The mission of the Department of Veterans Affairs is to serve America’s veterans and their families with dignity and compassion. VA also works to ensure that veterans receive the care, support, and recognition earned in service to our Nation. VA has three administrations that serve veterans: Veterans Health Administration, Veterans Benefits Administration, and the National Cemetery Administration. These administrations must provide services and benefits in a way that best meets the needs of all veterans. It is vital that they work in tandem with support services like financial management, procurement, and information management to maximize their effectiveness and efficiencies.

The Office of Inspector General’s (OIG) mission is to serve veterans and the public by conducting effective oversight of the programs and operations of VA through independent audits, inspections, investigations, and reviews. The OIG also recommends improvements in VA programs and operations, and acts to deter and detect waste, fraud, and abuse. 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.

OIG will continue to work with VA to address these issues to ensure the best possible service and benefits to our Nation’s veterans and their families, and to ensure appropriate expenditure of taxpayer money.

MICHAEL J. MISSAL
Inspector General
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<th>Estimated Resolution Time frame (Fiscal Year)</th>
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<td>Effective Information Security Program and System Security Controls (OI&amp;T)</td>
<td>2017</td>
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SECTION III: OTHER INFORMATION

OIG CHALLENGE #1: HEALTH CARE DELIVERY

STRATEGIC OVERVIEW
The VHA continues to face significant challenges in delivering timely and quality health care to patients. The OIG publications in fiscal year (FY) 2017 highlight the complexity of these challenges.

The opioid epidemic continues to impact veterans, and overdose deaths among veterans remain elevated when compared to the civilian population. Considering the unique experience of veterans, it is not surprising that so many suffer from some form of chronic pain. Pain management becomes even more complicated when a patient’s chronic pain occurs in the setting of comorbidities prevalent in the veteran population, such as post-traumatic stress disorder, depression, traumatic brain injury (TBI), and substance abuse disorder. This year, OIG published reports evaluating opioid prescribing practices in VHA.

With continued expansion of the VCP provider network, care continuity and coordination continue to challenge both VHA providers and patients. During FY 2017, OIG published multiple reports documenting persistent access to care concerns, including delays in patients receiving needed care within the system and also within the community. OIG found that many of the delays were attributable to staff not adhering to consult policies and procedures, limited availability of in-house and community specialists, and lack of efficiency and timeliness in authorizing community care for patients.

Suicide remains one of the most serious public health concerns. As a medical, psychiatric, and social issue, it is accentuated in the veteran population. Based on 2014 data, VA estimated that the number of veteran deaths by suicide averaged 20 per day. This number significantly exceeds the national average. The Veterans Crisis Line (VCL) was established in 2007 to provide suicide prevention and crisis intervention to veterans, Servicemembers, and their family members. OIG reported in FY 2017 that the VCL continues to face significant operational challenges as it strives to carry out its mission.

Instability and prolonged vacancies in key VHA leadership positions pose additional challenges to quality health care delivery. This year, OIG published two reports with key findings attributable to vacant critical leadership positions.

OIG SUB-CHALLENGE #1A: QUALITY OF CARE (VHA)

1. PROMOTING SAFE OPIOID PRESCRIBING PRACTICES
Overdose deaths involving prescription opioids have quadrupled since 1999. In 2015, more than 22,000 people died from overdoses involving prescription opioids. With increasing opioid overdose deaths, the emphasis on opioid prescribing has shifted to opioid dose reduction, increased assessment, and monitoring of patients on chronic opioid therapy. While prescribing practices continue to vary within VA

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1 Bohnert AS, Ilgen MA, Galea S, McCarthy JF, Blow FC. “Accidental poisoning mortality among patients in the Department of Veterans Affairs Health System.” Med Care. April 2011 49(4) 393 3962011; 4:393-396.
and the Nation, two initiatives implemented within VHA, the Opioid Safety Initiative (OSI) and the enabling of VHA providers to participate in state prescription drug monitoring programs (PDMPs), have armed VA prescribers with tools aimed at limiting high-dose chronic opioid therapy, concurrent use of benzodiazepines and opioids, and patients receiving opioid prescriptions from multiple providers.

**VA’s Program Response**

**Estimated Resolution Timeframe:** 2018

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

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

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

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

**FY 2017 Milestones:**

During FY 2017, VHA continued the full implementation of the OSI system-wide. Significant milestones include the publication of the VA/DoD Clinical Practice Guideline, *Management of Opioid Therapy for Chronic Pain*, in February 2017, which recommends against initiation of long-term therapy for chronic pain patients and gives providers clear and evidence-based guidance for risk mitigation strategies. VHA continued to expand education and training of providers in regard to the transformation in pain care within VHA through a variety of strategies. Clinical providers completed a mandated training about the risks associated with opioid prescribing and assessment and treatment of opioid use disorder by April 15, 2017. The VA and DoD issued the Joint Pain Education Program for training of primary care teams and continue to update the modules. The Academic Detailing Program expanded systemwide in 2017 and provides individual monitoring and feedback to clinicians about opioid prescribing, implementation of risk mitigation strategies, and in particular, prescribing of naloxone as opioid overdose rescue. The Opioid Overdose Education and Naloxone Distribution (OEND) program has been expanded to all sites, and 88,188 prescriptions for Naloxone were filled as of June 2017. The VHA PDMP directive was issued in October 2017, mandating the checking of state PDMP’s for VA providers in all available states. Forty-seven states and the District of Columbia are activated for VA data transmission to their PDMP. Since Quarter 3, FY 2013, VA providers have documented over 2 million queries to PDMPs to help guide treatment decisions. Facilities and clinical providers are supported by several dashboards, and risk assessment and identification tools for care coordination include improvements in the Opioid Therapy Risk Report and Stratification Tool for Opioids Risk Mitigation. VHA developed standards for interdisciplinary pain management teams at all facilities to include integrated access to addiction medicine. All facilities were mandated to identify pain team members. During FY 2017, VHA developed and delivered the plan to expand the scope of Complimentary and Integrative Health (CIH) services in the VA to include the selection of CIH Whole Health flagship pilot sites in each VISN to begin operations in FY 2018. Thus, VHA is in process to fully implement the requirements by the Comprehensive Addiction and Recovery Act.

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2 PDMPs are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients.
Peer Reviewed Medical Literature—Published in Medical Journals

VA’s efforts in opioid safety and risk management were highly represented in medical literature. An example of the articles and research studies is included below.

JAMA Internal Medicine published an article authored by Walid F. Gellad, MD, MPH; Chester B. Good, MD, MPH; and David J. Shulkin, MD reviewing the lessons learned during the VA’s efforts to address the opioid epidemic. The article provides data and research related to the VA’s efforts to address the opioid epidemic in an effort to inform other health care systems planning comprehensive actions to reduce risks associated with opioid therapy. The authors reviewed the broad strategies of education, pain management, risk mitigation, and addiction treatment.

Journal of the American Pharmacists Association published a paper by Dr. Oliva, et al., titled “Opioid overdose education and naloxone distribution: Development of the VHA national program.” The paper addresses key risk areas in the prevention of opioid overdoses nationally through the implementation of the OEND program. Dr. Oliva, and others, concluded that “VHA has successfully translated community-based OEND into health care system-based program targeting 2 patient populations”.

PAIN published an article by Dr. Lin, et al., titled “Impact of the OSI on opioid-related prescribing in Veterans.” This study examined the changes associated with the OSI implementation at the VA. The authors found the implementation of a national health care systemwide initiative was associated with reductions in outpatient prescribing of risky opioid regimes. The findings provided evidence for the potential utility of large-scale interventions to promote safer opioid prescribing.

VA DATA

From the peak of opioid prescribing in VHA in 2012, VHA achieved significant improvements in all opioid prescribing parameters of the OSI. This includes a reduction of Veterans on long-term opioid therapy by 41 percent (Quarter 4 FY 2012 to Q3 FY 2017) and a reduction of opioid and benzodiazepine used in combination by 64 percent over the same time period. Further improvements are anticipated in the coming years. VA’s efforts should provide safe and effective pain care and lessen the reliance on opioid medication, while specifically targeting the needs of the Veterans at risk for or with opioid use disorder, will require a sustained effort for the foreseeable future.

The OSI key clinical metrics measured from Quarter 4 FY 2012 (beginning in July 2012) to Quarter 3 FY 2017 (ending in June 2017) demonstrate VA’s success: 240,269 fewer patients receiving opioids (679,376 patients to 439,107 patients, a 35 percent reduction), 78,112 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 44,521 patients, a 64 percent reduction), and 181,232 fewer patients on long-term opioid therapy (438,329 to 257,097, a 41 percent reduction); patients on long-term opioid therapy with a urine drug screen completed in the last year to help guide treatment decision has increased from 37 percent to 87 percent (50 percent increase); and the overall dosage of opioids is decreasing in the VA system as 31,154 fewer patients (59,499 patients to 28,345 patients, a 52 percent reduction) are receiving greater than or equal to 100 morphine equivalent daily dose. The desired results of the OSI have been achieved during a time that VA has seen an overall growth of 171,634 patients (3,959,852 patients to 4,131,486 patients, a 4 percent increase) who have utilized VA outpatient pharmacy services.

Comparison of CMS and VA Data

VA’s own data, peer reviewed medical literature, and the Centers for Medicare and
Medicaid Services (CMS) suggest that VA is making progress relative to the rest of the Nation.

Sales of prescription opioids have nearly quadrupled in the United States from 1999 to 2014. The most recent opioid utilization data available for comparison to VA is CMS data for Part D beneficiaries, which are available from CY 2013 to CY 2016. On April 3, 2017, CMS notified Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties of opioid utilization rates for Part D beneficiaries for CY 2013 through CY 2016, which VA used to make its comparison. There are several factors to consider when comparing CMS Part D to VA health care such as (1) since CMS Part D is a payer of care and VA is predominantly a direct provider of care, VA has the ability to control utilization better than CMS; (2) CMS Part D beneficiaries are predominately over the age of 65; and (3) although 50 percent of VA patients are over 65 years of age, VA’s beneficiary population is characterized as having multiple co-morbidities and a very heavy disease burden.

Although annual data is not able to show the impact of organizational change as well as quarterly data can, the annual data in Table 1 demonstrates both CMS Part D and VA have experienced success reducing the percentage of enrollees utilizing opioids over time. From 2013 to 2016, the percentage of CMS Part D and VA enrollees utilizing opioids decreased by 1.6 percent and 2.6 percent, respectively. The total number of CMS Part D enrollees utilizing opioids increased 9.2 percent (11,794,908 to 12,885,620), while the total number of VA enrollees utilizing opioids decreased 15.3 percent (1,417,969 to 1,201,624).

However, the percent change in the number of enrollees utilizing opioids needs to be taken in context with the overall growth of enrollees between the two systems. CMS Part D has experienced a higher rate of growth of 15.1 percent (37,842,632 to 43,569,035) of enrollees, while the VA health care system only experienced a 1.3 percent rate of growth (8,926,610 to 9,046,663) of enrollees.

### Table 1: CMS Part D and VA Opioid Utilization Rates, 2013 - 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Total CMS Part D Enrollees</th>
<th>Total CMS Part D Enrollees Utilizing Opioids**</th>
<th>% CMS Part D Enrollees Utilizing Opioids***</th>
<th>Total VA Enrollees</th>
<th>Total VA Enrollees Utilizing Opioids</th>
<th>% VA Enrollees Utilizing Opioids</th>
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<tr>
<td>2013</td>
<td>37,842,632</td>
<td>11,794,908</td>
<td>31.2</td>
<td>8,926,610</td>
<td>1,417,969</td>
<td>15.9</td>
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<td>2014</td>
<td>39,982,962</td>
<td>12,308,735</td>
<td>30.8</td>
<td>9,093,511</td>
<td>1,395,926</td>
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<tr>
<td>2015</td>
<td>41,835,016</td>
<td>12,510,448</td>
<td>29.9</td>
<td>8,965,923</td>
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<td>2016</td>
<td>43,569,035</td>
<td>12,885,620</td>
<td>29.6</td>
<td>9,046,663</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>812,219#</td>
<td>9.0%#</td>
</tr>
</tbody>
</table>

* CMS Part D data is CY (January to December) and VA data is fiscal year (October to September).

** CMS data excludes cancer and hospice patients for all years, while VA data only breaks out cancer/hospice/palliative care patients for 2016. The effect of this difference is that VA’s success in reducing the utilization of opioids is under-reported.

*** CMS Part D enrollees utilizing opioid excludes hospice and cancer patients.

# VA enrollees utilizing opioids excludes hospice and cancer patients for 2016.

In reference to the OIG site-specific report, *Healthcare Inspection – Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles* Healthcare System (15-01669-246), the site completed the following actions in FY 2017. OIG closed one recommendation. The facility implemented a number of corrective actions to
address the OIG recommendations, including ongoing monitoring of consult compliance with VHA policies until 90 percent compliance is achieved for three consecutive months.

In reference to the OIG site-specific report, Healthcare Inspection – Opioid Prescribing Practice Concerns, VA Illiana Health Care System, Danville, Illinois (16-00462-192), no recommendations were made and there were no substantiated allegations.

2. CARE CONTINUITY AND COORDINATION
Care coordination is an activity aimed at ensuring that a patient’s needs are met during transitional periods of their health care, e.g., coordination of care between a primary care provider and a specialist, between different health care organizations, or transitions over periods of time such as the transition between a new patient appointment to a follow-up appointment. To ensure seamless continuity of care, the flow of critical patient information must occur in a timely manner. Within VA, business rules are in place to direct the processing and scheduling of electronic requests for clinical consults. These business rules direct consult processing and scheduling for both VA care as well as care requested through VA-purchased care providers.

VA’s Program Response

Estimated Resolution Timeframe: 2020

Responsible Agency Official: Under Secretary for Health

Associated Strategic Goal: 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 service delivery policies, procedures, and interfaces

Associated Performance Measure(s):
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
- OPM Federal Employee Viewpoint Survey Employee Engagement Index Score
- Employees feel encouraged to come up with new and better ways of doing things
- Employees have a feeling of personal empowerment with respect to work processes

FY 2017 Milestones:
VA is committed to providing first-class health care to our Veterans, whether they are at their home VA facility, receiving care in the community, or traveling. VA is working to optimize the experience for Veterans needing care from an alternate VA facility while traveling or relocating. Seamless Care is now one of the Department’s breakthrough initiatives under improving access to health care. With the Seamless Care for Traveling Veterans program, such care is possible. Veterans enrolled in the VA health care system can contact their patient aligned care team or specialty care provider when traveling or temporarily experiencing a change of address - such as living in one state during the winter and another during summer - to ensure a smoother experience, if health care is needed along the way at an alternate VA facility. The Seamless Care for Traveling Veterans program helps to ensure patients’ needs are consistently met during transitional periods of their health care. In 2015, the Seamless Care for Traveling Veterans program had 1,500 consults initiated. Based on data for the current year to date, the program is projected to grow to approximately 22,000 consults in calendar 2017.
SECTION III: OTHER INFORMATION

VHA Handbook 1101.11(2), Coordinated Care Policy for Traveling Veterans, was published on April 22, 2015. As of January 2016, each facility has indicated compliance with key requirements. Veterans do not need to re-enroll but will be registered at the alternate facility. This process has been streamlined at VAMCs and CBOCs so that multiple staff can re-register a Veteran on a 24/7 basis. There is a clinically trained Traveling Veteran Coordinator at each medical center to facilitate the care needs of traveling Veterans. Arrangements can now be made in advance to facilitate the care of the Veteran. An established process is now in place for pharmacists to provide a bridge supply of medications for onetime visits away from the home facility.

As part of the OCC’s continued goal to provide timely access to care through care continuity and coordination, a new operating model for referral and management of care in the community has been deployed. The new operating model is the future state vision for VA’s OCC, to operate as a “clinic within a clinic,” elevating local community care offices to a clinical department within the medical center and aligning the organization to clinical leadership to support the focus on providing care and care coordination for Veterans. The new operating model provides facilities processes that establish an oversight council, allows for alignment under clinical leadership, standardizes position descriptions, establishes integrated teams, and provides tools that enhance the ability to manage care in the community. Currently, there are 18 sites that are working through this process. Each of the 18 sites has a comprehensive implementation team and facility-specific plans. Each team includes a transformation lead at the site, field support staff, and a regional director who assists with all aspects of the operating model. All available tools have been implemented at each of the phased implementation sites as appropriate in accordance with the local IT/information security officer.

The OCC provided training that outlines the preparatory work needed to successfully adopt the One Consult Model at local sites. The One Consult Model transforms the processes and policies for consult management, allowing forwarding capabilities of an in-house consult to a community care consult and back to the initial clinic-related consult title as needed. This model will enhance the end-to-end process of consult management by utilizing the Consult Toolbox functionality to track and document consult reviews, updates, forwards, appointment information, and consult closures throughout the life cycle of the consult. Training was conducted in July 2017 and August 2017 to provide technical steps and instructions on how to implement the model to include necessary consult template changes and process configurations.

VA’s consult process requirements currently specify that a complete up-to-date list of medications and all applicable medical history information (e.g., prior pain management treatment, controlled substance agreements, applicable behavior health flags) be included with community care consults sent to the VA third-party administrators and shared with VA community care providers. The OCC has recently implemented a medical documentation tool that simplifies the process of gathering and organizing all applicable medical history information and a complete up-to-date list of medications into one uniform document. The Referral Documentation (REFDOC) tool compiles a package of documentation, including a comprehensive medications list of outpatient and pain management meds dispensed by VA in the last 12 months and current medications prescribed by non-VA sources that are recorded in the VA data warehouse. This electronic tool is being implemented, with full implementation to be completed by late 2017.

In reference to the OIG site-specific report, Healthcare Inspection – Consult Management
Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California (15-04681-228), the VA Greater Los Angeles Healthcare System completed the following actions in FY 2017. OIG closed recommendation 4. The facility implemented a number of corrective actions to address the OIG recommendations, including monitored accuracy of setting and urgency for consults, monitored timely closure/discontinuation of consults, and monitored and addressed the care needs of patients on the Electronic Wait List.

In reference to the OIG site-specific report, Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana (16-00621-175), the site completed the following actions in FY 2017. The facility requested closure on the three remaining recommendations. The facility implemented several corrective actions to address the OIG recommendations, including submitted the results of external peer review, and documented consultation with General Counsel about disclosure of adverse events and data on consult timeliness.

3. ENSURING VCL RESPONSIVENESS AND QUALITY

The primary mission of the VCL is “to provide 24/7, world-class suicide prevention and crisis intervention services to Veterans, Servicemembers, and their family members.” The VCL faces a number of challenges. They must meet the operational and business demands of responding to over 500,000 calls per year, along with thousands of electronic chats and text messages, and initiating rescue processes when indicated. They must also train staff to respond to Veterans and their family members in individual encounters during which a responder must make an accurate assessment of the needs of the caller under stressful, time-sensitive conditions. Further, they must ensure that clinicians are actively and appropriately involved in the governance of the VCL to ensure necessary involvement of all stakeholders.

VA’s Program Response

Estimated Resolution Timeframe: FY 2018

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(s):
Veterans’ experience of VA

FY 2017 Milestones:

VA recognizes the importance of VCL as a life-saving resource for our Nation’s Veterans who find themselves at risk of suicide. Of all the Veterans we serve, we most want those individuals in crisis to know that dedicated, expert VA staff, many of whom are Veterans themselves, will be there when they are needed. Since its inception in July 2007, the VCL has answered over 3 million calls and initiated the dispatch of emergency services to callers in imminent crisis over 84,000 times. Since launching chat in 2009 and text services in November 2011, the VCL has answered nearly 359,000 and nearly 78,000 requests for chat and text services, respectively. In addition, staff has forwarded more than 504,000 referrals to local VA Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with Veterans’ local VA providers. For FY 2016, more than 51,000 chats and 17,000 texts were answered by VCL responders. For FY 2017, nearly 54,000 chats and nearly 16,000 texts were answered by VCL responders. Emergency services were dispatched to over 12,000 callers in immediate crisis in FY 2016, and nearly 19,000 callers in immediate crisis in FY 2017. For FY 2016, nearly 87,000 referrals were made to local Suicide Prevention Coordinators.
for follow-up care and over 95,000 referrals were made in FY 2017.

Prior to the opening of the Atlanta call center in October 2016, VCL had a call rollover rate to backup call centers of more than 30 percent. Since January 2017, VCL’s year-to-date rollover average is 1.04 percent. Overall, VCL performance exceeds the National Emergency Number Association service level standard of answering >95 percent of calls in less than 20 seconds. VCL continues to meet these metrics, despite overall call volume continuing to rise.

New to the VCL, VCL responder trainees complete a four-tier process that certifies they are adequately trained, competent, and cleared for answering calls independently. Tiers include classroom training, on-the-job training with the trainee paired with a preceptor/mentor, supervisor verification of competency through monitoring of a call answered by the trainee, and ongoing silent monitoring of calls for quality assurance.

VCL leadership have established the Executive Leadership Council (ELC), a governance structure responsible for documenting, tracking, and directing action of clinical quality performance measures.

Although the FY 2017 OIG asserts that the VCL faces significant operational challenges as it strives to carry out its mission, VCL has already successfully completed corrective actions to address and close three issues and corresponding recommendations identified by OIG. Recommendations 3 and 4, recommending collaboration between Member Services and Office of Suicide Prevention, as well as delineating clinical and administrative decision making, have been accepted for closure with the creation and implementation of a VCL directive outlining relationship and roles. OIG recommended that processes be in place to analyze performance and quality data separately from the Atlanta and Canandaigua call centers. This has been established as VCL procedure and is reported monthly in VCL ELC meetings. Furthermore, through the clinical oversight provided to VCL by the Office of Mental Health and Suicide Prevention, VCL continues to make necessary corrective actions to address, by December 2017, the remaining issues and recommendations identified in the report.

4. LEADERSHIP AND QUALITY OF CARE

Hospital leaders oversee operations and guide the hospital on a day-to-day basis, ensuring that the hospital meets the needs of the patients it serves. By dedicating themselves to upholding the values and principles of the hospital’s mission, leaders promote collaboration, communication, problem solving, conflict management, and ethical standards—practices that are essential to delivering safe and effective health care. While essential personnel are found in every staffing level within a hospital, instability or long-term vacancies of key leadership positions can directly impact the delivery of quality care.

VA’s Program Response

Estimated Resolution Timeframe: The process of filling critical leadership positions in the health care arena is underway and will continue with the launch of the Healthcare Leadership Talent Institute (HLTI), the MyVA Critical Staffing Breakthrough Initiative, and the direct hiring provision of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017.

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 Veterans benefits and services

Associated Performance Measure(s):
• Organization’s leaders maintain high standards of honesty and integrity
• The average rating by patients of their recent VA hospitalization on a scale from 0 to 10 (inpatient)

**FY 2017 Milestones:**
The VA core values of Integrity, Commitment, Advocacy, Respect, and Excellence (I CARE) set the ethical tone across the entire VA organization. These core values define VA’s identity, are the foundation of VA culture, and help guide the actions of staff across VA. Additionally, these core organizational values support VA’s mission to provide the best care and services to Veterans, their families, and their beneficiaries.

The VHA follows the Standards of Ethical Conduct for Employees of the Executive Branch. Standards of ethical conduct are communicated through training in VA core values, government ethics and whistleblower rights and protection, and prohibited personnel practices, which are required annually and made available through VHA’s Talent Management System. Additionally, the Office of General Counsel provides government ethics training and advice.

VHA is committed to ensuring equal employment opportunity (EEO), constructively resolving workplace disputes at the lowest possible level, and promoting diversity and inclusion to maintain a high-performing workforce in service to our Nation’s Veterans. VHA will enforce all applicable federal EEO laws, executive orders, and management directives to ensure equal opportunity in the workplace for all VHA employees, applicants, and former employees. Managers will have adequate training in the management of a diverse workforce, early and alternative conflict resolution, and essential communications skills. Facility Directors are responsible for designating management officials who may propose and decide actions for code of conduct violations. Performance plans include elements that address ethics and adherence to policies and procedures.

Medical Center Directors (MCD) and other key hospital leaders provide oversight and guidance to clinical and administrative services to ensure patients’ needs are served. On a daily basis, leaders review aggregate data, critical reports, and emerging clinical and administrative trends throughout the facility to ensure regulatory requirements are met and related issues are appropriately and effectively addressed. In addition to guiding long-term planning, leaders manage the ongoing process of anticipating, receiving, addressing, and monitoring internal and external reviews, and work with VISN and VHACO communications teams to provide clear, accurate, and consistent messaging to external media, Veterans, and their families regarding long-term goals and emergent daily issues.

