Section III. Other Information

Schedule of Spending (Unaudited)

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

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

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

As some of the implementation and reporting details of the SOS are still being developed, OMB has directed the schedule be included in Other Information to permit VA to explore the optimal means of implementation and reporting. VA is interested in public feedback from the users of the financial statements regarding the presentation and classification of the data in the schedule of spending to evaluate the usefulness of the information as presented and possible alternatives to the current presentation, if necessary, to meet VA users' needs.

The SOS is presented in three sections as required for CFO Act agencies. The first section is entitled "What Money is Available to Spend?" This section of the SOS presents total budgetary resources that were available to spend reconciled to obligations incurred as shown in the Status of Budgetary Resources section of the SBR.

The second section is entitled "How was the Money Spent/Issued?" This section of the SOS presents services or items that were purchased and how obligations are incurred or the payment type within each VA administration consistent with the SBR and classified by the OMB Budget Object Class (BOC) as defined in OMB Circular No. A-11. The most significant BOCs and payment types are presented separately within each VA administration with the remaining BOCs presented in aggregate as "Other" within each administration. The "Total Amounts Agreed to be Spent" line item in this section of the schedule reconciles to obligations incurred in the SBR.

The third section is entitled "Who did the Money go to?" and reconciles to obligations incurred in the SBR. This section of the SOS presents obligations incurred as either Federal or Non-Federal obligations within each VA Administration. VA does not have

any special lines of business or special trading partners beyond the existing presentation that requires separate disclosure to accurately reflect its business activities.

USAspending.gov prime award financial data for VA contracts, grants and insurance is a subset of the obligations incurred and is reported in VA's financial systems, but is based on and reported when amounts are paid not when obligations are incurred which creates timing and reconciliation requirements between the two sets of data. Additionally, the current USAspending.gov data is not integrated with or maintained in the same financial management and reporting system as the SBR. USAspending.gov does not track or report data by obligations incurred numbers as reported in the SBR and SOS financial management system. VA is currently working on a system solution to cost effectively address timing differences and reconcile the data in both systems to enable it to integrate the current financial reporting and management assurance frameworks, validate the accuracy and completeness of the prime award financial data and provide assurance that internal controls are operating effectively when these new reporting requirements become effective. This process is not meant to supplant existing VA processes currently established that reconcile USAspending.gov prime award data with the SBR or the SF 133.

DEPARTMENT OF VETERANS AFFAIRS

COMBINED SCHEDULE OF SPENDING – UNAUDITED (dollars in millions)

FOR THE YEARS ENDED SEPTEMBER 30,

	2015		2014	
	Budgetary	Non-Budgetary Credit Program	Budgetary	Non-Budgetary Credit Program
What Money is Available to Spend?				
Total Resources	$ 199,137	$ 11,919	$ 187,112	$ 10,450
Less Amount Available but Not Agreed to be Spent	(16,331)	-	(7,305)	-
Less Amount Not Available to be Spent	(12,220)	(8,829)	(19,141)	(7,529)
Total Amounts Agreed to be Spent	**$ 170,586**	**$ 3,090**	**$ 160,666**	**$ 2,921**
How was the Money Spent/Issued?				
Veterans Health Administration				
Personnel Compensation and Benefits	$ 32,731	$ -	$ 30,502	$ -
Other Contractual Services	15,490	-	14,177	-
Supplies and Materials	11,542	-	9,447	-
Land and Structures	2,820	-	2,523	-
Equipment	2,976	-	1,825	-
Rent, Communications and Utilities	2,463	-	2,196	-
Grants, Subsidies and Contributions	1,848	-	1,658	-
Travel and Transportation of Persons	1,095	-	967	-
Other	-	-	67	-
Veterans Benefits Administration (Including Veterans Benefits, Life Insurance, Housing Credit and Administration)				
Insurance Claims and Indemnities*	77,940	511	72,221	937
Grants, Subsidies and Contributions**	14,976	736	15,880	75
Personnel Compensation and Benefits	2,126	-	2,009	-
Other Contractual Services	945	242	779	313
Rent, Communications and Utilities	165	-	155	-
Interest and Dividends	-	42	208	37
Land and Structures	1	1,517	3	1,529
Other	43	42	109	30
National Cemetery Administration				
Personnel Compensation and Benefits	142	-	136	-
Other Contractual Services	72	-	83	-
Grants, Subsidies and Contributions	47	-	51	-
Supplies and Materials	11	-	10	-
Rent, Communications and Utilities	12	-	11	-
Other	24	-	13	-
Indirect Program Administration				
Other Contractual Services	1,003	-	910	-
Personnel Compensation and Benefits	818	-	771	-
Equipment	617	-	902	-
Supplies and Materials	444	-	369	-
Rent, Communications and Utilities	156	-	143	-
Other	79	-	31	-
*Reconciling Adjustment for Prior Year Recoveries****	-	-	2,510	-
Total Amounts Agreed to be Spent	**$ 170,586**	**3,090**	**$ 160,666**	**$ 2,921**

DEPARTMENT OF VETERANS AFFAIRS

COMBINED SCHEDULE OF SPENDING – UNAUDITED (dollars in millions)

FOR THE YEARS ENDED SEPTEMBER 30,

	2015		2014	
	Budgetary	Non-Budgetary Credit Program	Budgetary	Non-Budgetary Credit Program
Where did the Money go to?				
Veterans Health Administration				
Federal	10,238	-	8,450	-
Non-Federal	60,727	-	54,912	-
Veterans Benefits Administration (Including Veterans Benefits, Life Insurance, Housing Credit and Administration)				
Federal	1,749	319	2,908	37
Non-Federal	94,447	2,771	88,454	2,884
National Cemetery Administration				
Federal	51	-	48	-
Non-Federal	257	-	258	-
Indirect Program Administration				
Federal	553	-	542	-
Non-Federal	2,564	-	2,584	-
*Reconciling Adjustment for Prior Year Recoveries****	-	-	2,510	-
Total Amounts Agreed to be Spent	**$ 170,586**	**$ 3,090**	**$ 160,666**	**$ 2,921**

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

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

***This line reflects VA's estimate of recoveries of prior year unpaid obligations for 2014 totaling $2.5 billion. This adjustment was recorded as an increase in "Recoveries of Prior Year Unpaid Obligations" and an increase in "Obligations Incurred" in the Combined Statement of Budgetary Resources for the year ended September 30, 2014. During 2015, VA implemented a software change in its Financial Management System (FMS) to record prior year recoveries that results in a more accurate report of changes to prior year transactions with no need for reconciling adjustments.

Summary of Financial Statement Audit and Management Assurances

The following tables provide a summary of audit-related or management-identified material weaknesses and the non-compliance with FFMIA and Federal financial management system requirements outlined in the 2015 Annual Financial Report.

Table 1 - Summary of Financial Statement Audit

Audit Opinion	**Unmodified**				
Restatement	**No**				
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
IT Security Controls	1	0	0	0	1
Financial Reporting	0	1	0	0	1
Procurement, Undelivered Orders and Reconciliations	0	1	0	0	1
Purchased Care Processing and Reconciliations*	0	1	0	0	1
Total Material Weaknesses	**1**	**3**	**0**	**0**	**4**

Table 2 - Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA § 2)						
Statement of Assurance	**Qualified**					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Financial Reporting	0	1	0	0	0	1
Total Material Weaknesses	**0**	**1**	**0**	**0**	**0**	**1**

Effectiveness of Internal Control over Operations (FMFIA § 2)						
Statement of Assurance	**Qualified**					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Procurement, Undelivered Orders and Reconciliations	0	1	0	0	0	1
Purchased Care Processing and Reconciliations*	0	1	0	0	0	1
Total Material Weaknesses	**0**	**2**	**0**	**0**	**0**	**2**

Conformance with Federal Financial Management System Requirements (FMFIA § 4)						
Statement of Assurance	**Systems conform, except for the below non-conformance**					
Non-Conformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
IT Security Controls	1	0	0	0	0	1
Total Non-Conformances	**1**	**0**	**0**	**0**	**0**	**1**

Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA)		
	Agency	**Auditor**
1. System Requirements	Lack of substantial compliance noted	Lack of substantial compliance noted
2. Accounting Standards	No lack of substantial compliance noted	No lack of substantial compliance noted
3. USSGL at Transaction Level	Lack of substantial compliance noted	Lack of substantial compliance noted

* 'Purchased Care Processing and Reconciliations' is stated on the Secretary's Statement of Assurance as 'Care in the Community'

Improper Payments Elimination and Recovery Act of 2010 (IPERA) Report

Overview

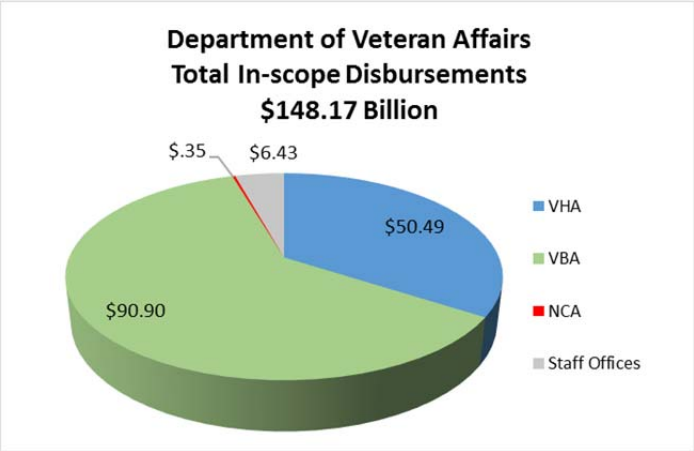
The reduction of improper payments is a top financial management priority for the Department of Veterans Affairs (VA). The results of this year's IPERA review of improper payments demonstrate that VA is in need of significant improvement over remediating improper payments. In FY 2015, VA established a new office – the Improper Payments Remediation and Oversight (IPRO) Office – whose sole focus is to implement, monitor and report on VA's progress in reducing improper payments. IPRO has a singular focus on reducing improper payments elevating the priority of this important objective in the Department. In addition, VA plans to re-double its focus on root causes, develop and implement the right corrective actions and regularly monitor progress leveraging the Improper Payments Governing Board – a board comprised of senior agency officials that can help drive accountability. However, as VA ensures that its corrective actions address the root causes of improper payments, the Department must do so without impacting Veterans timely access to care.

In a May 2015 report, VA Office of Inspector General's (OIG) application of the definition of improper payments included transactions where purchases did not follow acquisition regulations. Under OIG's application of the definition, VA must classify every payment made that did not follow all Federal Acquisition Regulations and where VA exceeded its regulatory authority as improper. This is a departure from how VA has traditionally reported improper payments related to the care in the community programs. Historically, VA only reported instances of care in the community as improper payments where the wrong party was paid, the wrong amount was paid, a duplicate payment was made, or services were not received. To ensure VA is making every effort to report in compliance with the statute and provide transparency, the Department has decided to apply OIG's definition of improper payments. This decision has resulted in a significant increase in both percentage and amount of improper payments made in two programs that acquire care in the community.

While the increase in the improper payment rate is not ideal under any circumstance, the Department contends that the increase does not represent improper payments where VA has wasted taxpayer money by paying too much for services or paying the wrong parties. The Department is confident that the significant majority of dollars associated with the improper payment increase in these two programs was spent to provide Veterans access to health care. While VA recognizes that our long-standing practice with care in the community is a control deficiency and has contributed to the significant increase in our improper payment rates, we cannot immediately stop this practice. Discontinuing our current practice will put millions of our Veterans at risk of not receiving critical medical services in a timely fashion. The Department is committed to finding a solution that balances our need to fix the long-standing practice while not

sacrificing our mission to provide timely and quality medical services to our Veterans. In FY 2016, VA will begin a multi-organization initiative to re-engineer our business practices and continue to seek legislative change that will provide relief from the restrictive regulations.

In FY 2014, VA issued $160.59 billion in diverse payments, of which $148.17 billion were subject to IPERA processes for measuring improper payments compliance. The amount of disbursements subject to IPERA review increased by more than $9.7 billion from 2013 to 2014, a 7 percent increase due primarily to the annual increases in program outlays across VA programs.



VA is comprised of three Administrations and a Central Office function. A brief description of the four components follows:

VHA

The Veterans Health Administration's (VHA) mission is to honor America's Veterans by providing exceptional health care that improves their health and well-being. With 152 VA Medical Centers (VAMCs) nationwide, VHA manages one of the largest health care systems in the United States. VAMCs, within the Veterans Integrated Service Network (VISN), work together to provide health care to Veterans in their geographic areas.

VBA

The Veterans Benefits Administration (VBA) manages five district offices and 56 regional offices to ensure necessary benefits and services are administered to Service members, Veterans, their families, and Survivors.

NCA

The National Cemetery Administration (NCA) manages 5 Memorial Service Networks (MSNs) and 131 National Cemeteries in 40 states and Puerto Rico, as well as 33 soldiers' lots and monuments. NCA provides Veterans and their families with the final resting places in national shrines and with lasting tributes that commemorate their service and sacrifice to our Nation.

Staff Offices

The VA Central Office is comprised of eight entities that serve as the managerial, policy, and administrative hub for Departmental activities.

Section I. Risk assessments performed for VA programs.

Annually, VA conducts risk assessments for all programs and activities that are new, have received a significant increase in funding, have experienced significant legislative changes, or have not undergone a full risk assessment in three years. During FY 2015, there were 11 VHA programs and 1 Staff Office existing activity that required risk assessment. VA uses qualitative and quantitative risk assessment factors to identify those programs that may be highly susceptible to significant improper payments as follows:

Qualitative factors:

1. Payment processing and internal control environment
   - Whether procurement, eligibility determinations, payment, and collection policies and procedures are well documented and accessible to staff;
   - Whether management plays an active role in establishing, implementing and monitoring internal controls, and holds program management and staff accountable for adhering to internal controls;
   - Whether employees receive appropriate training;
   - Whether segregation of duties exist in the procure to payment cycle;
   - Whether reviews are performed to ensure the payment is accurate and proper prior to issuance; and
   - Whether the program has recapture or collection activities designed to recoup improper payments.

2. Risk criteria set forth in OMB Circular A-123 Appendix C
   - Program length, complexity, payment volume, eligibility, and changes;
   - Personnel; and
   - Audit findings.

3. Information systems environment
   - Assessing the controls around the information systems

4. Contracting activities
   - Whether there are internal controls to mitigate acquisition risk

5. Monitoring environment
   - Whether employees have adequate time to complete and review work;
   - Whether program management provides oversight and monitors for fraudulent activity; and
   - Whether audit reports of the program are free from significant deficiencies and material weaknesses or have been remediated.

Quantitative factors:

1. Whether the previous testing results were greater than the statutory thresholds defined in the A-123 guidance,

2. Future risk indicators,

3. Expected program disbursement amounts, and

4. Inherent risks of improper payments due to the nature of agency programs or operations.

The results of the risk assessments came back with all 12 programs being low risk. In addition, during FY 2015, VA did not request any program exemptions from OMB.

For FY 2015 reporting, VA had 14 programs that were tested and reported on IPERA compliance, including six VHA programs, six VBA programs and two VA-wide activities. From the past risk assessments of these 14 programs, ten programs were deemed high risk and four programs were deemed low risk. As set forth in A-123, Appendix C, these ten high risk programs are already reporting an improper payment estimate, so they were not required to perform risk assessments. The required IPERA reporting is detailed in *Section III, Improper Payment Reporting for VA Programs* (Table 1).

Programs and Activities Assessed for Risk of Improper Payments in FY 2015
After undergoing the assessment and associated risk scoring, as mentioned before, these 11 VHA programs and 1 VA-wide activity were deemed low risk. Brief descriptions of these programs and activities follow below.

VHA

- **Canteen Service:** Operates approximately 172 canteens at VAMCs across the country as self-sustaining businesses at no cost to American tax payers.
- **Caregiver Support:** Provides medical, travel, training, and financial benefits to approved primary caregivers of eligible Veterans and service members who sustained a serious injury, including traumatic brain injury, psychological trauma or other mental disorder incurred or aggravated in the line of duty, on or after September 11, 2001.
- **DoD/VA Healthcare Sharing Incentive Fund:** Provides funding for creative sharing initiatives at facility, regional, and national levels to facilitate the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, quality, and cost effectiveness of the health care provided to beneficiaries of both departments.
- **Grants for Construction of State Extended Care Facilities:** Provides grant payments to construct State Home facilities for furnishing domiciliary or nursing home care to Veterans, and to expand, remodel, or alter existing buildings for furnishing domiciliary nursing home and adult day health care or hospital care to Veterans in State Homes.

- **Highly Rural Transportation Grants:** Provides grants to eligible entities to assist Veterans in highly rural areas through innovative transportation services to travel to VAMC, and otherwise assist in providing transportation services in connection with the provision of VA medical care to Veterans.
- **Homeless Care:** Provides contracts for the care and treatment for homeless Veterans.
- **Indian Health Services:** Reimburses Indian Health Service (IHS) or Tribal Health Program (THP) for payment of claims for direct healthcare services provided to Veterans under the Reimbursement for Direct Health Care Services Agreements.
- **Other Services:** Provides contracts and agreements for consulting and purchases of goods and/or services.
- **Pharmacy Medical Facilities:** Provides care by the VAMC or clinics with new or emergent prescriptions being dispensed directly from that VAMC or clinic.
- **Spina Bifida Health Care:** Provides benefits designed for Vietnam Veterans' and certain Korean Veterans' birth children diagnosed with Spina Bifida who are in receipt of a VA Regional Office award for Spina Bifida benefits.
- **Support Services for Veteran Families:** Provides grants to private non-profit organizations and consumer cooperatives that provide supportive services to very low-income Veteran families living in or transitioning to permanent housing.

Staff Offices

- **Payments to Federal Employees (PFE) – Travel:** Provides payments to Federal employees for Government related travel.

Section II. Statistical sampling processes performed for VA programs.

All VA IPERA sampling plans have been prepared by a statistician and certified by an agency official in accordance with OMB Circular A-123, Appendix C. Consistent with the prior year's statistical sampling approach, VA used a stratified sample design to separate the payment data into homogeneous strata by sub-program(s), sub-organization, or by type and dollar amount. The payments were ordered by amount within each stratum and a systematic random sample was selected to ensure a consistent representation of the payment universe. The sample size for each stratum was calculated using a proportional allocation method. For all programs, the program universe was constructed by collecting all payments from each fiscal quarter with samples selected from every quarter.

Strata modifications were made on an as-needed basis for the respective programs. Strata definitions were altered for Civilian Health and Medical Program of the VA (CHAMPVA), Compensation and Payroll programs to account for inherent structural differences in governing policy and regulations, implementation within each program and to provide better insight. For CHAMPVA, payments were divided into cohorts for the type of service, type of payment processing and payment size. Compensation program payments were divided into cohorts based on Veteran disability rating and payment size. The Payroll program payments were divided into cohorts based on Title

5 or 38 payments and pay plan. A systematic random sample was selected from each stratum to ensure a consistent representation of the payment universe.

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

Section III. Improper payment reporting for VA programs.

Table 1
Improper Payment (IP) Reduction Outlook
($ in millions)[1]

Program or Activity	2014 (based on 2013 actual data)			2015 (based on 2014 actual data)					2016 (based on 2015 estimated data)			2017 (based on 2016 estimated data)			2018 (based on 2017 estimated data)		
	OUTLAYS ($)	IP %	IP $	OUTLAYS ($)	IP %	IP $	Over-payments $	Under-payments $	OUTLAYS ($)	IP %	IP $	OUTLAYS ($)	IP %	IP $	OUTLAYS ($)	IP %	IP $
Beneficiary Travel	816.84	5.09	41.57	811.55	6.22	50.48	48.50	1.98	835.90	6.20	51.83	860.98	6.10	52.52	886.81	6.00	53.21
CHAMPVA	1,020.93	4.83	49.26	1,135.34	3.41	38.75	26.48	12.27	1,169.40	3.40	39.76	1,204.49	3.30	39.75	1,240.63	3.20	39.70
VA Community Care (2, 3)	3,371.19	9.24	311.46	3,912.17	54.77	2,142.69	2,096.25	46.44	4,029.54	53.00	2,135.66	4,150.43	50.00	2,075.22	4,274.95	47.00	2,009.23
Purchased Long Term Services and Support (3)	1,373.38	8.95	122.87	1,479.71	59.14	875.128	868.984	6.144	1,524.11	57.00	868.7427	1,569.84	55.00	863.412	1,616.94	53.00	856.9782
State Home Per Diem Grants	954.55	3.02	28.81	1,077.84	2.02	21.766	20.906	0.860	1,110.18	2.00	22.20	1,143.49	1.90	21.73	1,177.80	1.80	21.20
Supplies and Materials	2,361.82	0.00	0.06	2,457.24	1.32	32.440	32.44	-	2,530.96	1.31	33.16	2,606.89	1.30	33.89	2,685.10	1.29	34.64
Compensation (4)	53,913.44	1.32	713.16	58,449.56	2.33	1,361.35	713.72	647.63	71,698.78	2.33	1,670.58 (5)	76,758.03	2.33	1,788.46 (5)	80,457.95	2.33	1,874.67 (5)
Pension	5,583.60	4.64	258.85	5,832.79	4.53	264.19	232.70	31.49	5,610.44	4.52	253.59	5,947.34	4.51	268.23	6,310.60	4.50	283.98
VR&E	925.43	1.73	15.98	1,081.22	1.04	11.26	11.19	0.07	1,170.66	1.03	12.06	1,308.53	1.02	13.35	1,368.70	1.01	13.82
Education – Chapter 33	10,723.00	-	-	11,172.65	1.21	135.05	125.59	9.46	12,542.87	1.20	150.51	13,570.55	1.19	161.49	14,196.43	1.18	167.52
Education – Chapter 1606	151.08	0.66	1.00	147.15	1.05	1.55	0.56	0.99	152.14	1.04	1.58	156.60	1.03	1.61	161.66	1.02	1.65
Education – Chapter 1607	83.25	0.47	0.39	67.33	2.23	1.50	1.01	0.49	51.00	2.22	1.13	52.00	2.21	1.15	51.24	2.20	1.127
Disaster Relief Act – Hurricane Sandy (6)	19.64	2.04	0.40	27.27	5.71	1.558	1.558	-	22.83	5.70	1.301	48.80	5.60	2.733	66.16	5.50	3.64
PFE – Payroll	24,360.00	0.13	32.62	25,812.71	0.15	38.46	29.59	8.87	27,103.00	0.14	37.94	28,459.00	0.13	37.00	29,881.00	0.12	35.86
Totals	105,658.15	1.49	1,576.43	113,464.53	4.39	4,976.172	4,209.478	766.694	129,551.81	4.08	5,280.0437	137,836.97	3.89	5,360.545	144,375.97	3.74	5,397.2252

Notes to Table 1:

(1) In FY 2015, VA tested and reported on payments made in FY 2014.

(2) The VA Community Care program was previously reported in the FY14 Performance and Accountability Report as the Non-VA Medical Care program. The mission and objectives of the program remain the same.

(3) In the May 2015 VA OIG report on VA's compliance with IPERA, VA OIG cited contracting discrepancies related to VHA's compliance with FAR as improper. This would force VA to classify a large number of payments as improper and the Department is concerned this would misrepresent the actions taken to provide timely care to Veterans. VA has reported these systemic issues in the VA Statement of Assurance required by the FMFIA, Section II, as a material weakness.

(4) The changes necessary in the IPERA process are in statute and regulation. By changing these statutes and regulations, our processes can subsequently change. However, based on the current process to change regulations, this can take years to see effect. Therefore, Compensation anticipates no changes in reduction targets for the next three fiscal years.

(5) The increase in improper payment amounts for Compensation out years is due to an increase in program outlays and not the actual error rate.

(6) The remaining Disaster Relief Act funds are 5 year appropriations which are planned to be obligated in full as of the end of FY17. The remaining budgeted outlays of $46.41 million of these multi-year appropriations will be paid during FY18 and beyond.

Section IV. Improper payment root cause categories identified in VA programs.

Table 2 (For VHA)
Improper Payment Root Cause Category Matrix
($ in millions)[1]

Reason for Improper Payment (2)		Beneficiary Travel		CHAMPVA		VA Community Care		Purchased Long Term Services and Support		State Home Per Diem Grants		Supplies and Materials	
		Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment
Program Design or Structural Issue		-	-	-	-	1,745.68	-	765.924	-	-	-	-	-
Inability to Authenticate Eligibility		-	-	-	-	-	-	-	-	-	-	-	-
Failure to Verify:	Death Data	-	-	-	-	-	-	-	-	-	-	-	-
	Financial Data	-	-	-	-	-	-	-	-	-	-	-	-
	Excluded Party Data	-	-	-	-	-	-	-	-	-	-	-	-
	Prisoner Data	-	-	-	-	-	-	-	-	-	-	-	-
	Other Eligibility Data (explain)	18.46 (3)	-	1.93 (4)	-	29.88 (5)	-	-	-	4.724 (6)	0.082 (6)	-	-
Administrative or Process Error Made By	Federal Agency	22.38	1.98	23.39	12.27	301.64	46.44	75.418	6.144	0.984	0.136	10.79	-
	State Agency	-	-	-	-	-	-	-	-	0.33	0.642	-	-
	Other Party	-	-	-	-	-	-	-	-	-	-	-	-
Medical Necessity		5.04	-	-	-	-	-	-	-	-	-	-	-
Insufficient Documentation to Determine		2.62	-	1.16	-	19.05		27.642	-	14.868	-	21.65	-
Other Reason (explain)		-	-	-	-	-	-	-	-	-	-	-	-
TOTAL		48.50	1.98	26.48	12.27	2,096.25	46.44	868.984	6.144	20.906	0.860	32.44	-

Notes to Table 2 (For VHA):

(1) In FY 2015, VA tested and reported on payments made in FY 2014.

(2) In the May 2015 VA OIG report on VA's compliance with IPERA, VA OIG cited contracting discrepancies related to VHA's compliance with FAR as improper. This would force VA to classify a large number of payments as improper and the Department is concerned this would misrepresent the actions taken to provide timely care to Veterans. VA has reported these systemic issues in the VA Statement of Assurance required by the FMFIA, Section II, as a material weakness.

(3) Improper payments in Beneficiary Travel are due to lack of administrative qualification of the beneficiary or failure to verify services were received.

(4) Improper payments in CHAMPVA are due to the recipient being ineligible for payment.

(5) Improper payments in VA Community Care are due to the Veteran being ineligible for Fee care.

(6) Improper payments in State Home Per Diem Grants (both over and under payments) are due to unverified service connection or ineligible resident.

(7) A sampled payment in the State Home Per Diem Grants program can have multiple causes of error. The total payment error is the net of errors associated with each cause of error. Using this methodology, the following dollar amounts would be reported in Table 2: failure to verify other eligibility data $6.09 in overpayments and 0.08 in underpayments; administrative or process error made by Federal agency $10.25 in overpayments and 0.34 in underpayments; administrative or process error made by State agency $0.34 in overpayments and 0.57 in underpayments; and insufficient documentation to determine $4.34 in overpayments. Therefore, the reported estimate in Table 2 would be $22.01 million. As Table 1 and Table 2 must reconcile, VHA assigned the improper payments to the first error cause for reporting purposes so that it will reconcile to the overall program estimate of $21.766 million reported in Table 1.

Table 2 (For VBA, Disaster Relief Act and Payroll)
Improper Payment Root Cause Category Matrix
($ in millions)[1]

Reason for Improper Payment		Compensation		Pension		VR&E		Education – Chapter 33		Education – Chapter 1606		Education – Chapter 1607		Disaster Relief Act – Hurricane Sandy		PFE - Payroll	
		Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment	Over-payment	Under-payment
Program Design or Structural Issue		-		0.05	-	-	-	-	-	-	-	-	-	-	-	-	-
Inability to Authenticate Eligibility		-	-	2.15	-	-	-	-	-	-	-	-	-	-	-	-	-
Failure to Verify:	Death Data	-	-	23.18	-	-	-	-	-	-	-	-	-	-	-	-	-
	Financial Data	-	-	72.94	23.14	-	-	-	-	-	-	-	-	-	-	-	-
	Excluded Party Data	-	-		-	-	-	-	-	-	-	-	-	-	-	-	-
	Prisoner Data	-	-	10.56	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Eligibility Data (explain)	-	-	17.61 (2)	-	-	-	-	-	-	-	-	-	-	-	-	-
Administrative or Process Error Made By	Federal Agency	713.72	647.63	36.90	-	11.19	0.07	-	9.46	0.14	0.92	1.01	0.49	1.1507	-	29.59	8.87
	State Agency	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Party	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Necessity		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Insufficient Documentation to Determine		-	-	69.31	8.35	-	-	125.59	-	-	-	-	-	0.4073	-	-	-
Other Reason (explain)		-	-	-	-	-	-	-	-	0.42 (3)	0.07 (3)	-	-	-	-	-	-
TOTAL[1]		713.72	647.63	232.70	31.49	11.19	0.07	125.59	9.46	0.56	0.99	1.01	0.49	1.5580	0	29.59	8.87

Notes to Table 2 (For VBA, Disaster Relief Act and Payroll):
(1) In FY 2015, VA tested and reported on payments made in FY 2014.
(2) Pension improper payments in 'Failure to Verify: Other Eligibility Data' category resulted from inability to verify residency at Medicaid Nursing Homes.
(3) Education – Chapter 1606 improper payments in 'Other' category resulted from delay in paying cost of living adjustments.

Section V. Corrective actions being undertaken by VA programs.

Of the 14 VA programs identified as high risk, 8 programs exceeded the statutory thresholds for error rates and/or amounts of improper payments and are discussed below. The thresholds are defined as gross annual improper payments (i.e., the total amount of overpayments and underpayments) in the program exceeding (1) both 1.5

percent of program outlays and $10 million of all program or activity payments made during the fiscal year reported or (2) $100 million (regardless of the improper payment percentage of total program outlays).

VHA

Corrective actions for the 5 VHA programs that exceeded the statutory thresholds are presented below.

1. Beneficiary Travel

The Beneficiary Travel program is organizationally aligned under the VHA Chief Business Office (CBO). The program consists of mileage reimbursement and special mode transportation (ambulance, wheelchair van, etc.) to eligible Veterans and other beneficiaries.

Corrective Action Plan

CBO will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.02 percentage points in 2016. The Deputy Chief Business Officer for Member Services is accountable for ensuring execution of the corrective action plans.

Administrative or Process Error Made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Payments made without claimant signatures, reimbursements for benefits not allowable, payments made in the incorrect amount, or duplicate payments.	Nationwide compliance reporting was continued to confirm facility implementation of the supplemental tool to the Veterans Health Information Systems and Technology Architecture (VistA) beneficiary travel application that increased automation and decreased manual errors in the field.	March 2015
	CBO released a series of online Beneficiary Travel new claims processes to use time optimization option available in the dashboard that will reduce administrative and processing errors.	April 2015

Error Cause	Corrective Actions	Completion Date
	System patches were developed and released to enhance the accuracy of Beneficiary Travel claims processing and address deductible issues, missing claim date information and expanded special mode account selection options. These capabilities along with the ability to import electronic invoices in one standard format will reduce administrative and process errors.	September 2015
	The SharePoint Scheduling and Reporting System (SPSRS) to improve payment tracking became required for all Veterans Transportation Service locations without RouteMatch software. With built-in scheduling and document storage capabilities, SPSRS offers new reporting metrics and allows VISN and Program Office access to real-time payment information. SPSRS training for Mobility Managers is offered on a monthly basis. National deployment is scheduled to be completed by September 2016.	September 2016

Failure to Verify Other Eligibility Data

Error Cause	Corrective Actions	Completion Date
Payments made to an ineligible recipient.	The Veterans Financial Application Means Test Expiration Elimination was released as a Beneficiary Travel patch to improve reporting of claimant administrative eligibilities. In December 2014, priority updates to complement the documentation of administrative eligibility using the Beneficiary Travel Calculator were released.	March 2014

Medical Necessity

Error Cause	Corrective Actions	Completion Date
Lack of clinical documentation on file for special mode transportation.	CBO released an online Beneficiary Travel national training certification to increase standardization of processes in the field. Additionally, recurring national training sessions are conducted for Beneficiary Travel staff on relevant issues such as covered benefits, increasing field compliance with established policies, and improving consistencies in payment methodologies.	November 2014
	VA anticipates publication of proposed legislated program changes that will reduce improper payments. CBO has drafted modifications to Beneficiary Travel regulations to incorporate and clarify these regulatory changes	June 2017

Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Lack of supporting documents to validate payment.	CBO implemented a new Beneficiary Travel claim form to use when the Veteran is not requesting travel benefits in person. The new form reduces the insufficient documentation to determine errors.	July 2014

2. CHAMPVA

CHAMPVA is a health care benefits program in which VA shares the cost of covered health care services and supplies with eligible beneficiaries.

