, due to large projects previously approved in years prior to FTF, which were already under construction or lease acquisition. These projects began to enter the portfolio in FY 2013 and continued through FY 2014 and FY 2015, driving VA above its FY 2012 baseline. While VA continued to increase sq. ft. above the FY 2012 baseline, the growth in FY 2015 was significantly smaller compared to FY 2013.

VA has implemented new administrative office space standards to shrink overall space requirements. The new standard applies to new projects and lease renewals. The standard does not generate an immediate space reduction; however, as leases are replaced and the new standard used, overall office space will eventually be reduced. VA is also focusing on disposing vacant or underutilized assets (both office and warehouse) to help provide additional reduction in the portfolio.

In terms of costs, total operation and maintenance costs as reported in the Federal Real Property Profile (FRPP) rose 44.4 percent from \$99.57 million in FY 2012 to \$143.80 million in FY 2015. Due to inflation, each year, operation and maintenance costs increased by a few percentage points which escalates lease rental rates, utility rates, and other costs. In addition, VA experienced growth in its FTF sq. ft., which also contributed to an increase in operational costs. This combination of factors resulted in an increase in total operations and maintenance costs as reported in FRPP.



**SECTION D: CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION**

The *Federal Civil Penalties Inflation Adjustment Act of 1990* (the Inflation Adjustment Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties (CMP) to maintain their deterrent effect. Four statutes are excluded under the Inflation Adjustment Act: the *Internal Revenue Code of 1986*, the *Tariff Act of 1930*, the *Occupational Safety and Health Act of 1970*, and the *Social Security Act*. The table below depicts the covered civil monetary penalties that are under the Department’s purview.

Statutory Authority	Penalty (Name or Description)	Year Enacted	Latest year of adjustment (via statute or regulation)	Current Penalty Level (\$ Amount or Range)	Sub-Agency/ Bureau/ Unit	Location for Penalty Update Details
Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, as amended	False Loan Guaranty Certifications	1986	2016	The greater of 2 times the amount of loss not to exceed \$21,563	Veterans Benefits Administration/ Loan Guaranty	Federal Register 81(06/22/2016): 40524-40525
Program Fraud Civil Remedies Act of 1986, as amended	Fraudulent Claims or Statements	1986	2016	\$10,781	All VA Programs	Federal Register 81(06/22/2016): 40524-40525



## SECTION E: IMPROPER PAYMENTS DETAILED REPORT

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### Overview

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The reduction of improper payments continues to be a top financial management priority for VA. VA is focused on increasing IPERA compliance while also providing Veterans the benefits and services they have earned and deserve. In FY 2016, VA issued guidance to ensure the improper payment definition was consistently applied when testing acquisition payments in the Department. Leadership also increased communication to clarify roles and responsibilities in VA's IPERA program to further increase effectiveness of corrective actions to reduce improper payments. VA continued to leverage the IPERA Governing Board ensuring collaboration and awareness of improper payment challenges at the executive leadership level. The IPERA Governing Board, comprised of senior leadership, has worked to strategically strengthen program integrity by providing oversight of program activities to address vulnerabilities in programs, implement effective corrective actions, and track issues to resolution.

In FY 2016, VA is reporting an increase in overall improper payments from the amount reported in FY 2015; however, more than half of the 14 programs reporting improper payments successfully saw a reduction. The majority of the increase was a result of VA's enterprise-wide commitment to applying the improper payment definition correctly. Further, since VA reports improper payments one year in arrears, actions taken to reduce improper payments in FY 2015 and FY 2016 have not yet been fully realized. VA continues to enact specific corrective actions to remediate improper payments and strategically strengthen program integrity while ensuring Veteran access to healthcare and benefits.

In FY 2015, VA issued \$172.24 billion in diverse payments, of which \$158.88 billion were subject to IPERA processes for measuring improper payments compliance. The amount of disbursements subject to IPERA review increased by more than \$10.7 billion from 2014 to 2015, approximately a 7 percent increase due primarily to annual increases in program outlays across VA programs.

### Section I. Risk Assessments Performed for VA Programs

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In FY 2016, VA performed 73 required risk assessments for programs previously considered low risk.

VA uses qualitative and quantitative risk assessment factors to identify programs that may be susceptible to significant improper payments. Within the risk assessment process the following Office of Management and Budget (OMB) requirements are evaluated:

- Whether the program reviewed is new to the agency
- The complexity of the program reviewed, particularly with respect to determining correct payment amounts
- The volume of payments made annually
- Whether payments or payment eligibility decisions are made outside of the agency, for example, by a state or local government, or a regional federal office



- Recent major changes in program funding, authorities, practices, or procedures
- The level, experience, and quality of training for personnel responsible for making program eligibility determinations or certifying that payments are accurate
- Inherent risks of improper payments due to the nature of agency programs or operations
- Significant deficiencies in the audit reports of the agency including, but not limited to, VA Office of Inspector General (OIG) or Government Accountability Office (GAO) audit report findings, or other relevant management findings that might hinder accurate payment certification
- Results from prior improper payment work.

In addition to these risk elements, risk assessments include additional factors that could lead to improper payments. As such, some of these factors include:

- Assessing additional internal controls and inherent risk due to the nature of the program
- Assessing the controls around information systems
- Determining adequacy of controls in contracting activities
- Assessing the level of monitoring and oversight over payment activities.

Additionally in 2015 and 2016, the VA Office of Management conducted a review of 12 low-risk programs with disbursements greater than \$1 billion or greater than 90 percent of expenditures made to vendors. This review was performed in response to an OIG recommendation in the FY 2014 Review of VA's Compliance with IPERA. In 2016, VA considered the results of the judgmental review when assigning risk ratings in relation to acquisition activities for these 12 programs.

During FY 2016, the following programs completed risk assessments and qualitative and quantitative factors identified the programs as not susceptible to significant improper payments as defined by OMB Circular A-123 Appendix C. Chart 1 below provides the results:

<b>Chart 1: FY 2016 Risk Assessment Results - Programs Not Susceptible to Significant Improper Payments</b>		
<b>Administration/VACO</b>	<b>Program</b>	<b>Description</b>
Veterans Health Administration (VHA)	Activities with other Federal Agencies	Payments for direct inpatient and outpatient medical care, furnished by the U.S. Army, U.S. Air Force, U.S. Navy, and all other Federal hospitals.
VHA	Alcohol & Drug Treatment Rehabilitation	Contracted care payments for treatment and rehabilitation services for Veterans with alcohol, drug dependence, or abuse disabilities.
VHA	Canteen Service	Canteens operate at VA Medical Centers (VAMC) across the country as self-sustaining businesses.
VHA	Caregiver Stipend	Provides comprehensive assistance including healthcare, travel expenses, training, mental health services, respite care, and financial benefits to approved primary caregivers of eligible Veterans and Servicemembers who sustained a serious injury, including traumatic brain injury, psychological trauma or other mental disorders incurred or aggravated in the line of duty, on or after September 11, 2001.
VHA	Clothing Allowance	Benefit program providing a clothing allowance to eligible Veterans to replace or repair their clothing.



**Chart 1: FY 2016 Risk Assessment Results - Programs Not Susceptible to Significant Improper Payments**

Administration/VACO	Program	Description
VHA	Compensated Work Therapy/Incentive Therapy	Funds therapeutic work remuneration for Veterans in VAMCs through contracts with private industry providers or other sources.
VHA	Department of Defense (DoD)/VA Joint Incentive fund	Funds sharing initiatives at facility, regional, and national levels to facilitate the mutually beneficial coordination, use, or exchange of healthcare resources.
VHA	DoD/VA Medical Facility Demonstration Fund	Funds the operation of an integrated Federal healthcare facility that provides care to eligible VA and DoD beneficiaries.
VHA	Equipment	Personal property payments for medical, dental, and scientific equipment, vehicles and machinery, automatic data processing equipment, and office equipment.
VHA	Facility Maintenance and Operations	Funds facility engineering and housekeeping operations.
VHA	Foreign Medical Program	A healthcare benefit program for U.S. Veterans with VA rated service connected condition(s) living or traveling abroad.
VHA	General Post Fund	A trust fund consisting of gifts, bequests, and proceeds from the sale of property left in the care of VA facilities by former beneficiaries.
VHA	Grants Highly Rural Transportations	Provides grants to eligible entities to assist Veterans in highly rural areas with transportation services to VAMCs in connection with medical care.
VHA	Grants - Homeless Per Diem	Grant program offered annually to fund community-based agencies providing transitional housing or service centers for homeless Veterans.
VHA	Grants for Construction of State Extended Care Facilities	Grant program for the construction of State Home facilities for furnishing domiciliary or nursing home care to Veterans.
VHA	Homeless Care	Program that coordinates and provides contracts for the care and treatment for homeless Veterans.
VHA	Indian Health Services (IHS) / Tribal Health Program (THP) Reimbursement Agreement	Reimburses IHS or THP for payment of claims for direct healthcare services provided to Veterans under the Reimbursement for Direct Health Care Services Agreements.
VHA	Information Technology Services	Funds patient-centered care by facilitating the deployment of innovative, secure health data systems and collecting, analyzing, and disseminating health information for Veterans, Caregivers, clinicians, and administrative staff for decision making.
VHA	In-house Provider Services	Covers fees paid for clinical services to individuals in major employee classifications, which are provided on the grounds of a VA facility.
VHA	Insurance Claims and Interest Expense	Comprises of payments related to insurance claims and interest expense.
VHA	Land and Structures	Funds land and interest on land, buildings and other structures. Includes funding for buildings, non-structural improvements, architectural and engineering services, and fixed equipment, when acquired under contract.
VHA	Medical and Prosthetic Research	Funds basic biomedical research through the translation of research into practice, emphasizing the health concerns of Veterans.
VHA	Medical Facilities Recovery Act	The American Recovery and Reinvestment Act provided \$1 billion for the VHA non-recurring maintenance program for fiscal years 2009/2010.
VHA	Non-Medical Contracts and Agreements	Includes contractual services with the public or another Federal agency. Examples include contracted security guards, transcription services contracts, advertising expenses, licensing for bus drivers, and legal fees.



**Chart 1: FY 2016 Risk Assessment Results - Programs Not Susceptible to Significant Improper Payments**

Administration/VACO	Program	Description
VHA	Off-Station Provider Services	Provides funding for clinical services provided by Non-VA staff in a community setting.
VHA	Other Contracts, Services, Agreements, and Miscellaneous	Includes contracts for consulting and purchases of goods and services from Government accounts.
VHA	Pharmacy-Consolidated Mail Outpatient Pharmacies	Provides funding and contracts for the delivery of completed prescriptions to the patient by mail or other carrier.
VHA	Pharmacy - Medical Facilities	Provides care by the VAMC or clinics with new or emergent prescriptions being dispensed directly from that VAMC or clinic.
VHA	Printing and Reproduction	Funds printing, binding, graphic arts, reproduction, and related services.
VHA	Professional Services Contracts	Funds professional costs for consultants, attendings, and scarce medical specialists who are not VA staff.
VHA	Shared Services	Provides clinical contracts between VA and their sharing partners (e.g., Universities, DoD).
VHA	Special Adaptive Equipment and Maintenance	Benefit program that provides equipment and training to enable a disabled Veteran to operate a motor vehicle safely.
VHA	Spina Bifida Health Care	Provides benefits designed for Vietnam Veterans' and certain Korean Veterans' birth children diagnosed with Spina Bifida who are in receipt of a VA Regional Office award for Spina Bifida benefits.
VHA	Support Services for Veteran Families	Provides grants to nonprofit organizations and consumer cooperatives that provide supportive services to low-income Veteran families living in or transitioning to permanent housing.
VHA	Transportation of Things	Includes charges incurred for the transportation of things.
Veterans Benefits Administration (VBA)	Dependency and Indemnity Compensation	Benefit payable to surviving spouse, child, or parent of Servicemembers who died while on active duty, active duty for training, or inactive duty training or survivors of Veterans who died from service-connected disabilities.
VBA	Burial	VA burial allowances for partial reimbursements of an eligible Veteran's burial and funeral costs.
VBA	Restored Entitlement Program for Survivors	Educational benefits available to certain survivors of deceased veterans in addition to Chapter 35 benefits.
VBA	Automobile Grants	Automotive grant to be used towards the purchase of an automobile or other conveyance for Servicemembers with certain service-connected disabilities.
VBA	Montgomery GI Bill (Chapter 30)	Education benefits available to individuals who first entered active duty at any time after June 30, 1985; or to individuals who were eligible to receive Chapter 34 benefits on December 31, 1989.
VBA	Survivor and Dependents Education Assistance (Chapter 35)	Education benefit available to spouse or dependents for degree and certificate programs, apprenticeships/on-the-job training, correspondence courses, and other programs.
VBA	Education – Reporting Fees	Compensation available to institutions which helps cover the cost of administering their VA programs, including, but not limited to, attendance at VA sponsored training conferences. Institutions are compensated for each student (based on prior-year enrollment) which is to be used by the schools for the purposes of certification.
VBA	Education – State Approving Agencies	Compensation available to State Approving Agencies for certifying schools on behalf of VA and performing compliance audits.
VBA	Special Adaptive Housing	Grant available to severely disabled Veterans and Servicemembers to adapt or acquire suitable housing.



<b>Chart 1: FY 2016 Risk Assessment Results - Programs Not Susceptible to Significant Improper Payments</b>		
<b>Administration/VACO</b>	<b>Program</b>	<b>Description</b>
VBA	Loan Production	Loan Production helps Servicemembers, Veterans, and eligible surviving spouses become homeowners by providing a home loan guaranty benefit.
VBA	Loan Administration	Oversees lenders' activities for delinquent guaranteed loans.
VBA	Property Management	Portfolio of properties owned by VA that are either foreclosed or purchased under certain circumstances. VA oversees the contractor who manages these properties until they are sold.
VBA	Direct Loans	Portfolio of vendee/acquired and Native American direct loans managed by VA.
VBA	Loan Sales	VBA bundles together a portfolio of direct loans and sales them to investors. These loans are guaranteed so default payments are issued by this program.
VBA	National Service Life Insurance	Life insurance available to Servicemembers and Veterans who served during World War II era.
VBA	Service Disabled Veterans Insurance	Life insurance available to Veterans who apply within two years of receiving a new service-connected disability rating and total disabled Veterans.
VBA	Servicemen's Group Life Insurance	Low-cost term life insurance coverage available to eligible Servicemembers.
VBA	United States Government Life Insurance	Life insurance available to Servicemembers and Veterans who served during World War I era.
VBA	Veterans Insurance and Indemnities	For military and naval insurance, national service life insurance, Servicemembers indemnities, service-disabled Veterans insurance, and Veterans mortgage life insurance.
VBA	Veterans Reopened Insurance	Life insurance available to disabled Servicemembers and Veterans who served during the World War II and Korean War eras.
VBA	Veterans Special Life Insurance	Life insurance available to Servicemembers and Veterans who served during the Korean War era.
VBA	General Operating Expenses	Provides general operating expenses.
VBA	Vocational Rehabilitation and Employment Contract Counseling	Contract counseling provides service in remote areas and in situations where the workload has expanded beyond the capacities of existing VA staff.
VBA	Equal Access to Justice Act	Provides for the award of attorney fees and other expenses to eligible individuals and small entities who are parties to certain adversary adjudications in administrative proceedings against the Federal Government.
National Cemetery Administration	Burial	Provide burial and memorial benefits to Veterans and eligible family members.
VA Central Office (VACO)	Enterprise Operations	VA's Office of Information and Technology infrastructure and data center operations.
VACO	Office of General Counsel (OGC), Management, Planning, and Analysis (MPA)	MPA consists of Human Resources, Budget & Procurement, Knowledge Management, Reports, Planning, and Statistics, and Workforce Planning & Professional Development divisions which administratively support all of OGC nationwide operations.
VACO	OIG	Conducts effective oversight of the programs and operations of the VA through independent audits, inspections, and investigations.



**Chart 1: FY 2016 Risk Assessment Results - Programs Not Susceptible to Significant Improper Payments**

Administration/VACO	Program	Description
VACO	Travel	The FSC provides centralized program administration and management of VA's E-Gov Travel Service 2 (ETS2) and the VA Permanent Change of Station (PCS) Portal. ETS2 is a Government-wide, Web-based, world-class Temporary Duty (TDY) travel management service and the PCS Portal is a VA-wide Web-based travel management service. Both systems provide streamlined services and apply best practices to realize travel efficiencies while delivering transparent, accountable, and sustainable TDY and PCS travel services.
VACO	Supply Fund	Created to operate and maintain a VA supply system for procurement of supplies, equipment, and personal services.
VACO	Human Resources Administration	Leads the development and implementation of human capital management strategies, policies, and practices to cultivate an engaged, proficient, and diverse workforce, one that will continue to transform and improve the delivery of services to Veterans and their families.
VACO	Office of Information & Technology	Provides support to veterans and their families through adaptable, secure, and cost effective technology services across the Department.
VACO	Office of Acquisition, Logistics and Construction (OALC)	Multifunctional organization responsible for directing the acquisition, logistics, construction, and leasing functions within the VA.
VACO	General Administration	Provides for necessary operating expenses of the Department of Veterans Affairs, not otherwise provided for, including administrative expenses in support of Department-wide capital planning, management and policy activities, uniforms, or allowances.

VA determined that four programs reviewed are at-risk for significant improper payments. VA will report estimated improper payments for these programs in the FY 2017 Agency Financial Report in accordance with OMB Circular A-123, Appendix C. Chart 2 on the following page provides the detail on the new programs determined at-risk of significant improper payments:



**Chart 2: FY 2016 Risk Assessment Results - New Programs at Risk to Significant Improper Payments<sup>2</sup>**

Administration/ VACO	Program	Description	Explanation of Assessment of Risk Level	FY Improper Payment Rate and Amount will be Reported
VHA	Communications, Utilities, and Other Rent	Payments for use of communications, utility services, and charges for possession and use of land, structures, or equipment owned by others.	Probe sample results identified an elevated risk when obtaining utility services greater than the simplified acquisition threshold of \$150,000 where FAR requirements are not always met <sup>3</sup> .	FY 2017
	Medical Care Contracts and Agreements	Includes contracts for research, medical and educational data or services, reimbursements at contract per-diem rates for hospitalization, dialysis treatment furnished by a non-VA facility, indirect charges added for research and demonstration projects, and contracted EMS services.	Probe sample results identified an elevated risk where contracts were not always in place when required, payments were not made in the correct amount, and lack of supporting documentation existed.	FY 2017
	Prosthetics	Funds the provision of medically prescribed prosthetic and sensory aids, devices, assistive aids, repairs, and services to eligible disabled Veterans to facilitate the treatment of their medical conditions.	During testing of a judgmental sample, VHA identified situations where delivery of a product to the Veteran is made prior to a contract or purchase order in place. Specifically, this situation occurred often for medical/surgical implant devices where the procurement actions for the device were made after the appliance was used and received by the Veteran during surgery. Since the surgical implant was used prior to the order being placed, the payment has been identified as improper causing the program to be susceptible to significant improper payments.	FY 2017
	VA Community Care Choice payments made from the Veterans Choice Fund <sup>4</sup>	A temporary program to improve Veterans' access to healthcare by allowing certain Veterans to elect to receive healthcare from eligible providers outside of VA. Established by section 101 of the Veterans Access, Choice, and Accountability Act of 2014.	The VA Community Care Choice payments totaled \$15M and are considered susceptible to significant improper payments due to the lack of an available tool to properly determine the correct amount paid.	FY 2017

<sup>2</sup> New programs determined to be susceptible to improper payments as a result of the FY 2016 risk assessments will design and implement appropriate statistical sampling and estimation methods to produce statistically valid improper payment estimates the fiscal year following (FY 2017) the fiscal year in which the risk assessment was conducted in accordance with OMB Circular A-123 Appendix C.

<sup>3</sup> If utility services costs are above \$150,000 annually, a contract should be executed or based on FAR 41.202(c), when a utility supplier refuses to execute a tendered contract as outlined in 41.201(b), the agency shall obtain a written definite and final refusal signed by a corporate officer or other responsible official of the supplier (or if unobtainable, document any unwritten refusal) and transmit this document, along with statements of the reasons for the refusal and the record of negotiations, to GSA at the address specified at 41.301(a). Unless urgent and compelling circumstances exist, the contracting officer shall notify GSA prior to acquiring utility services without executing a tendered contract. After such notification, the agency may proceed with the acquisition and pay for the utility service under the provisions of 31 U.S.C. 1501(a)(8).

<sup>4</sup> The Veterans Choice Fund had \$700M in disbursements in FY 2015. The majority of these disbursements were cost transfers to pay for medical expenses allowable under the Account Adjustment statute, 31 U.S.C. 1534. The payments consisting of cost transfers out of the Veterans Choice Fund to other VHA programs maintained the risk level of their corresponding reporting program and were tested in FY 2016, if applicable. VHA created strata for VA Community Care Choice where initial expenses for FY 2015 totaled \$15M. Like all new programs a risk assessment was conducted to determine its risk level. The risk assessment identified the VA Community Care Choice payments to be susceptible to significant improper payments and will be tested as a part of the 2017 IPERA activities under the VA Community Care program consistent with reporting in other high-risk programs.



VA identified 14 High-Risk programs in previous fiscal years. Chart 3 below provides VA's high-risk programs and a description of the program's activities:

Chart 3: FY 2016 High-Risk Programs		
VA Administration/VACO	VA Program Name	Description
VHA	Beneficiary Travel	Beneficiary Travel is organizationally aligned under VHA Member Services. The program consists of mileage reimbursement, common carrier, and special mode transportation (ambulance, wheelchair van, etc.) to eligible Veterans and other beneficiaries. In addition, VA can provide or reimburse for the actual cost of bridge tolls, road tolls, and tunnel tolls. The actual cost for meals, lodging or both, not to exceed 50 percent of the amount allowed for government employees may also be provided in limited circumstances. The Beneficiary Travel Program is discretionary in nature with funding coming from the yearly VA healthcare medical care services appropriation.
VHA	Civilian Health and Medical Program (CHAMPVA)	CHAMPVA is a healthcare benefits program in which the VA shares the cost of covered healthcare services and supplies usually as a secondary payer or payer of last resort with certain eligible beneficiaries.
VHA	VA Community Care	VA Community Care is used to provide timely and specialized care to eligible Veterans. The program allows VA to authorize Veteran care at community care facilities when the needed services are not available through the VA, or when the Veteran is unable to travel to a VA facility.
VHA	Purchased Long Term Services and Supports	Purchased Long-Term Services and Supports is organizationally aligned under the VHA Geriatrics and Extended Care (GEC) Office that strives to empower Veterans and the Nation to rise above the challenges of aging, disability, or serious illness. GEC programs are for Veterans of all ages, including older, frail, chronically ill patients, their families and their caregivers. Further, because the course of chronic illness varies and healthcare needs of chronically ill patients change, it is possible that services of one, some, or all GEC long-term Services and Supports will be required over time.
VHA	State Home Per Diem Grants	Under the State Home Per Diem Grants program, states may provide care for eligible Veterans in need of care in three different types of programs: nursing home, domiciliary, and adult day healthcare.
VHA	Supplies and Materials	Includes supplies and materials whether acquired by formal contract or other form of purchase which are ordinarily consumed or expended within 1 year after they are put into use, converted in the process of construction or manufacture, or used to form a minor part of equipment or fixed property or other property not separately identified in the asset accounts.
VBA	Compensation	VA provides compensation to Veterans who are at least 10 percent disabled because of injuries or diseases that occurred or were aggravated during active military service.



Chart 3: FY 2016 High-Risk Programs		
VA Administration/VACO	VA Program Name	Description
VBA	Pension	VA helps Veterans and their families cope with financial challenges by providing supplemental income through Veterans Pension and Survivors Pension benefit programs.
VBA	Vocational Rehabilitation and Employment (VR&E)	VR&E program helps Veterans with service-connected disabilities and an employment handicap prepare for, find, and maintain suitable careers.
VBA	Education – Chapter 33	VA offers higher education and training benefits to Veterans, Servicemembers, and their families who served after September 10, 2001.
VBA	Education – Chapter 1606	VA offers education and training benefits to eligible members of the Selected Reserve.
VBA	Education – Chapter 1607	VA provides educational assistance to members of the Reserve components called or ordered to active duty in response to a war or national emergency declared by the president or Congress.
VACO	Disaster Relief Act – Hurricane Sandy (HS)	The Disaster Relief Appropriations Act provides aid to rebuild VA facilities after the Hurricane Sandy disaster.
VACO	Payments to Federal Employees (PFE) – Payroll	VA provides PFE - Payroll to employees through the DFAS.

## Section II. Statistical Sampling Processes Performed for VA Programs

The 14 VA programs identified as susceptible to significant improper payments in FY 2015 are required to select an annual sample for testing and report estimated improper payments in FY 2016 in accordance with OMB Circular A-123, Appendix C. Compliance can be accomplished by testing a standard statistically valid sample of transactions. Consistent with the prior year’s statistical sampling approach, VA used a stratified sample design to separate the payment data into homogeneous strata by sub-program(s), sub-organization, or by type and dollar amount. The payments were ordered by amount within each stratum, and a systematic random sample was selected to ensure a consistent representation of the payment universe. The sample size for each stratum was calculated using a proportional allocation method. Program universes were constructed by collecting payments from each fiscal quarter. Samples were then selected from each quarter.

Strata definitions were modified from the prior year for certain programs to account for governing policy and regulation changes, structural differences in program implementation, and to provide better program insight. Strata modifications were made on an as-needed basis for the following programs:

- VA Community Care used a combination of cost center, budget object code, and transaction code and payment size to divide payments into different cohorts.
- State Home Per Diem Grants and Purchase Long-Term Services and Supports used a combination of cost center and payment size, specific to each program, to divide the universe of payments into different cohorts.
- The Choice Act funding was associated with different VHA program payments. High-risk programs affected by this funding source (Beneficiary Travel, VA Community Care, and



Purchase Long-Term Services and Supports), had these payments classified in separate cohorts. A small number of samples were selected from each program, reviewed and included in program projections.

- Education programs used the business transaction codes and payment size to divide payments into cohorts.

A systematic random sample was selected from each stratum to ensure a consistent representation of the payment universe. Sample sizes varied by program and were determined using historical program error rates and power estimates that would meet OMB precision requirements. The sample size for each stratum was calculated using a proportional allocation method and historical information on improper payments. Payments selected for testing were then reviewed against program-specific criteria to determine payment accuracy.



Section III. Improper Payment Reporting for VA Programs

**Table 1**  
**Improper Payment (IP) Reduction Outlook**  
 (\$ in millions)<sup>(1)</sup>

Program or Activity	2015 (based on 2014 actual data)			2016 (based on 2015 actual data)					2017 (based on 2016 estimated data)			2018 (based on 2017 estimated data)			2019 (based on 2018 estimated data)		
	OUTLAYS (\$)	IP %	IP \$	OUTLAYS (\$)	IP %	IP \$	Over-payments \$	Under-payments \$	OUTLAYS (\$)	IP %	IP \$	OUTLAYS (\$)	IP %	IP \$	OUTLAYS (\$)	IP %	IP \$
Beneficiary Travel (2)	811.55	6.22	50.48	890.06	7.37	65.64	63.04	2.60	916.76	7.35	67.38	944.26	7.30	68.93	972.59	7.20	70.03
CHAMPVA	1,135.34	3.41	38.75	1,145.73	4.70	53.87	30.52	23.35	1,180.10	4.69	55.35	1,215.50	4.60	55.91	1,251.97	4.50	56.34
VA Community Care (2,3)	3,912.17	54.77	2,142.69	4,728.95	75.86	3,587.245	3,568.1722	19.0728	4,870.82	75.00	3,653.11	5,016.94	73.00	3,662.37	5,167.45	71.00	3,668.89
Purchased Long Term Services and Supports (2,3)	1,479.71	59.14	875.128	1,705.60	69.15	1,179.49	1,176.41	3.08	1,756.77	69.00	1,212.17	1,809.47	67.00	1,212.35	1,863.76	65.00	1,211.44
State Home Per Diem Grants	1,077.84	2.02	21.766	1,126.26	2.57	28.93	27.47	1.46	1,160.05	2.50	29.00	1,194.85	2.40	28.68	1,230.69	2.30	28.31
Supplies and Materials	2,457.24	1.32	32.440	2,476.71	0.90	22.27	22.24	0.03	2,551.01	0.89	22.70	2,627.54	0.88	23.12	2,706.37	0.87	23.55
Compensation	58,449.56	2.33	1,361.35	63,864.04	0.59	376.577	256.159	120.418	74,869.19	0.58	434.24	79,332.14	0.56	444.26	84,428.92	0.53	447.47
Pension	5,832.79	4.53	264.19	5,594.76	2.27	127.097	120.906	6.191	5,605.58	2.26	126.69	5,915.77	2.24	132.51	6,287.52	2.21	138.95
VR&E	1,081.22	1.04	11.26	1,260.38	0.55	6.95	6.92	0.03	1,444.91	0.54	7.80	1,556.94	0.52	8.10	1,652.48	0.49	8.10
Education – Chapter 33	11,172.65	1.21	135.05	11,344.07	0.03	3.92	3.92	-	11,969.61	0.02	2.39	12,564.69	-	-	13,118.27	-	-
Education – Chapter 1606	147.15	1.05	1.55	143.47	0.06	0.088	.076	.012	148.79	0.05	0.074	154.82	0.03	0.046	161.10	-	-
Education – Chapter 1607	67.33	2.23	1.50	47.73	1.31	0.623	.363	.260	32.86	1.30	0.427	17.78	1.28	0.228	17.87	1.25	0.223
Disaster Relief Act – HS	27.27	5.71	1.558	23.61	3.66	0.865	.865	-	37.26	3.65	1.36	37.26	3.64	1.357	33.12	3.63	1.203
PFE – Payroll (4)	25,812.71	0.15	38.46	27,368.24	0.12	32.079	24.786	7.293	28,841.65	0.12	34.610	30,456.78	0.12	36.548	32,162.36	0.12	38.595
Totals	113,464.53	4.39	4,976.172	121,719.61	4.51	5,485.644	5,301.8472	183.7968	135,385.36	4.17	5,647.301	142,844.74	3.97	5,674.409	151,054.47	3.77	5,693.101

**Notes to Table 1:**

- (1) In FY 2016, VA tested and reported on payments made in FY 2015.
- (2) The Beneficiary Travel, Purchase Long Term Services and Supports, and VA Community Care programs have not shown improper payment reductions in recent years. VA established reduction targets to show reduction while ensuring established targets are achievable. Statistically valid testing for IPERA is completed one year in arrears; so changes are not seen until up to 2 years later. For example, in 2016, VA will report the results of improper payments found from testing FY 2015 disbursements. Therefore, changes implemented in FY 2016 will not be tested and reported on until FY 2017 and will likely not impact projections until FY 2018. For VHA programs, VHA is taking a comprehensive approach to resolving acquisition issues through legislation changes and reviewing internal processes to identify areas to increase compliance without impacting Veterans access to care.
- (3) VA is committed to providing care for our Veterans. VA will continue to ensure that all Veterans get the care they need and deserve, which may result in authorizations that are categorized as improper payments because VHA does not have the authority to purchase care in the community without following FAR. Currently, when a Veteran needs care that cannot be provided timely at a VA facility, they are referred to a community provider. If VA does not have a contract with the provider that adheres to FAR, the payment for that care is considered improper.
- (4) Due to systems enhancements and ongoing changes in VA's internal business processes and procedures for Payments to Federal Employees that may impact future improper payment rates, VA has kept the target improper payment rates for future years at .12.

**High-Priority Program Reporting: Supplemental Measures**

Under Executive Order 13520 and its implementing guidance, OMB identifies programs that have more than \$750 million in annual estimated improper payments. VA has three programs that OMB deemed high-priority programs: VA Community Care, Purchased Long-Term Services and Supports, and Compensation Services. These programs are required to perform additional activities to drive the



reduction of improper payments. As such, VA has diligently worked to meet the additional requirements for its high-risk programs, and information on VA's efforts can be found on [PaymentAccuracy.gov](http://PaymentAccuracy.gov).

## VA Community Care

The VA Community Care program is used to provide timely and specialized care to eligible Veterans. The program allows VA to authorize Veteran care at community care facilities when the needed services are not available through the VA, or when the Veteran is unable to travel to a VA facility.

To facilitate appropriate oversight, the Department of Audits and Internal Controls within the Office of Community Care (OCC) completes testing throughout the fiscal year to ensure adequate internal controls are in place, which included 11 audits of VA Community Care during FY 2015. In addition, an internal audit team executes an annual audit plan that independently assesses the VA Community Care program and associated operations. Recommendations and corrective actions are developed in response to the audits.

To ensure adequate controls are in place, the Community Care Operations Program Office maintains a procedure guide that details the types of monitors that are required for the VA Community Care program. The Claims Adjudication and Reimbursement directorate is responsible for ensuring the procedure guide is thoroughly implemented, which is annually tested for sufficiency and compliance by the Department of Audits and Internal Controls. Any deficiencies identified during internal controls testing require identifying the cause and developing a corrective action plan, which is monitored through completion by the Internal Controls staff.

To comply with the Executive Order 13520, VA Community Care developed two supplemental measures and targets for FY 2016 and FY 2017:

### 1. Percentage of non-contract disbursements in the VA Community Care Program

As of September 2016, payments associated with non-contract authorizations totaled \$4.14 billion, accounting for approximately 69 percent of VA Community Care. By September 30, 2017, OCC will reduce payments associated with non-contract VA Community Care authorizations by 4 percent, from 69 percent to the target of 65 percent. VA's goal is to decrease the number of non-contract authorizations issued under 38 U.S.C. 1703 and increase the amount of non-VA healthcare services purchased through contracts awarded in accordance with FAR. Compliance with FAR reduces improper payment designations due to lack of acquisition authority to purchase care.

For the purposes of this measure, OCC tracks the payments associated with non-contract VA Community Care authorizations and will provide updated information quarterly. The movement from non-contract authorizations to contracts awarded in accordance with FAR is one of multiple steps OCC is taking to remediate the errors identified in FY 2015 that contributed to the significant increase in improper payments. Compliance with these purchasing authorities reduces contracting errors which led to the high-priority designation.