Through efficient use of Town Halls, rounds, and routine meetings, facility leadership maintains consistent and open communication with facility personnel to collect, analyze, and prioritize key health care service issues. MCD manage conflict and resolve issues by collaborating with the VISNs, and with VHA congressional advisory offices to mediate, advocate for and resolve incoming congressional issues and priorities. Facility leadership advances VA and VHA initiatives through close coordination with offices across the Department and by engaging appropriate stakeholders within and across organizations as needed to support key operations projects, to include Veteran Service Organizations, which are key in ensuring interests are addressed and needs are met for optimal outcome for Veterans.

In March 2016, VHA launched the HLTI. The organization recognized a need for a more systematic approach – combining leadership development, assessment, coaching, and succession planning to create a long-term,
comprehensive process for managing our succession pipeline. HLTI serves to identify, develop, and strategically manage the leadership talent across VA and continually grow an engaged performance-oriented workforce that delivers exceptional service experiences to our Nation’s Veterans.

HLTI set about establishing an integrated system to identify, develop, and manage VA talent to meet the need for high-performing transformational leaders aligned with the VA mission and strategic direction. HLTI applies two main principles in preparing the leadership pipeline.

A deliberate focus on developmental opportunities that maximize the acquisition of leadership competencies through growth activities that are 70 percent experiential (e.g., details, assignments, committees), 20 percent exposure (e.g., coaching, mentoring, shadowing), and 10 percent education and training.

Implementing a comprehensive evaluation process to assess and share specific and direct feedback to individuals within the leadership pipeline, HLTI undertook the design and pilot testing of a talent management process to identify those employees with the background and drive to become successful MCDs, and to provide them with developmental experiences to prepare them for future leadership roles. In FY 2018, HLTI will begin applying the methodology to support succession planning for other key facility senior leadership team positions (Associate/Deputy Director, Chief of Staff, and Associate Director for Patient Care Services).

VHA has also made significant strides in raising fill rates for key leadership positions through the use of innovative recruiting strategies, streamlined hiring processes, and efforts to strengthen the leadership pipeline with qualified candidates. VHA re-engineered the recruitment process for filling its MCD positions. Under the MyVA Critical Staffing Breakthrough Initiative, VHA partnered with the Corporate Senior Executive Management Office (CSEMO) to fill MCD positions through a national recruitment strategy by posting national vacancy announcements for multiple locations across the country and leveraging social media outlets and other venues to increase the public’s awareness of these leadership roles. Under this national recruitment strategy, VHA instituted a corporate approach in making selections and obtaining approvals to ensure MCD positions are filled within 120 days from the vacancy. As of today, we are currently at a 90 percent fill rate for MCD positions.

Although VHA has made tremendous progress in streamlining the recruitment process, filling MCD positions is still a laborious and lengthy process. To address this impediment, VHA will leverage the direct hiring provision of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, which provides the VA Secretary flexibility to directly hire MCDs.

VHA will continue to utilize all resources such as the HLTI, CSEMO training programs, and other departmental training entities to ensure leadership have the tools to promote opportunities to train qualified candidates for key leadership positions.

In reference to the OIG report, Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care (17-01846-316), the VA OCC implemented a medical documentation tool that simplifies the process of gathering and organizing all applicable medical history information and a complete up-to-date list of medications into one uniform document. The REFDOC tool compiles a package of documentation including a comprehensive medications list of outpatient and pain management meds dispensed by VA in last 12 months and current medications prescribed by non-VA sources that are recorded in the VA data warehouse. This complete package is...
automated and therefore assures complete information is transmitted to the non-VA provider.

In reference to the OIG report, *Evaluation of the Veterans Health Administration Veterans Crisis Line* (16-03985-181), VCL incorporated a new Customer Relationship Management system into the phone system so that call records are automatically populated with the phone number of the caller. VCL worked to update the policies and procedures for audio call recording and in the process of working with the OI&T to provide IT support. Member Services and the Office of Mental Health Operations establish a governance structure that is evident in the published VHA Directive 1503, “Operations of the Veterans Crisis Line Center,” May 31, 2017. The recently published VHA Directive 1503, “Operations of the Veterans Crisis Line Center,” presents the clear guidelines that were developed to delineate clinical and administrative decision making. VCL developed a process to review and ensure wait-time targets for call queuing and rollover are meeting predefined metrics.

In reference to the OIG report, *Interim Summary Report–Healthcare Inspection–Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC* (17-02644-202), an incident command center (ICC) was established to streamline medical supplies and logistics service processes, address staffing needs, and assess the overall environment of care. The ICC implemented a robust oversight process that identified and promptly addressed new supply or equipment shortages on a 24-hour basis, and included daily supply rounds in all patient areas by logistics and nursing staff, multidisciplinary Operating Room huddles, and timely review and action on issues brought forth to the ICC. VA also began the process of re-establishing an electronic management system, the Generic Inventory Package (GIP), at the facility that involved cataloging the Primary Inventory Point area, Warehouse inventory, critical secondary (ICU, ED, OR, Dialysis) inventories, and noncritical primary and secondary inventory points, and then entering them into the GIP.

In reference to the OIG report, *Review of the Implementation of the Veterans Choice Program* (15-04673-333), VHA OCC executed initiatives and projects to build and improve capabilities for Veteran community care and to streamline processes for accessing care under the VCP. Improvements incorporated those specified in a succession of legislative amendments to the Choice Act and are helping to reduce the consult/referral life cycle timeframe. Various actions taken have included contract modifications; training; documentation of flow maps, standard operating procedures (SOP); creation of Fact Sheets and internal printed communication resources designed to keep the field apprised of all new developments; directives; a REFDOC tool; single booking pilot; and a consult toolbox and overview.

**KEY RELATED LINKS:**

Healthcare Inspection–Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care  
8/1/2017 | 17-01846-316 | Summary |  

Healthcare Inspection–Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles Healthcare System  
5/23/2017 | 15-01669-246 | Summary |  

Healthcare Inspection–Consult Management Concerns, VA Greater Los Angeles Healthcare System, Los Angeles, California  
5/4/2017 | 15-04681-228 | Summary |  

Interim Summary Report–Healthcare Inspection–Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC  
4/12/2017 | 17-02644-202 | Summary |
OIG SUB-CHALLENGE #1B: ACCESS TO CARE (VHA)

Access to health care has been a recurring issue in VHA. For more than a decade, OIG, the Government Accountability Office, VA, and other organizations have issued numerous reports regarding issues with access to VA care including veteran wait times, scheduling practices, consult management, and Choice. Since the nationwide scandal on patient wait times in 2014, OIG has continued to identify problems with VHA’s management of health care access. OIG reviews at VISN 6 and at least six other VA medical facilities—Colorado Springs, Houston, Oklahoma City, Phoenix, St. Louis, and Tampa—showed that VHA continues to experience significant issues with the reliability of veteran wait times, scheduling practices, consult management, and access to Choice.

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 Veterans benefits and services; Evolve VA IT capabilities
to meet emerging customer service/empowerment expectations of both VA customers and employees

**Associated Performance Measure(s):**

- Percent of primary care patients who respond “Always” and “Usually” regarding their ability to get an appointment for a routine checkup as soon as needed
- Percent of specialty care patients who respond “Always” and “Usually” regarding their ability to get an appointment for routine checkup as soon as needed
- Percent of primary care patients who respond “Always” and “Usually” regarding their ability to get an appointment for needed care right away
- Percent of specialty care patients who respond “Always” and “Usually” regarding their ability to get an appointment for needed care right away.

**FY 2017 Milestones:**

VA has undertaken many activities to ensure Veterans receive quality, timely access to health services.

The Office of Veteran Access to Care, a national-level office, was expanded in FY 2017. This department provides oversight and direction for policy and operations for optimization of Veterans’ access to health care. This office is led by an executive-level Assistant Deputy Under Secretary for Health (ADUSH) for Access to Care who is a direct report to the Deputy Under Secretary for Health for Operation Management and also has a platform for interaction and feedback with the Secretary VA, Deputy Secretary VA, Under Secretary for Health, and Principal Deputy Under Secretary for Health.

VA’s highest priority for access has been to ensure that Veterans with urgent needs receive timely care. As a part of this, VA worked to deliver same day services for care needed right away in Primary Care and Mental Health. As of December 31, 2016, SDS were achieved at all
VAMCs and by the end of 2017, all CBOCs with Primary Care and Mental Health will have achieved SDS.

VA also worked to ensure that previously defined standardized processes to assure that new referrals to specialists are screened for urgent needs and scheduled timely is sustained throughout the organization. Back in Fiscal Year 2014, the average time it took for stat consults to be completed was 36 days. As of June FY 2017, the average time it took for completion of the stat consults was 1.7 days.

In support of the focus of stat consults, VA has continued a weekly national consult management call, whereby scheduling experts provide technical assistance to the field to ensure the timeliness of consult scheduling. The calls have become a driving force to deliver timely scheduling and completion of urgent consults. The call is well attended consistently with over 400 participants each week. Facilities across VA have also been working to reduce routine consult backlogs since June 2017.

To ensure the timely follow-up care for Veterans with urgent needs, in December 2016 VA implemented a process for providers to indicate priority for follow-up appointments to ensure that a Veteran’s timely follow-up needs are met. Providers indicate a no-later-than date in the return to clinic order that signals the scheduler to arrange for the follow-up appointment by that provider-recommended date. Since implementation, as of August 14, 2017, 107,000 time-sensitive appointments have been completed across VA, and of those, about 90 percent have been completed no later than the provider-recommended date.

In order to reduce scheduling errors, VA focused on enhanced training and identifying warning signs that schedulers at a given facility were generating scheduling errors. VA recognized that its scheduler training in the past was not effective. In December 2016, based upon strong practices, VA commenced systemwide mandatory face-to-face training of all schedulers. This included hands-on supervised practice scheduling sessions. No newly hired scheduler may commence scheduling Veterans until after they successfully pass this two-week training. To date, 100 percent of the approximately 20,000 Medical Support Assistants scheduling across the country in our VA health care system clinics had successfully completed this training program. Additionally, over 4,000 staff including clinicians completed training on the latest scheduling requirements as identified by VA’s updated scheduling directive. Additionally, a mandatory standardized Supervisory Audit Tool was implemented June 1, 2017 in order to ensure that audits are completed on every scheduler. These audit results will be used by Facility, VISN, and national leadership to ensure compliance and to assist with identifying opportunities for improvement.

VA has also worked to strengthen its Clinic Practice Management Program at each VA health care system based upon private sector and DoD strong practices. A critical function of this program is to monitor data and oversee the timeliness and accuracy of Veteran appointments. Each VA system has at least one Group Practice Manager as well as a Clinic Practice Management team comprised of clinical and administrative leadership from Primary Care, Mental Health, and Medical and Surgical Specialties. Additionally, a user friendly Clinic Practice Management dashboard was updated this past year based upon feedback from the field; this dashboard can be utilized by the Group Practice Managers as well as facility clinical and administrative leadership to monitor clinic activities and identify opportunities to improve. The dashboard includes new scheduling performance data down to the level of an individual scheduler. Also, weekly Community of Practice Calls are attended by an average of 200 employees.
To hold ourselves accountable to the community we serve and to empower veterans to make informed decisions about their health care, VA released a simplified tool in April, www.accesstocare.va.gov, to be transparent about our performance, while providing the meaningful data Veterans need. Veterans, their families, and caregivers can now easily use data related to how long patients are waiting to be seen at VA facilities in their area, how Veterans describe their experiences scheduling primary and specialty care, options available for care needed right away and information about the quality of health care delivered at every medical center.

Veterans Scheduling Enhancement is currently being implemented at all facilities within VA. At the time of this report, over half of our medical centers have started using this system to schedule patients for their appointments. This system will make scheduling simpler and reduce scheduling errors. Training of schedulers and implementation is nearing completion.

Some examples of the progress made with performance in VA are as follows. VHA Consumer Assessment of Health Providers and System patient satisfaction scores have increased in all domains during the current year when compared to FY 2016. The greatest increase has been in the “care needed right away” category domains.

<table>
<thead>
<tr>
<th></th>
<th>FY 2016</th>
<th>FY 17 thru March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Routine Care</td>
<td>83.6%</td>
<td>84.2% (+0.6%)</td>
</tr>
<tr>
<td>Primary Care Needed Right Away</td>
<td>72.4%</td>
<td>74.2% (+1.8%)</td>
</tr>
<tr>
<td>Specialty Care Routine Care</td>
<td>82.2%</td>
<td>83.3% (+1.1)</td>
</tr>
<tr>
<td>Specialty Care Needed Right Away</td>
<td>72.4%</td>
<td>73.8% (+1.4%)</td>
</tr>
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Overall VA completed 58 million appointments within VA during FY 2016. This was 12,000 more appointments each business day when compared to where we were during FY 2014. In FY 2016, 22 percent of the appointments completed in VA were completed the same day the patient requested the appointment. For telehealth, 12 percent of Veterans receiving care from VA last year obtained 2.17 million telehealth appointments. By the end of 2017, 8 Primary Care hubs and 10 Mental Health hubs will be fully operational to deliver telehealth to spoke sites where provider shortages exist. Additionally, many VISNs have or are in the process of setting up their own hubs. VA is also employing Video Connect, a simplified tool for telehealth, where secure appointments occur using a Veteran’s smart phone, I-Pad, or desktop computer. VA has focused on improving productivity. For this, clinical productivity measured as total work relative value units/clinical FTEE increased by 9 percent from FY 2014 to April 15, 2017.

Throughout FY 2016 and to present day in FY 2017, the VHA OCC executed initiatives and projects to build and improve capabilities for Veterans’ community care and to streamline processes for accessing care under the VCP. Improvements incorporated those specified in a succession of legislative amendments to the Choice Act and are helping to reduce the consult/referral life cycle timeframe. Various actions taken have included contract modifications; training; new and enhanced SOP; creation of Fact Sheets and internal printed communication resources designed to keep the field apprised of all new...
developments; directives; a REFDOC tool; single booking pilot; single booking processes; and the implementation of the OneConsult and consult toolbox.

The OCC modified current VCP contracts to simplify the referral process, increase continuity of care, decrease Secondary Authorization Requests workload, and resolve provider billing and payment issues. These contract modifications give VA the ability to include Episode of Care changes. Health Net/TriWest can update the duration of care approved by VA seven days earlier and up to 60 days later than the Episode of Care, and to lead adjudication actions for aged Secondary Authorization Requests uploaded to VA portals prior to January 27, 2017.

Contracts now align more closely with the Health Benefits Package (Title 38 Code of Federal Regulations 17.38). Veterans will be able to schedule their own appointments, while VA coordinates referrals directly with community care providers for some services. For providers, improved processes promote more timely payment while maximizing industry health information exchange systems, allowing providers to send medical documentation directly to VA.

Other contract enhancements include network adequacy, provider fraud, high-performing network, eligibility and enrollment, customer service, and increased transparency and quality monitoring. The OCC added Tele-Mental Health to covered services under the Choice contracts. Phase I of this program deployed in November 2016. As of April 12, 2017, the preliminary results indicated high Veteran satisfaction and high rates of return appointments. Tele-Mental for community care has also rolled out at 30 VA sites.

Other Program enhancements include the Update of Construction Authorization and Choice Improvement Act – Unusual or Excessive Burden Determination (UEXB). Under this amendment, the Secretary has discretion to define “other factors” creating the usual or excessive burden in travel and basis for VCP eligibility. UEXB no longer restricts authorization to previously identified specialty services. Effective February 24, 2017, VA clinicians may decide whether a Veteran is eligible to use VCP under the “other factors” provision of UEXB.

As part of the various actions taken to remedy issues specific to scheduling and care coordination, the OCC modified and enhanced VA Form 10-0386, VHA Choice Approval for Medical Care. The enhancements include making the Type of Specialist field completion mandatory by VA (helping to alleviate miscommunication and misdirection to inappropriate specialties), new date field format to prevent text entry/bypass, and improvements to descriptions of service. The enhancements to VA Form 10-0386 also included added contact information for Veterans, ensuring the most current contact information available when attempting to schedule care.

To further reduce scheduling delays, the OCC implemented the Choice Category of Care Withhold process allowing VA to expand the use of Veterans Choice Provider Agreements. Previously, VA limited provider agreements to services not offered in the contract, or referrals returned for specific reason for services that are in the Choice contract.

Through this process, VAMCs now identify referrals repeatedly returned for specific care categories and use other means to outsource the services, and use the information gathered on returned referrals to work with the Contractors on network development. The OCC communicates returned referral data to the VISN/VAMCs monthly, so that they may assess impact on their geographic areas. VA also communicates high return rate category lists to the contractor with a notice that the facility will not send the specific care category for the following month based on high return rates.
The single booking process will be fully implemented with the OneConsult and consult tool box rollout in the September timeframe. Single booking streamlines managing appointment requests greater than 30 days for eligible Veterans who seeking care outside the VA. Per the Enhancements to the VCP Referral Processes Memorandum, local Community Care offices must implement Single Booking by June 2017. Community Care leadership is closely monitoring the implementation of Single Booking. As of August 2017, 93 VAMCs fully implemented single booking, 23 VAMCs have partially implemented, and 24 VAMCs have not implemented the process.

In addition, VA has taken steps to reduce administrative burdens, enhance guidance, and speed provider payments. VA modified the contract to decouple medical documentation receipt from claims payment speeding up the provider payment process.

The mass mailing to community providers regarding Electronic Data Interchange submissions, along with other provider billing guidance, increased available resources to enhance the providers’ ability to receive a timelier payment.

Over the last year, the VCP provider network has continued to grow. Over the last year, there has been an increase nationally in the number of providers in Health Net and TriWest’s respective provider networks. As of December 31, 2016, the Patient Centered Community Care (PC3)/Choice Provider Network has grown by 63 percent compared to December 2015. Please note that Health Net covers 13 VISNs while TriWest only serves 8.

VA acknowledges that there have been performance issues with the Choice contractors, but they have implemented improvements through VA contract modifications and VA has the controls in place to continue to improve upon contractor oversight. VHA Choice modifications enacted during FY 2016 and FY 2017 prompted changes regarding the expected specific actions and specific timing for routine and urgent appointments. Choice contract modifications included:

- Requires the contractor to schedule urgent authorizations within two business days after the creation of the authorization. If the contractor cannot schedule the care within two business days, the authorization shall be returned on the third business day.
- Enhances the routine authorization return process, requiring the contractor to schedule routine care within 5 business days after the creation of the authorization for 95 percent of these authorizations, with no more than 5 percent being able to be appointed up to 10 business days. The contractor will return all authorizations not appointed by the 10th business day. This enhancement requires the contractors to begin returning authorizations based on the timing limits placed on scheduling appointments.

Performance monitoring is an ongoing activity. VHA aggressively pursued improvements in 2017 that would give the VHA more timely, accurate, and complete visibility into contractor performance.

VHA and the Choice Contractors conduct quarterly Performance Management Reviews, at which time both parties review monthly performance reports. The formal reviews are a key part of the controls that VHA established to ensure contractor performance and compliance with contract standards and to discuss issues and opportunities for further improvements. During 2016 and to present day, these reviews covered appointment and return authorization performance as well as confirmed the accuracy and timeliness of performance data received from the contractors. VHA sends Letters of Correction for areas failing to meet performance standards.

Weekly discussions between VHA and the contractors, called “Round Tables,” which
began in September 2016, as well as VHA internally staffed “portfolio” teams initiated in early 2016 have surfaced improvements for referral, appointing, and care coordination processes and data. The three major categories that these discussions have focused on relate to (1) policy and process enhancements; (2) scaling of existing technological efficiency enhancements to address data collection, reporting, and sharing of information; and (3) recommended contract enhancements for third-party administrator performance improvement.

Since the Choice contract origination in 2014, VA has worked to design and improve the monthly contractor performance reporting format and its related data collection activities. VA expanded automation activities to support data contractor quality, validation, and verification. Additional software was implemented by the contractors to assist with identifying data inaccuracies before submission to VA, to ensure the complete data set needed for performance reporting, and to enable greater reporting consistency between the two Choice contractors. This “Data Tracker” Tool incorporates automated data checks for each performance report field and includes filters to automatically calculate and report performance levels. The tool has improved the data collection process and overall third-party administrator data accuracy and integrity. It has improved the consistency of reporting. VHA recognizes that continuing changes in data requirements present data reporting challenges to the Contractors in the past. In FY 2017, there have been no further amendments to the data requirements, and from that time forward VHA has made a concentrated effort not to alter reporting requirements ad-hoc and only group many changes together and do them all at once.

In reference to the OIG VISN-specific report, Healthcare Inspection – Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6 (16-02618-424), VISN 6 completed the following actions in FY 2017. The facility requested closure on one recommendation. The facility implemented several corrective actions to address the OIG recommendations, including strengthened controls over access to health care and consult management across all facilities. The VISN educated schedulers on Consult Processes and Procedures, and audited scheduler performance biannually with use of the Supervisory Appointment tool. VISN 6 is in the process of reviewing staffing levels to determine if they are a contributing factor in addressing the requirements of the Choice program. The OCC modified the Choice contract and the Under Secretary for Health completed analyses of third-party administrator return authorization timeliness and appointment scheduling. Overall improvement in performance was noted.

In reference to the OIG site-specific report, Healthcare Inspection – Review of Alleged Improper Non-VA Community Care Consult Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina (14-02890-352), the report is closed and has no open recommendations. The facility took the following actions in FY 2017: completed a review of the care of one patient internally and externally. The review found that the procedures and time lines associated with processing of the consult did not change the outcome for the patient. The facility’s Non-VA Coordinated Care Service now tracks all consults, including those with no action within seven days, on a daily basis. This information is provided to the leadership team for review and action as needed.

In reference to the OIG site-specific report, Healthcare Inspection – Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System (14-02890-72), the site requested closure on all recommendations. The facility took the following actions in FY 2017: reviewed the
training records of all schedulers for compliance with VHA mandatory training requirements for scheduling. All schedulers were educated on the new VHA scheduling policy. The Compliance Office performed biweekly monitors of scheduling practices and reported outliers to the section chief for remediation and training. Leadership appointed an Administrative Board of Inquiry to determine how the Business Service Line officials created and used training materials which did not comply with VHA scheduling policy.

In reference to the OIG site-specific report, Healthcare Inspection – Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System (15-04672-342), the site took the following actions in FY 2017: completed review of the patients identified in the OIG report to ensure follow-up with appropriate services; implemented new software to allow automated data entry of vascular study results into the EHR; implemented a daily review of all vascular lab studies by a vascular surgeon; implemented a process to review open community care consults older than 120 days; supervisors review the report weekly; scheduling staff in the Choice-First program have been retrained to ensure consults are forwarded to Choice-First to the selected vendor timely.

**KEY RELATED LINKS:**
Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6
3/2/2017 | 16-02618-424 | Summary |

Review of the Implementation of the Veterans Choice Program
1/30/2017 | 15-04673-333 | Summary |

Review of Alleged Improper Non-VA Community Care Consult Practices at the Ralph H. Johnson VA Medical Center, Charleston, South Carolina
12/20/2016 | 14-02890-352 | Summary |

Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System
11/9/2016 | 14-02890-72 | Summary |

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System
10/4/2016 | 15-04672-342 | Summary |

**OIG CHALLENGE #2: BENEFITS DELIVERY**

**STRATEGIC OVERVIEW**
Delivering timely and accurate benefits is central to VA’s mission. The 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, VR&E, and life insurance. These programs are estimated to pay out over $107 billion in claims to veterans and their beneficiaries in FY 2018.

OIG conducts inspections of all 56 VAROs and the Veterans Service Center (VSC) in Cheyenne, Wyoming, generally on a three-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 residual disabilities related to 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 2017, OIG inspected 16 VAROs—initiating the third review cycle of VBA’s 57 claims processing offices. During FY 2017, OIG also reported the results of reviews related to VBA programs, operations, and complaints received through OIG’s Hotline Division. The results of these reviews demonstrate that additional improvement is necessary to ensure
the accuracy of processed claims and controls over claims processing are adequate.

**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 2017, OIG reported on the performance of 16 VAROs in the following areas:

- Residual disabilities related to TBI
- SMC and related ancillary benefits
- Benefits reductions
- Systems compliance
- Special controlled correspondence.