Corrective Action Plan

CBO will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of the below actions, VA expects to reduce improper payments by 0.01 percentage points in 2016. The Chief Business Office Purchased Care **(**CBOPC) Chief Operating Officer is accountable for ensuring execution of the corrective actions plans below. All corrective actions are monitored by

the Quality and Corrective Action Plan (QCAP) Manager and tracked through a database to ensure successful implementation.

Administrative or Process Error Made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Data entry errors, incorrect vendor file setup, incorrect claim redevelopment, lack of prior payment review, or system calculation errors when processing the claim.	CBO implemented automated business rules (J-Rules) that ensure certain bill types are appropriately adjudicated as outpatient or inpatient services.	April 2015
	CBO established a monthly "Think Tank" team in the Review and Resolution Department to engage front line employees in developing solutions to eliminate errors by identifying process improvements.	July 2015
	In 2014, CBO submitted multiple requests to the Office of Information and Technology (OI&T) for priority consideration. Two requests were submitted to fix catastrophic cap calculations within the automated claims processing system. Correcting these system inaccuracies will reduce errors associated with calculating the beneficiary's cost share. Two system enhancements were submitted to address errors associated with incorrect payments for ambulance services and payments for procedures with technical and professional components. The enhancement addressing ambulance payments is in progress and the enhancement to improve accurate calculation of procedures with technical and professional components has been completed. The final system improvement submitted was to automate the vendor file clean-up process that will reduce the number of vendor records by inactivating duplicate and inactive vendors. The reduction in vendor options will increase more accurate vendor selections.	December 2015

Failure to Verify Other Eligibility Data

Error Cause	Corrective Actions	Completion Date
Incorrectly determining a beneficiary's eligibility as a result of incorrect data received in the initial application for CHAMPVA benefits or changes in the beneficiary's status.	100 percent of initial eligibility determinations are reviewed and inaccuracies corrected.	Ongoing
	Additional quality reviews were implemented to monitor recent eligibility determinations. Training is provided when errors are detected.	Ongoing
	Data matches with Centers for Medicare & Medicaid Services and TRICARE are being utilized to detect changes in the beneficiary's status that could affect CHAMPVA eligibility.	Ongoing

Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Lack of supporting documents to validate payment.	CBO developed and implemented a monitoring plan to review claims sent to designated queues to ensure proper release according to policy and procedures	September 2015

3. VA Community Care

The VA Community Care program is used to provide timely and specialized care to eligible Veterans. The program allows VA to authorize Veteran care at a non-VA health care facility when the needed services are not available through the VA, or when the Veteran is unable to travel to a VA facility. In the May 2015 VA OIG report on VA's compliance with IPERA, VA OIG cited contracting discrepancies related to VHA's compliance with FAR and where VHA exceeded its regulatory authority as improper. Under OIG's application of the definition, VA must classify every payment made that did not follow all Federal Acquisition Regulations and where VA exceeded its regulatory authority as improper. This is a departure from how VA has traditionally reported improper payments related to the care in the community programs. Historically, VA only reported instances of care in the community as improper payments where the wrong party was paid, the wrong amount was paid, a duplicate payment was made, or services were not received. To ensure VA is making every effort to report in compliance with the

statute and provide transparency, the Department has decided to apply OIG's definition of improper payments. This decision has resulted in a significant increase in both percentage and amount of improper payments in the VA Community Care program.

Corrective Action Plan

CBO will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 1.77 percentage points in 2016. The CBOPC Chief Operating Officer is accountable for ensuring execution of the corrective action plans below. All corrective action plans are forwarded to the QCAP Manager to ensure they are successfully executed and tracked through a database.

Program Design or Structural Issue

Error Cause	Corrective Actions	Completion Date
Lack of appropriate acquisition actions as described below.	CBO released a memo outlining a hierarchy to appropriately purchase care in the community through the use of VAAR compliant contracts such as the contract for the Veteran's Choice Program.	May 2015
	A legislative proposal was submitted for Congressional consideration that would allow VA-initiated Veteran care agreements to authorize required non-VA medical services.	May 2015

38 USC 1703 provides authority for VA to purchase hospital care or medical services from public and private entities when VA cannot provide the necessary hospital care or medical services because of geographic inaccessibility or because the required services are not available. The statute, along with other applicable authorities, does not specify monetary limitations or restrictions on care purchased.

VA has multiple initiatives underway that serve as remediation. On May 12, 2015 The Acting Principal Deputy Under Secretary for Health issued a memorandum to VISN Directors establishing a mandatory hierarchy for the purchase of care in the community.

Within the hierarchy, VAMCs are instructed to first attempt to refer a Veteran to another local VA facility in accordance with usual inter-facility referral patterns. If a local VA facility cannot accept the Veteran then the facility is instructed to utilize other sharing agreement authorities with Department of Defense facilities or IHS and THP organizations. When these facilities are not capable of providing the necessary care then the VA facility is instructed to utilize the authority granted by the Veterans Choice and Accountability Act (Public Law 113-146 aka VA Choice Program) and attempt to schedule the Veteran using the Patient Centered Community Care (PC3)/VA Choice

contract. If the Veteran is not eligible under the Choice Program the facility is still capable of attempting to schedule the Veteran under a PC3 authorization outside of the Choice Program. Authorizations issued in accordance with these authorities comply with all contract laws.

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

Because of the requirements of the hierarchy, the existence of the PC3 contract, and the new authorities granted by the Choice Act, VA should be able to acquire the vast majority of services without the need for Individual Authorizations. Only after a VA facility exhausts all of these avenues for providing care in the community may a facility then utilize Individual Authorizations to approve Veterans to receive care in the community.

In an attempt to eliminate the need for individual authorizations entirely, VA submitted a legislative proposal to Congress in May of 2015 requesting provider agreement authority to cover all Care in the Community for Veterans. If this authority is granted by the Congress, VA will have a vehicle exempted from many Federal contracting laws that will allow VA to provide timely care of the highest quality while complying with all applicable regulations and statutes.

Administrative or Process Error Made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Claims processor selecting the wrong schedule to pay, not properly applying the Fee Basis Claims System (FBCS) scrubber edits, or other payment methodology errors. There errors were also attributed to lack of required contracts where a VAMC	CBO provided training and released supporting articles in The Bulletin (a publication for care in the community) on the subject of contract claims processing.	December 2014
	CBO will implement a system modification to FBCS that addresses compliance with claims processing standards, decreases improper payments, increases productivity, and enhances user ease of use, by integrating a module for Eligibility and Enrollment.	December 2015
	CBO will develop training and establish expectations on how to properly utilize FBCS supervisory review queue to review targeted	January 2016

Error Cause	Corrective Actions	Completion Date
referred a Veteran to a facility or hospital and only had authority to pay using a contract.	claims for proper adjudication.	
	CBO will develop a master list of VA Community Care training modules, identify target recipients by position, and determine the frequency of re-training required.	January 2016
	CBO will develop and implement a comprehensive internal controls procedures guide for VA Community Care that addresses all functional areas of the program.	April 2016
	CBO will develop and implement a standard process for issuing delegations of authority that support VA Community Care operations for routing, reporting, and monitoring processes.	July 2016

Failure to Verify Other Eligibility Data

Error Cause	Corrective Actions	Completion Date
Payments for patients that were not eligible for Fee care.	CBO released desk procedures to replace the current procedure guides. The desk procedures are a tool that contains information on topics currently found in multiple guides, making it easier to locate information in support of improved payment processing.	August 2014

Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Documents not being available or not supplied to justify services paid.	CBO provided training and released supporting articles in The Bulletin on the importance of complying with the National Archives and Records Administration documentation retention requirements and the need to provide audit documentation within set timelines.	September 2014
	CBO constructed a web-based repository using SharePoint for the storage of VA	May 2015

Error Cause	Corrective Actions	Completion Date
	Community Care contracts in support of timely, accurate contract claims processing.	

Additional Corrective Actions for Findings Identified by VA's Management Quality Assurance Service

Error Cause	Corrective Actions	Completion Date
Administrative or process error made by Federal Agency	CBOPC developed additional business logic rules in the Program Integrity Tool to help mitigate improper payments on Outpatient Prospective Payment System (OPPS) claims when codes billed by the provider do not follow the Medicare OPPS payment methodology as required. This review is conducted in the prepayment state and prevents improper payments from being made.	December 2014
	CBOPC developed written guidance to assist staff in researching Veterans' insurance coverage information when making eligibility determinations under 38 USC 1725. The guidance contains reference to VHA repositories where complete Veterans' insurance information may be reviewed, such as the Compensation and Patient Record Interchange system, which lists other VA facilities where Veterans may have reported their insurance coverage. The guidance also provides for the interim testing of 38 USC 1725 ineligibility revolving around Veterans' insurance coverage as a disqualifying factor.	March 2015
Failure to verify other eligibility data	CBOPC developed training for USC 1725 eligibility determinations. The training includes ways to identify insurance and validation procedures, to determine if a Veteran has an effective reimbursable insurance plan that will make payment on the claims.	May 2015

4. Purchased Long Term Services and Support

The Purchased Long Term Services and Support program is organizationally aligned under the VHA Geriatrics and Extended Care (GEC) Office that strives to advance quality care for aging and chronically ill Veterans by providing policy direction for the development, coordination, and integration of geriatrics and long term care clinical programs. In the May 2015 VA OIG report on VA's compliance with IPERA, VA OIG cited contracting discrepancies related to VHA's compliance with FAR and where VHA exceeded its regulatory authority as improper. Under OIG's application of the definition, VA must classify every payment made that did not follow all Federal Acquisition Regulations and where VA exceeded its regulatory authority as improper. This is a departure from how VA has traditionally reported improper payments related to the care in the community programs. Historically, VA only reported instances of care in the community as improper payments where the wrong party was paid, the wrong amount was paid, a duplicate payment was made, or services were not received. To ensure VA is making every effort to report in compliance with the statute and provide transparency, the Department has decided to apply OIG's definition of improper payments. This decision has resulted in a significant increase in both percentage and amount of improper payments in the Purchased Long Term Services and Support program.

Corrective Action Plan
GEC will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 2.14 percentage points in 2016. Presently, there is a legislative proposal pending before Congress and the changes within the program will have a significant impact on the error rate. The GEC Chief Consultant is accountable for ensuring execution of the corrective action plans shown below.

Program Design or Structural Issue

Error Cause	Corrective Actions	Completion Date
Lack of appropriate acquisition actions.	GEC has taken action to convert provider agreements to FAR based contracts to be compliant with the law and reduce improper payments. The vast majority of nursing home agreements have been converted (225 out of 300). GEC will provide individual technical assistance to the remaining VAMCs that are converting outstanding agreements to contracts.	To be determined based upon Congressional action on pending legislative proposal
	GEC will implement payment processes to incorporate AN98 process change to ensure purchased home and community-based	To be determined based upon

Error Cause	Corrective Actions	Completion Date
	service (HCBS) payments are made correctly. It must be noted that this cannot be completed without legislative action.	Congressional action on pending legislative proposal

In 2007, VHA commenced a test of provider agreements under 38 U.S.C. 1720(c)(1)(A). The purpose of the test was to determine if VHA could use a non-contract instrument to purchase nursing home care, based on locally established Medicare rates and to assist VAMCs which were experiencing severe problems in contracting for care due to Federal contracting and other non-clinical Federal rules. In 2009, on advice of Counsel, VHA ceased adding new test sites as it was determined that VA did not have authority to enter into provider agreements. The only permissible alternative with community-based nursing homes is a FAR-based contract for nursing home services. In February 2014, VHA instructed VAMCs to convert all provider agreements to contracts at the earliest possible date.

Proposed Legislation (S. 739) will potentially resolve the long standing issue related to VA's authority to enter into provider agreements to purchase services from private vendors. The legislation, based on an Administration proposal, has been introduced in the Senate and would fix legal deficiencies in VA's ability to purchase non-VA care using non-FAR based agreements. Without corrections to the law to support non-FAR agreements, VA will lose many community providers who currently partner with VA to provide extended care to our Veterans.

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

Administrative or Process Error Made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Payment methodology errors or delayed creation or renewal of contracts. Specifically, VHA has experienced agencies/homes that are unwilling to sign or re-sign contracts. There have been situations where it would be clinically inappropriate to move Veterans from these facilities which have led VA to continue paying for services.	GEC will release a tool-kit and checklist for completing the authorization template that will include accurate rate information, which will significantly reduce payment errors made in the incorrect amount, prevent the wrong schedule being used, and improve the claim approval process. It will also prompt the review of contracts to ensure they are current.	To be determined based upon Congressional action on pending legislative proposal
	GEC will conduct multiple trainings to educate the field on updated policies surrounding authorization and proper payment methodologies. Trainings will be held with national Purchased Long Term Services and Supports groups to include GEC.	To be determined based upon Congressional action on pending legislative proposal
	GEC will conduct separate trainings with VHA contracting for staff in the field to reiterate the importance of timely contract renewal processes to ensure accurate authorizations are established.	To be determined based upon Congressional action on pending legislative proposal
	GEC will implement payment processes to incorporate AN98 process change to ensure purchased HCBS payments are made correctly.	To be determined based upon Congressional action on pending legislative proposal

Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Missing admission applications or the lack of sufficient documentation made available to justify services paid.	GEC will submit a change request to embed the Case-Mix and Budget Tool in the authorization template to verify a Veteran's need for service and the amount of service needed, which will reduce lack of documentation errors in the authorization	To be determined based upon Congressional action on pending legislative proposal

5. State Home Per Diem Grants

Under the State Home Per Diem Grants program, states may provide care for eligible Veterans in need of care in three different types of programs: nursing home, domiciliary, and adult day health care.

Corrective Action Plan
CBO will implement, or has implemented, the following corrective actions to ensure greater compliance. With the implementation of these actions, VA expects to reduce improper payments by 0.02 percentage points in 2016. The CBOPC Director of Program Administration is accountable for ensuring execution of the corrective action plans below. All corrective action plans are forwarded to the QCAP Manager to ensure they are successfully executed and tracked through a database.

Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Missing admission applications or caused by documentation not being available or not supplied to justify services paid.	CBOPC completed the review of backlogged State Home Per Diem forms (10-10SH, 10-10EZ, 10-5588) in its central repository.	July 2015

Failure to Verify Other Eligibility Data

Error Cause	Corrective Actions	Completion Date
Unverified service connection of the	VA Handbook 1601SH.01 was completed and sent for concurrence to facilitate	June 2015

Error Cause	Corrective Actions	Completion Date
Veteran or ineligible resident.	standardization of program requirements to VISNs.	

Administrative or Process Error Made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Incomplete admission applications, incomplete receiving report on the invoice, or data entry errors resulting in an incorrect amount paid.	CBO provided application training as part of the ongoing monthly training to VAMC staff.	January 2015
	A system-wide electronic tracking tool for calculating daily cost of care and validating payment accuracy was implemented at all VAMCs.	June 2015
	CBO provided training to VAMC staff on improper payment errors, corrective action plans, and on the CBO database and how to submit program related questions.	July 2015
	An automated 10-10SH application was implemented in two VISNs.	September 2015
	An executive decision memorandum was completed for regionalization of operations based on the organizational change pilot conducted in 2014 to start projected rollout in 2016.	September 2017
	A feasibility gap analysis was completed to determine what is required to bring the program into compliance with the Digital Accountability and Transparency Act of2014.	September 2017

Administrative or Process Error Made by State Agency

Error Cause	Corrective Actions	Completion Date
Admission application for new residents not being received within 10-days and payment was issued for days of care prior to the date VA received the form	The State Home Per Diem Roles and Responsibilities Reference Guide was sent to the field and uploaded to the program's SharePoint site.	June 2015

Error Cause	Corrective Actions	Completion Date
for processing or when an incorrect calculation was recorded on the invoice (10-5588) and was not identified prior to payment.		

VBA

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

1. Compensation

VA provides compensation to Veterans who are at least 10 percent disabled because of injuries or diseases that occurred or were aggravated during active military service.

Corrective Action Plan

The Compensation program will implement the following corrective actions to ensure greater compliance. However, the program does not anticipate changes in reduction targets for the next three fiscal years as the changes necessary in the IPERA process are in statute and regulations. Based on the current process to change regulations, this can take years to see the effect in the program. The Deputy Director, Policy and Procedures, Compensation Service and Assistant Deputy Under Secretary for Field Operations are the responsible accountable officials for improper payment reduction targets.

Improper Payment Reason: Administrative or Process Error made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Improper payments totaled $1.36 billion with administrative or process error made by federal agency errors accounting for 100 percent of improper payments.	Identify reasons for underpayments in evaluations and determine best course of action for change in rules. This will involve working with appropriate offices to: 1) define and document requirements for additional parameters for quality review, 2) identify problems and impediments with current process, 3) assess training need for rating to address procedural and quality lapses and revise training, and 4) where appropriate, conduct training to	September 2016

Error Cause	Corrective Actions	Completion Date
	appropriate field rating employees to address identified lapses to curtail under evaluation.	
	Identify ways to process dependency claims more timely with continued use of contractors to process dependency claims. Temporary Veteran Service Representatives will conduct quality reviews of contractor work. Data analysis from these reviews will be used to examine the variants of how work is processed to drive future training needs.	September 2016
	Explore additional opportunities to automate or simplify drill pay. Tasks include developing and revising applicable forms to allow Veterans to waive drill pay, working with applicable staff to implement an interim solution to automation and implement a finalized automation plan and updating manual for simplification.	September 2016
	Through the development of a training plan and program, implement improvements to increase the skill certification pass rate which will reduce error rates associated with rating claims processing, to include correct processing of temporary total (100%) ratings.	September 2016
	Increase quality accuracy rates through implementation of improvements to skill certification and training on administrative actions.	September 2016
	Reduce errors associated with separation pay withholdings to include training to increase understanding for processing rules involving separation procedures.	September 2016
	Review and update procedural guidance to ensure clarity and revise policies and update field of changes, as necessary.	January 2016
	Develop and conduct consistency studies targeted on error trends found in test reviews.	July 2016

2. Pension

VA helps Veterans and their families cope with financial challenges by providing supplemental income through Veterans Pension and Survivors Pension benefit programs.

Corrective Action Plan
Pension will implement the following corrective actions to ensure greater compliance. Through implementation of these actions, it is anticipated improper payments will be reduced by 0.01 percentage points in 2016. The Director of Pension and Fiduciary Service and Assistant Deputy Under Secretary for Field Operations are the responsible accountable officials for reducing improper payments.

Improper Payment Reason: Failure to Verify Financial/Death/Prisoner/Other Eligibility Data

Error Cause	Corrective Actions	Completion Date
Approximately $147.43 million of improper payments resulted due to failure to verify financial/death/prisoner/ other data errors. Pension will implement the following corrective actions to ensure greater compliance.	Implementation of automatic suspension and termination of benefits upon notice of death was completed in July 2014. Currently exploring the possibility of establishing an agreement with Social Security Administration (SSA) to share data and information with regards to surviving spouse death.	September 2016
	Implement Veteran upfront income verification with Internal Revenue Service (IRS) and SSA was completed in November 2013. Upcoming tasks include extending upfront income verification to claims for special monthly pension, dependency, and medical adjustment and expanding the Federal Tax Information for all pension claims.	November 2015
	Implement the National Training Curriculum for FY 2016 to include refresher training to ensure Pension Management Center (PMC)	December 2015

Error Cause	Corrective Actions	Completion Date
	employees understand what income and expense to use when making pension determinations and IPERA awareness training.	
	Work in conjunction with the Office of Field Operations to establish PMCs timeliness standards for completing incarceration/fugitive felon adjustments and prepare and provide written and oral guidance for dissemination.	December 2015
	Provide refresher training on the VBA letter on fugitive felons.	December 2015
	Investigate whether VBA can improve data matching with the Bureau of Prisons or other sources to identify benefits awards that require adjustments.	December 2015

Improper Payment Reason: Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Approximately $77.66 million of improper payments resulted due to insufficient documentation to determine errors. Pension will implement the following corrective actions to ensure greater compliance.	Review PMC Capture Unit standard operating procedures and pertinent manual provisions regarding the scanning and uploading of documents. Revise materials to determine appropriate timeliness and process for scanning and uploading.	December 2015
	Centralized mail will transition the current mail processing to a centralized receipt and virtual analysis concept by using the United States Postal Service, contractor-operated scanning and automated work routing processes to add VA	December 2015

	correspondence received via mail directly to the Veterans Benefits Management System (VBMS) eFolder. This will eliminate paper handling and expeditiously upload claims, evidence, and other mail to a Veterans eFolder in VBMS.	

Improper Payment Reason: Administrative or Process Error Made Federal Agency, Inability to Authenticate Eligibility, and Program Design and Structural Issue

Error Cause	Corrective Actions	Completion Date
Approximately $36.90 million of improper payments resulted due to administrative or process error made by federal agency errors, $2.15 million due to inability to authenticate eligibility errors, and about $50 thousand due to program design and structural issue errors. Pension will implement, or has implemented, the following corrective actions to ensure greater compliance.	Perform Systematic Technical Accuracy Reviews (STAR) to identify deficiencies and disseminate findings to the PMCs on a monthly basis to include share claim specific errors, IPERA and special findings. This includes sharing specific errors with individual stations and require corrections be completed and increasing the frequency of site visits at the PMC and incorporate IPERA awareness training and compliance into site visit protocol.	On-going
	Review manual, policies, and procedures to determine if clarifications and/or updates are needed.	October 2015

3. Education – Chapter 33

VA offers higher education and training benefits to Veterans, Service members, and their families who served after September 10, 2001.

Corrective Action Plan
Education will implement the following corrective actions to ensure greater compliance. Through implementation of these actions, it is anticipated improper payments will be

reduced by 0.01 percent in 2016. The Director of Education Service is the responsible accountable official for bringing about a reduction in improper payments.

Improper Payment Reason: Insufficient Documentation to Determine

Error Cause	Corrective Actions	Completion Date
Out of the estimated $135.05 million in improper payments, approximately $125.59 million resulted due to insufficient documentation to determine errors.	VBA education programs conduct random compliance surveys at schools and training facilities to review compliance with VA education benefit reporting requirements. In instances where a school or training facility is found to be in non-compliant with IPERA, VBA takes necessary measures to collect over-payments and correct any identified under-payments. Additionally, VBA provides necessary training for school and training facility officials to assist them in adhering to VA education benefit reporting requirements. Finally, VBA suspends approval of programs, schools, and training facilities due to non-compliance with VA education benefit as appropriate.	October 2016
	Update School Certifying Official Handbook to include Standard Operating Procedures surrounding document requests for IPERA reviews. This handbook provides processes and procedures to VA Certifying Officials and anyone at a school involved with certification of beneficiaries of VA education benefits.	March 2016

Improper Payment Reason: Administrative or Process Error Made by Federal Agency

Error Cause	Corrective Actions	Completion Date
Out of the estimated $135.05 million in improper payments, approximately $9.46 million resulted due to administrative or process error made by federal agency.	Conduct refresher training for Regional Processing Offices on Chapter 33 manual entry procedures with a focus on the reduction of improper payments.	October 2015

Section VI. Internal control over payments made by VA programs.

This year, VA assessed the internal controls over payments made by VA programs in the five components of internal control.

Control Environment
This year VA has begun to place more emphasis on improving the control environment over payments. In FY 2015, the VA Interim CFO established the IPRO organization charged with improving leadership, oversight and guidance for the Department on reducing improper payments. Working through the CFO, IPRO has begun to engage the Improper Payments Governing Board to work on resolving long-standing issues with improper payments. The members of the Improper Payments Governing Board include the Deputy Assistant Secretary for Finance, the CFOs of the Administrations, and senior level program staff. The Administrations and IPRO provide briefings to the Improper Payments Governing Board on the status and progress of efforts to comply with IPERA requirements, corrective actions and emerging issues. During FY 2016, the VA CFO and IPRO will continue to engage the Governing Board using an increased focus on corrective actions to help reduce improper payments.

Additionally, the Administrations have assigned managers and staff to oversee and administer IPERA activities within the respective Administrations. During FY 2015, each of the programs reporting in excess of the statutory thresholds identified key members of management responsible for the implementation of corrective actions and the associated reduction in improper payments.

Risk Assessment
VA developed a two-step process that requires all programs and activities perform a Pre-Risk Assessment each year and a Risk Assessment, if required, based on the results of the Pre-Risk Assessment. The Pre-Risk Assessment determines whether the program or activity is new, has undergone a risk assessment within three years, had a significant change in legislation or increase in funding, or had a change that resulted in a substantial program or activity impact. If the results of the Pre-Risk Assessment Questionnaire determine that a risk assessment is required for a program or activity, the reporting entities complete the Risk Assessment. It should be noted that all programs currently reported under IPERA do not require risk assessments. The 12 risk assessments required and performed for VA programs in fiscal year 2015 resulted in those programs and activities being of low or medium risk susceptibility for improper payments (see Section I above for additional detail on these programs).

For those programs or activities resulting in high-risk assessments that are expected to exceed at least 1.5 percent and $10 million in total program outlays or $100 million at any rate, the program office developed: (1) statistical sampling to determine the improper payment rate, and (2) reported corrective action plans within the Annual Financial Report.

Additionally, throughout the performance of the annual IPERA process, consideration is given to the findings noted through the reports issued under the VA OIG's IPERA review, the VA's CFO Act financial statement audit, the findings of the A-123 Appendix A process, other VA OIG reporting related to the high risk programs and other significant issues that could impact IPERA compliance. These reports are reviewed and compared to the planned testing approaches of the relevant programs to ensure proper consideration of the noted risks.

Control Activities

Management's implementation of internal controls over payment processes includes existence of documentation to support payments made, the assessment of design and operating effectiveness of internal controls over payments, the identification of deficiencies related to payment processes, and whether or not effective compensating controls are present.

There are controls in place at both VHA and VBA to perform pre-payment and/or pre-award reviews. These procedures have the effect of preventing improper payments before they are made. Treasury's Do Not Pay Program is also being utilized to prevent improper payments. VA continues to move to more analytic tools and preventative procedures which will also have the effect of reducing the number of payments subject to recapture processes.

Information and Communication

VA's Improper Payments Program includes reporting and communication of information on preventing, reducing and recapturing improper payments both internally and to outside agencies. VA developed a SharePoint site to coordinate information for the Improper Payments Program. This site is within the VA security perimeter and houses training materials, testing documentation, and signed copies of completed templates. Additionally VA communicates the importance, the results, and the activities of the Program and the Improper Payments Governing Board meetings.

VA conducts various IPERA status meetings with stakeholders throughout the Department to discuss planning and progress, as well as ensure engagement and understanding of the Improper Payments Program. VA has undertaken efforts to update policy guidance, handbooks and training for processing personnel. Through the IPERA process, VA has prepared IPERA testing guides and systems crosswalks to help inform and train staff. The systems crosswalks identify key information systems and the relevant IPERA documentation obtained from them. VA engages program level managers and staff in IPERA related meetings throughout the fiscal year to discuss testing approaches, investigate scenarios, review specific payment samples and develop corrective action plans.

Additionally, there are clear lines of authority and responsibility within each program, the respective oversight offices within each Administration and at the VA Central Office level.

Monitoring

VA engages in multiple monitoring activities to determine if payments are made properly and tests the strength of documentation requirements and standards to support testing of design and operating effectiveness for key payment controls.

VA monitors accounts and activities in the Improper Payment Program through testing and remediation of identified weaknesses in controls. VA developed templates to help reporting entities in developing test plans for their programs and enable complete and accurate reporting of test results. VA's policy requires that test plans include, at a minimum:

- The details of each test planned for each program and payment type;
- The criteria to be applied in determining whether a payment is improper; and
- The steps necessary to determine the appropriateness of each payment, including review and verification of program managers for identified improper payments.

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

Table 3
Status of Internal Controls

Internal Control Standards	Beneficiary Travel	CHAMPVA	VA Community Care	Purchased Long Term Services and Supports	State Home Per Diem Grants	Compensation (1)	Pension	Education – Chapter 33
Control Environment	3	3	3	2	3	3	3	3
Risk Assessment	3	3	2	2	4	3	3	3
Control Activities	3	3	2	2	4	3	3	3
Information and Communication	3	3	3	2	3	3	3	3
Monitoring	3	3	3	3	3	3	3	3

Notes to Table 3:
(1) The internal control review is based on current controls in place for working claims. Some errors identified during the payment review were authorized prior to the implementation of current controls.

Legend:
4 = Sufficient controls are in place to prevent IPs
3 = Controls are in place to prevent IPs but there is room for improvement
2 = Minimal controls are in place to prevent IPs
1 = Controls are not in place to prevent IPs

Section VII. Accountability for reducing and recovering improper payments made by VA programs.

The Department's Improper Payments Governing Board is led by VA's Interim Chief Financial Officer, and includes the Deputy Assistant Secretary for Finance, the Administration CFOs, and senior level program staff as participating members. The Governing Board is focused on achieving IPERA compliance, identifying root causes of improper payments, establishing reduction goals and implementing corrective actions to reduce/prevent improper payments. During FY 2015, the Governing Board continued to drive accountability by proactively engaging all stakeholders. Accountability was increased by requiring program officials to attend these meetings and/or provide direct support to the respective Administration CFOs.

VHA

Annually, VHA publishes a Director Executive Career Field performance plan to communicate to senior executives the expectations of VA. The plan includes the goal of financial stewardship, which is to support the overall Department goal of best practices in financial and business processes. Each VISN ensures continual monitoring of facility performance on key financial and business compliance indicators and VA Leaders are measured on their ability to meet program performance targets. In 2015, VHA will issue VISN level reports to provide a comparison between VISNs, analysis of specific error categories and a breakout of facility level improper payment performance. This detailed information assists VISN Directors in understanding the frequency and occurrence of improper payments. In 2015, VHA will also require VAMCs to provide facility level corrective action plans and recovery efforts for each improper payment identified in the IPERA review to supplement national corrective actions reported in Section V of this report. More specifics for each of the high risk programs reporting above the statutory thresholds follow:

1. Beneficiary Travel

The Deputy Chief Business Officer for Member Services is accountable for ensuring execution of corrective action plans. Each individual reporting Program Office Director and corresponding subordinates are also held accountable to the senior executive performance plan expectations. Unique program corrective action plans are reported on a weekly, bi-weekly and monthly basis to senior executives for tracking and monitoring.

2. CHAMPVA

The CBOPC Chief Operating Officer is accountable for ensuring execution of corrective actions plans. CBOPC Operations has the primary responsibility for the

processing of CHAMPVA claims and works to address and correct improper payments. When errors are identified, CBOPC supervisors work to identify trends and provide education to the voucher examiners regarding the issue both individually and as a group. The Chief Operating Officer and the Director of Operations' performance plans include goals for financial stewardship, and the identification and implementation of corrective actions to address improper payments.

3. VA Community Care

The CBOPC Chief Operating Officer is accountable for ensuring execution of corrective action plans. CBOPC Operations has the primary responsibility for the processing of community care claims and works to address and correct improper payments. When errors are identified, CBOPC staff work to identify trends and provide education at both a local and national level. If additional training is needed, mentoring can be provided to the site by CBOPC staff. The Chief Operating Officer and the Director of Operations' performance plans include goals for financial stewardship, and the identification and implementation of corrective actions to address improper payments.

