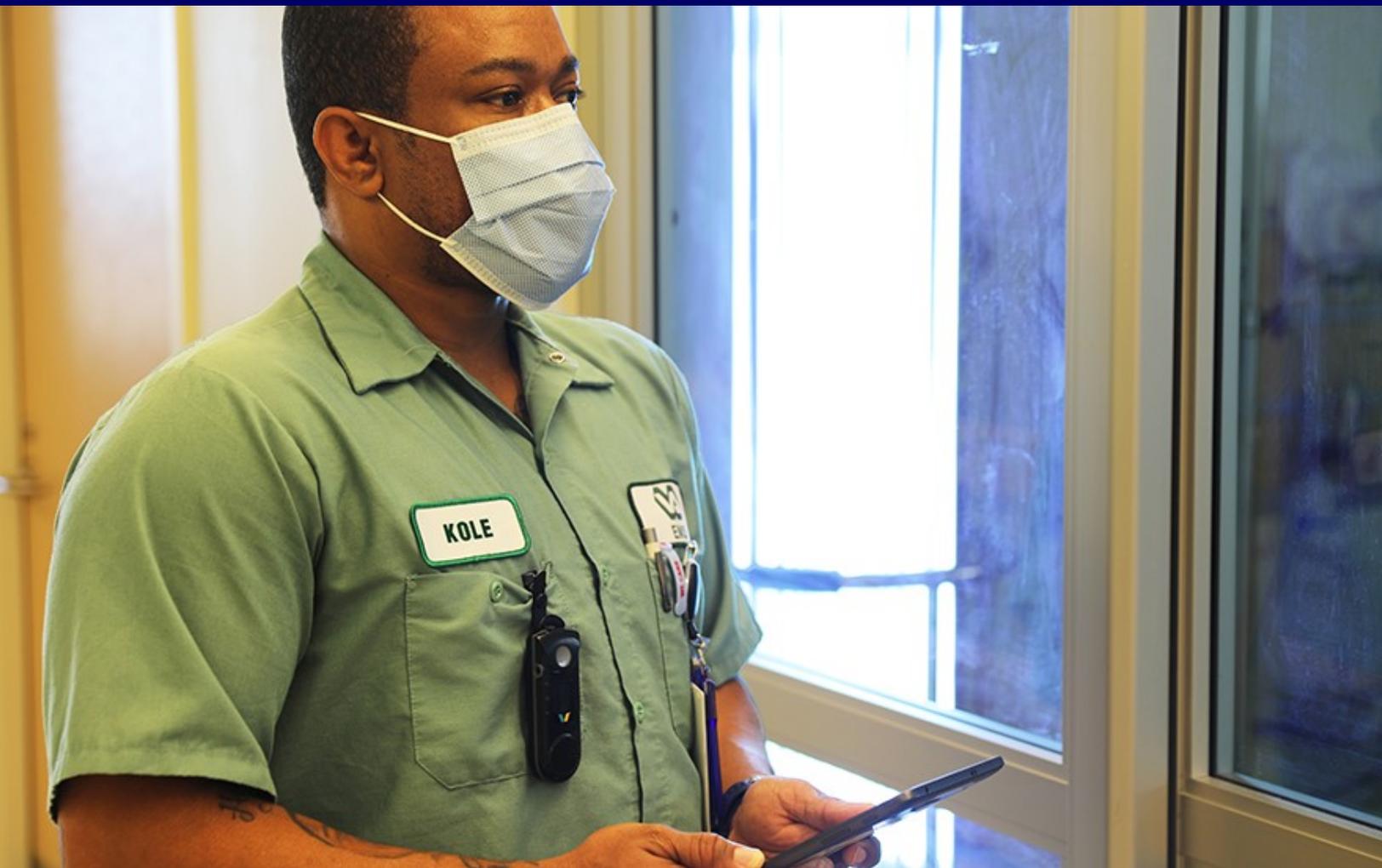# OTHER INFORMATION

Army Veteran is unsung hero in COVID-19 battle

Army Veteran Kolan Glass is not a doctor or a nurse. Still, in the battle against COVID-19, he is one of the most critical employees at North Las Vegas VA Medical Center (VAMC). Glass is the primary housekeeper in the emergency department. After a Veteran has been released, Glass ensures the room is sanitized and prepared for the next patient.

"I clean every room as I would want it if I was the next patient to be staying in it," says Glass. "I sanitize each room with my full attention."

Using technology to ensure safety

Glass and his fellow housekeepers employ the latest technology to prevent infection. This includes a remote-controlled system that uses ultraviolet light to purify equipment, room surfaces and objects.

"Probably about 90 percent of us [housekeepers] are Vets," he says. "That means we talk and we don't panic. Sure, we're dealing with a pandemic, but we still have to get the job done and keep everybody safe."

Glass experienced first-hand how a viral outbreak can test the emergency department. In March, Glass came in contact with a COVID-19-positive patient. He and other employees were placed on a 14-day quarantine.

"I didn't get nervous," Glass says. "I understood it was a precautionary measure, but I was ready to get back to work."

Glass's supervisor recognizes his dedication and leadership.

"Even after he had to self-isolate from his family, and with the stress of waiting for testing results, he immediately picked up right where he left off," says Jesse Diaz. Diaz is chief of environmental management safety at North Las Vegas VAMC. "He's been very vocal in educating the staff and his housekeeping peers in his area. He wants to develop a partnership with the clinical staff and EMS to help reduce the chances of COVID-19 infecting or impacting others."

Picture previous page: North Las Vegas VA housekeeper and Army Veteran Kolan Glass protects Veterans in emergency department from risk of infection.

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

FOREWORD

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, and the public by conducting effective oversight of Department of Veterans Affairs (VA) programs. The OIG recommends advancements to VA services, processes, and systems that will improve the lives of veterans and make the best use of taxpayer dollars. Each year, the Inspector General provides an annual update to VA summarizing its top management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

This year's major management challenges for VA continue to align with the OIG's strategic goals for addressing five areas of concern: (1) healthcare services, (2) benefits, (3) stewardship of taxpayer dollars, (4) information systems and innovation, and (5) leadership and governance. The OIG conducts extensive oversight of VA programs and operations in each of these five areas through independent audits, inspections, investigations, and reviews.

The challenges in these areas that VA must navigate in the fiscal year ahead have been identified by OIG personnel, other external oversight agencies and organizations, the veteran community, Congress, and additional stakeholders. They reflect the OIG's unwavering commitment to veterans, their families, and caregivers, and the VA leaders and staff who serve them.

The OIG recognizes the unprecedented challenges VA faces as it continues to deal with the COVID-19 pandemic. VA leaders and staff at all levels have worked tirelessly to continue to provide quality healthcare to millions of veterans, while treating those suffering from COVID-19 and protecting healthcare staff. The OIG commends all VA leaders and personnel who have continued to work through the COVID-19 pandemic promoting high-quality services and benefits to the nation's veterans and their families and caregivers.