Overall, OIG reviews disclosed deficiencies in SMC, benefits reductions, and special controlled correspondence. For example, 21 percent of the total 388 disability claims statistically selected from VAROs that related to SMC claims contained errors. The errors resulted in more than $684,000 in improper benefits payments. Also, VARO staff did not correctly process or complete 39 percent of 405 proposed benefits reductions cases, resulting in approximately $860,000 in improper benefits payments. OIG also determined VARO staff used inaccurate or incomplete claim and claimant information in 53 percent of 480 records in the electronic systems at the time of claim establishment.

**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 Measure(s):**

- 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 1,000)
- Appeals Processing - Notice of Disagreement (NOD) Pending Inventory
- Appeals Processing - NODs Average Days Pending
- Appeals Processing - Substantive Appeals to the Board (Form 9) Pending Inventory

The VBA is committed to providing Veterans with the care and services they have earned and deserve. As of July 31, 2017, the average age of pending compensation claims was 97.7 days. For the eighth consecutive year, VBA has
completed over 1 million disability claims and anticipates completing a record number of claims in FY 2017. Although 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, it continues to remain focused on nonrating claims.

VBA provides oversight and prioritization of proposed rating reduction cases at the national level. As of April 9, 2017, all ROs receive a daily distribution of actionable due process work that is priority homeless, priority terminally ill, part of VBA’s oldest pending claims, etc. Nationally, ROs are held to a standard that all work must be completed on a claim that is distributed to them within five days. Regional and District Office leadership, as well as the Office of Field Operations, routinely monitor stations’ performance related to the five-day Time In Queue standard. Since the National Work Queue (NWQ) began managing the distribution of End Product (EP) 600s (due process EPs), timeliness of these claims has improved by 30 days. In FY 2017, VBA established Non-Rating Resource teams at 12 ROs. NWQ routes primarily special project work to these teams. Currently, the teams are focused on SMC, drill pay, Federal Bureau of Prison matching, and character of discharge. If there is no actionable work available for the special project teams, NWQ routes additional nonrating priorities (e.g., dependency) to those teams. Since their establishment in April 2017, VBA has seen a 57 percent reduction in this nonrating inventory.

VBA also developed and implemented new performance standards for Veterans Service Representatives and Rating Veterans Service Representatives (RVSRs) to provide better support for VA’s national workload strategy. The updated standards shift from a focus on a singular final production target, to an emphasis on actions that promote improved efficiency throughout the entire claims development process.

VBA’s Rules-Based Processing System (RBPS) has enabled it to automate adjustments for adding and removing dependents. As of July 31, 2017, 72 percent of the dependency claims submitted through RBPS were automatically processed and Veterans’ award adjustments were completed within one day. Claims that do not meet 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 addition, distribution of dependency claims through NWQ will increase, further adding claims processing efficiencies.

VA’s modernization efforts focus on improving its performance to better serve Veterans, their families, caregivers, and Survivors while being good stewards of taxpayer dollars. To continue improving disability claim processing, VBA began implementing a program called Decision Ready Claims (DRC) in May 2017, with national implementation completed by September 1, 2017. The DRC Program is an expedited claims submission option available to Veterans who have elected accredited VSOs to assist them with preparing and submitting their disability claims. Under the DRC Program, VSOs work with Veterans to ensure all supporting evidence is included with the claim at the time of submission. This program will also enhance partnerships with VSOs by improving access and capabilities to assist with gathering all required evidence and information to accelerate claims decisions. Claims submitted in the DRC Program will result in a claims decision within 30 days of submission to VA.

The DRC Program was initially implemented on May 1, 2017, at the St. Paul RO, and all ROs will operate under this claims processing model by September 2017. Currently, 40 ROs have received the DRC training and have begun
receiving and processing DRCs. The remaining 16 ROs are scheduled to complete training by September 1, 2017, at which time they will begin receiving and processing DRCs. As of August 18, 2017, there have been 151 DRC submissions with 118 completed in an average of 8.7 days.

VBA completed deployment of the Centralized Mail Program to all ROs in 2015, and to the Pension Management Centers (PMC) 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. In FY 2017, VBA focused on File Bank Extraction (FBE), an effort to rapidly extract all inactive paper claims from ROs on a national level while having the Office of Business Process Integration and its Veterans Claims Intake Program assume logistical tracking control at the point of origin. FBE is a continuation of VBA’s transformation and transition from paper-based to electronic claims processing. FBE also assists in refocusing on the mission-critical work, such as CM, by alleviating the burden of paper from ROs.

The benefits of FBE are that it ensures claim materials are in the Veterans Benefits Management System (VBMS) on day 1 of future claims, it reduces the overall amount of space dedicated to storage, and it fully leverages document conversion capacity, directly supporting VBA’s strategic transformation goal to become completely paperless.

VBA also released an updated higher level SMC training course for RVSRs, Rating Quality Review Specialists, and Decision Review Officers. In addition, VBA updated training materials and released a video on system compliance for VSC personnel.

In FY 2017, VBA deployed a new Quality Management System (QMS), a platform that allows VBA quality control to be performed in one system. This means full integration of all checklist-based quality reviews such as Statistical and Technical Accuracy Reports, Individual Quality Reviews, In-Process Reviews, pension, and appeals. Furthermore, it positions VBA to integrate and use our systems more efficiently by moving quality into a national processing scope versus localized reviews. Additionally, QMS is able to support an entire quality cycle in one system from claim selection, quality review, peer and quality review team performance reviews, error corrections, and reconsiderations. In doing so, this allows a more permanent audit trail for every step in the quality review process, which furthers our commitment to transparency.

As of July 31, 2017, nationally, claim-based accuracy was at 86.2 percent (+/- 0.8 percent margin of error), and issue-based accuracy remained high at 94.5 percent (+/- 0.3 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.

During the 1990s, VBA received an increased volume of C&P claims, related to disability compensation, which created a need for an increase in the number of examinations required to process claims. As a result, legislation was enacted authorizing the SECVA to utilize contract examinations through VBA as
a means to address the need for increased exam capacity. The VBA Contract Exam Program was implemented in 1998 to supplement the C&P examination program traditionally covered by the VHA. Over time, this Congressionally mandated pilot expanded and in 2016, the Secretary of VA was provided authority to expand this program to all ROs. VBA created the Contract Exam Program Office to oversee all elements of the process as it related to acquisition, program operations, and vendor quality.

The original Mandatory Disability Examination (MDE) contract award was protested and after several legal actions, the Court of Federal Claims was given jurisdiction over the issue in January 2017. On June 12, 2017, the Court of Federal Claims resolved the pending litigation regarding VBA contract exams and found in favor of VA. As a result, the contract award assignments were upheld and the new vendor ramp-up period began on June 28, 2017. Vendors are afforded a 90-day ramp-up period to establish a provider network, employees, and building space. The vendor ramp-up period is in place until September 26, 2017.

The MDE vendor performance is assessed quarterly and is determined by evaluations of the vendors’ timeliness and quality of work completed. The vendor timeliness standard requires them to complete all Outside Continental U.S. disability examinations in an average of 20 days from the date the request is submitted to the date the vendor uploads the results into VBMS. The vendors’ performance standard is 10 days faster than VHA’s standard, thus decreasing claims processing time. The vendors are also required to maintain a minimum of 92 percent accuracy. The quality measure is based on a sample size of all work completed by each vendor in each district quarterly with a 95 percent confidence level.

VBA uses the MDE contract as a supplement to the C&P examination process. VHA capacity is used before VBA vendors are harnessed to complete examinations. This process requires constant communication with VHA to discuss issues related to capacity and timeliness. VBA uses VHA data through the Examination Request Routing Assistant tool to help claims processors across the country submit examination requests based on the availability of VHA facilities nationwide.

The current VA appeals process is a complex, nonlinear process that is unlike standard appeal processes found in other administrative or judicial systems. It has multiple steps, most of which occur at VBA as the agency of original jurisdiction. If a Veteran is not satisfied with the initial VBA determination, he or she may continue the appeal to the Board of Veterans’ Appeals (Board) for a final agency decision. A feature of the current VA appeals process is an open record that allows appellants to submit new evidence and/or make new arguments at any point in the appeals process. Additionally, the statutory duty to assist requires VA to gather further evidence on the Veteran’s behalf. When new arguments are presented and evidence is obtained, VA generally must re-adjudicate the appeal, which lengthens the timeline for final appellate resolution. VA’s appeals process essentially contains another claims process, as new contentions are added as part of the appeal, rather than initiated as a new claim, which delays a final outcome for Veterans.

Modernizing the appeals process through legislative reform and other people, process, and technology is one of VA’s top priorities. Accordingly, as part of an effort to streamline and improve appeals processing and demonstrate its commitment to appeals reform, in January 2017, VBA realigned its administrative appeals program under the Appeals Management Office (AMO). This realignment identified a single accountable official within VBA, the AMO Director, who is responsible for overseeing VBA’s appeals. This allows VBA to increase oversight and
management attention in its appeals program, while also allowing greater focus on the complex and challenging nonappeals workload and policy issues that arise in VBA’s business lines.

Following the creation of the AMO, appeals resources were streamlined to facilitate consistent benefit delivery and higher customer satisfaction. By the end of July 2017, VBA’s appeals production was 13.5 percent above the FY 2017 goal and was 24.1 percent above production at the same point in FY 2016. The substantive appeal (VA Form 9) inventory was reduced by 3.1 percent, to approximately 41,000. Moreover, VBA decreased its appeals inventory by 9 percent to 312,000 and its remand inventory by 13.4 percent to 29,000 since the beginning of FY 2017.

VA acknowledges that realignment of appeals resources alone cannot fix the broken appeals process. Accordingly, since early 2016, VA has worked very closely with VSOs and other stakeholders to design a new comprehensive legal framework for appeals.

On August 23, 2017, the President signed the new framework into law as the Veterans Appeals Improvement and Modernization Act of 2017. Under the new law, VA has 18 months to implement a new appeals process that eliminates the complexity and inefficient churning of appeals that was inherent in the old process, and provides Veterans with multiple options for early resolution of their disagreement with VA’s benefits claim decisions.

Once the appeals reform legislation goes into effect, following the proposed 18-month implementation period, VA plans to evaluate and report on the new process by examining wait times for Veterans with decision processing times meeting timeliness goal averages of 125 days in the higher-level review lane, 125 days in the supplemental claims lane, and 365 days for appeals to the Board in which there is no request for a hearing and no additional evidence is being submitted. VA plans to take a Veteran-centric approach to measuring the success of the new appeals process. VA will measure average Veteran wait times in the new process as one indicator of success. In addition, VA is working, internally, to determine the best way to measure Veteran satisfaction with the new process. VA will also continue to respond to congressional tracking reports, requests for information, and questions for the record from Congress, including any questions regarding the extent to which VA is improving Veterans’ experience in its appeals process. Internally, VA also plans to compare the new process to the current appeals process using various performance metrics, such as days to resolve an appeal.

KEY RELATED LINKS:

Inspection of the VA Regional Office Philadelphia, Pennsylvania
8/24/2017 | 17-01276-300 | Summary |

Inspection of the VA Regional Office Louisville, Kentucky
8/23/2017 | 17-00394-298 | Summary |

Inspection of the VA Regional Office Indianapolis, Indiana
8/3/2017 | 16-04918-263 | Summary |

Inspection of the VA Regional Office Seattle, Washington
8/3/2017 | 16-04764-266 | Summary |

Inspection of the VA Regional Office Boise, Idaho
6/21/2017 | 16-04762-232 | Summary |
OIG SUB-CHALLENGE
#2B: IMPROVING DATA INTEGRITY, INTERNAL CONTROLS, AND MANAGEMENT WITHIN VAROS (VBA)

OIG assessed the merits of OIG Hotline allegations regarding the manipulation of data and lack of controls over claims processing. In several instances, OIG substantiated the allegations. Specifically, OIG reviews documented that VARO claims processors improperly removed controls which resulted in the improper termination of veterans’ claims without the appropriate review and processing. OIG also determined that claims processors assigned incorrect effective dates when processing claims associated with “intent to file” (ITF) submissions. An ITF provides claimants the opportunity to submit minimal information related to their claim for benefits and allows up to one year for the claimant to provide additional information and evidence necessary to complete the claim. If benefits are subsequently established, VA may use the date the VARO received the ITF as the basis for an earlier effective date for benefits payments. However, VARO staff did not always assign the correct effective dates when they received an ITF. In addition, OIG determined opportunities existed to improve appeals workload management and processing timeliness. These opportunities included preventing periods of inactivity in which pending appeals were not being processed and errors that delayed appeals processing such as prematurely closing appeals.

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 1,000)

VBA takes seriously the issues OIG raised, has taken action to address them, and will continue to do so until they are resolved. VBA manages all rating claims and most nonrating claims from a national level through NWQ. ROs are also held to timeliness and quality standards.

The issue related to workload controls on EP 930s was specific to the San Juan RO, which was corrected locally through additional training and a comprehensive review of the 722 EP 930s that were processed during that time.

In July 2016, VBA issued final guidance on identifying and processing ITF claim filings.

On August 23, 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017. Under the new law, VA has 18 months to implement a new appeals framework that eliminates the complexity and
inefficient churning of appeals that was inherent in the old process, and provides Veterans with multiple options for early resolution of their disagreement with VA’s benefits claim decisions. Once the appeals reform legislation goes into effect, following the 18-month implementation period, VA plans to evaluate and report on the new process by examining wait times for Veterans with decision processing times meeting timeliness goal averages of 125 days in the higher-level review lane, 125 days for the supplemental claims lane, and 365 days in the Board’s nonhearing option lane.

In addition to Veteran wait times, VA plans to measure success of the new appeals process with the results from customer satisfaction surveys. VA believes that wait times and results from customer satisfaction surveys are the most appropriate, Veteran-centric metrics to capture success of the new process and to compare it to the legacy process. VA will also continue to respond to Congressional tracking reports, requests for information, and questions for the record from Congress, including any questions regarding the extent to which VA is improving Veterans’ experience in its appeals process. Internally, VA also plans to compare the new appeals process to the current appeals process using various performance metrics, such as days to resolve an appeal.

KEY RELATED LINKS:
Review of Alleged Removal of Workload Controls at the VA Regional Office in San Juan, Puerto Rico
5/24/2017 | 15-05235-200 | Summary |
Review of Alleged Use of Incorrect Effective Dates at VBA’s VA Regional Office in Chicago, Illinois
3/31/2017 | 16-02806-182 | Summary |

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. Each year, OIG conducts mandatory reviews of VA’s compliance with the Improper Payments Elimination and Recovery Act (IPERA) and the CFO Act, which requires an audit of VA’s CFS. Further, OIG performs additional audits and reviews of other programs and activities which assess VA’s management of appropriated funds.

Although VA has received an unmodified or “clean” opinion on its CFS from OIG’s contracted auditors, VA has continuously faced challenges in achieving those results. A clean opinion means the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States. However, OIG’s independent auditors found several material control weaknesses and deficiencies. Also, the IPERA review disclosed financial-related issues the Department needs to address. 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.

OIG SUB-CHALLENGE #3A: COMPLIANCE WITH IPERA (OM, VHA, VBA, AND OALC)
OIG conducted this mandatory review to determine whether VA complied with IPERA for FY 2016. VA reported improper payment estimates totaling approximately $5.5 billion in its FY 2016 AFR. VA did not comply with two of
six requirements that constitute compliance according to the OMB. Specifically, VA did not:

- Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was published in the FY 2016 AFR. Two VA programs - VA Community Care and Purchased Long Term Services and Support - exceeded 10 percent.
- Meet annual reduction targets for the following six programs: VA Community Care, Purchased Long-Term Services and Support, Beneficiary Travel, Civilian Health and Medical Program of the VA (CHAMPVA), State Home Per Diem Grants, and Supplies and Materials.

VA met four of the six IPERA requirements for FY 2016 by publishing the AFR, performing risk assessments, publishing improper payment estimates, and providing information on corrective action plans. Although VA published improper payment estimates as required, OIG determined estimates for the Supplies and Materials Program and the Post 9/11 G.I. Bill Program were not reliable because of weaknesses in sample evaluation procedures. OIG also noted further improvements VA could make in estimating improper payments for two programs and in reducing improper payments for another program that resulted from a program design issue.

**VA Program Response**

**Estimated Resolution Timeframe:** 2020

**Responsible Agency Official:** Acting Assistant Secretary for Management and Acting CFO (Lead), Acting Under Secretary for Health, and Acting Under Secretary for Benefits, Principal Executive Director of Office of Acquisition, Logistics, and Construction (OALC)

**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

**FY 2017 Milestones:**

VA is committed to achieving compliance with IPERA and the reduction of improper payments continues to be a high priority for the overall effort to strengthen financial management. Since 2015, VA reported increases in improper payment rates due to the continued improvement of testing surrounding acquisitions. This increased improper payment rate has continued into 2017 with the addition of three new programs that are also reporting errors related to contract compliance. These examples of noncompliance represent a systemic challenge for VA that requires judicious corrective actions to ensure there is no impact to Veterans’ access to care. Implementation of these corrective actions to remediate improper payments associated with care in the community and other acquisitions for Veterans will take time to implement. It is possible that it will be a few years before VA is fully compliant. Although these programs are reporting improper payments over 10 percent, the noncompliance issue does not represent an actual loss or a budgetary impact to VA. Furthermore, VA is also working to reduce improper payments caused by the concurrent payment of VA benefits and drill pay. To address root causes of improper payments, VBA has a collaborative drill pay workgroup between VA Compensation and the DoD and continues to develop a solution for moving drill pay adjustments to a monthly process. Title 38, Code of Federal Regulations, requires VA to provide a Veteran with notice of a proposed adverse action and 60 days to provide evidence showing why the adverse action should not be taken. This due process requirement is the largest barrier to timely resolving drill pay
improper payments, and will be noted in future AFRs.

To ensure accurate testing and reporting of improper payments, VA has made multiple improvements. For the Supplies and Materials program, VA developed testing procedures for payment testing under IPERA to better identify unauthorized commitments and pricing verification and developed an internal controls document detailing the direct to patient processes. VA also developed an alternative sampling plan (approved by OMB in June 2017) for Purchased Long Term Services and Support that reduces sample sizes to ensure Purchased Long Term Services and Support meets precision targets and allows VHA to increase resource investment into improving payment processes. VA also adjusted its sampling plan for VA Community Care to use a ratio-based estimate in order to meet precision targets. OMB confirmed a ratio-based estimate is in accordance with its Circular A-123 Appendix C requirements and does not require approval as an alternative plan. In addition, VBA Education Service now requests (1) school documentation for billing, attendance, and student transcripts; and (2) school catalog information verifying tuition and fees, as required by Title 38 CFR 21.4209, Examination of Records.

KEY RELATED LINK:
Review of VA’s Compliance With the Improper Payments Elimination and Recovery Act for FY 2016
5/15/2017 | 16-04416-231 | Summary |

OIG SUB-CHALLENGE #3B: IMPROVING FINANCIAL REPORTING (OM, VHA, VBA, AND OI&T)

Overall, the CFS audit reported VA’s complex, disjointed, and legacy financial management system architecture continued to deteriorate and no longer met increasingly stringent and demanding financial management and reporting requirements. As a result of the FY 2015 and 2016 CFS audit, OIG’s independent auditor reported that VA did not substantially comply with federal financial management systems requirements and the U.S. Standard General Ledger at the transaction level under the FFMIA. Also, the audit of VA’s FY 2016 CFS identified six material weaknesses and two significant deficiencies—two more in total than the prior year. The independent auditors made recommendations for VA to address identified issues that ranged from specific, targeted actions to broader improvements in policies, processes, and systems. Additionally, VA is currently working with the U.S. Department of Agriculture to obtain financial services. In FY 2017, VA began efforts to standardize business processes and identify changes required for its systems modernization effort.

VA’s Program Response

Estimated Resolution Timeframe:
VA estimates that it will achieve initial operating capability for the new financial system in Q1 FY 2020

Responsible Agency Official:
Assistant Secretary for Management (lead), Assistant Secretary for IT, and Principal Executive Director for OALC, VHA CFO, and VBA CFO

Associated Strategic Goal and Strategic Objective: Manage and improve VA operations to deliver seamless and integrated support, 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 concurs that our legacy financial management system does not fully comply with the FFMIA. To address this major challenge, VA is currently working with a FSSP on VA’s FMBT effort to migrate to a new integrated financial and acquisition management system, iFAMS. VA’s FMBT effort will increase the transparency, accuracy, timeliness, and reliability of financial information resulting in
improved fiscal accountability to American taxpayers, and offers a significant opportunity to improve care and services to our Veterans. The FMBT program goals capitalize on the opportunities for business process improvements to resolve systemic and procedural issues including:

- Standardizing, integrating, and streamlining financial processes including budgeting; procurement, accounting, resource management, and financial reporting through implementation of a USSGL compliant solution
- Facilitating management that is more effective by providing stronger analytics and projections for planning purposes
- Improving customer service and support of goods, supplies, and services for the Veteran
- Improving the speed and reliability of communicating financial information throughout the VA and providing timely, robust, and accurate financial reporting.

As VA modernizes our financial and acquisition systems, it will replace the financial management functionality of the IFCAP system and CAATS, and the procurement functionality of eCMS. The FMBT effort will resolve many of VA’s current areas of noncompliance with FFMIA and address many of the deficiencies related to the material weaknesses and significant deficiency on Undelivered Orders.

In addition, VA has initiated targeted actions to address the material weaknesses and significant deficiencies reported in the FY 2016 CFS Audit. Specifically, the VBA has procured actuarial contract support for both education and compensation benefits. Additionally, efforts are being made to hire a certified actuary in early FY 2018 that will effectively address the material weaknesses and significant deficiency related to VBA. The VHA drafted and issued Summary Level Guidance in May 2017 for the major business and financial processes of VHA Community Care. VHA is working to supplement the high-level guidance with detailed SOP by category of care. VHA kicked off the development of SOP by creating working groups to support the key processes within Community Care which include Cost Estimation, Obligations, Authorizations, Batch Processing, and Reconciliations.

To address the internal control material weakness noted for the reconciliation discrepancies between Fee Basis Claims System (FBCS) and FMS and the FBBCS cost estimation process, VA collaborated and developed an automated solution for the FBBCS to FMS Outpatient category of care reconciliation process. The FBBCS to FMS Variance Dashboard was created to automate the calculation for outpatient care which will bring structure, standardization, and increased visibility to the back-end reconciliation process.

To address the material weakness around financial reporting, VA identified and implemented a standardized approach to performing quarterly financial statement variance analysis and monthly abnormal balance reviews. As the variance and abnormal balance analyses and supporting research are now more thoroughly developed, VHA is identifying the root causes that drive abnormal balances and the actions needed to correct them; as well as providing well developed explanations to address material variances.

The Administrations and program offices are actively engaged and working to continuously improve and strengthen internal controls in financial management.

**KEY RELATED LINK:**
Audit of VA’s Financial Statements for Fiscal Years 2016 and 2015
11/15/2016 | 16-01484-82 | Summary
SECTION III: OTHER INFORMATION

OIG SUB-CHALLENGE #3C: IMPROVING MANAGEMENT OF APPROPRIATED FUNDS (OM, OI&T, AND VHA)

In FY 2016, OIG documented several instances of mismanagement of appropriated funds. Accordingly, in FY 2017, OIG reviewed several allegations received via OIG’s Hotline regarding the potential waste or misuse of appropriated funds. In each of the allegations that were substantiated, OIG found that VA staff overpaid for services or benefits to VA employees, non-VA providers, or contractors. None of the overpayments were intentional or resulted in criminal or disciplinary actions against a VA employee or contractor. However, the deficiencies revealed the need for improved controls over payments and the need to implement policies and procedures to ensure the disbursement of appropriated funds is cost effective and prudent. In several instances, VA did not use the controls in place or did not fully consider all the available options.

VA’s Program Response

Estimated Resolution Timeframe: 2020

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): Manage and improve VA operations to deliver seamless and integrated support

FY 2017 Milestones:

To address findings of overpayments, VA began collection activities on overpayments. VA is also updating policy and procedures to enhance controls so that disbursements are cost effective and prudent.

For overpayments related to Non-VA Care claims for physician-administered injectable drugs, VA completed these actions:

- An initial validation of the OIG findings and overpayments for Non-VA Care claims made by Florida VA Facilities (VISN 8) for physician-administered injectable drugs
- The initial corrective actions needed to resolve the OIG recommendations related to implementing Medicare Drug Schedules, and is proceeding with the Medicare pricing schedules’ purchase and implementation for use in VA’s FBCS
- Availability of the schedules in FBCS is on target for implementation in October 2017 with implementation to be accompanied by revised claims processing guidance and training for all VA voucher examiners
- Currently in the process of developing recommendations and a plan for remediation/recovery of the improper payments for physician-administered and injectable drugs
- VA will explore all appropriate remediation/recovery alternatives, including bills of collection and debt compromise. As community partnerships are vital to Veterans receiving timely access to high-quality care, VA will work closely with our community providers as we work to resolve these overpayment issues.