4. Purchased Long Term Services and Supports

The GEC Chief Consultant is accountable for ensuring execution of corrective action plans and will develop and monitor a performance measure related to improper payments.

5. State Home Per Diem Grants

The CBOPC Director of Program Administration is accountable for ensuring execution of corrective action plans. The State Home Per Diem Program Office works directly with the facility when improper payments are identified, as well as broadly across the program through monthly training events. A bill of collection standard operating procedure has been developed for use in capturing identified improper payments. The Chief Operating Officer, the Director of Program Administration, and the Department Chief's performance plans all include goals for financial stewardship. Specifically, the Chief of the State Home Per Diem Program's performance plan includes a goal to develop corrective action plans within 30-days of a finding being identified that addresses improper payments, oversight of payments, and the prevention and detection of fraud, waste and abuse.

VBA

The Under Secretary for Benefits (USB) continues to emphasize accountability and integrity at every level within the Administration. Underscoring the commitment to

achieving the goals set forth in IPERA, the USB appointed the Chief Financial Officer and Deputy Chief Financial Officer as senior accountable officials for achieving IPERA compliance. Overseen by both the CFO and Deputy CFO, the VBA committee of program managers, program officials and key accountable officers from all business lines continue their efforts in establishing and implementing guidelines and policies to meet improper payment reporting requirements.

1. Compensation and Pension

With the launching of the VBA Transformation Plan, leadership developed goals and initiatives to transform VBA into a streamlined, high-technology 21st century organization, which is enabling VBA to process Compensation, Pension, and DIC claims within prescribed time constraints, while maintaining high levels of accuracy. With Veterans and their families always at the forefront of all VBA strategic goals, the Transformation Plan is designed to transform three major areas: people, process, and technology. The sweeping multi-faceted changes are improving internal process controls and are poised to significantly reduce improper payments as a result of increased automation and improved accuracy.

VBA Regional Office Directors, Veterans Service Center Managers, PMC Managers, and all other management personnel share the same performance goals 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.

2. Education

Regional Processing Office Directors, Education Officers, all education management personnel, and individual employees are rated on accuracy of education claims processing. Local and national testing of education claims processing is conducted. Findings are used to target training, as well as the development of Performance Improvement Plans, as necessary.

Section VIII. VA's information systems and infrastructure put in place to reduce improper payments.

VHA

There are significant staffing shortages within VHA. Many errors were attributed to delayed creation or renewal of contracts due to staffing shortages in the contracting and

community care offices. As well, requests for fixes or improvements to information systems, which address improper payments, must compete to be prioritized within the Office of Information and Technology. The competitions for prioritization and limited staffing negatively impacts the requested system fixes and improvements. Additional information on the VHA programs which are reporting improper payments in excess of the statutory thresholds follow.

1. **Beneficiary Travel**
   Long term infrastructure and information system solutions for the Beneficiary Travel Program are underway. Initial funding approvals and key milestones have been met. Beginning in 2012, previous annual requests for funding were not successful during funding prioritization. Project start date is scheduled for fiscal year 2016.

2. **CHAMPVA**
   CBO has submitted multiple requests to the Office of Information and Technology for priority consideration, which would reduce errors by addressing identified systems issues and expand automated business rules to reduce the number of human entries and decisions. Additional quality reviews were implemented to monitor eligibility determinations. In 2015, data matches with Centers for Medicare and Medicaid Services and TRICARE are being utilized to detect changes in the beneficiary's status. CBO also utilizes queues for secondary review of claims which meet certain criteria, such as possible duplicate claims, or setting a percentage of voucher examiner claims to be reviewed by a lead.

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

4. **Purchased Long Term Services and Support**
   The improper payment rate for Purchased Long Term Services and Support has been impacted by acquisition issues. Creation of contracts in the community can take an extensive amount of time, partly due to the complicated nature of federal contracting regulations.

5. **State Home Per Diem Grants**
   The State Home Per Diem program currently relies on the Electronic Tracking Tool, a semi-automated Excel spreadsheet that reconciles the gains and losses related to resident activity at the State Veteran Home, and OB10 (Tungsten), for managing invoicing. The program recently completed an analysis to be in compliance with the Digital Accountability and Transparency Act of 2012 along with a 100 percent review of backlogged forms in its central repository. In 2015, the program automated the 10-10SH application form and implemented it in two VISNs. Continued improvements are anticipated once the future state of this program is realized.

VBA

VBA strives to improve payment practices and procedures by working in a collaborative environment to identify ways to streamline processes and enhance plans to reduce improper payments. Overall, these processes will improve consistency and data accuracy to help reduce improper payments. While VA has the necessary information infrastructure to meet current improper payment levels, additional information technology funds would allow further reduction in improper payments. Additional information on the VBA programs which are reporting improper payments in excess of the statutory thresholds follow.

1. **Compensation and Pension**
   VBA continues to enhance its automatic suspension and termination of benefit payments to Veterans and beneficiaries upon notice of death through data received from SSA. VBA is in the requirements stages of terminating and suspending awards upon notification of incarcerated beneficiaries from Bureau of Prisons. The Pension program has implemented upfront verification of income agreements between VBA, IRS, and SSA, which include timely verification of income received from all sources by a claimant prior to VA benefits eligibility determination.

2. **Education**
   VBA fielded and continues to update the Long Term Solution (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 51% of Chapter 33 supplemental claims in FY 2014. VBA internal controls include quarterly reviews of claims processing at the national level, annual site visits at the regional processing offices, and random surveys of

schools and training facilities to monitor compliance with claims processing procedures and enrollment reporting requirements.

Section IX. Statutory and regulatory barriers limiting VA corrective actions.

VHA

There are several statutory or regularity barriers impacting the VA Community Care and PLTSS programs which limit implementation of VHA's corrective actions. If the legislative proposals are passed, they will significantly decrease improper payments and improve Veterans access to care.

- A legislative proposal was submitted for Congressional consideration that would allow VA-initiated Veteran care agreements to authorize required non-VA medical services.
- Legislation has been introduced in the US Senate S.739 that would address VA's legal authority to enter into provider agreements for services.

VBA

For an adverse change in benefits, Veterans and/or beneficiaries are entitled to pre-determination notice of any decision made by VA (38 CFR 3.103), with limited exceptions. This results in continued payment at improper rates for a minimum of 60 days following discovery which impacts the Compensation and Pension programs.

Since the principles of due process are mandated by the Constitution, continued payments during the notification of reduction period are a necessary cost of administering the VBA Compensation and Pension programs.

Veterans and/or beneficiaries are responsible for notifying VBA of any event that may affect benefit payments, such as dependency changes. Additionally, notification of receipt of drill pay, by program design, occurs after activity has been completed, and annual notification from the Department of Defense has occurred. Late notifications of these events will subsequently cause improper payments until adequate notification is received. Though there are currently data matching systems in place, we consider this to be third party information. As required by law, due process must be provided before any adverse action is taken. VBA is continuing efforts to automate processes and working with stakeholders and partnering agencies to receive upfront information, which will allow timely adjustments, as part of our commitment to minimize and eliminate improper payments. This includes up-front notification for active duty pay offsets, and automation of non-rating related award actions.

Section X. Recapture of improper payment reporting for VA programs.

VA performed recapture audits for all programs with outlays of $1 million or more. VA has not excluded any programs or activities that are applicable from the payment recapture audit.

VHA

VHA's payment recapture audit program is focused on preventing, detecting and recovering overpayments. As part of VHA's payment recapture audit program, VHA utilized both internal and external payment recapture activities including the following:

CBO Internal Audit and Recovery Efforts

- Claim Check/Claim Scrubber Tool: performs a validation check prior to releasing payments. Claim Check prevented $52,950,000 in improper payments for FY 2014.
- Artificial Intelligence: translates policies and regulations into a form that can be acted on by the system, which is applied to medical claims submitted for payment. Artificial Intelligence prevented $40,150,000 in improper payments for FY 2014.
- Quality Inspector Tool: provides push-button inspection of all outpatient claims processed through FBCS to ensure proper payment in a pre-payment status. The tool avoided $19,460,874 in improper payments for FY 2014.
- SnapWeb Duplicate Payment Program: designed to identify potential duplicate payments in a pre-payment state. The use of the program avoided $5,844,598 in improper payments for FY 2014.
- Program Integrity Tool: a comprehensive set of program integrity tools to reduce fraud, waste, and abuse and improve payment accuracy in a pre-payment status. The tool avoided $805,373 in improper payments for FY 2014.
- Recapture Recovery Initiative: tracks overpayment collection and resolution of underpayments. During FY 2014, CBO recaptured $353,425 of identified improper payments.
- CBO Audit Teams conducted 18 audits over six different programs. These audits identified improper payments in the amount of $10,373,617 in FY 2014, which were referred to the Recapture Recovery Initiative to track the collection of overpayments, and resolution of underpayments.
    - 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.
    - Virtual Audit Team: structured to perform the IPERA audit and quarterly proper payment audits for the VA Community Care program and State Home Per Diem Grants program.

- Special Audit Team: focuses on special audit requests from both internal and external stakeholders.

CBO External Audit and Recovery Efforts

- CBO has retained recovery contracts for VA Community Care, CHAMPVA, and Spina Bifida Health Care through August 2013. Currently, CBO is working with contracting to establish a new recovery contract. VHA, through the use of recovery audit contracts, continued to collect $619,270 in overpayments throughout FY 2014. As well, proposed legislation would allow CBO to conduct recovery audits not only by contract, but internally as well.

VBA

In an effort to identify and recapture improper payments, VBA used a combination of full-case quality reviews and payment reviews to identify possible duplicates and overpayments.

The majority of VBA programs perform quality reviews on randomly selected cases. VBA tracks, monitors, and recovers overpayments eligible for recovery through combined efforts of the Debt Management Center (DMC), the Administrative and Loan Accounting Center, and ROs.

Root Cause of Improper Payments

VBA identified that a majority of payment errors were due to administrative and process errors made by the federal agency and insufficient documentation to determine.

Collection Process

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

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

In accordance with 38 U.S.C. 5302, VBA may waive benefit debts arising as a result of participation in a benefit program when collection would be against equity and good conscience and no evidence exists of fraud, misrepresentation, or bad faith. VBA will

notify the debtor of his or her rights and remedies and the consequences of failure to cooperate with collection efforts. The debtor has the right to dispute the existence or amount of the debt or to request a waiver from collection of the debt. VBA may waive benefit debts when the facts and circumstances of the particular case indicate a need for reasonableness and moderation in the exercise of the Government's rights and if the waiver request was made within the specified timeframes.

PFE

Improper payments to employees found through testing are recovered as they are identified. The recovery is made by adjusting the employees' paychecks for the amount of improper payment. Errors are confirmed with the employee's station payroll staff and once confirmed, payroll staff make the necessary adjustments. In some instances, improper payments were made to employees who have separated from the agency and VA does not currently have a way to recover those overpayments. However, the timing of the testing will be moved closer to payment dates so that the testing is done on a more real-time basis.

FSC

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

Pre-Payment Review

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

Post-Payment Review

FSC performs several post-payment reviews to detect improper payments:

- Payment files in excess of $2,500 are matched against disbursed payments over the previous 2 fiscal years to identify duplicate payments.
- Various performance measure reviews of payments are conducted using statistical sampling to verify their accuracy and timeliness.
- Reviews are conducted on FSC-issued interest penalty payments over $50 to determine if interest was actually due to the vendor.
- Vendor statements are reviewed to recover any outstanding prior year vendor credits not previously collected.

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

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

Collection Process
For improper payments detected in post-payment reviews, the following recovery actions are used by FSC, as appropriate, to recover the funds from the vendor/employee.

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

The Office of Acquisition, Logistics, and Construction (OALC) Activities
OALC works with OIG's Office of Contract Review (OCR) to recover funds owed VA due to defective pricing and price reduction violations. As part of OIG's 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.

Table 4 (For VHA)
Improper Payment Recaptures with and without Audit Programs [1]
($ in millions)

Overpayments Recaptured Through Payment Recapture Audits																						Overpayments Recaptured Outside of Payment Recapture Audits	
Program or Activity	Contracts					Grants					Benefits					Other					Total			
	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Beneficiary Travel	-	-	-	-	-	-	-	-	-	-	0.87	0.67	77.01	80.00	85.00	-	-	-	-	-	0.87	0.67	0.57	0.38
CHAMPVA (2)	-	-	-	-	-	-	-	-	-	-	11.7368	11.2518	95.87	85.00	90.00	-	-	-	-	-	11.7368	11.2518	-	9.39
VA Community Care	-	-	-	-	-	-	-	-	-	-	0.05	0.04	80.00	85.00	90.00	-	-	-	-	-	0.05	0.04	0.84	0.48
Purchased Long Term Services and Supports	-	-	-	-	-	-	-	-	-	-	0.01	0.01	100.00	95.00	95.00	-	-	-	-	-	0.01	0.01	0.01	0.01
State Home Per Diem Grants	-	-	-	-	-	0.01	0.01	100.00	95.00	95.00	-	-	-	-	-	-	-	-	-	-	0.01	0.01	1.27	1.27
Supplies and Materials	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.376	0.335	89.10	90.00	95.00	0.376	0.335	0.34	0.33
Other VHA Programs 1 (3)	-	-	-	-	-	0.20	0.20	100.00	95.00	95.00	-	-	-	-	-	3.25	2.88	88.62	90.00	95.00	3.45	3.08	5.79	4.66
Other VHA Programs 2 (4)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.07	0.05	71.43	85.00	90.00	0.07	0.05	0.31	0.26

Notes to Table 4:

(1) VA is reporting improper payments identified and recaptured during the period of October 1, 2013 through September 30, 2014. Additionally, VA is reporting the estimated recapture rate targets for FYs 2015 and 2016.

(2) CHAMPVA data is combined with CBO programs: Foreign Medical, Spina Bifida Health Care, and Caregiver Stipend. Overpayments recaptured outside of payment recapture audits consist of unsolicited funds received.

(3) Other VHA programs 1, using Medical Care Funds, includes the following programs for reporting purposes: Communications, Utilities, and Other Rent; Compensated Work Therapy and Incentive Therapy.
VHA - Equipment; Homeless Per Diem Grants; Insurance Claims and Interest Expense; Land and Structures; Other Services; Consolidated Mail Outpatient Pharmacy; Pharmacy Medical Facilities; Printing and Reproduction; Prosthetics; and Other VHA Activities.

(4) Other VHA programs 2, using Non-Medical Funds, includes the following programs for reporting purposes: DoD-VA Medical Facility Demonstration Fund; General Post Fund; Medical and Prosthetic Research; and Medical Facilities Recovery Act.

Table 4 (Remaining VA Programs)
Improper Payment Recaptures with and without Audit Programs [1]
($ in millions)

Program or Activity	Overpayments Recaptured Through Payment Recapture Audits																					Overpayments Recaptured Outside of Payment Recapture Audits	
	Contracts					Grants					Benefits					Other					Total			
	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	2014 Recapture Rate	2015 Recapture Rate Target	2016 Recapture Rate Target	Amount Identified	Amount Recaptured	Amount Identified	Amount Recaptured
Compensation	-	-	-	-	-	-	-	-	-	-	1.51	1.05	79.54	62.00	62.00	-	-	-	-	-	1.51	1.05	-	-
Pension	-	-	-	-	-	-	-	-	-	-	0.04	0.01	25.00	25.00	25.00	-	-	-	-	-	0.04	0.01	-	-
VR&E	-	-	-	-	-	-	-	-	-	-	0.03	0.02	66.67	85.00	85.00	-	-	-	-	-	0.03	0.02	-	-
Education	-	-	-	-	-	-	-	-	-	-	0.02	-	0.00	62.00	62.00	-	-	-	-	-	0.02	-	-	-
Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Loan Guaranty	-	-	-	-	-	-	-	-	-	-	4.36	3.55	81.42	42.00	42.00	-	-	-	-	-	4.36	3.55	0.39	-
VBA Other Direct Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.05	0.04	80.00	69.00	69.00	0.05	0.04	-	-
VBA GOE Fund	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.07	0.07	100.00	85.00	85.00	0.07	0.07	-	-
NCA Burial Programs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.89	0.13	14.61	85.00	85.00	0.89	0.13	0.23	0.23
PFE - Payroll	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.14	0.01
Staff Offices (2)	7.87	7.45	94.66	85.00	85.00	-	-	-	-	-	-	-	-	-	-	0.02	0.02	100.00	85.00	85.00	7.89	7.47	5.92	5.61
Total	7.87	7.45	94.66			0.21	0.21	100.00			18.6268	16.6018	89.13			4.726	3.525	74.59			31.4328	27.7868	15.81	22.63

Notes to Table 4:

(1) VA is reporting improper payments identified and recaptured during the period of October 1, 2013 through September 30, 2014. Additionally, VA is reporting the estimated recapture rate targets for FYs 2015 and 2016.

(2) Staff Offices include the following programs: CDCO Franchise Fund; HRA General Administration Annual; OALC Major and Minor Construction; OGC General Administration Annual; OIG; OIT programs; OM Franchise Fund and General Administration Annual; Supply Funds; and VA Employee Travel.

Table 5
Disposition of Funds Recaptured Through Payment Recapture Audits
($ in millions) [1]

Program or Activity	Amount Recovered	Type of Payment	Agency Expenses to Administer Program	Payment Recapture Auditor Fees	Financial Management Improvement Activities	Original Purpose	Office of Inspector General	Returned to Treasury	Other
All VHA Programs (2)	15.4468	All	-	-	-	15.4468	-	-	-
Compensation (3)	1.05	Benefit	-	-	-	1.05	-	-	-
Pension (3)	0.01	Benefit	-	-	-	0.01	-	-	-
VR&E (3)	0.02	Benefit	-	-	-	0.02	-	-	-
Loan Guaranty (4)	3.55	Benefit	-	-	-	3.55	-	-	-
Other Direct Benefits (3)	0.04	Other	-	-	-	0.04	-	-	-
VBA – GOE Fund (4)	0.07	Other	-	-	-	0.07	-	-	-
NCA Burial Programs	0.13	Other	-	-	-	0.13	-	-	-
Staff Offices	7.47	Other	-	-	-	7.47	-	-	-
TOTAL	27.7868	-	-	-	-	27.7868	-	-	-

Notes to Table 5:
(1) Amounts represent the disposition of funds recovered through payment recapture audits during FY 2014.
(2) Title 38 U.S.C. allows VHA to retain and use the recovery funds as no-year funding. The significant benefit to VA assures that lengthy collection activities, typically required to conduct these recovery actions, do not negatively impact the ability to use these funds. In addition, this benefit guarantees strong participation by assuring full recovery for medical facilities
(3) All funds recovered within the fiscal year of appropriation are returned to the fund for its original purpose. Funds recovered after the fiscal year ends, and up to five years after the appropriation has expired, are used for adjustment purposes only.
(4) Improper payments identified and recovered were from programs where the funds had not expired. All recoveries were returned to the fund for original purpose.

Table 6
Aging of Outstanding Payments Identified in Payment Recapture Audits[(1)]
($ in millions)

Program or Activity	Type of Payment (contract, grant, benefit, loan or other)	Amount Outstanding (0-6 months)	Amount Outstanding (6 months to 1 year)	Amount Outstanding (over 1 year)	Amount determined to not be collectable (include justification in Payment Recapture Narrative)
Beneficiary Travel	Benefit	0.18	0.02	-	-
CHAMPVA (2)	Benefit	-	-	-	0.485
VA Community Care	Benefit	-	0.01	-	-
Purchased Long Term Services and Supports	Benefit	-	-	-	-
State Home Per Diem Grants	Grant	-	-	-	-
Supplies and Materials	Other	0.03	0.01	-	-
Other VHA Programs 1 (3)	Other	0.35	0.02	-	-
Other VHA Programs 2 (4)	Other	0.02	-	-	-
Compensation	Benefit	0.46	-	-	-
Pension	Benefit	0.03	-	-	-
VR&E	Benefit	0.01	-	-	-
Education	Benefit	0.02	-	-	-
Insurance	Benefit	-	-	-	-
Loan Guaranty	Benefit	0.81	-	-	-
Other Direct Benefits	Other	0.01	-	-	-
VBA GOE Fund	Other	-	-	-	-
NCA Burial Programs	Other	0.76	-	-	-
PFE - Payroll	Other	-	-	-	-
Staff Offices (5)	Contract/Other	0.32	0.10	-	-
Total		3.00	0.16	-	0.485

Notes to Table 6:
(1) VA is reporting improper payments identified, recovered, and outstanding for the period of October 1, 2013 to September 30, 2014.
(2) CHAMPVA data is combined with CBO programs: Foreign Medical, Spina Bifida Health Care, and Caregiver Stipend. Write off were initiated where amounts determined to not be collectable.
(3) Other VHA programs 1, using Medical Care Funds, includes the following programs for reporting purposes: Communications, Utilities, and Other Rent; Compensated Work Therapy and Incentive Therapy; VHA - Equipment; Homeless Per Diem Grants; Insurance Claims and Interest Expense; Land and Structures; Other Services; Consolidated Mail Outpatient Pharmacy; Pharmacy Medical Facilities; Printing and Reproduction; Prosthetics; Transportation of Persons and Things (not including beneficiary travel and employee travel); and Other VHA Activities.
(4) Other VHA programs 2, using Non-Medical Funds includes the following programs for reporting purposes: DoD-VA Medical Facility Demonstration Fund; General Post Fund; Medical and Prosthetic Research; and Medical Facilities Recovery Act.
(5) Staff Offices include the following programs: CDCO Franchise Fund; HRA General Administration Annual; OALC Major and Minor Construction; OGC General Administration Annual; OIG; OIT programs; OM Franchise Fund and General Administration Annual; Supply Funds; and VA Employee Travel.

Section XI. Additional comments on VA efforts to reduce improper payments.

VHA

VA is committed to providing Veterans access to timely, high-quality health care. 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 limitations on its authority to enter into agreements with private vendors to purchase services without following FAR. VA is taking a comprehensive approach to resolving this issue through legislation and reviewing internal processes to identify areas to increase compliance without impacting access to care.

VBA

In 2014, VBA, on VA OIG's recommendation, added a review of school submitted enrollment documents to validate enrollment data into the IPERA review. While this additional step has proven beneficial and increases the confidence in education benefits IPERA review findings, it has also occasionally identified schools or training facilities that are not in compliance with VA enrollment reporting requirements or other regulatory requirements. In instances where a school or training facility cannot come into compliance, or those rare instances where the school or training facility is egregiously violating VA enrollment reporting or other regulatory requirements, VBA must suspend or withdraw approval. During the FY 2014 IPERA review, two payments were reviewed that were initiated by a school or training facility whose approval was withdrawn. Therefore, VBA was unable to acquire the information and documentation necessary to validate reported enrollment data from the school or training facility. Out of caution, and to ensure VBA reported the most accurate information possible, these payments were determined to be improper and accounted for 52% of the reported error rate and an estimated $49 million of the reported improper payment amount. While this phenomenon inflates reported improper education benefit amounts, VBA remains committed to enforcing school and training facility compliance and recognizes that it may impact the improper payment rate.

Staff Offices

IPRO will be examining the Improper Payments Program in FY 2016 to identify strategic and tactical improvements that can be made to improve the overall program. Key focus areas of this review include:

- Leveraging the Improper Payments Governing Board to improve collaboration, coordination and accountability of program offices that own the processes that support the various payments and benefits that Veterans receive;
- Conducting lessons learned from past improvement efforts to determine what has worked well and what can be improved;

- Establishing a comprehensive review process for the development of corrective action plans to ensure that planned actions will address the root causes for the improper payments;
- Examining where additional training, tools and desk aids can reduce errors and reduce improper payments; and
- Identifying and prioritizing IT enhancements needed to reduce manual processes prone to errors.

All of the above actions will strengthen the VA Improper Payment Program with the objective of lowering the rate of improper payments and improving internal controls.

Section XII. VA's reduction of improper payments with the Do Not Pay Initiative.

Treasury provides monthly matching of all VA payment files with the public Death Master File (DMF) and the System for Award Management (SAM) (also known as the public Excluded Parties List System) databases in Do Not Pay (DNP). VA provides a monthly extract of VA's Financial Management System (FMS) vendor file to Treasury for matching against all available databases contained in the DNP portal. VA continues to look for opportunities where other control measures may be leveraged to comply with IPERA.

As a result of VA's existing activities and programs designed to prevent improper payments, only a minimal number of payment errors have been detected through the DNP matching process. More information is provided below on other activities and programs VA utilizes to prevent improper payments.

VHA

The FSC provides VHA with the matches it receives from Treasury on a monthly basis for Agency Location Codes (ALCs) 36001200 and 36000785. These matches are from DMF and SAM databases described above. VHA then applies additional business rules for increased accuracy and sends out results to the VISNs and VAMCs. Once feedback is received on the accuracy of the payment, VHA consolidates the results and submits them to FSC. As a result of VA's existing activities and programs designed to prevent improper payments, only a minimal number of payment errors have been detected through the DNP matching process.

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

VBA

For this reporting period, over 71.12 million payments were matched with the DNP databases. In addition, VBA has agreements with other federal agencies such as SSA, IRS, and BOP, to share information on a recurring basis to determine VA beneficiaries' eligibility. Information derived from the matches may be used to adjust VA benefit payments.

NCA

For this reporting period, approximately 30 thousand payments were matched with the DNP databases. No improper payments were identified.

FSC

The FSC processed vendor payments for goods and services on behalf of VA central office, VHA, NCA, and VBA. The FSC implemented a DNP continuous monitoring process to reduce erroneous vendor payments in accordance with IPERA. The continuous monitoring process includes a monthly match of vendors that compares the existing VA FMS vendor file with Treasury's DNP solution.

Treasury provides matches based upon two criteria: 1) Taxpayer Identification Number, and 2) Name. The matches are then forwarded to VHA, VBA, and NCA for investigation and adjudication. If warranted, a payment hold is placed on the vendor record in FMS which prevents processing of future payments associated with the ineligible payee.

Grants

VA's Grant Program Offices (GPOs) utilize the DNP portal to determine the eligibility status of an applicant prior to award. Through the use of the portal, program offices are able to quickly confirm a potential awardee's eligibility status and to make thorough decisions regarding the award of federal funds.

Table 7
Results of the Do Not Pay Initiative in Preventing Improper Payments[1]

	Number (#) of payments reviewed for improper payments	Dollars ($) of payments reviewed for improper payments	Number (#) of payments stopped	Dollars ($) of payments stopped	Number (#) of potential improper payments reviewed and determined accurate	Dollars ($) of potential improper payments reviewed and determined accurate
Reviews with the DMF only (2)	94,150,000	112,792,120.00	9	11,303.00	94,149,991	112,780,817.00
Reviews with the SAM only (3)	94,150,000	112,792,120.00	0	0	94,150,000	112,792,120.00
Reviews with databases not listed in IPERA (4)	125,859	88,390,000.00	38,226	22,920,000.00	87,633	65,470,000.00

Notes to Table 7:
(1) Amounts represent the results of the Do Not Pay Initiative for FY 2014.
(2) Matching against the Death Master File of the Social Security Administration (DMF). VBA currently has effective internal control mechanisms in place to identify and stop improper payments through a pre-existing data matching agreement program with SSA's private DMF database. Until legislative changes are enacted, VBA will continue to stop payments through the private DMF.
(3) Matching against the System for Award Management (SAM).
(4) VBA currently has effective internal control mechanisms in place to identify and stop improper payments through a pre-existing data matching agreement program with SSA's private DMF database. Until legislative changes are enacted, VBA will continue to stop payments through the private DMF.

Freeze the Footprint (FTF)

OMB Memorandum 12-12, *Promoting Efficient Spending to Support Agency Operations*, section 3 and OMB Management Procedures Memorandum 2013-02, the Freeze the Footprint policy implementation guidance require CFO Act departments and agencies not increasing the total square footage (SF) of their domestic office and warehouse inventory compared to the FY 2012 baseline, unless increased footage is offset through consolidation, co-location, or disposal of space from the inventory of that agency.

Baseline Comparison

	FY 2012 Baseline	FY 2014 Reported	Change
Square Footage (in millions)	28.87	29.59	0.72

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

	FY 2012 Reported Cost	FY 2014 Reported Cost	Change
Operation and Maintenance Costs (in millions)	$99.57	$110.81	$11.24

VA's total SF subject to FTF for 2014 was 29.6 million SF, which represents a 2.5 percent increase over the 2012 baseline of 28.9 million SF.

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

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

In terms of cost, total operation and maintenance costs as reported in the Federal Real Property Profile (FRPP) rose 11.3 percent from $99.6 million in FY 2012 to $110.8 million in FY 2014. Each year, operation and maintenance costs increase by a few percentage points due to inflation, which escalates lease rental rates, utility rates, and other costs. In addition, VA did see growth in its FTF SF, which also contributed to an increase in operational costs. This combination of factors resulted in an increase in total operations and maintenance costs as reported in FRPP.

OIG Foreword to Major Management Challenges

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

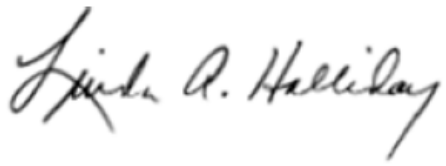
FOREWORD

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

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

This report contains the updated summation of major management challenges organized by the five OIG strategic goals—health care delivery, benefits processing, financial management, procurement practices, and information management—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 to the Nation's veterans and their dependents.



LINDA A. HALLIDAY
Deputy Inspector General

Major Management Priorities and Challenges

Major Management Challenge		Estimated Resolution Timeframe (Fiscal Year)	Page #
No.	**Description (Responsible Office)**		
OIG 1	**Health Care Delivery (VHA)**		
1A	Quality of Care **(VHA)**	2016	III-60
1B	Access to Care **(VHA)**	2016	III-67
1C	Care for Homeless Veterans **(VHA)**	2015	III-71
OIG 2	**Benefits Processing (VBA)**		
2A	Improving the Accuracy of Claims Decisions **(VBA)**	2016	III-75
2B	Improving Data Integrity and Management Within the VA Regional Offices **(VBA)**	2016	III-79
2C	Improving Management of the Fiduciary Program **(VBA)**	2016	III-82
OIG 3	**Financial Management (OM,OIT,VHA,VBA)**		
3A	Compliance with the Improper Payments Elimination and Recovery Improvement Act **(OM,VHA,VBA)**	2016	III-86
3B	Improving Management of Appropriated Funds **(OM,OIT,VHA)**	2015	III-89
OIG 4	**Procurement Practice (OALC,VHA)**		
4A	Improving Contracting Practices **(OALC,VHA)**	2015 (OALC, OPIA) 2016 (VHA)	III-93
4B	Improving Oversight of Patient Centered Community Care Contracts **(OALC,VHA)**	2015 (OALC) 2016 (VHA)	III-96
OIG 5	**Information Management (OIT)**		
5A	Develop an Effective Information Security Program and System Security Controls **(OIT)**	2016	III-98
5B	Improving Compliance with Federal Financial Management Improvement Act **(OIT)**	Unknown	III-102
5C	Improving Accountability and Oversight of the Project Management Accountability System **(OIT)**	2015	III-104

OIG CHALLENGE #1: HEALTH CARE DELIVERY
-Strategic Overview-

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

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

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

1. Making Mission-Driven Decisions. VHA's primary mission is, and should be, the delivery of high quality health care. VHA has a number of critical missions that include: (1) the provision of quality healthcare, (2) the training of tomorrow's healthcare providers, (3) the provision of healthcare to all citizens in a time of national disaster, and (4) the advancement of medical research. VA must consistently make decisions to ensure that veteran's healthcare is always the highest priority mission. Within VHA, the first test of a management decision should be an assessment of its impact upon the delivery of quality health care. For example, veterans who receive their medical care through VA need timely access to emergency care. The management of a possible myocardial infarction, stroke, or appendicitis requires not only a sophisticated emergency room and readily available imaging, but hospital specialty treatment rooms and dedicated teams to provide timely critical care. Many smaller VAMCs cannot provide timely expert care for patients with these conditions. VHA's decision to operate an emergency room or urgent care center should have the quality delivery of this care as its most important standard. Arguments that veterans prefer to receive their care at VA or that this care creates contracting difficulties are secondary to the imperative that high quality care be provided. All medical care provided at each facility should be considered against this test.