MICHAEL J. MISSAL
Inspector General

OIG CHALLENGE #1: HEALTHCARE SERVICES

Under the best of circumstances, ensuring the quality of patient-centered care in VHA facilities and in the community is a tremendously complex and difficult endeavor for what is the largest integrated healthcare system in the nation.

Even before the pandemic, the OIG had identified challenges that require ongoing VHA focus on maintaining adequate staffing, quality assurance, and other functions central to its mission. The COVID-19 pandemic has presented unprecedented challenges to healthcare delivery nationwide, including significant stresses on VHA's system. The unpredictable and evolving nature of the coronavirus caused VHA to initially focus primarily on providing medical care to infected veterans while simultaneously protecting its employees from COVID-19.

The OIG has been monitoring and reporting on VHA's COVID-19-related efforts that include expanding screening and testing, limiting access to facilities and vulnerable patient populations (such as community living centers/nursing homes), using telehealth and alternative care delivery, and providing personal protective equipment (PPE) and other supplies to personnel that help curtail the spread of the virus.

In this next fiscal year, VHA will have to continue to provide primary and specialty care to veterans while dealing with the impact of COVID-19. This includes ensuring primary and specialty care reaches veterans despite the delivery system adjustments made for COVID-19 and ensuring mental health services reach vulnerable veterans.

It is critical that hospitals have effective core services that promote quality care and patient safety and ensure key operations are running efficiently. These range from ensuring clean and safe environments to having adequate staff with needed expertise. During the OIG's March 2020 inspections of VHA's response to the pandemic, many leaders acknowledged low inventory of PPE for staff, and the inspection teams noted deficiencies in several facilities' screening processes and access controls.

VHA also has ongoing challenges in the provision of quality healthcare. As noted in the OIG's recently published comprehensive healthcare inspection reports, VHA providers continue to struggle with managing patients on long-term opioid therapy in the areas of behavioral risk assessments, urine drug screenings, informed consent, and follow-up evaluations to review the effectiveness of the medication regimen. These issues are significant in light of the continued opioid epidemic where veterans may find themselves with issues such as dependence, tolerance, abuse, and accidental overdose.

VHA also continues to be challenged with privileging processes whereby each facility's service chiefs and Executive Committee of the Medical Staff are tasked to make practitioners' privileging recommendations that are required to be based on focused and ongoing professional practice evaluations. Clinical privileges need to be specific and based on the individual practitioners' clinical competence, and the ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered.

Why This Is a Challenge.

VA operates over 1,200 medical facilities and has more than 9.2 million enrolled veterans. Ensuring timely and quality care was a significant challenge even before the COVID-19

pandemic, and serving veterans while maintaining a healthy workforce in the midst of the pandemic is difficult.

Healthcare systems may have well-developed plans for regional disasters such as weather events, but even the most thoughtful and comprehensive emergency management plans can be decimated by a global pandemic that infects massive numbers of patients, depletes equipment supply chains, exhausts available healthcare staff and has exacted an unimaginable toll on those infected and their families. In addition to straining its mammoth healthcare system, the pandemic has called VA into service for its "fourth mission" of supporting national, state, and local emergency management, public health, and safety efforts. As of June 30, 2020, VA had provided to others more than 235,000 pieces of PPE including gowns, gloves, masks, and face shields, according to its COVID-19 Pandemic Weekly Report. VA had also deployed personnel to more than 45 states to help local governments and facilities combat COVID-19, and opened the doors of its facilities to nonveterans needing critical care.

Although VA has taken extraordinary measures, the pandemic response has stressed weak points in a range of systems and practices, many of which have been previously identified by the OIG.

What the Department Needs to Do.

VA must take the necessary steps to maintain a healthy and productive workforce, ensure adequate testing and supplies of PPE are available, and make certain that safety protocols and practices for staff and patients consistently reflect the most current guidance and identified promising practices. Sharing what works is extremely important. The July 2020 OIG report on the department's response to the pandemic highlights that there are constantly emerging lessons learned.

Other aspects of patient safety that have recently been identified cannot be put on hold. These include quality management, credentialing and privileging of care providers, oversight of a surge of new hires, medication management, and the tracking of suspicious deaths.

Finally, VA must continue to engage with the most vulnerable veterans to ensure they receive the continuing care they require. VA has taken steps to engage the community in its suicide prevention and mental health initiatives. The veteran community, particularly individuals who have experienced posttraumatic stress disorder and the isolating effects of the pandemic, will need VA's continued attention on leveraging quality resources going forward.

VA Management's Response
VA acknowledges the challenges in healthcare service that the Department is facing, especially regarding COVID-19. In response to COVID-19 and other hiring needs, VHA activated broad hiring initiatives targeting the occupations and locations with the greatest need, as well as emergency deployments of staff to hard-hit areas. In March, VA released a strategic response plan for COVID-19 and guidance to assist the field in designing and deploying localized response plans. Additionally, VA released guidance to minimize the risk of infection for residents in VA community living centers, spinal cord injury and disorder units and blind rehabilitation centers.

Further, VA added screening and access guidance for VA facilities and developed a COVID-19 test that may be used when access to external testing is constrained. VA expanded telehealth and video telecare to shift care from a face-to-face model with its inherent risk of COVID-19 exposure to focus on virtual appointments covering primary care, mental health and specialty care. VA worked to secure personal protective equipment and supplies from manufactures that meet Food and Drug Administration regulations from around the world.

Lastly, VHA enhanced targeted strategies for identifying and reaching Veterans at increased risk for suicide and mental health challenges, as well as enhancing efforts to bolster operational protocols to ensure continued operation of its mission in the face of increasing demand and potential risks for staff who work in close proximity.

OIG CHALLENGE #2: BENEFITS FOR VETERANS

Starting March 19, 2020, VA regional offices were closed to the public. By leveraging telework, available information technology resources and other strategies, VBA has been working to administer nearly $125 billion in funding for federally authorized benefits and services to eligible veterans, caregivers, their dependents and survivors. In the next fiscal year, as offices are deemed safe to reopen, staff will need to continue to navigate safety measures while finding new ways of performing routine tasks. They must also work through the identified backlog of medical examinations, claims, and other matters while balancing ongoing demands. The pandemic's effect on education, training and the economy will be felt by veterans nationwide who have applied for a wide range of benefits. Similarly, the demand for healthcare benefits is expected to remain high.

Eligible veterans, their families, and caregivers must receive proper benefits and services in a timely manner. The OIG has made a range of recommendations that will need to be implemented through the coming fiscal year to advance expeditious and accurate VBA decision-making and processes for delivering benefits.