For overpayments related to VA’s recruitment, relocation and retention incentives, VA completed these actions:

- Recommendation 9 of OIG’s Audit of VA’s Recruitment, Relocation, and Retention Incentives (OIG 14-04578-371) recommended the Assistant Secretary for Human Resources and Administration review and update procedures and add internal controls for Administration (HRA) to monitor facilities’ compliance with VA Handbook 5007/46 requirements to initiate debt collection from individuals who did not fulfill their recruitment, relocation, or retention incentive service obligations.
- HRA will meet the requirements of the recommendation as follows: The proposed policy revision to VA Handbook 5007, part IV, chapter 2 will require all requests for
waivers due to breach of service obligations to be submitted, through channels, to the Assistant Secretary for Human Resources and Administration. Such requests will be routed to the Office of Human Resources Management (OHRM), Compensation and Classification Service for technical review prior to approval. Previously requests for waivers were routed to the original approval official. This change elevates all requests for waivers to a higher level and will require technical review in VA Central Office. Additionally, VA Handbook 5007 will be revised to include an enhanced review process and template that requires certification that appropriate action has been taken to initiate debt collection, as appropriate.

- OHRM convened a workgroup with Workforce Management and Consulting, FSC, and Human Resources Information Service (HRIS) in April 2017, to discuss the debt collection reporting requirement outlined in recommendation 9 and debt waiver procedures for individuals who do not fulfill their recruitment, relocation, or retention incentive service obligations. Several complexities were identified related to report creation, tracking mechanisms, and report development. OHRM is to work with FSC and HRIS to finalize system capabilities and ensure that debt collection for the recruitment, relocation and retention incentives can be accurately tracked to meet OIG reporting requirements.

- Implementation of this recommendation is still in progress. Policy updates are pending final approval prior to being sent for concurrence. Policy revision tentative publication date is FY 2018.

In reference to the OIG report, Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities (15-01080-208), VHA validated that VISN 8 facilities made some overpayments for physician injected drugs, but needs to conduct a further detailed review, particularly of invoices from physicians that included physician injected drugs as a professional charge. VHA’s FBCS pricing software currently contains Medicare pricing algorithms for non-VA physician-administered drugs (other than orally administered) for charges invoiced by a facility on a facility invoice. VHA has reached out to the FBCS software contractor, Document Storage Systems, Inc., (DSS) to obtain the additional software and schedules necessary to price physician invoiced physician-administered drugs according to Medicare pricing requirements. The purchase of the FBCS Medicare Drug Average Sales Price Schedule will ensure its availability for pricing physician invoiced charges properly. VA has developed corrective measures for the issues and resultant overpayments associated with physician injectable drugs.

In reference to the OIG VISN-specific report, Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System (15-02278-415), the site completed the following actions in FY 2017. The facility closed four recommendations. The facility implemented several corrective actions to address the OIG recommendations, including conducted an annual review of resident meal plans and evaluated the internal purchase of resident meals as an alternative to commercial sources.

**KEY RELATED LINKS:**

Review of Alleged Overpayments for Non-VA Care Made by Florida VA Facilities
6/5/2017 | 15-01080-208 | Summary |

Audit of VA’s Recruitment, Relocation, and Retention Incentives
1/5/2017 | 14-04578-371 | Summary |

Review of Alleged Misuse of VA Funds at the VA Pittsburgh Healthcare System
12/15/2016 | 15-02278-415 | Summary |

Review of Alleged Wasted Funds at Consolidated Patient Account Centers for Windows Enterprise Licenses
12/6/2016 | 16-00790-417 | Summary |
SECTION III: OTHER INFORMATION

OIG CHALLENGE #4: PROCUREMENT PRACTICES

STRATEGIC OVERVIEW
In FY 2016, according to the Federal Procurement Data System, VA spent an estimated $22.7 billion in contract actions. Therefore, it is imperative that VA ensures the controls over funds disbursed and project management of contracts is effective. In FY 2017, OIG conducted reviews regarding the award and administration of VA contracts. The deficiencies found indicate that VA is experiencing challenges in the management of construction and service contracts. VA must improve its acquisition processes and oversight to ensure the efficient use of funds. Further, OIG conducted a risk assessment of VA’s Charge Card Programs and determined sufficient evidence existed to assess a medium risk of illegal, improper, or erroneous purchases within VA’s purchase card program. OIG conducted several program reviews and the results indicate that VA still needs to improve its purchase card practices.

OIG SUB-CHALLENGE #4A: IMPROVING CONTRACTING PRACTICES (VHA, OM, AND OI&T)
OIG substantiated a Hotline allegation of improper management and oversight of minor, nonrecurring maintenance, and clinical specific initiative construction projects. The mismanagement of eight construction projects led to project cost overruns, delays, cancellations, unnecessary change orders, and additional work. In total, OIG identified approximately $2.8 million in unnecessary costs and delays in completing projects needed to serve veterans. In addition, reviews of service contracts found project management and oversight was ineffective which adversely impacts VA’s ability to ensure the value of contract deliverables and return on investment is adequate.

VA’s Program Response
Estimated Resolution Timeframe: Ongoing
Responsible Agency Official: Under Secretary for Health
Associated Strategic Goal: Strategic Goal 3, Manage and improve VA operations to deliver seamless and integrated support
Strategic Objective: Enhance productivity and improve efficiency of the provision of Veterans benefits and services
Associated Performance Measure(s): In my work unit, steps are taken to deal with poor performers who cannot or will not improve.

FY 2017 Milestones:
This response is only for action taken by VHA Procurement to improve contracting processes. VHA Procurement and Logistics has initiatives to track contract compliance and improve contract oversight. VHA Chief Procurement and Logistic Officer continues to monitor contracting actions via a metrics program that tracks contracting competition; Socio-Economic Program Performance; Procurement Action Lead Time; Federal Procurement Data System reporting; Procurement satisfaction; Integrated Funds Control, Accounting, and Procurement to eCMS reporting; eCMS contract Closeout; and Service Disabled Veteran-Owned Small Business/Veteran-Owned Small Business awards. VHA Chief Procurement and Logistic Officer has provided additional guidance to Contracting Officer Representatives to improve contract oversight and included the Acquisition Utilization Specialist positions in the Logistics/Supply Chain Management service standardized organizational structure effort. Improvements in Contracting Practices are ongoing. VHA Procurement continues to use a rigorous metrics program and worked with the...
VA Senior Procurement Council to create a contract compliance tool for implementation in FY 2018.

In reference to Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia, issued March 24, 2017, (report 15-03231-319), the facility has completed the following actions in FY 2017: The facility retrained contract personnel in need of training on the Independent Government Cost Estimate (IGCE) procedures and policies. The facility revised the workflow associated with developing IGCE and conducted inter-rater reliability studies as needed. The facility completed training of personnel on preparing project-funding requests.

In reference to the OIG VISN-specific report, Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the Phoenix VA Health Care System (15-01818-213), all four recommendations and the report are now closed.

KEY RELATED LINKS:
Review of Alleged Mismanagement of Construction Projects at the VA Medical Center in Clarksburg, West Virginia
3/24/2017 | 15-03231-319 | Summary

Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the Phoenix VA Health Care System
2/1/2017 | 15-01818-213 | Summary

Review of Alleged Waste of Funds on a Cloud Brokerage Service Contract
1/31/2017 | 15-02189-336 | Summary

OIG SUB-CHALLENGE #4B: IMPROVING PURCHASE CARD PRACTICES (VHA, OM, AND OI&T)
Based on prior year OIG purchase card reviews and risk assessments of VA charge card programs, OIG assessed the VA purchase card program as medium risk. In FY 2017, OIG conducted a review of purchase card programs based on a Congressional request and a Hotline allegation. Each of these reviews disclosed VA inappropriately made unauthorized commitments by splitting purchases and exceeding the micro purchase limit. VA approving officials did not adequately monitor purchase card transactions that led to the misuse of purchase cards. As a result of the purchase card misuse disclosed in OIG reviews, VA employees did not protect the Government’s interests when obtaining supplies and services. VA employees have a fundamental responsibility to be effective stewards of taxpayer resources and to safeguard those resources against unauthorized commitments and improper payments.

VA’s Program Response
Estimated Resolution Timeframe: Oversight of the purchase card program is continuous.

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 Veterans benefits and services

Associated Performance Measure(s): In my work unit, steps are taken to deal with poor performers who cannot or will not improve.

FY 2017 Milestones:

Split requirements are a continuous challenge for any purchase card program. VHA Procurement has collaborated with the OM’s OIC to identify and correct incidence of split requirements.

Facility repairs are susceptible to split requirement because of their urgent nature and the difficulty in determining the final cost before using the purchase card. VHA Procurement will continue to work with Network Contracting Offices to reduce the incidence of split requirements by adding contracts for facility repair services.

Starting in April 2016, VHA substantially reduced unauthorized commitments in the prosthetic implant purchases by implementing a pre-authorization process.

In reference to the Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3 (15-03678-210), the report reviewed a one-time occurrence at Network Contracting Office 3. Service Area Office East quickly fulfilled the requirements of two of three recommendations and OIG closed the recommendations. Ratifications of unauthorized commitments (recommendation 1) are in progress. It is important to note that in 2016, during the course of OIG’s review, Network Contracting Office 3 merged with Network Contracting Office 2; Network Contracting Office 3 no longer exists. Service Area Office East reviewed the issues raised by OIG for underlying causes and found that human error due to training deficiencies was the primary cause and that staff did not deliberately intend to make improper purchases. Service Area Office East properly trained all prosthetics purchase card holders in the contracting systems and reporting requirements and removed the individual in question from a supervisory role. Additionally, Service Area Office East reconciled the actual purchase card orders to remove the mistakenly reported items and entered accurate information. Any actions that could not be specifically reconciled are resolved via the ratification process. Current processes and Service Area Office East oversight preclude the likelihood of this mistake happening in the future. Any reporting of transactions that circumvent established systems is immediately flagged by the Service Area Office for resolution. Service Area Office East’s continuous monitoring of all Network Contracting Office operations will ensure adequate oversight and accountability of Network Contracting Office internal controls.

In reference to the Review of Alleged Irregular Use of Purchase Cards by VHA’s Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia (15-01217-249), the facility completed the following actions in Fiscal Year 2017: The facility reviewed micro-purchase card transactions by Engineering Service cardholders and identified unauthorized commitments. The facility ratified requests for the unauthorized commitments. The facility established an oversight mechanism to ensure that approving officials without the required approval were assigned no more than 10 cardholders each. The facility leadership ensured that appropriate administrative action was taken for each individual who made unauthorized commitments. The VISN issued a memorandum to the facility director citing requirements for adherence to Federal and VA regulations and policies. The VISN provided training to Engineering Service card holders on not splitting purchases, procuring supplies and services without proper authority, and making purchases exceeding established dollar limits.

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SECTION III: OTHER INFORMATION

At the time of this response, OIG has not published the report, Review of Use of Non IT Funds for IT Costs.

At the time of this response, OIG has not published the report, Review of Misuse of Purchase Cards at VISN 15.

KEY RELATED LINKS:
Review of Alleged Use of Wrong VA Funds To Purchase IT Equipment
9/29/2017 | 16-00753-338 | Summary |

OIG CHALLENGE #5: INFORMATION MANAGEMENT

STRATEGIC OVERVIEW
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. FISMA requires that agencies and their affiliates, such as government contractors, develop, document, and implement an organization-wide security program for their systems and data. The FY 2016 FISMA report included 31 recommendations necessary to improve VA’s information security program. Also, OIG substantiated Hotline allegations which document the need for an improved approach to information security.

OIG SUB-CHALLENGE #5A: EFFECTIVE INFORMATION SECURITY PROGRAM AND SYSTEM SECURITY CONTROLS (OI&T)
In both FISMA work and other reviews of VA systems, 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.

Review of Alleged Irregular Use of Purchase Cards by VHA’s Engineering Service at the Carl Vinson VA Medical Center in Dublin, Georgia
6/27/2017 | 15-01217-249 | Summary |

Review of Alleged Unauthorized Commitments for Prosthetic Purchases at VA Network Contracting Office 3
6/12/2017 | 15-03678-210 | Summary |
VA’s Program Response

Estimated Resolution Timeframe: December 2017

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

Associated Strategic Goal: Manage and improve VA operations to deliver seamless and integrated support

Strategic Objective: Evolve VA IT capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees

Associated Performance Measure(s): There are no public-facing performance measures for this issue

VA is well positioned to resolve high-impact potential risks to the Department through existing Enterprise Cybersecurity Program (ECSP) initiatives, which address tactical and strategic cybersecurity-related actions. The ECSP continues to serve as VA’s approach to sustaining a robust cybersecurity ecosystem, aligned with federal policies and the evolving threat landscape. Tactically in 2015, VA developed Plans of Action (POAs) to address OIG FISMA audit findings, address additional gaps, and identify the capabilities needed to resolve the highest priority risks. The POAs are supported by a 3,000+ line item integrated master schedule that is on track to be completed by the end of CY 2017. Progress against the schedule is reported weekly to the VA Chief Information Officer. From an ongoing strategic perspective, the ECSP created eight domains to address the full spectrum of security-related capabilities, including Access Control, Identification, Authentication; Application and Software Development; Cybersecurity Training and Human Capital; Governance; Medical Cyber; Operations, Telecommunications, and Network Security; Privacy; and Security Architecture, Engineering, and Design. For each finding and domain activity, VA performs comprehensive reviews to better understand the resources required to execute the tactical and strategic activities, respectively.

VA continues to enhance its existing cybersecurity risk management strategy, which aims to improve effective reporting of security control implementation status and risks. In order to enhance the risk management strategy, VA is working to evolve its current Assessment and Authorization Case Management function, which will allow for improved oversight and consistent enforcement of compliance and status tracking. As described in the Case Manager Handbook, the Case Manager role will strengthen VA compliance by providing oversight of expiring Authority to Operate (ATO) determinations and tracking of Plans of Action and Milestone status associated to security controls. Further allocation of resources assigned to the Case Management function, in addition to enhanced reporting processes surrounding Security Control Assessments, enhanced dashboard reporting within the Knowledge Service (KS), and standardized training for system stakeholders, will allow for more consistent execution and correct reporting of the security controls by the System Owners.

In addition to enhancement of the Case Management function, VA has begun to integrate the National Institute of Standards and Technology (NIST) Risk Management Framework (RMF) with the NIST Cybersecurity Framework (CSF). Aligning CSF and RMF will provide visibility into cybersecurity risk at the system-level and enterprise-level. The RMF provides VA with the ability to analyze compliance, measure operational risk, and ultimately make risk-based determinations for an information system’s ATO. Risks to VA information systems are documented and tracked within VA’s Governance, Risk, and Compliance tool, in accordance with VA Handbook 6500.3 Assessment, Authorization,
and Continuous Monitoring of VA Information Systems. VA designed existing RMF process workflows for routinely analyzing control implementation during ATO issuance. These workflows support the risk acceptance process used by the Authorizing Official to accredit the system. VA continues to update processes within its RMF capabilities to further analyze applicable risks to VA information systems (e.g., residual, accepted, mitigated) in support of its risk management program.

VA is also internally managing cybersecurity risk consistent with federal statutes, related OMB guidance, and NIST guidelines. This capability, referred to as the OI&T Information Security Board (ISB), provides governance for enterprise information security by reinforcing the business need for effective enterprise security, in order to achieve a sustainable security capability in line with VA’s mission. The ISB approaches cybersecurity as an enterprise-wide risk management issue, and provides input to VA’s Enterprise Risk Management (ERM) framework for leadership awareness. The ISB also functions as a centralized body to elevate and make authoritative decisions on enterprise cybersecurity risk. At its core, the ISB is designed to facilitate enhanced cybersecurity performance monitoring and measurement by actively tracking VA’s progress against the M-17-25 security domains and associated FISMA metrics on an ongoing basis. Furthermore, the ISB is structured to monitor other key performance indicators related to the OIG audit and other internal and government-wide reporting requirements. Using these metrics, VA executive leadership is better able to:

- Measure the effectiveness of VA’s cybersecurity program
- Identify improvement opportunities in VA cybersecurity capabilities and processes
- Prioritize procurement and/or enhancement of cybersecurity capabilities and processes
- Make risk-informed decisions regarding the Department’s cybersecurity risk.

Cumulatively, these metrics enable OI&T leadership to make strategic decisions around identifying and mitigating security gaps. This approach allows VA to continually assess its cybersecurity posture on an annual, quarterly, and ad-hoc basis. Moving forward, VA will further enhance the use of metrics and align/tailor future metrics based on OMB guidance and the NIST CSF.

Among VA’s ongoing initiatives to monitoring security controls and VA’s environment is the continuous monitoring program, which provides awareness around VA’s information security posture, vulnerabilities, and threats to support organizational risk management. In alignment with Department of Homeland Security’s Continuous Diagnostics and Mitigation (CDM) program, VA’s continuous monitoring program is an integral part of VA’s ECSP. VA is actively working to implement CDM capabilities to include vulnerability management as part of the Operations, Telecommunications, and Network Security security domain within the ECSP.

KEY RELATED LINKS:
Review of Alleged Failure of the National Work Queue To Perform in Production
8/10/2017 | 16-01401-295 | Summary |
VA’s Federal Information Security Modernization Act Audit for Fiscal Year 2016
6/21/2017 | 16-01949-248 | Summary |
Review of Unauthorized System Interconnection at the VA Regional Office in Wichita, Kansas
4/6/2017 | 16-00376-133 | Summary |
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 2017 AFR.

### TABLE 1 - SUMMARY OF FINANCIAL STATEMENT AUDIT

<table>
<thead>
<tr>
<th>Audit Opinion</th>
<th>Unmodified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restatement</td>
<td>No</td>
</tr>
<tr>
<td>Material Weaknesses</td>
<td>Beginning Balance</td>
</tr>
<tr>
<td>IT Security Controls</td>
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<tr>
<td>Education Benefits Accrued Liability</td>
<td>1</td>
</tr>
<tr>
<td>Control Environment Surrounding the Compensation, Pension, and Burial and Education Actuarial Estimates</td>
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</tr>
<tr>
<td>Community Care Obligations, Reconciliations, and Accrued Expenses</td>
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</tr>
<tr>
<td>Financial Reporting</td>
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</tr>
<tr>
<td>CFO Organizational Structure for VA and VHA</td>
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</tr>
<tr>
<td>Loan Guarantee Model</td>
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<tr>
<td><strong>Total Material Weaknesses</strong></td>
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</tr>
</tbody>
</table>

### TABLE 2 - SUMMARY OF MANAGEMENT ASSURANCES

#### Effectiveness of Internal Control over Financial Reporting (FMFIA § 2)

<table>
<thead>
<tr>
<th>Statement of Assurance</th>
<th>Qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material Weaknesses</td>
<td>Beginning Balance</td>
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<td>Financial Reporting</td>
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<tr>
<td>Education Benefits Accrued Liability</td>
<td>1</td>
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<tr>
<td>Control Environment Surrounding the Compensation, Pension and Burial, and Education Actuarial Estimates</td>
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</tr>
<tr>
<td>Loan Guarantee Model</td>
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<tr>
<td><strong>Total Material Weaknesses</strong></td>
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</table>

#### Effectiveness of Internal Control over Operations (FMFIA § 2)

<table>
<thead>
<tr>
<th>Statement of Assurance</th>
<th>Qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material Weaknesses</td>
<td>Beginning Balance</td>
</tr>
<tr>
<td>Community Care Obligations, Reconciliations, and Accrued Expenses</td>
<td>1</td>
</tr>
<tr>
<td>CFO Organizational Structure for VA and VHA</td>
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</tr>
<tr>
<td><strong>Total Material Weaknesses</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

#### Conformance with Federal Financial Management System Requirements (FMFIA § 4)

<table>
<thead>
<tr>
<th>Statement of Assurance</th>
<th>Systems conform, except for the below non-conformance</th>
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</thead>
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<td>Non-Conformances</td>
<td>Beginning Balance</td>
</tr>
<tr>
<td>IT Security Controls</td>
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</tr>
<tr>
<td><strong>Total Non-Conformances</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>
SECTION III: OTHER INFORMATION

| Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA) |
| --- | --- | --- |
| **Agency** | **Lack of compliance noted** | **Auditor** | **Lack of compliance noted** |
| 1. System Requirements | | |
| 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: PAYMENT INTEGRITY

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. As part of VA’s commitment to report improper payments accurately, improvements were made to risk assessments in FY 2016 to better identify those programs subject to high improper payment rates and testing by ensuring a consistent application of the definition of improper payments when it comes to acquisitions. As a result, VA is reporting improper payment projections in three new programs in FY 2017 and is again reporting an increase in its overall improper payment projections.

VA ensured a thorough review of these improper payments to correctly determine which improper payments represent a loss to the Government and which are technically improper because a mistake was made during the process, even though VA received purchased services or goods. In FY 2017, VA has approximately $10.7 billion in improper payments; however, more than 92.4 percent of these payments cannot be recovered and only about $807 million, or 7.6 percent, represented a monetary loss to the Government. The budgetary impact of improper payments is discussed in detail in the Understanding VA’s Improper Payments section.

Further, since VA reports improper payments one year in arrears, actions taken to reduce improper payments in FY 2016 and FY 2017 have not been
reflected in this report. VA continues to enact specific corrective actions to remediate root causes of improper payments and strategically strengthen program integrity while ensuring Veteran access to health care and benefits. VA also successfully received concurrence from the OIG and approval from the OMB to remove four programs from reporting in FY 2017. These programs, Education - Chapter 1606, Education - Chapter 1607, VR&E, and Payroll, have consistently determined through statistically valid testing that improper payments are below the threshold requiring reporting.

Additionally, the Improper Payments Remediation and Oversight Office (IPRO) is leading the “Seek to Prevent Fraud, Waste, and Abuse” (STOP FWA) effort to improve the identification and prevention of fraud, waste, and abuse at VA. This initiative will ultimately reduce VA’s improper payments that result in a loss to the Government and will be discussed in Section D, Fraud Reduction Report. VA continues to leverage the executive-level IPERA Governing Board to ensure collaboration and awareness of improper payment challenges, provide oversight of program activities to address vulnerabilities in programs, implement effective corrective actions, and track issues to resolution. The requirements to address the Fraud Reduction and Data Analytics Act of 2015 have also been incorporated into policy.

In FY 2016, VA issued $186.9 billion in diverse payments, of which $163.2 billion were subject to IPERA processes for measuring improper payments compliance. The amount of disbursements subject to IPERA review increased by more than $4.3 billion from FY 2016 to 2017, approximately a 3 percent increase due primarily to increases in VBA program outlays.
UNDERSTANDING VA’S IMPROPER PAYMENTS

Although VA has reported a significant increase in improper payments, many of these payments may not represent an actual monetary loss to the Government. For instance, payments that are improper due to insufficient documentation or an underpayment, do not result in an amount to collect and, therefore, have no related budgetary impact. For FY 2017, there are $9.9 billion, or 92.4 percent, of projected improper payments that do not represent a monetary loss.

An example of an improper payment that does not represent a monetary loss would be if VA pays a bill for a Veteran that received care in the community and the bill is paid at the correct Medicare rate; this payment is still considered improper because VA does not have the authority to purchase care in the community without a Federal Acquisition Regulation (FAR) compliant contract. In FY 2017, VA Community Care (VACC) and Purchased Long Term Services and Supports (PLTSS) programs identified approximately $6 billion, or 56 percent, of VA’s total improper payments due to non-compliance with contract requirements. These improper payments purchased Veteran care (1) in a community rehabilitation hospital, psychiatric facility, or long-term acute care hospital; (2) in the community for required care and services not available within VA; and (3) at home and in community long-term care facilities. These payments were necessary to provide health care for Veterans, but were deemed improper because they were not made in accordance with FAR requirements. VA has requested legislative authority to purchase necessary care in the community without following FAR requirements. Enactment of this legislation would greatly reduce VA’s improper payments in its community care programs.

An actual loss can be characterized as an overpayment, duplicate payment, payment to
the wrong person, or payment when the supplies or services were not received. Only in these instances, can the VA potentially pursue collection. For FY 2017, these monetary losses are projected to be $807, million or 7.6 percent. For those payments that represent a loss to VA, the VA is committed to identifying, recovering, and reducing these improper payments unless specific legislation exists that prevents VA from pursuing recovery.