VHA's Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Under Secretary for Health

Completed VHA FY 2015 Milestones:
(This sub-challenge is not related to any specific OIG reports or recommendations; VHA has no milestones or pending action items on which to report. VHA provides general comment in response to OIG's statements)

In the past year, the vast shortage of clinicians in VHA and the resultant difficulty Veterans experienced in accessing VA care shocked the country. Yet, clinician shortage and access problems are not unique to VA; private citizens in every community across the country experience similar, if not greater, difficulty accessing their private clinicians, especially in rural areas (40 percent of Veterans enrolled in VHA live in rural areas, compared with approximately 25 percent of the U.S. population). The Congressional decision to broaden the ability for Veterans to qualify for federally subsidized private health care increased the demand on local providers who are already in short supply because of coverage expansion and an aging population. Diverting Veterans to the private sector has not yet demonstrated a substantial increase in health care access for Veterans.

OIG's comments regarding VHA leadership decision making sheds light on the complex nature of managing a national health care system comprised of over 1,500 sites of care across 50 states and U.S. Territories. VHA leadership decisions are mission driven and nearly always influenced by competing demands, such as funding, urgency, ethical justification, implementation of law, and Congressional or Executive Branch priorities. For example, in the setting of limited funding, VHA might need to decide between providing urgent financial support to a facility having difficulty providing critical services to Veterans seeking care today compared to hiring 1,600 new mental health providers nationally within 6 months as mandated by Congress. Both are essential to ensure Veterans have access to care, yet one will take precedence over the other.

Certainly there are times when short-term goals, such as urgent hiring of 1,600 new mental health providers over a 6 month period, interfere with VHA's ability to consistently support innovation at local VAMCs. There are times when national emergencies, like Hurricanes Katrina and Sandy, substantially divert resources from facilities across the country, thus interfering with VHA's ability to provide timely access to care for all Veterans at all sites. And there are times when concerns about quality of care supersede access to care, such as converting an emergency room to an urgent care center when the site does not have appropriate staff to meet quality of care standards.

While it is not the first test VHA leadership considers when making decisions, assessment of the impact on the delivery of quality health care is a strong and important element of the decision making process. Currently VHA leadership's first concern is

whether any individual Veteran is at risk of harm and whether they received the care they need in the immediate situation. The next element of the decision is to assess the situation and gather pertinent facts. Leadership then considers options and proposals for resolving the situation. Within consideration of the options, VHA leadership considers the impact of the decision on the delivery of quality health care.

2. Aligning Resources with Health Care Needs. VHA provides veterans with comprehensive primary and specialty medical care; however, VHA continues to face challenges in matching health care needs with the appropriate resources. VHA's system-wide budget and execution data does not permit ready analysis at the Department or clinic level across VHA. The cost of providers and support staff is often a relevant cost in health care financial analysis. VHA does not have an adequate system to build the human requirements to provide health care appropriate for financial analysis. In recognition of this issue, Congress passed *The Choice Act,* which requires the OIG to report on the staffing needs of VHA for the next 5 years. OIG issued its first report on January 30, 2015, in which we noted that the five occupations with the largest staffing shortages were Medical Officer, Nurse, Physician Assistant, Physical Therapist, and Psychologist. The data underlying this initial determination was essentially VHA's "wish list" for talent, not a requirements-driven list. The data relied on ranking by VAMC leaders and produced a system-wide occupational ranking. While ranking data provides useful information on the relative needs, it does not provide the level of detail required to produce staffing targets. Data such as that generated by implementation of a staffing model would better facilitate an ongoing process by which VHA could adjust facility staffing. Additionally, this would facilitate comparison of current staffing to staffing model targets, further understanding of facility level barriers, and targeted interventions to address critical staffing needs.

<u>Completed VHA FY 2015 Milestones:</u>
As required by VACAA Section 301d, VHA developed, completed and submitted to Congress (March 9, 2015) a report outlining the staffing needs for each medical facility. In this report, VHA described advantages to be gained in further connecting the three pillars of clinical staff modeling, workforce planning and budget formulation. The report cited the nascent VA Planning, Programming, Budgeting and Execution (PPBE) (i.e., Manage for Results) process, whereby specific programs and initiatives will be qualified in terms of requirements on behalf of Veterans Care, and quantified in terms of both human capital and budget.

The FY16/FY17 PPBE cycle is underway, and programs are being introduced into this model, representing a key first step in achieving the objectives of Manage for Results. Simultaneously, VHA continues to evolve staffing models, to include implementation of the recently-refined Specialty Care productivity standards, and refinement of models in other practice areas, to include Primary Care and Mental Health.

As noted in the VACAA Staffing report cited above, there's no one-size-fits-all approach to clinical staff modeling; challenges in the private sector and Department of Defense

are very similar to ours. VHA recognizes the value of applying staffing models as an aid to requirements development, leading to improved alignment of resources. Ongoing activities such as workforce planning, manage for Results and staffing frameworks will help VHA realize greater efficiencies.

3. Promoting Safe Opioid Prescribing Practices. Of increasing concern in VA and the nation is the use of opioids to treat chronic pain and other conditions. Patients prescribed opioids frequently have complex comorbid conditions, making them more likely to be given multiple medications that can interact dangerously with opioid medications and potentially lead to death. In May 2014, OIG issued a national review, *Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy* (Report Number 14-00895-163), which described some of the issues facing patients on high dosages of opioids. The report included six recommendations to ensure that patients on opioids receive follow-up evaluations and urine drug tests, that medication reconciliations are performed to avoid adverse drug interactions, and that acceptable standards are followed when prescribing opioids in conjunction with acetaminophen and/or benzodiazepines. In addition to this national review, since 2011, OIG has issued nine reports detailing opioid prescription issues within VA. Common themes from these reports include:

- The use of high dose opioids in patients with a substance use disorder and mental illness is a common clinical situation.
- Adherence to clinical guidelines is not routine.
- Primary care providers bear the responsibility for managing these complex patients, often with limited support from pain management experts and related specialists.
- The use of high dose opioids causes friction within provider groups, where opinions on the proper use of these medications vary.
- Non-traditional therapies that may offer the benefit of less narcotic use are not fully utilized.

The use of high dose opioids for the primary treatment of pain conditions is all too common within the veteran population. OIG reviews have found that VHA is not following its own policies, procedures, and guidelines for managing patients with chronic pain. While OIG notes that VHA has taken actions to implement a number of OIG recommendations, VHA leadership must be vigilant in monitoring facility compliance with opioid prescription policies, ensuring recommendations are implemented, and promoting effective, evidence-based alternatives.

Completed VHA FY 2015 Milestones:
VA is actively engaged in a system-wide, multimodal approach to addressing opioid misuse and opioid use disorder in Veterans receiving care from VA. While these approaches are organized under several different and discreet programs, they are designed to be complementary and synergistic to achieve the same desired clinical outcomes; that is, safe and effective pain management. VA's own data, peer reviewed medical literature, and Centers for Medicare and Medicaid Services (CMS), suggest that VA is making progress relative to the rest of the Nation.

Fiscal Year 2015 activities/milestones include: (1) deploying VA's Academic Detailing (AD) program which includes dissemination of provider and patient education materials and promotion of VA evidence-based Clinical Practice Guidelines; (2) providing medication disposal services to allow Veterans to physically dispose of unwanted/unneeded medications; (3) obtaining informed consent and standardized education "Taking Opioids Responsibly" as mandated by policy published May 2015; (4) rationale for routine urine drug screening for Veterans on long-term opioid therapy and guidance to facilities with regard to verbal consent documentation. (Nationally 76.7% of patients on long-term opioid therapy have a documented urine drug screen within the prior 12 months.); (5) Substance Use Disorder (SUD) treatment and on-going monitoring for Veterans who are diagnosed with SUD, but who require opioid analgesics; (6) increased access to complementary and integrative medicine treatments for pain management; (7) providing opioid overdose education and naloxone distribution to high-risk patients; (8) regulation permitting VA prescribers to access the state PDMPs and VA to share their controlled substances prescribing data and drafted policy requiring VA providers to access state databases when prescribing controlled substance; and (9) implementation of the opioid therapy risk report available to VA prescribers at the point of care in the electronic medical record for a thorough assessment of risk for adverse outcomes facilitating more effective care coordination and case management; this complements the Opioid Safety Initiative (OSI) dashboard aggregate trending data; (10) development of an OSI Toolkit with 12 documents/lessons providing guidance / education on evaluation and management of risk including tapering opioid and benzodiazepines; (11) development and publication of an evidence-based DoD-VA pain management curriculum for primary care (JPEP); (12) further development of a system-wide DoD-VA program of training providers in acupuncture, with more than 1700 trainees; development and promulgation of the Pain Mini-residency.

Peer Reviewed Medical Literature—Published in Journal "PAIN"
This study reviewed the duration of opioid therapy, the median daily dose of opioids, and the use of opioids in Veterans with substance abuse disorders and co-morbid chronic non-cancer pain. Dr. Edlund and colleagues found that: (1) half of all Veterans receiving opioids for chronic non-cancer pain, are receiving them short-term (i.e., for less than 90 days per year); (2) the daily opioid dose in VA is generally modest, with a median of 20 Morphine Equivalent Daily Dose (MEDD), which is considered low risk; (3) the use of high-volume opioids (in terms of total annual dose) is not increased in VA

patients with substance use disorders as has been found to be the case in non-VA patients. Dr. Edlund and the other authors concluded “this suggests appropriate vigilance at VA, which may be facilitated by a transparent and universal electronic medical record.”

VA Data

The Opioid Safety Initiative’s (OSI) key clinical metrics measured from Quarter 4 Fiscal Year 2012 (beginning in July 2012) to Quarter 4 Fiscal Year 2015 (ending in September 2015) demonstrate VA’s success with: 125,307 fewer patients receiving opioids (679,376 patients to 554,069 patients); 42,141 fewer patients receiving opioids and benzodiazepines together (122,633 patients to 80,492 patients); 94,507 more patients on opioids that have had a urine drug screen to help guide treatment decisions (160,601 patients to 255,108); 105,543 fewer patients on long-term opioid therapy (438,329 to 332,786); the overall dosage of opioids is decreasing in the VA system as 13,73115,172 fewer patients (59,499 patients to 44,327 patients) are receiving greater than or equal to 100 Morphine Equivalent Daily Dosing. The desired results of the Opioid Safety Initiative have been achieved during a time that VA has seen an overall growth of 108,519 patients (3,959,852 patients to 4,068,371 patients) that have utilized VA outpatient pharmacy services.

Comparison of CMS and VA Data

The most recent prescription opioid utilization data for the United States from the National Health and Nutrition Examination Survey is available through 2012. This data is of limited value for comparison of VA’s effort to address opioid overutilization as the VA’s Opioid Safety Initiative (OSI) was not deployed to all VA facilities until August 2013. CMS data for Part D beneficiaries is available through 2014. Although CMS Part D beneficiaries are predominately over the age of 65 and VA facilities serve a population that represents a wider age distribution, it is still important to review how the CMS Overutilization Monitoring System (OMS) and the VA Opioid Safety Initiative (OSI) are measuring and monitoring opioid utilization trends. Since VA does not have access to CMS’s OMS quarterly reports, which is more sensitive to trend organizational change as it relates to opioid utilization, select VA OSI metric data was annualized to demonstrate the positive trends of both VA’s OSI and CMS’s OMS data that is available in their April 6, 2015 note to Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and other interested parties.

In 2014, CMS’s Part D enrollees utilizing opioids is 30.8 percent (12,308,735 out of 39,982,962 enrollees) and is consistent with estimated percentage of 30 percent of all USA adults who experience chronic pain. Overall, Part D enrollee opioid utilization, excluding hospice and cancer patients, from 2011 to 2014 has increased 22 percent (10,049,914 to 12,308,735 beneficiaries). The percent increase needs to be taken into context that the overall number of Part D beneficiaries has increased 27 percent (31,483,841 to 39,982,962) during the same time frame.

In 2014, VA Outpatient Veterans utilizing opioids was 17.5 percent (1,037,236 out of 5,927,104 Veterans) and is below the estimated percentage of 30 percent of all USA adults who experience chronic pain despite chronic pain being more prevalent in the Veteran population. For VA, overall opioid utilization from 2011 to 2014 has decreased 7 percent (1,112,324 to 1,037,236 Veterans). During this same time frame, the number of VA Outpatients has increased 6 percent (5,606,082 to 5,927,104 Veterans).

4. Ensuring Care Coordination. Veteran patients are not only complex because of comorbidities but also because they often receive health care from multiple locations both within and outside VA. For example, a patient may have a primary care provider at a CBOC, a mental health provider at the parent VAMC, and specialty care providers at both the parent VAMC and in the community through non-VA care. Patients may also prefer to have a non-VA primary care provider or may be mobile and see VA and non-VA providers in multiple cities or states. A study by VA's Health Services Research and Development group found that of the "6.5 million Veterans who received health care coverage under VA, Medicare, or Medicaid in fiscal year 2006 …, approximately one-third used more than one system of care."[2]

VHA's electronic health record (EHR) can be of tremendous benefit for managing patients who receive care from multiple providers and in multiple locations; however, it requires that EHR entries be timely, accurate, complete, and reviewed accordingly by providers. On November 14, 2014, OIG issued *Healthcare Inspection—Quality and Coordination of Care Concerns at Three Veterans Integrated Service Network 11 Facilities* (Report Number 14-01519-40). The review chronicled the case of a Veteran who received care at multiple VA facilities and some non-VA facilities. OIG found that communication breakdowns and providers' failures to review information available in the patient's EHR during care transitions compromised the patient's mental health and primary care. The exchange of health care information was particularly important for this high-risk patient with a complex psychosocial background and chronic pain history who was treated by multiple clinicians. OIG also found an absence of oversight in facilitating the continuum of care, which was especially challenging in this case as it touched several VAMCs, a CBOC, and multiple non-VA care sites. OIG made several recommendations to strengthen EHR documentation and oversight and care coordination. In addition, in recent months, OIG also issued two reports in which we reported backlogs and/or the lack of scanning of non-VA health care information into EHRs.

OIG's findings related to coordination of care are especially significant as VA expands non-VA health care options to veterans and more veterans opt to receive their health care from multiple sources, both VA and non-VA.

[2] Vandenberg P, Uppal G, Barker A, Flemming D. "The Impact of the Affordable Care Act on VA's Dual Eligible Population." http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm.

Completed VHA FY 2015 Milestones:

The Care Coordination/Care Transitions workgroup was chartered on April 30, 2015 to conduct a literature review, assess current care coordination processes and approaches; and develop evidence-informed policy recommendations for the optimization and coordination of Veteran care both within VA and within the larger continuum of community care. The specific work includes: identifying care coordination standards of care and best practices being employed both within VA and in community settings; assessing current care coordination processes and approaches within VA and how they compare to identified care standards and developing subject matter expert/evidence-informed policy recommendations for how coordination of Veteran care both within VA and within the larger continuum of community care can be optimized.

A preliminary report summarizing the completed work was submitted to the Office of the Deputy Under Secretary for Health for Policy and Services in early July 2015, with a final report including policy recommendations is expected to be completed in September 2015.

The preliminary report described a framework emerging within the literature and among national agencies for organizing and considering care coordination/care transitions, programs, and processes. A review of the literature highlighting several core elements of interest and focus including: population health approaches, care coordination/transition practices including those embedded within medical home platforms, data-informed/event defined interventions, and cross-network integration efforts.

The preliminary report also provided a cursory gap analysis of “best” and “deficient” care coordination/care transition practices within VHA. Several key themes and issues were identified including the importance of leadership, direction and oversight by a qualified Social Worker or Registered Nurse Case Manager to anticipate and coordinate Veteran needs. Scenarios that identified where care coordination needs were assessed and proactive care plans were developed in which can be improved in alignment with “best” practices occurring systematically within the VHA health care system.

The next step for this workgroup is to reconvene to develop specific recommendations for leadership consideration.

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

In FY 2015 the OIG published a series of five reports on VHA’s Patient-Centered Community Care (PC3) program. In April 2014, the OIG received a request from the U.S. House of Representatives Committee on Appropriations to review VA’s FY 2014 PC3 costs and the $13 million cost savings estimate presented in VA’s budget submission. Our analysis of available PC3 data determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its $13 million PC3 cost saving estimate. OIG found that

FY 2014 PC3 costs totaled about $14.9 million more than if VA had used the non-VA care program to purchase the same health care services. VA assumed that the PC3 contractors would develop adequate provider networks, VA medical facilities would achieve desired 25 to 50 percent contract utilization rates, and accrued PC3 cost savings for health care services would more than offset the contractors' fees. These flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent PC3 utilization rate in FY 2014. OIG recommended the Interim Under Secretary for Health (USH) revise VA's PC3 cost analyses and address VA's low PC3 utilization rates. Additionally, OIG recommended the Executive Director, Office of Acquisition, Logistics, and Construction (OALC), ensure all required contract documents are maintained in the PC3 contract files.

In July 2014, the OIG received an allegation asserting that VHA's use of PC3 contracted care was causing patient care delays. The allegation highlighted issues identified by VHA staff at seven VAMCs and one Veterans Integrated Service Network (VISN). OIG substantiated that PC3 contracted care issues were causing delays in care. PC3 was not achieving its intended purpose to provide Veterans timely access to care from a comprehensive PC3 provider network. OIG found pervasive dissatisfaction under both of the PC3 contracts, which has led all nine of the VA medical facilities reviewed by OIG to stop using the PC3 program as intended. From January 1 through September 30, 2014, the national utilization rate of the PC3 program was only about 9 percent.

Further, it took VHA an average of 19 days from the date of a VHA clinician's initial consult to submit the authorization to the PC3 contractors. OIG projected PC3 contractors returned, or should have returned, almost 43,400 of 106,000 authorizations because of limited network providers and blind scheduling (scheduling without patient involvement). PC3 contractors scheduled appointments without discussing the tentative appointment with the Veteran. OIG determined delays in care occurred because of the limited availability of PC3 providers to deliver needed care. VHA also lacks controls to ensure VA medical facilities submit authorizations and PC3 contractors schedule appointments and return authorizations timely. VHA needs to improve PC3 contractor compliance with timely notification of missed appointments and providing required medical documentation, as well as monitoring of completed authorizations. Also, VHA needs to ensure PC3 contractors submit authorizations within acceptable timeframes, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to ensure PC3 contractors comply with requirements.

OIG also conducted a review of the adequacy of the PC3 provider networks and determined that inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VA medical facility staff found the PC3 networks inadequate because:

- They lacked needed specialty care providers.

- Returned PC3 authorizations had to be re-authorized through non-VA care, thus increasing Veterans' wait times for care.
- More timely care was available to Veterans through non-VA care than PC3.

VHA expenditure of under $3.8 million in FY 2014 on PC3 health care services constituted less than 0.14 percent of VHA's approximate $2.8 billion in non-VA health care service expenditures in FY 2014. The expenditures ranged from $0 to about $468,000 for VA's 129 medical facilities with 50 VA medical facilities reporting no PC3 health care expenditures. During the first 6 months of FY 2015, VHA increased its PC3 health care service purchases to about $34.1 million. However, this still constituted less than 5 percent of VHA's $730.4 million non-VA care expenditures for the same period. VHA did not ensure the development of adequate PC3 provider networks and the use of PC3 because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning, awarding, and implementation of PC3. The CBO also did not provide critical information needed for PC3 contract specifications, develop an adequate network access performance measure, and lacked an effective PC3 implementation strategy.

OIG conducted another PC3 review to determine whether PC3 contractors provided clinical documentation and reported critical findings as specified in their contract performance requirements. OIG estimated PC3 contractors did not meet the clinical documentation requirements for 68 percent of episodes of care during the period of review from January 1 through September 30, 2014. Of the 68 percent, OIG estimates that 48 percent of the clinical documentation was provided to VA late and 20 percent of the clinical documentation was incomplete. Only an estimated 32 percent of the episodes of care had the required supporting clinical documentation, which was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation.

VHA made improper payments to PC3 contractors when payments were made to Health Net and TriWest prior to the return of complete clinical documentation. OIG estimated 20 percent of the documentation that was incomplete and provided to VA by PC3 contractors resulted in improper payments of about $5,400 to Health Net and $864,000 to TriWest from January 1 through September 30, 2014. OIG also determined that VHA did not apply the maximum allowable disincentive for lack of meeting contract performance requirements. OIG determined the maximum allowable disincentive that could be applied to Health Net's administrative fee was $15,909 for the period of July through September 2014. VHA only applied a disincentive of about $753 to Health Net for this 3 month period. By limiting the disincentive to only $753, VHA missed an opportunity to enforce performance requirements by penalizing Health Net an additional $15,156.

The PC3 contractors did not meet clinical documentation requirements because VA lacked an effective program for monitoring the contractors' performance. Contracting Officer Representatives (CORs) do not have an independent source of VA data to verify

contractor compliance with the contracts' Quality Assurance Surveillance Plan (QASP). The primary tool used by CORs to verify contractors' compliance was monthly reports populated with data that was self-reported by the contractors. As a result, VA lacks adequate visibility and assurance that Veterans are provided adequate continuity of care, and is at risk of improperly awarding incentive fees or not applying disincentive fees.

OIG also found that TriWest providers had performed colonoscopies and biopsied polyps for which the results should have been reported to VA as a critical finding. TriWest's monthly reports only reported one of three critical findings. OIG could not find evidence that TriWest notified VA of the critical findings within 48 hours as required under the provisions of the PC3 contract. The PC3 contracts have specific terms and conditions to identify and report critical findings, and prescribe financial penalties for not doing so. However, after interviewing CORs and reviewing the QASP, OIG determined there was not an adequate process established for CORs to verify whether the contractor exceeds, meets, or does not meet the performance standard. As a result, VA has not assessed financial penalties or issued any corrective action letters related to critical finding reporting to enforce TriWest meet contract performance standards.

VHA's Program Response
Estimated Resolution Timeframe: FY 2016
Responsible Agency Official: Under Secretary for Health

Completed FY 2015 Milestones:
In response to the concerns raised in the OIG reports "PC3 Contracts' Estimated Cost Saving" and "Review of Allegations of Delays in Care Caused by PC3", VHA's Chief Business Office for Purchased Care (CBOPC) has formed an integrated project team (IPT) to lead a new Patient-Centered Community Care (PC3) cost analysis. The IPT executed a contract for completion of a cost benefit analysis. Upon completion, the cost benefit analysis will help IPT members analyze potential cost savings VA may realize with future changes to the VA managed healthcare model, to include PC3. VHA's CBOPC also developed a comprehensive action plan that addresses delays in care findings associated with PC3 contracted care issues.

With regard to OIG report, "Review of VA's Patient Centered Community Care (PC3) Contracts Estimated Cost Savings," OALC corrected the identified deficiency and all documentation for the two contract files has been re-input into the Electronic Contract Management System (eCMS). Completion occurred prior to June 15, 2015 and OALC had requested OIG consider closure of the recommendation.

With regard to OIG's report on PC3 Provider Network Adequacy (published September 29, 2015), in fiscal year 2016 VHA will take actions to improve governance and oversight processes for managing PC3 provider networks, in coordination with other non-VA care efforts, such as the Choice Program. With regard to OIG's report on PC3

Health Record Coordination (published September 30, 2015), in fiscal year 2016 VHA will tighten internal controls on contractors responsible for submitting documentation of care prior to receiving payment.

OIG Sub-Challenge #1C: Care for Homeless Veterans (VHA)

VHA's National Call Center for Homeless Veterans (the Call Center) is VA's primary vehicle for communicating the availability of VA homeless programs and services to Veterans and community providers. OIG assessed the effectiveness of the Call Center in helping Veterans obtain needed homeless services. OIG determined that homeless and at-risk Veterans (homeless Veterans) who contacted the Call Center often experienced problems either accessing a counselor and/or receiving a referral after completing the Call Center's intake process. Of the estimated 79,500 homeless Veterans who contacted the Call Center in FY 2013, just under 21,200 (27 percent) could only leave messages on an answering machine as counselors were unavailable to take calls, almost 13,000 (16 percent) could not be referred to VA medical facilities because their messages were inaudible or lacked contact information, and approximately 3,300 (4 percent) were not referred to VA medical facilities despite the caller providing all necessary information.

Also, referred homeless Veterans did not always receive the services needed because the Call Center did not follow up on referrals to medical facilities. Of the approximately 51,500 referrals made in FY 2013, the Call Center provided no feedback or recommended improvements to VA medical facilities to ensure the quality of the homeless services. OIG noted that 85 percent of the 60 Veterans' records reviewed lacked documentation to prove the Veterans had received needed support services. In addition, the Call Center closed just under 24,200 (47 percent) referrals even though the VA medical facilities had not provided the homeless Veterans any support services. In total, OIG identified 40,500 missed opportunities where the Call Center either did not refer the homeless Veterans' calls to medical facilities or it closed referrals without ensuring homeless Veterans had received needed services from VA medical facilities. OIG recommended the Interim USH stop the use of the answering machine, implement effective Call Center performance metrics to ensure homeless Veterans receive needed services, and establish controls to ensure the proper use of Call Center purpose funds.

OIG also conducted an audit of the Grant and Per Diem (GPD) Program's case management oversight to determine if VHA ensures services to eligible Veterans are provided in accordance with grant agreements. OIG determined VHA's oversight of homeless providers' case management helped to ensure services were provided in accordance with grant agreements for those Veterans in the program. However, GPD Program eligibility requirements need to be clarified so all homeless Veterans have equal access to case management services. OIG found 15 of 130 (12 percent) VA medical facilities within 6 different VISNs required veterans to be eligible for VA health care to participate in the GPD Program. Additionally, of the 59 grant applications that

these 15 medical facilities oversaw during FY 2014, 4 had grant applications with the same eligibility limitation. GPD policy only requires an individual to have served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable to participate in the GPD Program.

VHA Handbooks and the United States Code provide minimum active duty requirements to be eligible for VA health care benefits. VHA has been silent on addressing this additional eligibility requirement in their current policy. VHA has not aggressively pursued an Office of General Counsel formal opinion and confusion at all program levels regarding GPD Program eligibility requirements has resulted in inequitable access to case management services. In addition, OIG observed medication security issues with 5 of 22 (23 percent) providers we visited within 5 of the 6 medical facilities in our sample. This occurred because VHA and program providers did not ensure controls were sufficient to properly secure medications. As a result, Veterans' health and rehabilitation are potentially at risk if needed medications become lost or stolen. OIG recommended the Interim USH establish a definitive legal position on GPD eligibility, revise policies and the grant application approval process, if necessary, when a formal opinion is provided to VHA, and ensure Veteran medications are safely secured through additional inspections and controls.

VHA's Program Response
Estimated Resolution Timeframe: **FY 2016**
Responsible Agency Official: Under Secretary for Health

Completed FY 2015 Milestones:
In January, 2015, the Health Resource Center (HRC) terminated the use of the answering machine at the National Call Center for Homeless Veterans (NCCHV) and implemented an Interactive Voice Response (IVR) System which allows for an infinite call queue and automatically pushes the caller to the first available responder.

HRC implemented new operation standards, processes, and organization for NCCHV to include: call forecasting and scheduling to ensure calls are handled quickly and within less than a 5 percent abandonment rate and with minimal wait times; new organizational chart aligned under HRC's Clinical Services Department; performance standards following HRC Call Center guiding principles to provide the highest level of program oversight by holding all staff levels directly accountable; metrics tracking for hourly, daily, weekly, monthly, and yearly call specifics; standardized processes such as the Threatening Caller and Medical Emergency Standard Operating Procedures; reporting structure for calls to support collaboration and national awareness; referral response monitoring to ensure referrals are sent correctly and crucial information is identified pertaining to calls; adequate NCCHV staff training; and proper funding controls to satisfy the recommendations of the OIG audit.

The 15 medical centers identified during the review that were requiring Veterans to be eligible for VA health care to participate in the Grant Per Diem (GPD) Program were

contacted and informed to use the definition of Veteran noted in VA regulations and policy. In addition, the VA GPD liaison staff was contacted via email in June 2014 to provide a reminder regarding the definition of Veterans for GPD.

VHA recognizes the risk associated with the storage of medications in its GPD funded transitional housing programs and has already taken actions to address OIG's recommendation. The GPD program established specific medication review standards in August 2013. These standards are incorporated into the annual re-inspection process and provide guidance to both VHA staff and GPD providers as to expectations regarding appropriate medication control systems within GPD funded programs. The standards include the requirement that individually stored medications must be safely and securely stored.

The GPD National Program Office reviewed medication control systems during the GPD operational provider call as well as the monthly GPD liaison call in November 2014.

VHA also initiated a national review of all operational GPD programs on November 2014, to ensure medication storage in these programs conformed to medication storage standards. Additional clarification was provided about the expectation for secured storage of medication. VA medical centers responsible for the oversight of the operations programs confirmed conformance with the medication storage standards.

OIG CHALLENGE #2: BENEFITS PROCESSING
-Strategic Overview-

Delivering timely and accurate benefits is central to VA's mission. VBA is responsible for oversight of the nationwide network of VAROs that administer a range of Veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. These programs are estimated to pay out over $99 billion in claims to Veterans and their beneficiaries in FY 2016.

OIG conducts inspections of all 56 VARO's and the VSC in Cheyenne, WY, on a 3-year cycle to examine the accuracy of claims processing and the management of VSC operational activities. After completion of each inspection, OIG issues reports with inspection results to the VARO Director, the appropriate Area Director, Compensation Service, Office of Field Operations, as well as to Members of Congress. These inspections address the processing of high-risk claims such as temporary 100 percent disability evaluations, residual disabilities related to traumatic brain injuries (TBI), and special monthly compensation (SMC) claims and related ancillary benefits payments reserved for Veterans with quality of life issues due to severe disabilities related to military service. In FY 2013, OIG initiated the second cycle of reviews of the 57 offices. As of June 2015, OIG has completed 52 of the 57 inspections during this new cycle.

Persistent large inventories of pending claims for benefits pose a continuing challenge for the Veterans Benefits Administration (VBA). While VBA has made progress in reducing its inventory of rating related claims, OIG is concerned that the improvement was at the expense of other VBA workload such as its non-rating and appeals workload. OIG is also concerned that the manner in which VBA reports and accounts for its workload lacks transparency and creates self-imposed challenges in managing the workload. For example, at the end of FY 2014, VBA reported its Compensation Maintenance non-rating inventory was 460,458; however, in FY 2015, VBA discontinued reporting the total number pending in this inventory and only reported on the average number of days the workload had been pending—as of August 2015, this inventory had been pending on average 281 days. Additionally, VBA does not include dependency-related claims in its non-rating workload nor is this workload monitored on VBA's Directors Performance Dashboards. As of August 2015, VBA had 226,286 dependency claims in its inventory pending on average for 359 days. Similarly, as of August 2015, VBA reported the total number of Notices of Disagreements (NOD) pending was 216,437—pending on average for approximately 400 days. However, this number is not reflective of VBA's total inventory of appealed claims as it does not include appealed claims that have advanced from the initial NOD stage to the advanced or remand stage. VBA attributes this backlog to an increase in the disability claims workload, in part due to returning Iraq and Afghanistan Veterans, reopened claims from Veterans with chronic progressive conditions related to Agent Orange, relaxed evidentiary requirements to process post-traumatic stress disorder claims, and additional claims

from an aging Veteran population with declining health issues. In efforts to address this backlog, VBA has implemented multiple transformation initiatives, including claims digitization and automated processing using the Veterans Benefits Management System. Other initiatives included provisional ratings for claims over 2 years old, expedited rollout of Disability Benefits Questionnaires, and mandatory overtime for claims processing staff at VBA's 56 VA Regional Offices (VAROs) and a Veterans Service Center (VSC) in Cheyenne, WY. Efforts to reduce the backlog of claims waiting to be processed have resulted in VBA actions to reprioritize workloads and redirect resources from other workloads to process rating-related disability claims. Recent and planned changes for VBA include implementation of standardized forms before claims processing actions can begin and a National Workload Queue which VBA plans to roll out beginning in FY 2016.