In the fall of 2015, the Acting Principal Deputy Under Secretary for Health issued a memorandum to Veterans Integrated Service Network (VISN) Directors establishing a mandatory hierarchy for the purchase of care in the community. Within the hierarchy, VAMCs are instructed to first attempt to refer a Veteran to another local VA facility in accordance with usual inter-facility referral patterns. If a local VA facility cannot accept the Veteran then the facility is instructed to utilize other sharing agreement authorities with Department of Defense facilities or Indian Health Services and Tribal

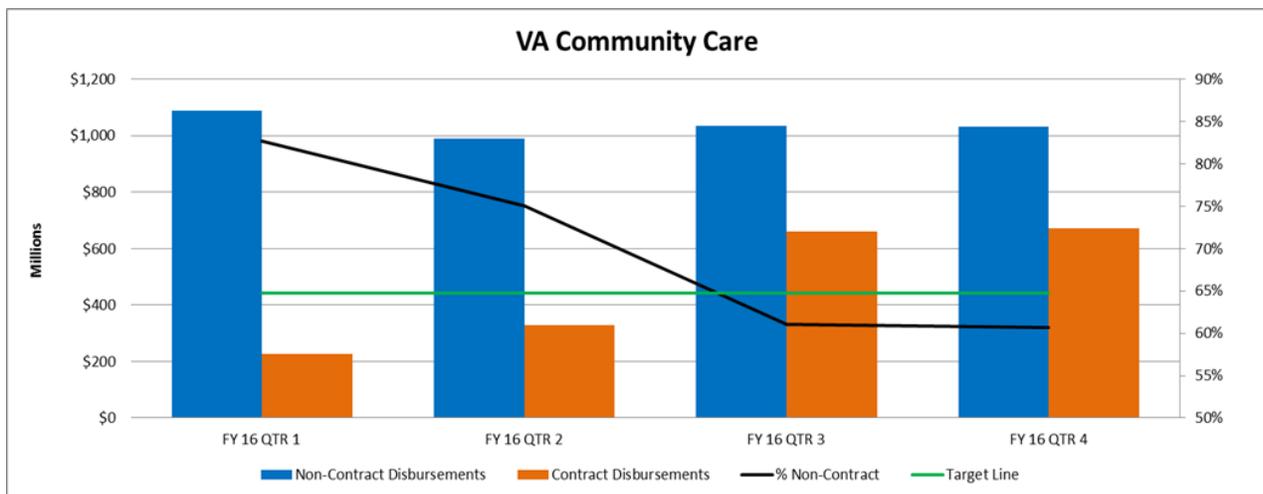


Health Program organizations. When these facilities are not capable of providing the necessary care then the VA facility is instructed to utilize the authority granted by the Veterans Choice and Accountability Act (Public Law 113-146 referred to as VA Choice Program) and schedule the Veteran using the Patient Centered Community Care (PC3)/VA Choice contract. If the Veteran is not eligible under the Choice Program the facility is still capable of scheduling the Veteran under a PC3 authorization outside of the Choice Program. Authorizations issued in accordance with these authorities are in compliance with FAR and other regulations.

In late calendar year 2015, VA introduced the use of VA-initiated provider agreements as authorized by PL 113-146. These provider agreements are non-contractual agreements that do not have to comply with FAR or VA Acquisition Regulations (VAAR) and will only be authorized for use when the contractor cannot schedule an otherwise eligible Veteran. Additionally, the local VA facilities will have to document satisfaction of the provider agreement criteria prior to signature and issuance of the agreements.

Only after a VA facility exhausts all of these avenues for providing care in the community may a facility then utilize individual authorizations to approve Veterans to receive care in the community. In an attempt to eliminate the need for individual authorizations entirely, VA submitted a legislative proposal to Congress in May 2015 requesting provider agreement authority to cover all care in the community for Veterans. If this authority is granted by Congress, VA will have a vehicle to provide timely, quality care while complying with all applicable regulations and statutes and will drastically reduce its reported improper payment rate.

The graph depicts total VA Community Care disbursements for FY 2016, broken into two categories that reflect whether payments were associated with contracts following FAR. The green line represents the target performance by the end of FY 2016, which is that payments associated with non-contract authorizations are less than 65 percent. The black line represents the actual performance by quarter.



Source for the data is FMS payment files.

There are risks associated with this supplemental measure. The impact associated with VA facilities using the Choice program to acquire community-based care will not be fully realized as part of the annual IPERA reviews for at least two more years, at which point the impact could be only short-term and tempered if and when Choice contracts are no longer available due to depleted funding and the needed legislative changes go unrealized. Until such time as proposed legislative and contractual remedies are implemented, VA will continue to utilize individual authorizations as

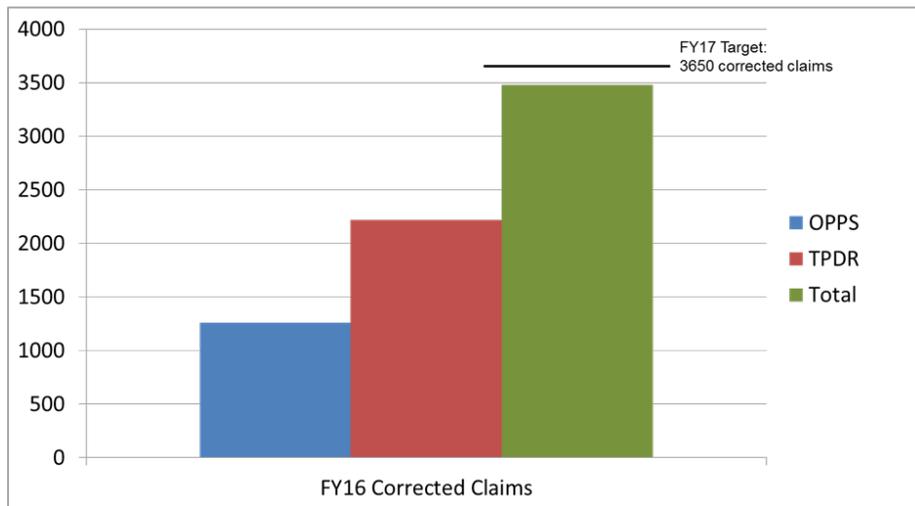


required to support Veterans’ timely access to care which will negatively impact this supplemental measure outcome

**2. Number of claims corrected prepayment through utilizing analytic and qualitative tools during claims processing in the VA Community Care Program**

As of September 2016, 3,480 claims were corrected prepayment. By September 30, 2017, OCC will increase the number of claims corrected in a prepayment state by 5 percent, from 3,480 claims in FY 2016 to the target of 3,650 claims in FY 2017, through use of analytic and qualitative tools. The increased utilization of the analytic and qualitative tools will increase the number of noncompliant healthcare claims identified in prepayment phase, allowing VA Community Care claims processing staff to proactively review, correct, and ultimately prevent improper payments before a payment is disbursed. OCC will be tracking the progress and provide updated information quarterly.

The graph depicts the number of VA Community Care claims corrected by OCC staff in a prepayment state in FY 2016 because a mandated qualitative tool identified the claim as a potential improper payment for review. The blue bar represents claims corrected through use of the Outpatient Prospective Payment System report; the red bar represents claims corrected through use of the Top Potential Duplicate Report; and the green bar represents the total of claims corrected through use of the two reports. The black line represents the FY 2017 performance target.



Sources: Program Integrity Tool Data Repository and Central Fee/SnapShot Web.

In March 2016, OCC leadership mandated the use of qualitative tools during claims processing to proactively review claims while in a prepayment state for common processing errors or errors resulting from gaps in technology that lead to improper payments. The tools had been developed and made available previously, but it wasn’t until the organizational realignment of staff from the VAMCs to OCC that a mandate was possible. The primary risk associated with this measure hinges on the mandate to utilize the tools. Should staff not comply with the mandate, it will directly impact the measure. OCC leadership is monitoring utilization on a monthly basis to ensure compliance with the mandate and address areas for improvement as they arise



## Purchased Long-Term Services and Supports

The Purchase Long-Term Services and Supports program is organizationally aligned under the VHA Geriatrics and Extended Care (GEC) Office that strives to empower Veterans and the Nation to rise above the challenges of aging, disability, or serious illness. The mission of GEC is to honor Veterans' preferences of health, independence, and well-being by advancing expertise, programs, and partnerships. GEC programs are for Veterans of all ages, including older, frail, chronically ill patients, their families and their caregivers. Further, because the course of chronic illness varies and healthcare needs of chronically ill patients change, it is possible that services of one, some, or all GEC long-term Services and Supports will be required over time. Existing internal controls over payments appear to be functioning. VHA and Office of Internal Control review indicates additional controls are needed in the authorization process.

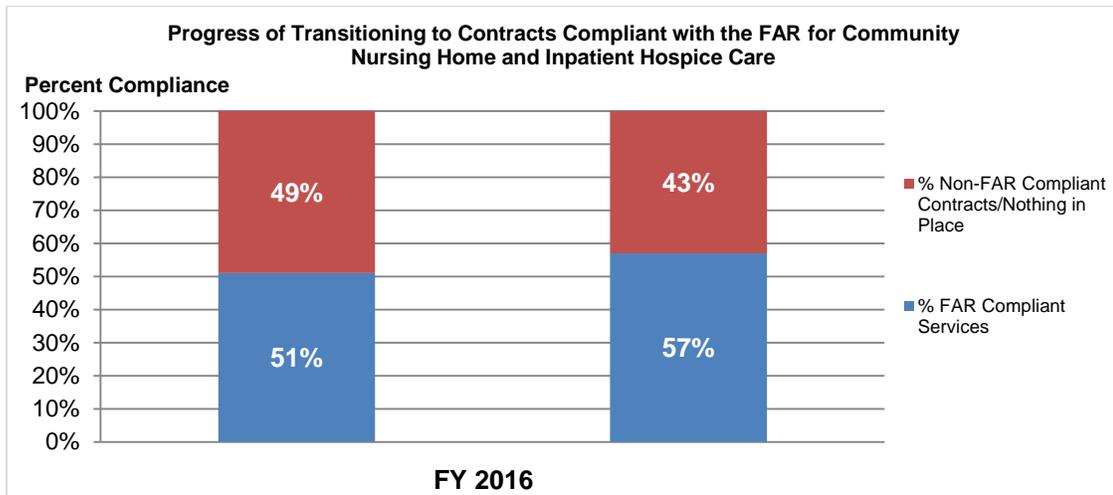
To comply with Executive Order 13520, Purchase Long-Term Services and Supports developed one supplemental measure and target for FY 2016 – 2017:

### 1. Percent of compliant contracts for Community Nursing Home and Inpatient Hospice Care

As of September 2016, 57 percent of Purchased Long-Term Services and Supports contracts fully comply with FAR. By September 30, 2017, VHA's goal is to increase the number of contracts complying with FAR for Community Nursing Homes and Inpatient Hospice Care to 85 percent. This increase directly correlates with the decrease of non-contract authorizations and the transition to contracts in compliance with FAR. Compliance with purchasing authorities reduces contracting errors which previously led to improper payment classifications. The increase to FAR compliant contracts will ultimately reduce the amount of improper payments. VHA is tracking the progress and will provide updated information quarterly.

There are risks associated with this supplemental measure. Market factors could affect VHA's ability to increase the percentage of FAR-compliant contracts. Some markets with strong trade associations have proved resistant to conversion to FAR-based contracts, despite years of VA open contract solicitations. VHA has more control over the ability to shift individual authorizations to provider agreements for home care services. Home care agencies have welcomed provider agreements which offer a recognized structure to the VA-agency relationship and do not require compliance with FAR.

This measure was developed during FY 2016 and shows an increase of contracts in compliance with the FAR from 51 percent to 57 percent at the end of FY 2016. The following graph depicts percentage of contracts following FAR for Community Nursing Homes and Inpatient Hospice Care.



Sources: VHA Contracting, List of Active Extended Care Contracts and GEC Community Nursing Home Certification Report.

## Compensation

VBA provides benefits and services to Veterans, their families and survivors in a responsive, timely, and compassionate manner in recognition of their service to our Nation. VBA's Compensation program provides monthly benefit payments to eligible Veterans in recognition of the effects of mental and physical disabilities incurred or aggravated from trauma, diseases, injuries, or events during active military service.

To facilitate appropriate oversight and maintain internal controls, Compensation Services continuously tests each fiscal year for improper payments, works with quality assurance personnel to identify and coordinate problem areas for remediation, provides training and review of regional office employees, ensures targets and measurable milestones in place, and appointed Accountable Officials to oversee IPERA remediation activities to drive the reduction of improper payments.

To comply with Executive Order 13520, Compensation developed three supplemental measures and targets for FY 2016 – 2017:

### 1. Percentage of Errors Related to Inaccurate Disability Evaluations Assigned

As of September 30, 2016, errors related to inaccurate disability evaluations accounted for 1.15 percent of quality assurance errors. By September 30, 2017, VBA will reduce the errors related to inaccurate disability evaluations from 1.15 percent to no more than 1.12 percent. The number of known errors in disability evaluations is based on quality assurance testing and includes instances where (1) the veteran is being underpaid disability compensation (under-evaluations) and (2) the veteran is being overpaid disability compensation (over-evaluations). The error rate for the under/over-evaluations in FY 2014 was 1.25 percent and dropped to 1.15 percent in FY 2015. VA is targeting a 2 percent decrease in the error rate to get to the target error rate of 1.12 percent. VBA is continuously tracking the progress and provide updated information biannually.

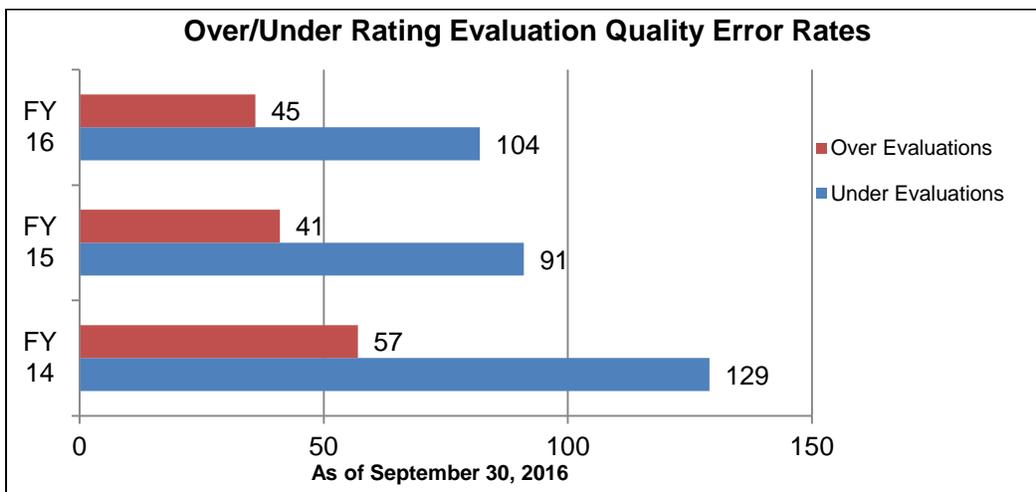
This Supplemental Measure targets errors resulting in incorrect amounts paid because the Veteran was entitled to higher/lower evaluation. Veterans are being evaluated and assigned a disability rating but the assigned ratings are lower or higher than they are entitled to under the Schedule for Rating Disabilities, 38 CFR Part 4. The root cause of these errors is that the Rating Veterans Service Representative assigns a disability rating that is lower/higher than the rating the Veteran is entitled to for their medical condition.



VBA has made strides in improving quality and consistency of Veterans' disability evaluations through the use of standardized and automated evaluation tools. Historically, Veterans have been evaluated and assigned a disability rating either higher or lower than they are entitled under the Schedule for Rating Disability leading to improper payments. VBA is taking steps to increase quality, which will impact the accuracy of disability evaluations and impact improper payments related to these errors.

The risk associated with this measure is that it only impacts current and future rating decisions. Since administrative errors made on rating decision determinations are usually not recoverable, Compensation Service is taking action to ensure that the correct rating evaluation is made. We mandate the use of job aids such as the evaluation builder, and the special monthly compensation calculator, to facilitate more accurate rating decisions. We also update manual guidance and administer consistency studies (consisting of a pretest, training, and posttest), on several aspects of rating evaluations.

The graphical representation below represents the reduced number of errors by fiscal year related to errors associated with over and under evaluations. Improvements in numbers are contributed to the use and compliance with standardized tools, to include the Evaluation Builder and Special Monthly Compensation Calculator.



Source: Statistical Technical Assessment Review

## 2. Number of Dependency Claims In Inventory

As of September 2016, VBA's dependency claim inventory is less than 115,000. By September 30, 2017, VBA will reduce the inventory of dependency claims by approximately 127,000 (about 56 percent) to 100,000. Dependency claims are among the major drivers of improper payments. At the end of FY 2015, the dependency claims inventory was almost 227,000. VBA is continuously tracking the progress and provide updated information quarterly.

Veterans who are awarded disability compensation at the 30-percent level or higher are entitled to additional compensation for their eligible dependents. Approximately 70 percent of the 4.1 million Veterans currently receiving compensation are eligible for this additional benefit – nearly 45 percent more than those eligible for the same benefits just five years ago. As the status of these Veterans' dependents change (through marriage, divorce, death, birth or adoption of children, step-children, and school attendance for children over 18 years of age), adjustments must be made to Veterans'



compensation awards. With VA's record-breaking levels of production of disability rating decisions (almost 1.4 million disability claims completed in FY 2015), more and more Veterans continue to be added to the compensation benefits.

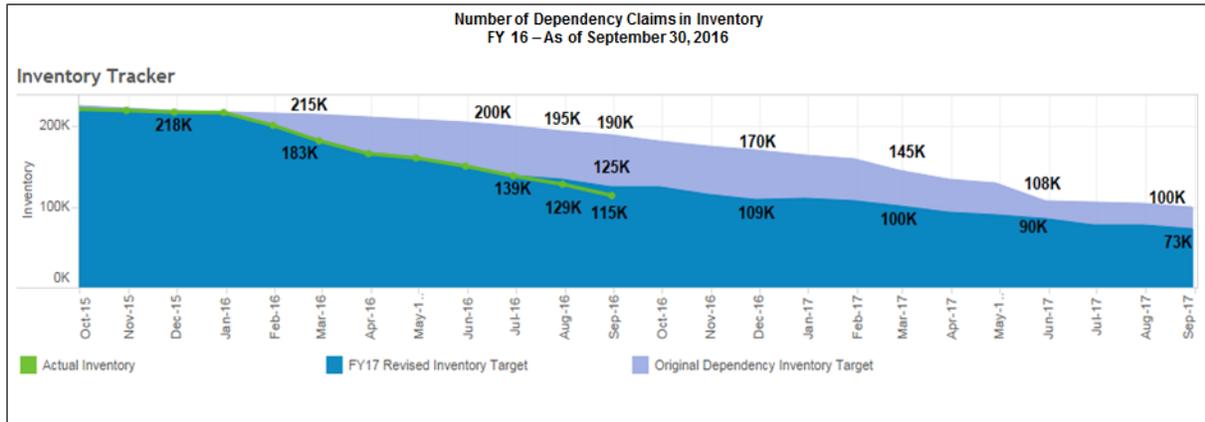
Veterans are required to provide the necessary evidence to add a dependent(s) into their monthly benefit and notify VA of changes in their dependent status. Improper payments occur when dependents are not added/removed timely when VA had the evidence on file of the change. Ensuring that Veterans receive timely and accurate claim decisions is paramount. The risks associated with this measure are that VBA is reliant on the beneficiary to update dependent status and the workload continues to increase as eligibility to dependency benefits continues to grow. As VA continues to improve timeliness of disability claims decisions, VBA will also focus on the dependency claims that are the direct result of the dramatic increase in completed disability rating decisions and growth in the number of Veterans receiving compensation at the higher disability evaluation levels.

VBA has already taken steps to expand our capability to address this growing inventory, which is a direct result of VBA's record-breaking achievements in reducing the claims backlog. Primarily, VBA engineered a rules-based processing system that is designed to complete most dependency claims. Veterans input data about their dependents into an automated form in eBenefits. VA has identified a set of exceptions that prevent automated processing and is reviewing the costs and functional requirements to eliminate these exceptions and expand Veterans' self-service.

In addition, VBA launched a pilot program in FY 2015 under which VA call center agents, who routinely receive calls from Veterans about the status of their dependency claims, obtained, and input dependency claim data to enable VA's rules-based processing system to automate dependency adjustments. The pilot proved successful as another method to expand automated processing to add a minor biological child, a spouse, a child in school between the ages of 18 and 23, and remove a spouse due to death or divorce. Since inception, more than 42,000 dependency claims were processed under the pilot. The program was expanded to the remaining call centers at the end of September 2015. All National call centers handle most dependency adjustments at the point of call while on the phone with the Veteran.

Processing dependency claims more timely will ultimately impact the amount of improper payments. VBA has an aggressive plan to reduce the inventory to 100,000 by the end of FY 2017. As the dependency claim inventory is reduced, claims are processed more timely and erroneous omissions of dependents from monthly benefit payments is also reduced. This ensures Veterans are receiving the accurate benefit payment they are eligible for, reducing the number of errors and, ultimately, the amount of improper payments.

The graphical representation below illustrates VBA's progress towards reducing the dependency inventory to 100,000 by September 30, 2017. As of September 30, 2016, the inventory was less than 115,000 which is a 47 percent decrease from December 2015.



Source: Performance Analysis & Integrity Non-Rating Bundle/Other Than Rating Dashboard (Report Hub)

When adjustments are made to correct dependency errors, the Veteran/beneficiary is notified in writing of any proposed adverse action. After the prescribed due process period, action is taken to reduce or terminate, and post-determination notice is provided to the Veteran/beneficiary. Any overpayment generated from this adverse action will be referred to the Debt Management Center for collection.

### 3. Percentage of Temporary 100 Percent Disability Claims Pending Over 125 Days

As of September 2016, 7.3% percent of temporary 100% disability compensation claims are pending over 125 days. By September 30, 2017, VBA’s goal is to reduce the number of temporary 100 percent disability claims pending for more than 125 days to no more than 15 percent of the total claims. Veterans are assigned temporary 100% evaluations for disabilities warranting 100% disability compensation for a finite period of time. Untimely processing may result in a Veteran keeping their 100% disability longer than potentially needed, resulting in an improper payment. Historically, VBA was not able to consistently achieve this standard when processing the temporary 100 percent disability claims. VBA is working to eliminate claims older than 125 days through routine monitoring of the pending workload. However, VBA has implemented tools to help track aging claims and promptly take necessary actions. VBA is continuously tracking the progress and provide updated information quarterly.

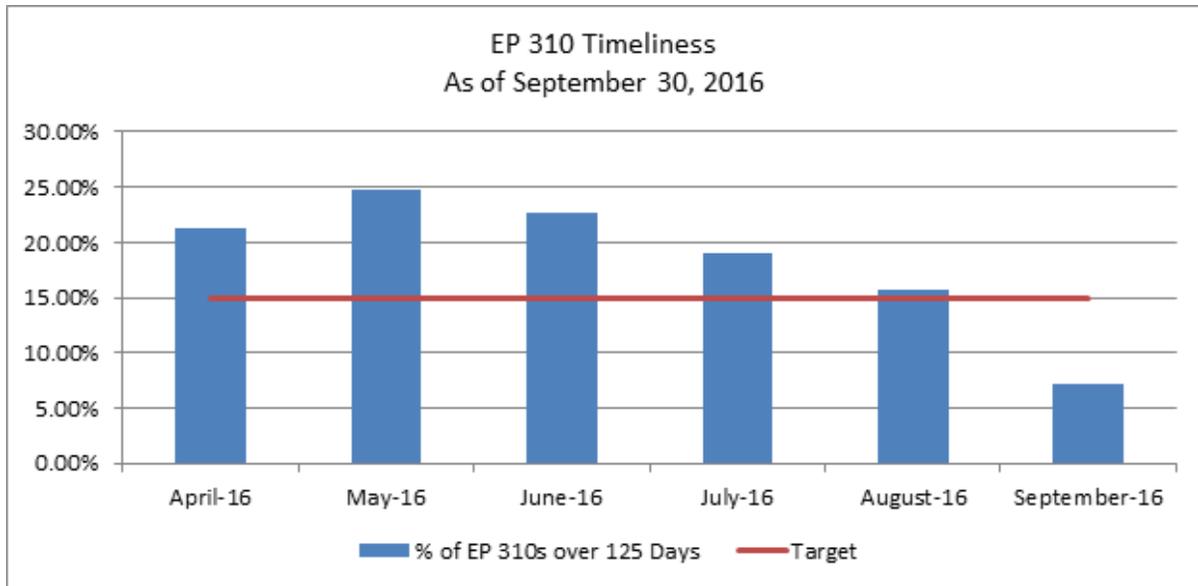
VBA policy requires a temporary total 100% evaluation benefit reduction disability for a service-connected disability following a veteran’s surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, Regional Office staff are required to request a follow-up medical examination if available evidence is not adequate to help determine whether to continue the veteran’s 100% disability evaluation. It was found that VBA was not correctly evaluating and monitoring temporary total 100% evaluation benefit reduction disability resulting in improper payments. The risk associated with this measure is that if the Veteran does not receive the medical examination or medical evidence is not available within 125 days, the temporary 100% evaluation may be unnecessarily prolonged.

VBA implemented a procedure to ensure appropriate action is taken on all temporary 100-percent disability evaluations within 180 days of inclusion on the monitoring report, or maturation of VBA’s future examination indicator that is established when the Veteran is awarded a temporary 100-percent evaluation. In addition, the Office of Field Operations (OFO) monitors the temporary 100-percent workload and distributes reports weekly to all Regional Offices showing specific claims requiring expedited processing. VBA has developed measureable milestones and performance



goals are in place to track progress. VBA will continue to work diligently to decrease the percentage of temporary 100 Percent Disability Claims Pending Over 125 Days and focus efforts on completing any necessary adjustment within 125 days.

The graphical representation below illustrates VBA's progress towards reducing the number of temporary 100 percent disability claims pending more than 125 days to no more than 15 percent of total claims. As of September 30, 2016, 7.3% over of temporary 100 percent disability compensation claims were pending over 125 days.



Source: PA&I Weekly Reports – Temporary 100% Review (Reports Hub)



Section IV. Improper Payment Root Cause Categories Identified in VA Programs

**Table 2 (For VHA)**  
**Improper Payment Root Cause Category Matrix**  
 (\$ in millions)<sup>(1)</sup>

Reason for Improper Payment	Beneficiary Travel		CHAMPVA		VA Community Care		Purchased Long Term Services and Supports		State Home Per Diem Grants		Supplies and Materials		
	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	
Program Design or Structural Issue	-	-	6.51	14.23	3,327.6433	-	923.19	-	-	-	-	-	
Inability to Authenticate Eligibility	-	-	-	-	-	-	-	-	-	-	-	-	
Failure to Verify:	Death Data	-	-	-	-	-	-	-	-	-	-	-	
	Financial Data	-	-	-	-	-	-	-	-	-	-	-	
	Excluded Party Data	-	-	-	-	-	-	-	-	-	-	-	
	Prisoner Data	-	-	-	-	-	-	-	-	-	-	-	
	Other Eligibility Data (2,3,4,5,6)	25.05	-	0.03	-	125.5607	-	1.36	-	0.94	-	-	
Administrative or Process Error Made By	Federal Agency	17.59	2.60	23.98	9.12	104.4136	19.0728	199.00	3.08	2.18	0.75	5.55	0.03
	State or Local Agency	-	-	-	-	-	-	-	-	0.32	0.71	-	-
	Other Party	-	-	-	-	-	-	-	-	-	-	-	-
Medical Necessity	8.47	-	-	-	-	-	-	-	-	-	-	-	
Insufficient Documentation to Determine	11.93	-	-	-	10.5546	-	52.86	-	24.03	-	16.69	-	
Other Reason (explain)	-	-	-	-	-	-	-	-	-	-	-	-	
<b>TOTAL</b>	<b>63.04</b>	<b>2.60</b>	<b>30.52</b>	<b>23.35</b>	<b>3,568.1722</b>	<b>19.0728</b>	<b>1,176.41</b>	<b>3.08</b>	<b>27.47</b>	<b>1.46</b>	<b>22.24</b>	<b>0.03</b>	

**Notes to Table 2(For VHA):**

- (1) In FY 2016, VA tested and reported on payments made in FY 2015.
- (2) Beneficiary Travel improper payments are due to lack of administrative qualification of the beneficiary or failure to verify/document services were received.
- (3) CHAMPVA improper payments are due to the recipient being ineligible for payment because Veteran/Beneficiary information was not input or determined correctly either at the time of application or after the application has been entered and program office is not notified of the change.
- (4) VA Community Care improper payments are due to the Veteran being ineligible for Fee care.
- (5) Purchased Long-Term Services and Supports improper payments are due to the Veteran being ineligible for purchased care.
- (6) State Home Per Diem Grants improper payments are due to unverified service connection or ineligible resident.



**Table 2.1 (For VBA, Disaster Relief Act and Payroll)  
Improper Payment Root Cause Category Matrix  
(\$ in millions)<sup>(1)</sup>**

Reason for Improper Payment	Compensation		Pension		VR&E		Education – Chapter 33		Education – Chapter 1606		Education – Chapter 1607		Disaster Relief Act – HS		PFE - Payroll		
	Overpayment	Underpayment	Overpayment	Underpayment	Overpayment	Underpayment	Overpayment	Underpayment	Overpayment	Underpayment	Overpayment	Underpayment	Overpayment	Underpayment	Overpayment	Underpayment	
Program Design or Structural Issue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.001	-	
Inability to Authenticate Eligibility	119.382	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Failure to Verify:	Death Data	-	12.738	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Financial Data	-	26.945	2.831	-	-	-	-	-	-	-	-	-	-	-	-	
	Excluded Party Data	-	-	-	-	-	-	-	-	-	-	-	.002	-	-	-	
	Prisoner Data	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Other Eligibility Data (2)	2.853	3.497	-	-	-	-	-	-	-	-	-	-	-	-	-	
Administrative or Process Error Made By	Federal Agency	132.343	116.921	2.001	-	6.92	0.03	3.92	-	.076	.012	.363	.260	.802	-	12.552	7.293
	State Agency	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Party	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Necessity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Insufficient Documentation to Determine	1.581	-	35.530	-	-	-	-	-	-	-	-	-	-	.045	-	12.233	-
Other Reason (3, 4)	-	-	43.692	3.360	-	-	-	-	-	-	-	-	-	.016	-	-	-
<b>TOTAL</b>	<b>256.159</b>	<b>120.418</b>	<b>120.906</b>	<b>6.191</b>	<b>6.92</b>	<b>0.03</b>	<b>3.92</b>	<b>-</b>	<b>.076</b>	<b>.012</b>	<b>.363</b>	<b>.260</b>	<b>.865</b>	<b>-</b>	<b>24.786</b>	<b>7.293</b>	

**Notes to Table 2.1 (For VBA, Disaster Relief Act and Payroll):**

- (1) In FY 2016, VA tested and reported on payments made in FY 2015.
- (2) Other Eligibility Data represents failure to verify dependency data.
- (3) Other reason category for Pension represents recipients not notifying VA of income changes in a timely manner.
- (4) Other reason category for Disaster Relief Act – HS represents a fund transfer error.



## Section V. Corrective Actions Being Undertaken by VA Programs

Corrective Action Plans (CAPs) are used to remediate errors identified as the root cause of improper payments. Each program reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. Of the 14 VA programs identified as high-risk, 7 programs exceeded the statutory thresholds for error rates and/or amounts of improper payments and are discussed below.

### VHA

Of the six VHA programs identified as high risk, five programs exceeded the statutory thresholds for error rates and/or amounts of improper payments and are discussed below.

#### 1. Beneficiary Travel

Member Services will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.02 percentage points in 2017. The Acting Deputy Under Secretary for Health for Operations Management is accountable for ensuring execution of the corrective action plans.

Member Services has been prioritizing clinical need, timely access, and payment processing above administrative details that could delay critical care or Veteran travel reimbursements. Since 2014, VA has redoubled efforts to provide quality care to Veterans and has taken steps at national and local levels to ensure timely access to care. VHA has delivered a coordinated, systemwide initiative to accelerate care to Veterans. Each VAMC is either enhancing their clinic capacity to help Veterans get care sooner, or where we cannot increase capacity, increasing the care we acquire in the community.

#### **Corrective Actions to Address Root Causes:**

##### **Root Cause: Failure to Verify Other Eligibility Data (38.16%)**

- Error Cause: Payments made to an ineligible recipient where the beneficiary did not meet administrative qualification criteria through service connection, income level, reception of VA pension, travel related to Compensation and Pension, or emergency situations.

In December 2015, the Beneficiary Travel calculator was updated to collect income information when necessary to determine eligibility for those Veterans who are not required or exempt from entering Means Tests or Copay Tests or those eligible who wish to have their deductible requirement waived.

This action was complete in January 2016, when National training was provided to the field on how to implement the new changes.



- Error cause: Failure to verify services were received or proof that medical care was provided due to not having real-time access to national level Beneficiary Travel claim data. In May 2016, the Web-based solution (VetRide) will further improve payment tracking for all Veterans Transportation Service locations. Four sites have passed user acceptance testing and transitioned from RouteMatch or the SharePoint Scheduling and Reporting System to VetRide as of June 2016.

Anticipated completion date of this corrective action is December 2018.

**Root Cause: Administrative or Process Error Made by Federal Agency (30.75%)**

- Error cause: Payments made without claimant signatures, reimbursements for benefits not allowable, payments made in the incorrect amount or duplicate payments due to lack of automated payment processes. System patches were developed and released to enhance the accuracy of claims processing and address deductible issues, missing claim date information, and expanded special mode account selection options. These capabilities along with the ability to import electronic invoices in one standard format will reduce administrative and process errors.

This action was complete in September 2016.

Additionally, system patches are being developed to enhance the accuracy of claims processing. These capabilities address waiver, deductible, and dashboard issues and will reduce administrative and process errors.

Anticipated completion date of this corrective action is September 2017.

As a long-term automated solution Beneficiary Travel Self-Service Solution (BTSSS) is being created to allow self-service and improved electronic travel claims processing of payments. The BTSSS will completely automate the front end of the mileage claims processing up to the point of payment then will integrate with fiscal systems for completion of payment. While maintaining segregation of duties, results will reduce administrative, processing, and lack of documentation errors of mileage, special mode transportation and other than mileage payments.

Anticipated completion date is approximately 3 to 5 years.

**Root Cause: Insufficient Documentation to Determine (18.18%)**

- Error cause: Lack of supporting documentation to validate payment due to insufficient tracking mechanisms. In February 2016, The OCC and Member Services partnered to pilot an electronic Beneficiary Travel invoice payment solution using the Fee Basis Claims System (FBCS) nationwide. The pilot program is expected to improve the timeliness and accuracy of ambulance invoices. The initial pilot phase was executed in April 2016 and completed in May 2016.