In order to provide an accurate representation of actual loss, the following table summarizes VA’s improper payments results for FY 2017, which report on FY 2016 payments, for only those improper payments that represent a monetary loss to the Government. Of the 13 programs listed, 4 are new programs that were identified as being at risk for significant improper payments in FY 2016 and tested for the first time in FY 2017: VA Community Care Choice, Prosthetics, Communications Utilities and Other Rents (CUOR), and Medical Care Contracts and Agreements (MCAA).³

The table below reports both the actual monetary loss found during testing and the projected loss based on the statistical sample. The projected amounts do not represent losses that the VA can recover because the projected is based on a statistical calculation and does not identify individual recoverable payments.

³ VA Community Care has been included in prior years’ testing of improper payments. In FY 2017, the Choice program was added to the VA Community Care payment universe.

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Actual Monetary Loss ($)</th>
<th>Projected Monetary Loss ($)</th>
<th>IP % Monetary Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Travel</td>
<td>0.164</td>
<td>81.93</td>
<td>9.21</td>
</tr>
<tr>
<td>CHAMPVA</td>
<td>0.047</td>
<td>17.82</td>
<td>1.43</td>
</tr>
<tr>
<td>VACC</td>
<td>0.821</td>
<td>316.09</td>
<td>5.26</td>
</tr>
<tr>
<td>PLTSS</td>
<td>0.005</td>
<td>8.44</td>
<td>0.45</td>
</tr>
<tr>
<td>State Home</td>
<td>0.094</td>
<td>0.96</td>
<td>0.08</td>
</tr>
<tr>
<td>Supplies and Materials</td>
<td>0.002</td>
<td>8.09</td>
<td>0.32</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>0.078</td>
<td>57.04</td>
<td>2.36</td>
</tr>
<tr>
<td>MCCA</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>CUOR</td>
<td>0.0000003</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Compensation</td>
<td>0.007</td>
<td>276.03</td>
<td>0.41</td>
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<tr>
<td>Pension</td>
<td>0.005</td>
<td>24.57</td>
<td>0.44</td>
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<tr>
<td>Education – Ch. 33</td>
<td>0.0002</td>
<td>16.16</td>
<td>0.14</td>
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<tr>
<td>Disaster Relief Act – HS</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Total</td>
<td><strong>1.22</strong></td>
<td><strong>807.14</strong></td>
<td><strong>0.78</strong></td>
</tr>
</tbody>
</table>

Notes to Table:
(1) In FY 2017, VA tested and reported on payments made in FY 2016. These payments were made directly by VA using federal money.
(2) The improper payment percentage for monetary loss is calculated by dividing the projected monetary loss amount by the FY 2017 outlays reported in the FY 2017 Total IP by Program table below.
In FY 2017, VA identified $103.2 billion of payments that were subject to IPERA testing for measuring improper payments compliance. Of this amount, testing identified $10.7 billion of statistically projected improper payments.

**FY 2017 Proper vs. Improper Payments**

($ in billions)

- **PROPER,** $92.54 (90%)
- **IMPROPER,** $10.66 (10%)

In order to comply with OMB Circular A-136, *Financial Reporting Requirements*, dated August 15, 2017, the following table summarizes VA’s total improper payments in FY 2017. This table displays all improper payments, including those that are considered technically improper and those that represent an actual loss. As stated above, there are four new programs listed in the table that were identified for testing. In FY 2017, VA requested relief from the annual reporting requirements for four programs: Education - Chapter 1606, Education - Chapter 1607, VR&E, and Payroll. These four programs documented at least two consecutive years of improper payments that were below the statutory threshold as required by OMB Circular A-123, Appendix C. This request for reporting relief was submitted to OMB and VA obtained approval in August 2017.

Furthermore, to meet the requirements outlined in OMB Circular A-136, *Financial Reporting Requirements*, dated August 15, 2017, all improper payment information provided from this section forward will represent all improper payments, both monetary loss and technically improper.

More detailed information on VA’s improper payments, including historical improper payment data, can be found on PaymentAccuracy.gov.
### FY 2017 TOTAL IMPROPER PAYMENTS (IP) BY PROGRAM ($ in millions)\(^{(1)}\)

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>2017 Outlays</th>
<th>2017 Proper %</th>
<th>2017 Proper $</th>
<th>2017 IP Rate (based on 2016 actual data)</th>
<th>2017 IP Amount (based on 2016 actual data)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Over Payment</td>
<td>Under Payment</td>
</tr>
<tr>
<td>Beneficiary Travel</td>
<td>889.86</td>
<td>74.85</td>
<td>666.10</td>
<td>25.10</td>
<td>0.05</td>
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<tr>
<td>CHAMPVA</td>
<td>1,247.49</td>
<td>94.39</td>
<td>1,177.50</td>
<td>1.43</td>
<td>4.18</td>
</tr>
<tr>
<td>VA Community Care</td>
<td>5,628.87</td>
<td>6.60</td>
<td>371.31</td>
<td>93.35</td>
<td>0.05</td>
</tr>
<tr>
<td>Purchased Long Term Services and Supports</td>
<td>1,890.46</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
<td>0.00</td>
</tr>
<tr>
<td>State Home Per Diem Grants</td>
<td>1,188.83</td>
<td>98.69</td>
<td>1,173.22</td>
<td>1.29</td>
<td>0.03</td>
</tr>
<tr>
<td>Supplies and Materials</td>
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<td>81.24</td>
<td>2,077.06</td>
<td>18.76</td>
<td>0.01</td>
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<tr>
<td>Prosthetics</td>
<td>2,415.92</td>
<td>40.05</td>
<td>967.59</td>
<td>59.88</td>
<td>0.07</td>
</tr>
<tr>
<td>Medical Care Contracts and Agreements</td>
<td>947.27</td>
<td>83.39</td>
<td>789.96</td>
<td>16.60</td>
<td>0.003</td>
</tr>
<tr>
<td>Communications, Utilities, and Other Rent</td>
<td>1,444.21</td>
<td>75.58</td>
<td>1,091.47</td>
<td>24.42</td>
<td>0.00</td>
</tr>
<tr>
<td>Compensation</td>
<td>67,696.73</td>
<td>99.33</td>
<td>67,240.56</td>
<td>0.41</td>
<td>0.27</td>
</tr>
<tr>
<td>Pension</td>
<td>5,542.50</td>
<td>97.37</td>
<td>5,396.60</td>
<td>2.63</td>
<td>0.01</td>
</tr>
<tr>
<td>VR&amp;E(^{(2)})</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education – Chapter 33</td>
<td>11,719.64</td>
<td>98.58</td>
<td>11,553.48</td>
<td>1.42</td>
<td>0.00</td>
</tr>
<tr>
<td>Education – Chapter 1606(^{(2)})</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education – Chapter 1607(^{(2)})</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disaster Relief Act – HS</td>
<td>34.84</td>
<td>99.92</td>
<td>34.81</td>
<td>0.08</td>
<td>0.00</td>
</tr>
<tr>
<td>Payroll(^{(2)})</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>103,203.47</strong></td>
<td><strong>89.67</strong></td>
<td><strong>92,539.68</strong></td>
<td><strong>10.10</strong></td>
<td><strong>0.23</strong></td>
</tr>
</tbody>
</table>

**Notes:**

1. In FY 2017, VA tested and reported on payments made in FY 2016. These payments were made directly by VA using federal money.
2. In FY 2017, VA requested relief from the annual reporting requirements for four programs: Education - Chapter 1606, Education - Chapter 1607, VR&E, and Payroll. These four programs documented at least two consecutive years of improper payments that were below the statutory threshold as required by OMB Circular A-123, Appendix C. OMB approved the request for reporting relief on August 8, 2017.
### ROOT CAUSE OF IMPROPER PAYMENTS FOR PROGRAMS BELOW OMB THRESHOLD

The below tables summarize the dollar amounts associated with each root cause for those programs that are below the OMB threshold for significant improper payments.

#### Table: Improper Payment Root Cause Programs Below OMB Threshold ($ in millions)

<table>
<thead>
<tr>
<th>Reason for Improper Payment</th>
<th>State Home Per Diem Grants</th>
<th>Disaster Relief Act - HS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Over Payment</td>
<td>Under Payment</td>
</tr>
<tr>
<td>Program Design or Structural Issues</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inability to Authenticate Eligibility</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Failure to Verify:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death Data</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Financial Data</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Excluded-Party Data</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prisoner Data</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Eligibility Data</td>
<td>0.01</td>
<td>-</td>
</tr>
<tr>
<td>Administrative or Process Error Made By:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Agency</td>
<td>11.11</td>
<td>0.01</td>
</tr>
<tr>
<td>State or Local Agency</td>
<td>0.91</td>
<td>0.29</td>
</tr>
<tr>
<td>Other Party</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>3.28</td>
<td>-</td>
</tr>
<tr>
<td>Other Reason (explain)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>15.31</strong></td>
<td><strong>0.30</strong></td>
</tr>
</tbody>
</table>

**Notes:**
(1) In FY 2017, VA tested and reported on payments made in FY 2016.
(2) State Home Per Diem Grants expects to reduce improper payments by 0.01 percentage points, to 1.30 percent in FY 2018.
(3) Disaster Relief - HS expects to reduce improper payments by 0.01 percentage points, to 0.07 percent in FY 2018.

### ROOT CAUSE AND CORRECTIVE ACTION PLAN FOR PROGRAMS ABOVE OMB THRESHOLD

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 and monitor targets. In FY 2017, VA strengthened programs’ CAPs by performing deep-dive analysis of past corrective actions to ensure that tasks were measurable, timely, and effective. The analysis verified the effectiveness of measurements with quantitative and qualitative analysis and established several cross-discipline working groups to address systemic acquisition errors. Lessons learned informed creation of corrective...
actions in FY 2017 to increase effectiveness. Of the 13 VA programs identified as high-risk, 11 programs exceeded the statutory thresholds for error rates and/or amounts of improper payments and require CAPs. For each program that met the OMB threshold for significant improper payments, the subsequent graph depicts the over and/or under payments for each root cause and a table presents the corrective action(s) for each identified root cause. Additionally, OMB has identified three VA programs as high priority, defined as having more than $750 million in annual estimated improper payments. These programs, VACC, PLTSS, and Compensation, are required to perform additional supplemental measures to drive the reduction of improper payments. Details on these supplemental measures can be found on PaymentAccuracy.gov.

**VETERANS HEALTH ADMINISTRATION**

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

**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 may also be provided in limited circumstances but is not to exceed 50 percent of the amount allowed for government employees. The Beneficiary Travel Program (BTP) is discretionary in nature with funding coming from the yearly VA health care medical care services appropriation. The below table represents the OMB root causes identified during testing.

| Insufficient Documentation to Determine | $131.13 |
| Medical Necessity                     | $9.14  |
| Administrative or Process Error Made by: | $51.37 | $0.40 |
| Failure to Verify: Other Eligibility Data | $31.72 |
| **Total**                              | **$223.35** | **$0.40** |

VHA Member Services will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of these actions, VA expects to reduce improper payments by 0.05 percentage points to 25.10 in FY 2018. The Acting Deputy Under Secretary for Health for Operations Management and the Interim Executive Director of Member Services are 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, system-wide initiative to accelerate care to Veterans. Each VAMC is either enhancing their clinic capacity to help Veterans get care sooner, increasing the care VA acquires in the community.

### BENEFICIARY TRAVEL CORRECTIVE ACTION PLANS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>The new Member Services’ Compliance and Internal Controls Program Office (MS CICPO) assisted in creating additional internal controls for its programs, which included Beneficiary Travel. MS CICPO will establish an independent testing program that will bypass facility provided documentation. Such access will ensure accuracy of claims processing, address deductible issues and missing claim date information, and allow for expanded special mode account selection options, which reduces administrative and process errors.</td>
<td>Completed August 2017</td>
</tr>
<tr>
<td>Failure to Verify Other Eligibility Data</td>
<td>The Beneficiary Travel Self-Service System (BTSSS), COTS, Software-as-a-Service solution, will provide a customized and enhanced tool to streamline claims; automate eligibility determinations, payment processing, and detection and prevention of improper payments; and enhance reporting and auditing capabilities. Scheduled testing of BTSSS began at test sites in September 2017. Once test sites have proven successful, implementation will be scheduled throughout VA.</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>In December 2016, 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 and copay tests or those eligible who wish to have their deductible requirement waived. The Web-based hosted solution VetRide will further improve payment tracking for all Veterans Transportation Service locations by tracking Veteran trips with associated eligibility data, which prevents improper claims being paid and allows for reconciliation of special mode transportation trips against contracted rates and targeted invoice tracking. National deployment to 81 participating Veteran Transportation Services sites was completed in August 2017. As of June 2017, 64 sites are operational. An additional 17 VetRide sites will be transitioned in</td>
<td>Completed January 2017</td>
</tr>
<tr>
<td></td>
<td>Administrative Computerized Patient Record System (CPRS) templates were developed to enhance the accuracy of claims processing. Reminder dialogs are used to initiate the clinical request, and the approval is issued with a response dialog that allows travel staff to reply to clinical staff in confirmation of approval or denial related to patient travel. Response dialogs leverage branch logic to ensure clinical requests for patient travel are accurate. As of July 2017, test sites have started volunteer use of both dialogs. These capabilities address waiver, deductible, and dashboard issues and will reduce medical necessity as well as clinical administrative and process errors.</td>
<td>Completed August 2017</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>The CPRS reminder dialog templates were developed and released to enhance the accuracy of claims processing. In May 2017, the revised clinical templates were approved for testing at various locations. The revised clinical templates will reduce medical necessity errors resulting from lack of medical justification to support the payment.</td>
<td>Completed May 2017</td>
</tr>
</tbody>
</table>
### CHOMPVA

CHAMPVA is a health care benefits program in which the VA shares the cost of covered health care services and supplies usually as a secondary payer or payer of last resort with certain eligible beneficiaries. The below table represents the OMB root causes identified during testing.

#### CHAMPVA - FY 2017 OMB Root Causes

<table>
<thead>
<tr>
<th>Category</th>
<th>Overpayments, $</th>
<th>Underpayments, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin. or Process Error Made by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Agency</td>
<td>$13.61</td>
<td>$52.17</td>
</tr>
<tr>
<td>Failure to Verify: Other Eligibility Data</td>
<td>$2.09</td>
<td></td>
</tr>
<tr>
<td>Program Design or Structural Issue</td>
<td>$2.12</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$17.82</td>
<td>$52.17</td>
</tr>
</tbody>
</table>

The OCC will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of the below actions, VHA expects to reduce improper payments by 0.01 percentage points to 5.60 percent in FY 2018.

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.
SECTION III: OTHER INFORMATION

CHAMPVA CORRECTIVE ACTION PLANS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td><strong>Continuation of the IT project to streamline vendor selection, lower the threshold for claims to be routed to a High Dollar Review Queue, eliminate manual work arounds for reopened claims, and develop other enhancements to improve payment accuracy.</strong>&lt;br&gt;<strong>Implement a daily prepayment review on all claims paid over $75,000 to identify major processing issues more timely and facilitate sustainment training for individual staff.</strong>&lt;br&gt;<strong>Lower the threshold for the over-reimbursement review queue from $75,000 to $50,000.</strong>&lt;br&gt;<strong>In September 2017, a quarterly reporting process was developed that allows for more targeted reviews of Sole Community Hospitals’ vendor files to review for critical changes prior to staff reviews, avoiding vendor file selection errors.</strong>&lt;br&gt;<strong>Review existing vendor desk procedures for the Health Care Reimbursement staff, make necessary updates, and conduct refresher training for all voucher examiners, leads, and queue clearers for the critical connection between payment accuracy and proper vendor and facility type selection.</strong></td>
<td>March 2018&lt;br&gt;September 2018&lt;br&gt;September 2018&lt;br&gt;September 2018&lt;br&gt;September 2018</td>
</tr>
<tr>
<td>Program Design or Structural Issue</td>
<td><strong>Implement a daily post payment review of approximately 20 percent of each employee's workload.</strong></td>
<td>September 2018</td>
</tr>
<tr>
<td>Failure to Verify Other Eligibility Data</td>
<td><strong>Since 2015, data matches with CMS and Tricare are being utilized to detect changes in beneficiary status that could affect CHAMPVA eligibility.</strong></td>
<td>September 2018</td>
</tr>
</tbody>
</table>

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. The below table represents the OMB root causes identified during testing.

![VA Community Care - FY 2017 OMB Root Causes ($ in Millions)](chart)

**Overpayment, $5,254.76**  **Underpayments, $2.79**

Total $5,254.76 **$2.79**

Department of Veterans Affairs – FY 2017 Agency Financial Report
SECTION III: OTHER INFORMATION

OCC will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of these actions, VA expects to reduce improper payments by 1.00 percentage points to 92.40 percent in FY 2018. 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.

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>Remove the restriction for VHA to have medical records prior to payment.</td>
<td>Completed January 2017</td>
</tr>
<tr>
<td></td>
<td>A legislation change moved VHA from the secondary payer to primary payer. A Revenue Utilization Review (RUR) for Veterans with Other Health Insurance (OHI) is no longer required.</td>
<td>Completed April 2017</td>
</tr>
<tr>
<td></td>
<td>Finalize duplicate payment mitigation strategies – including implementing Program Integrity Tool (PIT) duplicate review prepayment for all expedited and Choice payments.</td>
<td>December 2017</td>
</tr>
<tr>
<td></td>
<td>Transition Choice claims to FSC’s Plexis Claims Manager (PCM), which is an adjudication system that will apply pricing and industry standard claim edit checks</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td>Ensure contractor compliance with the use of Network Providers or Provider Agreements, and/or modify contracts to align with industry standards and reasonable, executable processes.</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td>Develop and implement a plan to ensure all non-VA physician-administered drugs (other than orally administered) are paid in accordance with the Code of Federal Regulations.</td>
<td>February 2018</td>
</tr>
<tr>
<td></td>
<td>Develop and implement guidance and SOP regarding adherence to FBCS scrubber edits and proper processes to follow when scrubber edits do not apply to the claim.</td>
<td>April 2018</td>
</tr>
<tr>
<td></td>
<td>Implement business rules into the PIT and FBCS to proactively identify improper payments in a prepayment stage.</td>
<td>May 2018</td>
</tr>
<tr>
<td></td>
<td>Obtain full compliance adopting the following Medicare schedules, when applicable: -Durable Medical Equipment, Prosthetics/Orthodontics, and Supplies -Hospital Outpatient Critical Access Hospital -Skilled Nursing Facility -Rural Health Clinic -Federally Qualified Health Center -Community Mental Health Center</td>
<td>June 2018</td>
</tr>
<tr>
<td></td>
<td>Define the process to purchase care consistent with FAR requirements for individual authorizations greater than $10,000. Decrease the number of non-contract authorization payments issued under 38 U.S.C. 1703 and increase the amount of non-VA health care services purchased through FAR-based contracts.</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>Define the process to purchase care consistent with VA Acquisition Regulations (VAAR) requirements for individual authorizations less than $10,000 and increase the percentage of VAAR compliant individual authorizations under $10,000 to purchase care in the community with the appropriate delegation of authority.</td>
<td>September 2018</td>
</tr>
<tr>
<td>Failure to Verify Other Eligibility Data</td>
<td>Office of Clinical Integration (CI) will review and update (as needed) all pertinent training materials and advise field of the same.</td>
<td>March 2018</td>
</tr>
</tbody>
</table>
SECTION III: OTHER INFORMATION

### IMPROPER PAYMENT CATEGORY

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>Implement a process to validate that payments made using bulk payment processes are not duplicates of prior payments. Implement a single repository for all Choice claims to check duplicate prepayments and aide internal controls and auditing functions. CI will review training material and guidance to the field for referral to the Choice program through the contractor portal (10-0386, eligibility documentation, referral process flows and SOPs, etc.), make updates as needed, and reinforce the field.</td>
<td>December 2017, April 2018</td>
</tr>
</tbody>
</table>

### 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 health care 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. The below table represents the OMB root causes identified during testing.

#### Purchase Long Term Services & Supports - FY 2017 OMB Root Causes

($ in millions)

- Overpayments, $1,890.46
- Underpayments, $0

| Insufficient Documentation to Determine       | $177.55 |
| Administrative or Process Error Made by: Federal Agency | $930.49 |
| Program Design or Structural Issue           | $782.43 |
| Total                                       | $1,890.46 |

GEC will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of these actions, VA expects to reduce improper payments by 0.10 percentage points to 99.90 percent in FY 2018. The GEC Chief Consultant is accountable for ensuring execution of the corrective action plans.
### PURCHASED LONG-TERM SERVICES AND SUPPORTS CORRECTIVE ACTION PLANS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>Conducted field training on timely and accurate contract renewals to ensure correct authorizations were established and continued to be featured once each quarter on a monthly national call.</td>
<td>Completed September 2017</td>
</tr>
<tr>
<td></td>
<td>VHA had a supplemental measure to increase the number of FAR compliant contracts for Community Nursing Home and Inpatient Hospice care to 85 percent by September 30, 2017. As of July 2017, 78 percent of contracts (Basic Ordering Agreements [BOA]) were signed by Contracting Officers; however, these payments remain improper because order officer delegations were not established as required. VHA has pilots in two VISNs, working on the development and implementation for converting BOAs to Indefinite Delivery, Indefinite Quantity FAR-compliant contracts.</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>Define the process to purchase care consistent with FAR requirements for individual authorizations greater than $10,000. Decrease the number of non-contract authorization payments issued under 38 U.S.C. § 1703 and increase the amount of non-VA health care services purchased through FAR-based contracts.</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>Define the process to purchase care consistent with VAAR requirements for individual authorizations less than $10,000 and increase the percentage of VAAR compliant individual authorizations less than $10,000 to purchase care in the community with the appropriate delegation of authority.</td>
<td>September 2018</td>
</tr>
<tr>
<td>Program Design or Structural Issue</td>
<td>VHA has provided guidance for cost estimates for hospice care, improving the accuracy of authorizations.</td>
<td>Completed September 2017</td>
</tr>
<tr>
<td></td>
<td>VHA has provided technical assistance to VAMCs that have converted skilled home care authorizations to the Medicare Prospective Payment System (PPS). VHA has clarified the types of skilled home care authorizations that are appropriate for Medicare PPS. VHA has provided guidance to VAMCs on the use of Choice provider agreements for skilled home care.</td>
<td>September 2018</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>Issue memorandum to the IPERA VISN Points of Contact (POCs) listing their responsibilities to respond to IPERA requirements. For example, the memo will notify VISN POCs of their responsibility to promptly distribute samples to stations upon receiving; upload supporting documentation to the VHA SharePoint in accordance with requested due date and in a proper filename format; review supporting documentation for completeness, using the document checklist as a reference; respond to follow-up requests from VHA in a timely manner; and provide complete and thoughtful responses to concurrence requests in a timely manner.</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td>Define and revise management process for resolving Purchased Long Term Services and Supports audit findings for lack of supporting documentation.</td>
<td>September 2018</td>
</tr>
</tbody>
</table>

### SUPPLIES AND MATERIALS

Supplies and materials includes those acquired by formal contract or other form of purchase that are ordinarily consumed or expended within one-year after they are put into use, converted in the process of construction or manufacturing, or used to form a minor part of equipment or fixed property or other property not separately identified in the asset accounts. The below table represents the OMB root causes identified during testing.
VHA OF and the VHA Procurement and Logistics Office (P&LO) will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of the below actions, VHA expects to reduce improper payments by 0.01 percentage points to 18.75 percent in 2018. The Chief Procurement and Logistics Officer is accountable for ensuring execution of the corrective action plans.

### SUPPLIES AND MATERIALS CORRECTIVE ACTIONS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>VHA will work closely with the VA National Acquisition Center (NAC) and Strategic Acquisition Center (SAC) to document internal controls and ways to verify line item pricing on national contracts for IPERA testing.</td>
<td>September 2018</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>VHA will issue a memorandum to the IPERA VISN POCs listing their responsibilities to respond to IPERA requirements. For example, the memo will notify VISN POCs of their responsibility to promptly distribute samples to stations upon receiving; upload supporting documentation to the VHA SharePoint in a timely manner and proper filename format; review supporting documentation for completeness, using the document checklist as a reference; respond to follow-up requests from the IPERA office; and provide complete responses to concurrence requests in a timely manner. VHA will work closely with the VHA Consolidated Mail Out Pharmacy (CMOP) to obtain USPS/UPS tracking numbers to confirm receipt and the VA NAC to obtain line item pricing to verify amount paid. VHA P&amp;LO personnel will review contracted payments and proposed acquisition findings as subject matter experts to determine appropriate payment determination. P&amp;LO will also assist with updating test plans and explore best practices and corrective actions to remediate identified errors. VHA P&amp;LO will assist in providing the delegation of authority for purchase card payments when not readily available by the field.</td>
<td>September 2018</td>
</tr>
</tbody>
</table>

**PROSTHETICS**

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. This was...
a new program identified as being at risk of significant improper payments in FY 2016 and tested for the first time in FY 2017. The below table represents the OMB root causes identified during testing.