Challenges include addressing previously identified recurring deficiencies such as inadequate planning for systems or process changes; mismanagement of backlogs; vague guidance for disability claims medical examinations processing and disability claims decisions; unclear definition of roles and responsibilities for local or regional oversight; lack of controls; and limited information technology (IT) functionality, which contributes to inefficiencies and inaccuracies.

As a result of these recurring issues involving VBA's processes, compounded by COVID-19 demands, staff have significant challenges ahead maintaining the accuracy and timeliness of essential claims and conducting appeals-related activities.

Why This Is a Challenge.

Recent OIG reports have identified significant challenges in VBA's attempts to deliver accurate and timely claims decisions and appeals. Failures in guidance, training, quality assurance, and systems have been well-documented, particularly in regard to particularly complex claims. For example, one recent report found problems with processing errors including improper evaluations, missed secondary conditions, and evaluations based on inadequate medical examinations for veterans submitting claims for disabilities related to conditions of the spine.

The OIG has also reported on inadequate oversight of contracted disability exam cancellations. The MISSION Act requirement to deliver more community care has also taxed VA processes and procedures, and the OIG has reported on mismanaged appeals of non-VA care claims and non-VA emergency care claims.

The COVID-19 pandemic has complicated benefit determinations by reducing VA resources available to conduct in-person medical examinations. This was compounded by the hesitancy of veterans to get the exams needed to determine their level of benefits because of the in-person requirement.

In April 2020, VA suspended its in-person medical disability examinations for its Compensation and Pension Program. On May 28, 2020, VA resumed the in-person exams where doing so was considered safe. As of July 4, 2020, VBA reported more than 425,000 pending disability compensation and pension claims with more than 168,000 pending for more than 125 days since receipt.

Some of the exams were shifted to telehealth, but many of the compensation and pension medical examinations cannot be completed virtually. During the pandemic, VBA increased the number of authorized compensation and pension exam disability benefit questionnaires that could be completed by telehealth from 16 to 29. Another tool implemented by VBA to assist with reducing the medical examination backlog is the use of acceptable clinical evidence exams. This process allows latitude to those who make decisions related to disability claims to use current medical evidence already associated with the veteran's VA medical records.

Although VA has reported a dramatic uptick in the use of telehealth, a significant backlog for in-person appointments will likely persist because of the imbalance between capacity and demand for telehealth appointments, the inability to perform many types of healthcare services without person-to-person contact, and information technology-related issues that limit some patients' abilities to obtain service via telehealth.

VA must also continue to address increased claims following the implementation of the Blue Water Navy Act of 2019 on January 1, 2020, which extended the presumption of herbicide exposure, also known as Agent Orange exposure, to nearly 90,000 veterans who served as far as 12 nautical miles from the shore of Vietnam between January 9, 1962, and May 7, 1975, and have since developed one of 14 conditions related to exposure.

As VA continues to manage the effects of the pandemic on its facilities and staff, veterans have become less hesitant to report for in-person exams, safety measures have been put in place, and protocols have been communicated. VA has steadily increased the number of compensation and pension exams it has processed and, according to senior VA leader testimony to Congress, VA has reprogrammed funds, freeing up more overtime availability to process the exams. VA has also proposed legislation to Congress that would allow some flexibilities for other medical professionals besides doctors to conduct the exams, such as nurse practitioners. This would allow VA to expand its capacity to process the exams, according to VA senior leaders.

What the Department Needs to Do.

The OIG has made many recommendations in recent years related to improving the accuracy and timeliness of VBA's claims decisions and appeals processes. According to feedback from VBA personnel, some of the issues have occurred because production standards to address backlogs and timeliness have had the unintended consequence of sacrificing accuracy of the disability claims process. This may require investments in staff, systems, and other resources. Many of the root causes are at the senior leadership level, where recommendations include conducting focused analyses to assess the accuracy of claims processes and implementing policy and systems that improve the efficacy of the program, implementing plans to provide consistent oversight and training through national performance and training plans, and updating the rating schedules, procedures manuals, and disability benefits questionnaire forms. With the many challenges presented by the pandemic on top of previously identified obstacles to achieving its goals, VBA must develop a plan that addresses timeliness, accuracy, and quality assurance.

VA Management's Response
VBA appreciates the management challenges identified by OIG and will continue to work in partnership to address OIG's valued findings. VBA is dedicated to providing accurate and timely service to Veterans; reducing the claims backlog to 77,162 as of March 31, 2020. However, due to the COVID-19 pandemic and the resulting delays with in-person examinations and obtaining federal records, VBA's claims backlog increased to 198,425 claims as of July 31, 2020. In response, VBA shifted operations and processes virtually and continued to process claims whenever possible using evidence of record or tele-C&P examinations. As in-person examinations resume, VBA expects the backlog to decrease and timeliness to improve.
VBA has also implemented various process improvements to ensure accurate and timely benefits delivery. VBA's training program has undergone extensive reviews of its methodologies and frequency of delivery, as well as updates to program content. VBA also continues to work toward updating the entire VA Schedule of Rating Disabilities to increase medical accuracy, and further align rating criteria with the actual impairment experienced by Veterans. To date, VBA has successfully updated over half of the pending body systems and the remaining updates are in process.
VBA continues to make progress on its legacy appeals elimination efforts. VA estimates that legacy appeals, excluding a small number of returning remands, will be resolved by December 2022.

OIG CHALLENGE #3: STEWARDSHIP OF TAXPAYER DOLLARS

The OIG has consistently identified procedures and strategies for improving the responsible use of VA-appropriated funds, including sound and closely monitored procurement practices and the need for internal controls that reduce the risk of fraud, waste, and misuse of resources. When funds are wasted or misused, valuable resources are diverted from benefiting veterans, their families, and caregivers.

As described below, the OIG has identified costs due to delays or mismanagement of IT systems. Tax dollars have also been wasted or misused because of a lack of internal oversight and poor planning within programs. As with the areas of concern previously discussed, the pandemic has stressed systems further and required that some controls be circumvented to adjust to emergency conditions. While certainly understandable, the impact has created additional challenges for VA that will be felt for some time.

To assist with the response to the COVID-19 pandemic, Congress passed the CARES Act, which provided $19.6 billion in supplemental funding for VA. However, even before the pandemic, VA's size and complexity of operations made effective budget management extremely challenging. VA's financial management system is over 25 years old and has functional limitations well-documented in OIG reports. The pandemic is intensifying long-standing challenges and delaying initiatives intended to remediate these problems, including financial management reforms and the transformation of business processes.