This action was complete in May 2016.



- Error cause: Lack of supporting documents to validate payment. VHA revised the 2016 IPERA testing checklist for 2017 into two separate testing plans to clarify the documentation required from facilities to properly support payment accuracy for either a mileage or special mode transportation claim.

This action was complete in September 2016.

#### **Root Cause: Medical Necessity (12.91%)**

- Error cause: Lack of medical documentation on file for special mode transportation due to poor storage and retrieval processes or lack of medical justification notes. The Computerized Patient Record System reminder templates were developed and released to enhance the accuracy of claims processing. In July 2015, the templates were approved for national use and were tested at various locations. The new clinical templates reduce medical necessity errors resulting from lack of medical justification to support the payment. The templates were mandated for national use in May 2016.

This action was complete in May 2016.

- Error cause: Lack of medical documentation on file for special mode transportation to show travel was medically required and/or preauthorized. In August 2014, the VHA released a new series of recurring online Beneficiary Travel national educational forum sessions to increase standardization of processes in the field. Each interactive forum is targeted to facility and VISN level Beneficiary Travel, Enrollment, and Financial staff on relevant issues such as covered benefits, increasing field compliance with established policies, and improving consistencies in payment methodologies. In November 2014, two on-demand Beneficiary Travel national training certifications were released: one for Beneficiary Travel Claim Processors and one for Beneficiary Travel Supervisors. Completion of training was nationally mandated in February 2016.

This action was complete in February 2016.

- Error cause: Lack of medical justification on file for special mode transportation. VA anticipates publication of proposed legislated program changes that will reduce improper payments related to lack of medical necessity. At this stage of the rulemaking, these changes are currently within VHA concurrence.

Anticipated completion date is approximately 3 to 5 years.

## **2. CHAMPVA**

OCC will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of the below actions, VHA expects to reduce improper payments by 0.01 percentage points in 2017. The Executive Director of Delivery Operations is accountable for ensuring execution of the corrective action plans. All corrective actions are monitored by the Quality and Corrective Action Plan Manager and tracked through a database to ensure successful implementation.

CHAMPVA is in the process of finalizing a Business Requirements Document to support contracting out development of outstanding technology modifications. Once the contract can be awarded and development completed, OCC anticipates a 25-60 percent reduction in improper payments. Interim



corrective actions that address the major error causes include continued revisions and staff training on vendor file management and selection processes, daily prepayment reviews of a percentage of claims for accuracy, and manual reconciliation process for vendor types that are associated with high error rates such as Sole Community Hospitals.

### **Corrective Actions to Address Root Causes:**

#### **Root Cause: Administrative or Process Error Made by Federal Agency (61.43%)**

- Error cause: Beneficiary having other health insurance that should have been billed prior to VA, incorrect claim redevelopment, incorrect vendor file setup or vendor selection, incorrect patient responsibility, data entry error, incorrect queue clearing, or system calculation errors when processing the claim. CHAMPVA is a secondary payer when a beneficiary has other health insurance and should only pay after the primary insurance plan has paid against the claim. Errors in the vendor data files can create improper payments and manual data entry errors. VHA has developed a Business Requirements Document to support multiple system modifications that will significantly contribute to improper payment reduction. System enhancements include streamlining vendor selection, lowering threshold for claims to be routed to a High Dollar Review Queue, elimination of manual work-arounds for reopened claims, and other enhancements to improve payment accuracy.

This action was complete in September 2016.

In addition, VHA implemented a daily postpayment review on all claims paid over \$75,000 to identify major processing issues more timely and facilitate sustainment training for individual staff.

This action was complete in October 2016.

VHA is also developing a process that allows for Sole Community Hospitals' vendor files, that also have a General Hospital vendor file, to be reviewed for critical changes prior to staff use to avoid vendor file selection errors.

Anticipated completion date is November 2016.

#### **Root Cause: Program Design or Structural Issue (38.51%)**

- Error cause: Improper processing documentation (bill, itemized statement, etc.), incorrect or untimely eligibility documentation, vendor documentation, or other health insurance documentation in the initial application resulting in an improper payment. Many of these errors come from documentation gaps, which result when a change in health insurance status or marital status was not available in time to properly process the initial benefits application or a claim. VHA reviewed existing vendor desk procedures for the Health Care Reimbursement staff, made necessary updates, and conducted refresher training for all voucher examiners, leads, and queue clearers for the critical connection between payment accuracy and proper vendor and facility type selection.

This action was complete in August 2016.



### Root Cause: Failure to Verify Other Eligibility Data (0.06%)

- Error cause: Beneficiary's information not input in accordance with policy (i.e., date of marriage, date of birth, Medicare dates, etc.) or eligibility status incorrectly determined for CHAMPVA benefits either at the time of application or after the application has been entered and program office is not notified of the change. These types of errors are very difficult to prevent due to not having access to real-time data. In 2015, data matches with Centers for Medicare and Medicaid Services and Tricare are being utilized to detect changes in the beneficiary's status that could affect CHAMPVA eligibility.

This corrective action is ongoing.

### 3. VA Community Care

OCC will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.86 percentage points in 2017. The Executive Director of Delivery Operations is accountable for ensuring execution of the corrective action plans. All corrective action plans are forwarded to the Quality and Corrective Action Plan Manager to ensure they are successfully executed and tracked through a database.

VA has requested a change in legislation to become compliant with FAR and has been actively pursuing remedies since the issue was first raised during the OIG's 2015 review of VA's compliance with IPERA. Until such time as proposed legislative and contractual remedies are implemented, VA will continue to utilize individual authorizations as required to support Veterans' timely access to care. As a result, VHA's IPERA improper payment rate will continue to exceed the 10 percent threshold. VA is taking steps to mitigate the situation in absence of legislative relief. In May 2015, VHA issued a hierarchy of care memorandum that requires the Choice contract to be the primary vehicle for Veteran care outside the VA Healthcare System. In the fall of 2015, the hierarchy of care memorandum was further revised. Should the Choice program be unable to support the needed care, further options are delineated with individual authorizations being the last option. The impact associated with VA facilities using the Choice program to acquire community-based care will not begin to be realized as part of the annual IPERA reviews for at least two more years, at which point the impact could be only short-term and tempered if and when Choice contracts are no longer available due to depleted funding and the needed legislative changes go unrealized.

VA Community Care utilizes a highly manual claims processing system with limited automation to process claims for community-based services. This manual system, coupled with multiple program authorities and payment schedules, has created a very complex process that leaves the program open to human error throughout the claims adjudication process. In October 2015 a plan to consolidate Community Care programs was submitted to Congress for consideration. Key elements of this plan include creating a singular community care program that meets the needs of Veterans while remaining simple to administer and easy to understand and moving towards a claims payment system where a high percentage of claims are auto-adjudicated, enabling timely and accurate reimbursement.

Interim corrective actions have been developed to address short-term processing accuracy needs. In March 2016, OCC leadership mandated that staff utilize qualitative tools that review claims in a prepayment state for potential improper payments, allowing staff an opportunity to correct errors in advance of the payment being finalized. One of the tools scans for potential duplicate payments across the entire VA Community Care payment system, something that cannot be done in real time



by staff members due to the decentralized nature of the current claims processing system. Another tool reviews claims for potential coding errors, such as unbundled charges, that lead to improper payments.

Guidance and standard operating procedures are also in development to support proper application of claims system coding edits. The current claims system relies on Medicare edits to drive claims processing; however, there are times when care authorized by VHA is outside of the Medicare billing standard. In those instances it is appropriate for VHA to issue payment in accordance with the authorized services, but it is equally important that documentary evidence be available to justify to payment when edits do not apply to the claim.

A new corrective action that will be implemented in October 2016 is a daily prepayment review of VA Community Care inpatient claims to ensure appropriate payment methodology and calculations are applied by staff. Errors within this claim type tend to be high-dollar value with multiple providers submitting claims for one episode of care. This manual review will be resource-intensive, but OCC anticipates a significant contribution to reducing improper payments.

Additional corrective actions underway include reinforcing to staff that expired contracts, such as the former Project HERO contracts, cannot be used to authorize or pay for community care services and collaborating with OCC revenue staff to improve the availability of insurance information in Veterans Health Information Systems and Technology Architecture (VistA). Under 38 USC 1725, VHA has authority to consider the availability of third party insurance in its claims processing decisions. When staff do not have timely access to accurate insurance information, it creates a situation where claims may be processed correctly at the time but become incorrect once the full information is available. By collaborating with OCC revenue staff to streamline the availability of this information, it is OCC's belief that the number of improper payment findings associated with the error cause "not an eligible Veteran" will quickly diminish.

### **Corrective Actions to Address Root Causes:**

#### **Root Cause: Program Design or Structural Issue (92.8%)**

- Error cause: Lack of appropriate acquisition actions. 38 U.S.C. 1703 provides authority for VA to purchase hospital care or medical services from public and private entities when VA cannot provide the necessary hospital care or medical services because of geographic inaccessibility or because the required services are not available. The statute, along with other applicable authorities, does not specify monetary limitations or restrictions on care purchased. The VA OIG has cited contracting discrepancies related to compliance with the FAR and where VHA exceeded its regulatory authority as improper. Beginning in 2015, if FAR or VAAR were not fully met, VHA considered the payments improper. This error cause had a significant impact on the program being designated as a high-priority program and the corrective actions have been tailored to meet compliance while balancing Veterans' access to care. To help address, OCC submitted to Congress a plan to consolidate Community Care programs under a singular authority.

This action was complete in October 2015.

In addition, VA implemented the use of VA Provider Agreements utilizing the authority already provided by the Choice Act.

This action was complete in February 2016.



In May 2015, Community Care released a memo outlining a hierarchy to appropriately purchase care in the community through the use of VAAR-compliant contracts such as the contract for the Veterans Choice Program. The implementation of this memo is ongoing with full impact and compliance anticipated during FY 2017. Additionally, within FY 2017, OCC will release a memo related to 38 U.S.C. 1703 individual authorizations clarifying to field facilities the need to utilize other purchasing mechanisms.

Anticipated completion date is September 2017.

Also in May 2015, a legislative proposal was submitted for Congressional consideration that would allow VA-initiated Veteran care agreements as authority for required non-VA medical services. Additionally, VA provided comments on multiple bills in this session of Congress that may achieve the same goal.

This corrective action is pending Congressional action.

**Root Cause: Failure to Verify Other Eligibility Data (3.5%)**

- Error cause: Payments made for patients not eligible for non-VA care. VHA will collaborate across business lines to improve availability of insurance information available to voucher examiners in order to appropriately adjudicate claims under 38 USC 1725.

Anticipated completion date is July 2017.

**Root Cause: Administrative or Process Error Made by Federal Agency (3.4%)**

- Error cause: Claims processor selecting the wrong schedule to pay, not properly applying the FBCS scrubber edits, or other payment methodology errors. Errors were also attributed to lack of required contracts where a VAMC referred a Veteran to a facility or hospital and only had authority to pay using a contract such as Rehabilitation Hospitals and Long-Term Acute Care Hospitals. System modification to FBCS that addresses compliance with claims processing standards, decreases improper payments, increases productivity, and enhances user ease of use, by integrating a module for Eligibility and Enrollment.

This action was complete in December 2015.

VHA also mandated utilization of three qualitative tools that proactively identify potential improper payments among claims in a prepayment state.

This action was complete in March 2016.

VHA updated the Non-VA Inpatient Hospital Payment Methodology Procedure Guide to incorporate newborn care processes.

This action was complete in September 2016.



VHA developed and implemented guidance and standard operating procedures regarding adherence to FBSC scrubber edits and proper processes to follow when scrubber edits do not apply to the claim.

This action was complete in September 2016.

VHA implemented a manual, prepayment review of inpatient claims to ensure appropriate payment methodology and calculations.

Anticipated completion date is November 2016.

VHA will develop a written statement and make an announcement regarding use of expired contracts to authorize and/or pay for Community Care.

Anticipated completion date is November 2016.

VHA will develop business case for adding professional coding staff to the organizational structure to improve training, processes, monitoring, and compliance.

Anticipated completion date is December 2017.

#### **Root Cause: Insufficient Documentation to Determine (0.3%)**

- Errors cause: Lack of supporting documentation to validate payment or justify services paid. VHA will revise the Compensation & Pension desk procedures to incorporate step-by-step instructions.

Anticipated completion date is November 2016.

#### **4. Purchased Long Term Services and Supports**

GEC will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.15 percentage points in 2017. The GEC Chief Consultant is accountable for ensuring execution of the corrective action plans.

In February 2014, VHA instructed VAMCs to convert all nursing home agreements to contracts following the FAR at the earliest possible date. Beginning in 2015, if FAR or VAAR contracting requirements were not met, VHA considered the payments improper.

As part of a revision to Title 38 Code of Federal Regulations § 17.56, a change in the payment regulation impacts community care providers for home health services and hospice care without an existing contract in place. If VA does not have a contract in place, VA will pay non-VA home health services and hospice care claims utilizing the Centers for Medicare and Medicaid Services Medicare fee schedule or Home Health Prospective Payment System amount (Medicare Rate), when possible. The effective date for the new payment methodology was June 1, 2014; however, the implementation date was October 1, 2014. VHA continues to seek resolution of long-standing legal issues which led to the incomplete implementation of AN98. Ultimately, this issue requires legislative action for complete resolution. Beginning with 2015, VHA considered § 17.56 errors as improper payments.



## Corrective Actions to Address Root Causes:

### Root Cause: Program Design or Structural Issue (78.27%)

- Error cause: Lack of appropriate acquisition actions to include error cause mentioned under this section for VA Community Care and errors resulting from the AN98 regulatory change. These error causes had a significant impact on the program being designated as a high-priority program and the corrective actions are tailored to meet compliance while balancing Veterans access to care. VHA will incorporate regulatory change (AN98) on payment processes for non-skilled Purchased Home and Community-Based Services (HCBS) to correct errors in payment structure. These changes would affect Homemaker/Home Health Aide services (H/HHA), Purchased Skilled Home Community Adult Day Health Care, In-Home Respite and Veteran Directed HCBS. The primary effect would be on H/HHA as that is the largest program.

Anticipated completion date is April 2017.

VHA continues to implement regulatory change on payment processes for Purchased Skilled Home Care to correct errors in payment structure.

Anticipated completion date of the re-evaluation of this corrective action is March 2017.

In April 2016, VHA introduced Local VA Provider Agreements to purchase non-skilled HCBS in lieu of individual authorizations to correct errors in acquisitions.

Anticipated completion date is September 2017.

### Root Cause: Administrative or Process Error Made by Federal Agency (17.13%)

- Error cause: Lack of appropriate acquisition actions to include lack of contracts, delayed creation or renewal of contracts, and payment methodology errors. These error causes had a significant impact on the program being designated as a high-priority program and the corrective actions have been tailored to meet compliance while balancing Veterans access to care. VHA will conduct multiple trainings to educate the field on updated policies surrounding authorization and proper payment methodologies. Trainings will be held with national Purchased Long-Term Services and Supports groups. Active oversight and technical assistance will be provided to VISNs and VAMCs.

Anticipated completion date is December 2016.

VHA will release a tool-kit and checklist for completing the authorization template that will include accurate rate information, which will significantly reduce payment errors made in the incorrect amount, prevent the wrong schedule being used, and improve the claim approval process. It will also prompt the review of contracts to ensure they are current. Active oversight and technical assistance will be provided to VISNs and VAMCs. VHA will also increase utilization of Medicare benchmark rates for Hospice Care.

Anticipated completion date is December 2016.

VHA is also working to embed the Purchased HCBS Case Mix and Budget Tool into the authorization template and increase awareness of Bowel and Bladder payment procedures by



completing a Desk Guide for distribution to VAMC staff that outlines proper procedures that must be followed when determining payment rates for these services.

Anticipated completion date is April 2017.

VHA will also convert purchasing of Nursing Home Care and Inpatient Hospice Care to FAR-based contracts

Anticipated completion date is September 2017.

**Root Cause: Insufficient Documentation to Determine (4.48%)**

- Error cause: Missing admission applications or the lack of sufficient documentation provided to justify services paid. VHA conducted IPERA training for VISN and stations to highlight the preferred format of requested documentation to increase compliance and establish best practices for submission. Updated and distributed the Documentation Guide and Checklist with embedded examples to provide additional resources to complete data calls. Training will be updated annually and information will be covered in other written material.

This action was complete in March 2016 and will be complete annually.

**Root Cause: Failure to Verify Other Eligibility Data (0.12%)**

- Error cause: Payments made for Veteran not eligible for care. VHA has conducted field training on timely and accurate contract renewals to ensure correct authorizations are established.

This action was complete in May 2016

**5. State Home Per Diem Grants**

OCC will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.07 percentage points in 2017. The Executive Director of Delivery Operations is accountable for ensuring execution of the corrective action plans. All corrective action plans are forwarded to the Quality and Corrective Action Plan Manager to ensure they are successfully executed and tracked through a database.

VHA's State Home Per Diem Grants program has made significant progress since FY 2013 in reducing improper payments. In 2016 however, VHA was able to identify an increase in improper payments associated with missing or incomplete documentation for domiciliary residents. This is due in part to a change in sampling stratification allowing VHA to identify and address additional issues that will benefit the program long-term.

Historically, the State Home offices tracked patient movements manually until the Electronic Tracking Tool was mandated by the State Home program office. Implementing and conducting training on the new application form and updated invoice forms will streamline the eligibility and application processing time lines and improve associated invoice processing accuracy. These corrective actions are limited by the lack of encryption software that prevents full automation. A pilot is underway right now to assess the impact associated with automating the application form similarly to how the eligibility form was automated.



With the State Home program, the Approval and Denial letters are crucial to communicating application determinations to the State Home regarding each resident's status. If the VAMC does not properly issue Approval or Denial letters, the State Home operates under the assumption that the originally-submitted application is accurate for invoicing purposes, which leads to improper payments. The State Home program office has mandated each VAMC issue standardized letters to their State Homes and Domiciliary outlining the approval and level of care to be paid for each patient on a monthly basis. Standardizing these letters ensures proper communication between VAMCs and State Homes and facilitates continued payment accuracy.

### **Corrective Actions to Address Root Causes:**

#### **Root Cause: Insufficient Documentation to Determine (83.06%)**

- Error cause: State Homes are required to submit complete applications within specified time frames and VA is required to reference those applications prior to processing payment. These errors resulted from missing admission applications or documentation not available or not supplied to justify services paid. VHA changed the source document for internal reviews from a VAMC-completed roster of documents to the mandated Electronic Tracking Tool, which will ensure VAMCs upload all applications to the SharePoint site once the State Homes submits completed applications. Additionally VA staff must utilize proper tracking mechanisms to accurately reconcile the invoice receiving report before issuing payment.

This action was complete in October 2015.

In addition, VHA implemented internal control processes for State Home Per Diem program staff to complete the application review using the Electronic Tracking Tool to identify errors, then follow-up with the field on correction of identified errors. Provided training and continued monitoring after review to ensure process improvements are maintained through quarterly progress reports.

This action was complete in October 2015.

VHA is continuing to redefine strategic relationship with the VISN/VAMC Business Implementation Managers and Fiscal Quality Assurance Managers to have a State Home Per Diem Point of Contact delegated at the VAMC of jurisdiction to process the eligibility of Veterans in the State Home. State Home program office has developed a SharePoint site to capture the Delegation of Authority appointments for the point of contact and State Home Per Diem Clerk as well as the Fiscal point of contact at every VAMC to target an interactive competency assessment to be taken yearly by these key staff to ensure properly trained staff are reviewing the application packages prior to payment.

Anticipated completion date is January 2017.

#### **Root Cause: Administrative or Process Error Made by Federal Agency (10.13%)**

- Error cause: State Homes are required to submit complete applications within specified time frames and VA is required to reference those applications prior to processing payment. VA staff must also utilize proper tracking mechanisms to accurately reconcile the invoice receiving report before issuing payment. These errors resulted from incomplete admission applications, incomplete receiving report on the invoice, or data entry errors resulting in an incorrect amount paid. VHA will conduct training on the new application form with a more detailed administrative



section and comprehensive instructions. The automated application will provide the State Veteran Home with a guided form that will highlight required information and restricts submission to only completed forms. Submits electronically and securely from the State Home to the VA once it has been filled out completely and has business rules built into the form to help standardize outcomes.

Anticipated completion date is April 2017.

**Root Cause: Administrative or Process Error Made by State Agency (3.56%)**

- Error cause: Admission application for new residents are not received within 10 days and payment for days of care was issued prior to the date VA received the form for processing or when an incorrect calculation was recorded on the invoice and was not identified prior to payment. VHA provided training on the updated invoice. Updated forms now have built-in calculations to decrease improper payments. Training will ensure claims for payment of benefits are processed accurately, in a timely manner, and are fully justified and documented for program management and auditing. Continue training quarterly during the State Home Per Diem monthly training call with the field with an emphasis on the time lines needed to ensure payment occurs from date of admission if application is received within 10 days of admission of the Veteran.

This action was complete in September 2016.

**Root Cause: Failure to Verify Other Eligibility Data (3.25%)**

- Error cause: Errors caused by unverified service connection of the Veteran or ineligible resident. VHA provided training on the standardized Approval/Denial letters and appeal rights when the Veteran is denied the level of care due to eligibility.

This action was complete in June 2016.

**VBA**

Corrective actions for the two VBA programs that exceeded the statutory thresholds are presented below.

**1. Compensation**

The Compensation program is implementing the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.01 percentage points in 2017. The Deputy Director, Policy and Procedures, Compensation Service, and Assistant Deputy Under Secretary for Field Operations are the responsible accountable officials for improper payment reduction targets.

**Corrective Actions to Address Root Causes:**

**Root Cause: Administrative or Process Error Made by: Federal Agency (66.19%)**

- Error cause: Processing, failing to reduce benefits appropriately, entitlement to a higher evaluation errors, and dependency adjustments. These errors impact the payment amounts that our Veterans and beneficiaries receive. Compensation Service is reviewing the medical



evaluation process and providing training to positively impact the quality of rating evaluations by regional offices. This will address issues/errors found where a Veteran was entitled to a higher or lower evaluation, but not evaluated at the correct disability level, or may or may not have been potentially entitled to extra special monthly compensation payment which resulted in an incorrect amount paid to the Veteran.

In addition, Compensation Service implemented improvements to reduce error rates associated with rating claims processing, to include correct processing of temporary total (100%) ratings. Consistency studies will assess and train regional office employees on specific subjects related to errors found on IPERA testing and quality reviews. During these consistency studies, there is a pretest which must be passed at the 100% correct rate, in order to bypass remedial training and a posttest. Improvement from pretest to the posttest is expected. This will enable employees to recognize the correct actions/procedures to take when processing temporary total ratings.

Also, Compensation Service is reviewing and updating procedural guidance via Knowledge Management manual throughout the fiscal year will ensure clarity. These changes occur due to changes in legislation, changes in policy, and procedural updates. Manual references are updated on an ongoing basis so regional office employees have the most current procedures.

Anticipated completion date is September 2017.

#### **Root Cause: Failure to Verify: Other Eligibility Data (1.69%)**

- Error cause: Veteran/beneficiaries are not correctly paid for their beneficiaries, not paid timely for their dependents, or timely removal of dependents was not done. This impacts the payment amount that our Veterans and beneficiaries receive for their dependents. Compensation Service continued use of Rules-Based Process System (RBPS) as an intermediate automated process for suitable dependency claims has resulted in an ongoing increase in acceptance of dependency claims through this electronic processing system. This is due to:
  - Identifying reasons for the rejection rate and determine best course of action for change in rules
  - Reviewing acceptance rates from programming rule to determine if additional updates are needed.

The continued use and improvements to the RBPS is expected to incrementally increase the acceptance rate for the automated processing of dependency claims.

In addition, Compensation Service uses consistency studies to assess and train regional office employees on specific subjects related to errors found on IPERA testing and quality reviews. During these consistency studies, there is a pretest which must be passed at the 100% correct rate, in order to bypass remedial training and a posttest. Improvement from pretest to the posttest is expected. This will enable employees to recognize the correct actions/procedures to take when processing dependency awards, and paying retroactive awards for dependents when there is an increased rating evaluation.

Anticipated completion date is September 2017.



### **Root Cause: Inability to Authenticate Eligibility (31.70%)**

- Error cause: Rating decisions where service treatment records noted a diagnosis of a condition, which was shown at present but there was no nexus of this condition from service to the present. The Veteran had been granted service connected benefits for this condition in error. The eligibility for this Veteran to receive service connection for the condition is not warranted, and a clear and unmistakable error was called.

Compensation Services continues to review and update procedural guidance via Knowledge Management manual throughout the fiscal year to ensure clarity. These changes occur due to changes in legislation, changes in policy, and procedural updates. Manual references have been updated on an ongoing basis so regional office employees will have the most current procedures. In addition, develop and administer consistency studies targeting error trends found on testing.

Anticipated completion date is September 2017.

### **Root Cause: Insufficient Documentation to Determine (0.42%)**

- Errors related to dependency entitlement and payment occurred when Veteran/beneficiaries are not correctly paid for their beneficiaries, not paid timely for their dependents, or timely removal of dependents due to sufficiency of documentation. This impacts the payment amount that our Veterans and beneficiaries receive for their dependents. Compensation Service continued use of RBPS as an intermediate automated process for suitable dependency claims has resulted in an ongoing increase in acceptance rates due to:
  - Identifying reasons for the rejection rate and determine best course of action for change in rules
  - Reviewing acceptance rates from programming rule to determine if additional updates are needed.

The continued use and improvements to the RBPS is expected to incrementally increase the acceptance rate for the automated processing. In addition, Compensation Service uses consistency studies to assess and train regional office employees on specific subjects related to errors found on IPERA testing and quality reviews. During these consistency studies, there is a pretest which must be passed at the 100% correct rate, in order to bypass remedial training and a posttest. Improvement from pretest to the posttest is expected. This will enable employees to recognize the correct actions/procedures to take when processing dependency awards, and paying retroactive awards for dependents when there is an increased rating evaluation.

Anticipated completion date is September 2017.

## **2. Pension**

Pension will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.01 percentage points in 2017. The Director of Pension and Fiduciary Service and Assistant Deputy Under Secretary for Field Operations are the responsible accountable officials for reducing improper payments.



## Corrective Actions to Address Root Causes:

### Root Cause: Administrative or Process Error Made by: Federal Agency (1.57%)

- Error cause: Miscalculation of income and medical expenses that resulted in the erroneous payment of VA benefits to Veterans and their survivors. In addition, employees did not properly calculate or process and authorize the claims which led to the incorrect disbursement of VA payments. Pension Service conducted site visits to assist the Pension Management Center (PMC) in identifying or detecting any operational deficiencies that may have negatively impacted the accurate and efficient processing and authorization of pension-related claims. The site visit team also addressed training-related issues and provided awareness of how incorrect actions taken on pension claims impacts IPERA. This increased awareness may help reduce the number and amount of over/underpayments made to Veterans and survivors.

This action was complete in FY 2016:

- Philadelphia site PMC visit completed in November 2015
- Milwaukee PMC site visit completed in April 2016
- St. Paul PMC site visit completed in August 2016.

In addition, Pension Service, in conjunction with Employee Development and Training (ED&T), hosted an Instructor Qualification Workshop (IQW) in July 2016, which is designed to enhance the skills sets of employees responsible for providing training with the PMCs. IQW should improve the overall quality of training which can assist employees in gaining a better understanding of the importance of accurately processing pension claims.

This action was complete in July 2016.

Pension Service is in the process of developing standardized training for pension, DIC, burial, and accrued benefits, which is scheduled for implementation in FY 2017. The training will ensure consistency in the processing and authorization of pension-related claims.

Target completion dates of the training:

- Standardized Pension Training scheduled to begin in FY 2017 and will be ongoing (new hires and refresher)



### **Root Cause: Failure to Verify: Death Data (10.02%)**

- Error cause: Survivor benefits were continuously paid although Share SSA system interface showed beneficiary as deceased. In addition, notification of beneficiary's death had not been received by VA. VA implemented automatic suspension of beneficiary's benefits based on system notification from the Social Security Administration. This action occurs weekly and results in award suspension (payments are suspended) as well as a notification to the beneficiary's estate and a work item for the Regional Office (RO). The work item requires the RO to take final action in a timely manner by terminating the deceased beneficiary's VA benefits. This also reduces the possibility of an overpayment due to the beneficiary's death. In addition, Pension Service ensures the PMC process these work items in a timely manner.

This action was complete in July 2014.

### **Root Cause: Failure to Verify: Financial Data and Other Reason (60.45%)**

- Error cause: Failure or inability to verify financial data. VBA began using Federal Tax Information (FTI) obtained from the IRS and SSA for income evaluation when processing original claims. This evaluation is designed to validate income prior to initiating benefits as opposed to the historical process of paying benefits and then validating income.

This action was complete in November 2013.

Additionally, Pension Service is extending the utilization of FTI for income verification to all pension claims, to include claims for special monthly pension, dependency, and medical adjustment. Pension Service will also implement the National Training Curriculum (NTC), which includes refresher training, to ensure PMC employees understand what income and expense to use when making pension determinations and the impact that improper claims adjudication has on IPERA.

Anticipated completion date of these corrective actions:

- January 2017 (expansion of upfront income verification)
- Estimated completion is December 2016 (NTC Training).

### **Root Cause: Insufficient Documentation to Determine (27.96%)**

- Errors cause: Lack of supporting documents to validate payment. Pension completed its transition to a centralized receipt and virtual analysis concept by using the United States Postal Service and a contractor-operated scanning and automated work routing process that results in VA correspondence received via mail being directly scanned into a digital format. Once scanned, the mail is evaluated by the PMCs Intake Processing Center (IPC) for claims establishment and direct upload into the Veterans Benefits Management System (VBMS) eFolder. This eliminated paper handling and provides expeditious uploading of claims, evidence, and other mail to a Veterans eFolder in VBMS.

This action was complete in February 2016.



## Section VI. Internal Control Over Payments Made by VA Programs

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VA continues to evaluate and strengthen internal controls to improve program and payment activities throughout the Department. VA is leveraging its existing internal control environment and assurance process to evaluate whether VA's internal controls over improper payments are in place and operating effectively.

In response to requirements of the Federal Managers Financial Integrity Act of 1982, VA established an agency-wide management control program, which is managed by the Office of Internal Controls. VA accomplishes the objectives of the program by:

1. Integrating management controls into business processes and financial management systems at all organizational levels
2. Reviewing management controls and financial management systems' controls on a regular basis
3. Developing corrective action plans for control weaknesses and monitoring those plans until weaknesses are eliminated.

The long-term efforts of the Department are beginning to have a tangible impact on reducing the rate of improper payments in some programs. In 2014, VA identified six programs as noncompliant, by 2015 that number rose to eight. In 2016, VA's internal process will report only five programs. This turnaround is the direct result of the Department's oversight and attitude of establishing and maintaining sound internal controls. VA understands there is still work to be done. In FY 2017, VA will continue efforts to ensure accurate determination of root causes of improper payments and the actions needed to eliminate that cause of improper payments.

To ensure a comprehensive assessment of VA's high-priority programs, the Department's Office of Internal Controls evaluated the effectiveness of both key and non-key internal controls when evaluating the risk, information and communication, control activities and environment, and monitoring for VACC, PLTSS, and Compensation. Evaluating the effectiveness of these controls identifies areas needing improvement and will help ensure the Department is making payments timely and accurately.

Table 3 contains an assessment of the internal control standards for VA programs that exceeded the improper payment thresholds of A-123, Appendix C.



**Table 3  
Status of Internal Controls**

Table 3: Internal Control Standards														
Internal Control Standards	Beneficiary Travel	CHAMPVA	VA Community Care	Purchase Long Term Services and Supports	State Home Per Diem Grants	Supplies and Material	Compensation	Pension	VR&E	Education – Chapter 33	Education – Chapter 1606	Education – Chapter 1607	Disaster Relief Act - HS	Payroll
Control Environment	2	2	2	2	2	2	3	3	4	4	4	4	3	4
Risk Assessment	2	2	2	2	2	2	3	3	3	4	4	4	3	4
Control Activities	2	2	2	2	2	2	2	3	3	3	2	2	2	2
Information and Communication	2	2	2	2	2	2	3	3	3	4	4	4	3	3
Monitoring	2	2	2	2	2	2	3	3	3	4	4	4	3	3

**Legend:**

4 = Sufficient controls are in place to prevent IPs  
 3 = Controls are in place to prevent IPs but there is room for improvement

2 = Minimal controls are in place to prevent IPs  
 1 = Controls are not in place to prevent IPs



## Section VII. Accountability for Reducing and Recovering Improper Payments Made by VA Programs

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Departmental oversight and accountability of improper payments is established via the Department's IPERA Governing Board. Led by VA's Interim Chief Financial Officer (CFO), the Governing Board is focused on achieving IPERA compliance, identifying root causes of improper payments, establishing reduction goals and implementing effective corrective actions to reduce/prevent improper payments. Other key membership includes the Deputy Assistant Secretary for Finance, the Administration CFOs, Senior Accountable Officials (SAO) and other senior-level program staff. During FY 2016, the Governing Board re-established its Charter and increased membership to ensure that all stakeholders were proactively engaged in the governance of reducing improper payments.

VA recognizes the importance of maintaining adequate internal controls to ensure proper payments, and is dedicated to continuous improvement in the overall disbursement processes. In FY 2016, VA repurposed existing resources to expand its Improper Payments Remediation and Oversight (IPRO) Office – whose sole focus is to implement, monitor, and report on VA's progress in reducing improper payments. IPRO collaborates across the Department and with other Federal partners to strengthen integrity of payments and achieve essential goals in reducing improper payments. For FY 2017 and beyond, VA will continue its efforts to improve the integrity of its disbursements and actions to reduce improper payments.

In FY 2016, IPRO worked with SAOs to ensure that they understood roles and responsibilities. In early FY 2017, VA will codify this clarification in its IPERA financial policy. Updates will include, but are not limited to, identifying SAO responsibility for:

- Remediating improper payments
- Overseeing payment recapture audits
- Development and implementation of corrective action plans
- Development of supplemental measures for high-priority programs
- Quality of testing reviews

### **VHA**

Throughout FY 2015, VA initiated the process of assessing the current state of IPERA and determined that actions could be taken to strengthen outcomes. One of the first changes was designating the right SAO to drive change and ultimately reducing improper payments. Designating SAOs resulted in increased awareness, ownership, and a path forward.