<table>
<thead>
<tr>
<th>Administrative or Process Error Made by: Federal Agency</th>
<th>Insufficient Documentation to Determine</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overpayments, $1,446.61</td>
<td>$764.74</td>
<td>$1,446.61</td>
</tr>
<tr>
<td>Underpayments, $1.72</td>
<td>$681.87</td>
<td>$1.72</td>
</tr>
<tr>
<td>Total</td>
<td>$1,446.61</td>
<td>$1.72</td>
</tr>
</tbody>
</table>

The National Program Office for Prosthetic and Sensory Aids Service (PSAS) will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of the below actions, VHA expects to reduce improper payments by 0.15 percentage points to 59.80 percent in 2018. The National Program Director for PSAS is accountable for ensuring execution of the corrective action plans.

**PROSTHETICS CORRECTIVE ACTIONS**

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>PSAS Program Office created and implemented a pre- and post-surgical PSAS consult for the field. This enables the clinical staff member to communicate to PSAS on their implant needs for an upcoming procedure, thus allowing for PSAS to communicate to the vendor and contracting on the specific surgical implants needed for surgery resulting in a drastic decrease of unauthorized commitments. Additionally, the use of the post-surgical PSAS consult is used to confirm the quantity/type of surgical implants used during the procedure. This effort has significantly reduced the quantity of unauthorized commitments and improved accountability of what was requested, implanted, and paid. Pre- and post-surgical consults were pushed to the field in April 2016 with improved compliance in FY 2017.</td>
<td>Completed September 2017</td>
</tr>
<tr>
<td></td>
<td>Additional efforts to streamline the implant ordering process for surgical implant contracts is being addressed by coordinating efforts to ensure timely access to services and unburden VA providers requesting PSAS items. VA is working towards delegating 8123 authority to the Under Secretary for Health and implement ordering official designation for purchasing agents in PSAS. This will allow for clinical staff or designee to verbally request implants from vendors and PSAS staff to pay for those devices locally over $3,500.</td>
<td>January 2018</td>
</tr>
</tbody>
</table>
SECTION III: OTHER INFORMATION

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>VHA will work closely with the VA NAC to obtain national contracts when referenced in purchase orders.</td>
<td>September 2018</td>
<td></td>
</tr>
<tr>
<td>The VHA P&amp;LO will provide training to Contracting Officers on the IPERA contracting testing guidance so that they can avoid mistakes that lead to improper payments.</td>
<td>October 2018</td>
<td></td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>Starting June 2017, the PSAS National Program Office has provided an additional level of quality assurance efforts to support local field efforts with meeting suspense dates and expectations for documentation uploads. The National Program Office continues to assist the IPERA review team with the retrieval of supporting documentation and uploading of necessary documents to review for proper payments. The National Program Office designated a team member to review samples alongside the IPERA review team to identify any issues or concerns needing to be addressed at a national level. PSAS will work with VISN Purchase Card Managers to provide required purchased card supporting documentation to include VA Forms 0242 and reconciliation reports for the 2018 IPERA review.</td>
<td>Completed August 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Completed September 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>September 2018</td>
</tr>
</tbody>
</table>

MEDICAL CARE CONTRACTS AND AGREEMENTS

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. This was a new program identified as being at risk of significant improper payments in FY 2016 and tested for the first time in FY 2017. The below table represents the OMB root causes identified during testing.

VHA OF and VHA P&LO will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of the below actions, VHA expects to reduce improper payments by 0.11 percentage points to 16.50 percent in 2018. The Chief Procurement and Logistics Officer is accountable for ensuring execution of the corrective action plans.

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MEDICAL CARE CONTRACTS AND AGREEMENTS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>VHA will work closely with P&amp;LO, the VA NAC, and the VA SAC to establish ways to verify line item pricing on VHA and national contracts for IPERA testing.</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>The VHA P&amp;LO will provide training to Contracting Officers on the IPERA contracting testing guidance so that they can avoid mistakes that lead to improper payments.</td>
<td>October 2018</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>VHA will issue a memorandum to the IPERA VISN POCs listing their responsibilities to respond to IPERA requirements. For example, the memo will notify VISN POCs of their responsibility to promptly distribute samples to stations upon receiving; upload supporting documentation to the VHA SharePoint in a timely manner and proper filename format; review supporting documentation for completeness, using the document checklist as a reference; respond to follow-up requests from the IPERA office; and provide complete responses to concurrence requests in a timely manner.</td>
<td>January 2018</td>
</tr>
<tr>
<td></td>
<td>VHA P&amp;LO personnel will review contracted payments and proposed acquisition findings as subject matter experts to determine appropriate payment determination. P&amp;LO will also assist with updating test plans and explore best practices and corrective actions to remediate identified errors.</td>
<td>September 2018</td>
</tr>
</tbody>
</table>

COMMUNICATION, UTILITIES, AND OTHER RENT

Communications, Utilities, and Other Rent funds payments for use of communications, utility services, and charges for possession and use of land, structures, or equipment owned by others. This was a new program identified as being at risk of significant improper payments in FY 2016 and tested for the first time in FY 2017. The below table represents the OMB root causes identified during testing.

Communications, Utilities, and Other Rents- FY 2017 OMB Root Causes

($ in millions)

- Insufficient Documentation to Determine: $7.08
- Administrative or Process Error Made by Federal Agency: $345.66
- Total: $352.47

Overpayments, $352.74  Underpayments, $0
SECTION III: OTHER INFORMATION

VHA OF and VHA P&LO will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of the below actions, VHA expects to reduce improper payments by 0.02 percentage points to 24.40 percent in 2018. The ADUSH for Administrative Operations is accountable for ensuring execution of the corrective action plans.

COMMUNICATIONS, UTILITIES, AND OTHER RENT

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>For utilities over the simplified acquisition threshold of $150,000, local fiscal offices will review new and existing VA Forms 1358, Obligation or Change in Obligation, and require facilities to give evidence that FAR Part 41 (Utilities) has been complied with. Fiscal offices will not establish new 1358s without complying with FAR Part 41. Program offices utilizing non-compliant 1358s will have one month to submit requirements to Network contracting office to establish a contract. Contracting offices will have three months to attempt to award a contract. OM will update VA 1358 policy as needed to ensure the success of this corrective action.</td>
<td>September 2018</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>VHA will issue a memorandum to the IPERA VISN POCs listing their responsibilities to respond to IPERA requirements. For example, the memo will notify VISN POCs of their responsibility to promptly distribute samples to stations upon receiving; upload supporting documentation to the VHA SharePoint in a timely manner and proper filename format; review supporting documentation for completeness, using the document checklist as a reference; respond to follow-up requests from the IPERA office; and provide complete responses to concurrence requests in a timely manner.</td>
<td>January 2018</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>VHA P&amp;LO personnel will review contracted payments and proposed acquisition findings as subject matter experts to determine appropriate payment determination. P&amp;LO will also assist with updating test plans and explore best practices and corrective actions to remediate identified errors.</td>
<td>September 2018</td>
</tr>
</tbody>
</table>

VETERANS BENEFITS ADMINISTRATION

Presented below are the corrective actions for the three VBA programs that exceeded the statutory thresholds for error rates and/or amounts of improper payments.

COMPENSATION

The Compensation program 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. The below table represents the OMB root causes identified during testing.
**SECTION III: OTHER INFORMATION**

**Compensation - FY 2017 OMB Root Causes**
($ in Millions)

- Overpayments, $276.03
- Underpayments, $180.14

<table>
<thead>
<tr>
<th>Category</th>
<th>Corrective Action</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>$27.71</td>
<td></td>
</tr>
<tr>
<td>Administrative or Process Error Made by: Federal Agency</td>
<td>$238.09 (Underpayments $180.14)</td>
<td>March 2018</td>
</tr>
<tr>
<td>Failure to Verify: Other Eligibility Data</td>
<td>$10.23</td>
<td>September 2018</td>
</tr>
<tr>
<td>Total</td>
<td>$276.03 (Overpayments $276.03) and Underpayments $180.14</td>
<td></td>
</tr>
</tbody>
</table>

The Compensation program is implementing the following corrective actions to ensure greater compliance with IPERA. With the implementation of these actions, VA expects to reduce improper payments by 0.01 percentage points to 0.66 percent in FY 2018. The Deputy Director of Policy and Procedures for Compensation Service, and Assistant Deputy Under Secretary for Field Operations are the responsible accountable officials for improper payment reduction targets.

**COMPENSATION CORRECTIVE ACTION PLANS**

<table>
<thead>
<tr>
<th>Improper Payment Category</th>
<th>Corrective Action</th>
<th>Target Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>VBMS has scoped enhancements to automate and streamline due process notification letters to Veterans for proposed rating reduction. Additionally, implementation of Enhanced Non-Permanent Award Displace will create subsequent ratings where temporary total evaluation and individual unemployability entitlement have ended. These enhancements will minimize improper payments to Veterans.</td>
<td>March 2018</td>
</tr>
<tr>
<td>Failure to Verify Other Eligibility Data</td>
<td>Consistency studies will assess and train regional office (RO) employees on errors found during IPERA testing and quality reviews. Participants in the consistency study must achieve 100 percent on the retest in order to bypass remedial training and a posttest. 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.</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>The continued use of RBPS as an intermediate automated process for suitable dependency claims has resulted in an ongoing increase in acceptance of dependency claims near the 65 percent rate. Functionality developed in RBPS allows the Veteran to immediately add, remove, and change the status of certain dependents. This system allows for more timely adjustment to Veterans’ awards.</td>
<td>September 2018</td>
</tr>
</tbody>
</table>
## SECTION III: OTHER INFORMATION

### IMPROPER PAYMENT CATEGORY

<table>
<thead>
<tr>
<th>纠正措施</th>
<th>目标完成日期</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and update procedural guidance via Knowledge Management manual throughout the fiscal year to ensure RO employees will have the most current procedures.</td>
<td>September 2018</td>
</tr>
<tr>
<td>Consistency studies will assess and train RO employees on errors found during IPERA testing and quality reviews. Participants in the consistency study must achieve 100 percent on the pretest in order to bypass remedial training and a posttest. This will enable employees to recognize the correct actions/procedures to take when processing claims for service-connected disability benefits and paying retroactive awards for dependents when there is an increased rating evaluation.</td>
<td>September 2018</td>
</tr>
</tbody>
</table>

在VA的FY 2015 AFR中，Compensation报告了13.611亿美元的不当支付。作为结果，OMB将Compensation指定为报告不当支付超过7.5亿美元门槛的高优先级项目。通过实施补充措施和纠正措施，Compensation报告了FY 2017的不当支付预计为4.56亿美元，显示了显著改善。

### PENSION

The VA Pension program helps Veterans and their families cope with financial challenges by providing supplemental income through Veterans Pension and Survivors Pension benefit programs. The below table represents the OMB root causes identified during testing.

#### Pension - FY 2017 OMB Root Causes ($ in Millions)

- **Overpayment, $145.55**
- **Underpayment, $0.35**

<table>
<thead>
<tr>
<th>原因</th>
<th>金额</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>$26.91</td>
</tr>
<tr>
<td>Administrative or Process Error Made by: Federal Agency</td>
<td>$1.93</td>
</tr>
<tr>
<td>Failure to Verify: Other Eligibility Data</td>
<td>$9.22</td>
</tr>
<tr>
<td>Failure to Verify: Financial Data</td>
<td>$107.50</td>
</tr>
<tr>
<td>Total</td>
<td>$145.55</td>
</tr>
</tbody>
</table>

Pension will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of these actions, VA expects to reduce improper payments by 0.03 percentage points to 2.60 percent in FY 2018. The Director of Pension and Fiduciary Service and Assistant Deputy Undersecretary for Field Operations are the responsible accountable officials for reducing improper payments.

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PENSION CORRECTIVE ACTION PLANS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>Provide refresher training courses to VA employees on claims processing procedures to ensure timely award adjustments.</td>
<td>January 2018</td>
</tr>
<tr>
<td>Failure toVerify Financial Data</td>
<td>Implemented quarterly post-award auditing, which is an income match with Internal Revenue Service (IRS) and Social Security Administration (SSA) that allows VA to verify a beneficiary’s eligibility for continuation of VA benefits.</td>
<td>Completed April 2017</td>
</tr>
<tr>
<td>Failure to Verify Other Eligibility Data</td>
<td>Provide refresher training to VA employees on claims processing procedures to ensure accurate benefit awards.</td>
<td>January 2018</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>Conduct spot checks to ensure documents in support of payments are scanned and uploaded into appropriate eFolder (electronic folder).</td>
<td>December 2017</td>
</tr>
</tbody>
</table>

Although Pension has reported an overall increase in projected improper payments for FY 2017, corrective actions implemented during the past three years have reduced errors related to insufficient documentation. Insufficient documentation errors have decreased by $42.13 million and $8.62 million in FY 2016 and FY 2017, respectively. This was a result of Pension’s efforts to ensure that payments were placed into the paperless claim system for IPERA review.

EDUCATION – CHAPTER 33

The VA Education – Chapter 33 program offers higher education and training benefits to Veterans, Servicemembers, and their families who served after September 10, 2001. The below table represents the OMB root causes identified during testing.

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Education: Chapter 33 - FY 2017 OMB Root Causes

($ in millions)

- Insufficient Documentation to Determine: $131.25
- Administrative or Process Error Made by Federal Agency: $34.91
- Total: $166.16

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*Pension reported improper payments related to insufficient documentation errors of $77.66 million and $35.53 million in FY 2015 and FY 2016, respectively.*
SECTION III: OTHER INFORMATION

Education – Chapter 33 will implement, or has implemented, the following corrective actions to ensure greater compliance with IPERA. With the implementation of these actions, VA expects to reduce improper payments by 0.02 percentage points to 1.40 percent in FY 2018. The Director of Education is the responsible accountable official for reducing improper payments.

EDUCATION – CHAPTER 33 CORRECTIVE ACTION PLANS

<table>
<thead>
<tr>
<th>IMPROPER PAYMENT CATEGORY</th>
<th>CORRECTIVE ACTION</th>
<th>TARGET COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative or Process Error Made by Federal Agency</td>
<td>Review current Chapter 33 manual entry procedures. The procedures were validated by the Quality Assurance and National Training Teams to ensure integrity with the process, and there is a dual-certification process in place to mitigate improper payments.</td>
<td>Completed July 2017</td>
</tr>
<tr>
<td></td>
<td>Review error trends and modify current training to correct errors. Administrative and quarterly quality errors through Quarter 3 were evaluated as of August 31, 2017. Further analysis will be conducted through Quarter 4.</td>
<td>Completed September 2017</td>
</tr>
<tr>
<td></td>
<td>Conducted targeted refresher training to all Regional Processing Offices based on error trend analysis. Refresher training is an ongoing activity. The Quality Assurance Team submits suggested training topics to the National Training Team highlighting eligibility, entitlement, and verification of service data with the DoD. Additionally, the Education Service manual was updated in August 2017 to address these issues.</td>
<td>Completed September 2017</td>
</tr>
<tr>
<td>Insufficient Documentation to Determine</td>
<td>Request additional documentation, such as a school catalog, schedule, or tuition and fees during IPERA testing. Additional documentation will ensure integrity that the amount certified and paid to VBA was correct at the time of payment.</td>
<td>Completed June 2017</td>
</tr>
</tbody>
</table>

In response to VA OIG’s recommendation in 2014, VBA added a requirement for schools to submit enrollment documents to validate enrollment data during the IPERA review. In response to VA OIG’s recommendation in 2017, VBA added the procedure of reviewing school catalogs to validate tuition and fees during the IPERA review process. While these additional steps have proven beneficial and increased the confidence in IPERA review findings for education benefits, it has been difficult to obtain these required documents from schools or training facilities that are no longer in operation. During the FY 2017 IPERA review, four payments were related to a school or training facility whose approval was withdrawn resulting in closure of that institution. All four transactions were deemed improper since VBA was unable to acquire the documentation necessary to validate reported enrollment data and tuition and fees. This resulted in $131 million of improper payments, which accounted for 79 percent of the reported error rate, and resulted in Education – Chapter 33 being identified as susceptible to significant improper payments, thereby increasing its annual IPERA reporting requirements. VBA remains committed to enforcing school and training facility compliance and recognizes that it may impact the improper payment rate.

RECAPTURE OF IMPROPER PAYMENTS REPORTING

OMB Circular A-136 requires detailed information on 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 tables under this section. VA has not excluded any programs or activities with outlays of $1 million or more from the
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payment recapture audit program. VA continued to refine payment recapture and recovery activities in FY 2017.

FINANCIAL SERVICES CENTER

VA vendor payment activities are centralized at the FSC, a franchise fund (fee-for-service) organization that services VHA, NCA, and VACO Staff Offices. FSC’s Recapture and Recovery program is focused on prevention, detection, and recovery of overpayments for each program FSC services that expends $1 million or more annually. The program reviews post-payments, evaluates root causes of improper payments and develops corrective action plans, and tracks the recapture of improper payments along with disposition of recaptured funds.

POST PAYMENT REVIEW

FSC reviews approximately $2.2 billion in payments annually in order to identify potential duplicate payments. If potential duplicate payments are found, they are forwarded to the FSC payment resolution team for action. Payments issued outside of FSC that are identified as potential duplicate payments are forwarded to the appropriate VA facility for resolution.

In addition, payment files over $2,500 are matched monthly against disbursed payments over the previous two fiscal years to identify if any potential duplicate payments exist. These matches are researched to ensure there are no false positives and then sent to either the FSC payment resolution team or to the appropriate VA facility for verification and collection. All potential duplicates identified are tracked to resolution.

To verify the accuracy and timeliness of payments, statistically valid payment reviews are conducted monthly and quarterly. The results from these reviews are used to strengthen recapture and recovery activities and internal controls over payments.

Finally, FSC reviews payments with interest penalties over $50. This consists of reviewing interest payments and determining if interest was accurate and appropriate. If an interest payment is determined to be inaccurate, it is sent to the FSC payment resolution team for verification and/or collection.

ROOT CAUSES OF IMPROPER PAYMENTS AND CORRECTIVE ACTIONS

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. The identification of the cause of past improper payments aids in developing new automated processes within a system or tool to identify and/or prevent potential improper payments. FSC has implemented corrective actions to include increased use of electronic invoicing and optical character recognition technology to minimize improper payments via reviews in the prepayment state. Corrective action plans have resulted in processes being implemented to extract key payment data from paper invoices to reduce input errors to ensure consistency in payment processing and streamline procedures.

COLLECTION PROCESS

Bills of collection (BOC) are generated by FSC for all improper payments and overpayments of $30.00 or more. When improper payments have been detected during post-payment reviews, the following collection process is used to recover the funds from the vendor or employee:

• When the full amount of an improper payment was paid via electronic funds transfer (EFT), FSC processes a letter of reversal/letter of indemnity in an attempt to recover the funds by having the bank reverse the erroneous transaction.
In cases where the improper payment was issued with a Treasury check or when the improper amount was less than the full EFT amount, the FSC or appropriate VA facility issues a BOC to the vendor. After a minimum of 45 days, if the vendor has not returned the funds, requested additional information, or disputed the BOC, an internal offset is processed to collect the funds from the next FSC-issued payment(s) to that same vendor until the BOC is satisfied.

VETERANS HEALTH ADMINISTRATION

VHA’s payment recapture audit program is focused on identifying 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 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.


VETERANS BENEFITS ADMINISTRATION

In an effort to identify and recapture improper payments, VBA uses a combination of quality reviews and payment reviews to identify possible duplicates and overpayments. A majority of VBA programs perform quality reviews on randomly selected cases that ensure eligibility determinations, proper case processing, and payment accuracy. For all other programs, VBA performs payment reviews to identify potential duplicate payments and other potential improper payments. 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 ROs.

ROOT CAUSES OF IMPROPER PAYMENTS

VBA identified that a majority of payment errors were due to administrative and process errors made by the Federal agency and failure to verify eligibility data. 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, therefore preventing collection. VBA is taking action to correct these issues by using continuous process improvement and standardized tools to improve claims processing outcomes. When errors are discovered, ROs take action as soon as possible to correct these ratings and ensure the most accurate evaluation for the Veteran.

**COLLECTION PROCESS**

DMC provides AR and debt management services for VBA, along with helping Veterans and families understand their rights, meet their obligations, and provide solutions to resolve overpayments. 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 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 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.

**PAYROLL**

Defense Finance and Accounting Service (DFAS) processes VA’s payroll transactions. When the payroll system disburses an overpayment, DFAS oversees the debt collection process for VA. Debts due to overpayment of wages generally occur for two reasons (1) a retroactive time and attendance adjustment or (2) retroactive personnel data was processed in the system.

**COLLECTION PROCESS**

Under the terms of the Debt Collection Improvement Act (DCIA), the agency is required to give advance notification of any debt collection for a debt that is incurred for pay periods older than four pay periods unless the debt is less than $50. Debts incurred within the most recent four pay periods or less than $50 do not require advance notification prior to collection.

The debt letter outlines the employee’s options with regard to the debt:

- Request a waiver (requires acknowledgement of the validity of the debt, but the employee must provide reasons why they do not feel they should have to repay)
- Request a hearing (dispute the validity of the debt itself)
- Make payment directly to the agent cashier or Pay.Gov
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- Request a lower repayment amount (the lowest acceptable amount is $25 per pay period; however, debt must be repaid within three years)
- Do nothing and allow DFAS to collect via payroll deduction.

If the employee opts to allow DFAS to collect via payroll deduction, DFAS will collect 15 percent of net disposable income until debt is paid in full.

Debts repaid within the same tax year will have only the net amount paid out collected. If the repayment crosses into the next tax year, the employee is responsible to also repay the taxes that were deducted on the unpaid portion. DFAS will issue a credit memo at the end of the year so the employee can claim that repayment amount on their taxes.

Employees have 30 days from the date of the debt letter to request a waiver or hearing, at which time the payroll office can request that the debt be placed on hold pending decision. Once collection begins, it does not stop even if the employee requests a waiver at a later date.

Employees have three years to request a waiver. However, if a waiver is requested later and is approved, DFAS will refund all collections made prior to that time.

OFFICE OF ACQUISITION AND LOGISTICS

The VA Office of Acquisition and Logistics works with the OIG Office of Contract Review (OCR) to recover funds owed to 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 post award 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 health care resource proposals, claims, and special purpose reviews. In FY 2017, this audit recovery program recovered more than $40 million.

### Improper Payment Recaputure Activities

**Veterans Health Administration**

(1) ($ in millions)

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Type of Payment</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
<th>2016 Recapture Rate</th>
<th>2017 Recapture Rate Target</th>
<th>2018 Recapture Rate Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Travel Benefit</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>CHAMPVA (2)</td>
<td>Benefit</td>
<td>8.75</td>
<td>39.40</td>
<td>96.98</td>
<td>450.26</td>
<td>85.00</td>
</tr>
<tr>
<td>VA Community Care – Choice (3)</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
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<tr>
<td>State Home Per Diem Grants</td>
<td>Grant</td>
<td>-</td>
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</table>

<table>
<thead>
<tr>
<th>Overpayments Recaptured Outside of Payment Recapture Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overpayments Recaptured</td>
</tr>
<tr>
<td>Amount Identified</td>
</tr>
<tr>
<td>0.77</td>
</tr>
<tr>
<td>0.77</td>
</tr>
<tr>
<td>1.06</td>
</tr>
<tr>
<td>0.02</td>
</tr>
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</table>

Department of Veterans Affairs – FY 2017 Agency Financial Report
### Overpayments Recaptured Through Payment Recapture Audits

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Type of Payment</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
<th>2016 Recapture Rate</th>
<th>2017 Recapture Rate</th>
<th>2018 Recapture Rate</th>
<th>Target</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
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<tbody>
<tr>
<td>Supplies and Materials</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.25</td>
<td>0.14</td>
</tr>
<tr>
<td>Communications, Utilities, &amp; Other Rent</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.53</td>
<td>0.41</td>
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<tr>
<td>Medical Care Contracts and Agreements</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.33</td>
<td>0.24</td>
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<tr>
<td>Prosthetics</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.03</td>
<td>0.01</td>
</tr>
<tr>
<td>Other VHA Programs (4)</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4.29</td>
<td>181.24</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>8.75</td>
<td>39.40</td>
<td>-</td>
<td>450.26</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>7.27</td>
<td>200.31</td>
</tr>
</tbody>
</table>

**Notes:**
1. Current-year data is reported in table above.
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 include the following VHA activities: Activities with Other Federal Agencies; Compensated Work Therapy/Incentive Therapy; DoD/VA Medical Facility Demonstration Fund; Equipment; Facility Maintenance and Operations; General Post Funds; Grants-Homless Per Diem; Homeless Care; IT Services; In-house Provider Services; Land and Structures; Medical and Prosthetic Research; Non-Medical Contracts and Agreements; Other Contracts, Services, Agreements, and Miscellaneous; Pharmacy CMOP; Pharmacy – Medical Facilities; Professional Services Contracts; and Shared Services.
5. Due to differing reporting requirements, Other VHA Programs will not reconcile to data reported on PaymentAccuracy.gov.