Also, while VA has numerous initiatives to curb fraud, waste, and abuse, the pandemic is creating novel opportunities for bad actors, particularly because of the need to facilitate rapid purchases of essential goods and services. As VA has struggled to expand its supply chain fast enough to curtail the spread of COVID-19, many companies—some nefarious and some neophytes—have sought contracts for PPE and other medical supplies worth millions of dollars that they cannot fulfill. Some of these potential fraudsters have been identified by VA leaders and referred to the OIG, underscoring the challenges for VA to be vigilant in a chaotic environment. For example, in one of the first and largest COVID-19-related fraud cases brought to date, OIG investigators collaborated with other law enforcement authorities to arrest a Georgia resident for attempting to sell millions of nonexistent respirator masks and other PPE totaling over $750 million to VA in exchange for large upfront payments.

Why This Is a Challenge.

As reported in the most recent Semiannual Report to Congress, the Federal Financial Management Improvement Act (FFMIA) requires all agencies covered by the Chief Financial Officers Act to implement financial management systems that substantially comply with three essential requirements: (1) federal financial management systems requirements, (2) federal accounting standards, and (3) the United States Standard General Ledger at the transaction level. The law further requires that the head of the agency annually assess and the agency auditor report whether the agency's financial management systems substantially comply with the law's essential requirements. Accordingly, the VA OIG is required to report instances and reasons when VA has not met the intermediate target dates established in the VA remediation plan to bring VA's financial management system into substantial compliance with FFMIA.

The Audit of VA's Financial Statements for Fiscal Years 2019 and 2018 reported the following, including some findings that represent long-standing unmet challenges:

- VA did not substantially comply with federal financial management systems requirements and the United States Standard General Ledger at the transaction level under FFMIA, which has been repeatedly reported in part for more than 10 years.
- VA did not fully comply with the intent of the Federal Managers' Financial Integrity Act, which has been reported by the OIG since FY 2015. Improvements are needed.

- VA did not comply with the Improper Payments Elimination and Recovery Act for FY 2018, as reported by the OIG since 2012.

These conditions are primarily due to the complex and disjointed architecture of VA's legacy financial management system, which has difficulty meeting increasingly demanding financial management and reporting requirements. VA continues to be challenged in consistently enforcing established policies and procedures throughout its geographically dispersed portfolio of legacy applications and systems.

With respect to fraud, waste, and abuse, the combination of millions of dollars in emergency spending, the need for expedited contracts for medical supplies and other life-saving resources, and the ingenuity and speed at which those who would capitalize criminally on the pandemic adapt, creates a trifecta of high-risk conditions. In such a context, VA is vulnerable to various fraud schemes, including contract and procurement fraud, bribery and kickback schemes, and internal issues such as employee theft and the improper reporting of overtime.

Even before the pandemic in fiscal years 2019 and 2020, the OIG investigated hundreds of instances of fraud, bribery, theft, and False Claims Act violations, resulting in judicial actions that involved hundreds of millions of dollars in VA monetary benefits. The most recent Semiannual Report to Congress reported investigative actions that impacted $209 million in monetary benefits.

What the Department Needs to Do.

VA will need to ensure that duties for purchasing, approving, and receiving goods and services do not remain with a single individual and that reasonable efforts are made to monitor expedited transactions. Compliance with this and other VA policies remains essential even in emergency situations. As the Information Systems and Innovation section discusses below, delays and changes in implementing new systems have implications for effective financial management that can only be addressed through comprehensive and coordinated planning. Additional engagement with community and third-party administrators of VA programs also requires continuous monitoring and access to other systems' data or reports for verification purposes.

On numerous recent occasions, VA has referred suspicious activity to the OIG for investigation, with noteworthy outcomes. Continued, quick handoffs between VA and the OIG, as well as the use of the OIG's predictive analytics of procurement and claims data, will help address criminal activity and other misconduct arising during and even beyond the pandemic.

VA Management's Response
VA acknowledges the stewardship challenges the Department is facing related to the financial management systems. VA is committed to resolving the financial management system weaknesses and has continued implementing corrective actions through a major improvement initiative to replace and modernize the antiquated systems. This effort will increase the transparency, accuracy, timeliness and reliability of financial information, resulting in improved financial controls and fiscal accountability to American taxpayers in accordance with FFMIA. In response to the COVID-19 pandemic, VA coordinated with stakeholders to revise the implementation timeline for deployment of the new financial system

at NCA. The extension provides additional time for workforce readiness activities and training and mitigates resource constraints.

VA also acknowledges challenges related to fraud, waste and abuse during the acquisition process. Being intentional stewards of taxpayer dollars requires an integrated enterprise approach to the transformation of business systems. This approach not only includes technology but encompasses developing and applying proven acquisition best practices that include harnessing technology to drive behavior changes, providing updated functionality and capability for VA employees, and assuring our first priority of quality customer service leading to measurable results. VA continues to implement corrective actions over the acquisitions process to assure application of proven programmatic business practices. These practices aim to improve program outcomes and a quality return on the investment of taxpayer dollars.

OIG CHALLENGE #4: INFORMATION SYSTEMS AND INNOVATION

The challenges associated with information systems and innovation strongly affect VA's ability to conduct its programs and services. The provision of timely and quality health care and benefits for veterans and other eligible individuals discussed above, for example, depends in large part on the functionality, effectiveness, and ease of use of underlying systems. The OIG has amassed many reports and recommendations that assess and propose enhancements to VA's infrastructure systems, including IT and data security. Through findings and report recommendations, the OIG highlights practices that promote quality standards that can be implemented throughout VA, particularly those that effectively use program planning, budget forecasting, and other predictive tools.

For example, the OIG has identified multiple systems that lack the functionality or proper controls to ensure that large backlogs, errors, inefficiencies, and obstacles to information sharing are minimized or redressed. Some challenges center on the planning and execution of new IT systems and transitioning from legacy systems, while others also involve patterns of user abuse or mistakes that can go largely undetected for long periods. Decentralized oversight, unrealistic timelines, inadequate engagement of all stakeholders and end users, and minimal testing for some systems have plagued IT projects. Delays, changes in direction and even vendors, and user resistance all carry steep costs to VA. The OIG has detailed recurrent issues that run through reports on the GI Bill implementation, changes to systems affecting benefits to eligible veterans, medical appointment scheduling, payments for care in the community, medical supply and equipment inventory, financial management, electronic healthcare waiting lists, and police information management. These are among the many systems for which the OIG has published recommendations related to frequently encountered challenges.

Perhaps the most visible and challenging of these is VA's Electronic Health Record Modernization (EHRM) Program, one of the largest IT projects in government history. The OIG has been conducting early oversight of VA's efforts because of the tremendous cost and scale of the effort. In addition to the almost $10 billion contract, VA estimates another $6.1 billion will be needed for program management and infrastructure-related costs. Of this amount, approximately $4.3 billion is for program infrastructure and the remaining $1.8 billion is estimated for program management. The infrastructure cost estimates, however, do not cover

some of the physical upgrades to the individual healthcare facilities, which are to be funded by VHA.