#### **1. Beneficiary Travel**

The Acting Deputy Under Secretary for Health for Operations Management is designated as the program SAO and accountable for ensuring execution of corrective action plans. The SAO's FY 2017 performance plan will include a measure to meet the measurable milestones with 90 percent success based on date and action. Step down performance measures will be set as 80 percent and 70 percent.



Each individual reporting Program Office Director and corresponding subordinates are also held accountable to the Senior Executive performance plan expectations. Unique program corrective action plans are tracked and monitored for routine reporting. In November 2015, Member Services added a Compliance and Internal Controls Program Office to assist in creating additional internal controls for its programs inclusive of Beneficiary Travel. This will increase accountability and Senior Executive knowledge and understanding of the complexity related to Beneficiary Travel payments and the IPERA process. The additional oversight also allows for new insight into the root causes of improper payments most notably identifying how VA is streamlining business practices to align payment processing to abide with laws while vigilantly upholding core values. VA's evaluation of the Veteran experience from transportation request to reimbursement has fostered key collaborative efforts and initiatives leading to long-term solutions.

## **2. CHAMPVA**

The Executive Director of Delivery Operations is designated as the program SAO and accountable for ensuring execution of corrective action plans. OCC has the primary responsibility for the processing of CHAMPVA claims and works to address and correct improper payments. When errors are identified, OCC supervisors work to identify trends and provide education to the voucher examiners regarding the issue both individually and as a group. The Director of Claims Adjudication and Reimbursement's performance plan includes goals for financial stewardship and the identification and implementation of corrective actions to address improper payments.

## **3. VA Community Care**

The Executive Director of Delivery Operations is designated as the program SAO and accountable for ensuring execution of corrective action plans. The SAO's FY 2017 performance plan includes a measure to meet the measurable milestones with 90 percent success based on date and action. Step down performance measures will be set as 80 percent and 70 percent.

OCC has the primary responsibility for the processing of community care claims and works to address and correct improper payments. When errors are identified, OCC staff work to identify trends and provide education at both a local and national level. If additional training is needed, mentoring can be provided to the site by OCC staff. The Director of Claims Adjudication and Reimbursement and the Director of Community Care Operation's performance plans include goals for financial stewardship and the identification and implementation of corrective actions to address improper payments.

## **4. Purchased Long-Term Services and Supports**

The GEC Chief Consultant is designated as the program SAO and accountable for ensuring execution of corrective action plans. The SAO's FY 2017 performance plan includes a measure to meet the measurable milestones with 90 percent success based on date and action. Step-down performance measures will be set as 80 percent and 70 percent.

## **5. State Home Per Diem Grants**

The Executive Director of Delivery Operations is designated as the program SAO and accountable for ensuring execution of corrective action plans. The State Home Per Diem Program Office has the primary responsibility for processing claims and works directly with the



facility when improper payments are identified, as well as broadly across the program through monthly training events. The Director of Community Care Operation's performance plan includes goals for financial stewardship and the identification and implementation of corrective actions to address improper payments.

## **VBA**

Principal Deputy Under Secretary for Benefits, Performing the Duties of Under Secretary for Benefits continues to emphasize accountability and integrity at every level within the Administration. Underscoring the commitment to achieving the goals set forth in IPERA, SAOs have been designated for each program to oversee IPERA remediation activities. Furthermore, a committee of program managers, program officials and key accountable officers from all business lines work in a collaborative environment, specifically for the purpose of establishing and implementing guidelines and policies to meet improper payment reporting requirements.

With the launching of the VBA Transformation Plan, leadership developed goals and initiatives to transform VBA into a streamlined, high-technology 21<sup>st</sup> century organization, which is enabling VBA to process Compensation, Pension, and claims within prescribed time constraints, while maintaining high levels of accuracy. With Veterans and their families always at the forefront of all VBA strategic goals, the Transformation Plan is designed to transform three major areas: people, process, and technology. The sweeping multifaceted changes are improving internal process controls and are poised to significantly reduce improper payments as a result of increased automation and improved accuracy. VBA Regional Office Directors, Veterans Service Center Managers, PMC Managers, and all other management personnel share the same performance goal standards with respect to delivering high-quality products and benefits to Veterans. Non-supervisory employees are also responsible for maintaining standards set forth by management, to include maintaining quality, continued training, and staying abreast of legislative and technological changes in order to reduce or avoid improper payments.

## **Section VIII. VA's Information Systems and Infrastructure Put in Place to Reduce Improper Payments**

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### **VHA**

There are significant staffing shortages within VHA. Many errors were attributed to delayed creation or renewal of contracts due to staffing shortages in the contracting and community care offices. As well, requests for fixes or improvements to information systems, which address improper payments, must compete to be prioritized within the Office of Information and Technology (OI&T). The competitions for prioritization and limited staffing negatively impacts the requested system fixes and improvements. Additional information on the VHA programs which are reporting improper payments in excess of the statutory thresholds follow.

VA has a separate appropriation for information technology. All information technology funding requests compete for available funding. Administrative updates compete with clinical updates and often do not rate as high. VHA continues to present the updates for review each year. Additional information on the VHA programs which are reporting improper payments in excess of the statutory thresholds follow.



## 1. Beneficiary Travel

Long-term (3 to 5 years) infrastructure and information system solutions for the Beneficiary Travel program are underway. Initial funding approvals for key milestones have been met. Beginning in 2012, previous annual requests for funding were not successful during funding prioritization. Project start date for the BTSSS payment to Veterans began in FY 2016 with an award anticipated in FY 2017. Project funding for BTSSS payment to Vendors was funded in mid-FY 2016 with an anticipated award in FY 2018.

## 2. CHAMPVA

OCC has submitted multiple requests to the Office of Information and Technology over the last several years to improve the claims processing system for CHAMPVA. These changes would reduce errors by addressing identified system issues in VistA and expanding automated business rules to reduce the number of human entries and decisions. These changes have not yet been realized and OCC is in the process of finalizing a Business Requirements Document to support contracting out the development and implementation of these system changes with an estimated cost of \$8 million. In the interim additional quality reviews were implemented to monitor eligibility determinations. Ongoing data matches with Centers for Medicare and Medicaid Services and Tricare are being utilized to detect changes in the beneficiary's status. OCC also utilizes queues for secondary review of claims which meet certain criteria such as possible duplicate claims, or setting a percentage of any voucher examiners claims to be reviewed by a lead.

## 3. VA Community Care

Several information systems have been developed to assist in decreasing improper payments within this program, and are detailed in Section X of this report. For example, FBCS contains a claim scrubber that provides valuable information and edits to staff to assist them with appropriate claims processing. The Quality Inspector Tool is an audit tool run by the supervisor before batches are released to effectively identify errors and decrease improper payments. The Snap Web Duplicate Payment Program identifies duplicate payments in a prepayment state and the Program Integrity Tool uses a set of business rules to detect and prevent improper payments in a prepayment state.

Of an \$8 million cost estimate placed with VA Community Care for needed long-term Information Technology solutions, \$2 million is associated with incorporating new fee schedules and controls into the current claims processing system. Incorporating these new fee schedules into the system would reduce the manual retrieval and data entry during claims processing and allow increased oversight and payment accuracy. The remaining \$6 million is associated with hosting fees for a new version of the current claims processing system that introduces significant auto-adjudication to the process. As previously discussed, the highly manual nature of the claims processing system coupled with complex programs and claims processing requirements directly contributes to the program's payment accuracy. Realizing this functionality would be two large steps forward towards improving the payment accuracy for errors not associated with FAR compliance.



#### **4. Purchased Long-Term Services and Supports**

The improper payment rate for Purchased Long-Term Services and Supports is impacted by acquisition issues. Creation of contracts in the community can take an extensive amount of time, partly due to the complicated nature of Federal contracting regulations.

#### **5. State Home Per Diem Grants**

The State Home Per Diem program currently relies on the Electronic Tracking Tool, a semi-automated Excel spreadsheet that reconciles the gains and losses related to resident activity at the State Veteran Home, and invoiced items within the e-invoicing system VA utilizes. Prior to the electronic tracking tool being constructed in Microsoft Excel, VAMC staff tracked patient movement manually. The implementation of the Electronic Tracking Tool has significantly improved payment accuracy for the State Home program; however, limitations remain. One of the primary issues that cannot be overcome in the current state is the existence of approximately 200 Excel workbooks that house the Electronic Tracking Tool. \$500,000 in funding would support development of SQL integration of the workbooks and construction of artificial intelligence that would aid in tracking accuracy, national reporting and oversight, and support OCC compliance with the DATA Act that goes into effect May 2017. This enhanced solution would also include an encryption process for external stakeholders (State Veteran Homes) and aid in improving payment accuracy.

The program recently completed a 100 percent review of backlogged forms in its central repository. To support long-term technology improvement, the State Home program office received funding in 2015 to kick off a project referred to as the "Automated Grants Management System" and included this effort on its FY 2015 IPERA corrective action plan. However, lack of funding resulted in halting the project prior to development. The proposed Automated Grants Management solution would be a Web-based platform operating in an environment which is fully integrated with the full suite of VA and other Federal government databases, such as the Department of the Treasury. Both VA staff and State Home personnel would log into this common platform to request authorization, review requests, track residents, invoice, and report. This would eliminate the need for the Electronic Tracking Tool and facilitate the State Home program's compliance with the DATA Act. Continued improvements in payment accuracy are anticipated once the future state of this program is realized.

### **VBA**

VBA has implemented internal controls, acquired human resources, and developed information systems and other infrastructure to reduce improper payments. While VBA has the necessary information infrastructure to meet current improper payment levels, system enhancements and additional IT funds would allow further reduction in improper payments.

#### **1. Compensation**

VBA has established a collaborative work group with members of the DoD to work toward a solution to move the current annual drill pay adjustment process to a monthly process. In the interim, VBA has established a process where due process is sent out simultaneously with the initial notice of the drill pay days for the previous fiscal year. This action will save 60 days, which will allow adjustments to be made quickly and efficiently.



## 2. Pension

The Centralized Mail Activity (CMA) process was implemented within the Pension Management Centers to reduce claimants' mail handling by employees and to provide a more efficient way of processing pension-related claims accurately and in a timely manner. Currently, VBA is in the testing phase of post award audits, which will allow automatic issuance of due process after independent verification of income from the claimant. VBA will also implement upfront verification expansion, which involves a review of FTI for all pension claims to include claims for special monthly pension, medical and income adjustments, and dependency-related issues. VBA continues to provide manual policies and procedural updates, conduct annual site visits to determine if proper internal controls are sufficient and assess training needs in order for employees to be proficient at claims processing.

## Section IX. Statutory and Regulatory Barriers Limiting VA Corrective Actions

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### VHA

#### 1. Beneficiary Travel

There are several statutory or regulatory barriers impacting the Beneficiary Travel Program that limit implementation of VHA's corrective actions. These are detailed below:

- A legislative proposal was submitted for Congressional consideration that would allow expansion of VA's Income Verification Matching (IVM) authority. This proposed legislation would amend 38 U.S.C. § 5317 to expand VA's IVM authority and consequently allow VA to verify the self-reported incomes of service-connected Veterans in enrollment priority groups two and three who are requesting based on income, transportation reimbursement benefits, and/or a medication copayment exemption. VA currently has authority to verify non service-connected Veterans' incomes by matching income data reported by these Veterans with the Internal Revenue Service. As a result, VA is at risk for possible non collection of legislatively required medication copayments as well as improper payments.

#### 2. VA Community Care and Purchase Long-Term Services and Supports

VA Community Care and Purchase Long-Term Services and Supports were designated high-priority programs in November 2015 and have numerous challenges and barriers to overcome to improve payment accuracy. First and foremost is the matter of complying with FAR. VA will require a change in legislation to become compliant with the FAR and has been actively pursuing the required changes since the issue was first raised during the OIG's 2015 review of VA's compliance with IPERA.

Additional challenges that were also previously discussed pertain to the multiple legislative authorities and payment methodologies under VA Community Care that increase claims processing complexity coupled with the highly manual claims processing system. In October 2015, VA submitted a plan to Consolidate Community Care Programs to Congress that contains multiple elements in support of reducing improper payments and improving VA's compliance with IPERA. Key elements of this plan include creating a singular community care program that meets the needs of Veterans while remaining simple to administer and easy to understand and moving toward a claims payment system where a high percentage of claims



are auto-adjudicated, which enables timely and accurate reimbursement. The consolidation of multiple programs into a singular authority would allow for greater consistency in fee schedules and contribute to improved accuracy and timeliness of payment.

VA also needs legislative authority to enter into provider agreements to purchase care in the community for our Veterans. This would eliminate a large portion of our improper payments. Currently, when a Veteran needs care that cannot be provided timely at a VA facility, they are referred to a community provider. If VA does not have a contract with the provider that adheres to the FAR the payment for that care is improper. The need for provider agreements is particularly acute for Purchased Long-Term Services and Supports. VA lost more than 500 community nursing homes due to additional contracting rules, which do not apply to Medicare providers.

- Non-FAR-based arrangements are necessary because some smaller providers and those who see only a few Veteran patients a year are often unwilling or unable to comply with the FAR. It is unrealistic that contracts can be awarded for all healthcare services a Veteran may need that cannot be provided by VA.
- VA's authority for provider agreements under Choice is limited – both time limited to the life of the Choice program, which is anticipated to expire in FY 2017, and to the services available under Choice. Choice cannot be used for nursing home care, which is another area where VHA greatly needs a non-FAR-based purchasing mechanism.

## **VBA**

There are statutory or regulatory barriers affecting the Compensation and Pension programs that affect improper payments rates. In 2012, VA received permission from the Internal Revenue Service to transmit and store FTI electronically. Using this electronic data feed, VA successfully implemented an up-front income verification process, which allows its Pension Management Centers to verify a claimant's reported income during the initial claim adjudication process, prior to the granting of benefits. This approach allows VA to maintain the integrity of its program, while reducing improper payments.

Under current law, Federal agencies that use tax returns and return information for purposes of tax administration may disclose this information to contractors, to the extent that such disclosure is in connection with the processing, storage, transmission, and reproduction of such returns and return information, and the programming, maintenance, repair, testing, and procurement of equipment. Because VA does not use tax returns or tax information for tax administration purposes, section 6103 prohibits VA from using contractors to augment VA OI&T staff, or contractors and vendors that help administer benefit programs, if the contractors would encounter tax returns or return information. The prohibition inhibits innovation in agencies that rely on contractors to maintain agency systems. The prohibition also does not reflect current standards for Federal agencies' information security safeguards or paperwork reduction, as it relates to the use of contractors regarding maintenance of other sensitive records, such as healthcare records.

The proposal to give contractors access to FTI data, would enable VA to expand initiatives to verify eligibility for needs-based pension before making the first benefit payment by using tax return information. The current law complicates what would otherwise be a routine interagency data matching exercise by establishing unnecessarily restrictive disclosure requirements. The contractor prohibition in section 6103 precludes VA from using its current IT business model for purposes of developing and maintaining systems and for purposes of administering the income-based benefits programs where contractors and vendors are used to process documents. Consequently, it requires VA to expend



scarce resources to safeguard tax information from contractors, despite the fact that VA contractors meet all of the Federal requirements for access to other sensitive information. This proposal would remove the requirement for VA to create a complex IT solution to mitigate contractor access to VA systems and benefits-related documents that contain tax information.

Lastly, VBA is continuing efforts to automate processes, expanding the use of up-front verification, and implementing postaudit awards. This will allow timely adjustments, as part of VA's commitment to reduce improper payments. This program improvement will prove beneficial to VBA Compensation and Pension programs.

## Section X. Recapture of Improper Payment Reporting for VA Programs

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OMB Circular A-136 requires detailed information recovery auditing programs, as well as other efforts related to the recapture of improper payments. Some VA programs have results to report in this area, and those results are included in the following tables. VA has not excluded any programs or activities with outlays of \$1 million or more from the payment recapture audit program. VA is in the process of refining payment recapture and recovery activities. FY 2016 marks the first year that VA is reporting current-year recapture of improper payment data following a discussion with OMB in September 2016.

### VHA

VHA's payment recapture audit program is focused on preventing, detecting, and recovering overpayments. As part of VHA's payment recapture audit program, VHA used both internal and external payment recapture activities including those identified below.

#### **OCC Audit and Recovery Efforts**

OCC's pricing software is comprehensive code auditing software that helps manage medical benefit dollars and lower administrative costs through accurate, consistent, and timely reimbursements per payment policies. The pricing software applies expert edits from the industry and provides recognized knowledge base to analyze claims for accuracy and applicability to the payment policies. The pricing software prevented \$50.48 million in improper payments for FY 2015. In addition, artificial Intelligence translates policies and regulations into a form that can be acted on by the system, which is applied to medical claims submitted for payment. Artificial Intelligence prevented \$52.05 million in improper payments for FY 2015.

OCC also has the Quality Inspector Tool, which provides push-button inspection of all outpatient claims processed through FBCS to ensure proper payment in a prepayment status. The tool avoided \$15.22 million in improper payments for FY 2015. The SnapWeb Duplicate Payment Program was designed to identify potential duplicate payments in a prepayment state. The use of the program avoided \$10.23 million in improper payments for FY 2015. The Program Integrity Tool provides a comprehensive set of program integrity tools to reduce fraud, waste, and abuse and improve payment accuracy in a prepayment status. The tool avoided \$4.03 million in improper payments for FY 2015.

OCC's Recapture Recovery Activities tracked overpayment collection and resolution of underpayments for CHAMPVA, Caregiver Support, Foreign Medical, and Spina Bifida Health Care. In FY 2016, finance identified \$10.28 million in overpayments and recovered \$9.97 million.



OCC develops an annual audit plan that independently assesses the VA Community Care, State Home Per Diem, and CHAMPVA programs and associated operations. Recommendations and corrective actions are developed in response to the audits. Identified improper payments were referred to the Recapture Recovery Initiative to track the collection of overpayments and resolution of underpayments. OCC's audit teams include:

- Veteran Family Member Benefit Audit Team: identifies overpayments in the CHAMPVA program through the IPERA audit, a biannual eligibility determination audit, and special audits identified from other audit findings or requested by management.
- State Home Program Audit Team and VA Community Care Audit Team: structured to perform the IPERA audits for their respective programs.
- Special Audit Team: focuses on special audit requests from both internal and external stakeholders.

OCC retained external recovery contracts for VA Community Care, CHAMPVA, and Spina Bifida Health Care through August 2013. Currently, OCC is working with contracting to establish a new recovery contract. VHA, through the use of recovery audit contracts, continued to collect \$462,502 in overpayments throughout FY 2015. As well, proposed legislation would allow OCC to conduct recovery audits not only by contract, but internally as well.

## **VBA**

In an effort to identify and recapture improper payments, VBA used a combination of full-case quality reviews and payment reviews to identify possible duplicates and overpayments. A majority of VBA programs perform quality reviews on randomly selected cases. VBA tracks, monitors, and recovers overpayments eligible for recovery through combined efforts of the Debt Management Center (DMC), the Administrative and Loan Accounting Center, and Regional Offices.

### **Root Cause of Improper Payments**

VBA identified that a majority of payment errors were due to administrative and process errors made by the Federal agency, failure to verify eligibility data, and inability to authenticate eligibility. Overpayments as a result of administrative and process errors made by the Federal agency were found to be mainly due to rating decision errors. In such instances, under current regulations, VA rating disability decisions are legally binding unless VA determines a finding of fraud or clear and unmistakable error (CUE), therefore preventing collection. VBA is taking deliberate action to correct these issues by using continuous process improvement and standardized tools to improve claims processing outcomes. When errors are discovered, Regional Offices take action as soon as possible to correct these ratings and ensure the most accurate evaluation for the Veteran.

### **Collection Process**

DMC provides accounts receivable and debt management services for VBA. DMC is responsible for collecting debts resulting from an individual's participation in VA's Disability Compensation, Pension, or Education programs. Once a debt has been established, it is referred to the DMC, which aggressively pursues the collection of all debts through lump-sum offset from current or future benefit payments or by installment payments agreed upon by the debtor. If DMC cannot collect the debt, the delinquent debt is referred to the Treasury Offset Program (TOP) for collection.



VBA local offices are also responsible for establishing and collecting debts for the loan guaranty program, general operating expenses, and other programs where the debt is not currently handled by DMC. For duplicate or improper payments identified, VBA determines collectability, and if needed, establishes a debt in the core Financial Management System (FMS).

In accordance with 38 U.S.C. 5302, VBA may waive benefit debts arising as a result of participation in a benefit program when collection would be against equity and good conscience and no evidence exists of fraud, misrepresentation, or bad faith. VBA will notify the debtor of his or her rights and remedies and the consequences of failure to cooperate with collection efforts. The debtor has the right to dispute the existence or amount of the debt or to request a waiver from collection of the debt. VBA may waive benefit debts when the facts and circumstances of the particular case indicate a need for reasonableness and moderation in the exercise of the Government's rights and if the waiver request was made within the specified time frames.

### **PFE**

Improper payments to employees found through testing are recovered as they are identified. The recovery is made by adjusting the employees' paychecks for the amount of the improper payment.

### **FSC**

Most VA vendor payment activities are centralized at the FSC, a franchise fund (fee for service) organization that services VHA, NCA, and the VACO. FSC's payment recapture and recovery activities are focused on preventing, detecting, and recovering overpayments and includes a four-step process that includes a postpayment review, root cause review, and collection process.

### **Prepayment Review**

Three times a day, FSC matches scheduled commercial vendor payments against other payments and against the previous 90 days of disbursed payments to identify and prevent duplicate payments before their submission to the Department of the Treasury for disbursement. Duplicate payments identified through this process are cancelled before the payments are made.

### **Postpayment Review**

FSC performs several postpayment reviews to detect improper payments:

- Payment files in excess of \$2,500 are matched against disbursed payments over the previous 2 fiscal years to identify duplicate payments.
- Various performance measure reviews of payments are conducted using statistical sampling to verify their accuracy and timeliness.
- Reviews are conducted on FSC-issued interest penalty payments of more than \$50 to determine if interest was actually due to the vendor.

In addition, FSC periodically reviews audit reports prepared by VA's OIG and the GAO to identify additional potential areas of interest.



## Root Cause of Improper Payments

FSC has identified several root causes for improper payments, including erroneous input of invoice numbers, dates, or vendor identification numbers and vendor invoicing inconsistencies, such as resubmitted invoices using different invoice numbers, dates, or purchase order numbers. FSC has implemented corrective actions, which include increased use of electronic invoicing and optical character recognition technology to minimize improper payments. This process extracts key payment data from paper invoices to reduce input errors, along with a business rules engine to ensure consistency in payment processing and streamlined procedures.

## Collection Process

For improper payments detected in postpayment reviews, the following recovery actions are used by FSC, as appropriate, to recover the funds from the vendor/employee:

- On payments paid via electronic funds transfer (EFT), where the improper payment amount was the full amount of the EFT payment, FSC processes a Letter of Reversal/Letter of Indemnity in an attempt to recover the funds by having the bank reverse the erroneous transaction back to Treasury as a returned EFT.
- In cases where the improper payment is paid via check or where the improper amount was less than the full amount of the EFT, FSC/VA facilities process a bill of collection requesting the vendor return the funds for the improper amount.
- After a minimum of 45 days, if the bill of collection has not been repaid and no correspondence has been received from the vendor disputing the bill or requesting additional information, FSC sets up an internal offset to collect the funds from the next FSC-issued payment(s) to the vendor until the bill is satisfied.

## OALC

The VA Office of Acquisition and Logistics works with the OIG Office of Contract Review (OCR) to recover funds owed VA due to (1) defective pricing – whether the prices for the items awarded were based on accurate, complete, and current disclosures by the contractor during contract negotiations; and (2) price reduction violations – whether the contractor complied with the terms and conditions of the price reductions clause. As part of the OIG postaward contract reviews, staff also looks for and collects overcharges that were the result of the contractor charging more than the contract price. Other reviews conducted by OCR include healthcare resource proposals, claims, and special purpose reviews. In FY 2016, this audit recovery program recovered more than \$11 million.



**Table 4 (For VHA)**  
**Improper Payment Recaptures with and without Audit Programs <sup>(1)</sup>**  
 (\$ in millions)

Overpayments Recaptured Through Payment Recapture Audits																				Overpayments Recaptured Outside of Payment Recapture Audits				
Program or Activity	Contracts					Grants				Benefits					Other					Total		Amount Identified	Amount Recaptured	
	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified			Amount Recaptured
Beneficiary Travel	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.845	0.667
CHAMPVA (2)	-	-	-	-	-	-	-	-	-	-	10.28	9.97	96.98	85.00	85.00	-	-	-	-	-	10.28	9.97	-	6.92
VA Community Care – Choice (3)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.219	0.983
State Home Per Diem Grants	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.339	0.339
Supplies and Materials	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.089	0.073	82.02	85.00	85.00	0.089	0.073	0.267	0.247
Other VHA Programs (4)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.498	0.338	67.87	85.00	85.00	0.498	0.338	8.285	7.671

**Notes to Table 4:**

- (1) Starting in FY 2016, current-year data is reported in table 4.
- (2) CHAMPVA recapture/recovery data is combined with OCC programs: Caregiver Support, Foreign Medical, and Spina Bifida Health Care. Overpayments recaptured outside of payment recapture audits consist of unsolicited funds received.
- (3) FY 2016 disbursements include VA Community Care Choice payments within VA Community Care activities.
- (4) Other VHA Programs includes the following VHA activities: Activities with Other Federal Agencies; Communications, Utilities, and Other Rent; Compensated Work Therapy/Incentive Therapy; DoD/VA Health Care Sharing Incentive Fund; DoD/VA Medical Facility Demonstration Fund; Equipment; General Post Funds; Grants-Homeless Per Diem; Homeless Care; Insurance Claims & Interest Expense; Land and Structures; Medical and Prosthetic Research; Other Services; Pharmacy – Medical Facilities; Prosthetics; and Transportation of Things.



**Table 4.1 (Remaining VA Programs)  
Improper Payment Recaptures with and without Audit Programs <sup>(1)</sup>**  
(\$ in millions)

Overpayments Recaptured Through Payment Recapture Audits																				Overpayments Recaptured Outside of Payment Recapture Audits				
Program or Activity	Contracts					Grants					Benefits					Other					Total		Amount Identified	Amount Recaptured
	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured	2016 Recapture Rate	2017 Recapture Rate Target	2018 Recapture Rate Target	Amount Identified	Amount Recaptured		
Compensation	-	-	-	-	-	-	-	-	-	-	0.1966	0.0559	28.43	62.00	62.00	-	-	-	-	-	0.1966	0.0559	-	-
Loan Guaranty	-	-	-	-	-	-	-	-	-	-	1.63	0.61	37.42	42.00	42.00	-	-	-	-	-	1.63	0.61	-	-
PFE – Payroll (2)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	56.445	33.817
VBA GOE	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.032	0.013
NCA Burial Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.0537	.0537
VACO Programs (3)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	12.54	13.84
<b>Total</b>	-	-	-	-	-	-	-	-	-	-	12.1066	10.6359	87.85	-	-	0.587	0.411	70.02	-	-	12.6936	11.0469	80.026	64.551

**Notes to Table 4.1:**

- (1) Starting in FY 2016, current-year data is reported in table 4.1.
- (2) PFE – Payroll figures come from the Defense Finance and Accounting Service, VA's Payroll provider.
- (3) VACO Programs include the following activities/programs: Corporate Data Center Operations (CDCO) Franchise Fund, HRA General Administration, OALC Major and Minor Construction, OI&T programs, General Administration, Supply Fund programs, to include OIG postaward contract reviews, Payroll, and travel.



**Table 5**  
**Disposition of Funds Recaptured Through Payment Recapture Audits**  
 (\$ in millions) <sup>(1)</sup>

Program or Activity	Amount Recovered	Type of Payment	Agency Expenses to Administer Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose	Office of Inspector General	Returned to Treasury	Other
All VHA Programs (2)	10.381	All	-	-	-	10.381	-	-	-
Compensation (3)	0.0559	Benefits	-	-	-	0.0559	-	-	-
Loan Guaranty (3)	0.61	Benefits	-	-	-	0.61	-	-	-
<b>TOTAL</b>	<b>11.0469</b>	-	-	-	-	<b>11.0469</b>	-	-	-

**Notes to Table 5:**

- (1) Starting in FY 2016, current-year data is reported in table 5.
- (2) Title 38 U.S.C. allows VHA to retain and use the recovery funds as no-year funding. The significant benefit to VA assures that lengthy collection activities, typically required to conduct these recovery actions, do not negatively impact the ability to use these funds. In addition, this benefit guarantees strong participation by assuring full recovery for medical facilities.
- (3) Improper payments identified and recovered were from programs where the funds had not expired. All recoveries were returned to the fund for original purpose



**Table 6**  
**Aging of Outstanding Payments Identified in Payment Recapture Audits<sup>(1)</sup>**  
 (\$ in millions)

Program or Activity	Type of Payment (contract, grant, benefit, loan or other)	Amount Outstanding (0-6 months)	Amount Outstanding (6 months to 1 year)	Amount Outstanding (over 1 year)	Amount determined to not be collectable
CHAMPVA (2)	Benefits	-	-	-	0.31
Supplies and Materials	Other	0.016	-	-	-
Other VHA Programs (3)	Other	0.16	-	-	-
Compensation	Benefits	0.1343	0.0064	-	-
Loan Guaranty	Benefits	0.58	0.44	-	-
<b>TOTAL</b>	-	0.8903	0.4464	-	0.31

**Notes to Table 6:**

- (1) Starting in FY 2016, current-year data is reported in table 6.
- (2) CHAMPVA data is combined with OCC programs: Foreign Medical, Spina Bifida Health Care, and Caregiver Stipend. Write offs were initiated when amounts were determined to be uncollectable. Examples include:
  - a. The beneficiary is deceased.
  - b. The debt was discharged under bankruptcy.
  - c. Administratively written off because the Committee on Waivers and Compromise approved the beneficiaries' request for waiver.
  - d. Administratively written off due to inability to collect based on the age of the debt, Treasury Offset Program (TOP) reporting, the last date the vendor/beneficiary was paid, and the likelihood of future payments.
  - e. Administratively written off due to not meeting the criteria for TOP.
 Some debts are considered permanent write-offs and others are considered temporarily written off. Permanent write-offs are: waivers, deceased, and debts discharged under bankruptcy. The others can be re-established in Vista if a means of collection is identified. Vista System limitations prevents an accounts receivable record from being labeled permanent write-off versus temporary write-off. The Third Party is not included in the write-off data because third party is a recovery effort and not considered debt owed.
- (3) Other VHA Programs: Activities with Other Federal Agencies; Communications, Utilities, and Other Rent; Compensated Work Therapy/Incentive Therapy; DoD/VA Health Care Sharing Incentive Fund; DoD/VA Medical Facility Demonstration Fund; Equipment; General Post Funds; Grants-Homeless Per Diem; Homeless Care; Insurance Claims & Interest Expense; Land and Structures; Medical and Prosthetic Research; Other Services; Pharmacy – Medical Facilities; Prosthetics; and Transportation of Things.

**Section XI. Additional Comments on VA Efforts to Reduce Improper Payments**

**VHA**

VA is committed to providing Veterans access to timely, high-quality healthcare. In today's complex and changing healthcare environment, where VA is experiencing a steep increase in demand for care, it is essential that VA partner with providers in communities across the country to meet the needs of Veterans. VA is working diligently to resolve the issue surrounding the lack of authority to enter into agreements with private vendors to purchase services without following FAR. VA is taking a comprehensive approach to resolving this issue through legislation and reviewing internal processes to identify areas to increase compliance without impacting access to care.

**VBA**

Within VBA's Compensation program, the Department strives to ensure that Veterans and their families receive needed benefits in the right amount and at the right time while making progress toward reducing



and preventing improper payments. In 2016, OIG issued reports highlighting issues and areas of concern for certain high-risk programs; consideration is being given to these reports in evaluating future opportunities to strengthen internal controls and increase payment accuracy. VBA is working toward integrating solutions to these highlighted issues to reduce and eliminate improper payments.

The Compensation program error rate has improved during the last fiscal year with a decrease of 1.74 percentage points. Program improvements can be attributed, in part, to the increase in the statistical sample size, which allowed a more varied group of payments to be included for testing; provision of additional training to test case reviewers to address testing issues and to ensure that reviewing protocols are being adhered to; engagement of field operation leadership on IPERA issues to emphasize the importance of the reduction and elimination of improper payments; and the implementation of corrective actions. Compensation Service is continually working to reduce improper payments through monitoring test reviews and improving work processes for the claims of Veterans' and their dependents'.

In addition, VBA's Pension program has seen improvement in the IPERA error rates during the past 2 years due to system enhancements, which allow for accurate decisions to be made and direct focus on ensuring that benefits are properly paid or terminated in a timely manner.

### **VACO**

In FY 2016, IPRO examined VA's IPERA activities to identify strategic and tactical improvements that can be made across the department. Key improvements include the following:

- Leveraged the IPERA Governing Board to improve collaboration, coordination, and accountability of program offices that own the processes that support the various payments and benefits disbursed;
- Conducted lessons learned from past improvement efforts to determine what has worked well and what can be improved;
- Collaborated with Federal partners to implement and integrate best practices
- Performed comprehensive review of acquisition practices across the department and incorporated additional aspects of potential acquisition vulnerability into testing;
- Increased Departmental awareness of root causes of improper payments; and
- Identified IT enhancements needed to reduce manual processes prone to errors.

All of the above actions strengthened IPERA activities across VA, helped VA progress in its objective of improving internal controls, and will contribute to corrective actions designed to reduce the rate of improper payments.

## **Section XII. VA's Reduction of Improper Payments with the Do Not Pay Initiative**

VA and Treasury are working together to obtain greater utilization of the Do Not Pay (DNP) Portal, leverage existing Treasury analytical and processing capabilities, and increase VA's access and effectiveness with the DNP Portal. Currently, VA uses the DNP Portal for postpayment review activities, which do not allow



VA to stop payments before they are made. However, VA uses additional monitoring efforts outside of the DNP portal to stop payments to vendors and recipients that have already been determined ineligible for receiving payments. VA and Treasury are committed to continue working together to build on the recent progress and further leverage the DNP Initiative to ensure compliance with IPERA. Treasury provides monthly matching of all VA payment files with the public Death Master File (DMF) and the System for Award Management (SAM) databases in DNP. FY 2016 marks the first year that VA is reporting current-year DNP data following a discussion with OMB in September 2016.

VA has incorporated databases into existing business processes and programs to prevent improper payments. More information is provided below on other activities VA uses to prevent improper payments.