VBA continues to experience challenges in ensuring all 56 VAROs comply with VA regulations and policies and deliver consistent operational performance. Some initiatives to reduce the claims backlog were put in place without adequate controls. 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 VBA's disability claims processing. OIG reports issued in 2015 highlight continued VBA challenges in managing the claims backlog and ensuring accuracy in disability benefits processing.

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

VBA staff faced challenges providing accurate decisions on Veterans' disability claims. For our 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. Claims processing that lacks compliance with VBA procedures could increase the risk of improper benefits payments to Veterans and their families. . From September 2014 through June 2015, OIG inspected 16 VAROs and reported on their performance in five claims areas:

- Temporary 100 percent disability evaluations.
- Residual disabilities related to TBI.
- SMC and related ancillary benefits.
- Systematic Analyses of Operations (SAOs).
- Dates of claims.
- Benefits reductions.

OIG determined VA Benefit Office staff did not correctly process 19 percent of the total 1,232 disability claims sampled, resulting in over $2.7 million in improper benefits payments. Specifically, VARO staff incorrectly processed:

- 26 percent of 480 temporary 100 percent disability evaluations, resulting in identification of more than $1.9 million in improper benefits payments.
- 8 percent of 437 TBI claims, resulting in identification of approximately $42,700 in improper disability payments.
- 24 percent of 315 claims involving SMC and ancillary benefits resulting in identification of more than $772,400 in improper benefits payments.

VARO staff used incorrect dates when establishing claims in VBA's electronic system of records for 3 percent of the 480 cases reviewed. OIG also determined VARO staff did not correctly process or complete 32 percent of 443 proposed benefits reductions cases, resulting in approximately $879,900 in improper benefits payments.

Beginning in FY 2014, VBA began concurrently tracking the accuracy of rating-related disability claims using the traditional, claims-based model and a newly implemented issue-based model. Since the issue based model was implemented in October 2013, the accuracy rates have remained at approximately 96 percent. As such, OIG is concerned that the increased accuracy reported using the issue-based model is related to the change in methodology rather than actual improvement in the accuracy of claims being processed.

VBA's Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Acting Under Secretary for Benefits

Completed 2015 Milestones:
VA is committed to providing Veterans with the care and services they have earned and deserve. The Veterans Benefits Administration (VBA) is currently undergoing the largest transformation in its history to fundamentally redesign and streamline the delivery of benefits and services to Veterans, their families, and Survivors. As of September 30, 2015, VBA has reduced the inventory of disability claims requiring a rating decision from 883,930 in July 2012 to 363,034 (a 58.9-percent reduction), and the backlog of disability claims pending over 125 days from 611,073 in March 2013 to 71,352 (an 88.3-percent reduction). Additionally, the average age of pending claims was reduced from 282 days in March 2013 to 93.1days (a 67-percent reduction). These dramatic improvements were achieved without sacrificing quality. Nationally, claim-based accuracy increased from 83 percent in FY 2011 to 90.7 percent. Issue-based accuracy has remained high at 96.3 percent and increased to over 98 percent in seven of the eight error categories, with the last one at 97.7 percent. Issue-based accuracy is measured by individually evaluating medical conditions within a rating-related compensation claim. Each issue must go through the same claims process that represents a series of completed tasks, such as development, research, adjudication, and decision, that could result in a specific benefit for a Veteran or survivor. More importantly, issue-based accuracy provides VBA the opportunity to precisely target medical issues where adjudication is most error-prone and additional training is needed.

Combined with such initiatives as increased brokering of claims, centralized mail, access to the Social Security Administration's Government Services Online system, electronic service treatment records, and mandatory overtime, VBA completed a record-breaking 1.4 million rating bundle claims in FY 2015 surpassing the previous record of 1.3 million claims in FY 2014.

As VBA continues to receive and complete more disability claims, one result is a corresponding increase in non-rating claims. Despite completing a record 2.7 million non-rating claims in FY 2014, this volume of work continues to grow. In FY 2015, VBA received 3.1 million non-rating claims, an increase of 15.3 percent over FY 2014 and 36.2 percent over FY 2013. Nationwide, VBA has identified a need for an additional 625 full-time employees to bring the non-rating workload to a steady-state inventory in FY 2017.

Even as VBA focused on its priority goal to eliminate the disability rating claims backlog for Veterans who have been waiting the longest, and is achieving record-breaking levels of production, VBA did not ignore non-rating claims. As part of the transformation effort, VBA developed a new Rules-Based Processing System (RBPS) to automate dependency claim submission and payment through self-service features. Over 225,000 Veterans have already filed their request to add or change their dependency status online. Over 60 percent of the dependency claims filed through RBPS are automatically processed and paid within one to two days. VBA also contracted for assistance with entering data from dependency claims filed in paper form into RBPS. In October 2014, VBA implemented the Dependency Rapid Response Pilot at the St. Louis and Phoenix National Call Centers, where call agents take dependency claims over the phone and submit them to the contractors to enter the data into RBPS. Full pilot implementation to the remaining call centers was completed in September 2015.

Similar to the increase in non-rating claims, the volume of appeals increases as VBA continues to receive and complete a record-breaking number of disability rating claims. Over the past 20 years, VA appeals rates have held steady between 11 and 12 percent of the total volume of completed disability rating claims. It is important to note that in VA's current appeals process, a Veteran's record remains open, meaning new evidence can be presented at any time during the appeal, which triggers a fresh review of the entire appealed decision.

While specific metrics reported on the Director's Performance Dashboard change over time, and as noted by the OIG, did not include the non-rating portion of VBA's claims inventory in FY 2015, non-rating claims have been consistently reported over the past decade as part of the Traditional Aggregate (TA) Tab of the publically available Monday Morning Workload Report (MMWR), with additional detail provided on the TA-Regional Office tab of the same report. Dependency-related claims have been and remain included in the non-rating workload of the MMWR. In addition, VBA provides other, internal claims reporting tools that allow senior VBA leadership and local regional offices to drill down to individual claims for detailed workload management purposes. The

MMWR provides transparent reporting on the entire appeals inventory, to include those in the Form-9, Remand, or Travel Board stages, as well as Notice of Disagreements.

Since VBA issued guidance on temporary 100-percent disability evaluations, VBA has improved the timeliness of appropriate action. As of September 30, 2015, the average days pending for temporary 100-percent claims (End Product 684) was 84 days, an improvement of 262 days. Overall inventory of these claims has decreased by 83 percent, from 7,925 in February 2014, to 1,344 as of September 30, 2015.

VA currently requires each Veterans Service Center Manager (VSCM) complete a program of systematic analyses of operations (SAO). Under current policies and procedures, VSCMs must complete ten SAOs that generally cover all areas of service center operations, including timeliness, quality, and internal controls, and may conduct additional SAOs on specific areas of operations as necessary. Additionally, Compensation Service (CS) reviews each regional office's (RO) most recent SAOs prior to all CS site visits to ensure that all required areas are sufficiently analyzed by RO management; operational weaknesses are identified, with appropriate recommendations for improvement; and recommendations from the previous year's SAOs were completed.

In May 2013, VBA issued Fast Letter (FL) 13-10, *Guidance on Date of Claim Issues*, which provided guidance to ROs that was designed to ensure there was no disincentive in VBA's processing procedures to take action on any previously undecided claim that may be subsequently identified in a Veteran's claims record (possibly many years or even decades later). As a result of OIG's investigations related to this guidance, VBA quickly took several measures. VBA terminated the use of FL 13-10, informed all VBA personnel to no longer use FL 13-10, and directed all VBA personnel to immediately follow the permanent procedural guidance in the M21-1MR and M21-4 for all claims, including those referred to as "found claims" in FL 13-10.

VBA also developed and mandated new refresher training courses for Veterans Service Representatives and Rating Veterans Service Representatives on the topics of military retired pay, severance pay, special monthly compensation (SMC), and effective dates. In addition, VBA updated training materials on the following topics for the VSC personnel:

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

OIG Sub-Challenge #2B: Improving Data Integrity and Management Within VA Regional Offices (VBA)

Since June 2014, OIG has initiated 13 reviews addressing allegations of mismanagement and data manipulation at 11 of VBA's 56 VAROs—indicating systemic trends involving inappropriately enhanced performance metrics. OIG substantiated and reported on issues relating to data manipulation and mismanagement at the following VAROs: Baltimore, Boston, Hawaii, Houston, Los Angeles, Oakland, and Philadelphia.

In late May 2014, the OIG began receiving a number of allegations through the VA OIG Hotline of mismanagement at the Philadelphia VARO. Many of these allegations involved staff who had a serious mistrust of VARO management. OIG substantiated serious issues involving mismanagement and distrust of VARO management which impeded the effectiveness of its operations and services to Veterans. Overall, OIG made 35 recommendations for improvement at the Philadelphia VARO, encompassing mismanagement of VA resources resulting in compromised data integrity, lack of financial stewardship, and lack of confidence in management's ability to effectively manage workload, to include mail management and protecting documents containing personally identifiable information (PII). There is an immediate need to improve the operation and management of this VARO and take actions to ensure a more effective work environment. Further, the extent to which management oversight has been determined to be ineffective and/or lacking requires VBA's oversight and action. It is imperative to ensure VBA leadership and the VARO Director implement plans to ensure the unprocessed workload OIG identified is processed and to provide appropriate oversight that is critical to minimizing the potential future financial risk of making inaccurate benefit payments. This includes maintaining oversight needed to ensure all future workload is processed timely and in ensuring the accurate and timely delivery of benefits and services. As of September 2015, VBA provided sufficient evidence to close 16 of the 35 recommendations. OIG will continue to follow up on the progress VBA makes toward implementing the corrective actions for the remaining 19 recommendations.

In July 2014, the OIG received a request for assistance from the Under Secretary for Benefits (USB) to review allegations that the VARO in Oakland, CA, had not processed nearly 14,000 informal requests. The allegation indicated some claims dated back to the mid-1990s. In addition, another complainant alleged that "informal claims" were being improperly stored. OIG substantiated the allegations that VARO staff had not processed informal claims. OIG confirmed that staff had not properly controlled these claims documents, which were accidently found in a filing cabinet, during a construction project. OIG did not identify any current storage or control issues during our site visit.

VARO management advised that a team assisting the Oakland VSC had located approximately 14,000 informal claims, some of which dated back to the mid-1990s, then saying they had identified 13,184 claims with 2,155 needing reviews. At the time of our onsite review, OIG could not confirm the existence of the 13,184 informal claims, of

which were 2,155 claims needing review or action. OIG reviewed a sample of 34 of these newly "discovered" claims and found 7 (21 percent) remained unprocessed. While no claims in our sample dated back to the mid-1990s, some were as old as July 2002. OIG also found VARO staff had repeatedly reviewed these seven informal claims from December 2012 through June 2014 for various reasons, but took no additional action on them as required. VARO staff did not maintain adequate records or provide proper supervision to ensure informal claims received timely processing. From April through May 2014, the VARO discovered additional claims where the VARO's special project team had previously annotated these claims as reviewed. VARO management determined these claims remained unprocessed. VARO management did not initially determine how many informal claims it found until it created a tracking spreadsheet in June 2014. Then, management determined staff did not process 537 informal claims. As a result, Veterans did not receive consideration for benefits to which they may have been entitled. OIG recommended the VARO Director complete and certify the review of the 537 informal claims, take appropriate action, and provide documentation to certify these actions are complete. Also, the Director should better enforce compliance with existing VBA and VARO policies pertaining to the processing of informal claims.

OIG also received an anonymous allegation in July 2014 that staff at the Little Rock VARO inappropriately applied VBA Fast Letter 13-10, "Guidance on Date of Claim Issues," dated May 20, 2013. The complainant alleged that adjusting the dates of claims was done to give the appearance that VBA was making more progress than it actually had in eliminating its backlog of disability claims. In June 2014, the USB suspended use of Fast Letter 13-10 after the OIG determined staffs were misapplying the guidance at another VARO. OIG had previously reported to the USB that the guidance was used inappropriately to adjust dates of claims for unadjudicated claims discovered in the files. Changes to Veterans' claims were made to process old mail instead of unadjudicated claims information found in the files. OIG substantiated the allegation that Little Rock VARO staff adjusted dates of claims for unadjudicated claims discovered in the files; however, staff did so in compliance with VBA Fast Letter guidance in effect at that time. OIG reviewed documentation on 48 unadjudicated claims that VARO staff located in claims folders from May 2013 through June 2014. Staff adjusted the dates of claim for all 48 cases reviewed, resulting in the claims having more current dates than the dates they were initially received within VA.

VBA staff interviewed by OIG raised concerns that the use of this guidance led to Veterans being provided with incorrect information on claims processing timeliness. The application of this guidance was also considered inconsistent with VBA standard policy requiring use of the earliest date that a document is stamped as received at a VA facility as the date of claim. This VARO maintained records of the changes made to Veterans' claims per the requirements in the guidance. To mitigate the potentially adverse effect the date adjustments would have on Veterans' benefits, Little Rock VARO staff took the initiative to develop a spreadsheet to track all unadjudicated claims found in the claims folders where dates of claims were changed. Based on OIG's review, it was concluded that adjusting the dates of aging

claims to more recent "discovered" dates resulted in a lack of assurance that staff would expedite processing of the discovered unadjudicated claims, further delaying benefits decisions for Veterans. Adjusting the dates of claims also misrepresented the time required for VARO staff to process the claims, potentially making performance look better than in actuality. In order to minimize confusion or misinterpretation of guidance for future claims processing, OIG recommended that VBA maintain a standard, universal policy for establishing dates of claims. Of further concern, VBA took immediate action to notify VARO's to suspend the use of the Fast Letter pending further guidance on June 27, 2014; however, the Fast Letter was not terminated until January 2015.

VBA's Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Acting Under Secretary for Benefits

Completed 2015 Milestones:
VBA takes OIG reports seriously and has taken action to address the issues raised. VBA will continue to aggressively address all recommendations made by OIG until achieving full resolution. Specifically, as it pertains to the Philadelphia RO, under the Director's leadership, the RO has made tremendous improvements in service to Pennsylvania Veterans in addition to serving national missions such as processing pension and survivor claims, and assisting Veterans and other beneficiaries at the call centers. The RO has reduced the backlog of compensation claims from its peak in December 2011 at 12,826 claims to 2,608 as of September 30, 2015, a 79.7 percent improvement. Additionally, the average days pending has also improved from 264 days in April 2013, to 129.7 days as of September 30, 2015, a 134.3 day improvement. Furthermore, the backlog of pension and survivor claims has also been reduced from its peak in July 2013 at 13,306 claims to 666 as of September 30, 2015, a 95 percent improvement while also reducing wait times by 80 days. As of September 30, 2015, 16 of the 35 recommendations made by OIG are closed, and 6 of the remaining 19 recommendations were fully implemented by VBA and VBA will request closure by OIG.

The Oakland RO concurred with the OIG's recommendations to improve operations and fully implemented all of the recommendations. The Oakland RO conducted two separate reviews of the approximately 13,000 informal claim documents to identify items that could potentially affect a Veteran's benefits and needed correction. About three percent of the documents required further action, which has been completed. The Oakland RO also recently implemented the national centralized mail initiative, which significantly reduces the potential for delayed handling of paper documents. All of the Oakland RO's claim-related mail is now directed to a centralized scanning facility for conversion from paper to electronic digital format.

In May 2013, VBA issued FL 13-10, *Guidance on Date of Claim Issues*, which provided guidance to ROs that was designed to ensure there was no disincentive in our processing procedures to take action on any previously undecided claim that may be

subsequently identified in a Veteran's claims record (possibly many years or even decades later). This FL instructed ROs to use the date the claim was discovered ("found") in the claims record, instead of the date the claim was received, for tracking purposes. This was done while ensuring that the date the claim was originally received was used as the effective date for any benefits awarded to the claimant. This ensured the full benefits due were paid to the claimant.

Special controls were put in place to manage and oversee this process. Authority to apply these procedures and establish a claim based on a discovered document was delegated only to RO Directors and Assistant Directors. ROs were also required to notify VBA's Compensation Service when any claim was established based on discovered documents.

As a result of OIG's investigations on found claims guidance, VBA quickly took several measures. VBA terminated the use of FL 13-10 effective June 27, 2014. VBA informed all RO personnel to no longer use FL 13-10, and directed all VBA personnel to immediately follow the permanent procedural guidance in the M21-1MR and M21-4 for all claims, including those referred to as "found claims" in FL 13-10.

Prior to March 24, 2015, Veterans were entitled to submit a claim in any format, including handwritten notes or letters. At times, this led to claims being discovered later in the process. Effective March 24, 2015, VA implemented an important regulatory change to make the claims process easier and more efficient for Veterans through the use of standardized claim and appeal forms. This regulatory change includes a new intent to file process that replaces the informal claims process. This gives the applicants additional time to gather all of the information and evidence needed to submit their formal application for benefits. This new process protects the earliest possible effective date if the applicant is determined eligible for benefits and helps ensure anyone wishing to file a claim receives the information and assistance they need.

OIG Sub-Challenge #2C: Improving Management of the Fiduciary Program (VBA)

The Fiduciary Program was established to protect Veterans and other beneficiaries who, due to injury, disease, or age, are unable to manage their VA benefits. Field examinations are a critical tool for VBA to assess the competency and welfare of these beneficiaries. OIG conducted an audit to assess whether the Fiduciary Program scheduled and completed field examinations within timeliness standards. The audit also assessed whether the program prepared field examination reports, and followed up on reported concerns in accordance with policy. VBA did not meet timeliness standards for about 45,500 (42 percent) of approximately 109,000 pending and completed field examinations during calendar year (CY) 2013. OIG followed-up by examining reported program performance for the first 9 months of CY 2014 and determined that field examinations not completed and already exceeding timeliness standards increased approximately 15 percent from about 19,000 in January 2014 to approximately 21,900 in September 2014. This occurred because field examination staffing did not keep pace

with the growth in the beneficiary population. Also, VBA did not staff the hubs according to their staffing plan, and did not use all relevant performance measures for the field examination function. As a result, untimely field examinations placed about $360.7 million in benefit payments and approximately $487.6 million in estate values at increased risk.

In addition, VBA did not schedule required field examinations for a projected 1,800 beneficiaries in CY 2013. Lapses in field examination scheduling occurred because of inadequate management oversight to ensure required field examinations were scheduled. As a result, OIG projected the Fiduciary Program did not schedule field examinations for about 1,800 beneficiaries, placing beneficiaries' well-being and approximately $36.1 million in benefit payments at increased risk in CY 2013. OIG recommended the USB implement a plan to meet timeliness standards for field examinations, expand program performance measures, improve controls to identify unscheduled field examinations, and enhance case management system functionality.

OIG also conducted an audit to determine whether VBA protected the VA-derived income and estates of beneficiaries, who are unable to manage their financial affairs, when misuse of beneficiary funds is alleged. Misuse is the diversion of funds for the use of anyone other than the beneficiary and/or VA-recognized dependents. If misuse is suspected or alleged, certain actions must be taken within specific timeframes. They are termed "misuse actions." For the period January 1 through December 31, 2013, OIG determined 147 of 304 (48 percent) required misuse actions associated with the management of 122 beneficiaries were not performed timely or according to policy. These conditions occurred due to increases in workload, a lack of policies, and staff not being clear about some policies. Also, VBA did not perform monitoring or quality reviews of all misuse activities. OIG projected that, during CY 2013, VBA did not timely complete required actions to ensure the protection of 758 beneficiaries. These beneficiaries had combined VA-derived estates of approximately $45.2 million. VBA also did not take action to restore $2.1 million of misused funds. Unless VBA ensures actions taken are timely and according to policy, VBA may not adequately protect approximately $16 million in annual benefits payments or $80 million during CYs 2014 through 2018. OIG recommended the USB implement mechanisms to ensure VBA completes misuse actions timely and as required.

VBA beneficiary funding managed by the Fiduciary Program are at risk for fraud based on program weaknesses. From April 1, 2010, to March 31, 2015, OIG conducted 216 investigations involving fiduciary fraud and arrested 94 fiduciaries and/or associates. OIG investigations highlight program vulnerabilities that are exploited by unscrupulous individuals at the expense of VA beneficiaries.

Three recent examples illustrate the effective approach OIG has in combating fiduciary fraud by pursuing prosecution and court-ordered restitution against those individuals diverting funds intended for VA beneficiaries. In the first example, a former VA-appointed fiduciary, who was also an administrator of a nursing home, was indicted and

arrested for Misappropriation by a Fiduciary. A VA OIG investigation determined that the defendant embezzled more than $313,000 from a Veteran. In the second example, a former VA fiduciary was arrested for Theft of Government Funds and Misappropriation by a Federal Fiduciary. A VA OIG investigation revealed that for over 5 years the defendant stole approximately $141,000 from 22 Veterans, using “excessive fees” and her sham company to justify excessive expenses. In the last example, a former VA fiduciary was sentenced to 30 months’ incarceration and 3 years’ supervised release after pleading guilty to Theft of Government Funds. A VA OIG, Social Security Administration (SSA) OIG, Railroad Retirement Board OIG, and the Montana Attorney General’s Office investigation revealed that the defendant embezzled $369,585 of SSA, VA, and railroad retirement funds while operating a for-profit fiduciary business.

VBA’s Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Acting Under Secretary for Benefits

Completed 2015 Milestones:
In FY 2015, VBA implemented improvements to enhance service delivery and protection of beneficiaries within its fiduciary program. These efforts include implementing operational efficiencies, clarifying and strengthening policies and procedures, modernizing information technology systems, and providing training to fiduciary program staff and fiduciaries. In October 2014, VBA implemented policy to streamline the field examination process for certain beneficiaries who are at a lower risk of exploitation, such as those who reside in a facility licensed or monitored by a state or other government agency, or whose fiduciary is also their spouse. These beneficiaries and their fiduciaries are contacted via telephone or letter to assess their well-being and financial position. By soliciting information through a streamlined process for this specific population of beneficiaries, VBA is able to devote additional resources to perform face-to-face visits with those beneficiaries who are at greater risk. This is expected to reduce the follow-up field examination backlog.

VBA revised its site survey protocol in December 2014 and July 2015, to ensure that site visit teams conduct comprehensive inspections of fiduciary hub compliance with program policies and procedures. Under the protocol, the site visit teams also review processing operations and station controls for data integrity, quality, and training. In FY 2015, VBA conducted site visits at two fiduciary hubs.

In January 2015, VBA deployed its electronic Knowledge Management (KM) system to all fiduciary program staff. KM replaced the fiduciary intranet site and several other reference points, making it the single source for all fiduciary-related information used by program personnel. The site includes the Fiduciary Program Manual, all pertinent regulations, statutes, job aides, and other program guidance.

VBA also took steps to enhance procedures that identify and prevent misuse of beneficiary funds. In February 2015, VBA developed mandatory misuse training for all

VBA fiduciary personnel. This training provided instruction on how to identify misuse and take appropriate action depending upon the employee's position. Additionally, in May 2015, VBA released a custom misuse workflow in the Beneficiary Fiduciary Field System (BFFS) that facilitates and tracks all misuse actions from the allegation of misuse to the collection of the debt against the fiduciary. These measures will ensure accountability of misuse action processing.

In June 2015, VBA implemented a quality review database within BFFS, which provided increased data analysis capabilities for accuracy review and improved tracking of error trends. Incorporation of both the sampling methodology and reporting database will allow for real-time review of cases to expedite feedback to the fiduciary hubs.

In July 2015, VBA completed a work measurement study (WMS) of fiduciary work tasks performed by field examiners and legal instruments examiners. The WMS captured work performed using BFFS and other efficiencies gained in the fiduciary program responsibilities. The WMS information will assist VBA in more accurately defining and quantifying the time involved in completing fiduciary program work and resource requirements.

The above initiatives reflect VBA's priority and focus on improving and enhancing the oversight of beneficiaries to ensure their well-being, and appointing and conducting oversight of fiduciaries who manage their benefits.

OIG CHALLENGE #3: FINANCIAL MANAGEMENT
-Strategic Overview-

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

For the 16th consecutive year, OIG's independent auditors provided an unqualified opinion on VA's FY 2013 and FY 2014 consolidated financial statements (CFS). VA restated its FY 2013 financial statements for Cumulative Results of Operation and Unexpended Appropriations, although this had no effect on Total Net Position. As a result, the contractor replaced its FY 2013 auditor's report with its FY 2014 report on the restated financial statements. With respect to internal control, the contractor identified one material weakness, "Information Technology Security Controls," which was a repeated condition. They also identified two significant deficiencies, "Financial Reporting" and "Accrued Operating Expenses." Additionally, the contractor reported that VA did not substantially comply with Federal financial management systems requirements and cited instances of non-compliance with section 5315 of title 38 and section 3715 of title 31 of the United States Code pertaining to the charging of interest and recovery of administrative costs. The independent auditors will follow up on these internal control and compliance findings and evaluate the adequacy of corrective actions taken during the FY 2015 audit of VA's CFS.

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

OIG conducted an FY 2014 review to determine whether VA complied with the requirements of the Improper Payments Elimination and Recovery Act (IPERA). VA reported improper payment estimates totaling approximately $1.6 billion in its FY 2014 Performance and Accountability Report (PAR) compared with $1.1 billion in its FY 2013 PAR. The increase was due primarily to higher estimated improper payments for the Compensation and Pension programs under VBA. VA did not comply with two of six IPERA requirements for FY 2014. VBA reported four programs that did not meet its reduction targets and VHA reported a missed target for one program. Further, VBA did not meet the requirement to publish an improper payment estimate for one program because the estimate was not considered reliable. OIG also noted VA's risk and that VA should assess acquisition risk in some programs currently not reporting under IPERA. Further, VBA and VHA should make improvements in their sample evaluation procedures. While reviewing VBA's Compensation program, OIG noted this program crossed an Office of Management and Budget (OMB) threshold for potential designation as a high-priority program due to OIG's review identifying additional

improper payments within the sample transactions. For this reason, OIG increased the projection of the potential improper payment in VBA's Compensation program.

OIG also conducted an audit to determine the accuracy of payments for VHA's non-VA medical care emergency transportation claims. Inaccurate payments affect VA's commitment to delivering timely and high quality health care to Veterans while controlling costs. OIG found that VHA's Non-VA Medical Care Program improperly paid 129 of 353 (37 percent) emergency transportation claims from April 1 through September 30, 2013. Of the total 353 payments valued at $585,800, the 129 improper payments amounted to $167,600. These claims were improperly paid because staff did not conduct an adequate review to ensure that all documentation was received prior to processing the claim and did not correctly determine Veterans' eligibility for emergency transportation. Staff also misunderstood the criteria for processing non-service and service-connected emergency transportation claims. As a result, OIG projected an annual improper payment amount of approximately $11.2 million. Over the next 5 years, OIG projected improper payments of approximately $56.2 million if claims processing controls are not strengthened. OIG recommended the Interim USH implement periodic training and systematic reviews of emergency transportation claims, and instruct the sampled VA medical facilities to initiate recovery of overpayments and reimbursement of underpayments identified in this audit.

VA Program Response
Estimated Resolution Timeframe: FY 2016
January 2016 (For Risk Assessment Recommendations)
2015 (For OIT)
Responsible Agency Officials
Acting Assistant Secretary for Management and Interim Chief Financial Officer (Lead), Under Secretary for Health, and Acting Under Secretary for Benefits, Assistant Secretary for Information and Technology

Completed FY 2015 Milestones:
When the 2013 Performance and Accountability Report was published, VBA anticipated higher improper payment estimates for FY 2014 since we were in the process of enhancing our FY 2014 test plans to cover additional elements that could lead to identification of additional improper payments or to address prior OIG findings. Using the enhanced test plans, VBA did identify additional improper payments, which led to the FY 2014 estimates exceeding the target reduction rates.

As reported in the 2014 Performance and Accountability Report, the target error rate for Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) was 4.80 percent. In 2015, VHA expects to be compliant and report an error rate that meets the reduction target for CHAMPVA. VHA increased the sample size in the CHAMPVA review from 364 to 1,500 for Fiscal Year 2015 and revised its sample design to reduce the risk presented by outliers. The updated sample design stratifies by services and selects more samples from potential high risk areas to focus on problem areas and gain a better understanding of the root cause(s) of error.

In 2014, OIG cited contracting discrepancies related to VHA's compliance with Federal Acquisition Regulations and VA Acquisition Regulations (VAAR). In the 2015 Improper Payments Elimination & Recovery Improvement Act (IPERIA) review, VHA incorporated contracting aspects into the test plans for Non-VA Medical Care and Purchase Long Term Services and Supports program reviews, which resulted in a significant increase in improper payments over the prior year. These errors relate to program design and structural issues.

The Chief Business Office for Purchased Care (CBOPC) has taken multiple steps to address OIG findings identified during the review of emergency transportation claim payments made under VHA's Non-VA Medical Care Program. Efforts to recoup overpayments and complete additional reimbursements for underpayments were initiated and newly developed training reinforcing appropriate processing guidelines and authorities were delivered to staff. This training has since been delivered to a live audience twice and is available upon request.

In FY 2015, VBA's Compensation Service revised its test plans to focus on feedback received from the Quality Review Teams conducting the sampling testing. Refresher training was conducted for testers to assist them in recognizing improper payments. VBA initiated a strategic partnership with the Department of Defense to incorporate a process to streamline upfront waivers for active duty/drill pay. Due to resource constraints, DoD was unable to agree to the proposed implementation. VBA will revisit this with DoD in FY 2016. VBA's Vocational Rehabilitation and Employment Service completed nationwide deployment of an advanced training program on fiscal issues, aimed at training Vocational Rehabilitation Counselors on key control weaknesses previously identified during review and quality assurance testing. VBA's Pension and Fiduciary (P&F) Service expanded its upfront income verification for original claims to improve decision accuracy and program integrity. Refresher training was conducted for Pension Management Center (PMC) employees on determinations of benefits and award adjustments. P&F Service is incorporating IPERA awareness training and compliance into the PMC site visit protocol. VBA's Education Service incorporated processes into its IPERA review for the Post-9/11 GI Bill that request additional documentation from schools validating enrollment data. The test plan was revised to include source document reviews. Additionally, refresher training is provided to regional processing offices, schools, and training facilities to ensure adherence to proper reporting and focusing on reducing improper payments.

<u>FY 2015 – FY 2016 OM Action Plan:</u>
In May 2015, the Office of Management (OM) established a new Improper Payments Remediation and Oversight (IPRO) Office, reporting to the Associate Deputy Assistant Secretary for Finance. IPRO is charged with improving leadership, oversight, and guidance for the Department on improper payment estimation and reporting, as well as strategically evaluating current Governance processes and procedures to identify opportunities for improvements. Under the leadership of the Director, IPRO, VA

expects to improve coordination across the Department, and ensure corrective action plans are implemented and addressing the root causes of deficiencies resulting in improper payments, that are within the Department's control to remediate. In response to OIG's recommendation to ensure risk assessments properly account for known acquisition risks, responsible program officials amended risk assessments for the 12 programs required to perform risk assessments in FY 2015 on FY 2014 disbursements to consider acquisition risk. IPRO also updated the IPERA Risk Assessment to be used by VA Programs going forward in FY 2016 and beyond, to ensure acquisition risks are considered and will codify the updated risk assessment in IPERA policy in early FY 2016. In addition, IPRO led a coordinated effort to assess acquisition risk in 19 programs not currently reporting under IPERA, to address OIG's other acquisition risk related recommendations. The results of this effort will be used to inform management's risk assessments of FY 2015 disbursements in FY 2016.