### Improper Payment Recapture Activities

**Veterans Benefits Administration and VACO Staff Offices (1)**

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Type of Payment</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
<th>2016 Recapture Rate</th>
<th>2017 Recapture Rate</th>
<th>2018 Recapture Rate</th>
<th>Target</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
</tr>
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<tbody>
<tr>
<td>Compensation</td>
<td>Benefit</td>
<td>0.08</td>
<td>0.02</td>
<td>28.43</td>
<td>27.38</td>
<td>62.00</td>
<td>-</td>
<td>1,183.47</td>
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<tr>
<td>Loan Guaranty</td>
<td>Benefit</td>
<td>0.52</td>
<td>0.19</td>
<td>37.42</td>
<td>37.48</td>
<td>42.00</td>
<td>-</td>
<td>155.60</td>
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<tr>
<td>Education</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>500.08</td>
<td>623.44</td>
</tr>
<tr>
<td>Payroll (2)</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>55.89</td>
<td>33.50</td>
</tr>
</tbody>
</table>

(1) Overpayments recaptured outside of payment recapture audits consist of unsolicited funds received.
## SECTION III: OTHER INFORMATION

### Overpayments Recaptured Through Payment Recapture Audits

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Type of Payment</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
<th>2016 Recapture Rate</th>
<th>2017 Recapture Rate</th>
<th>2018 Recapture Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBA GOE</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NCA Burial Programs</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>VACO Programs (3)</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>OIG post award contract reviews</td>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>TOTAL</td>
<td>-</td>
<td>0.60</td>
<td>0.22</td>
<td>-</td>
<td>36.09</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes:
(1) Current-year data is reported in table above.
(2) Payroll figures are provided by DFAS, VA’s Payroll provider.
(3) VACO programs include the following activities/programs: Corporate Data Center Operations Franchise Fund; HRA OHRM; HRA General Administration; OALC Major and Minor Construction; O&I&T programs; General Administration; Franchise Fund; Supply Fund programs; and Travel.
(4) Due to differing reporting requirements, Compensation, Loan Guaranty, and Education programs will not reconcile to data reported on PaymentAccuracy.gov.

### Overpayments Recaptured Outside of Payment Recapture Audits (4)

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Amount Identified</th>
<th>Amount Recaptured</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBA GOE</td>
<td>4.40</td>
<td>4.39</td>
</tr>
<tr>
<td>NCA Burial Programs</td>
<td>0.04</td>
<td>0.04</td>
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<td>VACO Programs (3)</td>
<td>2.15</td>
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<tr>
<td>OIG post award contract reviews</td>
<td>39.94</td>
<td>40.74</td>
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<td>TOTAL</td>
<td>1,941.58</td>
<td>1,535.94</td>
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## DISPOSITION OF FUNDS RECAPTURED THROUGH PAYMENT RECAPTURE AUDITS (1)

### ($ in millions)

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Amount Recovered</th>
<th>Type of Payment</th>
<th>Agency Expenses to Administer Program</th>
<th>Payment Recapture Auditor Fees</th>
<th>Financial Management Improvement Activities</th>
<th>Original Purpose</th>
<th>Office of Inspector General</th>
<th>Returned to Treasury</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAMPVA (2)</td>
<td>39.40</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>39.40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Compensation (3)</td>
<td>0.02</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.02</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Loan Guaranty (3)</td>
<td>0.19</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.19</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>39.62</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>39.62</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes:
(1) Current-year data is reported in table above.
(2) Amounts recovered go back to the year funding was originally used.
(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.
### AGING OF OUTSTANDING PAYMENTS IDENTIFIED IN PAYMENT RECAPTURE AUDITS

($ in millions)

<table>
<thead>
<tr>
<th>Program or Activity</th>
<th>Type of Payment (contract, grant, benefit, loan, or other)</th>
<th>Amount Outstanding (0-6 months)</th>
<th>Amount Outstanding (6 months to 1 year)</th>
<th>Amount Outstanding (over 1 year)</th>
<th>Amount Determined to not be Collectable</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAMPVA</td>
<td>Benefit</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.271</td>
</tr>
<tr>
<td>Compensation</td>
<td>Benefit</td>
<td>0.037</td>
<td>0.023</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Loan Guaranty</td>
<td>Benefit</td>
<td>0.087</td>
<td>0.236</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>0.124</td>
<td>0.259</td>
<td>-</td>
<td>0.271</td>
</tr>
</tbody>
</table>

**Notes:**
(1) Current-year data is reported in table above.
(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, 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 prevent an AR record from being labeled as a permanent write-off versus a temporary write-off. Third-parties are not included in write-off data because third-party related amounts entail a recovery effort and are not considered debt owed.

### AGENCY IMPROVEMENT OF PAYMENT ACCURACY WITH THE DO NOT PAY INITIATIVE

VA is committed to improving its efforts to prevent improper payments before they are made as part of the Do Not Pay (DNP) Initiative. VA’s activities for this initiative can be discussed as two main activities: those performed in conjunction with use of the Treasury DNP Portal and those monitoring efforts done by VA offices outside the portal.

VA and the Treasury Department continue to work collaboratively to obtain greater utilization of the DNP Portal, evaluating existing Treasury analytical and processing capabilities and increasing VA’s access and improvement of payment accuracy with the DNP Initiative. As the DNP Portal owner for VA, the FSC has organized quarterly DNP working group sessions with VBA and VHA representatives to add better synergy and focus on the DNP Initiative. As part of the effort toward auditability, FSC is diligently reviewing the data sources that are available in the portal and the admin/program offices within VA that will benefit from the use of these data sources. In addition, FSC continually looks for opportunities to improve methodologies as well as continue to implement cross-utilization of best business practices related to improved system edits and procedures.

Currently, VA uses the DNP Portal for post payment review activities, which do not allow VA to stop payments before they are made. However, VA uses monitoring efforts outside of the DNP Portal to stop payments to vendors and recipients that have already been determined ineligible for receiving payments or VA determines the payment should not be made for other reasons. VA and Treasury are committed to working together. The result of this collaboration has produced positive results as VA and Treasury continue to explore ways to maximize the use of the DNP Portal.
Tampa VA Reaches out to Veterans and the Community

The James A. Haley VA Medical Center in Tampa stepped up to take in transfer patients from the Bay Pines facility who were in the direct path of the storm. Once the storm had passed, they ensured those patients had a safe ride back to Bay Pines. In addition, VA officials met with Veterans in the area who had evacuated their homes to assure them that VA was ready to assist them in any way possible as recovery efforts continued.

Non-Veterans were also assisted during and after Hurricane Irma. VA made beds available where possible to non-Veteran nursing home patients who were affected during the storm. VA participates in disaster relief efforts as part of its fourth mission to support national, state, and local emergency management, public health, safety, and homeland security endeavors, and also as part of a mission assignment under the Stafford Act. The VA worked in close concert with the U.S. Department of Health and Human Services and the Federal Emergency Management Agency as well as state and local partners on the overall response.

One inspirational story from the storm involves a quadriplegic pharmacy technician at the Tampa VA who rode his motorized scooter seven miles to the hospital and then rode the storm out all night. This was to ensure all of the hospital’s patients would receive their medications without delay.
VA’S PREPAYMENT AND PRE-AWARD ACTIVITY

The DNP Initiative is an important step in reducing improper payments. It reinforces VA’s current operational processes with policy and defined expectations. The DNP Portal is a beneficial support tool that adds value. However, VA has identified areas of improvement working in the portal and in partnership with the Treasury, both organizations are working on identifying automated solutions. VA has incorporated the following databases for use within the portal: Death Master File (DMF), Public; System for Award Management (SAM), Restricted; List of Excluded Individuals/Entities (LEIE); and Credit Alert Verification Reporting System (CAIVRS) with LEIE and CAIVRS having single search functionality. Working group sessions found that larger Administrations within VA, such as the VHA, find it increasingly difficult to accurately adjudicate potential improper payments in a timely manner due to the sheer volume of claims and system limitations. In FY 2017, VA continued to strengthen the use of the DNP Initiative by providing additional support and guidance for reducing improper payments uniformly across VA.

VETERANS HEALTH ADMINISTRATION

As part of VHA’s DNP activities, multiple internal and external activities are in place that focus on the prevention of overpayments and are further described below.

Quality Inspection Tool (QIT) - QIT was developed to review closed batches of claims prior to release for payment. The OCC/VACC program utilizes the QIT to ensure proper payment of all outpatient claims in a prepayment status processed through FBCS. This tool reviews the Health Care Financing Administration and universal billing data extracted from FBCS, which allows the user to review pertinent line item data to help ensure the correct processing of payments by OCC Claims Processing Staff. The QIT provides line item inspection of payments prior to the release of each batch to include Current Procedural Terminology code use, payment methodology, obligation selection, and Purpose of Visit codes. QIT avoided $74.73 million in improper payments for FY 2017.

Program Integrity Tool (PIT) - Using a set of business rules, PIT is utilized to detect and prevent improper payments in a prepayment state. In FY 2017, the OCC changed the claims payment process for Choice and PC3 in order to make timely reimbursements per payment policies. As such, expedited payments were processed through the PIT and business rules were incorporated to avoid duplicate payments. As of July 2017, all expedited Choice claims are scored and analyzed using the PIT prepayment, which has prevented $21.88 million in duplicate payments through September 2017. During FY 2017, FSC began paying the Choice claims for TriWest and payments for HealthNet through its PCM processing system. In addition to PIT, PCM has also incorporated prepayment edits that avoid improper payments and speak to both OIG and GAO reports of outdated manual processes.

Artificial Intelligence (AI) - The pricing software for OCC family member programs utilizes AI, which encompasses expert edits from the industry and provides a recognized knowledge base to analyze claims for accuracy and applicability to the payment policies. OCC’s pricing software includes comprehensive code auditing software that helps manage medical benefit dollars and lower administrative costs through accurate, consistent, and timely reimbursements per payment policies. The AI contained in the pricing software prevented $66.32 million in improper payments for FY 2017. In addition, the AI translates policies and regulations into a form that can be acted on by the system, which is applied to medical claims submitted for payment. The AI prevented...
$98.71 million in improper payments for FY 2017. Together, the claim auditing software and AI prevented $165.03 million in improper payments for FY 2017.

Top Potential Duplicate Report (TDPR) - The TDPR flags high-dollar inpatient claim items greater than $1,000 for duplicate analysis. Through this process, VHA avoided $15.42 million in improper payments in FY 2017.

Outpatient Prospective Payment System (OPPS) Report - This report identifies potential improper payments at the VISN/Station level. The VISN/Stations review reports within 24 hours in order to identify and make necessary changes to claims prior to disbursement to avoid potential improper payments. OPPS avoided $617,092 of improper payments in FY 2017. Other OCC claims utilize comprehensive pricing software that applies industry-approved rules and processes to analyze claims for accuracy and applicability to payment policies.

Pre-Award Checks - VHA performs pre-award checks against SAM for all contracts greater than $3,500 as part of the procurement process. Also, 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.

VETERANS BENEFITS ADMINISTRATION

VBA receives continuous information from several Federal agencies, which it uses to verify the status of VA beneficiaries. This information matches cases where there may be inconsistencies between VA records and data furnished by other Federal agencies that may affect entitlement to C&P benefits. The following describes these agreements:

Fugitive Felon Match - The OIG enters into computer matching agreements (CMA) with law enforcement agencies for matching lists of individuals with felony arrest warrants against VA records to identify beneficiaries that might be fugitive felons. Matches are researched for accuracy and benefits are adjusted as per applicable regulations.

Social Security Verification Match - Once a year, the SSA provides information on SSA rates for recipients of VA pension and Parents’ Dependency and Indemnity Compensation to verify reported income.

SSA Prison Match - Under a Memorandum of Understanding, SSA provides VA with information on prisoners. Periodically, data from C&P records are run against SSA’s inmate database to identify VA beneficiaries who may be subject to reduction or termination of benefits.

Bureau of Prisons (BOP) Match - BOP provides VBA with information on Federal prisoners. On a monthly basis, C&P files are matched with BOP’s inmate database to identify incarcerated beneficiaries, which may require a reduction or termination of benefits.

Social Security DMF - SSA compiles death information into a system of record called the DMF. On a weekly basis, C&P master records are matched with the DMF to identify possibly deceased beneficiaries in order to terminate benefits.

Information derived from the above matches may be used to adjust VA benefit payments before they are made. However, in some situations, due process provisions may be required since matching program information is third-party information. Through these data matching agreements, VBA was able to prevent $97.57 million in improper payments in FY 2017.

FINANCIAL SERVICES CENTER

Most VA vendor payment activities are centralized at the FSC, a franchise fund (fee for service) organization that services VHA, NCA, and VACO. FSC’s activities are focused on preventing improper payments.
FSC matches vendor payments, excluding medical payments, against the previous 90 days of disbursed payments to identify duplicate payments before their submission for disbursement. Duplicate payments identified through this process are cancelled before the payments are made.

FSC has additional activities in place that focus on the prevention of overpayments and are further described below.

**Commercial Payments (Financial Operation Service)** - The mission of the Commercial Operations Division (COD) is to process commercial certified, commercial, matched, and construction payments, so that accurate and timely payments can be made in accordance with the PPA while maximizing discounts taken and minimizing interest penalties. To ensure payments are made accurate and timely, COD conducts prepayment checks for non-compliant Prompt Pay Act invoices, duplicate invoices, and improper invoices by Certifying Officials.

COD stopped 269,887 non-compliant Prompt Pay Act invoices for a total of $1.95 billion. In addition, 18,164 duplicate invoices were stopped for a total of $192.79 million and 73,309 improper invoices by Certifying Officials were stopped for a total of $687.46 million.

**Charge Card Operations Division** - Provides VA-wide customer support by providing financial analysis and overall guidance on program administration and oversight. During prepayment checks, the division stopped 12,241 unauthorized merchant transactions for a total of $3.95 million and closed 2,052 credit card accounts for fraud caused by non-VA employees.

**Financial Healthcare Service (FHS)** - FHS mission is to provide prompt, accurate payment of medical claims for the VA. It also provides program management for IT projects in order to improve medical claims.

To ensure accuracy of payments, in FY 2017, FHS conducted a prepayment check on Dialysis, Choice, and Camp Lejeune claims. Dialysis denied 13,436 duplicate claims for a total of $607.24 million. A total of $62.12 million of 90,844 Choice claims were denied or rejected for duplication/authorization issues and 720 in duplicate Camp Lejeune claims in the amount of $2.45 million were denied.

**BARRIERS**

VA is committed to providing Veterans access to timely, high-quality health care and benefits earned. While regulatory and statutory requirements continue to pose challenges, VA is working with Congress and stakeholders to identify ways to simplify statutory and regulatory requirements. In today’s complex and changing health care 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. Additionally, VA is committed to streamlining policies and procedures and automating more business processes to provide Veterans their deserved benefits. Allowing contractors access to Federal Tax Information...
(FTI) data would aid in these efforts. Listed below are several legislative proposals that will assist in better identifications, prevention, and recovery of improper payments.

**VETERANS HEALTH ADMINISTRATION**

**BENEFICIARY TRAVEL**

There is one statutory or regulatory barrier impacting the BTP that limits implementation of VHA’s corrective actions. 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. Section 5317 to expand VA’s IVM authority and allow VA to verify the self-reported income of service-connected Veterans in enrollment priority groups two and three who are requesting reimbursement based on income, transportation reimbursement benefits, and/or a medication copayment exemption. VA currently has authority to verify nonservice-connected Veterans’ income by matching income data reported by these Veterans with the IRS and SSA. As a result, VA is at risk for possible non-collection of legislatively required medication copayments as well as improper payments.

**CHAMPVA**

CHAMPVA does not have any statutory or regulatory barriers that limit its corrective actions taken to reduce improper payments.

**VA COMMUNITY CARE AND PURCHASED LONG-TERM SERVICES AND SUPPORTS**

VA Community Care and PLTSS 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 fully eliminate improper payments due to noncompliance with FAR. VA 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 2017, VA submitted the Veteran Coordinated Access & Rewarding Experiences (CARE) legislation to Congress. The bill aims to clarify and simplify eligibility requirements, set the framework for VA to continue to build a high-performing network, streamline clinical and administrative processes, implement new care coordination support for Veterans, and merge and modernize community care programs. This legislation would include 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; keeping administration simple 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 payments.

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 the 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 PLTSS. VA lost more than 500 community

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nursing homes due to additional contracting rules, which do not apply to Medicare providers. In addition, the hiring freeze impacted Claims Adjudication and Reimbursement’s ability to take corrective action and implement controls to ensure proper payments.

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 health care services a Veteran may need that cannot be provided by VA.

VA’s authority for provider agreements under Choice is limited – both time limited due to the life of the Choice program, which is anticipated to expire when funding runs out, and to the services available under Choice. Choice cannot be used for community nursing home care, which is another area where VHA greatly needs a non-FAR-based purchasing mechanism.

Recently identified issues regarding community nursing home and other home health ordering officials without delegations of authority to order services even though contracts are in place have caused improper payments to increase. PLTSS and VACC are working to resolve this issue.

SUPPLIES AND MATERIALS
It is not yet known if the Supplies and Materials program has any statutory or regulatory barriers that limit its corrective actions taken to reduce improper payments. VHA has expended great effort to procure prosthetics implants in accordance with FAR and doing so does not meet the clinical needs of our medical centers. VA has authority under U.S.C. Section 8123 to procure prosthetic appliances without regard to FAR, but has not yet been determined if implementing this authority will require rule making or other regulatory actions.

PROSTHETICS
The limitations of VAAR or FAR impedes streamlined operational business processes to meet Veterans’ clinical needs to prescribed care. Clinicians, Prosthetic, and Contracting are burdened with cumbersome business processes. The proposed use of 38 U.S.C. Section 8123 will support Prosthetics with the ability for non-warranted individuals to contact vendors to request prosthetic appliances (i.e., make verbal obligations) and grant ordering official status for purchase card orders over $3,500 for items on national contracts and issue purchase card orders once the item is used. PSAS is advancing methods to address process flow of durable medical equipment and streamline purchasing efforts with the addition of national and local contracts and consignment agreements. Recruitment and retention of purchase card staff will impact process compliance. Prosthetics education and training plan will provide current and newly on boarded PSAS staff with the tools to be successful with IPERA requests. With the volume of VA administrative and clinical staff, external clinicians, and vendors who manage each and every order, there are huge barriers to success with the amount of people who touch a single purchase order and one administrative mistake does not necessarily translate to a loss to the government.

COMMUNICATION, UTILITIES, AND OTHER RENT
Communication, Utilities, and Other Rent program does not have any statutory or regulatory barriers that limit its corrective actions taken to reduce improper payments.

MEDICAL CARE CONTRACTS AND AGREEMENTS
Medical Care Contracts and Agreements program does not have any statutory or regulatory barriers that limit its corrective actions taken to reduce improper payments.
SECTION III: OTHER INFORMATION

VETERANS BENEFITS ADMINISTRATION

COMPENSATION

Compensation Service complies with laws and regulations pertaining to due process under 38 U.S.C. Section 3.103(b)(2), which requires an independent verification followed by a notification of adverse action prior to reduction or termination of a Veteran's or beneficiary's benefit payment. This due process takes a minimum of 60 days, which results in the continuation of payments at improper payment rates during this timeframe. Currently, VA is drafting regulation for relief from this due process prior to making drill pay adjustments. This regulatory relief will allow VA to take action on drill pay adjustments immediately after data is received from the DoD.

PENSION

In 2012, VA received permission from the IRS to transmit and store FTI electronically. Using this electronic data feed, VA successfully implemented an up-front income verification process that allows its PMC 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.

However, FTI data cannot be accessed by VA’s contractors, which has limited how VA can process and maintain this data in IT systems. Under current law, only 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 of the IRS code prohibits VA from using contractors to augment VA OI&T staff or using contractors and vendors to help administer benefit programs if the contractors would encounter tax returns or return information. The prohibition inhibits agencies that rely on contractors to maintain agency systems. It 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 health care records.

VA has submitted a legislative proposal every year since 2013 to give contractors’ access to FTI data. The proposal 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 contractor prohibition in section 6103 of the IRS code 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 limits VA’s ability to move to a cloud-based IT storage system and requires VA to expend scarce resources to safeguard tax information from contractors, though 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.

Since 2015, VA has submitted a legislative proposal to extend the length of CMAs to align with the timeframes found in the Improper Payments Elimination and Recovery Improvement Act of 2012. Based on the current law, CMAs may only be active for a maximum of 18 months, and agencies can extend these agreements for an additional 12 months. CMAs rarely have substantive changes that would require the reduced timeframe required by the
Computer Matching and Privacy Protection Act. More often than not, the only changes are updates to the effective dates and contact information for the respective agencies. The shorter 18-month timeframes creates a burden on VA’s limited resources. The GAO Report 14-44, OMB and Selected Agencies Need to Ensure Consistent Implementation, stated “officials at six of the seven agencies we reviewed told us that the act’s rigorous requirements and the CMA review processes within and among agencies were lengthy and resource-intensive and that statutory timeframes for conducting matching activities were too short, discouraging implementation of CMAs." The report noted that several agencies spent the entire length of an active CMA working on the next CMA to prevent expiration and disruption of operations. Increasing the time that agreements remain active would reduce administrative burden and enhance continuity of agency operations.

EDUCATION – CHAPTER 33
Education – Chapter 33 does not have any statutory or regulatory barriers that limit its corrective actions taken to reduce improper payments.

ACCOUNTABILITY
Departmental oversight and accountability of improper payments is established via the Department’s IPERA Governing Board. Led by VA’s Acting CFO with participation from Administration CFOs and Senior Accountable Officials (SAO), in FY 2017, the Governing Board focused on achieving IPERA compliance, identifying root causes of improper payments, establishing reduction goals, and implementing effective corrective actions to reduce/prevent 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. VA’s IPRO office is responsible for the oversight and reporting of VA’s IPERA programs. IPRO collaborates across the Department and with other Federal partners to strengthen integrity of payments and achieve essential goals in reducing improper payments.

In FY 2017, VA provided clarification on roles and responsibilities in its revised IPERA financial policy to further increase effectiveness of corrective actions and defines accountability for reducing improper payments. Key updates included identifying SAO responsibility for:

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

For FY 2018 and beyond, VA will continue its efforts to improve the integrity of its disbursements and actions to reduce improper payments.

VETERANS HEALTH ADMINISTRATION
Throughout FY 2017, VA continued assessing the current state of IPERA and determined that actions could be taken to strengthen outcomes. The designation of SAOs in FY 2015 has resulted in increased awareness, ownership, and a path forward for improper payments.

BENEFICIARY TRAVEL
The Acting Deputy Under Secretary for Health for Operations Management is designated as the program SAO and is accountable for ensuring execution of corrective action plans. The SAO’s FY 2018 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 at 80 percent and 70 percent.

In November 2015, Member Services introduced MS CICPO to assist in creating additional internal controls for its programs inclusive of Beneficiary Travel. MS CICPO has increased accountability and senior executive knowledge and understanding of the complexity related to Beneficiary Travel payments and the IPERA process. This 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 with legislative requirements 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.

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 SAO's FY 2018 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 at 80 percent and 70 percent.

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 2018 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 at 80 percent and 70 percent.

SUPPLIES AND MATERIALS
The Chief Procurement and Logistics Officer is designated as the program SAO and accountable for ensuring execution of corrective action plans. The SAO's FY 2018 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 at 80 percent and 70 percent.