In addition to EHRM, VA considers the implementation of the Defense Medical Logistics Standard Support (DMLSS) System as a solution to an inefficient, poorly functioning $10 billion supply chain. The VA Logistics Redesign Program Office's goal is to implement the DMLSS System to modernize VA's supply chain, establish an integrated IT system to support business functions and supply chain management, and address the system's many identified supply chain deficiencies. As with EHRM, interoperability with VA systems and holistic changes to business processes will be significant hurdles to VA's implementation of the DMLSS System.

The OIG also has focused on these and other IT initiatives because prior modernization efforts by VA have failed in important ways. The OIG has identified VA's information management as a major management challenge since 2000 because VA has a history of not always properly planning, overseeing, and implementing updates to its critical IT investments. Moreover, the GAO previously reported that these prior efforts have cost VA over a billion dollars.

Why This Is a Challenge.

Challenges to implementing new technologies across a decentralized and complex system are numerous. For example, unrealistic deadlines and inadequate planning are symptomatic of trying to be responsive to identified needs and demonstrate progress without addressing identified and emerging problems. Shortcuts often result in costly delays and complications. For EHRM implementation VA-wide, challenges are intensified by VA's need to coordinate and collaborate with DoD, as well as to modernize VA's aging infrastructure to accommodate the new system. OIG reports demonstrate that failures in oversight, planning, and coordination have already affected plans for the new system's roll out.

COVID-19 has delayed VA's implementation of the electronic health record as healthcare providers are largely unavailable to assist in developing and testing parts of the new system. Secretary Wilkie announced the delay in an April 3, 2020, letter to congressional leaders. Nevertheless, VA continues to make some progress. On April 18, 2020, the Federal Electronic Health Record Modernization Program Office, VA, and the DoD launched a joint health information exchange, which modernized data-sharing capability, enhancing both departments' ability to securely exchange records with community healthcare partners. In addition, VA has shifted the schedule of sites scheduled to go live with the new electronic health record system to account for what has been developed to date and the ongoing impacts of COVID-19.

What the Department Needs to Do.

The OIG recognizes the significant level of effort and commitment required by VA to manage and facilitate the implementation of the massive and complex electronic health record system, including the tremendous work already conducted by VA staff.

In preparation for the new electronic health record system's deployment at VA healthcare facilities, significant upgrades are needed to VA's infrastructure. The department should establish an infrastructure-readiness schedule for future deployment sites that incorporates lessons learned from DoD and from VA's initial effort at Mann-Grandstaff VAMC in Spokane, Washington. VA should continue to reassess the enterprise-wide deployment schedule to

ensure projected milestones are realistic and achievable, and that training is effective and evaluated. VA should fill infrastructure-readiness team vacancies until optimal levels are attained. Failure to redress identified issues puts VA at risk for additional failures, breakdowns, and delays when deploying the new electronic health record system nationwide in the years to come.

With respect to the implementation of DMLSS, VA needs to conduct appropriate testing to ensure business processes are appropriately implemented and data access and transfers are effective.

The long-standing and repeat areas of weakness identified in VA technology projects require across-the-board improvements in project planning, scheduling, the calculation of associated costs, user and stakeholder engagement, leadership, security, and infrastructure enhancements, and other areas where the OIG has repeatedly recommended corrective actions.

VA Management's Response
VA recognizes that information technology modernization is critical to improving VA's performance to better serve Veterans, their families, caregivers and survivors while being good stewards of taxpayer dollars. VA continues to drive aggressive progress to modernizing system infrastructure while improving processes to ensure technology projects are delivered on schedule and within budget.
With respect to the Defense Medical Logistics Standard Support (DMLSS) System, VA started implementation at sites nationwide beginning with the Captain James A. Lovell Federal Health Care Center (FHCC) in August 2020. Prior to go-live at the FHCC, the DMLSS team conducted business process testing to validate the DMLSS functional processes. The testing demonstrated that the DMLSS business processes worked as designed but revealed data transfer anomalies that are in the process of remediation. Based on this finding, the DMLSS Team and VA Logistics Redesign Office will implement stronger data mapping oversight of implementation at upcoming sites.
With respect to infrastructure upgrades needed for deployment of the new electronic health record system, VA acknowledges the challenges highlighted by the OIG and commits to implementing the action plan developed in response to the original report published by the OIG. VA's plan includes an Infrastructure Readiness schedule that accounts for lessons learned from the Department of Defense deployment.

OIG CHALLENGE #5: LEADERSHIP AND GOVERNANCE

The VA has many dedicated leaders who are committed to providing the best possible services to veterans, often under very stressful conditions. However, many emergent problems have arisen and some problems that are pervasive and persistent have gone unaddressed because of frequent turnover or vacancies in key positions and failures in leadership, including lack of accountability, poor governance, and misconduct by individuals in positions of trust. The challenge of maintaining stable and effective leadership cuts across all areas of concern previously discussed. The OIG has identified frequent changes (and lapses) in leadership and

workforce or staffing issues as major management challenges to VA in providing veterans with timely access to quality care.

Why This Is a Challenge.

VA governance and oversight is often decentralized. Oftentimes, there are multiple offices that oversee aspects of a particular initiative or function within VA. The policy office may, for example, develop guidance or even training, but oversight, quality control, and staffing may be handled by others. Oversight roles and duties are often misunderstood, and guidance may be vague, conflicting, or simply in too many different places to navigate. Reorganizations and realignments of offices and responsibilities can further confuse matters. Information critical to operations may not be well-documented, shared, or used for decision-making.

What the Department Needs to Do.

Leaders need to take on persistent problems and establish clear lines of authority that promote accountability for accuracy, efficiency, and effectiveness in carrying out responsibilities.

A good example of how VA has overcome past staffing challenges is its expedited hiring during the pandemic. Yet VA has experienced chronic shortages of healthcare professionals since at least 2015. VA's inability to adequately recruit, onboard, and retain clinicians and support staff, particularly in specific service areas, reflects problems with competitive pay, widespread shortages in some professions or positions, unfavorable leadership and work climate, inadequate planning, and other factors.

What remains to be seen is whether the department can resolve persistent issues. While the pandemic has provided new resources and initiatives for hiring, the hiring push also happened against the backdrop of record highs in unemployment nationally. Many of the problems previously reported related to staffing will likely continue after the pandemic has ended. The OIG has repeatedly called for VHA to develop additional comprehensive staffing models that address national needs while supporting flexibility at facilities. This approach would help ensure taxpayer dollars are invested in delivering the highest quality of care to veterans as promptly as possible. These staffing models, however, cannot be completed without accurate data. In reports on VA's self-reported staffing data, the OIG found that VA and some of its medical facilities were unable to provide accurate numbers of vacancies. Focusing on serving the individual and aggregate needs of veterans in different geographic areas and using that understanding to develop comprehensive staffing models will help VA achieve more efficient and targeted hiring and retention practices. Additional recommendations call on VHA to refine and formalize its position categories for clinical and nonclinical staff across all facilities.