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

OIG conducted a review of the Service-Oriented Architecture Research and Development (SOARD) information technology (IT) pilot project in response to allegations received by the VA OIG Hotline. OIG evaluated the merits of four allegations that VHA mismanaged SOARD. OIG substantiated an allegation that VHA misused Medical Support and Compliance (MS&C) appropriations to pay for SOARD instead of using Congressionally-mandated IT systems appropriations. This occurred because the former Assistant Deputy USH for Administrative Operations inappropriately authorized $2.6 million of MS&C appropriations for SOARD. In addition, the former USH inappropriately approved an additional $48.8 million of MS&C appropriations to deploy Maximo, the software for SOARD, nationwide. VA's Office of Information and Technology (OIT) subsequently denied VHA's request for additional IT Systems appropriations for SOARD, thus ending nationwide deployment of Maximo before VHA could obligate the $48.8 million. Additionally, although OIT used the Project Management Accountability System (PMAS) to manage SOARD, OIT lacked controls to prevent VHA's improper use of MS&C appropriations before using PMAS to manage IT projects. OIG did not substantiate the other two allegations. OIG recommended the Interim USH establish an oversight mechanism, remedy all MS&C appropriations used to pay for SOARD, and determine if VA should take administrative action against VHA senior officials involved in SOARD funding decisions. OIG also recommended the Executive in Charge, OIT, obtain Chief Financial Officer certification that VA is using proper appropriations to fund IT projects.

In addition, OIG received a hotline allegation that VHA had "parked" approximately $43 million in annual appropriations at the U.S. Government Printing Office (GPO) and the funds remained unexpended. OIG initiated this review to determine if VHA's CBO legally had the GPO "hold" funds, appropriated for use in one fiscal year, for use in another year, making them 'no-year' funds. OIG substantiated the allegation. OIG identified a breakdown of VA's fiscal controls and a lack of management oversight that

led to the parking of funds. These expired funds were held for an excessively long period and VA financial managers failed to detect, properly use, and manage these funds responsibly. Approximately $35.2 million of approximately $43.1 million had remained at the GPO unused for 36 months. In addition, VHA's CBO paid approximately $5.6 million to the VA Supply Fund in service fees and only expended approximately $2.3 million from October 2011 through July 2014. As such, CBO was able to use the funds in its 'GPO account' at its discretion and with no designated purpose. VA officials responsible for Supply Fund management acknowledged that they should not have accepted the funds without a *bona fide* need, or charged fees on funds transferred through these accounts. OIG recommended the Deputy Assistant Secretary for Acquisition, Logistics, and Construction remedy the inappropriate expenditure of approximately $2.3 million of expired funds, determine whether VA should de-obligate any outstanding balances, and evaluate the need to return Supply Fund service fees of approximately $5.6 million.

OIG also recommended the Deputy Assistant Secretary for Acquisition, Logistics, and Construction implement a corrective action plan to ensure that fiscal controls are enforced to avoid future misuse of appropriated funds. Also, OIG recommended the Deputy Assistant Secretary for Finance review the fiscal controls in the Financial Management System (FMS) to ensure data integrity and an audit trail that reflects the occurrence and source of any accounting record changes. Finally, OIG recommended VA management determine the appropriate administrative action to take, if any, against the staff directing the misuse of the appropriated funds and circumventing controls over the management of funds.

VA's Program Response
Estimated Resolution Timeframe: FY 2016
Responsible Agency Official: Under Secretary for Health, Deputy Assistant Secretary for Finance and Acting Deputy Chief Financial Officer Assistant Secretary for Information and Technology

Resolved February, 2015: The Office of Inspector (OIG) identified a lack of transparency in FMS regarding any changes made to obligation end dates. They indicated that changes to obligation end dates were not clearly documented or readily available for analysis and reporting purposes. The OIG also noted that extracting the documents required intervention from VA Finance.

Due to the large volume of financial transactions, FMS only stores certain information, in this case, zero dollar administrative changes such as a date change, for a limited number of days. As a result, these types of zero dollar administrative changes are visible to the user community for a very limited amount of time.

Due to this system deficiency, certain audit trails are only available for a short time period. To remediate this issue, a process was implemented in February 2015 to store this administrative information relating to obligations at the time they are processed. As a result, the information is now stored daily providing the ability to track the history of all new obligations from the implementation date forward.

Completed FY 2015 Milestones:
In response to the OIG finding that VHA misused $2.6 million of Medical Support and Compliance (MS&C) appropriations to pay for VHA's program office to pilot the deployment process for Maximo software instead of using Information Technology System appropriations, VHA and Office of Information & Technology's (OIT) formalized the process for reviewing project funding requests. Each VHA project is reviewed to ensure it supports VHA's strategic plan. Then, the VHA Resource Management Committee and the National Leadership Council review and approve for final funding. To strengthen the OIT oversight mechanisms, the OIT Planning, Budgeting & Budget Execution Board established a standing OIT/Non-OIT Working Group. This working group is chaired by the Director of OIT Financial Management & Oversight and the members include: VHA, Office of General Counsel, Veterans Benefits Administration, and others. If this working group determines that a VHA project requires non-OIT funding, VHA will institute the administration's oversight mechanism for usage of MS&C appropriations.

The Office of the Inspector General (OIG) found that VHA had "parked" approximately $43 million in annual appropriations at the U.S. Government Printing Office (GPO). The Office of Acquisition and Logistics (OALC) worked with VHA to process the necessary transactions to fund these expenditures with the correct year of appropriated funds.

OALC returned $35 million of unexpended funds from GPO to VHA. In addition, they returned all Supply fund fees associated with this recommendation.

OALC implemented a corrective action plan to ensure that fiscal controls are enforced to avoid future misuse of appropriated funds, including inappropriate use of the VA Supply Fund, and the parking of funds. Also, OALC discontinued the collection of funds from the customer in advance of orders and issued new internal policy for acquiring printing and copying services requiring all requisitions and funding commitments be validated by the VA Supply Fund Chief Financial Officer. OALC further insured that the VA Supply Fund is not used for "parking of funds" by requiring all 1VA+ obligations of expiring funds comply with the policy issued by OALC, which requires approval by the sponsoring organization's Deputy Under Secretary, or equivalent as well as approval by OALC Head of Contracting Authority.

Completed 2015 MMC Sub-challenge Milestones (OIT):

VA's Office of Information and Technology has implemented the appropriate internal controls through its planning, programming, budgeting and execution (PPBE) processes as well as provides oversight for compliance through its PPBE Board, which is chaired by the Deputy Assistant Secretary for IT Resource Management/IT Chief Financial Officer. OI&T is also working with the Administrations to create comprehensive guidance on the use of the IT appropriation and other VA appropriations, for the acquisition, development, and operation of VA IT resources in a secure, consistent, effective and efficient manner, as directed by Congressional authority and in compliance with all federal laws and regulations.

OIG CHALLENGE #4: PROCUREMENT PRACTICE
-Strategic Overview-

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

Recurring systemic deficiencies in the procurement process, including the failure to comply with the Federal Acquisition Regulation and VA Acquisition Regulation, and the lack of effective oversight increase the risk that VA may award contracts that are not in the best interest of the Department. Further, VA risks paying more than fair and reasonable prices for supplies and services and making overpayments to contractors. VA must improve its acquisition processes and oversight to ensure the efficient use of VA funds and compliance with applicable acquisition laws, rules, regulations, and policies.

OIG Sub-Challenge #4A: Improving Contracting Practices (OALC, VHA)
In FY 2012, OMB reported that Government spending for support service functions had quadrupled over the past decade. Previous OIG audits identified recurring systemic deficiencies in virtually all phases of VHA contracting processes. VHA's support service contract costs increased 60 percent from approximately $503 million for about 5,100 contracts in FY 2012 to just over $805 million for about 4,700 support service contracts in FY 2013. OIG found VHA did not have effective internal controls or follow existing controls to ensure adequate development, award, monitoring, and documentation of support service contracts. Within our statistical sample of 95 support service contracts, OIG found 1 or more deficiencies in each contract reviewed. The contract deficiencies included insufficient documentation of key contract development and award decisions, assurance that paid invoice amounts were correct and funds were de-obligated following the contract completion, and a complete history of contract actions in VA's mandatory Electronic Contract Management System (eCMS).

These deficiencies occurred because VHA management did not have an effective quality assurance program, integrated oversight process reviews were not completed, and contracting officers did not delegate and meet with contracting officers' representatives as required. If VHA does not take timely action to improve its support service contracting processes, OIG estimated it will inappropriately compete, award, and manage contract funds totaling $159 million annually or $795 million over the next 5 years through FY 2019. OIG recommended VHA improve their quality assurance and training programs, revise and complete integrated oversight process reviews, objectively evaluate contracting officer's performance, and ensure contracting officers' representatives are delegated and met with quarterly. The Interim USH concurred with

OIG's recommendations and provided an acceptable action plan. OIG will follow up on the implementation of the corrective actions.

OIG also evaluated the merits of complaints received by the VA OIG Hotline that VA's Office of Public and Intergovernmental Affairs (OPIA) awarded an outreach contract to Woodpile Studios, Inc. The complainants alleged the contract award resulted in no apparent increase in VA services used by Veterans and that OPIA continued to solicit for additional contracts. OIG substantiated the allegations regarding OPIA mismanagement of its outreach contracts. OIG confirmed that in July 2010, OPIA awarded a contract to Woodpile to provide support for outreach campaigns at an initial cost of $5.2 million. However, OPIA could not demonstrate that contract activities resulted in increased awareness of and access to VA health care, benefits, and services for Veterans. OIG also confirmed that OPIA solicited significant new outreach service contracts without evaluating the effectiveness of the previous contract. OPIA management stated that leadership turnover contributed to ineffective oversight of the outreach contract management and solicitations. Consequently, Woodpile contractors performed functions that were inherently Governmental.

Questionable use of a labor-hour order instead of a performance-based contract contributed to invoices for activities that did not clearly link to accomplishment of VA outreach goals. By awarding new contracts without first evaluating the performance of the prior Woodpile contract, OPIA continued to expend funds on questionable outreach activities. OPIA also lacked performance metrics to fully assess improvements in access to VA benefits and services for Veterans. OIG recommended that the Assistant Secretary for OPIA ensure effective oversight of outreach contract management and prevent contractors from performing inherently Governmental tasks. The Assistant Secretary should also implement metrics to ensure the outreach campaigns improve Veteran awareness and access to VA services.

In addition, OIG substantiated allegations relating to the award and administration of contracts to Tridec Technologies for the Virtual Office of Acquisition software development project. The contracts, valued at more than $15 million, were awarded sole-source to Tridec by VA's Technology Acquisition Center utilizing the provisions of section 8127 of title 38 of the United States Code. The review substantiated that VA management officials, one of whom had a personal relationship with one of Tridec's owners, split the requirements to ensure that Tridec was awarded the contracts without competition. Two former VA management officials, one of whom was a personal friend of one of Tridec's owners, engaged in lack of candor when interviewed by OIG criminal investigators.

VA's Program Response
Estimated Resolution Timeframe (VHA): FY 2016
Estimated Resolution Timeframe Fiscal Year (OPIA): FY 2015
Estimated Resolution Timeframe OALC: FY 2015
Title of Responsible Agency Officials: Under Secretary for Health (VHA), Acting Deputy Assistant Secretary, Office of Public and Intergovernmental Affairs (OPIA), Principal Executive Director, Office of Acquisition, Logistics, and Construction (OALC)

VHA Completed FY 2015 Milestones:
The VHA Procurement and Logistics Office (P&LO) has been working to ensure effective quality assurance and training programs, integrated oversight processes, and Contracting Officer Representation (COR) programs are in place. In FY 2015, VHA P&LO further defined the roles and responsibilities of CORs and contracting officers and increased their efforts to build collaborative and supportive relationships with CORs across VHA. VHA P&LO established an integrated project team to develop alternate solutions for addressing deficiencies in the quality assurance program and the integrated oversight process. The VHA P&LO internal procurement audit office completed additional audits in FY 2015 to increase monitoring of contract deficiencies and to increase management accountability efforts. VHA P&LO plans to continue addressing internal controls and the quality of contracts in FY 2016 and will coordinate with the Department's MY VA Support Services team.

OPIA Completed FY 2015 Milestones:
To ensure all OPIA Contracting Officer's Representatives (COR) appropriately manage all contracts, OPIA coordinates with OALC to draft and publish Standard Operating Procedures (SOP) to be adhered to by all OPIA CORs and Program Managers. The SOP was published in FY 2015, and addressed the following five completed milestones pertaining to this sub-challenge: ensuring proper procedures are followed for all significant contract modifications; appropriate oversight is conducted for all outreach contracts; correct contract types are utilized for contracted work; significantly limit the use of Time and Materials contracts; and ensure Statements of Work and contracts include specific performance-based metrics.

Completed FY 2015 Milestones:
In OIG Sub-Challenge #4A, reference to the Office of Public and Intergovernmental Affairs' contract with Woodpile derived from the related VA OIG issued report, Number 13-01545-11, "Review of Alleged Mismanagement of VA's Office of Public and Intergovernmental Affairs Outreach Contract." Although the VA OIG report only provided recommendations for the program office (OPIA) to resolve, and none for OALC's action, OALC implemented the corrective actions listed below to remedy the contractor's performance.

(1) The Contracting Officer (CO) suspended the vendor's work on the contract after receiving allegations from the Contracting Officer Representative (COR) that the contractors were performing outside the scope of the contract.

(2) The CO also asked the contractor to submit more detailed invoices to clearly outline services provided.

(3) After talking to all parties, the CO determined that no further services were necessary, terminated the contract, and the contractor was notified of such.

(4) During its review, OIG requested basic contract information from the CO, which CO provided accordingly.

(5) The CO determined all performance deliverables were rendered and accepted prior to the work suspension and subsequent contract termination.

OIG Sub-Challenge #4B: Improving Oversight of Patient Centered Community Care Contracts (OALC,VHA)

OIG's review of PC3 contracts is a series of five reports published on PC3 in FY 2015. OIG determined that PC3 contracts were not developed or awarded in accordance with acquisition regulations, established VA policy, and commercial best practices. OIG found significant weaknesses in the planning, evaluation, and award due to this non-compliance. These regulations and policies ensure services acquired are based on need and at fair and reasonable prices.

VA awarded PC3 in September 2013, to provide a comprehensive, nationwide network of high-quality, specialty health care services for Veterans. The contracts were awarded for approximately $27 billion for a 1-year base period, with the option to renew the contracts annually for each of the succeeding 4 years. The contracting officials solicited proposals from vendors without clearly articulating VA's requirements. Thus, the vendors bidding on the solicitation had very little information upon which to base the type of specialty health care services they would need to provide, where they were to provide them, or the frequency of which specialty care services would be needed at which location. Therefore, the risk for providing the unknown amount of network was placed on the contractors and additional risk can lead to limited competition. OIG found documentation supporting vital contract award decisions was either not in VA's eCMS or incomplete. In the few documents available, OIG noted the awarded costs were actually negotiated at higher rates than proposed by one of the vendors in its original proposal. The rationale for these decisions was not documented in the price negotiation memorandum.

VA's Program Response
Estimated Resolution Timeframe (VHA): FY 2016
Estimated Resolution Timeframe (OALC): June 2015
Responsible Agency Official: Under Secretary for Health (VHA), Principal Executive Director, Office of Acquisition, Logistics, and Construction (OALC)

Completed FY 2015 Milestones:
VHA's Chief Business Office for Purchased Care (CBOPC) formed an integrated project team (IPT) to lead a new Patient-Centered Community Care (PC3) cost analysis. The IPT has executed a contract for completion of a cost benefit analysis. Upon completion, the cost benefit analysis will help the IPT analyze potential cost savings VA may realize with future changes to the VA managed healthcare model, to include PC3. VHA's CBOPC also developed a comprehensive action plan that addresses delays in care findings associated with PC3 contracted care issues.

Completed FY 2015 Milestones:
OALC has corrected the identified deficiency and has requested closure of the recommendations. Specifically, all documentation for the two contract files has been re-input into the Electronic Contract Management System (eCMS). Completion occurred prior to June 15, 2015. Over 250 paper files were scanned, as needed, and then those and any available electronic files were uploaded into the PC3 (Patient Centered Community Care) contract files, located within eCMS.

OIG CHALLENGE #5: INFORMATION MANAGEMENT (OIT)
-Strategic Overview-

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

Under the leadership of the Executive in Charge for IT, VA's OIT is positioning itself to facilitate VA's transformation into a 21st century organization through improvement strategies in five key IT areas: (1) quality customer service, (2) continuous readiness in information security, (3) transparent operational metrics, (4) product delivery commitments, and (5) fiscal management. OIT's efforts are also focused on helping accomplish VA's top three agency priority goals of expanding access to benefits and services, eliminating the claims backlog in 2015, and ending Veteran homelessness in 2015.

However, OIG oversight work indicates that additional actions are needed to effectively manage and safeguard VA's information resources and processing operations. As a result of the FY 2014 CFS audit, OIG's independent auditor reported that VA did not substantially comply with requirements of the Federal Financial Management Improvement Act of 1996. While providing an unqualified opinion on the CFS, the independent auditor continues to identify IT security controls as a material weakness.

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

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

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

been lost or stolen, including PII, thus exposing millions of Americans to the loss of privacy, identity theft, and other financial crimes. The need for an improved approach to information security is apparent and one that senior Department leaders recognize. OIG's recent work on the CFS audit supports OIG's annual Federal Information Security Management Act (FISMA) assessment. During FY 2014, OIG reported that VA continued to implement its Continuous Readiness in Information Security Program to ensure continuous monitoring year-round and establish a team responsible for resolving the IT material weakness. In August 2013, VA also implemented an IT Governance, Risk and Compliance Tool to improve the process for assessing, authorizing, and monitoring the security posture of the agency. As FISMA work progressed, OIG noted more focused VA efforts to implement standardized information security controls across the enterprise. OIG also noted improvements in role-based and security awareness training, improved contingency plan testing, a reduction in the number of outstanding Plans of Action and Milestones (POA&M), the development of initial baseline configurations, a reduction in the number of IT individuals with outdated background investigations, and improvement in data center web application security.

However, these controls require time to mature and show evidence of their effectiveness. Accordingly, OIG continues to see information system security deficiencies similar in type and risk level to our findings in prior years and an overall inconsistent implementation of the security program. Moving forward, VA needs to ensure a proven process is in place across the agency. VA also needs to continue to address control deficiencies that exist in other areas across all VA locations. OIG continues to find control deficiencies in security management, access controls, configuration management, and contingency planning. Most importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support transmitting financial and sensitive information between VAMCs, VAROs, and Data Centers. This is a result of an inconsistent application of vendor patches that could jeopardize the data integrity and confidentiality of VA's financial and sensitive information.

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

OIG's FY 2014 FISMA audit report discussed control deficiencies in four key areas:

(1) configuration management controls, (2) access controls, (3) change management, and (4) service continuity controls. Improvements are needed in these key controls to prevent unauthorized access, alteration, or destruction of major application and general support systems. VA has over 9,000 system security risks and corresponding POA&Ms that still need to be remediated to improve the overall information security posture. More importantly, OIG continues to identify significant technical weaknesses in databases, servers, and network devices that support the transmission of sensitive information among VA facilities. Many of these weaknesses may be attributed to inconsistent enforcement of an agency-wide information security program and ineffective communication between VA management and the individual field offices. The FY 2014 FISMA report provided 27 current recommendations to the Executive in Charge for Information and Technology to improve VA's information security program. The report also highlighted 6 unresolved recommendations from prior years' assessments for a total of 33 outstanding recommendations. Overall, OIG recommended that VA focus its efforts in the following areas:

- Addressing security-related issues that contributed to the IT material weakness reported in the FY 2014 CFS audit of the Department.
- Successfully remediating high-risk system security issues in its POA&Ms.
- Establishing effective processes for evaluating information security controls via continuous monitoring and vulnerability assessments.

In October 2014, the House Committee on Veterans' Affairs provided the OIG a complainant's allegation that the VA Palo Alto Health Care System Chief of Informatics entered into an illegal agreement with Kyron, a health technology company, to allow data sharing of sensitive VA patient information. This allegation involved Veterans' PII, protected health information, and other sensitive information being vulnerable to increased risks of compromised confidentiality. Allegedly, sensitive VA patient information was transmitted outside of VA's firewall. The complainant also alleged Kyron personnel received access to VA patient information through VA systems and networks without appropriate background investigations.

OIG did not substantiate the allegations that the Chief of Informatics formed an illegal agreement with Kyron or that sensitive patient information was transmitted outside of VA's firewall. However, OIG substantiated the allegation that Kyron personnel received access to VA patient information without appropriate background investigations. Based on our interviews, a review of available documentation and relevant criteria, and personal judgment, OIG determined the Chief of Informatics, who was also the local program manager for the pilot program, failed to ensure Kyron personnel met the appropriate background investigation requirements before granting access to VA patient information. The Chief of Informatics also failed to ensure Kyron personnel completed VA's security and privacy awareness training.

Further, the Information Security Officers failed to execute their required responsibilities in accordance with VA Handbook 6500, Information Security Program. OIG found that

Information Security Officers did not coordinate, advise, and participate in the development and maintenance of system security documentation and system risk analysis prior to Kyron placing its software on a VA server. As a result, Kyron did not have formal authorization to operate its software on a VA server. Given the nature and seriousness of sensitive Veteran data being vulnerable to increased risks of compromised confidentiality, OIG recommended the VA Executive in Charge for Information and Technology take immediate action to ensure the local and regional Information Security Officers determine the appropriate security level for Kyron's software and pilot program.

VA's Program Response
Estimated Resolution Timeframe: 2016
Responsible Agency Official: Assistant Secretary for Information and Technology

Completed 2015 MMC Sub-challenge Milestones:
VA established an Enterprise Cybersecurity Strategy Team (ECST) to define an overall cybersecurity strategy across VA, including management of current projects such as CRISP, and holistic development and review of VA's cybersecurity requirements and operations.

VA implemented a centralized approach for gathering information security metrics and managing compliance related to the prioritization and implementation of critical patches across the enterprise. VA uses security automated tools to scan for vulnerabilities across assets to map critical and high-level vulnerabilities. As part of the Department of Homeland Security (DHS) Cyber Sprint effort, VA identified High Value Assets (HVA) and reviewed security practices and controls around VA HVAs.

VA developed streamlined assessment and authorization processes with technically-focused risk-based accreditation requirements. VA also standardized Security Control Assessment (SCA) procedures across the enterprise, refining procedures based on past OIG findings and lessons-learned from SCA site visits. In FY 2015, DHS' US-CERT began providing weekly cyber hygiene reports that contained the results of US-CERT vulnerability scans of VA Internet facing hosts. For all the cyber hygiene reports delivered in FY 2015, the VA has resolved all of the small number of critical vulnerabilities identified in those reports. Eight were deemed false positives by US-CERT and one was patched within two weeks of notification. None of these critical vulnerabilities exceeded the 30 day limit for patching/mitigation, and VA is currently working to address all other vulnerabilities identified in VA systems as a result of our own vulnerability scans on our systems.

VA made multiple access control improvements in FY 2015 to ensure that VA networks are protected from threats. As part of its "defense in depth" strategy, VA acquired new network monitoring capabilities, improved vulnerability scanning of outward-facing applications, increased desktop security, and enhanced its speed in detecting and combating attackers. Increasing numbers of malware attempts are now blocked at the

gateway, before attacks reach VA networks. In the wake of large-scale PII breach incidents (OMB Reference Number: AR-15-20001C), and as directed by the Federal CIO Cyber Sprint Strategy, the VA began its search for the specific DHS identified indicators of compromise (IOC) on April 20, 2015 and completed the initial pass of network on June 9, 2015. VA also began a more comprehensive implementation of two-factor authentication (2FA) across the Department. In July 2015, the Deputy Assistant Secretary for Information Security directed two-factor authentication for internal access to VA systems. As of the end of July 2015, 80% of all VA users (non-patient facing) are required to access VA networks through PIV authentication, by managerial direction and/or technical controls. As of August 2015, VA has achieved 50% compliance, and full compliance will be achieved in FY 2016.

The VA also is making progress in reducing the number of staff with elevated privileges.

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

VA is not in substantial compliance with the Federal financial management systems requirements of the Federal Financial Management Improvement Act of 1996. This condition is due to VA's complex, disjointed, and legacy financial management system architecture that has difficulty meeting increasingly demanding financial management and reporting requirements. In particular, OIG's independent financial statement auditors reported the following:

- VA's core accounting system — FMS — has functional limitations that were further exacerbated by operational and security vulnerabilities due to the age of the system and its supporting technology.
- VA's Integrated Funds Distribution Control Point Activity, Accounting and Procurement System (IFCAP)—a major feeder system to FMS for obligations—has only a one-directional interface with FMS. Therefore, IFCAP is not updated for changes to obligations made in FMS, and VA is unable to perform a complete reconciliation of obligations and fund status between the two systems.
- The Veterans Health Information Systems and Technology Architecture (VistA) does not provide VA with the ability to effectively and efficiently monitor nationwide Medical Care Collection Fund (MCCF) activities. Personnel cannot generate combined reports for all facilities under their purview, and a nationwide report cannot be generated to aggregate MCCF transactions at a sufficient level of detail. Reconciliation of revenue transactions to collections and the supporting audit trail is more complicated. Additionally, VistA cannot produce a consolidated accounts receivable aging report at a sufficient level of detail. Management does not have the tools to properly assess the reasonableness of its allowance for loss provision or perform a retrospective analysis to ascertain the reasonableness of its allowance methodology.
- Transactions initiated and recorded in IFCAP cannot be reconciled to the procurement source documentation maintained in eCMS. Also, eCMS does not

have a procurement file structure to maintain acquisition documentation in a consistent and efficient manner. The information in eCMS is incomplete and could be unreliable.

VA's Program Response
Estimated Resolution Timeframe: Unknown
Responsible Agency Official: Assistant Secretary for Management

To improve compliance with the Federal Financial Management Improvement Act (FFMIA) Assurance Statement process, VA provides oversight and review of internal controls over financial reporting. VA has been investigating the best approach to replace the aging Financial Management System (FMS). We acknowledge all of the items identified in the OIG Sub-Challenge #5B: Improving Compliance with Federal Financial Management Improvement Act (OIT). This is a complex issue and replacing the FMS is a fundamental step in the overall solution. There are more than 50 major interfaces that send data to FMS. Current interface capability is very limited with the legacy system and gives rise to the problems identified. VA will conduct exploration of the Federal Shared Service providers for a possible solution to replace the outdated FMS system. We anticipate beginning this process in earnest during FY16.

Two systems, Electronic Contract Management System (eCMS) and Integrated Funds Control, Accounting, and Procurement (IFCAP), are not interfaced for the exchange of obligation data. Reconciliation can partially occur as Contracting Officers do enter the IFCAP purchase order number (FMS Obligation number) into eCMS following the processing of the VA Form 2138, Order for Supplies or Services in IFCAP. For Centralized Administrative Accounting Transaction System (CAATS) transactions, since eCMS generates the obligation number for passing onto FMS, a100% reconciliation can occur. Enterprise Acquisition Service (EAS) has reported on this finding in the past to the Office of Management. The core application of eCMS is a Commercial Off-the-Shelf (COTS) product. As such, EAS must rely on the COTS manufacturer to make product enhancements. Contracting personnel can and do maintain acquisition and procurement files in eCMS, and the COTS product does allow an index of items to be created, mimicking common file structures of the past paper environments. Since Contracting Officers are the only federal employees that can "obligate" the federal government and the core obligation documents are created and maintained in eCMS, the obligation data in eCMS should be considered official. The unreliability stems from the fact that for IFCAP transactions, no data interface exists despite two attempts to resolve that issue.

OIG Sub-Challenge #5C: Improving Accountability and Oversight of the Project Management Accountability System (OIT)

Although steps were taken to improve PMAS, OIT still has not fully infused PMAS with the discipline and accountability necessary for effective oversight of IT development projects more than 5 years after system launch. Two OIT offices did not adequately perform planning and compliance reviews. The PMAS Business Office (PBO) still had

Federal employee vacancies, and the PMAS Dashboard lacked a complete audit trail of baseline data. Project managers continued to struggle with capturing incremental costs, and project teams were not reporting costs related to enhancements on the PMAS Dashboard.

These conditions occurred because OIT did not provide adequate oversight to ensure OIG's prior recommendations were sufficiently addressed and that controls were operating as intended. OIT also did not adequately define enhancements in the PMAS Guide. As a result, VA's portfolio of IT development projects was potentially being managed at an unnecessarily high risk. OIG also identified approximately $6.4 million in cost savings OIT could achieve by hiring Federal employees to replace contract employees currently augmenting PBO staff.

VA's Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Assistant Secretary for Information Technology

Completed 2015 MMC Sub-challenge Milestones:

OI&T has established procedures to ensure the office of Product Development completes all required Planning Reviews. As specified by PMAS Guide 5.0, the relevant Offices of Responsibility (OOR) within OI&T conduct Planning Reviews within their respective organizational units. The outcomes of these reviews determine whether a recommendation is made for a project to remain in a planning state, move to the provisioning state or active state, be re-evaluated, or be closed. This process was implemented in the second quarter of FY 2015.

To ensure personnel performing Compliance Reviews assess the accuracy and reasonableness of cost information reported in PMAS, OI&T modified its policies, practices, and methodologies in February 2015. These changes ensure that project teams input into the PMAS Dashboard all data that is necessary to capture and report planned and actual total project and increment level costs. Enterprise Risk Management (ERM) is currently assessing the Compliance Review process; upon completion of this activity, ERM will document the process established by Program Planning and Oversight (PPO), Service Delivery and Engineering (SDE), and OOR to record project cost information. ERM will then develop a review process to validate dashboard data.

To ensure that project managers capture and report reliable cost data and maintain adequate audit trails to support how cost information is reported, OI&T is manually inputting cost information into the PMAS Dashboard. Since the start of FY 2015, relevant OORs within OI&T have reviewed the detailed cost data that is captured in the Milestone review deck with project managers prior to all pre-briefs for Milestone Zero (MS0) through Milestone Four (MS4), and have ensured alignment with cost details in the Budget Tracking Tool (BTT) and other data sources. These practices will continue, and will yield greater accuracy of the cost data that is manually entered into the PMAS Dashboard at the time of the Milestone review.

OI&T has defined the phrase “enhancement of an existing system or its infrastructure” in a PMAS policy memorandum signed on June 5, 2015. VA will incorporate this language into the next version of the PMAS Guide, but the signing of the memorandum substantiates the change in policy immediately. Project costs will be tracked in the PMAS Dashboard, as specified in the clarified policy.

Only two of the thirteen approved FTE PMAS Business Office (PBO) positions are currently vacant. Candidates for these positions are currently being sought.

OI&T has implemented an interim approach that allows for an audit trail of planned, revised, and actual cost data, until OI&T is able to develop capabilities that allow the PMAS Dashboard to interface with the systems and databases where relevant authoritative financial information is maintained.