### **VHA**

VA's FSC provides VHA with the matches it receives from Treasury on a monthly basis for Agency Location Codes (ALCs) 36001200 and 36000785. These matches are from the DMF and SAM databases described above. VHA then applies internal business rules for increased accuracy and sends out results to the VISNs and VAMCs. Once feedback is received on the accuracy of the payment, VHA consolidates the results and submits them to Treasury via the FSC. FSC relayed results to Treasury due to an IT issue preventing VHA from having direct access to DNP for the reporting period. Treasury and VA have since enabled users to log onto the DNP Portal using a Personal Identification Verification Card.

VHA performs preaward checks against SAM for all contracts greater than \$3,000 as part of the procurement process. Internal control procedures for purchase cardholders require cardholders to check the SAM database for excluded parties prior to each new order for regular and recurring purchases to the same vendor. Cardholders are required to document matching against the SAM database on a quarterly basis. OCC's Program Integrity Tool was updated to include the List of Excluded Individuals/Entities to check all Community Care claims processed in FBCS in a prepayment state.

### **VBA**

VBA has agreements with other Federal agencies (e.g., Social Security Administration, Internal Revenue Service, Bureau of Prisons) to share information on a recurring basis to determine VA beneficiaries' eligibility. Information derived from the matches may be used to adjust VA benefit payments.



**Table 7**  
**Results of the Do Not Pay Initiative in Preventing Improper Payments<sup>(1)</sup>**  
 (in millions)

	Number (#) of payments reviewed for improper payments	Dollars (\$) of payments reviewed for improper payments	Number (#) of payments stopped	Dollars (\$) of payments stopped	Number (#) of improper payments reviewed and determined accurate	Dollars (\$) of improper payments reviewed and determined accurate
Reviews with the Do Not Pay Databases (2)	93.64	123,805.44	0	0	0.019	30.67
Reviews with databases not listed in IPERA (3)	0.12	96.58	0.12	96.23	0.0004	.35

**Notes to Table 7:**

- (1) Starting in FY 2016, current-year data is reported in Table 7.
- (2) Databases VA utilizes for DNP- DMF and SAM. Data is October 2015 to August 2016, September data unavailable at publishing.
- (3) VBA currently has effective internal control mechanisms in place to identify and stop improper payments through a preexisting data matching agreement with Social Security Administration's private DMF database. Data reflects October 2015 through September 2016 timeframe.



## SECTION F: MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY THE INSPECTORS GENERAL

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### OIG Foreword to Major Management Challenges

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**Department of Veterans Affairs  
Office of Inspector General  
Washington, DC 20420**

#### FOREWORD

Our Nation depends on VA to care for the men and women who have sacrificed so much to protect our freedoms. These servicemembers made a commitment to protect this Nation, and VA must continue to honor its commitment to provide for these heroes and their dependents in a manner that is as effective and efficient as possible. VA health care and benefits delivery must be provided in a way that meets the needs of all veterans. It is vital that VA's health care and benefits delivery work in tandem with support services like financial management, procurement, and information management to be valuable and useful to the veterans who turn to VA for the services and benefits they have earned.

Office of Inspector General (OIG) audits, inspections, investigations, and reviews recommend improvements in VA programs and operations, and act to deter and detect waste, fraud, and abuse in order to help VA become the best-managed service delivery organization in Government. Each year, pursuant to Section 3516 of Title 31, United States Code, OIG provides VA with an update summarizing the most serious management and performance challenges identified by OIG work as well as an assessment of VA's progress in addressing those challenges.

This report contains the updated summation of the major management challenges and high-risk areas facing the Department within OIG's six strategic goals—health care delivery, benefits processing, financial management, procurement practices, information management, and workforce investment—with assessments of VA's progress on implementing OIG recommendations.

In addition to OIG's major management challenges, VA has provided a response to each sub-challenge outlined by OIG. OIG takes exception to VA's responses for sub-challenges 2B and 3B as they minimize the importance of OIG findings in these areas and in some instances are incorrect. OIG's position is supported by the reports that have been issued during the past year.

For sub-challenge 2B, Improving Data Integrity, Internal Controls, and Management Within VA Regional Offices' (VARO), OIG disagrees with VBA's statement that the claims-related documents found in employees' personal shred bins for non-claims-related documents at the Los Angeles VARO would have passed through the final internal control process of a Records Management Officer's (RMO) review. OIG found the Los Angeles VARO did not have an RMO at the time of our review, which is VBA's final control to prevent shredding of claims-related documents under its January 2011 policy on management of veterans' and other governmental paper records. Additionally, Support Service Division (SSD) staff who took over the duties of the RMO



at the Los Angeles VARO lacked training regarding maintaining, reviewing, protecting, and appropriately destroying veterans' and other governmental paper records.

In addition, VBA's assertion that only 0.0025 percent of the 438,000 documents reviewed by OIG at 10 VARO's during the national review of claims-related documents pending destruction at VAROs had the potential to affect benefits deflates the extent of inappropriate destruction of documents. Of the 155 claims-related documents, 69 (45 percent) were improperly scheduled for destruction; 2 of the documents affected benefits, 9 had the potential to affect benefits, and 58 did not affect benefits but were still required to be included in the veteran's claims folder or VBA's electronic system prior to destruction. OIG believes this error rate is a more accurate representation of the issue and is indicative of a systemic issue, and OIG reiterates that the potential effect on veterans cannot be minimized.

Finally, in their response VA states "VBA is addressing all recommendations made by OIG in the Follow-Up Audit of VBA's Internal Controls over Disability Benefits Questionnaires (DBQs)." This statement is incorrect. VBA did not concur with the report's Recommendation 5 and has reported they will not address this recommendation, which was that the Acting Under Secretary for Benefits revise VARO quality assurance review methodologies to review appropriate samples of claims including public-use DBQs.

For sub-challenge 3B, Improving Management of Appropriated Funds, the Interim Assistant Secretary for Management and Interim Chief Financial Officer's response concerning our report, Audit of VA's Conference Management for Fiscal Year 2014, states that OIG's assessment was based on an outdated VA policy on VA conference management and oversight, and did not identify any wasteful spending, abuse, or misuse of funds. Further, the response states that many of the issues of noncompliance identified by the OIG were the result of a complex and burdensome policy that did not accommodate how conferences were organized or executed across VA. Under the policy in place until March 2015, OIG identified a very high rate of noncompliance with VA's policy. While OIG agrees that VA implemented revisions to its policy on VA conference management and oversight in March 2015, OIG does not agree that the revisions invalidated the results of the review of conferences completed during FY 2014, nor improved overall accountability of the process. On the contrary, some of the "streamlining" in the policy, while likely to reduce VA organizations' compliance burden, weakened controls needed to ensure conferences are cost-effective and reduce the risk of inappropriate spending.

OIG will continue to work with VA to address these issues to ensure the best possible service and benefits to the Nation's veterans and their dependents.

A handwritten signature in black ink, appearing to read "Michael J. Missal", is positioned above the printed name.

MICHAEL J. MISSAL  
Inspector General



## Major Management Priorities and Challenges

Major Management Challenge		Estimated Resolution Time frame (Fiscal Year)	Page #
No.	Description (Responsible Office)		
<b>OIG 1</b>	<b>Health Care Delivery (VHA)</b>		<b>229</b>
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<b>OIG 2</b>	<b>Benefits Processing (VBA)</b>		<b>245</b>
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2B	Improving Data Integrity, Internal Controls, and Management Within VA Regional Offices (VBA)	2017	250
<b>OIG 3</b>	<b>Financial Management (Lead: OM, contributing: OIT,VHA,VBA)</b>		<b>254</b>
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<b>OIG 4</b>	<b>Procurement Practice (Lead: OALC, contributing: VHA)</b>		<b>261</b>
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<b>OIG 5</b>	<b>Information Management (OIT)</b>		<b>265</b>
5A	Develop an Effective Information Security Program and System Security Controls (OIT)	2017	265
5B	Improving Compliance with Federal Financial Management Improvement Act (Lead: OM, contributing: VHA, OCLA, VHA)	2021	269



## **OIG CHALLENGE #1: HEALTH CARE DELIVERY**

### ***-Strategic Overview-***

Historically, the VHA has been a national leader in the quality of care provided to patients when compared with other major U.S. healthcare providers. However, in recent years, VHA has experienced significant challenges in delivering high-quality, timely healthcare in an environment of increased and varied demand, competing goals and priorities, operational inefficiencies, organizational barriers, and inadequate information systems to manage healthcare resources efficiently and effectively.

VHA continues to face its most significant challenges in ensuring timely access to high-quality healthcare, whether that care is provided within VHA or through VHA's ability to arrange for services in the community. During fiscal year (FY) 2016, the Office of Inspector General (OIG) published multiple hotline inspection reports documenting access to care concerns that have existed within VHA in recent years, to include non-compliance with VHA scheduling policies resulting in delays in patient care and delays in obtaining care in the community through the Veterans Choice Program and other VHA programs. In some instances, these conditions resulted in delays in healthcare, placing patients at unnecessary risk.

OIG's August 26, 2014 report, *Veterans Health Administration Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* identified numerous deficiencies in scheduling practices at the Phoenix VA Medical Center. Of particular concern, this year OIG published three reports identifying continuing access and quality of care challenges at the Phoenix VA Medical Center. In FY 2016, additional work by OIG identified continuing concerns regarding access to care issues in the urology service, a delay in care for a lung cancer patient, and access and quality of care deficiencies in the Emergency Department. Other conditions placing veterans at risk include weaknesses in testing and follow-up care of Veterans receiving prescription opioid pain medications; failure to plan for and maintain continuity of care during intermittent staffing shortages; lack of timely documentation in the medical record to ensure sound clinical decision-making; and deficiencies in Veterans Crisis Line Responsiveness and Quality.

OIG invests about 40 percent of its resources in overseeing the healthcare issues of our Nation's veterans by conducting inspections at VA medical centers (VAMCs) and community-based outpatient clinics (CBOCs), national reviews and audits, issue-specific Hotline reviews, and criminal investigations. The following subchallenges further highlight the major issues facing VHA today.

### **OIG Sub-Challenge #1A: Quality of Care (VHA)**

#### ***1. Promoting Safe Opioid Prescribing Practices***

During FY 2016, the use of opioids to treat chronic pain and other conditions continued to be a serious concern in VA and the nation. While opioids are considered an important part of pain management, they are also associated with serious adverse effects. Patients prescribed opioids frequently have complex comorbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications and potentially lead to death. Clinicians vary widely in their chronic opioid therapy prescribing practices within VA and the Nation. An observed geographic variation cannot be accounted for even when taking into account other factors such as the healthcare



utilization of the population.<sup>5</sup> This suggests that there is little agreement regarding the appropriate use of opioids for treating pain, especially chronic noncancer pain.

In FY 2016, OIG's Office of Healthcare Inspections (OHI) published three Hotline inspection reports addressing various aspects of VA opioid prescribing practices. OIG's FY 2016 work on this topic identified many of the same issues previously reported in our FY 2014 national review, *Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy* (Report Number 14-00895-163, issued May 14, 2014).

In *Healthcare Inspection—Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California* (Report Number 15-00827-68, issued January 5, 2016), OIG determined that the quality of care provided for a patient's chronic pain did not follow recommendations of the VA/Department of Defense (DoD) *Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain*, a clinical practice guideline developed to promote evidence-based management of patients' chronic pain. OIG found that system providers did not order urine drug testing, complete a suicide risk assessment, or obtain an opioid pain care agreement as part of the patient's chronic pain therapy. The patient continued to receive refills of an opioid without a face-to-face assessment with a provider for 22 months. Also, in *Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California* (Report Number 14-04897-221, issued March 30, 2016), OIG found that a primary care provider did not refer a patient who was on long-term high-dose opioid treatment to specialists for a second level review as required by VA policy.

In *Healthcare Inspection—Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina* (Report Number 15-01982-113, issued September 29, 2016), OIG identified challenges with the clinical environment in which CBOC providers prescribe opioids and manage the pain-related needs of their patients. OIG noted a lack of non-opioid pain management options for outpatients and, despite the opening of the Veterans' Integrated Pain Management Clinic at the parent facility, the high demand for non-opioid pain management options continue. OIG also found that facility leadership and primary care providers needed to improve adherence to required benzodiazepine appropriateness evaluations for patients on chronic opioid therapy who have post-traumatic stress disorder. Further, OIG found that facility leadership needed to develop proactive organizational solutions to ensure that consistent monitoring and timely patient reassessments and prescription refills could occur.

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<sup>5</sup> McDonald DC, Carlson K, Izreal D. Geographic Variation in Opioid Prescribing in the U.S. *J Pain*. 2012 Oct;13(10):988–96.



**VA's Program Response**

**Estimated Resolution Timeframe:** VA will continue to follow the trends of the Opioid Safety Initiative (OSI) key clinical metrics for Fiscal Year 2017

**Responsible Agency Official:** Under Secretary for Health

**Associated Strategic Goal:** Empower Veterans to Improve their well-being

**Strategic Objective:** Improve Veteran wellness and economy security

**Associated Performance Measure(s):** No public-facing measures are associated with this issue.

VA is actively engaged in a systemwide, multimodal approach to addressing opioid misuse and opioid use disorder in Veterans receiving care from VA. While these approaches are organized under several different and discreet programs, they are designed to be complementary and synergistic to achieve the same desired clinical outcomes; that is, safe and effective pain management. VA's own data, peer-reviewed medical literature, and the Centers for Medicare & Medicaid Services (CMS) suggest that VA is making progress relative to the rest of the Nation.

Fiscal year (FY) 2016 activities/milestones include: (1) utilizing VA's Academic Detailing (AD) program which includes dissemination of provider and patient education materials and promotion of VA evidence-based Clinical Practice Guidelines; (2) providing medication disposal services to allow Veterans to physically dispose of unwanted/unneeded medications; (3) standardized education "Taking Opioids Responsibly" including rationale for obtaining informed consent and routine urine drug screening for Veterans receiving opioids for longer than 90-days; (4) substance use disorder (SUD) treatment and on-going monitoring for Veterans who are diagnosed with SUD but who require opioid analgesics; (5) increased access to complementary and integrative medicine treatments for pain management; (6) providing opioid overdose education and naloxone distribution to high-risk patients; (7) regulation permitting VA prescribers to access the state Prescription Drug Monitoring Programs and VA to share their controlled substances prescribing data and drafted policy requiring VA providers to access state databases when prescribing controlled substance; (8) the opioid therapy risk report is available to VA prescribers at the point of care in the electronic medical record for a thorough assessment of risk for adverse outcomes facilitating more effective care coordination and case management; this complements the OSI dashboard aggregate trending data; and (9) publication of a study in the journal "*PAIN*"<sup>6</sup>.

*VA Data*

The OSI key clinical metrics measured from Quarter 4 FY 2012 (beginning in July 2012) to Quarter 3 FY 2016 (ending in June 2016) demonstrate VA's success with: 171,529 fewer patients receiving

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<sup>6</sup> Patterns of opioid use for chronic noncancer pain in the Veterans Health Administration from 2009 to 2011. Edlund MJ, Austen MA, Sullivan MD, Martin BC, Williams JS, Fortney JC, Hudson TJ. *Pain*. 2014 Nov;155(11):2337-43. doi: 10.1016/j.pain.2014.08.033. Epub 2014 Aug 29. PMID: 25180008.



opioids (679,376 patients to 507,847 patients); 57,734 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 64,899 patients); 90,588 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 patients to 251,189); 133,219 fewer patients on long-term opioid therapy (438,329 to 305,110); the overall dosage of opioids is decreasing in the VA system as 21,515 fewer patients (59,499 patients to 37,984 patients) are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing. The desired results of the OSI have been achieved during a time that VA has seen an overall growth of 136,944 patients (3,959,852 patients to 4,095,350 patients) that have utilized VA outpatient pharmacy services. In reference to the site-specific report, *Healthcare Inspection—Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California* (Report Number 15-00827-68, issued January 5, 2016), VA San Diego Healthcare System (VASDHS) has worked to improve opioid safety and to follow the universal opioid precautions detailed in the VA/DoD Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain in a number of different ways. The OSI resulted in further attention to opioid safety beginning in July of 2013. An OSI team has presented education to various services on opioid safety topics. The educational efforts included alerting staff to required minimal opioid universal precautions which include yearly urine toxicology screens, signed opioid use agreement, yearly check of State Prescription Drug Monitoring programs and follow-up visits every 6 months. The OSI team reviews all patients receiving narcotics in doses greater than 100mg morphine equivalents and makes recommendations in the chart to help guide primary care providers with difficult cases.

Reports monitoring progress with elements of the Guidelines and the OSI were developed with the assistance of VISN 22 Pain Committee and VISN22 PBM team. Specific note were implemented to document State Prescription Drug Monitoring, and presence of completed opioid agreements. The VISN 22 PBM team established a dashboard that allows tracking of the metrics and allows drill down to the provider level. At this time, the dashboard includes all of the opioid precautions except monitoring follow-up visit frequency. In Q1-2 FY 2016, a report was developed to track face-to-face visit frequency, and this report is currently being validated. Academic Detailers from the VISN22 Academic Detailing program meet with providers who are outliers to provide education on pain management and universal opioid precautions.

Primary care providers also have access to the nationally developed Opioid Therapy Risk Report (OTRR) which provides clinical teams with real-time information at point of care about various factors that are related to patient safety when they are prescribing long-term opioid analgesics to Veterans suffering from pain. Specific data about patients who are prescribed long-term opioids include: patient opioid prescription history; opioid doses; urine toxicology; pain scores; mental health diagnoses; most recent visits with Primary Care, Pain and/or Mental health clinics; future or pending primary care visits; completion of the Chronic Opioid consent; and Overdose Education and Naloxone Distribution (OEND) Kit dispensing.

VHASDHS informatics established local clinical reminders which alert the provider at visits when an opioid agreement is required, a urine drug screen is required, and state prescription monitoring is required. These reminders are displayed to all providers. Additionally, an opioid refill note was developed that is utilized to document when a patient calls for an opioid renewal. The note lists the status of opioid universal precautions including the last face-to-face visit with the prescribing provider. Finally, a functional assessment template was developed for Primary Care to use to track changes in function over time to understand the impact of treatment.

In Summary, VHASDHS has made considerable progress in improving opioid safety. Monitoring follow-up visit frequency for patients on chronic opioid therapy is a recent addition to our dashboard and



reports. The OSI Team and Pain Council will continue to track progress monthly and report progress to VHSDHS Medical Executive Committee.

In reference to the site-specific report, *Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California* (Report Number 14-04897-221, issued March 30, 2016), the VA Long Beach Healthcare System (VALBHS) completed the following actions in FY 2016. In FY 2016, a Chronic Pain Management team was developed consisting of a Pain Specialist Physician, Pain Nurse Practitioner, Pain RN Case Manager, Pain Pharmacist, and Pain Psychologist. In Quarter 2, a Formal Chronic Pain Clinic Consult was established for tracking and monitoring patients beyond the Primary Care Chronic pain specialization. In Quarter 3, VALBHS developed an Interdisciplinary Chronic Pain Clinic emphasizing different methods of pain management. This clinic optimizes opioid dosage and focuses on patient safety. Also, this clinic optimizes pain modalities including holistic approaches to pain management.

VALBHS recognized that the combined efforts in supporting the OSI from various departments led to sequential and sustained progress towards the goals of the OSI. Additionally, VALBHS established a Patient Advisory Board. Members are the Chief of Primary Care, Chief of Mental Health/Provider, Chief Pharmacist, Pain Pharmacist, Chief of Pain, Inpatient Attending Physician, and Patient Advocate.

## **2. Care Continuity and Provider Coverage**

To ensure continuity of care and minimize disruptions to patient care and follow-up, it is critical to develop and implement contingency plans for the sudden departure of care providers, staffing losses over time, and/or unexpected surges in demand. In FY 2016, OIG's OHI published two Hotline inspection reports detailing how the lack of staffing contingency plans contributed to significant patient care delays and patients being lost to follow-up. Effective staffing contingency plans would assist in not only identifying alternative care options, such as other VA facilities, non-VA care, or contracted care, but also in determining care priorities and methods for identifying high-risk patients.

In *Healthcare Inspection—Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ* (Report Number 14-00875-03, issued October 15, 2015), OIG determined that the Health Care System (HCS) suffered a significant urology staffing shortage, yet leaders did not have a plan to provide urological services during the shortage of providers in the Urology Service. HCS leaders' failure to respond promptly to the staffing crisis may have contributed to thousands of patients being "lost to follow-up" and staff frustration due to lack of direction.

In *Healthcare Inspection—Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina* (Report Number 15-01982-113, issued September 29, 2016), OIG also noted how the CBOC experienced inadequate primary care provider staffing when a new provider abruptly resigned, leaving a panel of 1,100 patients without a provider. Patients were reportedly called about their clinic appointment cancellations during the first 2 days after the provider resigned; however, the facility had no contingency plan that would ensure continuity of, and access to, appropriate primary care. Reportedly, nurse practitioners assigned to the parent facility were detailed to see patients in the CBOC for a period of time, but this was not sufficient to cover the needs of patients on chronic opioid therapy. Nurse practitioners were unable to prescribe opioid medications, and the Chief of Primary Care had to fulfill this task by writing refill prescriptions from the facility 70 miles away.



**VA's Program Response**

**Estimated Resolution Timeframe:** 2020

**Responsible Agency Official:** Under Secretary for Health

**Associated Strategic Goals:**

Empower Veterans to Improve their Well Being  
Manage and Improve VA Operations to Deliver Seamless and Integrated Support

**Strategic Objective:** Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

**Associated Performance Measure(s):**

- OPM Federal Employees Viewpoint Survey Employee Engagement Index Score
- Employees have a feeling of personal empowerment with respect to work processes
- I feel encouraged to come up with new and better ways of doing things
- My organization's leaders maintain high standards of honesty and integrity
- Percent of patients who responded 'Always' regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of patients who responded 'Always' regarding their ability to get an appointment for needed care right away

Providing adequate staffing to meet the healthcare needs of patients is required in all healthcare systems. Planning for contingencies, including not only absences in critical staff due to illness or other personal circumstances but also situations in which these critical staff members leave abruptly, provides challenges for everyone. VA has taken multiple steps to try to address these challenges, including:

- Hiring primary care providers before patient case load increase to the level necessitating such hiring, using data such as a new provider's caseload already becoming 50 percent full. In addition, many practices have hired a "float" primary care provider to assist with unanticipated absences.
- Beginning to implement a policy expecting providers to give sufficient notice when they leave, with that expectation clearly spelled out when the provider is hired.
- Developing virtual care initiatives. One example is the joint Office of Rural Health (ORH) National Teleradiology Program (NTP), which provides remote, store, and forward image interpretation services to 20 rural VA sites of care where there are shortages in local radiology professionals. Since its 2010 inception, NTP has interpreted images for more than 350,000 rural Veterans at 20 rural sites across the country.
- Continuing to invest in new virtual care strategies, including TelePrimary Care, Telemental Health, TeleICU, and TeleAudiology.



- For rural populations, utilizing mobile medical units, telehealth technology, and close coordination with rural community providers. Transportation solutions include mobility management, shuttle service, and direct transport of rural Veterans to available VA providers.
- Deploying the Rural Expansion of Tele-Primary Care Enterprise-Wide Initiative. This initiative, Virtual IMPACT, is part of a comprehensive effort to provide timely access to primary care using telehealth clinical video technology. Virtual IMPACT uses a hub-and-spoke model of care to build a national solution that provides virtual primary care provider services to VHA sites with provider vacancies.
- Including the basic tenants of a contingency plan in the newly developed access policy and educating Group Practice Managers on the plan.
- Developing and implementing the Interim Staffing Program (ISP), which is VHA's ready-reserve of VACO-employed, VHA-credentialed, badged, and trained clinicians. ISP registered nurses support all aspects of nursing care, while its provider staff (including physicians, psychiatrists, psychologists, nurse-practitioners, and physician-assistants) deliver primary and subspecialty care. ISP clinicians arrive at subscribing VHA facilities ready to engage the electronic health record and to join the facility healthcare team in serving Veterans. Thus far in FY 2016, the scalable and expandable ISP has hired 39 additional clinicians to achieve a total clinician-complement of 120. Of our more-than-125 deployments, several were critical and helped facilities preserve patient-access to care.
- Improving VHA's ability to recruit physicians through competitive salaries. The new annual pay ranges for primary care physicians approved by Secretary VA on June 22, 2016, will enhance VA's ability to recruit and retain highly qualified providers to serve our Nation's Veterans. This will take effect the first pay period following the required 60-day notification period in the Federal Register.

Ensuring optimal availability of staff for each specialty at all of VHA's 1,700 sites of care is a daunting challenge. Staffing to peak patient demand will dramatically increase costs, while staffing at average levels creates a waiting time for patients. No matter where the staffing level is at a given point in time, VHA will have unanticipated and sometimes unpredictable areas of provider loss leading to associated increases in waiting times. For example, losing nearly all of a urology department in a short time is a very different problem than losses associated with planned retirements. The strategic question is how to build reasonable contingency plans given many possible scenarios that may become reality. As noted above, these plans have included the use of telehealth, "float" hiring, and sharing of resources. In addition, many VA Medical Centers have chosen to implement contracts with local providers to support care being provided at facilities in as uninterrupted a manner as possible. Current authorities offer limited flexibility for offering overtime for employees or additional pay incentives for part time hires.

VHA's FY 2015 turnover rate was 9.3 percent. This includes voluntary quit rate of 4.9 percent and retirement rate of 3.2 percent and favorably compares to 18.8 percent quit rate and 30 percent total turnover rate among the healthcare and social services industry (Bureau of Labor Statistics, 2014). At the same time, sudden and unpredictable losses can lead to a local crisis. Certainly existing contracts, community care providers and locum tenens providers are an option.

To address long-term workforce shortages, ORH has partnered with the Office of Academic Affiliations since 2012 to invest in a Rural Health Training Initiative that provides workforce educational opportunities at 21 rural locations across the country for students, including physicians, nurses, pharmacists, mental health workers, and other allied healthcare professionals. Offering training opportunities in rural settings is likely to attract new hires. To date, this continuing program has trained more than 1,100 students in rural settings.



See the VHA Response for Sub-Challenge #1A4, which addresses access to urology services at the PVAHCS.

Upon publication of the OIG report, Healthcare Inspection—Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community-Based Outpatient Clinic, Rutherfordton, North Carolina (Report Number 15-01982-113, issued September 29, 2016), OIG closed recommendations 1 through 6, which closed the report. The facility implemented a number of corrective actions to address the OIG recommendations. As part of the Opioid Safety Initiative, the facility implemented a new Primary Care Opioid Renewal note. The Opioid Safety Initiative staff worked with both Primary Care Serve and Mental Health Service to complete the evaluations for the opioid therapy patients receiving benzodiazepines. The Veterans Integrated Pain Management Clinic staff worked with System Redesign Coordinators to analyze processes and develop improvements to increase scheduling efficiency and timeliness. The Primary Care physician positions were fully staffed by the end of 2016, which resulted in a ratio of one Gap physician for every 10 primary care panels. Additionally, the Primary Care Service and Chief of the Mental Health Service educated the staff on the importance of provider to provider communication to coordinate care for posttraumatic stress disorder patients receiving both opioids and benzodiazepines. Lastly, each week during leadership morning report, each Community Based Outpatient Clinic (CBOC) reported on quality measures, workload, patient satisfaction scores, access, staff vacancies affecting productivity, and other quality oversight data in order to ensure regular communication between the facility leadership and CBOC leadership.

### **3. Ensuring Veterans Crisis Line Responsiveness and Quality**

According to its Web site, “the Veterans Crisis Line connects veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline, online chat, or text.”<sup>7</sup> In FY 2016, OIG’s OHI published a Hotline inspection report, *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York* (Report Number 14-03540-123, issued February 11, 2016), addressing allegations received from a complainant on May 8, 2014, as well as additional allegations received from the U.S. Office of Special Counsel on February 3, 2015, of unanswered phone calls or calls routed to a voicemail system, lack of immediate assistance to callers, untrained staff, and confusing contact information for the Veterans Crisis Line (VCL), located in Canandaigua, New York.

OIG found that some calls routed to back-up centers went into a voicemail system and that the VCL and back-up center staff did not always offer immediate assistance to callers. For example, OIG’s review identified over 20 calls that were routed to voicemail at 1 backup center. When VCL management investigated these complaints, they discovered that backup center staff was not aware the voicemail system existed; thus, they did not return these calls. In addition to being uncertain as to how long callers were in backup center queues, VCL management reported that they were unsure if the back-up centers thoroughly reported every call through direct contact or disposition e-mails to the VCL staff. Although VCL management had not confirmed this concern using call number data, they reported that calls had gone to back-up center voicemail systems without any notification to the VCL that a call had been received.

OIG also found that VCL social service assistants (SSAs), who do not answer calls but assist responders during interventions with individuals in crisis and conduct follow-up activities, did not receive

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<sup>7</sup> Veterans Crisis Line website, <https://www.veteranscrisisline.net/>, accessed 5/18/16.



orientation and ongoing training that met VCL training requirements. In addition, OIG could not find documentation that the majority of SSAs had received training on rescues and the use of potential resources. VCL supervisors could only find 2 of the 24 orientation checklists OIG requested for the SSAs hired between August 2012 and September 2014. During interviews, SSA staff reported that orientation consisted mostly of sitting with another SSA who may or may not have been experienced and access to a handbook that did not instruct them on specific SSA procedures or processes. Some SSAs stated that they did not feel they had adequate training and had received erroneous or inadequate information from other SSAs, including information regarding rescue procedures and consult resources.

OIG also identified gaps in the VCL quality assurance process, including an insufficient number of required staff supervision reviews, inconsistent tracking and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data. OIG determined that a contributing factor for the lack of organized VCL quality assurance processes was the absence of a VHA directive or handbook to provide guidance for VCL quality assurance and other processes and procedures.

**VA's Program Response**  
**Estimated Resolution Timeframe:** Fiscal Year (FY) 2016  
**Responsible Agency Official:** Under Secretary for Health  
**Associated Strategic Goal:** Empower Veterans to Improve their Well-being  
**Strategic Objective:** Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces  
**Associated Performance Measure:** Veterans experience of VA

Since its inception in July 2007, the Veterans Crisis Line (VCL) has answered nearly 2.4 million calls and initiated the dispatch of emergency services to callers in imminent crisis over 62,000 times. The Veterans Chat, an online, one-to-one “chat service” for Veterans who prefer reaching out for assistance using the internet, has answered nearly 294,000 requests for chat services since its inception on July 4, 2009. Since its inception in November of 2011, the Crisis Line texting service has answered nearly 56,000 requests for text services. The Text number is 838255. Staff has forwarded nearly 384,000 referrals to local VA Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with Veterans local VA providers.

VCL has made significant progress in addressing the recommendations for quality assurance in response to OIG report, *Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York* (Report Number 14-03540-123, issued February 11, 2016). Canandaigua requested closure on recommendations 1, 5, and 6. Recommendations 2, 3, 4, and 7 remain in progress with a target completion of September 2016. Major milestones for FY 2016 include the following: realignment of VCL from Office of Mental Health Operations to VHA Member Services, resulting in increased call center resources and support; overall improvement of the New Employee Orientation experience, with streamlined curriculum, instruction, tracking, and reporting for both Health Science Specialist Responders and Social Services Assistants; and silent call monitoring of Responder calls began April 2016, with 70 percent success rate with one or more monitors completed for 98 percent of responders. The Standard Operating Procedures have been modified and improved with feedback from front line staff, ongoing tracking and resolution of complaints and compliments, along with use of an End of Call Satisfaction Question; creation of a VCL Handbook, an internal guide for VCL Employees; and the contract with Link2Health Solutions was executed on April 1, 2016, including monthly reporting with Quality Assurance Metrics.



#### 4. Ensuring Timely Information for Clinical Decision Making

Complete and accurate documentation in patient electronic health records (EHRs) is essential for sound, fully-informed clinical decision making. When VA patients receive care from non-VA providers, it is critical that non-VA assessment and treatment records are obtained and promptly scanned into VA EHRs. VA policy requires results from non-VA care to be scanned into EHRs; however, the policy does not include timeliness standards for doing so.<sup>8</sup> In FY 2016, OIG's OHI published two Hotline inspection reports that identified deficiencies in obtaining and scanning non-VA clinical records, and OIG continues to identify similar issues in our ongoing work.

In *Access to Urology Service at the Phoenix HCS* (Report Number 14-00875-03, issued October 15, 2015) and *Healthcare Inspection—Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona* (Report Number 14-00875-325, issued September 30, 2016), OIG found that non-VA providers' clinical documents were not consistently available for HCS providers to timely review. Consequently, referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to these non-VA clinical records. These records are vital in understanding a patient's overall health status and care. Gaps in non-VA documentation, such as those found in these two Hotline inspections, put patients at risk and make continuity of care between various providers and specialties more difficult to achieve.

##### VA's Program Response

**Estimated Resolution Timeframe:** Complete

**Responsible Agency Official:** Under Secretary for Health

**Associated Strategic Goal:** Manage and Improve VA Operations to

Deliver Seamless and Integrated Support **Strategic Objective:**

Enhance productivity and improve efficiency of the provision of Veteran benefits and services

**Associated Performance Measure(s):** No public-facing measures are associated with this issue

VHA guidance has been developed and implemented by Non VA Care Coordination (NVCC) staff. NVCC staff work with Community Care providers to retrieve all necessary medical documentation for inclusion into the Veteran's Electronic Health Record. Once this information has been received and included in the Veterans Electronic Health Record, it is available for VA clinicians. Community Care has published bulletin articles on the subject and presented information on the Monthly National Call performed by the Community Care Operations Program Office. The Monthly National Call provides a forum in which processes are reviewed, to include new processes, changed processes, or refresher information on current processes.

In FY 2016, in reference to access to urology services and the site-specific report, Healthcare Inspection - Access to Urology Service, Phoenix VA Health Care System (PVAHCS), Phoenix, AZ (Report Number 14-00875-03, issued September 30, 2016), the VA Long Beach Healthcare System (VALBHS) completed the actions described below. Prior to the report's release, PVAHCS increased its Urology staffing to 7.5 of its allocated 8.5 clinical staff. PVAHCS continues to recruit for one staff

<sup>8</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.



urologist. During 2016, PVAHCS reduced its average wait time to be seen in the Urology Clinic to 5 days for established patients and 14 days for new patients. Meetings between PVAHCS and TriWest leadership resulted in improved communications and more timely availability of records from non-VA healthcare providers. Tri-West coordinates care delivered by non-VA healthcare providers for the PVAHCS. All TriWest non-VA care providers are obligated by contract to provide medical records within 14 days. TriWest is obligated by contract to load those records into the portal within 48 hours of receipt so VA staff can retrieve the information. The results of services provided outside of the TriWest contract are returned to the Purchased Care Service and scanned into the computerized patient record system within four business days. PVAHCS and TriWest field staff conduct a weekly teleconference. PVAHCS reviewed eight cases identified by the OIG, took appropriate action, and addressed the results with the Veterans or their next of kin. On June 16, 2016, OIG closed report 14-00875-03 based on these actions.