VA Management's Response
VA is committed to addressing this challenge and in FY 2020 the Office of Human Resources and Administration/Operations, Security and Preparedness (HRA/OSP) developed and implemented corrective actions to support the Department, which will continue in FY 2021. An Executive Resources Board (ERB), co-chaired by the Assistant Secretary, HRA/OSP, is accountable for executive-level governance to include position management, performance

management, merit staffing, leadership development, succession planning and executive pay. The Corporate Senior Executive Management Office (CSEMO) has been utilizing the National Announcement strategy for Medical Center Director positions to enable every Veterans Integrated Service Network (VISN) Director to review the best qualified candidates against the vacancy requirements. This strategy improves executive time-to-hire by weeks and allows VISNs to collaborate on hiring selections.

As noted above, human capital leadership and governance has been amplified during the COVID-19 pandemic. The Office of the Chief Human Capital Officer (OCHCO) demonstrated the effectiveness of centralized policy and governance side-by-side with the human resources (HR) servicing offices in VHA, VBA and NCA. OCHCO implemented weekly communications, problem-solving and external engagement to resolve human capital issues in real-time and mitigate challenges that could have impacted VA's ability to maintain a safe workforce and meet its mission.

VA continues to work to improve employee engagement and retention. The Stay Touchpoint initiative is being diffused across VHA to reduce voluntary separation rates. HRA/OSP also continues to work with the administrations and the Office of Congressional and Legislative Affairs on legislative proposals to improve hiring, competitive pay and retention of healthcare professionals. Along with the Office of Management (OM), HRA/OSP also co-chairs a governance council for Human Resources Information Technology (HRIT) to ensure investments are focused on modern enterprise HRIT systems to improve the experience of HR professionals, managers and employees.

HRA/OSP's Manpower Management Services (MMS) is working to improve the accuracy of vacancy data reports by occupation (Section 505, MISSION Act). Ongoing position validation and enhancements to human capital systems will yield greater accuracy and reporting of funded and unfunded vacancies. VHA's Office of Productivity, Efficiency and Staffing (OPES) continues to lead the development of staffing models for clinical professions. Since 2007, OPES has been developing staffing management tools, systems and studies to optimize clinical productivity in support of clinical excellence, access and safe and compassionate care.[3]

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[3] VHA Directive 1065(1), *Productivity and Staffing Guidance for Specialty Group Provider Practice* requires VAMCs to use the OPES standards to inform resource decisions for their specialty provider group practices. When practices are out of range (high/low) VAMCs should develop and implement remediation plans to improve specialty physician group practice productivity.

RELATED REPORTS:

Selected Related Reports from fiscal year 2020 (with a comprehensive list of publications available at www.va.gov/oig):

Related Report	Challenge #1	#2	#3	#4	#5
Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness	X	X			X
OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness [for] March 19–24, 2020	X				X
Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia	X				X
Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center	X				X
Inadequate Oversight of the Medical/Surgical Prime Vendor Program's Order Fulfillment and Performance Reporting for Eastern Area Medical Centers	X		X		X
Audit of VA Medical Center Management of Medical Supply Inventories	X		X	X	
Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia	X		X	X	
Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package	X		X	X	
Inadequate Oversight of Contracted Disability Exam Cancellations		X			X
Accuracy of Claims Decisions Involving Conditions of the Spine		X			X
VHA Did Not Effectively Manage Appeals of Non-VA Care Claims	X			X	X
Non-VA Emergency Care Claims Inappropriately Denied and Rejected	X				X
Disability Compensation Benefit Adjustments for Hospitalization Need Improvement		X			
Audit of VA's Financial Statements for Fiscal Years 2019 and 2018		X	X	X	
VA's Compliance with the Improper Payments Elimination and Recovery Act for Fiscal Year 2019			X		
Fiscal Year 2019 Risk Assessment of VA's Charge Card Program			X		

Related Report	Challenge				
	#1	#2	#3	#4	#5
Overtime Use in the Office of Community Care to Process Non-VA Care Claims Not Effectively Monitored	X				X
Insufficient Oversight of VA's Undelivered Orders			X	X	X
VA Improved the Transparency of Mandatory Staffing and Vacancy Data					X
Critical Care Unit Staffing and Quality of Care Deficiencies at the Charlie Norwood VA Medical Center Augusta, Georgia	X				X
Deficient Staffing and Competencies in Sterile Processing Services at the VA Black Hills Healthcare System, Fort Meade Campus South Dakota	X				X
FY 2019 OIG Determination of Veterans Health Administration's Occupational Staffing Shortages	X				X
Staffing and Vacancy Reporting under the MISSION Act of 2018, June 25, 2019					X
OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018, June 14, 2018	X				X
Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System	X			X	
Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center Spokane, Washington	X			X	

Related Congressional Testimony	Challenge				
	#1	#2	#3	#4	#5
Statement of Inspector General Michael J. Missal, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, U.S. House of Representatives, Hearing on Critical Impact: How Barriers to Hiring at VA Affect Patient Care and Access, September 18, 2019	X				X
Statement of Deputy Inspector General David Case, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Technology Modernization, Committee on Veterans' Affairs, U.S. House of Representatives: Hearing on "Getting It Right: Challenges with the Go-Live of Electronic Health Record Modernization", March 5, 2020	X			X	

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

The following tables provide a summary of audit-related or management-identified material weaknesses and the noncompliance with FFMIA and Federal financial management system requirements outlined in the 2020 AFR.

Audit Opinion			Unmodified		
Restatement			Yes		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Controls Over Significant Accounting Estimates	1	-	-	-	1
Obligations, Undelivered Orders and Accrued Expenses	1	-	-	-	1
Financial Systems and Reporting	1	-	-	-	1
IT Security Controls	1	-	-	-	1
Entity Level Controls including CFO Organizational Structure	1	-	-	-	1
Total Material Weaknesses	5	-	-	-	5

Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA § 2)						
Statement of Assurance				Modified		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Controls Over Significant Accounting Estimates	1	-	-	-	-	1
Financial Systems and Reporting	1	-	-	-	-	1
Total Material Weaknesses	2	-	-	-	-	2
Effectiveness of Internal Control over Operations (FMFIA § 2)						
Statement of Assurance				Modified		
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
GAO High-Risk List	1	-	-	-	1	-
Obligations, Undelivered Orders and Accrued Expenses	1	-	-	-	-	1
Entity Level Controls including CFO Organizational Structure	1	-	-	-	-	1
Total Material Weaknesses	3	-	-	-	-	3
Conformance with Federal Financial Management System Requirements (FMFIA § 4)						
Statement of Assurance		Systems conform, except for the below nonconformance				
Nonconformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
IT Security Controls	1	-	-	-	-	1
Total Nonconformances	1	-	-	-	-	1
Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA)						
		Agency		Auditor		
System Requirements		Lack of compliance noted		Lack of compliance noted		
Accounting Standards		No lack of compliance noted		No lack of compliance noted		
USSGL at Transaction Level		Lack of compliance noted		Lack of compliance noted		