APPENDIX A

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

OIG MAJOR MANAGEMENT CHALLENGE #1: HEALTH CARE DELIVERY

Healthcare Inspection–Alleged Suicides and Inappropriate Changes to Mental Health Treatment Program, Coatesville VA Medical Center, Coatesville, Pennsylvania
9/30/2015 | 13-04038-521 | Summary |

Review of Allegations Regarding Quality of Care, Professional Conduct, and Contractual Issues for Cardiothoracic Surgery and Perfusion Services at the VA North Texas Health Care System Provided by the University of Texas—Southwestern Medical Center
9/30/2015 | 14-04598-461 | Summary |

Review of Alleged Inappropriate Referrals at VHA's Southern Nevada Healthcare System to a Non-VA Medical Provider
9/30/2015 | 15-01590-523 | Summary |

Review of Patient-Centered Community Care (PC3) Health Record Coordination
9/30/2015 | 15-00574-501 | Summary |

Healthcare Inspection–Follow-up Review of the Pause in Providing Inpatient Care VA Northern Indiana Healthcare System, Fort Wayne, Indiana
9/29/2015 | 13-00670-540 | Summary |

Healthcare Inspection–Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois
9/29/2015 | 14-02952-498 | Summary |

Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System
9/29/2015 | 14-03434-530 | Summary |

Review of VHA's Patient-Centered Community Care (PC3) Provider Network Adequacy
9/29/2015 | 15-00718-507 | Summary |

Healthcare Inspection–Alleged Substandard Prostate Cancer Screening, VA Eastern Colorado Health Care System, Denver, CO
*9/3/2015 | 14-03833-385 | Summary *

Healthcare Inspection–Alleged Delayed Mental Health Treatment and Other Care Issues, Kansas City VA Medical Center, Kansas City, MO
9/2/2015 | 14-03531-402 | Summary |

Review of Alleged Mismanagement at the Health Eligibility Center
9/2/2015 | 14-01792-510 | Summary |

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages
9/1/2015 | 15-03063-511 | Summary |

Review of VHA's Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC
8/31/2015 | 15-02397-494 | Summary |

Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists
8/25/2015 | *13-03917-487* | *Summary* |

Healthcare Inspection–Unexpected Death of a Patient During Treatment with Multiple Medications, Tomah VA Medical Center, Tomah, WI
8/6/2015 | *15-02131-471* | *Summary* |

Healthcare Inspection–Alleged Mold and Environment of Care Concerns in the Spinal Cord Injury and Disorders Units, Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
7/30/2015 | *15-02842-450* | *Summary* |

Healthcare Inspection–Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | *15-01579-457* | *Summary* |

Healthcare Inspection–Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015 | *14-04530-452* | *Summary* |

Healthcare Inspection–Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015 | *14-04530-414* | *Summary* |

Healthcare Inspection–Delay in Emergency Airway Management and Concerns about Support for Nurses, VA Northern California Health Care System, Mather, CA
7/28/2015 | *15-00533-440* | *Summary* |

Healthcare Inspection–Quality of Care Issues, Sheridan VA Healthcare System, Sheridan, Wyoming
7/14/2015 | *14-00903-422* | *Summary* |

Healthcare Inspection–Alleged Dental Service Scheduling and Other Administrative Issues, VA Palo Alto Health Care System, Palo Alto, CA
7/9/2015 | *14-04755-428* | *Summary* |

Healthcare Inspection–Alleged Poor Quality of Care and Refusal to Pay for Lung Transplantation, Iowa City VA Health Care System, Iowa City, Iowa
7/9/2015 | *15-01968-424* | *Summary* |

Healthcare Inspection–Alleged Colorectal Cancer Screening and Administrative Issues, VA Palo Alto Health Care System, Palo Alto, California
7/9/2015 | *14-04754-407* | *Summary* |

Healthcare Inspection–Vascular Surgery Resident Supervision, VA Nebraska-Western Iowa Health Care System, Omaha, Nebraska
7/9/2015 | *14-04037-404* | *Summary* |

Healthcare Inspection–Communication and Quality of Care Concerns, VA Black Hills Health Care System, Fort Meade, SD
7/8/2015 | *14-04491-394* | *Summary* |

Healthcare Inspection–Staff and Management Concerns at the Jacksonville Outpatient Clinic, Jacksonville, Florida
7/8/2015 | *14-04401-416* | *Summary* |

Healthcare Inspection–Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado

7/7/2015 | *14-04049-379* | *Summary* |

Healthcare Inspection–Alleged Short-Stay Rehabilitation Unit Concerns, Tuscaloosa VA Medical Center, Tuscaloosa, Alabama

7/7/2015 | *15-01445-400* | *Summary* |

Healthcare Inspection–Alleged Quality of Care Issues at the Community Based Outpatient Clinic, Casa Grande, AZ

7/7/2015 | *14-04260-395* | *Summary* |

Healthcare Inspection–Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, AK

7/7/2015 | *14-04077-405* | *Summary* |

Healthcare Inspection–Testing for Legionella, VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania

7/6/2015 | *14-03688-399* | *Summary* |

Healthcare Inspection–Alleged Quality of Care Concerns, Gene Taylor Community Based Outpatient Clinic, Mount Vernon, Missouri

7/6/2015 | *14-04547-398* | *Summary* |

Healthcare Inspection–Alleged Lapse in Timeliness of Care, West Palm Beach VA Medical Center, West Palm Beach, Florida

7/2/2015 | *15-00191-406* | *Summary* |

Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues

7/1/2015 | *14-04116-408* | *Summary* |

Healthcare Inspection–Alleged Mental Health Access and Treatment Deficiencies, Brunswick Community Outpatient Clinic, Brunswick, Georgia

6/30/2015 | *15-01116-390* | *Summary* |

Review of Alleged Mismanagement of Medical Supplies at the VA Medical Center, East Orange, New Jersey

6/29/2015 | *15-01927-375* | *Summary* |

Audit of VHA's Homeless Providers Grant and Per Diem Case Management Oversight

6/29/2015 | *14-01991-387* | *Summary* |

Healthcare Inspection–Alleged Improper Maintenance of Reprocessing Equipment, Huntington VA Medical Center, Huntington, West Virginia

6/25/2015 | *14-02634-397* | *Summary* |

Healthcare Inspection–Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities

6/25/2015 | *14-04547-401* | *Summary* |

Healthcare Inspection–Credentialing and Privileging Concerns, Wm. Jennings Bryan Dorn VA Medical Center, Columbia, SC

6/24/2015 | *14-05078-393* | *Summary* |

Healthcare Inspection–Evaluation of a Patient's Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, Georgia

6/23/2015 | *15-02276-391* | *Summary* |

Healthcare Inspection–Administrative and Quality of Care Concerns, Martinsburg VA Medical Center, Martinsburg, West Virginia

5/21/2015 | *13-04212-346* | *Summary* |

Review of Alleged Mismanagement of Radiologists Interpretations at Central Arkansas Veterans Healthcare System
4/30/2015 | *14-04493-198* | *Summary* |

Healthcare Inspection–Alleged Lack of Timeliness and Quality of Care Concerns at the Memphis VA Medical Center, Memphis, Tennessee
4/16/2015 | *15-00347-154* | *Summary* |
Healthcare Inspection–Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
4/14/2015 | *14-03824-155* | *Summary* |
Healthcare Inspection–Patient Telemetry Monitoring Concerns, Michael E. DeBakey VA Medical Center, Houston, Texas
3/31/2015 | *14-03927-197* | *Summary* |
Healthcare Inspection–Suicide Risk and Alleged Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia
3/30/2015 | *14-02139-156* | *Summary* |
Healthcare Inspection-Delay of Care, Goshen Community Based Outpatient Clinic, Goshen, Indiana
3/24/2015 | *15-00794-151* | *Summary* |
Healthcare Inspection–Staffing and Quality of Care Issues in the Community Living Center, Charlie Norwood VA Medical Center, Augusta, Georgia
3/19/2015 | *14-02437-117* | *Summary* |
Audit of VHA's Home Telehealth Program
3/9/2015 | *13-00716-101* | *Summary* |
Healthcare Inspection–Inadequate Follow-Up of an Abnormal Imaging Result, Charlotte Community Based Outpatient Clinic, Charlotte, North Carolina
3/9/2015 | *15-00190-146* | *Summary* |
Healthcare Inspection–Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
3/3/2015 | *14-04473-132* | *Summary* |
Healthcare Inspection–Radiology Scheduling and Other Administrative Issues, Phoenix VA Health Care System, Phoenix, Arizona
2/26/2015 | *14-00875-133* | *Summary* |
Healthcare Inspection–Alleged Lack of Training and Support for Interventional Radiology Procedures, Salem VAMC, Salem, Virginia
2/18/2015 | *14-02022-134* | *Summary* |
Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
2/18/2015 | *14-04194-118* | *Summary* |
Healthcare Inspection–Staffing and Patient Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
2/12/2015 | *14-01708-123* | *Summary* |
Healthcare Inspection–Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, Wisconsin
2/6/2015 | *11-04212-127* | *Summary* |

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages
1/30/2015 | *15-00430-103* | *Summary* |

Interim Report–Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ
1/28/2015 | *14-00875-112* | *Summary* |

Healthcare Inspection–Alleged Quality of Care and Courtesy Issues at the Alamosa Community Based Outpatient Clinic, Alamosa, Colorado
1/13/2015 | *14-00615-61* | *Summary* |

Healthcare Inspection–Ophthalmology Service Concerns, VA Illiana Health Care System, Danville, Illinois
1/8/2015 | *14-02412-69* | *Summary* |

Healthcare Inspection–Alleged Insufficient Staffing and Consult Management Issues, Carl Vinson VA Medical Center, Dublin, Georgia
1/7/2015 | *14-04702-60* | *Summary* |

Healthcare Inspection–Quality of Care Issues, West Palm Beach VA Medical Center, West Palm Beach, Florida
12/18/2014 | *14-02887-64* | *Summary* |

Healthcare Inspection–Follow-Up Evaluation of Quality of Care, Management Controls, and Administrative Operations, William Jennings Bryan Dorn, VA Medical Center, Columbia, SC
12/15/2014 | *13-00872-52* | *Summary* |

Healthcare Inspection–Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet
12/15/2014 | *14-04705-62* | *Summary* |

Healthcare Inspection–Alleged Inappropriate Opioid Prescribing Practices, Chillicothe VA Medical Center, Chillicothe, OH
12/9/2014 | *14-00351-53* | *Summary* |

Audit of VHA's National Call Center for Homeless Veterans
12/3/2014 | *13-01859-42* | *Summary* |

An Analysis of Mental Health, Primary Care, and Specialty Care Productivity and Related Issues, El Paso VA Health Care System, El Paso, Texas
12/2/2014 | *14-05128-51* | *Summary* |

Healthcare Inspection–Radiology Scheduling and Other Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California
11/24/2014 | *14-00661-43* | *Summary* |

Healthcare Inspection–Quality and Coordination of Care Concerns at Three Veterans Integrated Service Network 11 Facilities
11/14/2014 | *14-01519-40* | *Summary* |

Healthcare Inspection–Alleged Nursing Deficiencies Led to Patient's Death, Hampton VA Medical Center, Hampton, Virginia
11/5/2014 | *13-02527-23* | *Summary* |

Healthcare Inspection–Follow-Up of Quality of Care, Management, and Operations, Iowa City VA Health Care System, Iowa City, Iowa
10/21/2014 | *14-01261-03* | *Summary* |

Healthcare Inspection–Emergency Department Concerns, Dwight D. Eisenhower VAMC, Leavenworth, Kansas

10/1/2014 | 14-03212-295 | Summary |

Congressional Testimony 9/22/2015

Statement of Linda A. Halliday Deputy Inspector General Office of Inspector General Department of Veterans Affairs Before The Committee On Homeland Security And Governmental Affairs United States Senate Hearing On Improving VA Accountability: Examining First-Hand Accounts Of Department Of Veterans Affairs Whistleblowers Read

Congressional Testimony 8/25/2015

Statement of Andrea C. Buck, MD Chief of Staff For Healthcare Oversight Integration Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States Senate Field Hearing On Exploring The Veterans Choice Program's Problems in Alaska Read

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Statement of Linda A. Halliday Deputy Inspector General Office of Inspector General Department of Veterans Affairs Before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies Committee on Appropriations United States Senate Hearing on Whistleblower Claims at the U.S. Department of Veterans Affairs Read

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Statement of the Office of Inspector General, Department of Veterans Affairs, Statement for the Record, Senate Homeland Security and Governmental Affairs Committee Hearing "Watchdogs Needed: Top Government Investigators Left Unfilled for Years" Read

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Statement of The Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States House Of Representatives Hearing On "Examining Access And Quality Of Care And Services For Women Veterans" Read

Congressional Testimony 4/29/2015
Statement of John D. Daigh, Jr., M.D., CPA Assistant Inspector General Office of Healthcare Inspections Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States Senate Hearing On "GAO's High Risk List And The Veterans Health Administration" Read

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Statement of John D. Daigh, Jr., M.D., CPA, Assistant Inspector General For Healthcare Inspections Office of Inspector General Department of Veterans Affairs Before A Joint Field Hearing Of The Committee On Veterans Affairs United States House Of Representatives And The Committee On Homeland Security And Governmental Affairs United States Senate On The Operations Of The Tomah VA Medical Center Tomah, Wisconsin Read

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Oral Statement of John D. Daigh, Jr., M.D., CPA, Assistant Inspector General For Healthcare Inspections Office of Inspector General Department of Veterans' Affairs Before The Committee On Veterans' Affairs US House Of Representatives And Committee On Homeland Security And Governmental Affairs United States Senate Hearing On Tomah Department Of Veterans Affairs Medical Center Read

Congressional Testimony 3/26/2015
Statement Of John D. Daigh, Jr., M.D., CPA, Assistant Inspector General For Healthcare Inspections Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States Senate Hearing On "Opiate Prescription Policies Of The Department Of Veterans Affairs And Efforts In Combating Overmedication" Read

Congressional Testimony 3/19/2015
Statement of Richard J. Griffin Deputy Inspector General Office of Inspector General Department of Veterans Affairs Before The Committee On Appropriations Subcommittee On Military Construction, Veterans Affairs, And Related Agencies United States House Of Representatives Read

OIG CHALLENGE #2: BENEFITS PROCESSING

Review of VBA's Alleged Mismanagement of Unemployability Benefits at VARO Seattle, Washington
9/30/2015 | 15-02745-522 | Summary |

Audit of Fiduciary Program Controls Addressing Beneficiary Fund Misuse
8/27/2015 | 13-03922-453 | Summary |

Review of Alleged Shredding of Claims-Related Evidence at the VA Regional Office Los Angeles, California
8/17/2015 | 15-04652-448 | Summary |

Audit of Fiduciary Program's Management of Field Examinations
6/1/2015 | 14-01883-371 | Summary |

Review of Alleged Data Manipulation and Mismanagement at VA Regional Office Philadelphia, PA
4/15/2015 | 14-03651-203 | Summary |

Review of Alleged Data Manipulation at VA Regional Office, Boston, Massachusetts
4/15/2015 | 15-01332-121 | Summary |

Review of Alleged Data Manipulation at VA Regional Office Honolulu, HI
3/26/2015 | 15-00880-157 | Summary|

Review of Alleged Data Manipulation at the VA Regional Office Little Rock, Arkansas
2/26/2015 | 14-03963-139 | Summary |

Review of Alleged Mismanagement of Informal Claims Processing at VA Regional Office Oakland, California
2/18/2015 | 14-03981-119 | Summary |

Congressional Testimony 6/11/2015
Statement of Gary K. Abe Deputy Assistant Inspector General for Audits and Evaluations Office of Inspector General Department of Veterans Affairs Before The Subcommittee On Disability Assistance And Memorial Affairs Committee on Veterans' Affairs United States House of Representatives Hearing On "Exploring VA's Fiduciary Program" Read

Congressional Testimony 4/22/2015
Statement of Linda A. Halliday, Assistant Inspector General For Audits and Evaluations Office of Inspector General Department of Veterans Affairs Before the Committee on Veterans' Affairs United States House of Representatives Hearing on "Philadelphia and Oakland: Systemic Failures and Mismanagement" Read

Congressional Testimony 10/3/2014
OIG Statement at House Veterans' Affairs Subcommittee Field Hearing on "Rhetoric v. Reality: Investigating the Continued Failures of the Philadelphia VA Regional Office - Statement of Linda Halliday, Assistant Inspector General for Audits and Evaluations, before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans Affairs, US House of Representatives, Field Hearing, October 3, 2014, at Burlington County College, Pemberton Campus, Pemberton, New Jersey. Read

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

Review of Alleged Improper Pay at VHA's Hudson Valley Health Care System
9/30/2015 | 15-02053-537 | Summary |

Review of Alleged Mismanagement of VHA's Service-Oriented Architecture Research and Development Pilot Project
8/5/2015 | 14-00545-343 | Summary |

FY 2014 Review of VA's Compliance With the Improper Payments Elimination and Recovery Act
5/14/2015 | 14-03380-356 | Summary |

Audit of Non-VA Medical Care Claims for Emergency Transportation
3/2/2015 | 13-01530-137 | Summary |

Review of Alleged Misuse of VA Funds to Develop the Health Care Claims Processing System
3/2/2015 | 14-00730-126 | Summary |

Audit of VA's Financial Statements for Fiscal Years 2014 and 2013
11/12/2014 | 14-01504-32 | Summary|

OIG CHALLENGE #4: PROCUREMENT PRACTICE

Review of a Covered Drug Manufacturer's Interim Agreement under Letter Contract with VA's National Acquisition Center
9/30/2015 | 14-02899-415 | Summary |

Review of Land Purchase for the Replacement Hospital in Louisville, Kentucky
9/17/2015 | 14-02666-456 | Summary |

Review of Healthcare Services Contracts at VA Pittsburgh Healthcare System in Pittsburgh, Pennsylvania
8/7/2015 | 13-03592-443 | Summary |

Improper Use of Title 38 Section 8153 Contracts to Fund Educational Costs of the Graduate Medical Education Programs of Affiliated Schools of Medicine
7/7/2015 | 14-04259-409 | Summary |

Review of VA's Patient Centered Community Care (PC3) Contracts Estimated Costs Savings
4/28/2015 | 14-02916-336 | Summary|

Review of Allegations Regarding the Technical Acquisition Center's Award of Sole-Source Contracts to Tridec for the Virtual Office of Acquisition
12/8/2014 | 12-02387-59 | Summary |

Review of Alleged Mismanagement of VA's Office of Public and Intergovernmental Affairs Outreach Contracts
11/20/2014 | 13-01545-11 | Summary |

Audit of VHA's Support Service Contracts
11/19/2014 | 12-02576-30 | Summary |

Congressional Testimony 5/14/2015

Statement of Linda A. Halliday Assistant Inspector General For Audits And Evaluations Office of Inspector General Department of Veterans Affairs Before The Subcommittee On Oversight And Investigations Committee On Veterans' Affairs United States House Of Representatives Hearing On "Waste, Fraud, And Abuse In VA's Purchase Card Program" Read

Congressional Testimony 3/16/2015

Statement of Maureen T. Regan Counselor To The Inspector General Office Of Inspector General, Department of Veterans Affairs Before The Committee On Veterans' Affairs United States House of Representatives Hearing On "The Power Of Legislative Inquiry – Improving The VA By Improving Transparency" Read

Congressional Testimony 3/16/2015

Oral Statement of Maureen T. Regan Counselor to the Inspector General Office of Inspector General, Department of Veterans Affairs Before the Committee on Veterans' Affairs United States House of Representatives Hearing on "The Power of Legislative Inquiry- Improving the VA by Improving Transparency" Read

OIG CHALLENGE #5: INFORMATION MANAGEMENT

Review of Alleged Data Sharing Violations at VA's Palo Alto Health Care System

9/28/2015 | *14-04945-413* | *Summary* |

Follow-up Review of VA's Veterans Benefits Management System

9/14/2015 | *13-00690-455* | *Summary* |

Federal Information Security Management Act Audit for Fiscal Year 2014

5/19/2015 | *14-01820-355* | *Summary* |

Follow-up Audit of the Information Technology Project Management Accountability System

1/22/2015 | *13-03324-85* | *Summary* |

Review of Alleged Mismanagement at VHA's Massachusetts Veterans Epidemiology Research and Information Center

12/17/2014 | *14-00517-54* | *Summary* |

Congressional Testimony 11/18/2014

Statement of Sondra F. McCauley Deputy Assistant Inspector General For Audits And Evaluations Office of Inspector General Department of Veterans Affairs Before The Committee On Veterans' Affairs United States House Of Representatives Hearing On "VA's Longstanding Information Security Weaknesses Are Increasing Patient Wait Times And Allowing Extensive Data Manipulation" Read

High Risk Areas

High-Risk Areas Identified by the U.S. Government Accountability Office (GAO)

The U.S. Government Accountability Office (GAO) evaluates VA's programs and operations. In February 2015, GAO issued an update to its High-Risk Series (GAO-15-290). The GAO-identified High-Risk Areas (HRAs) that are specific to VA are summarized below. In response to each of the HRAs, the Department has provided the following:

- ***Estimated resolution timeframe (fiscal year)*** for VA to eliminate each HRA
- ***Responsible Agency Official*** for each HRA
- ***Completed 2015 milestones*** in response to the HRA
- ***Planned 2016 milestones*** along with ***estimated completion quarter***

High-Risk Area		Estimated Resolution Timeframe (Fiscal Year)	Page #
No.	Description		
GAO 1	**Managing Risks and Improving VA Health Care (VHA)**	**2016 - 2018**	**III-117**
GAO 2	**Improving the Management of IT Acquisitions and Operations (OIT)**	**Continuing Resolution**	**III-125**
GAO 3	**Improving and Modernizing Federal Disability Programs (VBA)**	**2016**	**III-127**
	Appendix		

GAO High Risk Area	1: Managing Risks and Improving VA Health Care (VHA)
GAO Write-up	Although VA has taken actions to address recommendations GAO has made related to VA health care, there are currently more than 100 that have yet to be fully resolved, including recommendations related to the five broad areas of concern highlighted in GAO's High Risk Series: 1.) *Ambiguous policies and inconsistent processes;* 2.) *Inadequate oversight and accountability; 3.) Information technology challenges;* 4.) *Inadequate training for VA staff; and* 5.) *Unclear resource needs and allocation priorities*. For example, to ensure that its facilities are carrying out processes at the local level more consistently—such as scheduling Veterans' medical appointments and collecting data on Veteran suicides—VA needs to clarify its existing policies. VA also needs to strengthen oversight and accountability across its facilities by conducting more systematic, independent assessments of processes that are carried out at the local level, including how VA facilities are resolving specialty care consults, processing claims for non-VA care, and establishing performance pay goals for their providers. GAO also recommended that VA work with DOD to address the administrative burdens created by the lack of interoperability between their two IT systems. A number of GAO's recommendations aim to improve training for staff at VA facilities, to address issues such as how staff are cleaning, disinfecting, and sterilizing reusable medical equipment, and to more clearly align training on VA's new nurse staffing methodology with the needs of staff responsible for developing nurse staffing plans. Finally, GAO has recommended that VA improve its methods for identifying VA facilities' resource needs and for analyzing the cost-effectiveness of VA health care. **Sub-part 1: Ambiguous policies and inconsistent challenges** Ambiguous VA policies lead to inconsistency in the way VA facilities carry out processes at the local level. In numerous reports, we have found that this ambiguity and inconsistency may pose risks for Veterans' access to VA health care, or for the quality and safety of VA health care they receive. For example, in December 2012, we reported that unclear policies led staff at VA facilities to inaccurately record the required dates for appointments, and to inconsistently track new patients waiting for outpatient medical appointments at VA facilities. These practices may have delayed the scheduling of Veterans' outpatient medical appointments and may have increased Veterans' wait times for accessing care at VA facilities. In some cases, we found that staff members were manipulating medical appointment dates to conform to VA's timeliness guidelines, which likely contributed further to the inaccuracy of VA's wait-times data for outpatient medical appointments. Without accurate data, VA lacks assurance that Veterans are receiving timely access to needed health care. In November 2014, we reported that VA policies lacked clear direction for how staff at VA facilities should document information about Veteran suicides as part of VA's behavioral health autopsy program (BHAP). The BHAP is a national initiative to collect demographic, clinical, and other information about Veterans who have died by suicide and use it to improve the department's suicide prevention efforts. In a review of a sample of BHAP records from five VA facilities, we found that more than half of the records had incomplete or inaccurate information. The lack of reliable data limits the department's opportunities to learn from past Veteran suicides and ultimately diminishes VA's efforts to improve its suicide prevention activities. We have also identified gaps in VA policies related to facilities' response to adverse events—clinical incidents that may pose the risk of injury to a patient as the result of a

GAO High Risk Area	1: Managing Risks and Improving VA Health Care (VHA)
	medical intervention or the lack of an appropriate intervention, such as a missed or delayed diagnosis, rather than due to the patient's underlying medical condition. Specifically, we found that VA policies were unclear as to how focused professional practice evaluations (FPPE) should be documented, particularly what information should be included. An FPPE is a time-limited evaluation during which a VA facility assesses a provider's professional competence when a question arises regarding the provider's ability to provide safe, quality patient care. In our December 2013 report, we reported that gaps in VA's FPPE policy may hinder VA facilities' ability to appropriately document the evaluation of a provider's skills, support any actions initiated, and track provider-specific incidents over time.
Estimated Resolution Timeframe	FY 2017
Responsible Official	Under Secretary for Health
Completed FY 2015 Milestones	On August 4, 2015, the Under Secretary for Health charged a workgroup to develop a plan and implement process changes to improve enterprise policy management in the Veterans Health Administration (VHA) and assist the field in developing appropriate local policies that align with national policies. This workgroup's efforts will serve to address High Risk Area 1, Ambiguous Policies and Inconsistent Process; and High Risk Area 2, Inadequate Oversight and Accountability, which are inextricably linked.
Planned FY 2016 Milestones	VHA will evaluate the overall requirements, existing documentation for policy making, implementation, and communication to create an assessment through consistent analysis (Q1). With key stakeholders, VHA will generate a prioritized list of VHA's top tier strategies to address GAO high risk areas based on a systematic and consistent methodology (Q1). Recommendations, including an implementation plan, will be completed and presented to VHA leadership for approval (Q2). VHA will assign responsibilities for the implementation of approved strategies. At minimum, elements of the implementation plan will include accountability for implementation, determination of any revised or additional response/mitigation strategies, and implementation of a consistent policy monitoring and reporting approach (Q2).

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 2: Inadequate Oversight and Accountability**
GAO Write-up	We also have found weaknesses in VA's ability to hold its health care facilities accountable and ensure that identified problems are resolved in a timely and appropriate manner. Specifically, we have found that (1) certain aspects of VA facilities' implementation of VA policies are not routinely assessed by the department; (2) VA's oversight activities are not always sufficiently focused on its facilities' compliance with applicable requirements; and (3) VA's oversight efforts are often impeded by its reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete. In a July 2013 report, for example, we reported that VA needed to take action to improve the administration of its provider performance pay and award systems. In that report, we found that VA had not reviewed performance goals set by its facilities for providers and, as a result, did not have reasonable assurance that the goals created a clear link between performance pay and providers' performance in caring for Veterans. At four VA facilities included in our review, performance pay goals covered a range of areas, such as clinical competence, research, teaching, patient satisfaction, and administration. Providers who were eligible for performance pay received it at all four of the facilities we reviewed, despite at least one provider in each facility having personnel actions taken against them related to clinical performance in the same year. Such personnel actions resulted from issues including failing to read mammograms and other complex images competently, practicing without a current license, and leaving residents unsupervised during surgery. In March 2014, we found that VA lacked sufficient oversight mechanisms to ensure that its facilities were complying with applicable requirements and not inappropriately denying claims for non-VA care. Specifically, the March 2014 report cited noncompliance with applicable requirements for processing a sample of non-VA emergency care claims. The noncompliance caused staff at four VA facilities to inappropriately deny about 20 percent of the claims we reviewed and to fail to notify almost 65 percent of Veterans whose claims we reviewed that their claims had been denied. We found VA's field assistance visits, one of the department's primary methods for monitoring facilities' compliance with applicable requirements, to be lacking. In these annual on-site reviews at a sample of VA facilities, VA officials were to examine the financial, clinical, administrative, and organizational functions of staff responsible for processing claims for non-VA care; however, we found that these visits did not examine all practices that could lead VA facilities to inappropriately deny claims. Further, although VA itself recommended that managers at its facilities audit samples of processed claims to determine whether staff processed claims appropriately, the department does not require VA facilities to conduct such audits, and none of the four VA facilities we visited were doing so. In a September 2014, report and in three previous testimonies for congressional hearings, we identified weaknesses in VA's oversight of Veterans' access to outpatient specialty care appointments in its facilities. VA officials told us they use data reported by VA facilities to monitor how the facilities are performing in meeting VA's guideline of completing specialty care consults—requests from VA providers for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure, such as a colonoscopy—within 90 days. We found cases where staff had incorrectly closed a consult even though care had not been provided, and found that VA does not routinely audit consults to assess whether its facilities are appropriately managing them and accurately documenting actions taken to resolve them. Instead, VA relies

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 2: Inadequate Oversight and Accountability**
	largely on facilities' self-certification that they are doing so.
Estimated Resolution Timeframe	FY 2017
Responsible Official	Under Secretary for Health
Completed FY 2015 Milestones	On August 4, 2015, the Under Secretary for Health charged a workgroup to develop a plan and implement process changes to improve enterprise policy management in the Veterans Health Administration (VHA) and assist the field in developing appropriate local policies that align with national policies. This workgroup's efforts will serve to address High Risk Area 1, Ambiguous Policies and Inconsistent Process; and High Risk Area 2, Inadequate Oversight and Accountability, which are inextricably linked.
Planned FY 2016 Milestones	VHA will evaluate the overall requirements, existing documentation for policy making, implementation, and communication to create an assessment through consistent analysis (Q1). With key stakeholders, VHA will generate a prioritized list of VHA's top tier strategies to address GAO high risk areas based on a systematic and consistent methodology (Q1). Recommendations, including an implementation plan, will be completed and presented to VHA leadership for approval (Q2). VHA will assign responsibilities for the implementation of approved strategies. At minimum, elements of the implementation plan will include accountability for implementation, determination of any revised or additional response/mitigation strategies, and implementation of a consistent policy monitoring and reporting approach (Q2).