### **OIG Sub-Challenge #1B: Access to Care (VHA)**

#### **1. Ensuring that VHA Scheduling Policies and Procedures are Followed So That Veterans Receive Timely Access to Care**

In August 2014, OIG reported on a myriad of allegations regarding patient deaths, patient wait times, and scheduling practices at the Phoenix VA Health Care System. The report recommended, among other things, that the VA Secretary ensure that the facility follows VA consult guidance and appropriately reviews consults prior to closing them to ensure Veterans receive necessary medical care.

On June 20, 2016, OIG issued *Veterans Health Administration-Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas* (Report Number 15-03073-275, issued June 20, 2016) addressing allegations that leadership at that facility and its associated CBOCs incorrectly recorded clinic cancellations as appointment cancellations requested by patients. OIG substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to incorrectly record cancellations as canceled by the patient. As a result, VHA's recorded wait times did not reflect the actual wait experienced by the Veterans and the wait time remained unreliable and understated. These issues have continued despite VHA having identified similar issues during a May and June 2014 systemwide review of access. These conditions persisted because of a lack of effective training and oversight. OIG made six recommendations to the Veterans Integrated Service Network (VISN) 16 Director to improve scheduling processes and ensure accountability for continued deficiencies.

OIG also published healthcare inspections which identified use of unapproved wait lists in calendar year 2015 at other facilities [*Eye Care Concerns Eastern Kansas Health Care System Topeka and Leavenworth, Kansas*, Report Number 15-00268-66, issued December 22, 2015; and *Access and Oversight Concerns for Home Health Services Washington DC VA Medical Center Washington, District of Columbia*, Report Number 14-03823-19, issued November 16, 2015].

Since the allegations at the Phoenix VA Health Care System in April 2014, OIG has conducted extensive work related to allegations of wait time manipulation that were investigated by OIG criminal investigators. OIG continues to receive such allegations.

OIG needed to hold release of information regarding the findings of these investigations for a time when doing so would not impede any planned executive or administrative action. OIG has provided information to VA's Office of Accountability Review for appropriate action and has completed and published more than 70 of these administrative summaries of criminal investigations on wait times. To date there has been one successful criminal prosecution, but largely OIG has found instances of



substantiated administrative misconduct were more appropriate for referral to the Department for any administrative personnel action deemed appropriate rather than criminal prosecution.

**VA's Program Response**  
**Estimated Resolution Timeframe:** 2019  
**Responsible Agency Official:** Under Secretary for Health  
**Associated Strategic Goal:** Manage and Improve VA Operations to Deliver Seamless and Integrated Support  
**Strategic Objective:** Enhance productivity and improve efficiency of the provision of Veteran benefits and services; Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees

**Associated Performance Measures:**

- Percent of patients who responded 'Always' regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of patients who responded 'Always' regarding their ability to get an appointment for needed care right away
- Percent of primary care patients who respond "Always" regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of specialty care patients who respond "Always" regarding their ability to get an appointment for routine checkup as soon as needed
- Percent of primary care patients who respond "Always" regarding their ability to get an appointment for needed care right away
- Percent of specialty care patients who respond "Always" regarding their ability to get an appointment for needed care right away

VHA has 30+ year old scheduling software is designed as multiple "clinics" (multiple schedule calendars) for each provider rather than single "resources" (or one schedule calendar) per provider. The system does not allow VA the ability to measure or manage access with traditional community standards. For example, serving one patient by making multiple appointments at check-out requires over 10 minutes, hundreds of keystrokes, and review/management of multiple individual lists and clinics. This reality underlies the development, training, and implementation of a complex set of scheduling business rules among ~25,000 schedulers who turn over at a rate of ~25 percent per year in order to manage access in VA. In addition to the software, training, and turnover, the science of using certain administrative time stamps to reflect patient waiting times is underdeveloped.

In order to improve the reliability of the scheduling process, VA's strategic direction is multipronged: 1) move the evaluation and accountability for Veteran Access to measures that are more reflective of the Veterans experience of the scheduling process; 2) simplify the scheduling process, 3) improve the training, oversight and feedback and 4) improving electronic scheduling tools. VA has initiatives addressing each of these strategies in addition to improving customer service and Medical Support Assistant hiring.



Even the most sophisticated scheduling software and processes does not address the fundamental question of how best to evaluate the adequacy of access to needed healthcare services. For instance, there are no healthcare industry-wide benchmarks for clinic waiting times. VHA has made the strategic decision to gauge the ultimate success of our Access initiatives through the eyes of the Veteran, using the Consumer Assessment of Health Providers and Systems (CAHPS) survey. Our current Agency Priority Goal (APG) for Access for FY 2016-2017 focuses on improvement in the percentage of Veterans who state they can *Always* or *Usually* receive Primary Care and Specialty Care services when needed for Routine Care (e.g. check-ups) and Care Needed Right Away (urgent care). This agency goal is based on a composite of 4 CAHPS items. We note that CAHPS represents the only access measure currently endorsed by the National Quality Forum. CAHPS has the additional advantages of 1) ability to benchmark with private sector health systems and 2) avoiding potential for manipulation by assessing self-reported ability to receive care when needed for routine and urgent medical problems.

While VA's updated scheduling policy has been published, the development and implementation of the electronic scheduling application known as VistA Scheduling Enhancement has very high leverage potential to improve the day to day processes. In addition, VA is working toward enabling patients to directly schedule their own appointments through a hand-held application.

Accomplishments this year in these areas include:

- Publication of the Declaration of Access establishing VHA's access direction.
- Publication of VHA Outpatient Scheduling Process and Procedures policy.
- Finalization and anticipated Publication in September 2016 of the Consult and Outpatient Clinic Practice Management Policy.
- Establishment of systematic oversight for Consult processes.
- Development and field testing of Version 1.0 of VistA Scheduling Enhancement (VSE) which converts VHA scheduling to a graphical point and click application.
- Development and field testing of Veterans Appointment Request app allowing Veterans to first request and eventually make their own appointments from handheld applications.
- MyVA Access best practice implementation and support in the area of access.
- VHA "stand downs" to address pending urgent consults and appointments
- Implementation of the Consult Trigger Tool, an oversight tool to help improve consult management
- Completion of the first Consult Improvement Initiative, consisting of a group of 6 facilities working together to improve their consult performance.
- Development of new management reports assisting facilities in right-sizing the number of practices needed to maintain access.

Future strategic goals include developing, implementing, and training improved VA electronic scheduling software; training existing and new staff on VA's new scheduling policy; and enhancing oversight and feedback.

In reference to the site-specific report, *Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas* (Report Number 15-03073-275, issued June 20, 2016), VHA notes OIG's concern and it is being addressed locally. It does not appear that this is a systemic issue. VHA welcomes OIG's recommendations on policies and procedures across the enterprise.

In reference to the site-specific report, *Healthcare Inspection – Eye Care Concerns Eastern Kansas Health Care System Topeka and Leavenworth, Kansas*, Report Number 15-00268-66, the OIG



substantiated that the Leavenworth VA Medical Center (VAMC) Eye Clinic staff used an unapproved wait list for patients awaiting cataract surgery. However, the OIG did not substantiate that the unapproved wait list was created to falsify cataract surgery wait times. The Eastern Kansas Health Care System (EKHCS) Director and the VISN 15 Heartland Network Director both agreed that the list not an unapproved wait list; rather it was an electronic checklist used to ensure Veterans received the appropriate and necessary pre-surgical work-up prior to cataract surgery. The checklist was a tracking mechanism that followed multiple facets of care, including progress of clinical work-up through clinical disposition, and was maintained at the local facility. No VHA-wide mechanism was available that met the specific needs of the eye clinic procedures. In his report, the Assistant Inspector General for Healthcare Inspections disagreed with their assessment and maintained that the review found that list was used to track patients awaiting cataract surgery in lieu of the electronic wait list. The OIG substantiated that providers did not consistently enter eye care requests for new Leavenworth VAMC and Topeka VAMC Eye Clinic patients using the consult referral process as required. However, they did not substantiate the allegation that the providers did not follow the required consult process in an attempt to falsify wait times. The OIG did not substantiate that cataract surgeries were completed unnecessarily for the two identified patients or that patients were harmed while awaiting surgery.

In reference to improving home health services and to address the site-specific report, *Access and Oversight Concerns for Home Health Services Washington DC VA Medical Center Washington, District of Columbia* (Report Number 14-03823-19, issued November 16, 2015), the DC VA Medical Center completed a number of actions to described below. In FY 2016, staff revised the Geriatric and Extended Care Organizational Chart outlining the restructuring of the program. The Director signed the revised policy, Medical Center Memorandum, No. 11D-33 H/HHA Program. Staff training for the policy has been loaded into Talent Management System. There is now improved communication of between GEC reviews and referral sources of H/HHA by adding them as a co-signer. There is improved monitoring and oversight of DC VAMC's H/HHA EWL to ensure Veterans and family members are informed of delay in services and appropriate steps are followed in accordance with policy. An H/HHA monitoring tool was developed to assess staffs compliance of the program quality indicators. Random quarterly audits will be conducted. Staff developed an enhanced GEC screening process to better track and monitor referrals volume and dispositions. Additionally, there is ongoing monitoring and oversight activities of Veterans and community agencies receiving H/HHA services now occur.

## **2. Ensuring that VA Can Purchase Timely, High Quality Care in the Community**

On February 11, 2016, OIG testified before the United States House of Representative's Subcommittee on Health, Committee on Veterans' Affairs, about the challenges VA faces in administering its purchased care programs. VA's purchased care programs include the Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. VA continues to experience challenges with Veterans receiving timely access to care in the VCP which was created in November 2014 under Public Law 113-146, Veterans Access, Choice, and Accountability Act of 2014.

On February 4, 2016, OIG issued *Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, Colorado* (Report Number 15-02472-46, issued February 4, 2016), substantiating the allegation that eligible Colorado Springs Veterans did not receive timely care in six reviewed services. The services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and Primary Care. OIG reviewed 150 referrals for specialty care consults and 300 primary care appointments and, of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the list in a timely manner. Specifically, OIG found that:



- Scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days for 59 of the 288 veterans; and
- Non-VA Care Coordination staff did not add 56 veterans to the VCL and did not add 173 veterans to the list in a timely manner; and
- Scheduling staff did not take timely action on 94 consults and primary care appointment requests.

As a result, VA staff did not fully use VCP funds authorized by Congress to afford Colorado Springs CBOC Veterans the opportunity to receive timely care.

Additionally, on February 5, 2016, OIG issued *Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida* (Report Number 15-03026-101, issued February 5, 2016), substantiating that James A. Haley Veterans' Hospital staff did not always cancel the veteran's VA appointment when staff made a VCP appointment. Consequently, VA appointments were not available for other Veterans waiting for care. For example:

- OIG found that for 12 Veterans, staff did not cancel the Veterans' corresponding VA appointments because Non-VA Care Coordination staff did not receive prompt notification from the contractor when a Veteran scheduled a VCP appointment and no longer needed the VA appointment; and
- OIG substantiated that the facility did not add all eligible Veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List. This occurred because Tampa VAMC schedulers thought they were appropriately removing the veteran from the Electronic Wait List when they were actually removing the veteran from the Veterans Choice List.

**VA's Program Response**  
**Estimated Resolution Timeframe:** Complete  
**Responsible Agency Official:** Under Secretary for Health  
**Associated Strategic Goal:** Manage and Improve VA Operations to Deliver Seamless and Integrated Support  
**Strategic Objective:** Enhance productivity and improve efficiency of the provision of Veteran benefits and services  
**Associated Performance Measure(s):** No public-facing measures are associated with this issue

VHA continues to work to improve access to care for all Veterans. Community Care has guidance outlining the process for managing Veteran Choice List appointments. This guidance has been reviewed in numerous training sessions, and is available for staff to download to be readily available. Information regarding this subject was also reviewed on a Monthly National Call.

In reference to the site-specific report, *Review of Alleged Untimely Care at the Community Based Outpatient Clinic, Colorado Springs, Colorado* (Report Number 15-02472-46, issued February 4, 2016), VHA has taken note of OIG's concern and shall address it locally. It does not appear that this is a systemic issue. VHA welcomes OIG's recommendations on policies and procedures across the enterprise.



VA Eastern Colorado Health Care System (ECHCS) fully supports the Veteran's right to pursue the "Choice" option if they meet eligibility criteria. We are currently in the top 5 facilities in the nation for the volume of referrals to the Veterans Choice Program. Through March of FY 2016, ECHCS has referred 27,716 episodes of care to our region's third party administrator, Health Net Federal Services (Health Net), resulting in 17,251 appointments in the community. To ensure we maintain this success, ECHCS has added Veterans Choice List entry criteria to the performance plans of schedulers and issued the revised plans during mid-year review in March 2016.

In regards to the appointment requests for newly enrolled Veterans within 1 day of the approved appointment, there is no known policy with this requirement. Per VHA Directive 2012-001 regarding time requirements for processing Enrollment applications, the office responsible for processing applications is responsible for processing all applications, regardless of the method of submission, into the Veterans Information Systems and Technology Architecture (VistA) within 5 business days of the time stamp date. The appointment requests for newly enrolled patients are populated onto the Newly Enrolled/Appointment Requested Report and processed daily by the site for which the Veteran requested care.

In reference to the site-specific report, *Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida* (Report Number 15-03026-101, February 5, 2016), the Tampa VA Medical Center took the actions described below. The Acting Chief, Health Administration Service (HAS) collaborated with the VISN 8 Field Assistant who explained that any changes would require a national Contract Modification. At the national level, there are no plans for modification as the needed information is obtainable through the Health Net portal. HAS will continue to retrieve community CHOICE appointments through the portal and cancel VA appointments accordingly. On average, appointment notifications are received within two to ten days prior to the community CHOICE appointments.

The Acting Chief, HAS, validated that Health Net complies with the contract by updating the portal with the date/time of the community appointment. Health Net is not obligated to provide an electronic alert. HAS will continue to retrieve community appointments through the portal.

The HAS Performance Improvement (PI) section developed an audit program report in May 2015 which utilizes VistA. The report is run daily for the appointments made on the previous date. The report has three tabs that monitor Veteran's Choice List (VC List) entries, VCL Dispositioned entries, and appointments that should have been added to the VC List but were not. This report is sent daily via Outlook to all section chiefs and supervisors of scheduling staff with instructions on how to take action for each tab. The supervisors share the audit results with appropriate staff for awareness and corrective action.

HAS PI section runs the daily VC List reports to verify VC List entries were made. Those that have been dispositioned from the list are verified for "Deceased status" with Decedent Affairs staff. Veterans not identified as deceased are reported to supervisors to be re-entered correctly to the VC List. The HAS PI Committee performs ongoing audits for previously dispositioned Veterans, as well as audits to identify patients scheduled for appointments, but not entered to the VC List as required. The Committee reports their findings to the PI Section Chief. The PI Section Chief then sends a list to supervisors to have the corrective actions entered.

In accordance with the National Clarification to Scheduling Guidelines introduced in May 2015, the PI section conducted refresher scheduling training from July through September 2015. The training included CHOICE, Electronic Wait List/VC List training and was provided to all staff and supervisors possessing the scheduling menus. Staff were required to self-certify that they had attended,



understood, and would comply with the training requirements. Training certification for those that attend training is entered in staff's Talent Management System (TMS) Learning History, and certification memorandums are maintained by the PI section.

The scheduling menus were removed from those staff that did not attend and certify compliance. CHOICE, Electronic Wait List /VCL training is now part of the scheduling training conducted at James A. Haley Veterans' Hospital prior to scheduling menus being assigned. Veterans are now entered on the VCL by a scheduler in the respective specialties.

## **OIG CHALLENGE #2: BENEFITS PROCESSING** **-Strategic Overview-**

Delivering timely and accurate benefits is central to VA's mission. The Veterans Benefits Administration (VBA) is responsible for oversight of the nationwide network of VA Regional Offices (VARO) that administer a range of veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs are estimated to pay out over \$104 billion in claims to Veterans and their beneficiaries in FY 2017.

OIG conducts inspections of all 56 VARO's and the Veterans Service Center (VSC) in Cheyenne, Wyoming, generally on a 3-year cycle to examine the accuracy of claims processing and the management of VSC operational activities. These inspections address the processing of high-risk claims such as temporary 100 percent disability evaluations, residual disabilities related to traumatic brain injuries (TBI), and special monthly compensation (SMC) claims and related ancillary benefits payments reserved for Veterans with quality-of-life issues due to severe disabilities related to military service. In FY 2016, OIG inspected 5 VAROs—completing the second review cycle of VBA's 57 claims processing offices.

During FY 2016, OIG also reported the results of 14 reviews related to VBA programs, operations, and complaints received through OIG's Hotline Division. Since FY 2011, VBA has aggressively pursued multiple initiatives outlined in its Strategic Plan to eliminate the backlog of compensation claims, also referred to as rating-related claims. VBA's goal for reducing the backlog was to process all compensation claims within 125 days with 98 percent accuracy by 2015. However, OIG is concerned that the improvement made in reducing the backlog of compensation claims was at the expense of other VBA workload such as its non-rating and appealed claims workload.

The manner in which VBA reports and accounts for its workload lacks transparency and creates self-imposed challenges to managing that workload. For example, in April 2016, VBA reported it completed 135,172 dependency claims since the start of the FY—representing 32 percent of its target completion goal of 422,090 during FY 2016. As part of VBA's transformation efforts, VBA developed a Rules-Based Processing System (RBPS) to automate dependency claim submission and payment through self-service features; however, claims processed under RBPS are excluded from VBA's performance dashboards. VBA reported that over 60 percent of the dependency claims filed through RBPS are automatically processed and paid within 2 days; yet, dependency claims processed under traditional claims processing systems for FY 2016 have taken, on average, 353 days to complete. While VBA reports the success of RBPS, performance metrics such as the accuracy of claims processed using RBPS are unknown. It is unclear how VBA and stakeholders, to include OIG, can determine if VBA successfully reduced its inventory of dependency claims and whether or not improvement in this workload can be attributed to RBPS. Similarly, while VBA focused efforts on reducing its inventory of rating-related disability claims, its appealed claims inventory continued to rise. According to VBA's



Monday Morning Workload Reporting system, the appealed claims inventory increased by 31 percent—from 247,780 in September 2011 to 325,291 as of May 14, 2016.

### **OIG Sub-Challenge #2A: Improving the Accuracy and Timeliness of Claims Decisions (VBA)**

OIG continues to report the need for enhanced policies and procedures, training, oversight, quality reviews, and other management controls to improve the timeliness and accuracy of claims decisions. Claims processing that lacks compliance with VBA procedures could increase the risk of improper benefits payments to Veterans and their families. During inspections, OIG sampled claims with certain medical disabilities considered to be at higher risk of processing errors, thus results do not necessarily represent the overall accuracy of disability claims processing at the VAROs. In FY 2016, OIG reported on the performance of five VAROs in the following areas:

- Temporary 100 percent disability evaluations;
- Residual disabilities related to TBI;
- SMC and related ancillary benefits;
- Dates of claims; and
- Benefits reductions.

OIG determined VBA staff correctly processed disability claims related to TBI; however, 16 percent of the total 186 disability claims statistically selected from 5 VAROs that related to temporary 100 percent disability evaluations and SMC claims contained errors. The errors resulted in more than \$186,000 in improper benefits payments. Specifically, VARO staff incorrectly processed:

- 20 percent of 114 temporary 100 percent disability evaluations, resulting in identification of more than \$138,100 in improper benefits payments; and
- 32 percent of 19 claims involving SMC and ancillary benefits, resulting in identification of more than \$47,900 in improper benefits payments.

VARO staff used incorrect dates when establishing claims in VBA's electronic system of records for 1 percent of the 150 cases reviewed. OIG also determined VARO staff did not correctly process or complete 26 percent of 141 proposed benefits reductions cases, resulting in approximately \$206,400 in improper benefits payments. For the cases with processing delays, an average of 6 months elapsed before staff took the required actions to reduce benefits.

In FY 2014, as part of its transformation initiatives, VBA implemented an issue-level model for reporting the accuracy of claims processed at VAROs—deviating from its traditional claim-level model for reporting accuracy. VBA explained that under the issue-level model, a claims processor that properly decided 15 out of 16 medical issues correctly received an accuracy rate of 93.7 percent. Under the claim-level model, if one of the 16 issues were incorrectly decided, the entire claim would be an error. VBA began concurrently tracking the accuracy of rating-related disability claims using the traditional and claim-level model. Under the claim-level model, the accuracy of rating-related claims remained at approximately 90 percent while the accuracy of claims using the issue-level model remained around 96 percent through the second quarter of FY 2016. As such, OIG is concerned that the increased accuracy reported using the issue-level model is related to the change in methodology rather than actual improvement in the accuracy of claims being processed.

Additionally, in March 2015, VBA implemented a regulatory change that standardized the manner in which beneficiaries must submit claims. Prior to the regulatory change, beneficiaries were entitled to submit a claim in any format, including handwritten notes or letters. The regulatory change included a



new “intent to file” process. VBA reported that the formalized process gives applicants additional time to gather all of the information and evidence needed to submit their formal application for benefits; however, VBA has a fundamental duty to assist Veterans in this process. OIG is concerned that the new policy created a mechanism in which claims processing staff could reject claims unless it was submitted on a specific form, thereby delaying assisting Veterans with their claims and ultimately in the delivery of benefits and services.

**VA Program Response**

**Estimated Resolution Timeframe:** 2017

**Responsible Agency Official:** Under Secretary for Benefits

**Associated Strategic Goal:** Empower Veterans to Improve Their Well-being

**Strategic Objective:** Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

**Associated Performance Measures:**

- Percentage of VA Disability Rating Claims pending more than 125-days
- Percentage of Disability Compensation Rating Claims inventory pending more than 125-days
- National Accuracy Rate – Disability Compensation Rating Claims
- National Accuracy Rate – Disability Compensation Rating Claims – Issue Based
- Percent of Disability Compensation Claims received virtually/electronically
- Percentage of Dependency and Indemnity Compensation Claims inventory pending more than 125-days
- Non-Rating Claims, Compensation Average Days Pending
- Non-Rating Claims, Compensation Average Days to Complete
- Dependency Claims Processing: Inventory (Claims Pending)
- Dependency Claims Processing: Timeliness (Month-to-Date Average Days to Complete as of the last month of the year)
- Compensation: Overall customer satisfaction index score (out of 1000)
- Appeals Processing - Notices of Disagreement (NODs) Average Days Pending
- Appeals Processing - Formal Appeals to the Board (Form 9) Pending Inventory
- Appeals Processing - Notices of Disagreement (NODs) Pending Inventory

The Veterans Benefits Administration (VBA) is committed to providing Veterans with the care and services they have earned and deserve. As of September 30, 2016, the average age of pending compensation claims was 85 days, a 197-day reduction from the 282-day peak in March 2013. For the seventh year in a row, VBA completed over a million disability claims. Even as VBA focused on its priority goal to eliminate the disability rating claims backlog for Veterans who have waited the longest,



and is achieving record-breaking levels of production, VBA remained focused on non-rating claims, as well. As VBA completed record-breaking numbers of disability rating claims in recent years, one result is an associated increase in the volume of non-rating claims and appeals. Despite completing three million non-rating and administrative action end products in fiscal year (FY) 2016, this volume of work continues to grow.

VBA developed the Rules-Based Processing System (RBPS) to automate adjustments for adding or removing dependents. During FY 2016, 66 percent of the dependency claims submitted through RBPS were automatically processed and Veterans' award adjustments were completed within one day. Claims that do not fit the criteria for automatic processing or claims that cannot be validated through the automated rules-based decision criteria are routed for manual processing. VBA will continue to focus efforts on completing the oldest dependency claims while continuing to reduce overall inventory. In the third quarter of FY 2016, VBA continued to track improvement projects across identified work streams to increase the volume of dependency claims eligible for automatic processing. Distribution of dependency claims through the National Work Queue (NWQ) will increase, further adding claims processing efficiency. VBA will continue to work with the myVA initiative to prioritize information technology improvements and market the electronic submission channels that enable automatic dependency claim processing.

Modernizing the appeals process through legislative reform and other people, process, and technology initiatives is one of VA's 12 Breakthrough Priorities. VBA received funding that allowed the hiring of 200 additional appeals full-time employees in FY 2016, increasing the appeals workforce to 1,495 employees. VBA also allocated \$10 million in overtime funds for the appeals workload. The additional funding has allowed VBA to increase its appeals output to more than 202,000 appeals actions in FY 2016, which represents a 20 percent increase over FY 2015. VBA was able to lower the Substantive Appeal (VA Form 9) pending inventory by 11 percent, and the Board remand inventory by 8 percent in FY 2016, while maintaining a steady NOD pending inventory, compared to FY 2015. In addition, VBA issued over 30,000 more statements of the case in FY 2016 compared to the previous year. Overall, VBA resolved 113,197 appeals in FY 2016 – over 15,000 more appeal resolutions compared to FY 2015. Furthermore, beginning in November 2015, VBA started gathering requirements for processing appeals in VBMS, leveraging efficiencies through automation and the NWQ. However, as VA has increased claims decision output over the past 6 years, appeals volume has grown proportionately.

Despite the people, process, and technology improvements, increases in productivity have not been significant enough to keep pace with inflow of new appeals and the current appeals workload is projected to continue to grow. VBA received more than 176,000 new appeals in FY 2016 – nearly 63,000 appeals more than it was able to resolve. Within the current legal framework, the average processing time for all appeals resolved in FY 2016 was approximately 3 years. For those appeals that reach the Board, on average, Veterans were waiting at least 5 years for an appeals decision, with thousands of Veterans waiting much longer. VA projects that under the current process, without significant legislative reform, Veterans will be waiting an average of 10 years for a decision on their appeal by the end of 2027. Comprehensive legislative reform is required to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, simple, transparent, and fair. In early 2016, VA sponsored an "Appeals Summit" – a series of meetings held with Veterans Service Organizations (VSOs), advocacy groups, and congressional staff to design a new appeal process, with additional meetings and ongoing communication following. The product of these collaborative, detailed discussions between VA, VSOs, and other key stakeholders was a new appeals framework. VA provided Congress with draft language setting forth this framework, which is the subject of four bills pending in Congress (H.R. 5083, H.R. 5620, S. 3170, and S. 3328).



Nationally, claim-based accuracy increased from 84 percent in FY 2011 to 88.1 percent (+/- .8 percent margin of error), as of September 30, 2016, and issue-based accuracy remained high at 95.5 percent (+/- .3 percent margin of error). Issue-based accuracy is measured by assessing each medical disability decision within a rating-related compensation claim. Each issue a Veteran raises must go through the same series of discrete tasks, such as VBA providing duty to assist, gathering evidence, and making the decision. VBA may err on one aspect of the claim for a medical issue, but correctly process the remaining issues within the claim. Hence, the outcome of claim-based accuracy, which considers a claim to be processed either correctly or incorrectly, is not beneficial for analysis or training purposes and presents a misleading picture of VBA's accuracy. Issue-based accuracy provides VBA the opportunity to precisely target medical issues where adjudication is more error-prone and additional training is needed.

VBA continues to gain efficiency as a result of a blend of people, process, and technology improvements. The automation capabilities provided by the Veterans Benefits Management System (VBMS), coupled with the implementation of the NWQ and the Centralized Mail (CM) program, are clear examples of enhancements to increase the efficiency of claims processing.

VBMS deployed major releases in FY 2016, using an agile development model to deliver new functionality and enhancements to users every three months. These releases focused on the reduction of legacy systems, as well as automation, integration with the Department of Defense (DoD), and electronic access to communications for Veterans. For enhanced efficiency, VBMS can now systematically request DoD service treatment records when a Veteran initiates his or her claim. Additionally, VBMS now automatically triggers a review of a claim when requested evidence is marked as received, helping move the claim toward a decision.

In February 2016, VBA launched NWQ, a national workload distribution tool. NWQ was built within VBMS and takes advantage of paperless capabilities to improve VBA's overall production capacity and assist with reaching claims processing goals. With 99.7 percent of the pending disability compensation claims inventory converted to a digital format, VBA is able to efficiently and centrally manage the claims workload, set priorities nationally, and electronically distribute claims that are ready to be worked based on individual regional office (RO) capacity levels. As of May 8, 2016, all ROs are receiving disability rating claims through NWQ.

VBA completed deploying CM to all ROs in 2015, and completed deploying CM to the Pension Management Centers in FY 2016. Since deployment, VBA has gained proficiency in electronic mail processing and is now able to provide assistance with virtual mail processing as needed across ROs. VBA continues to explore the possibility of expanding CM use to other business lines.

Prior to March 24, 2015, Veterans could submit claims in any format, including handwritten notes or letters. This practice sometimes led to VBA discovering claims later in the process. Effective March 24, 2015, VBA regulations made the claims process easier and more efficient for Veterans through the use of standardized claim and appeal forms. This regulatory change includes a new intent to file (ITF) process that replaces informal claims. The ITF process gives applicants additional time to gather all of the information and evidence needed to submit with their formal application for benefits. The ITF process protects the earliest possible effective date if VBA determines that the applicant is eligible for benefits and helps ensure anyone wishing to file a claim receives the information and assistance he or she needs.

VBA also developed and mandated new refresher training course for Veterans Service Representatives, Rating Veterans Service Representatives, and Decision Review Officers regarding



special monthly compensation (SMC). In addition, VBA updated training materials on the following topics for the Veterans Service Center personnel:

- Temporary 100-percent disability evaluations
- Traumatic brain injury
- SMC and related ancillary benefits
- Dates of claims
- Benefits reductions

### **OIG Sub-Challenge #2B: Improving Data Integrity, Internal Controls, and Management Within VAROs (VBA)**

VBA continues to experience challenges in ensuring all 56 VAROs comply with the Veterans Health Information Systems and Technology Architecture (VistA) regulations and policies and deliver consistent operational performance. During FY 2016, OIG published 14 reports relating to VBA program operations, management, and allegations of wrongdoing. In total, OIG made 41 recommendations for improvement and substantiated many of the allegations raised through OIG's Hotline. Recommendations for improvement addressed data integrity issues, weaknesses in internal controls, and mismanagement of VBA operations and programs. Specific challenges that OIG reported on in FY 2016 are summarized in this section.

In May 2016, OIG identified concerns warranting VBA management attention while assessing the merits of allegations that VARO management inappropriately interfered with established procedures for reconsidering local quality review errors at the San Diego VARO. In *Review of Alleged Manipulation of Quality Review Results at VA Regional Office San Diego, California*, (Report Number 15-02376-239, issued May 9, 2016), OIG determined VBA's local quality review program lacked controls sufficient to ensure staff took timely actions to correct claims processing errors identified during the quality review process. Of the 50 errors OIG sampled, 39 required corrective actions, such as revised decision documents, while the 11 remaining errors related to actions like improper development for evidence which did not require revised decision documents. On average, it took VARO staff 66 days to correct the errors. OIG recommended the San Diego VARO Director implement a plan to ensure staff comply with local policy to correct individual quality review errors and that the Under Secretary for Benefits (USB) establish a timeliness standard for VBA staff at its 56 VAROs to follow when correcting individual quality review errors.

OIG issued two reports, *Review of Alleged Data Manipulation of Appealed Claims at VA Regional Office Wichita, Kansas* (Report Number 15-03581-204, issued April 26, 2016) and *Review of VBA's Alleged Inappropriate Prioritization of Appeals at VA Regional Office Roanoke, Virginia* (Report Number 15-02384-212, issued April 19, 2016), related to data integrity and mismanagement. The data integrity issues regarding appealed claims processing actions at the Wichita VARO resulted from a lack of management oversight and conflicting guidance provided by the Compensation Service. The guidance required VARO staff to enter incomplete and/or inaccurate information in Veterans Appeals Control and Locator System (VACOLS). VACOLS is the electronic records system used to track and manage its appeals workloads—the effectiveness of tracking appealed claims is dependent upon the accuracy and timeliness of the information entered. OIG reviewed 36 Notices of Disagreements (NOD) at the Wichita VARO and found staff did not follow VBA policy when processing this workload. In addition to recommending that VARO staff correct the errors OIG identified, the USB modified the policy on processing the appealed claims workload to ensure appellate claims are accurately processed.

At the Roanoke VARO, OIG confirmed that leadership did not follow workload management plans, which required appeals staff to prioritize appealed claims based on the age of the appealed claims.



Instead, as directed by VBA's Southern Area Office Director to reduce appeals inventory, Roanoke VARO management implemented a NOD reduction plan. The reduction plan focused on processing less complex, newly initiated appeals. OIG confirmed that 82 percent of the appealed claims processed by Roanoke VARO staff in FY 2014 had been pending less than 1 year and that older appealed claims were not processed.

In January 2015, OIG received an anonymous allegation that staff at the Los Angeles, California, VARO were shredding mail related to veterans' disability compensation claims. The complainant also alleged that supervisors were instructing staff to shred these documents. OIG substantiated in *Review of Alleged Shredding of Claims-Related Evidence at VA Regional Office Los Angeles, California* (Report Number 15-04652-266, issued April 14, 2016), that VARO staff were not following VBA's January 2011 policy on management of Veterans' and other governmental paper records. OIG found nine claims-related documents that VARO staff incorrectly placed in personal shred bins for non-claims-related documents—eight of which had the potential to affect Veterans' benefits. OIG could not determine if records were incorrectly shredded prior to the visit because, as part of the normal contractor shred schedule, documents stored for destruction were picked up 11 days prior to OIG's visit. OIG will continue to follow up on the VARO's progress toward implementing the recommendations and corrective actions made in the report.

In order to determine whether the improper destruction of Veterans' claims-related documents was an isolated problem or a systemic issue, OIG conducted unannounced inspections at 10 selected VAROs across the nation. The 10 sites were Atlanta, Georgia; Baltimore, Maryland; Chicago, Illinois; Houston, Texas; New Orleans, Louisiana; Oakland, California; Philadelphia, Pennsylvania; Reno, Nevada; San Juan, Puerto Rico; and St. Petersburg, Florida. OIG found that VBA's controls were not effective to prevent VARO staff from potentially destroying claims-related documents, identifying 69 of 155 claims-related documents improperly scheduled for destruction at 6 of the 10 VAROs. As such, OIG concluded this was a systemic issue within VBA. OIG found that noncompliance with policy, inadequate controls, and outdated guidance led to the potential destruction of claims-related documents. VARO management and staff found VBA's policy confusing, they did not always receive annual training as required, and records management staff did not consistently review documents or maintain violation logs. These actions put documents at risk for inappropriate destruction, which can result in loss of claims and medical evidence, incorrect decisions, and delays in claims processing.