PAYMENT INTEGRITY INFORMATION ACT REPORTING

In FY 2020, VA successfully reduced overall reported improper payments by $620 million or 5% and is reporting five programs below thresholds despite challenges in obtaining documentation due to COVID-19. This is VA's second consecutive year of reported reductions. Less than 8% (about $890 million) of VA's reported improper payments represent a monetary loss and VA continues to prioritize reducing improper payments. VA's Payment Integrity Information Act and high priority program reporting can be found at https://paymentaccuracy.gov/.

FRAUD REDUCTION REPORT

In FY 2020, VA continued to improve its efforts to combat fraud. The following sections provide additional information about VA's fraud reduction efforts, established strategies and activities.

VA'S FRAUD REDUCTION EFFORTS

VA's OIG reported $100.5 million in confirmed fraud in FY 2020. VA implemented financial and administrative controls and improved use of Federal risk management principles to manage fraud risks in major programs.

IMPLEMENTATION OF FINANCIAL AND ADMINISTRATIVE CONTROLS AND THE FRAUD RISK PRINCIPLE (STANDARDS FOR INTERNAL CONTROLS)

The GAO Standards for Internal Control in the Federal Government require management to assess fraud risk by considering the potential for fraud when identifying, analyzing and responding to risk. To comply with these standards, VA Administrations and Staff Offices complete an annual assessment that includes assessing the adequacy of their fraud risk management processes. VA Administrations and Staff Offices submit evidence to support their assessment to VA's Office of Business Oversight (OBO), identify any deficiencies and create corrective action plans. OBO elevates reported deficiencies to VA management.

IMPLEMENTATION OF OMB CIRCULAR NO. A-123, WITH RESPECT TO MANAGING FRAUD RISK AND IDENTIFICATION OF RISK AND VULNERABILITIES TO FRAUD

In alignment with OMB Circular No. A-123 guidance with respect to managing fraud risk, VA uses a comprehensive risk survey questionnaire that scores responses based on 10 fraud risk factors. The assessment enables VA to identify the extent to which programs are susceptible to fraud and pinpoint the programs at highest risk. In FY 2020, VA worked with the highest fraud risk programs from prior-year assessments and required those programs to identify their top fraud risks and mitigation plans. OBO shared the assessment results with Administrations for vetting and distribution to VA Enterprise Risk Management for inclusion in VA's risk register.

VA identified risks and vulnerabilities to fraud in VA's major programs and established strategies and procedures to mitigate those risks as described below.

PAYROLL

VATAS is a web-based, centralized and standardized timekeeping system that helps reduce risk and vulnerabilities to fraud in payroll. With more than 400,000 users, VATAS has a robust Help Desk team comprised of subject matter experts to support stations and users across the country. This support, along with a myriad of tools, desktop reference guides, instructional videos and a searchable knowledgebase on the VATAS SharePoint site, facilitates the

timeliness and accuracy of timesheet processing in accordance with policy and improves the delivery of approximately $1.7 billion in payroll each pay period.

Having a centralized timekeeping system provides the agency both greater insight through surveillance capabilities and enhanced reporting tools to help identify trends as well as risks and potential fraud in payroll processing. In FY 2021, VATAS will be migrated to the VA cloud-based environment which will allow for improved responsiveness and reporting while creating an improved platform for launching system enhancements enforcing VA payroll policy. The VA workforce is educated on the proper use of VATAS and the abundance of training and support ensures VATAS can provide increased oversight and the reduction of fraud risk.

In FY 2018, FSC began offering optional payroll operational services to VA facilities. This optional approach standardizes processes and ensures proper governance over employee pay. Surveillance capabilities and additional security enhancements are in place to mitigate entry points for fraud, waste and abuse (FWA). Training on payroll operations is performed biweekly to ensure any new laws, legislation and/or policy updates are understood and updated in payroll protocol.

BENEFICIARY PAYMENTS

VBA's Counter-Fraud teams identify FWA activities using advanced analytics and investigatory techniques to protect Veterans' benefits payments and the integrity of the agency. As of September 2020, VBA investigated 2,522 cases where Veterans had their benefits redirected. Of $3.6 million in actual or attempted benefits theft, the VBA teams prevented or recovered $1.9 million, equating to an increased recovery rate from approximately 48% in FY 2019 to approximately 63% in FY 2020. This coincided with a significant decrease in month-to-month fraud since summer 2019. The team worked with va.gov and the Defense Manpower Datacenter to deploy new identity verification and authentication capabilities, helping bring an average of over 500 cases per month down to just over 100 in FY 2020. The team also applied its persistent monitoring capabilities to protect over $660 million in Blue Water Navy payments issued since the beginning of calendar year 2020.

GRANTS

In FY 2020, OBO assessed VHA Homeless Veteran Grants to determine if they were being used as intended and administered in compliance with current legislation. OBO conducted Grant Per Diem and Supportive Services for Veteran Families Grantee reviews to (1) determine if Grantee costs were allocable, allowable and reasonable in accordance with OMB directives; (2) ensure services were being provided to Veterans as prescribed by program requirements; (3) confirm compliance with expense thresholds and program cap requirements; and (4) review Grantee fiscal operations to determine if effective internal controls and fraud risk management existed.

LARGE CONTRACTS

OALC updated and is implementing a fraud risk management framework, focusing on subcontracting and compliance with legislative and Federal Acquisition Requirements. The framework consists of resources and tools that will assist VA contracting officers in monitoring compliance that include limitations on subcontracting and other subcontracting requirements. In addition, the framework includes internal controls to identify and prevent fraud along with

various approaches to assess potentially fraudulent activities. The framework will be fully implemented by the end of second quarter FY 2021.

CHARGE CARDS (PURCHASE AND TRAVEL)

The FSC tracks and analyzes charge card transactions through development and use of a full range of analytic methods, such as data collection, data integration, data profiling and use of predictive models/forensic accounting methods. These audits and data analyses gather transactional data from card charges to identify spend patterns, anomalies and usage violations that enable the Department to identify and correct deficiencies and make programmatic changes to mitigate risk and prevent future violations. Results of all analyses and OMB Circular No. A-123 compliant audits are provided to VA executive leadership and program managers for distribution to oversight bodies for business process improvements.