PURCHASED LONG-TERM SERVICES AND SUPPORT
The GEC Chief Consultant is designated as the program SAO and accountable for ensuring execution of corrective action plans. The SAO’s FY 2018 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 at 80 percent and 70 percent.
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.

**COMPENSATION**

The Deputy Director of Policy and Procedures is designated as the program SAO and accountable for all completed IPERA activities. The SAO’s FY 2018 performance plan includes a performance requirement to oversee the development of policy guidance and promulgation of regulations that improve VA’s compensation benefit program, conduct systematic reviews of current policies and procedures to identify changes that may improve program integrity or facilitate efficiency delivery of benefits, and take action to implement all necessary changes in an effort to reduce improper payments.

**PENSION**

The Director of Pension and Fiduciary is designated as the program SAO and accountable official for completing IPERA activities. The SAO’s FY 2018 performance plan includes requirements to (1) ensure the program develops and maintains an efficient systems of internal and external program integrity controls; (2) manage the program responsibilities under IPERA and other internal auditing practices established by law; (3) ensure recommendations for business requirements for IT systems are IPERA compliant and certify that system designs meet program needs; (4) make certain that transactions performed are in accordance with established policies, regulations, and procedures; (5) discuss and coordinate program integrity issues with the VA OIG and GAO; (6) develop and certify that corrective measures are implemented as part of the operations function; (7) conduct on-site visits and national reviews, meet with management/leadership to address hindrances, and provide constructive feedback with regard to goals of significant impact on service outcomes; and (8) ensure organizational standards related to quality, customer service, and timeliness are met.

**EDUCATION – CHAPTER 33**

The Director of Education Services is designated as the program SAO and accountable official for overseeing improper payment activities. This includes oversight of quality reviews conducted by Education Service to include quarterly reviews, special projects, and IPERA audits. The SAO is held accountable by being directly responsible for passing IPERA audits each fiscal year and ensuring corrective action plans are developed and implemented. Additionally, the SAO’s FY 2018 performance plan includes a performance evaluation criteria that require the SAO to assess and adjust to changing situations, implementing innovative solutions to make organizational improvements, ranging from incremental improvements to major shifts in direction or approach, as appropriate.

**AGENCY INFORMATION SYSTEMS AND OTHER INFRASTRUCTURE**

VA is committed to improving its financial processes, demonstrating fiscal responsibility and integrity, strengthening technology controls, minimizing the risks of improper payments, and reducing improper payments. A major initiative underway is the FMBT. FMBT will transition VA from its legacy core financial management system to a modernized FSSP’s financial management system solution. It will increase the transparency, accuracy, timeliness, and reliability of financial information, resulting in improved fiscal accountability to American
taxpayers. This initiative is currently ongoing and is anticipated to be fully implemented in the next five years.

The below 11 programs describe the internal controls, human capital, and information systems and other infrastructure needed to reduce improper payments to the levels that VA has targeted.

**VETERANS HEALTH ADMINISTRATION**

VHA is focused on improving financial and procurement processes. Many processes are manually intensive and the new financial management system will automate internal controls and help with VHA staffing shortages.

VHA is taking a comprehensive approach to resolving improper payments causes without affecting Veterans’ access to care. Additional information on the VHA programs that are reporting improper payments in excess of the statutory thresholds follow.

**BENEFICIARY TRAVEL**

Long-term (three to five years) infrastructure and information system solutions for the BTP are underway. In 2017, all key milestones were met. Development of the BTSSS is currently underway. Beginning in FY 2018, BTSSS will enable automated payments to Veterans. FY 2018 project funding for BTSSS payment to vendors has been awarded.

**CHAMPVA**

CHAMPVA’s claims processing system issues affected their accuracy and production goals throughout FY 2016. In addition, the hiring freeze prevented CHAMPVA from filling vacancies and training adequate staff; therefore, many departments were understaffed. The needed IT 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. December 2017 is the projected implementation timeline for two key system enhancements: streamlining vendor selection and the automation of the EDI reopen process. While the completion of these IT projects is pending, CHAMPVA has implemented additional manual quality reviews to monitor eligibility determination and training opportunities for the staff. Ongoing data matches with CMS and Tricare are being utilized to detect changes in beneficiary statuses. OCC also utilizes queues for secondary review of claims that meet certain criteria such as possible duplicate claims or for setting a percentage of any voucher examiner’s claims to be reviewed by a lead.

**VA COMMUNITY CARE**

Of an $8 million cost estimate placed with VA Community Care for long-term Information Technology solutions needed, $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.

**PURCHASED LONG-TERM SERVICES AND SUPPORT**

The improper payment rate for PLTSSS 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.

**SUPPLIES AND MATERIALS**

The new VA financial management transformation will reduce improper payments by eliminating duplicative tasks and adding in automated internal controls for customers and contracting officers.

**PROSTHETICS**

PSAS is working diligently with the current staffing levels and support structure in place to identify the impact IPERA will have on PSAS at the national and field level. VA is assessing internal systems and infrastructure to identify present and future state support systems and what is needed to aggressively reduce PSAS improper payments and sustain process improvement initiatives outlined in the PSAS action plan. Prosthetics does not have established IPERA internal controls and human capital to address the error rate nor does it have a full understanding of the quality assurance and assessment needed, as 2017 is the first-year for Prosthetics IPERA testing. Based on the first year review findings, Prosthetics identified actions and improvements it believes will decrease the error rate; however, additional time is necessary to formulate resources, systems, and an infrastructure plan for 2018 and future review years. It has been identified that the turnover rate with purchasing agents and lack of continuity with documentation processes may contribute to the volume of improper payments. Additionally, PSAS field staff had minimal knowledge about IPERA and VA anticipates that the education and training plan will reduce the overall improper payment rate.

**COMMUNICATIONS, UTILITIES, AND OTHER RENT**

The new VA financial management transformation will reduce improper payments by eliminating duplicative tasks and adding in automated internal controls for customers and contracting officers.

**MEDICAL CARE CONTRACTS AND AGREEMENTS**

The new VA financial management transformation will reduce improper payments by eliminating duplicative tasks and adding in automated internal controls for customers and contracting officers.

**VETERANS BENEFITS ADMINISTRATION**

VBA continues to implement internal controls, acquire human resources, and develop information systems and other infrastructure to reduce improper payments. With implementation in FY 2016, VBA is able to efficiently manage the claims workload centrally, prioritizing and distributing the claims electronically across its network of ROs to maximize resources and improve processing timeliness at the national level with the NWQ. With a national workload approach, VA will continue to focus on ensuring Veterans, their families, and survivors receive timely and accurate claim decisions. 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.

**COMPENSATION**

In FY 2015, VBA 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. To date, the workgroup has assessed available data and identified necessary system changes. 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 FY. This action will save 60 days, which will allow adjustments to be made quickly and efficiently.
### PENSION

The Centralized Mail Activity process was implemented within the PMCs 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. Additionally, VBA implemented post-award audits, which allows automatic issuance of due process to the claimant after verification of income from the IRS and SSA. In FY 2018, VBA will implement upfront verification expansion to include a review of FTI for claims involving 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 to ensure employees are proficient at claims processing.

### EDUCATION

VBA continues to update the LTS to reduce manual data input requirements by VBA education claims processing employees. Additionally, VBA works closely with school and training facility officials to provide them access to Web-based enrollment reporting systems. This facilitates timely and accurate transmission of enrollment data. Electronic submission of enrollment data supports the end-to-end automation function of LTS, which automatically processes Chapter 33 claims using a rules-based engine requiring no human intervention, therefore reducing input data errors. End-to-end automation processed 45.2 percent of Chapter 33 supplemental claims in FY 2016. VBA internal controls include quarterly reviews of claims processing, quarterly reviews for IPERA, at the national level, annual site visits at the Regional Processing Office, and random surveys of schools and training facilities to monitor compliance with claims processing procedures and enrollment reporting requirements.

### SAMPLING AND ESTIMATION

The 13 VA programs identified as susceptible to significant improper payments in FY 2016 are required to select an annual sample for testing and report estimated improper payments in FY 2017 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 approaches, VA used systematic random sampling and stratified sample designs to separate the payment data into homogeneous strata for each of the 13 programs being tested and to select the payments for testing. The payment characteristics used to stratify the payment populations vary by program. VA considered payment characteristics such as sub-program(s), sub-organization, payment type, and dollar amount. The details of each stratification approach are available within each program’s respective sampling plan.

Sample sizes varied by program and were determined using historical program error rates and statistical power calculations that would meet OMB precision requirements. Based on discussion held with VA OIG in March 2017, VA submitted an approval request to OMB for

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5 Initially VA identified 17 programs susceptible to significant improper payments in FY 2016, which required annual sample for testing. However, VA, with concurrence from the OIG, requested relief from the annual reporting requirements for four programs: Chapter 1606, Chapter 1607, VR&E, and Payroll. These four programs documented at least two consecutive years of improper payments that were below the statutory threshold as required by OMB Circular A-123, Appendix C. OMB approved the request for reporting relief on August 8, 2017.
alternative sampling plans that used a ratio-estimate approach. However, OMB indicated that a ratio-estimate was allowed and therefore did not need approval by OMB as an alternative plan. To reduce the amount of uncertainty for FY 2017 sampling, VA did shift to a ratio-estimate to calculate the improper payment rates and precision of the estimates. The dollar-amount estimates were then derived by applying these ratios to the total of population dollars. This approach was detailed in the sampling plans and submitted to OMB and accepted as a standard approach. Payments selected for testing were then reviewed against program-specific criteria to determine payment accuracy. In many instances, samples were selected quarterly to allow payment testing activities to begin earlier in the FY, and in other instances, samples were selected semiannually or annually. These details may be found in the respective sampling plan for each program.

VA submitted sampling programs that were updated for FY 2017 to OMB in advance of the June 30 deadline and OMB accepted all of the plans. The PLTSS sampling plan was modified from the prior year in order to reduce the large sampling size required under the previous methodology. The alternative sampling approach allowed for results greater than the 2.5 percent precision at a 90 percent confidence level or greater than 3 percent precision at 95 percent confidence as required by OMB Circular A-123, Appendix C, guidance. OMB approved this alternative sampling plan under two conditions that were agreed to by VA (1) The cost savings from reducing their third and fourth quarter sampling sizes is funneled back with the purpose of preventing and reducing improper payments within the PLTSS program, and (2) VA produce a plan for FY 2018 that will be both statistically valid and robust (i.e., it will meet a 95 percent confidence interval with a 3 percent or better precision level). All other methods remain consistent with those discussed above.

SECTION D: FRAUD REDUCTION REPORT

OVERVIEW

On April 27, 2017, the SECVA made the reduction of fraud, waste, abuse (FWA) a top priority, with the announcement of the “Seek to Prevent Fraud, Waste, and Abuse (STOP FWA)” initiative that capitalizes on existing departmental activities that prevent or identify FWA, as well as reduces duplication and improves business processes. Previously, VA’s approach to STOP FWA was decentralized. The initiative, led by the Acting Assistant Secretary for Management, will improve governance and understanding of current activities as well as identify programs that need additional strategies to mitigate the risk of FWA. VA expanded the scope of its existing executive-level IPERA Board to increase awareness of the need for program integrity beyond just compliance with improper payments legislation. This new board, STOP FWA Governing Board, had an inaugural meeting September 20, 2017 and stressed the need for collaboration and awareness of FWA risks, discussed oversight as needed of activities to address those risks, and what aid is needed in the implementation of corrective actions. In addition, the Fraud, Waste, and Abuse Advisory Committee was established to obtain best practices and an internal Fraud Act Working Group was established to collect and
analyze data from reporting mechanisms on detected fraud and to decide how best to monitor fraud trends to continuously improve fraud prevention controls. VA is committed to creating an organizational culture and structure conducive to FWA risk management that detects, prevents, and addresses FWA in order to protect its resources.

**VA’S FRAUD REDUCTION EFFORTS**

The VA OIG reported $313.65 million in confirmed fraud within FY 2017. To accomplish fraud reduction, VA has implemented financial and administrative controls, standards for internal control in fraud risk, and efforts to manage fraud risk within its programs. In FY 2017, VA elevated awareness of the priority to reduce the risk of FWA by creating the STOP FWA initiative.

**IMPLEMENTATION OF THE FRAUD RISK PRINCIPLE (STANDARDS FOR INTERNAL CONTROLS)**

The Government Standards for Internal Control’s fraud risk principle states that management should consider the potential for fraud when identifying, analyzing, and responding to risk. To comply with this principle, VA will implement ERM and establish policy for the Risk Assessment Tool to ensure consistency across the VA and determine appropriate mitigation strategies for risks identified in all VA programs. These efforts are further discussed in the below sections.

**IMPLEMENTATION OF OMB CIRCULAR A-123 MANAGING FRAUD RISK**

In alignment with OMB Circular A-123 guidance to integrate ERM across the government, VA’s Office of Enterprise Integration (OIE) developed the ERM Framework & Implementation Plan (ERM FIP) and Risk Profile. The ERM FIP includes a framework for how VA will identify, evaluate, respond, monitor, and report on all risk types, including fraud risk. VA ERM FIP will list the required processes and products related to ERM and suggest leading practices for implementing ERM at the Administration, staff office, and VA program level. Also included in

Implement the plan is the integration of ERM activities, communications, and data with internal controls and fraud prevention/reduction activities at the department level. In addition, the ERM FIP includes a maturity model that will build data analytics capabilities once policies, procedures, governance, and infrastructure are established to support large data sets and visualization tools. As OEI identifies risks related to FWA, they are working with risk owners and affected stakeholders to understand mitigation strategies and corrective action plans, and they are monitoring these activities for progress. The VA ERM program will continue to work in coordination with the STOP FWA working group, OIC, and the Enterprise Risk Council to strengthen VA’s detection, prevention, and response to fraud vulnerabilities. OEI will also continue to build communication channels at all levels of the organization to increase situational awareness of emerging risks, including fraud.

**IDENTIFICATION OF RISK AND VULNERABILITIES TO FRAUD**

VA has made progress in identifying risk and vulnerabilities to fraud in payroll, beneficiary payments, grants, large contracts, and purchase and travel cards but recognizes the need for a consistent and objective approach to assessing its risk of fraud, waste, and abuse. In FY 2017, VA partnered with the Department of Treasury to improve its implementation of risk management and reduction of improper payments. In FY 2018, VA expects to report on additional progress made through this effort.

**PAYROLL**

In FY 2017, VA’s OIC completed a test of design narrative for the HR and Payroll management process in the VATAS. This
process traces financial transactions resulting from HR and Payroll actions from inception through reporting and identifies key financial controls and internal control gaps that could allow for FWA. Also, in FY 2017, pursuant to OMB Circular A-123 (appendix A, Internal Control Over Reporting), VA assessed the design of financial controls in its HR onboarding and payroll management process. This assessment analyzed whether VA’s financial controls are suitably designed to prevent or detect material error within the payroll and grants processes, including errors that may arise as a result of fraud. Grants management controls were determined to be effectively designed in FY 2017.

**BENEFICIARY PAYMENTS**

VBA implemented a centralized approach that enables data analysis and the identification of trends and preventive mechanisms to increase the probability of preventing fraud before it occurs. In 2015, the newly formed VBA Incident Team began investigating all incidents of identified potential fraud cases in benefit programs. These potential fraud cases are detected through a combination of data analytics and incident reports. Additionally, in September 2016, VBA awarded a contract to a Veteran-owned small business to centralize the handling of reported diversions of payments to beneficiaries. VBA now has the capability to identify trends and use data analytics to identify linked cases of fraud, indicators of fraud risk, or potential fraud cases. This approach along with the work of the VBA Incident Team empowers VBA to expedite corrective actions to reissue payments and build robust cases to assist the OIG with their investigations. As of June 2017, the VBA Incident Team recouped $3.3 million since its inception. VBA’s fraud prevention analytical model identifies fraudulent accounts with an estimated 85 percent accuracy rate.

**GRANTS**

In FY 2017, pursuant to OMB Circular No. A-123 (Appendix A, Internal Control Over Reporting), OIC assessed the design of financial controls in its grants management processes. This assessment analyzed whether VA’s financial controls are suitably designed to prevent or detect material error within grants processes, including errors that may arise as a result of fraud. Grants management controls were determined to be effectively designed in FY 2017.

**LARGE CONTRACTS**

FSC provides data analytics services to aid in basic data migration/collection activities to assist with development and deployment of a full range of advanced analytic methods in support of large contract purchases.

**PURCHASE AND TRAVEL CARDS**

OIC performs regular government purchase card data mining/data analytics reviews and targets unauthorized commitments, which generally occur when purchases are split or when micro purchase thresholds between $2,000 to $3,500 are exceeded. Through a service level agreement with FSC, purchase card data is uploaded into software, which aggregates information and produces interactive visualization tools and charts to simplify analyzing purchase card data. Also, FSC performs and assists OIC in tracking and analyzing purchase card information through development and use of a full range of analytic methods, such as data collection, integration, data profiling, and use of predictive models/forensic methods. These methods identify anomalies and trends associated with the programs. These are used to discover issues such as split purchases and other possible cases of FWA. Results of these analyses are delivered to leadership and oversight bodies.
SECTION III: OTHER INFORMATION

ESTABLISHED STRATEGIES, PROCEDURES, AND OTHER STEPS TO CURB FRAUD

IPRO and FSC’s Data Analytics Division have collaborative relationships with other federal agencies involved in fraud detection and analysis. IPRO participates in the Improper Payment Community of Practice meeting and contributes to data sharing discussions. FSC collaborates with the University of Texas as a potential partner in fraud detection and analysis. Additionally, VA’s DMC has proposed and initiated staffing for an Internal Controls & Process Improvement Division that will review internal processes. VA entered into a partnership with the Department of Treasury in FY 2017 to increase capabilities and improve activities designed to identify and prevent instances of fraud, waste, and abuse. VA has also begun discussions with the Department of Health and Human Services to identify areas for collaboration in payments for community care.

Additionally, starting in July 2016, the VHA OCC Department of Program Integrity (DPI) began working closely with training staff to produce annual training videos. A different topic of training is developed annually based on emerging trends or new schemes in health care fraud. These courses teach users how to identify and report potential FWA for issues such as compound drugs. DPI coordinates with multiple Assistant U.S. Attorneys and actively collaborates with 18 different health care task forces to include participation with the Healthcare Fraud Prevention Partnership. Since July 1, 2016, the DPI opened 378 new FWA health care cases. Excessive charges rank as the highest percentage of cases (45 percent) DPI identified. DPI currently has 86 active civil and/or criminal OIG investigations.

DPI utilizes a broad spectrum of internally developed reports to detect suspicious activity with health care claims. These reports are used to identify providers and beneficiaries that are displaying unusual billing patterns and behaviors. DPI is currently working with the various family member programs such as Foreign Medical Program, CHAMPVA, and Spina Bifida health care program to identify risks, areas of waste, and potential fraud. Through its investigations, DPI assisted with policy changes and implementation of internal controls within OCC to strengthen controls already in place and add additional controls where none were present. The most noteworthy was the series of investigations that led to the identification of vulnerabilities involving compound drug costs in 2016. Through the implementations of these controls, the monthly compound drug paid amounts saw a significant decrease, from a peak of almost $5 million in August 2015 to just over $70 thousand in September 2016 leading to a 98 percent decrease. Additionally, totals for FY 2015 of almost $30 million dropped to just $2.4 million for FY 2016, resulting in an estimated total savings of more than $27 million for FY 2016.

VA’s Center for Faith-based and Neighborhood Partnerships has engaged in diverse outreach efforts to support a VA priority goal: eliminating homelessness among Veterans.
Consistent with the OMB Freeze the Footprint memorandum (M-12-12), OMB released Reduce the Footprint (RTF) (M-12-12 section 3) on March 25, 2015. As VA’s mission continues to expand and evolve in its efforts to meet the needs of Veterans and their families, VA continues to implement a suite of strategies to manage the office and warehouse space necessary to provide service to Veterans. VA successfully submitted its RTF implementation plan to OMB and GSA covering the FY 2017 through FY 2021 time period. The plan includes these strategies for better utilizing space, as well as presenting owned asset disposal opportunities. VA also completed its first full year (FY 2016) of the RTF initiative against the newly established FY 2015 baseline. VA will continue to work with OMB and GSA to pursue aggressive disposal and reuse opportunities in support of RTF.

### BASELINE COMPARISON

<table>
<thead>
<tr>
<th></th>
<th>FY 2015 Baseline</th>
<th>FY 2016 Reported</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Square Footage</td>
<td>28.24</td>
<td>28.17</td>
<td>-0.07</td>
</tr>
<tr>
<td>(in millions)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### REPORTING OF OPERATION AND MAINTENANCE COSTS – OWNED AND DIRECT LEASE BUILDINGS

<table>
<thead>
<tr>
<th></th>
<th>FY 2015 Reported Cost</th>
<th>FY 2016 Reported Cost</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operation and</td>
<td>$134.86</td>
<td>$129.81</td>
<td>-$5.05</td>
</tr>
<tr>
<td>Maintenance Cost</td>
<td>(in millions)</td>
<td>(in millions)</td>
<td></td>
</tr>
<tr>
<td>(in millions)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VA’s total square feet subject to RTF for FY 2016 was 28.17 million, which represents a decrease of approximately 0.3 percent over the FY 2015 baseline of 28.24 million.

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.

VA estimated to reduce 523,071 square feet of its office and warehouse space between FY 2018 and FY 2022. In terms of looking for opportunities for reduction targets in office and warehouse space, VA continues to focus on disposal of unneeded assets.

In terms of costs, total operation and maintenance costs as reported in the Federal Real Property Profile decreased 3.7 percent from $134.86 million in FY 2015 to $129.81 million in FY 2016. This small drop was due in part to the reduction in square feet, combined with improved efficiency in operations at facilities and changes in utility costs.

*Department of Veterans Affairs – FY 2017 Agency Financial Report*
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 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 VA’s purview.

<table>
<thead>
<tr>
<th>Statutory Authority</th>
<th>Penalty (Name or Description)</th>
<th>Year Enacted</th>
<th>Latest year of Adjustment (via Statute or Regulation)</th>
<th>Current Penalty Level ($ Amount or Range)</th>
<th>Sub Agency/Bureau/Unit</th>
<th>Location for Penalty Update Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans’ Benefits Improvement and Health-Care</td>
<td>False Loan Guaranty Certifications</td>
<td>1986</td>
<td>2016 (via regulation)</td>
<td>The greater of (a) two times the amount of Secretary’s loss on the loan, or (b) another appropriate amount not to exceed $21,563</td>
<td>VBA/Loan Guaranty</td>
<td>Federal Register 81 (09/23/2016): 65551-65552</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

VA intends to publish a regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2018, soon after the October 2017 CPI factor is published.
Enacted on January 28, 2016, the GONE Act requires the head of each agency to submit to Congress, in coordination with the Secretary of Health and Human Services, a report on Federal grant cooperative agreement awards that have not yet been closed out and for which the period of performance, including any extensions, elapsed for more than two years. The GONE Act also sets forth follow-on reporting and analysis requirements by various entities. Only “Federal grant awards” (meaning grants and cooperative agreements as defined in Sections 200.51 and 200.24 of Title 2, C.F.R., or any successor thereto) are subject to the GONE Act. Other types of financial assistance, including loans, are excluded from the reporting requirements of the GONE Act.

Pursuant to the OMB Uniform Guidance in 2 C.F.R. Section 200.343(b), recipients of grants and cooperative agreements must liquidate all obligations incurred under their awards within 90 days after the end of the period of performance, unless the awarding agency authorizes an extension or program-specific statutes specify a different liquidation period.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>2-3 Years</th>
<th>&gt;3-5 Years</th>
<th>&gt;5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Grants/Cooperative Agreements with Zero Dollar Balances</td>
<td>13</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Number of Grants/Cooperative Agreements with Undisbursed Balances</td>
<td>0</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Total Amount of Undisbursed Balances</td>
<td>$0</td>
<td>$1,707,912</td>
<td>$2,018,230</td>
</tr>
</tbody>
</table>

VA faced challenges due to the loss of personnel within one of the key grant program offices. The remaining staff focused on current awards to avoid disruption to grantees during the hiring freeze. The position has been filled enabling focus on closing aged grants. In addition, the emphasis GONE Act placed on closing grants resulted in VA developing reports to monitor aging grants, which will result in more timely closing. The remaining open grants are expected to be closed in the first quarter of FY 2018.