Additionally, VBA's shredding policy contained control weaknesses because supervisors were not required to document or track shredding violations, and records management staff were only required to spot check documents identified by employees as non-claims-related. The policy also lacked standardized procedures for the collection of documents, and VBA had not updated its policy to include procedures for electronic claims processing. OIG made seven recommendations in the report *Review of Claims-Related Documents Pending Destruction at VA Regional Offices* (Report Number 15-04652-146, issued April 14, 2016) to the Acting USB, including revising VBA policy on management of veterans' and other Governmental paper records to ensure documents printed from Veterans Benefits Management System (VBMS) are clearly identified, and to provide detailed standardized procedures for the collection and review of material by records management staff.

Furthermore, OIG confirmed that St. Petersburg VARO staff did not adequately prepare documents for scanning at VA contracted scanning facilities. OIG observed claims evidence that was improperly stored, comingled with contractor documentation, or that was disorganized and not ready for scanning. Overall, the St. Petersburg VARO had more than 41,900 mail packages containing claims material and over 1,600 boxes requiring scanning. OIG also found that VBA did not provide effective oversight of contractor personnel to ensure documents were timely processed or safeguarded at the contractor facility.



On February 25, 2016, OIG published the results of an audit to assess VBA's implementation of its 2012 recommendations to strengthen internal controls over Disability Benefit Questionnaires (DBQs) and to determine whether VBA could use DBQs more effectively. In *Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires* (Report Number 14-02384-45, issued February 25, 2016), OIG found VBA did not establish adequate controls to identify and minimize potential DBQ fraud or fully implement OIG's prior recommendations to address control weaknesses. OIG estimated that claims processors did not identify approximately 23,100 of about 24,700 claims (93 percent) that included DBQs. Generally, this occurred because VARO staff did not consistently and correctly apply special issue indicators in VBA's electronic systems to identify claims that included DBQs, and VBA lacked adequate policies and procedures and quality assurance reviews. Further, unnecessary medical examinations caused Veterans and VA to needlessly expend time and money and may have delayed Veterans receiving benefits. OIG estimated VA will spend at least \$4.8 million annually and at least \$24 million over the next 5 years for unnecessary VA examinations if DBQs are not used more effectively.

**VA Program Response**

**Estimated Resolution Timeframe:** 2017

**Responsible Agency Official:** Under Secretary for Benefits

**Associated Strategic Goal:** Empower Veterans to Improve Their Well-being

**Strategic Objective:** Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

**Associated Performance Measures:**

- Percentage of VA Disability Rating Claims pending more than 125-days
- Percentage of Disability Compensation Rating Claims inventory pending more than 125-days
- National Accuracy Rate – Disability Compensation Rating Claims
- National Accuracy Rate – Disability Compensation Rating Claims – Issue Based
- Percent of Disability Compensation Claims received virtually/electronically
- Percentage of Dependency and Indemnity Compensation Claims inventory pending more than 125-days
- Non-Rating Claims, Compensation Average Days Pending
- Non-Rating Claims, Compensation Average Days to Complete
- Dependency Claims Processing: Inventory (Claims Pending)
- Dependency Claims Processing: Timeliness (Month-to-Date Average Days to Complete as of the last month of the year)
- Compensation: Overall customer satisfaction index score (out of 1000)

VBA takes seriously the issues OIG raised and has taken action to address them, and will continue to do so until they are resolved.



The issue related to appeals workload management was specific to the Roanoke RO, which VBA addressed locally rather than systemically. Five of the OIG reports noted above resulted in national recommendations, and VBA is implementing them as expeditiously as possible. On March 4, 2016, VBA established a five-day standard for correcting errors identified by Quality Review Teams. VBA reminded all RO staff about the policy for controlling appeals on April 28, 2016. In March 2015, as a result of OIG's findings from the St. Petersburg RO, VBA increased the number of visits to the scanning facilities, provided more detailed instructions for site audits, and authorized an on-site government staff member for each mail intake site.

VBA is committed to ensuring Veterans' records are protected and maintained with accuracy and care. OIG inspected the Los Angeles RO in January 2015, to review documents pending destruction. OIG reviewed approximately 13,800 documents to be shredded and found 9 claims-related documents in individual employees' shred boxes/envelopes, demonstrating a 99.93 percent accuracy rate of the RO's shredding process. VBA believes that OIG intercepted all of these documents before they completely passed through the RO's internal controls process, including the Records Management Officer's review. The OIG proceeded to conduct additional inspections regarding documents pending destruction at 10 ROs, reviewing 438,000 documents and noting 11 documents (0.0025 percent) that were erroneously identified for disposal and had the potential to affect benefits. While VBA knows that every Veteran's record is important and sincerely regrets these errors, it has been working diligently to eliminate the potential for errors by transforming its antiquated paper-based system to a fully electronic environment. Conversion of paper records to digital records significantly strengthens the systemic protection of Veterans' claim documents, early and rapidly integrating them into the Veterans' electronic claims folders. Ensuring these protections remains a top priority for VBA. VBA is also in the process of revising its records management policy to align with the current environment, which provides electronic document storage and centralized mail handling.

VBA is addressing all recommendations made by OIG in the *Follow-Up Audit of VBA's Internal Controls over Disability Benefits Questionnaires (DBQs)*. VBA revised the Adjudication Procedures Manual, M21-1, to clarify procedures pertaining to public-use DBQs. Specifically, the revisions updated guidance on how to obtain missing information from public-use DBQs, procedures for determining if clinicians who prepared the public-use DBQs are private or Veterans Health Administration clinicians, and additional steps to take after receiving insufficient public-use DBQs.

VBA also made improvements to the local quality assurance reviews. On January 1, 2016, VBA released a revised in-process review checklist to address compliance with public-use DBQ indicators, RO compliance with complete clinician's information on the public-use DBQs, and whether claims processors obtained unnecessary examinations after receiving DBQs adequate for rating purposes. In addition, on May 15, 2016, a revised Systematic Technical Accuracy Review checklist captured whether the submitted public-use DBQ was adequate for rating purposes.

VBA revised the standard operating procedure (SOP) for reviewing DBQs completed by non-VA providers. The revised SOP requires Compensation Service (CS) to analyze local quality assurance reviews to identify systemic issues related to the use of special-issue indicators, complete clinician information, and potential instances of unnecessary examinations.

VBA continues to assess the business requirements to verify the credentials of private physicians. VBA is also in the process of implementing front-end controls in the Veteran Claims Intake Program and Centralized Mail Portal, verifying the examiner by the National Provider Identifier (NPI), and by adding the private provider NPI as a data field so data can be pulled and sorted through data requests.



### **OIG CHALLENGE #3: FINANCIAL MANAGEMENT** **-Strategic Overview-**

Sound financial management represents not only the best use of limited public resources, but also the ability to collect, analyze, and report reliable data on which resource use and allocation decisions depend. OIG's oversight assists VA in identifying opportunities to improve the quality of VA's financial information, systems, and assets. Addressing these and other issues related to financial systems, information, and asset management would promote improved stewardship of the public resources entrusted for VA's use.

For the 17<sup>th</sup> consecutive year, OIG's independent auditors provided an unqualified opinion on VA's FY 2015 and FY 2014 consolidated financial statements (CFS). With respect to internal controls, the contractor identified four material weaknesses, Information Technology Security Controls (a repeat condition); Procurement, Undelivered Orders, and Reconciliations; Purchase Care Processing and Reconciliations; and Financial Reporting. The independent auditors also identified two significant deficiencies, Accrued Operating Expenses (a repeat condition) and CFO Organizational Structure for VHA and VA. Additionally, the contractor reported that VA did not substantially comply with Federal financial management systems requirements and the United States Standard General Ledger at the transaction level under P.L. 104-208, Federal Financial Manager Improvement Act (FFMIA) of 1996, and cited instances of non-compliance with section 5315 of title 38 of the United States Code pertaining to the charging of interest and recovery of administrative costs. The independent auditors will follow up on these internal control and compliance findings and evaluate the adequacy of corrective actions taken during the FY 2016 audit of VA's CFS.

#### **OIG Sub-Challenge #3A: Compliance with the Improper Payments Elimination and Recovery Act (Office of Management (OM), VHA, VBA)**

OIG conducted an FY 2015 review to determine whether VA complied with the requirements of P.L. 111-204, Improper Payments Elimination and Recovery Act (IPERA) of 2010. VA reported improper payment estimates totaling approximately \$5 billion in its FY 2015 Agency Financial Report (AFR), compared with \$1.6 billion for FY 2014, primarily because of improvements in estimating improper payments for four programs. In both years, VA reported improper payment data based on the previous fiscal year activity. VA did not fully comply with IPERA. In fact, the Office of Management and Budget (OMB) designated the VA Community Care, Purchases Long Term Services and Support programs, and the Compensation programs as high-priority programs in FY 2016. Each of these programs had estimated improper payments in excess of OMB's threshold of \$750 million. This designation places additional requirements on VA and OIG for FY 2016 reporting.

VA met four of six IPERA requirements for FY 2015 by publishing the AFR, performing risk assessments, publishing improper payment estimates, and providing information on corrective action plans. VA did not comply with two of the six IPERA requirements by not maintaining a gross improper payment rate of less than 10 percent and not meeting reduction targets for all programs published in the AFR. The two programs that exceeded the 10 percent threshold are the VA Community Care program and Purchased Long Term Care Support and Services program. The programs that did not meet reduction targets are: (1) Compensation; (2) Education Chapter 1606; (3) Education Chapter 1607; (4) VA Community Care; (5) Purchased Long Term Services and Support; (6) Beneficiary Travel; (7) Supplies and Materials; and (8) Disaster Relief Act—Hurricane Sandy.

In addition, VHA underestimated improper payments for one program and did not achieve the expected level of accuracy for two others. Likewise, VBA expended considerable effort to collect improper payments because of a program design issue with drill pay, and it needs to develop a plan and seek



the assistance of Office of Management and Budget to coordinate future resolution. VA management concurred with OIG's recommendations, and OIG will follow up on corrective actions in the FY 2016 review.

OIG also conducted an audit to evaluate VBA's oversight of the Post-9/11 Veterans Educational Assistance Act of 2008 (Post-9/11 G.I. Bill) tuition and fee payments to determine if payments were appropriate and accurate (Report Number 14-05118-147, issued September 30, 2016). OIG's review of a sample of more than \$1.7 million in payments made during the academic year from August 1, 2013, to July 31, 2014, determined that VBA Regional Processing Offices (RPOs) had made 46 improper payments to 20 schools. The RPOs made these improper payments totaling just under \$90,900 on behalf of 43 of the 225 students reviewed. These improper payments occurred because:

- School certifying officials made errors, were unaware of program requirements, or did not follow program requirements when they submitted students' certifications for payment;
- VBA did not ensure sufficient verification and monitoring of tuition and fee certifications;
- VBA lacked adequate guidance on allowable book fees and repeated classes; and
- VBA did not verify and obtain supporting documentation for mitigating circumstances.

Of the more than \$5.2 billion in payments made in academic year 2013-2014, OIG projected that VBA made about \$247.6 million in improper payments. If VBA does not improve program controls, improper payments could total an estimated \$1.2 billion over the next 5 academic years.

OIG also identified improper payments concerning incarcerated Veterans in *Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans* (Report Number 13-02255-276, issued June 28, 2016). OIG conducted an audit to determine whether VBA was adjusting compensation and pension (C&P) benefit payments timely for Veterans incarcerated in Federal, state, and local penal institutions. Federal law requires VBA to reduce C&P benefits for Veterans incarcerated for more than 60 days in a Federal, state, or local penal institution. VARO and Pension Management Center (PMC) staff did not consistently take action to adjust C&P benefits for Veterans incarcerated in Federal penal institutions. Specifically, based on Federal incarceration data ranging from May 2008 through June 2015, VBA did not adjust veterans' C&P benefits, as required, in an estimated 1,300 of 2,500 cases (53 percent), which resulted in improper payments totaling approximately \$59.9 million. Without improvements, OIG estimated VBA could make additional improper benefit payments totaling about \$41.8 million for Federal incarceration cases from FY 2016 through FY 2020.

VARO and PMC staff also did not take consistent and timely action to adjust C&P benefits for veterans incarcerated in state and local penal institutions. Based on incarceration notifications received from March 2013 to August 2014—the most current data available at the time of OIG's audit—VBA did not effectively adjust veterans' C&P benefits in an estimated 3,800 of 21,600 state and local incarceration cases (18 percent), which resulted in significant delays and improper payments totaling approximately \$44.2 million. Without improvements, OIG estimated VBA could make additional improper benefit payments totaling about \$162 million for state and local incarceration cases from FY 2016 through FY 2020. In general, VBA did not place a priority on processing incarceration adjustments because VBA did not consider these non-rating claims to be part of the disability claims backlog. Both VBA Central Office and VARO staff consistently reported that incarceration adjustments were not a high priority.

OIG also identified improper payments during its review of VBA's SMC Housebound Benefits (Report Number 15-02707-277, issued September 29, 2016). The OIG reviewed whether VBA granted entitlement to all statutory housebound SMC benefits for veterans with a disability rated at 100 percent



and additional disabilities independently rated at 60 percent. OIG also assessed whether VBA accurately processed SMC for veterans receiving compensation at the housebound rate. VBA's processing of SMC housebound benefits needs improvement. OIG identified processing inaccuracies in 45 of 250 cases where Veterans were entitled to statutory housebound benefits, resulting in estimated underpayments of \$110.1 million through February 2015. Generally, errors occurred because staff overlooked the issue and VBA's electronic reminder was ineffective. In addition, VBA did not accurately process 127 of 247 cases where Veterans were being paid at the housebound rate. For cases with a combined evaluation of 90 percent or less, errors resulted in estimated overpayments of \$44.3 million through February 2015. In many instances, the errors were due to ineffective training and a multi-step process in VBA's electronic system. Together, these errors resulted in improper payments of \$154.4 million through February 2015.

**VA's Program Response**

**Estimated Resolution Timeframe:** FY 2020

**Responsible Agency Officials:** Interim Assistant Secretary for Management and Interim Chief Financial Officer (Lead), Under Secretary for Health, and Acting Under Secretary for Benefits, Principal Executive Director of Office of Acquisition, Logistics, and Construction

**Associated Strategic Goal:** Empower Veterans to Improve their Well-being

**Strategic Objective:** Increase customer satisfaction through improvements in benefits and services delivery policies, procedures, and interfaces

**Associated Performance Measure(s):** No public-facing measures are associated with this issue.

The Inspector General raised concerns about the VA's compliance with IPERA in their report released on May 15, 2015, and VA provided a detailed response in the FY 2015 Agency Financial Report (<http://www.va.gov/finance/docs/afr/2015VAafrSectionIII.pdf>, pg. 86). VA continues to address root causes of improper payments through the IPERA Governing Board and individual program corrective actions developed to mitigate findings from the OIG's 2016 IPERA report issued May 13, 2016.

In 2015, VA saw a significant increase in our improper payment rates. This was due to VHA's continued incorporation of contract compliance [Federal Acquisition Regulations (FAR) and VA Acquisition Regulations (VAAR)] into their test plans for VA Community Care and Purchased Long-Term Services and Support. This increased improper payment rate has continued into 2016 as VHA improves testing methodology and educating staff on proper contract regulations.

As the OIG noted, elimination of VBA improper payments for VA benefits processing related to military drill pay offsets are hampered by the current statutory framework. Legislative changes, funding, and computer system changes will be required, and therefore VA is working with the Office of Management and Budget (OMB) to determine whether this significant reform has long-term potential for implementation.

To help mitigate identified compliance issues within learning institutions, VBA will deploy an outreach team to assess areas of vulnerability in non-compliant institutions. In addition, VBA is updating the



School Certifying Official Handbook to include Standard Operating Procedures surrounding document retention and ensuring available documentation is provided timely for IPERA requests.

After reviewing the data on Federal incarcerations from May 2008 through June 2015, VBA identified a backlog of cases and initiated a review to process potential award adjustments. In the first quarter of FY 2016, VBA began a data-matching agreement with the Bureau of Prisons.

VBA deployed systemic changes to the Veterans Benefits Management System-Rating (VBMS-R) application on June 17, 2016, which included new programming that prevents staff from completing decisions without considering potential eligibility to statutory housebound benefits any time a Veteran has a single 100 percent evaluation. Rating Veteran Service Representatives and Decision Review Officers were required to take mandatory training on evaluating higher level of Special Monthly Compensation. This training was completed on July 1, 2016.

Utilizing proactive identification of root causes of improper payment, Compensation Service (CS) provided focused training to regional offices and deployed a Rules-Based Processing System for dependency claims to improve claim accuracy through automation. In FY 2016, VBA was able to reduce the number of pending dependence claims by approximately 50 percent.

Pension Service conducted site visits to assist the Pension Management Centers in identifying or detecting any operational deficiencies that may have negatively impacted the accurate and efficient processing and authorization of pension related claims. The site visit team also addressed training related issues and provided awareness of how incorrect actions taken on pension claims impacts IPERA.

Reducing improper payments is a high priority for VA's overall effort to strengthen financial management. VA is committed to achieving compliance with IPERA and remediating improper payments as part of our stewardship of taxpayer dollars.

VA continues to strengthen its efforts to ensure the improper payment definition is consistently applied, improve the accuracy and completeness of testing, develop and implement effective corrective actions, and increase awareness and accountability throughout the Department. Leadership has increased communication to clarify roles and responsibilities with Senior Accountable Officials to strategically strengthen program integrity by addressing vulnerabilities in programs, implementing effective corrective actions, and tracking issues to resolution.

### **OIG Sub-Challenge #3B: Improving Management of Appropriated Funds (OM, OIT, VHA)**

In September 2012, OIG issued *Administrative Investigation of the FY 2011 Human Resources Conferences in Orlando, Florida* (Report Number 12-02525-291, issued September 30, 2012), which identified inadequate controls resulting in wasteful spending. OIG conducted an audit of FY 2014 conferences to assess the adequacy of the actions VA took to address identified control weaknesses identified in the September 2012 Administrative Investigation.

In OIG's report *Audit of VA's Conference Management for Fiscal Year 2014* (Report Number 15-01227-129, issued April 6, 2016), policy and oversight weaknesses were identified that could undermine the cost-effectiveness of conferences and increase the risk of inappropriate spending. VA organizations did not comply with policy for 11 of 12 randomly selected FY 2014 conferences. VA organizations did not prepare Conference Packages in accordance with policy for 10 conferences with budgets totaling approximately \$11.6 million. VA organizations also did not prepare Final Conference Reports in accordance with policy for 11 of 12 conferences, with expenditures totaling approximately \$7.9 million.



Weaknesses in policy implementation occurred because VA did not issue adequate guidance, implement adequate oversight procedures, or provide adequate accountability to ensure VA organizations complied with conference policies. As a result, these weaknesses contributed to VA reporting approximately \$3.9 million in conference expenditures to Congress that could not be adequately traced to source documentation to verify their accuracy and appropriateness.

OIG also completed a report *Audit of VHA's Non-VA Medical Care Obligations* (Report Number 14-02465-47, issued January 12, 2016), that assessed whether VHA adequately managed non-VA medical care miscellaneous obligation cost estimates and related management and system controls. The Non-VA Care (NVC) Program expenditures of about \$4.8 billion included \$1.9 billion in obligated funds that remained unspent as of the end of FY 2013. Significant under or over obligation of these program funds could affect overall VHA operations.

VHA medical facilities did not adequately manage the obligations used to purchase NVC. From October 1, 2013, through March 31, 2015, VHA medical facility officials determined that they had overestimated the funds needed to pay for these services by about \$543 million. The unnecessary obligation of these funds prevented VHA from using \$543 million of the \$1.9 billion (29 percent) obligated for NVC for any purpose during FY 2013. Reducing the over obligation of NVC funds from about 29 to 10 percent would have freed up about \$358 million to acquire additional NVC services. This occurred because VHA did not:

- Provide the facilities with adequate tools to reasonably estimate the costs of NVC services;
- Require medical facility staff to routinely adjust cost estimates for individual authorized services to better reflect actual costs;
- Ensure NVC staff adjusted the estimated amount of obligated funds in the VistA after payments are complete; or
- Require facilities to analyze the accuracy of prior year obligation balances.

Additionally, in March 2015, U.S. Senator Mark Warner requested the OIG evaluate the merit of an allegation that a task order to develop e-learning courses for the supply chain workforce was improperly terminated. In *Review of the Alleged Improper Termination of the e-Learning Task Order* (Report Number 15-02776-240, issued September 19, 2016), OIG did not substantiate that VA's decision to terminate the e-learning task order was without just cause, as the Federal Acquisition Regulation (FAR) provides broad latitude for termination for convenience by the Government. However, OIG did determine that the Veterans Affairs Acquisition Academy did not properly plan and coordinate the e-learning task order with the Office of Logistics and Supply Chain Management officials. Consequently, it did not meet the program office's training needs. Had the Veterans Affairs Acquisition Academy taken the appropriate planning and coordination steps, it may have mitigated the termination risk and saved VA approximately \$1.9 million for supply management courseware that was not completed.

OIG also substantiated an allegation that the Detroit VAMC had not installed and utilized 282 of 300 purchased televisions or their associated accessories in *Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan* (Report Number 16-02729-350, issued August 9, 2016). The facility acquired the equipment in September 2013 as part of a project to replace the patient television system in the facility, but as of April 2016, 282 of the televisions and associated accessories were in storage. Despite having all the televisions and accessories on hand for more than 2 years, the facility was unable to install the items in the patient rooms because they did not meet the design specifications identified in the patient television system architect and engineer (AE) services contract.



OIG determined Detroit VAMC officials did not communicate with the AE contractor in a timely manner to ensure the televisions purchased were compatible with the design and specifications of the project. As a result, the Detroit VAMC issued a contract modification for \$19,052 to adjust the design and specifications of the project to support the televisions purchased. The televisions and related accessories should have been purchased closer to award of the construction contract. By purchasing these items more than 2 years before a construction contract to install them was awarded, the facility exposed itself to unnecessary financial risk in the event it does not proceed with the patient television system upgrade project. As of April 2016, the facility had not yet awarded a contract to install these televisions. Further, by purchasing too early in the process the facility allowed valuable warranties to expire, increasing the risk of incurring additional expenses to replace any faulty televisions.

**VA's Program Response**  
**Estimated Resolution Timeframe:** 2017  
**Responsible Agency Official:** Interim Assistant Secretary for  
Management and Interim Chief Financial Officer  
**Associated Strategic Goal:** Manage and Improve VA Operations  
to Deliver Seamless and Integrated Support  
**Strategic Objective:** Enhance Productivity and Improve Efficiency  
of the Provision of Veteran Benefits and Services  
**Associated Performance Measure(s):** No Public Facing  
Measures are Associated with this Issue

VA is committed to financial management excellence through sound stewardship of taxpayer dollars. Thus, VA constantly strives to improve our financial practices and policies. In OIG's Audit of VA's Conference Management for Fiscal Year (FY) 2014 (Report Number 15-01227-129, issued April 6, 2016), VA's compliance was assessed with an outdated policy that was replaced in March of 2015. As such, many of the issues of noncompliance identified were the result of a complex and burdensome policy that did not accommodate how conferences were organized or executed across VA. Further, OIG's reported noncompliance with the outdated policy did not identify any wasteful spending, abuse or misuse of funds. Prior to the OIG's review, VA had developed an updated policy which maintained accountability, while ensuring it could be practicably applied in the development and approval of conferences.

VA acknowledges that its new policy did not specifically address those conferences held multiple times within a year or offered at Government-owned facilities. The policy will be further updated to provide additional clarity to the process and align with recent clarification from the Office of Management and Budget. VA takes its planning and execution of conferences seriously, and believes the new policy and procedures will ensure proper spending and accountability.

VA continues to make progress in addressing findings from the audit of VHA's Non-VA Medical Care Obligations (Report Number 14-02465-47, issued January 12, 2016). The Office of Community Care's Purchased Care program has enhanced the Fee Basis Claims System (FBCS) cost estimation tool to assist VA medical centers (VAMCs) in developing more accurate authorization estimates. In addition, on a daily and monthly basis, multiple reports are generated by Purchased Care and distributed to the VAMCs to identify potential issues with authorization estimates. In FY 2016, the Deputy Under Secretary for Health for Operations and Management added a requirement for all Veterans Integrated



Service Networks (VISNs) to certify that their VAMCs have completed a review of the previous months' FBCS authorization estimates for accuracy.

VA has also improved the reconciliation process between FBCS and the Financial Management System (FMS) by requiring VAMCs to reconcile FBCS authorization estimates to corresponding FMS obligations and payments on a monthly basis. VISN Directors certify monthly that the reconciliation is performed.

In March of 2015, Senator Mark Warner requested that OIG evaluate the merit of an allegation that a task order to develop e-learning courses for the supply chain workforce was improperly terminated; VA is awaiting final publication of the OIG report and any related recommendations.

VA concurred with the recommendations on the site-specific report, Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan (Report Number 16-02729-350, issued August 9, 2016), and has developed and implemented a plan to utilize the purchased televisions. A contract for the installation of the televisions cited in the report was awarded in June of 2016, and the installation project began in July of 2016.

VA takes our financial responsibilities seriously. Maintaining the public's trust of our financial stewardship remains one of our highest priorities.

### **OIG Sub-Challenge #3C: Improving the Timeliness of Payments to Purchased Care Providers (VHA)**

In 2016, OIG testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, about the challenges VA faces in administering its purchased care programs. From August 2014 through February 1, 2016, VA has spent \$224.4 million on the VCP. VA has reimbursed Health Net and Tri West \$171.4 million of \$224.4 million (76 percent) for administering the program and \$53.0 million of \$224.4 million (24 percent) for medical services provided to Veterans. OIG's audits and reviews have shown that VA faces challenges in administering its purchased care programs, not only with access to care, but with proper expenditure of funds, and timely payment of providers. VA lacked adequate processes to manage these funds and oversee program execution. While purchasing healthcare services from non-VA providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. With non-VA healthcare costs of about \$6 billion in FY 2015 and future costs expected to increase, VA needs to improve program controls over timely payments. Without adequate controls, VA's consolidation plan is at increased risk of not achieving its goal of delivering timely and efficient healthcare to Veterans.

OIG determined veterans faced significant barriers accessing medical care through the VCP. These barriers included cumbersome authorization and scheduling procedures, insufficient provider networks, and potential liability for treatment costs. These barriers occurred because VCP implementation was inadequately planned and administrative burdens placed on network providers and low reimbursement rates discouraged their participation. As a result, from November 1, 2014, through September 30, 2015, very few veterans received care through the VCP. Only 13 percent of veterans who were waiting more than 30 days for VA care utilized the VCP. Those who successfully navigated the VCP's cumbersome procedures waited an average of 45 days to receive care. Also, VA spent about \$165.2 million administering the program compared to \$15.1 million providing medical care for veterans. VA is currently planning a new acquisition to replace the existing VCP contracts. For this new acquisition to be successful, VA will need to ensure OIG's recommended changes are addressed in a timely manner.



**VA's Program Response**  
**Estimated Resolution Timeframe:** 2016  
**Responsible Agency Official:** Under Secretary for Health  
**Associated Strategic Goal:** Manage and Improve VA Operations to Deliver Seamless and Integrated Support  
**Strategic Objective:** Enhance productivity and improve efficiency of the provision of Veteran benefits and services. Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees.  
**Associated Performance Measure(s):** No public-facing measures are associated with this issue.

VA Community Care has taken steps to improve claims processing timeliness. As of July 22, 2016, 82.54 percent of all clean claims were aged less than 30 days as compared to 1 year ago when 70.45 percent of all claims were aged less than 30 days. This amounts to a 12 percent improvement over that period.

The Claims Adjudication and Reimbursement (CAR) program has made significant strides in reducing the aged inventory and has implemented standardized processes across the country to ensure claims are processed consistently with the same rules. CAR, in conjunction with Program Oversight and Informatics staff, has developed a “Dashboard” for field Supervisors to view claim level detail and staff member detail. This capability helps ensure that the oldest claims are being processed.

CAR has also established teams to work on the “other than clean claims” and “unauthorized claims”. Such claims have gone from 56.95 percent in July 2015 to 75.85 percent, July 2016, aged less than 45 days in age. These claims are much more complicated and require specific eligibility to be met to approve these claims for payment.

CAR continues to monitor claims status and standardize claims processes in order to increase claims processing timeliness and reduce claims inventory.

#### **OIG CHALLENGE #4: PROCUREMENT PRACTICE** **-Strategic Overview-**

VA operations require the efficient procurement of a broad spectrum of services, supplies, and equipment at national and local levels. OIG audits and reviews of support service contracts, PC3, and allegations regarding other contracts identified systemic deficiencies in all phases of the procurement process, including planning, solicitation, negotiation, award, and administration. OIG attributes these deficiencies to inadequate oversight and accountability.

Recurring systemic deficiencies in the procurement process, including the failure to comply with the FAR and VA Acquisition Regulation, and the lack of effective oversight increase the risk that VA may award contracts that are not in the best interest of the Department. Further, VA risks paying more than fair and reasonable prices for supplies and services and making overpayments to contractors. VA must



improve its acquisition processes and oversight to ensure the efficient use of VA funds and compliance with applicable acquisition laws, rules, regulations, and policies.

#### **OIG Sub-Challenge #4A: Improving Contracting Practices (OALC, VHA)**

The replacement of the Denver VAMC, Eastern Colorado Health Care System (Denver project) has experienced significant, and unnecessary, cost overruns and schedule slippages. The project dates back to the late 1990s. This was in response to the region's growth in the veteran population and the need to replace an aging and inadequate facility built in 1951. VA's 2009 acquisition plan initially estimated the Denver project would cost approximately \$536.6 million to build with construction finished in 2013. The project's \$800 million budget included items such as the cost of land acquisition, design, construction, and consultant services. Congress provided appropriations between 2004 and 2012 to cover these costs. However, current estimates for the project place the final cost at \$1.675 billion or more than twice VA's FY 2009 approved project budget.

The construction portion of the project was a little more than half completed and is estimated to be completed approximately two years after the new contract was awarded to Kiewit-Turner on October 30, 2015. VA issued a task order to the U.S. Army Corps of Engineers to provide oversight of this new contract. According to a VA official, activation of the hospital is estimated to take up to an additional six months and approximately \$315 million. This means Veterans will not likely be served by a fully functioning facility before mid to late 2018 or almost 20 years after VA identified the need to replace and expand its aging facility in Denver.

The Denver project's escalating cost estimates and schedule slippages are the result of poor business decisions, inexperience with the type of contract used, and mismanagement by VA senior leaders. It is now too late for VA to undo the negative effects of its poor management decisions concerning the Denver project because it is a little more than half completed. Although, VA contracted the U.S. Army Corps of Engineers to manage the Denver project there are "lessons learned" that VA can apply to VA's remaining and future construction projects.

*In Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System* (Report Number 15-04945-331, issued August 18, 2016), the allegation that VA acquisition personnel mismanaged the award of ambulette services task orders at the New York Harbor Healthcare System (NYHHS) was substantiated. Specifically, acquisition personnel improperly awarded two task orders for ambulette services when the contractor's Federal Supply Schedule contract did not offer the services VA was seeking. In addition, the contracting officer's award determination for the re-solicited requirement was not clearly justified. Further, acquisition personnel did not document all pertinent contracting actions in VA's Electronic Contract Management System (eCMS). This occurred because VA's Integrated Oversight Process (IOP) reviews designed to improve contract quality were not always completed. While the IOP was in place, contracting staff did not conduct required reviews for the first two task orders. If performed, these pre-award reviews may have revealed the vendor did not offer the services VA was seeking. Further, personnel turnover caused confusion as to who should ensure contract documentation was included in eCMS. As a result, acquisition personnel put VA at risk for protests and payment to protesters for restitution.



**VA's Program Response**  
**Estimated Resolution Timeframe:** 2016  
**Responsible Agency Official:** Principal Executive Director, Office of Acquisition, Logistics, and Construction  
**Associated Strategic Goal:** Manage and Improve VA Operations to Deliver Seamless and Integrated Support  
**Strategic Objective:** N/A  
**Associated Performance Measure(s):** There are no public-facing measures associated with this issue

In regard to OIG's review of VA's National Acquisition Center's (NAC) procurement strategy used under the DoD Digital Imaging Network-Picture Archival Communication System contract (DIN-PACS), OALC has not received a copy of the draft report to provide comment. As summarized by OIG, in the text above, the following allegations were not substantiated: the manipulation of technical evaluations, excessive equipment purchases, or an award that was made 30 percent higher than recommended. OALC welcomes the opportunity to review the draft report, *Review of Alleged Contract Practices at the National Acquisition Center (NAC)* and any specific findings or recommendations when the draft report becomes available.

The Office of Inspector General previously raised concerns regarding the replacement of the Denver Medical Center in a draft report released in May 2016. VA provided a detailed response to the OIG in June 2016. An excerpt from our response follows:

The Office of Acquisition, Logistics, and Construction (OALC) agrees with the findings of the OIG draft report and acknowledges that it is too late to undo the mistakes made on the Denver project. OALC has learned from those mistakes and has embarked on an enterprise-wide effort to improve our processes. As indicated in the report, OALC and the Office of Construction and Facilities Management (CFM) in particular have put in place sound construction management processes based on best practices from private industry and other Federal agencies; lessons learned, including those from the Denver project; and recommendations made to the Department of Veterans Affairs (VA) from various stakeholders including the Office of the Inspector General (OIG), the Government Accountability Office, the United States Army Corp of Engineers (USACE), and construction industry partners. These process improvements will help ensure proper execution of our major construction projects and future success in the construction program, allowing VA to provide increased access to care for Veterans and their families around the country.

In regard to the report, *Review of Alleged Mismanagement of Ambulette Services Contract at the VA New York Harbor Healthcare System*, VHA Procurement and Logistics has initiatives to implement contracting officer warrant boards to assess employee skills prior to issuing contracting officer warrants. VHA revised the contract award review thresholds and processes to align risk with more robust review.