ESTABLISHED STRATEGIES, PROCEDURES AND OTHER STEPS TO CURB FRAUD

VA continues to take a data analytics-driven approach and is leveraging partnerships with internal and external stakeholders to reduce fraud risks across the Department.

OCC's Department of Program Integrity (DPI) Program Integrity Tool (PIT) data repository has a new terminal data feed from the Community Care Reimbursement System (CCRS). DPI is currently validating CCRS data files for claim line scoring and incorporation into a bidirectional feed with PIT. The bidirectional feed from CCRS and the Electronic Claims Adjudication Management System (eCAMS) will be critical tools for predefined fraud reduction business logic inventory, called J-Rules, used as prepayment edits and in post-payment fraud detection. Leveraging the consolidated repository of business rules will ensure all claims processing data is centralized for scoring and reviewed for fraud prior to payment. Furthermore, these system feeds will expand the data repository with new information to perform analysis and provider outlier detection across programs. This information is critical to collaboration efforts with our Third-Party Administrators and partnering with the VA OIG.

OM, as the office responsible for internal control oversight, has dedicated resources to perform in-depth reviews of internal systems, processes and controls to identify and address vulnerabilities in financially impacted systems. OM's increased efforts for fraud prevention and detection aim to address the constantly evolving nature of fraud and attacks that exploit both technology and people to steal Government resources. OM is implementing a multi-pronged approach that includes: delivering fraud awareness training to VA's financial community; reviewing and assessing internal policies and internal controls against industry reported fraud schemes to determine if VA controls adequately mitigate fraud risks; and developing a more robust internal audit function to continuously review financial systems and activities to ensure adequate internal controls to fight fraud.

Other VA steps to curb fraud included our continued partnership with Health and Human Services Centers for Medicare and Medicaid Services (CMS). VA and CMS implemented the computer matching agreement to share provider screening information, which will protect VA patients and health care funds. VA and the Defense Health Agency strengthened our partnership in FY 2020 by analyzing claims data and exploring options for coordinating benefits for dual eligible individuals to reduce fraud.

REAL PROPERTY

VA REAL PROPERTY PORTFOLIO

VA has a vast holding of diverse capital assets consisting of VA-owned buildings and real estate, VA-leased buildings, EULs and sharing agreements pertaining to capital assets.

The following table summarizes VA's recent capital asset inventory holdings.

| | Owned Assets | | | | | Leased Assets | |
	Bldgs.	Historic Bldgs.	Building Sq. Ft	Vacant Sq. Ft	Land Acres	Operational Leases	Lease Sq. Ft
VHA	5,655	2,119	153,012,050	6,040,969	16,393	1,663	19,104,655
VBA	16	-	815,322	-	33	182	4,559,239
NCA	596	143	1,289,749	60,712	23,076	5	17,187
Staff	10	1	1,771,034	-	193	108	3,565,966
VA Totals	**6,277**	**2,263**	**156,888,155**	**6,101,681**	**39,695**	**1,958**	**27,247,047**

Data Source: VA Capital Asset Management System

VHA assets are predominantly clinical in nature, such as hospitals, outpatient buildings and research facilities. VHA also has supporting buildings, such as office buildings and warehouses, necessary to fulfill the VHA mission. VBA's assets are predominantly service delivery space, including both Veteran facing space and internal space for VBA to deliver benefits and process claims. NCA manages most of VA's land assets to support cemetery operations, and also has several types of buildings providing support space for public-facing services, administration and maintenance. The number and composition of assets in the VA portfolio is constantly changing in response to VA's needs and priorities.

REDUCE THE FOOTPRINT

In accordance with OMB Memorandum M-20-03, Implementation of Agency-wide Real Property Capital Planning, VA has implemented a suite of strategies to manage the office and warehouse space necessary to provide service to Veterans. VA most recently submitted its Reduce the Footprint (RTF) implementation plan to OMB and GSA covering the FY 2020 through FY 2024 time period. As VA continues to work with OMB and GSA to pursue aggressive disposal and reuse opportunities in support of RTF, the results of these efforts will be publicly available at the following website: https://www.performance.gov/real-property-metrics/.

FEDERAL REAL PROPERTY PROFILE

VA submits its portfolio data to the Federal Real Property Profile (FRPP) annually to provide a point in time picture of VA's capital assets. The public dataset from the FRPP is available at the following link: https://www.gsa.gov/policy-regulations/policy/real-property-policy/asset-management/federal-real-property-profile-frpp/federal-real-property-public-data-set.

CIVIL MONETARY PENALTY ADJUSTMENT FOR INFLATION

The Federal Civil Penalties Inflation Adjustment Act of 1990 (the Inflation Adjustment Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. The table below depicts the covered civil monetary penalties that are under VA's purview.

Statutory Authority	Penalty (Name or Description)	Year Enacted	Latest Year of Adjustment (via Statute or Regulation)	Current Penalty Level ($ Amount or Range)	Sub-Agency/ Bureau/Unit	Location for Penalty Update Details
Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, as amended	False Loan Guaranty Certifications	1986	2020 (via regulation)	The greater of (a) two times the amount of Secretary's loss on the loan, or (b) another appropriate amount not to exceed $23,331	VBA/Loan Guaranty	Federal Register 85 (02/07/2020): 65551-65552
Program Fraud Civil Remedies Act of 1986, as amended	Fraudulent Claims or Statements	1986	2020	$11,665	All VA Programs	Federal Register 85 (02/07/2020): 65551-65552

In February 2020, VA published a regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2020. VA will also publish an updated regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2021. Per the law, VA will update their penalty rates in the Federal Register annually by January 15th.

GRANT PROGRAMS

Pursuant to the OMB Uniform Guidance in 2 C.F.R. § 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.

VA is required to disclose the number of awards and balances for which closeout has not yet occurred, but for which the period of performance has elapsed by 2 years or more prior to September 30, 2020. The summary of this information is disclosed in the table below.

CATEGORY	2-3 Years	>3-5 Years	>5 Years
Number of Grants/Cooperative Agreements with Zero Dollar Balances	10	15	0
Number of Grants/Cooperative Agreements with Undisbursed Balances	14	0	0
Total Amount of Undisbursed Balances	$427,219	$0	$0

Although VA planned to have all grants closed out by September 30, 2020, the Department's response to COVID-19 became a priority, causing a reduced focus on the closeout of older grants. This shift in priority, in addition to a leadership change, has caused the State Home Construction grant office not to meet the September 30, 2020 goal for closeout. State Home Construction comprises 3 of the grants with undisbursed balances, totaling $200,966.

Additionally, the Adaptive Sports grant office is awaiting actions from grantees preventing those grants from being closed. Adaptive Sports comprises 11 of the grants with undisbursed balances, totaling $226,253.