#### **OIG Sub-Challenge #4B: Improving Purchase Card Practices (OALC, VHA)**

In April 2014, OIG's OHI briefed VA New Jersey Health Care System (VANJHCS) leadership regarding the results of a criminal investigation of purchase card abuse in the Engineering Service. In OIG's report *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System* (Report Number 11-00826-261, issued April 26, 2016), the objective was to determine whether the inappropriate practice of split purchasing occurred in services other than the Engineering Service at VANJHCS.



OIG found the inappropriate practice of split purchasing extended beyond the Engineering Service at VANJHCS. OIG determined VANJHCS employees split purchases in 64 of the 76 purchase card transactions (84 percent) reviewed, totaling \$125,270. This included 19 purchase cardholders working in 6 different services. Based on the sample results, OIG estimated that VANJHCS staff inappropriately made about 4,750 split purchases totaling approximately \$8.9 million from December 2012 through May 2014. This occurred because of a disregard for internal controls that are an integral part of every Federal Government purchase card program. Additionally, management did not provide effective oversight and did not hold VANJHCS purchase cardholders, their supervisors, and the approving officials accountable for policy violations.

OIG estimated that split purchasing resulted in approximately \$8.9 million in unauthorized commitments and increased the risk of fraud, waste, and abuse of taxpayer resources at VANJHCS. The lack of oversight and ineffective controls also prevented VANJHCS management from determining whether VANJHCS received all purchased goods and services. Management needs to take immediate corrective action and make long-term improvements to ensure sound financial stewardship of taxpayer resources.

**VA's Program Response**  
**Estimated Resolution Timeframe:** On-going  
**Responsible Agency Official:** Principal Executive Director, Office of Acquisition, Logistics, and Construction  
**Associated Strategic Goal:** Manage and Improve VA Operations to Deliver Seamless and Integrated Support  
**Strategic Objective:** N/A  
**Associated Performance Measure(s):** There are no public-facing measures associated with this issue

The VA New Jersey Health Care System (VANJHCS) Purchase Card Coordinator terminated 18 purchase cards that were issued to 18 different individuals to decrease the possibility of misuse. In addition, they centralized their purchasing program and hired one full-time employee assigned to the Chief of Logistics Service, who will manage the purchasing program. Purchase Card holders are currently required to complete the training, which is tracked in the Talent Management System (TMS). Purchase card training topics include unauthorized commitments, GSA SmartPay, quarterly reconciliations, procurement integrity, and online IFCAP training. TMS training is currently tracked and the Purchase Card Coordinator sends out monthly email reminders to the Service Chief and Purchase Card Holder. In addition, to ensure stronger oversight, VANJHCS Logistics Service, with assistance from the VA New York/New Jersey Veterans Integrated Service Network, reviewed all items used in the engineering shops. VANJHCS decided that all items would have master numbers in order to have these items added to the Generic Inventory Packages; and based upon usage, they will either be standard or on-demand. VANJHCS Logistics Inventory Management Specialists are assisting with completion. VANJHCS has encouraged each Service to review their recurring purchases in order to establish contracts for these items. In addition, the facility is currently reviewing all actual occurrences of split orders that have resulted in unauthorized commitments and will continue the ratification process as these are identified.

VHA Procurement is responsible for administration of the purchase card program within VHA. Split requirements are a continuous challenge for any purchase card program. VHA Procurement has collaborated with the Office of Management's Office of Internal Controls to identify and correct incidence of split requirements. With regard to the erroneous input of FPDS data, the situation was a



one-time mistake in judgment by an employee. The action was corrected and no further strategic improvement was required.

VHA Procurement will continue to work the VA Office of Internal Controls to reduce the incidence of split requirements.

### **OIG CHALLENGE #5: INFORMATION MANAGEMENT** **-Strategic Overview-**

The use of information technology (IT) is critical to VA providing a range of benefits and services to veterans, from medical care to compensation and pensions. If managed effectively, IT capital investments can significantly enhance operations and support the secure and effective delivery of VA benefits and services. However, when VA does not properly plan and manage its IT investments, they can become costly, risky, and counter-productive. Lacking proper safeguards, computer systems also are vulnerable to intrusions by groups seeking to obtain sensitive information, commit fraud, disrupt operations, or launch attacks against other systems.

Under the leadership of the Assistant Secretary and Chief Information Officer, VA's Office of Information and Technology (OIT) is positioning itself to facilitate VA's transformation into a 21st century organization through improvement strategies in five key IT areas: (1) quality customer service, (2) continuous readiness in information security, (3) transparent operational metrics, (4) product delivery commitments, and (5) fiscal management. OIT's efforts are also focused on helping accomplish VA's top three agency priority goals of expanding access to benefits and services, eliminating the claims backlog, and ending Veteran homelessness.

However, OIG oversight work indicates that additional actions are needed to effectively manage and safeguard VA's information resources and processing operations. As a result of the FY 2015 CFS audit, OIG's independent auditor reported that VA did not substantially comply with requirements of the FFMIA of 1996. While providing an unqualified opinion on the CFS, the independent auditor continues to identify IT security controls as a material weakness. Furthermore, CFS auditors noted material weaknesses related to: (1) contract procurements, undelivered orders, and account reconciliations; (2) purchased care processing; and (3) key processes supporting accurate financial reporting.

OIG work indicates VA has only made marginal progress toward eliminating the material weakness and remediating major deficiencies in IT security controls. OIT also has not fully implemented competency models, identified competency gaps, or created strategies to ensure its human capital resources can support VA's current and future mission requirements with necessary IT enhancements or new initiatives. Despite implementation of the Project Management Accountability System and VA's transition to the Veteran-focused Integration Process framework to ensure IT oversight and accountability, the Department is still challenged in effectively managing its IT systems initiatives to maximize the benefits and outcomes from the funds invested.

#### **OIG Sub-Challenge #5A: Develop an Effective Information Security Program and System Security Controls (OIT)**

Secure systems and networks are integral to supporting the range of VA mission-critical programs and operations. Information safeguards are essential, as demonstrated by well-publicized reports of information security incidents, the wide availability of hacking tools on the internet, and the advances in the effectiveness of attack technology. In several instances, VA has reported security incidents in



which sensitive information has been lost or stolen, including personally identifiable information, thus exposing millions of Americans to the loss of privacy, identity theft, and other financial crimes. The need for an improved approach to information security is apparent and one that senior Department leaders recognize. OIG's recent work on the CFS audit supports OIG's annual Federal Information Security Modernization Act (FISMA) assessment. During FY 2015, OIG reported that VA continued to implement its Continuous Readiness in Information Security Program to ensure continuous monitoring year-round and establish a team responsible for resolving the IT material weakness. In August 2013, VA also implemented an IT Governance, Risk, and Compliance Tool to improve the process for assessing, authorizing, and monitoring the security posture of the agency. In FY 2015, the VA's Chief Information Officer formed an Enterprise Cybersecurity Strategy team that was charged with delivering an enterprise cybersecurity strategic plan. The plan was designed to help VA achieve transparency and accountability while securing veteran information. The team's scope included management of current cybersecurity efforts, as well as development and review of VA's cybersecurity requirements from desktop to software to network protection.

As FISMA work progressed, OIG noted more focused VA efforts to implement standardized information security controls across the enterprise. OIG also noted improvements in role-based and security awareness training, a reduction in the number of IT individuals with outdated background investigations, and improvement in data center Web application security. However, these controls require time to mature and show evidence of their effectiveness. Accordingly, OIG continues to see information system security deficiencies similar in type and risk level to findings in prior years and an overall inconsistent implementation of the security program. Moving forward, VA needs to ensure a proven process is in place across the agency. VA also needs to continue to address control deficiencies that exist in other areas across all VA locations. OIG continues to find control deficiencies in security management, access controls, configuration management, and contingency planning. Most importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support transmitting financial and sensitive information between VAMCs, VAROs, and Data Centers. This is a result of an inconsistent application of vendor patches that could jeopardize the data integrity and confidentiality of VA's financial and sensitive information.

VA has made progress in deploying current patches; however, older patches and previously identified vulnerabilities continue to persist on networks. Even though VA has made some progress in these areas, more progress must be made to improve deployment of patches that will mitigate security vulnerabilities and to implement a centralized process that is consistent across all field offices. Many of these weaknesses can be attributed to an inconsistent enforcement of an agency-wide information security program across the enterprise and ineffective communication between VA management and individual field offices. Therefore, VA needs to improve its performance monitoring to ensure controls are operating as intended at all facilities and communicate security deficiencies to the appropriate personnel tasked with implementing corrective actions.

OIG's report *VA's Federal Information Security Modernization Act Audit for Fiscal Year 2015* (Report Number 15-01957-100, issued March 15, 2016), discussed control deficiencies in four key areas: (1) configuration management controls, (2) access controls, (3) change management, and (4) service continuity controls. Improvements are needed in these key controls to prevent unauthorized access, alteration, or destruction of major application and general support systems. VA has over 9,500 system security risks and corresponding Plans of Action and Milestones (POA&Ms) that still need to be remediated to improve the overall information security posture. More importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support the transmission of sensitive information among VA facilities. The FY 2015 FISMA report provided 31 current recommendations to the Assistant Secretary for Information and Technology to improve VA's information security program. The report also highlighted 4 unresolved recommendations from prior



years' assessments for a total of 35 outstanding recommendations. Overall, OIG recommended that VA focus its efforts in the following areas:

- Address security-related issues that contributed to the IT material weakness reported in the FY 2015 CFS audit of the Department;
- Successfully remediate high-risk system security issues in its POA&Ms; and
- Establish effective processes for evaluating information security controls via continuous monitoring and vulnerability assessments.

In December 2014, OIG's Hotline Division received an allegation that ProCare Home Medical, Inc., (ProCare), located in Anchorage, Alaska, was improperly storing and sharing VA sensitive data on contractor personal devices in violation of Federal information security standards. More specifically, the complainant alleged that ProCare was allowing its employees to use personal computers and phones to access the company computer system and download VA sensitive data to include Veterans' personal health information. OIG substantiated the allegation that ProCare, according to its staff, accessed electronic sensitive Veteran data with its personal computers from home through an unauthorized cloud-based system without encryption controls in *Review of Alleged Contractor Information Security Violations in the Alaska VA Healthcare System* (Report Number 15-01994-238, issued July 12, 2016). OIG also noted that personnel or malicious users could potentially use personal devices on an unauthorized wireless network to access sensitive veteran information. Additionally, OIG determined that ProCare was storing sensitive hard copy and electronic Veteran information in an unsecured manner at their facility. OIG recommended the VA Northwest Health Network management assign a local contracting officer representative and information security officer to provide oversight of Alaska VA Healthcare System contractors. OIG also recommended the VA Northwest Health Network management, in conjunction with the Assistant Secretary for Information and Technology, conduct a site assessment of ProCare information security controls to ensure compliance with VA information security requirements.

**VA's Program Response**

**Estimated Resolution Timeframe:** December 2017

**Responsible Agency Official:** Assistant Secretary for the Office of Information and Technology (OI&T)

**Strategic Goal** – Manage and Improve VA Operations to Deliver Seamless and Integrated Support

**Strategic Objective** – Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees

**External Facing Measure** – There are no public-facing measures associated with this issue

VA is committed to protecting all Veteran information and VA data, and limiting access to only those with the proper authority. Meeting this commitment requires a comprehensive strategic approach that spans VA and the cyberspace ecosystem in which Veterans, VA, and VA's partners operate. In response, VA created the Enterprise Cybersecurity Strategy, which is predicated on protecting and countering the spectrum of threat profiles through a multi-layered defense in depth model spanning eight domains.

As part of its work, the Enterprise Cybersecurity Strategy Team created individual Plans of Action (POAs) to address the 35 recommendations provided by the OIG as a result of the FY 2015 Federal



Information Security Management Act Report. The goal of this effort is to remediate the VA's longstanding Material Weakness in information security while also improving the organization's security posture in support of protecting Veteran data. VA leadership – including the Secretary of the Department of Veterans Affairs – are tracking the status of the 35 OIG recommendations' POAs on a weekly basis to monitor progress of the actions taken by VA to address the identified weaknesses. These plans are part of a comprehensive Integrated Master Schedule with specific timelines to support closure of the identified weakness. As of this date, three of these plans are completed and awaiting final verification. The remaining 32 are projected for completion no later than December 2017.

With regard to improving access control, VA now has the ability to ensure security compliance for the computers used by all remote users who connect to the VA network using their government furnished equipment, due to our 3<sup>rd</sup> quarter, FY 2015 implementation of Network Access Control (NAC) for virtual private network connections. Beyond this capability, VA is planning to expand the above NAC capability, via efforts inextricably linked to the DHS Continuous Diagnostics and Monitoring (CDM) Program (CDM Phase 2), with an expansion of the asset discovery capability. This initiative is planned to be fully implemented by the end of July 2017. Further enhancement of the NAC capability would expand upon the asset discovery capability and is tentatively scheduled to be deployed by the end of 2018. Since the 3<sup>rd</sup> quarter of FY 2015, VA has also reduced the number of accounts with elevated privileges by 95 percent, from 267,000 to approximately 10,000, and remediated 23 million critical and high vulnerabilities as of July 2016. Through close partnership with the clinical staff in VHA, the new Chief Information Security Officer, with concurrence of the CIO, has rescinded prior Personal Identification Verification (PIV) exemptions and is now requiring 100% (PIV) participation, to include those providing patient care. OI&T and VHA are implementing a joint collaborative surge effort to better implement technical enforcement of PIV compliance beginning August 8, 2016. VA is also committed to improving its management of medical devices and has established a review process for ensuring appropriate Medical Device Isolation Architecture Access Control List (ACL) reviews have been applied. To date, 55% (2234 of 4061) ACLs have been remediated to provide better security to Veterans.

VA is not satisfied with the status quo and is committed to finding significant ways to remediate each deficiency that is highlighted within the MMC report. By the end of 2016, VA strives to accomplish the following:

- Enable two-factor authentication using PIV cards for 75% of VA personnel by September 30, 2016.
- Complete 15 cyber security plans of action by December 31, 2016 to address OIG recommendations.
- Eliminate three Material Weakness findings by December 31, 2016, leading to marked improvements in System Development/Change Management Controls, Continuous Monitoring, and Contractor Systems Oversight.
- Implement improvements in systems auditing during the 1<sup>st</sup> quarter, FY 2017, to provide increased visibility into security events and system alerts requiring attention.
- Continue to decrease the number of elevated privilege accounts to a target in keeping with the organizational risk tolerance.

As VA moves forward in the implementation of an enterprise security information and event management deployment, OI&T has implemented organizational improvements such as updating the firewall policy and updating the concept of operations related to the automated collection and analysis of application and systems audit logs. In addition to providing weekly status reports on key cybersecurity metrics to the CIO, OI&T is also in the process of implementing an IT dashboard, which



will provide near-real-time situational awareness for VA IT executives on cybersecurity performance measurements and trends.

While VA still has more work to do to fully address all cybersecurity needs, the Department has made strides toward the future state and developed data-based performance measurement to demonstrate progress toward a number of goals, for both internal and external oversight purposes.

### **OIG Sub-Challenge #5B: Improving Compliance with Federal Financial Management Improvement Act (OIT)**

FFMIA requires agencies to implement and maintain financial systems that comply substantially with Federal financial system requirements, applicable Federal accounting standards, and the U.S. Standard General Ledger (USSGL) at the transaction level. The OIG's independent financial statement auditors reported that VA's financial management systems did not substantially comply with Federal financial management systems requirements, and the USSGL at the transaction level. In particular, the auditors reported the following:

- VA's core accounting system—Financial Management System (FMS)—has functional limitations that were further exacerbated by operational and security vulnerabilities as VA continued to operate FMS on a database no longer supported by the vendor.
- VA's Integrated Funds Distribution Control Point Activity, Accounting and Procurement System (IFCAP) is a module within VistA that is used by VHA, contracting officers, and other VA personnel to initiate and authorize purchase of goods and services, as well as to accumulate vendor invoices for payment. Because the commitment accounting module was not activated during the implementation of FMS, obligations in FMS are recorded based on approved purchase requisitions or Miscellaneous Obligor Documents (1358s) from IFCAP instead of valid contracts or purchase orders. Further, transactions initiated and recorded in IFCAP cannot be centrally and completely reconciled to those in FMS or to the procurement source documentation maintained in eCMS.
- VistA does not provide management with the ability to effectively and efficiently monitor nationwide Medical Care Collection Fund activities at the transaction level. Consolidated Patient Accounting Center personnel cannot generate combined reports for all facilities under their purview. Reports are generated separately for individual medical centers, which leads to inefficiencies in operations and revenue management. Further, a nationwide report at a sufficient level of detail cannot be generated. Reconciliation of revenue transactions to collections and the supporting audit trail is more complicated. Additionally, VistA is not able to produce a consolidated accounts receivable aging report at a sufficient level of detail. Management does not have the tools to properly assess the reasonableness of its allowance for loss provision or perform a retrospective analysis to ascertain the reasonableness of its allowance methodology.
- Fee Basis Claims System (FBCS) is used to manage the authorization and payment processes for VHA's purchase care program. FBCS sits "on top" of VistA and runs in a decentralized manner similar to VistA. Transactions initiated in FBCS were not completely reconciled to those in IFCAP and FMS.
- eCMS is an intranet-based contract management system mandated by VA policy. VA does not utilize eCMS to electronically process the approval and reviews performed for its acquisitions.
- Regarding noncompliance with the USSGL at the transaction level, budgetary execution transaction code and interface issues resulted in incorrect data in accounts that have long



remained unresolved in FMS. Significant journal entries were needed to correct the balances. FMS also lacked functionality to meet U.S. Department of the Treasury reporting requirements related to intragovernmental transactions, which created the need for significant journal entries.

The auditors reported that noncompliance with FFMIA was due to VA's complex, disjointed, and legacy financial management system architecture that has continued to deteriorate and no longer meets increasingly stringent and demanding financial management and reporting requirements. In VA's 2015 AFR, the Secretary stated that the Department will pursue the possibility of either upgrading its current financial system or migrating to a shared service provider.

**VA's Program Response**  
**Estimated Resolution Timeframe:** 2021  
**Responsible Agency Official:** Assistant Secretary for Information and Technology and Chief Information Officer, and Interim Assistant Secretary for Management and Interim Chief Financial Officer  
**Associated Strategic Goal:** Manage and Improve VA Operations to Deliver Seamless and Integrated Support  
**Strategic Objective:** Evolve VA Information Technology Capabilities to Meet Emerging Customer Service  
**Associated Performance Measure(s):** No Public Facing Measures are Associated with this Issue

VA concurs that our legacy financial system does not fully comply with the Federal Financial Management Improvement Act (FFMIA). To address this significant challenge, VA has embarked on a major effort to replace our current financial system. VA plans to migrate to a Federal Shared Service Provider, as mandated by the Office of Management and Budget. This system modernization effort will resolve many of VA's current areas of noncompliance with FFMIA. As VA modernizes our financial system, we will assess the feasibility of updating other VA legacy feeder systems such as IFCAP, VistA, and eCMS. We will use this opportunity to re-engineer any outdated business processes. VA is committed to addressing long-standing financial system deficiencies and making our financial operations more efficient and effective.



## APPENDIX A

The Appendix lists selected reports pertinent to the five key challenges discussed. However, the Appendix is not intended to encompass all OIG work in an area.

### **OIG MAJOR MANAGEMENT CHALLENGE #1: HEALTH CARE DELIVERY**

#### **Healthcare Inspection–Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona**

9/30/2016 | 14-00875-325 | [Summary](#) |

#### **Healthcare Inspection–Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina**

9/30/2016 | 15-00084-370 | [Summary](#) |

#### **Healthcare Inspection–Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina**

9/29/2016 | 15-01982-113 | [Summary](#) |

#### **Healthcare Inspection–Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor Healthcare System, New York, New York**

9/29/2016 | 14-04274-418 | [Summary](#) |

#### **OIG Determination of VHA Occupational Staffing Shortages**

9/28/2016 | 16-00351-453 | [Summary](#) |

#### **Healthcare Inspection–Lack of Follow-Up Care for Positive Colorectal Cancer Screening, New Mexico VA Health Care System, Albuquerque, New Mexico**

9/27/2016 | 15-00018-349 | [Summary](#) |

#### **Healthcare Inspection–Colorectal Cancer Screening Practices, Charlie Norwood VA Medical Center, Augusta, Georgia**

9/22/2016 | 15-05328-373 | [Summary](#) |

#### **Healthcare Inspection–Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii**

9/22/2016 | 15-04655-347 | [Summary](#) |

#### **Healthcare Inspection–Alleged Manipulation of Outpatient Appointments, Central Alabama VA Health Care System, Montgomery, Alabama**

9/21/2016 | 15-03942-392 | [Summary](#) |

#### **Healthcare Inspection–Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VA Medical Center, Spokane, Washington**

9/14/2016 | 15-03713-288 | [Summary](#) |

#### **Healthcare Inspection–Administrative Response to Deaths and Quality of Care Irregularities, VA North Texas Health Care System, Dallas, Texas**

8/26/2016 | 14-02725-316 | [Summary](#) |

#### **Healthcare Inspection–Diagnosis and Treatment of a Patient’s Adrenal Insufficiency at a Virginia VA Medical Center**

8/25/2016 | 14-04505-346 | [Summary](#) |

#### **Healthcare Inspection–Review of Primary Care Ghost Panels, Veterans Integrated Service Network 23, Eagan, Minnesota**



8/11/2016 | 16-01708-340 | [Summary](#) |

**Healthcare Inspection—Reported Primary Care Staffing at St. Cloud VA Health Care System, Veterans Integrated Service Network 23, Eagan, Minnesota**

8/11/2016 | 15-05490-367 | [Summary](#) |

**Healthcare Inspection—Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA Health Care System, Minneapolis, Minnesota**

8/11/2016 | 14-04655-369 | [Summary](#) |

**Healthcare Inspection—Cardiothoracic Surgery Program and Cardiac Catheterization Laboratory Concerns, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma**

8/4/2016 | 14-04361-348 | [Summary](#) |

**Healthcare Inspection—Evaluation of Reported Wait Times, VA Greater Los Angeles Healthcare System, Los Angeles, California**

6/30/2016 | 16-02197-339 | [Summary](#) |

**Healthcare Inspection—Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota**

6/23/2016 | 15-03867-287 | [Summary](#) |

**Review of Allegation of Underutilized MRI Scanner in Waco, Texas**

6/23/2016 | 15-01887-282 | [Summary](#) |

**Review of VHA's Alleged Manipulation of Appointment Cancellations at VA Medical Center, Houston, Texas**

6/20/2016 | 15-03073-275 | [Summary](#) |

**Review of VA's Guidance on Protecting Religious Beliefs**

6/16/2016 | 15-03700-283 | [Summary](#) |

**Healthcare Inspection—Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VA Medical Center, Mountain Home, Tennessee**

6/7/2016 | 14-04435-265 | [Summary](#) |

**Healthcare Inspection—Alleged Patient Safety Concerns, Miami VA Healthcare System, Miami, Florida**

6/7/2016 | 14-03183-317 | [Summary](#) |

**Healthcare Inspection—Quality of Care Concerns in the Management of a Hepatitis C Patient, Grand Junction Veterans Health Care System, Grand Junction, Colorado**

5/11/2016 | 15-01599-289 | [Summary](#) |

**Healthcare Inspection—Operating Room Concerns, Marion VA Medical Center, Marion, Illinois**

5/5/2016 | 14-04310-280 | [Summary](#) |

**Healthcare Inspection—Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina**

5/3/2016 | 14-02890-286 | [Summary](#) |

**Healthcare Inspection—Restraint Use, Failure To Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida**

4/13/2016 | 15-01432-264 | [Summary](#) |

**Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California**

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**Healthcare Inspection–Alleged Employee Intimidation Related to Research Study Results, VA North Texas Health Care System, Dallas, Texas**  
3/28/2016 | 15-01283-220 | [Summary](#) |

**Healthcare Inspection–Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York**  
2/11/2016 | 14-03540-123 | [Summary](#) |

**Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida**  
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**Review of Alleged Mismanagement of Group Therapy Access at VA Outpatient Clinic, Austin, Texas**  
2/5/2016 | 14-04501-13 | [Summary](#) |

**Review of Alleged Untimely Care at VHA’s Community Based Outpatient Clinic, Colorado Springs, Colorado**  
2/4/2016 | 15-02472-46 | [Summary](#) |

**Healthcare Inspection–Environment of Care and Safety Concerns in Operating Room Areas, Edward Hines Jr. VA Hospital, Hines, Illinois**  
1/19/2016 | 14-05173-92 | [Summary](#) |

**Healthcare Inspection–Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama**  
1/14/2016 | 14-04530-41 | [Summary](#) |

**Healthcare Inspection–Alleged Unsafe Patient Transportation Practices, VA Hudson Valley Health Care System, Montrose, New York**  
1/13/2016 | 15-02217-85 | [Summary](#) |

**Healthcare Inspection–Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana**  
1/7/2016 | 14-05075-447 | [Summary](#) |

**Healthcare Inspection–Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina**  
1/6/2016 | 15-00992-71 | [Summary](#) |

**Healthcare Inspection–Poor Follow-Up Care and Incomplete Assessment of Disability, VA San Diego Healthcare System San Diego, California**  
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**Healthcare Inspection–Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas**  
12/22/2015 | 15-00268-66 | [Summary](#) |

**Healthcare Inspection–Quality of Care Concerns at a Residential Rehabilitation Treatment Program, VA Maryland HCS, Baltimore, Maryland**  
12/1/2015 | 14-01910-459 | [Summary](#) |

**Healthcare Inspection–Point of Care Testing Program Concerns, Louis Stokes Cleveland VA Medical Center, Cleveland, Ohio**  
12/1/2015 | 14-02576-40 | [Summary](#) |

**Healthcare Inspection–Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center, Washington, District of Columbia**  
11/16/2015 | 14-03823-19 | [Summary](#) |

**Audit of the Seismic Safety of VA’s Facilities**  
11/12/2015 | 14-04756-32 | [Summary](#) |

**Healthcare Inspection–Alleged Program Inefficiencies and Delayed Care, Veterans Health Administration’s National Transplant Program**  
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**Healthcare Inspection–Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California**

10/28/2015 | 14-02890-497 | [Summary](#) |

**Healthcare Inspection–Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona**

10/15/2015 | 14-00875-03 | [Summary](#) |

**Congressional Testimony 2/11/2016**

Statement of Gary K. Abe, Deputy Assistant Inspector General For Audits And Evaluations, Office Of Inspector General, Department Of Veterans Affairs, Before The Subcommittee On Health, Committee On Veterans' Affairs, United States House Of Representatives, Hearing On "Choice Consolidation: Improving VA Community Care Billing And Reimbursement" [Read](#)

**Congressional Testimony 2/25/2016**

Statement of Linda A. Halliday, Deputy Inspector General, Office of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Military Construction, Veterans Affairs, And Related Agencies, Committee On Appropriations, United States House Of Representatives, Hearing On The Office of Inspector General's Work and FY 2017 Budget Request [Read](#)

**Congressional Testimony 4/19/2016**

Statement of Larry Reinkemeyer, Assistant Inspector General For Audits And Evaluations (Designee), Office Of Inspector General, Department Of Veterans Affairs, Before The Committee On Veterans' Affairs, United States House Of Representatives, Hearing "A Continued Assessment Of Delays In Veterans' Access To Health Care" [Read](#)

**Congressional Testimony 5/31/2016**

Statement of Michael J. Missal, Inspector General, Department of Veterans Affairs, Before The Committee On Homeland Security And Governmental Affairs, United States Senate, Field Hearing On "The Quality And Culture Of Care At The Department Of Veterans Affairs Medical Center in Tomah, Wisconsin" [Read](#)

**OIG CHALLENGE #2: BENEFITS PROCESSING**

**Review of Alleged Manipulation of Quality Review Results at VA Regional Office, San Diego, California**

5/9/2016 | 15-02376-239 | [Summary](#) |

**Review of Alleged Misuse of eBenefits Accounts by a VA Supportive Services for Veteran Families Provider**

5/5/2016 | 15-01951-281 | [Summary](#) |

**Review of Alleged Manipulation of Quality Review Results at VA Regional Office, San Diego, California**

5/9/2016 | 15-02376-239 | [Summary](#) |

**Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System**

4/28/2016 | 15-03802-222 | [Summary](#) |

**Review of Alleged Data Manipulation of Appealed Claims at VA Regional Office, Wichita, Kansas**

4/26/2016 | 15-03581-204 | [Summary](#) |

**Review of VBA's Alleged Inappropriate Prioritization of Appeals at VA Regional Office, Roanoke, Virginia**

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**Review of Claims-Related Documents Pending Destruction at VA Regional Offices**

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**Review of Alleged Shredding of Claims-Related Evidence at VA Regional Office Los Angeles, California**

4/14/2016 | 15-04652-266 | [Summary](#) |



**Review of Alleged Untimely Processing of VBA's Specially Adapted Housing Grants at the Regional Loan Center in Phoenix, Arizona**

3/31/2016 | 15-01651-209 | [Summary](#) |

**Follow-Up Audit of VBA's Internal Controls Over Disability Benefits Questionnaires**

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**Follow Up Review on the Mismanagement of Informal Claims Processing at the VA Regional Office, Oakland, California**

1/8/2016 | 14-03981-54 | [Summary](#) |

**Review of Alleged Supervisory Influence To Expedite a Friend's Disability Claim at VA Regional Office, New York, New York**

1/7/2016 | 14-04302-12 | [Summary](#) |

**Review of Alleged Problems With VBA's Veterans Benefits Management System and Claims Processing**

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**Review of Alleged System Access Failures for Veterans' to VBA's eBenefits Program**

1/5/2016 | 14-04810-05 | [Summary](#) |

**Review of Alleged Beneficiary Travel Irregularities at Hudson Valley HCS, Hampton & Lexington VAMCs**

12/7/2015 | 15-02400-524 | [Summary](#) |

**Congressional Testimony 1/12/2016**

Statement of Brent Arronte, Deputy Assistant Inspector General For Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs, Before The Committee On Veterans' Affairs, United States House Of Representatives, Hearing On "1988 to 2016: VETSNET To VBMS: Billions Spent, Backlog Grinds On" [Read](#)

**Congressional Testimony 4/14/2016**

Statement For The Record Of The Office Of Inspector General Department of Veterans Affairs, For The Subcommittee On Economic Opportunity, The Committee On Veterans' Affairs, United States House Of Representatives, Legislative Hearing [Read](#)

**Congressional Testimony 6/15/2016**

Statement of Brent Arronte, Deputy Assistant Inspector General For Audits And Evaluations, Office Of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Disability Assistance And Memorial Affairs, Committee On Veterans' Affairs, United States House Of Representatives, Hearing On "Investigating VA's Management Of Veterans' Paper Records" [Read](#)

**OIG CHALLENGE #3: FINANCIAL MANAGEMENT**

**Audit of VBA's Post-9/11 G.I. Bill Tuition and Fee Payments**

9/30/2016 | 14-05118-147 | [Summary](#) |

**Review of Alleged Waste of Funds at VHA's Madison VA Medical Center**

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**Review of VBA's Special Monthly Compensation Housebound Benefits**

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**Review of VA's Alleged Improper Termination of the e-Learning Task Order**

9/19/2016 | 15-02776-240 | [Summary](#) |

**Review of Alleged Waste of Funds at the VA Medical Center in Detroit, Michigan**

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**Audit of VBA's Compensation and Pension Benefit Payments to Incarcerated Veterans**

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## **Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2015**

5/12/2016 | 15-04252-284 | [Summary](#) |

## **Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2015**

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## **Review of Alleged Misuse of Hurricane Sandy Funds at VA New York Harbor Healthcare System**

1/6/2016 | 14-04152-370 | [Summary](#) |

## **Audit of VA's Conference Management for Fiscal Year 2014**

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## **Review of Alleged Wasted Funds in VHA's Southern Arizona VA Health Care System**

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## **Audit of VHA's Non-VA Medical Care Obligations**

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## **Audit of VA's Financial Statements for Fiscal Years 2015 and 2014**

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## **Congressional Testimony 9/27/2016**

Statement of Michael J. Missal, Inspector General, Department of Veterans Affairs, Before The Subcommittee On Disability Assistance And Memorial Affairs, Committee On Veterans' Affairs, United States House Of Representatives, Hearing On "Investigating How VA Improperly Paid Millions To Incarcerated Veterans" [Read](#)

## **OIG CHALLENGE #4: PROCUREMENT PRACTICE**

### **Review of VA's Award of the PC3 Contracts**

9/22/2016 | 15-01396-525 | [Summary](#) |

### **Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System**

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### **Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System**

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### **Audit of VA's Green Management Program Solar Panel Projects**

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### **Review of Alleged Improper Contract Awards in OI&T's Service, Delivery, and Engineering Office**

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### **Audit of Modular Ramps Purchased by the Malcom Randall VA Medical Center, Gainesville, Florida**

6/29/2016 | 15-04248-305 | [Summary](#) |

### **Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System**

4/26/2016 | 11-00826-261 | [Summary](#) |

### **Congressional Testimony 11/4/2015**

Statement of Quentin G. Aucoin, Assistant Inspector General For Investigations, Office of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Oversight And Investigations, Committee On Veterans' Affairs, and The Subcommittee On Contracting And Workforce, Committee On Small Business, United States House Of Representatives, Joint Hearing On "An Examination Of Continued Challenges In VA's Vets First Verification Process" [Read](#)



**OIG CHALLENGE #5: INFORMATION MANAGEMENT**

**Review of Alleged Breach of Privacy and Confidentiality of Personally Identifiable Information at the Milwaukee VA Regional Office**

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**Review of Alleged Contractor Information Security Violations in the Alaska VA Healthcare System**

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**Review of Alleged Lack of Access Controls for VA's Project Management Accountability System (PMAS) Dashboard**

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**Review of Alleged Lack of Access Controls for VA's Project Management Accountability System (PMAS) Dashboard**

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**VA's Federal Information Security Modernization Act Audit for Fiscal Year 2015**

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**Review of Alleged Violation of VHA's Datawatch Data Pump Server Software License Agreement**

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**Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Web Site**

4/7/2016 | 15-02781-153 | [Summary](#) |

**Review of Alleged Unauthorized Devices and Equipment on Networks at VHA's Southern Arizona VA Health Care System**

1/7/2016 | 14-04979-11 | [Summary](#) |

**Congressional Testimony 3/16/2016**

Statement of Brent Arronte, Deputy Assistant Inspector, General for Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs, Before The Subcommittee On Information Technology, Committee On Oversight And Government Reform, United States House Of Representatives, Hearing On "VA Information Technology And Cybersecurity Oversight" [Read](#)