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 3: Information Technology Challenges**
GAO Write-up	In recent reports, we also have identified limitations in the capacity of VA's existing information technology (IT) systems. Of particular concern is the outdated, inefficient nature of certain systems, along with a lack of system interoperability—the ability to exchange information—which presents risks to the timeliness, quality, and safety of VA health care. For example, we have reported on VA's failed attempts to modernize its outpatient appointment scheduling system, which is about 30 years old. Among the problems cited by VA staff responsible for scheduling appointments are that the system requires them to use commands requiring many keystrokes and does not allow them to view multiple screens at once. Schedulers must open and close multiple screens to check a provider's or a clinic's full availability when scheduling a medical appointment, which is time-consuming and can lead to errors. VA undertook an initiative to replace its scheduling system in 2000 but terminated the project after spending $127 million over 9 years, due to weaknesses in project management and a lack of effective oversight. The department has since renewed its efforts to replace its appointment scheduling system, including launching a contest for commercial software developers to propose solutions, but VA has not yet purchased or implemented a new system. In FY 2014, we reported that interoperability challenges and the inability to electronically share data across facilities led VA to suspend the development of a system that would have allowed it to electronically store and retrieve information about surgical implants (including tissue products) and the Veterans who receive them nationwide. Having this capability would be particularly important in the event that a manufacturer or the Food and Drug Administration (FDA) recalled a medical device or tissue product because of safety concerns. In the absence of a centralized system, VA clinicians track information about implanted items using stand-alone systems or spreadsheets that are not shared across VA facilities, which makes it difficult for VA to quickly determine which patients may have received an implant that is subject to a safety recall. Further, as we have reported for more than a decade, VA and the DOD lack electronic health records systems that permit the efficient electronic exchange of patient health information as military servicemembers transition from DOD to VA health care systems. The two departments have engaged in a series of initiatives intended to achieve electronic health record interoperability, but accomplishment of this goal has been continuously delayed and has yet to be realized. The ongoing lack of electronic health record interoperability limits VA clinicians' ability to readily access information from DOD records, potentially impeding their ability to make the most informed decisions on treatment options, and possibly putting Veterans' health at risk. One location where the delays in integrating VA's and DOD's electronic health records systems have been particularly burdensome for clinicians is at the Captain James A. Lovell Federal Health Care Center (FHCC) in North Chicago, the first planned fully integrated federal health care center for use by both VA and DOD beneficiaries. We found in June 2012 that due to interoperability issues, the FHCC was employing five dedicated, full-time pharmacists and one pharmacy technician to conduct manual checks of patients' VA and DOD health records to reconcile allergy information and identify possible interactions between drugs prescribed in VA and DOD systems.
Estimated Resolution Timeframe	FY 2016 - 2018

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 3: Information Technology Challenges**
Responsible Official	Under Secretary for Health
General Statement VHA	VA Information Systems Technology Architecture (VistA) Evolution (VE) is the joint VHA-OIT program chartered to improve interoperability of clinical information systems, to promote quality and efficiency of health care, and to improve the acquisition of information management capabilities. It manages modernization of the healthcare components of current VistA. The modernized collection of these products is called VistA 4, which will be completed in FY 2018. By the end of 2016, in accordance with the 2014 National Defense Authorization Act (NDAA), VistA 4 will include many improvements that allow interoperability of health care information. Its major product is the Enterprise Health Management Platform (eHMP), which is a platform built around VHA's current Electronic Health Record.
Completed FY 2015 Milestones	The VE program team stood up an integrated program management office (PMO), delivering eHMP version 1.2, which allows clinicians and managers to view and act on a complete longitudinal picture of patients with data from all VA locations, DoD, and eventually the community. VA made significant progress in electronic exchange of patient health information through ongoing partnerships with federal and community partners. VA Lifetime Electronic Record (VLER) Health, also known as the Veterans Health Information Exchange (VHIE), provides bidirectional exchange of Health Information with private sector and some Federal partners. VHIE doubled the number of partners to 59 total, reaching 600 plus hospitals nationwide. Monthly rates of VHIE clinical adoption transactions and required Veteran's authorizations both increased by 400 percent. In addition, VA and DoD exchanged over 40 million requests for patient information back and forth through to support direct patient care, which is in line with the previous year. Most importantly, VHA now has information systems that provide an advanced level of interoperability for clinical use through the Joint Legacy Viewer (JLV) and eHMP. JLV is a clinical information viewer that collects into memory a patient's data and presents it as a single longitudinal record, and is a product of collaboration with the Defense Health Agency (DHA) and Defense Medical Information Exchange (DMIX). In FY 2015 there were three releases of the JLV application each closing additional interoperability gaps, standardizing more data domains and providing a continually more powerful tool to staff in both Departments. VA JLV users grew more than 13-fold from the start of FY 2015 to the end of Q3 FY 2015.
Planned FY 2016 Milestones	VE will begin testing eHMP v 1.3 in select sites (Q2). Milestones relevant to clinicians and patients include: national availability of eHMP v1.3 and transition of part of the clinical JLV user community to this product; beginning of testing of eHMP 2.0, which will include much of the basic capabilities required for outpatient primary care and consults; VistA scheduling enhancements; delivery of capability to natively capture structured data for many outpatient functions; delivery of VistA Immunization Management Module 2.0; and mapping of clinically relevant data domains to national standards to meet 2014 NDAA requirements (Q4). VHA looks forward to opportunities to consult with GAO to refine FY 2016 goals.

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 4: Inadequate Training for VA Staff**
GAO Write-up	In a number of reports, we have identified gaps in VA training that could put the quality and safety of Veterans' health at risk. In other cases, we have found that VA's training requirements can be particularly burdensome to complete, particularly for VA staff who are involved in direct patient care. In a November 2014 report that examined VA's monitoring of Veterans with major depressive disorder (MDD) and whether those who are prescribed an antidepressant receive recommended care, we determined that VA data may underestimate the prevalence of major depressive disorder among Veterans and that a lack of training for VA clinicians on diagnostic coding may contribute to the problem. In a review of medical record documentation for a sample of Veterans, we found that VA clinicians had not always appropriately coded encounters with Veterans they diagnosed as having MDD, instead using a less specific diagnostic code for "depression not otherwise specified." VA's data on the number of Veterans with MDD are based on the diagnostic codes associated with patient encounters; therefore, coding accuracy is critical to assessing VA's performance in ensuring that Veterans with MDD receive recommended treatments, as well as measuring health outcomes for these Veterans. In a May 2011 review, we found that training for staff responsible for cleaning and reprocessing reusable medical equipment (RME), such as endoscopes and some surgical instruments, was lacking. Specifically, VA had not specified the types of RME for which training was required; in addition, VA provided conflicting guidance to facilities on how to develop this training. Without appropriate training on reprocessing, we found that VA staff may not be reprocessing RME correctly, posing patient safety risks. In our October 2014, report on VA's implementation of a new, nationally standardized nurse staffing methodology, staff from selected VA facilities responsible for developing nurse staffing plans reported that VA's individual, computer-based training on the methodology was time-consuming to complete and difficult to understand. These staff members said they had difficulty finding the time to complete it while also carrying out their patient care responsibilities. Many suggested that their understanding of the material would have been greatly improved with an instructor-led, group training course where they would have an opportunity to ask questions.
Estimated Resolution Timeframe	FY 2017
Responsible Official	Under Secretary for Health
Completed FY 2015 Milestones	VHA governance committees and workforce programs analyzed GAO reports and developed an action plan to address cited concerns and recommend the establishment of an enterprise learning system that identifies learning requirements aligned with the organizational strategies; allocates appropriate resources; evaluates return on investment; and provides oversight and authority to enforce VHA education and make decisions on national educational initiatives and requirements. VHA eliminated or deferred over 31,900 burdensome mandatory training assignments for physicians, nurse practitioners and physician assistants to allow them to focus on direct clinical care. New VA/VHA rules and guidance were administered in Quarter 1 of FY 2015 to streamline professional training conference planning, approval, oversight, and reporting processes. As a result of the changes in FY 2015, two to three times the number of VHA clinicians have been able to attend VA-sponsored and non-VA sponsored conferences. This provides clinicians the

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 4: Inadequate Training for VA Staff**
	opportunity to attend trainings that maintain clinical licensure and supports clinical competence.
Planned FY 2016 Milestones	VHA governance committees will engage and collaborate with workforce programs to define requirements and a way forward (Q1). VHA will develop and submit requirements for the financial system (Q2). VHA will develop an implementation plan (Q2) for the Under Secretary for Health's approval by (Q3) to establish an enterprise learning system for piloting and implementation in FY 2017 including national training policies and processes for setting national standards, accountability, vetting, and leveraging processes. VHA looks forward to opportunities to consult with GAO to refine FY 2016 goals.

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 5: Unclear resource needs and allocation priorities**
GAO Write-up	In many of our reports, we have found gaps in the availability of data required by VA to efficiently identify resource needs and to ensure that resources are effectively allocated across the VA health care system. For example, in October 2014, we reported that VA facilities lacked adequate data for developing and executing nurse staffing plans at their facilities. Staffing plans are intended to help VA facilities identify appropriate nurse staffing levels and skill mixes needed to support high-quality patient care in the different care settings throughout each VA facility, and are used to determine whether their existing nurse workforce sufficiently meets the clinical needs of each unit, or whether they need to hire additional staff. At selected VA facilities, staff responsible for developing and executing the nurse staffing plans told us that they needed to use multiple sources to collect and compile the data in some cases manually. They described the process as time-consuming, potentially error-prone, and requiring data expertise they did not always have. In a May 2013 report, we reported that VA lacked critical data needed to compare the cost-effectiveness of non-VA medical care to that of care delivered at VA facilities. Specifically, VA lacks a data system to group medical care delivered by non-VA providers by episode of care all care provided to a Veteran during a single office visit or inpatient stay. As a result, VA cannot efficiently assess whether utilizing non-VA providers is more cost-effective than augmenting its own capacity in areas with high non-VA health care utilization. In a September 2014 report, we identified concerns with VA's management of its pilot dialysis program, which had been implemented in four VA-operated clinics. Specifically, we found that, five years into the pilot, VA had not set a timetable for the completion of its dialysis pilot or documented how it would determine whether the pilot was successful, including improving the quality of care and achieving cost savings. We also found that VA data on the quality of care and treatment costs were limited due to the delayed opening of two of the four pilot locations. Veterans who receive dialysis are one of VA's most costly populations to serve, but VA has limited capacity to deliver dialysis in its own facilities, and instead refers most Veterans to non-VA providers for this treatment. VA began developing its dialysis pilot program in FY 2009 to address the increasing number of Veterans needing dialysis and the rising costs of providing this care through non-VA providers.

GAO High Risk Area	**1: Managing Risks and Improving VA Health Care (VHA)** **Sub-part 5: Unclear resource needs and allocation priorities**
Estimated Resolution Timeframe	FY 2018
Responsible Official	Under Secretary for Health
Completed FY 2015 Milestones	The Under Secretary for Health implemented the Integrated Clinical Program Review (ICPR) process to assess clinical and business objectives associated with a discrete group of cohesive Integrated Clinical Practice Teams. The ICPR process represents a functional reorientation of strategy, resource planning, and execution. These teams will synchronize with the Federal Program Inventory.
Planned FY 2016 Milestones	ICPR teams will be developed that foster vertical and horizontal integration across the organization (Q1). ICPR teams will develop approved business plans that describe key clinical and business outcomes (Q2). Business plans will be used to determine business priorities and future year allocations (Q3).

GAO High Risk Area	**2: Improving the Management of IT Acquisitions and Operations (OIT)**
GAO High Risk Area	Failed IT projects often suffer from a lack of disciplined and effective management, such as project planning, requirements definition, and program oversight and governance. In many instances, agencies have not consistently applied best practices that are critical to successfully acquiring IT investments. GAO has identified nine critical factors underlying successful major acquisitions that support the objective of improving the management of large-scale IT acquisitions across the federal government: (1) program officials actively engaging with stakeholders; (2) program staff having the necessary knowledge and skills; (3) senior department and agency executives supporting the programs; (4) end users and stakeholders involved in the development of requirements; (5) end users participating in testing of system functionality prior to end user acceptance testing; (6) government and contractor staff being stable and consistent; (7) program staff prioritizing requirements; (8) program officials maintaining regular communication with the prime contractor; and (9) programs receiving sufficient funding. GAO has identified two ongoing investments at VA with significant issues requiring attention: • The DOD and VA electronic health records initiative is intended to share data among the departments' health information systems, but achieving this has been a challenge for these agencies over the last 15 years. In March 2011, the Secretaries of DOD and VA committed their two departments to developing a new, common, integrated electronic health record, and in May 2012 announced their goal of implementing it across the departments by 2017. The departments estimated the life-cycle cost of this effort at about $25 billion. However, as GAO noted, the Secretaries announced in February 2013 that instead of developing a new common, integrated electronic health record system, the departments would focus on integrating health records from separate DOD and VA systems. VA has stated that it will continue to modernize its existing system while pursuing the integration of health data, while DOD announced in May 2013 that it planned to purchase a commercial, off-the-shelf product. The Secretaries offered several reasons for this new direction, including cutting costs, simplifying the problem of integrating DOD and VA health data, and meeting the needs of Veterans and Servicemembers sooner rather than later. Nevertheless, the Departments' recent change in the program's direction and history of challenges in improving their health information

GAO High Risk Area	2: Improving the Management of IT Acquisitions and Operations (OIT)
	systems heighten concern about whether this latest initiative will be successful. • VA has invested significant resources into developing a system for outpatient appointment scheduling, but these efforts have faced major setbacks. The department terminated its previous scheduling system project in September 2009, after spending an estimated $127 million over 9 years. The investment was to modernize VA's more than 25-year-old outpatient scheduling system, but the department had not yet implemented any of the planned system's capabilities before terminating the project. On October 1, 2009, VA began a new initiative that it refers to as HealtheVet Scheduling. In May 2010, we reported that VA's efforts to successfully complete the Scheduling Replacement Project were hindered by weaknesses in several key project management disciplines and a lack of effective oversight that, if not addressed, could undermine the department's second effort to replace its scheduling system. GAO recommended that, as the department proceeded with future development, it take actions to improve key processes, including acquisition management, system testing, and progress reporting, which are essential to the department's second outpatient scheduling system effort.
Estimated Resolution Timeframe	Continuing Resolution
Responsible Official	Assistant Secretary for Information Technology
Completed FY 2015 Milestones	OI&T continues to use program management principles and practices to ensure the involvement of stakeholders and users in the key acquisition processes for IT investments. Specifically, VA program managers actively engage with stakeholders through established Integrated Project Teams (IPTs) and OI&T and VA executive leadership (to include VA Deputy Secretary) reviews that provide oversight and guidance (VistA Evolution is reviewed weekly). For Medical Appointment Scheduling System (MASS) and VistA Evolution, there is active IPT representative engagement in acquisition, development, and evaluation of offerors' proposals. The VHA Access and Clinical Administration Program prioritizes all functional requirements for MASS. The VistA Evolution Executive IPT, which includes representatives from VHA, OI&T and the Interagency Program Office, prioritizes all functional requirements for VistA Evolution. The Departments of Defense and Veterans Affairs agreed to focus efforts on the exchange of health care information as a viable alternative allowing each Department to pursue separate courses of modernization for their electronic health records. End users and stakeholders are actively involved in the development of requirements and participating in testing system functionality. MASS program end users were involved in developing requirements for the MASS acquisition and evaluating offeror proposals. For VistA Evolution, business stakeholders provide business requirements and are involved in developing and approving all requirements specifications for acquisitions. Likewise, MASS and VistA Evolution end-users are included in testing activities for all end-user facing capabilities. To ensure appropriate program staff have the necessary skills, MASS and VistA Evolution assigned leadership have Federal Acquisition Certification Program/Project Manager senior certification credentials. Both programs have stable government project staff and mechanisms are in place to ensure quality and timeliness of contractor deliverables regardless of contractor staff. VistA Evolution program leadership maintains regular communication with prime contractors. **MASS Completed Milestones for FY15**: MASS Request for Proposal released November 19, 2014; proposals received January 9, 2015; Final Source Selection briefing occurred May 18, 2015; and briefing to the Deputy Secretary occurred June 17, 2015. MASS Award/Execution is pending. **VistA Evolution Completed Milestones for FY15:** Feature Set 1 completed September 30, 2014;

GAO High Risk Area	2: Improving the Management of IT Acquisitions and Operations (OIT)
	and Feature Set 2 completed September 30, 2015.
Planned FY 2016 Milestones	**MASS Planned Milestones for FY15:** Complete Pilot Implementation Plan, receive leadership approval for pilot implementation in Q1FY16; start requirements gathering, analysis, and pre-assessment; start design and approvals in Q2FY16; complete design and approvals; complete requirements gathering, analysis, and pre-assessment in Q3FY16; receive approval to start development; and begin development and pilot implementation in Q4FY16. **VistA Evolution Completed Milestones for FY16:** feature Set 3 deliverables: FileMan Modernization in Q1FY16; enhancements to Pharmacy National Deployment in Q2FY16; VistA Service Assembler Infrastructure Build Out in Q3FY16; enhancements to Electronic Health Management Platform (eHMP); Interoperable Electronic Health Record (EHR); VistA Scheduling Enhancements (VSE); VistA Immunization (VIMM) Enhancements; and API Exposure, 2.0 in Q4FY16.

GAO High Risk Area	3: Improving and Modernizing Federal Disability Programs (VBA)
GAO Write-up	Federal disability programs across government remain fragmented and in need of modernization. Numerous federal programs provide a patchwork of services and supports to people with disabilities, and work independently without a unified vision and strategy or set of goals to guide their outcomes. Further, three of the largest disability benefit programs—managed by the Social Security Administration (SSA) and the Department of Veterans Affairs (VA) —rely on outdated criteria to determine whether individuals should qualify for benefits. Although SSA and VA have undertaken efforts to update their criteria, aspects of their programs continue to emphasize medical conditions when assessing an individual's ability to work without sufficient consideration of improvements offered by advances in medicine, technology, or changes in the modern work environment. Moreover, these programs may continue to face growing disability claims workloads resulting in part from individuals with disabilities leaving the workforce during a difficult economic recovery and from Servicemembers returning from war. These workload challenges are likely to persist, notwithstanding SSA and VA efforts to process more claims. Beginning in 2009 and continuing after GAO's 2013 update, VA has made progress in updating the criteria it uses for rating disability, and has developed project plans and identified resources to help ensure its efforts are successful. However, some of its plans have yet to be tested. VA made progress updating its disability ratings, but has yet to finalize and implement initial revisions. VA's plans to conduct regular updates of its ratings every 10 years are relatively new and its plans to ensure sufficient capacity going forward are still in process. As such, it will take time to determine whether VA's efforts to date are sufficient. VA will need to continue to closely monitor its progress and to seek additional capacity as needed. Continued leadership focus is needed on VA's appeals backlog. Specifically, VA should continue to develop plans to reform and streamline its appeals process, and to accurately monitor its workload across components, including monitoring the effect that increased claims decisions have on appeals workloads.
Estimated Resolution Timeframe	2016

GAO High Risk Area	**3: Improving and Modernizing Federal Disability Programs (VBA)**
Responsible Official	Acting Undersecretary for Benefits
Completed FY 2015 Milestones	In FY 2015, VBA continued to execute its claims transformation plan, the aim of which is to change the way it delivers benefits and services to Veterans, their families, and survivors for generations to come. VBA continues to leverage the capabilities of its electronic applications (e.g., the Veterans Benefits Management System (VBMS) and the Veterans Relationship Management (VRM)) by adding increased functionality. As of September 30, 2015, VBA went from touching 5,000 tons of paper annually to processing 99.8 percent of disability compensation claims electronically. There are 342,000 claims in the electronic inventory and only 21,000 pension and dependency and indemnity compensation (DIC) claims in paper. VBA has completed 3.7 million rating decisions and over 2 million claims in VBMS. Due to VBA's extensive outreach efforts, more Veterans are using the joint Department of Defense (DoD)/VA web portal eBenefits to interact with VBA. Veterans can now file claims online through eBenefits. Additionally, the Stakeholder Enterprise Portal, an electronic web portal that mirrors eBenefits, allows VA partners and Veterans Service Organizations (VSOs) to electronically file claims for benefits and services on behalf of Veterans they represent. These actions and initiatives support VBA's efforts to improve the timeliness and accuracy of claims processing. With the growing number of appeals and current legislative structure, VA cannot efficiently serve Veterans in the appeals process. VA's *Strategic Plan to Transform the Appeal Process*, which was submitted to the Senate Committee on Veterans' Affairs in February 2014, focuses on employee training, tools, and assignment of work; streamlining the appeal process; and implementing modern technology solutions in systems that are under development. However, VA cannot fully transform its appeal process without stakeholder support for resources and legislative reform. In 2015, ROs implemented an Appeals Checklist to ensure employees adhered to proper procedures when certifying and transferring jurisdiction of appeals to the Board of Veterans' Appeals (the Board) and shipping files to the Veterans Claims Intake Program for scanning into VBMS. In addition, effective March 25, 2015, VA requires claimants to file notices of disagreement on a standard form. VBA has made significant process towards eliminating the claims backlog and improving accuracy. As of September 30, 2015, VBA: • Reduced backlog from peak of 611,073 in March 2013 to 71,352, an 88.3-percent reduction in 30 months – lowest since VBA started measuring the backlog. • Reduced inventory from peak of 883,930 in July 2012 to 363,034, a 58.9-percent reduction. The lowest level since 2008. • Increased claim-level accuracy from 83 percent in June 2011 to 90.7 percent; at the issue-level, accuracy is 96.3 percent. • Completed a record-breaking 1.4 million claims in FY 2015. • Veterans with a pending claim are waiting an average of 189 days less for a claim decision, from peak of 282 days in March 2013 to 93 days. VBA improved the availability and accessibility of claims processing policy and procedural guidance by consolidating them into a single web portal, the Compensation and Pension Knowledge Management Portal. The M21-1, or "Live Manual," is an integrated, up-to-date resource that incorporates into one authoritative source existing guidance previously found in various locations.

GAO High Risk Area	3: Improving and Modernizing Federal Disability Programs (VBA)
	VBA continued to make progress with updating the VA Schedule for Rating Disabilities (VASRD). In FY 2015, VBA published the following five body systems as proposed regulations in the Federal Register: Hemic and Lymphatic, Gynecological and Breast, Eye, Endocrine, and Dental/Oral. VBA continued to provide Quality Review Team (QRT) challenge sessions for new QRT members to promote uniformity. VBA conducted 22 consistency studies during the fiscal year to provide individual computer-based training on high-error subjects to persons who did not pass a pre-test. In addition, VBA conducted monthly quality calls that focused on both authorization and rating issues, also allowing participants to receive training, discuss error trends, and other technical topics. VBA also refined its Systematic Technical Accuracy Review (STAR) sampling methodology to account for claims production and processing accuracy at each RO to determine sample size. VBA no longer excludes claims from the sample based upon a change of jurisdiction. Instead, VBA samples completed work according to the RO that completed the claim. This change, which began in February 2015, ensures that VBA's quality review sample includes brokered claims. Further, VBA now calculates and reports the margin of error for its accuracy data. The Private Medical Record (PMR) Program, which uses contractors to obtain private treatment records, was deployed nationally in November 2014. Upon implementation, the program was fully integrated with the Centralized Mail (CM) program, which resulted in VBA receiving all of its responses electronically. Since national deployment and the implementation of optimized changes in August 2015, the PMR program has processed over 148,000 requests, with the average request pending less than 11 days. VBA continues to develop an upfront income verification process by expanding the data sharing agreement with Social Security Administration (SSA) that enables VBA to electronically and securely receive federal tax information. Once VBA receives a claim for a total evaluation based upon individual employability (TDIU), VBA will request the reported employment wages through the SSA portal and receive a response within 10 to16 days. This process will more efficiently and timely provide VBA with income data and maintain the integrity of the TDIU program while reducing improper payments. In FY 2015, VBMS completed three major and eleven minor releases, which included: • New rating evaluation builders • Enhanced mapping and pre-population of additional Disability Benefits Questionnaire data into rating calculators • Enhancements to claim establishment, development, rating, and awards functionality • Standardized correspondence to Veterans and/or third party representatives VBMS continues to reduce reliance on legacy computer applications, reduce processing time, and improve accuracy by increasing consistency. In addition, VBMS delivered National Work Queue (NWQ) functionality in support of a national paperless workload management initiative that will be deployed to all ROs in November 2015. Some of the VBMS functionalities that will support the NWQ include the Command Center, a robust deferral process, automatic routing of claims to ROs, and enhanced automatic assignment features within the RO.

GAO High Risk Area	3: Improving and Modernizing Federal Disability Programs (VBA)
	VBA continued to make progress in simplifying burial benefit payments. VBA finalized the business requirements for automating plot/interment payments. In addition, VBA completed implementation of VBMS awards functionality for DIC and pension claims. In September 2015, VBA began a pilot program to process burial and accrued awards in VBMS. After successful validation, VBA will deploy this functionality to the Pension Management Centers. The Enterprise Veterans Self-Service (EVSS) is one element of VRM that supports the long-term vision of VA, providing information and services by conveniently and seamlessly interacting with Veterans, Servicemembers, VSOs, and the community of VA business partners and stakeholders. EVSS streamlines access to self-service capabilities (such as eBenefits, viewing claim and appeals status, electronically chatting with VBA public contact personnel, and electronically submitting forms) and provides a fully-functional and secure entry point to VA's web-based systems. In FY 2015, EVSS deployed four major releases that provided multiple enhancements and/or new features.
Planned FY 2016 Milestones	Increased VBMS functionality will help reduce reliance on legacy systems, support integration with DoD, improve electronic communications, and provide Veterans access to their eFolder. (Q4) VBA and the Board will continue to partner on training throughout FY 2016 to increase efficiencies in appeals processing. Active engagement with stakeholders, including VSOs and Congress, on ways to further modernize the VA appeals process will also continue in FY 2016. (Q4) VBA expects to publish the proposed rules for the remaining VASRD body systems by the end of FY 2016. (Q4) VBA will continue to use consistency studies, QRT training sessions, and monthly quality calls to provide training and address error trends, urgent issues, and technical concerns. (Q4) The PMR program will continue to focus on process improvements, including working with larger healthcare networks to provide records more timely, further streamlining the CM process, and automatically sending record requests received through e-Benefits to the PMR vendor for completion. (Q4) VBA will implement the upfront verification of wages for TDIU claimants, as well as begin annual eligibility reviews of the wages for Veterans already receiving TDIU. (Q2) VBA will implement the post-award audit process to replace the former income verification match, ensuring that those receiving pension benefits maintain their eligibility. (Q2) VBA will automatically suspend awards by utilizing information received from the SSA death match. (Q3) VBA will begin to release the NWQ in a phased rollout to all ROs in early FY 2016. The NWQ is a paperless workload management initiative designed to improve VBA's overall productive capacity by allowing VBA to prioritize and distribute workload across the ROs. NWQ will allow VBA to achieve the following: • Standardize workload management best practices • Match work assignments with VBA capacity and resources • Increase output by identifying and routing actionable claims to ROs • Identify rework trends to identify and rectify training gaps

GAO High Risk Area	3: Improving and Modernizing Federal Disability Programs (VBA)
	VBA expects NWQ to positively impact quality using its diagnostic tool and the trends gathered from its robust deferral process. VBMS Major Release 9.1, which will implement a phased rollout of the NWQ at the first eight ROs, will be deployed in October 2015. In November 2015, VBA will deploy NWQ to all remaining VBA ROs. (Q1) VBA will automate the payment of plot/interment allowances. (Q1) After successful validation, VBA will deploy VBMS functionality for processing accrued and burial claims to the Pension Management Centers. (Q1) VBA will deploy EVSS updates every two months to rapidly provide more agile development and deliver new features. (Q4)

Abbreviations and Acronyms

ACA
Affordable Care Act

ACSI
American Customer Satisfaction Index

AD
Academic Detailing

ADA
Anti-Deficiency Act

AFGE
American Federation of Government Employees

AFR
Agency Financial Report

ALAC
Administrative and Loan Accounting Center

ALS
Amyotrophic Lateral Sclerosis

AMAS
Automated Monument Application System

AMC
Appeals Management Center

APA
Administrative Procedures Act

APG
Agency Priority Goal

ARRA
American Recovery and Reinvestment Act of 2009

BDD
Benefits Delivery at Discharge

BDN
Benefits Delivery Network

BFFS
Beneficiary Fiduciary Field System

BHAP
Behavioral Health Autopsy Program

BHIE
Bi-Directional Health Information Exchange

BOSS
Burial Operations Support System

BPA
Blanket Purchase Agreement

BPEB
Benefits Portfolio Executive Board

BPSC
Benefits Portfolio Steering Committee

BRD
Business Requirement Document

BTP
Beneficiary Travel Program

BTT
Budget Tracking Tool

BVA
Board of Veterans' Appeals

C&A
Certification and Accreditation

C&P
Compensation and Pension

CAATS
Centralized Automated Accounting Transaction System

CAMS
Capital Asset Management System

CAP
Combined Assessment Program

CARES
Capital Asset Realignment for Enhanced Services

CBO
Chief Business Office

CBOC
Community-Based Outpatient Clinic

CFS
Consolidated Financial Statements

CHAMPVA
Civilian Health and Medical Program of the Department of Veterans Affairs

CIP
Critical Infrastructure Program

CIO
Chief Information Officer

CLA
Clifton Larson Allen LLP

CLC
Community Living Center

CM
Centralized Mail

CMOP
Consolidated Mail Outpatient Pharmacy

CMS
Centers for Medicare and Medicaid Services

CO
Contracting Officer

COLA
Cost of Living Adjustment

COOP Continuity of Operations Plan

COR
Contracting Officer Representative

COTS
Commercial Off-the-Shelf

COVERS
Control of Veterans Records System

CPGI
Clinical Practice Guideline Index

CPEP
Compensation and Pension Examination Program

CRC
Colorectal cancer

CRISP
Continuous Readiness in Information Security Program

CRMS
Customer Relationship Management System

CSRS
Civil Service Retirement System

CVT
Clinical Video Telehealth

CLA
Clifton Larson Allen LLP

DATA Act
Digital Accountability and Transparency Act of 2014

DBQ
Disability Benefits Questionnaire

DMC
Debt Management Center

DIC
Dependency and Indemnity Compensation

DMDC
Defense Manpower Data Center

DoD
Department of Defense

DOOR
Distribution of Operational Resources

DRO
Decision Review Officer

DSS
Decision Support Service

EA
Enterprise Architecture

eCMS
Electronic Contact Management System

ECST
Enterprise Cybersecurity Strategy Team

EFT
Electronic Funds Transfer

E-GOV
Electronic Government

eHMP
Enterprise Health Management Platform

EHR
Electronic Health Record

EP
End Products

ERM
Enterprise Risk Management

EVD
Ebola Virus Disease

ETS2
E-Gov Travel Service 2

EVM
Earned Value Management

EVR
Eligibility Verification Reports

EVSS
Enterprise Veterans Self Service

EWL
Electronic Wait List

DMIX
Defense Medical Information Exchange

F&FE
Fiduciary and Field Examination

FAR
Federal Acquisition Regulations

FASAB
Federal Accounting Standards Advisory Board

FASB
Financial Accounting Standards Board

FBCS
Fee Basis Claims System

FDC
Fully Developed Claims

FECA
Federal Employees' Compensation Act

FERS
Federal Employees Retirement System

FFMIA
Federal Financial Management Improvement Act

FFS
Federal Financial System

FHHC
Federal Health Care Center

FHIE
Federal Health Information Exchange

FISCAM
Federal Information Systems Control Audit Manual

FISMA
Federal Information Security Management Act

FMFIA
Federal Managers' Financial Integrity Act

FMS
Financial Management System

FMTC
Financial Management Training Conferences

FOBT
Fecal Occult Blood Test

FPDS-NG
Federal Procurement Data System – Next Generation

FPPE
Focused Professional Practice Evaluation

FRPC
Federal Real Property Council

FSC
Financial Services Center

FSSI
Federal Strategic Sourcing Initiative

FTE
Full-time Equivalent

FTF
Freeze the Footprint

FY
Fiscal Year

GAAP
Generally Accepted Accounting Principles

GAO
Government Accountability Office

GPD
Grant Per Diem

GPO
Government Printing Office

GPRA
Government Performance and Results Act

GRC
Governance, Risk and Compliance

GSO
Government Services Online

GTAS
Government-wide Treasury Account Symbol Adjusted Trial Balance System

HAC
Health Administration Center

HCIP
Human Capital Investment Plan

HCN
Health Care Network

HHS
Health and Human Services

HIPAA
Health Information Portability and Accountability Act

HR
Human Resources

HRA
Human Resources & Administration

HRC
Health Resource Center

HRPP
Human Research Protection Program

HUD
Housing and Urban Development

HUD-VASH
HUD-VA Supportive Housing

HVA
High Value Assets

I CARE
Integrity Commitment Advocacy Respect Excellence

IA
Interagency Agreement

ICU
Intensive Care Unit

IDES
Integrated Disability Evaluation System

iEHR
Integrated Electronic Health Record

IHS
Indian Health Service

IOC
Indicators of Compromise

IPERA
Improper Payments Elimination and Recovery Act

IPIA
Improper Payment Information Act of 2002

IPO
Interagency Program Office

IPPS
Invoice Payment Processing System

IPRO
Improper Payments Remediation and Oversight

IRS
Internal Revenue Service

ISA
Interconnection Security Agreements

ISO
Information Security Officers

IT
Information Technology

IVM
Income Verification Match

IVR
Interactive Voice Response

IWT
Instructor Web-based Training

JFMIP
Joint Financial Management Improvement Program

JLV
Joint Legacy Viewer

KM
Knowledge Management

LGY
Loan Guaranty

LTC
Long-Term Care

MASSI
Medical Appointment Scheduling System

MCCF
Medical Care Collections Fund

MCO
Mission Critical Occupations

MEDD
Morphine Equivalent Daily Dose

MinX
Management Information Exchange

VLER
Virtual Lifetime Electronic Record

MMC
Major Management Challenge

MMC
Mobile Medical Center

MMWR
Monday Morning Workload Report

MOU
Memorandum of Understanding

MS&C
Medical Support and Compliance

MSN
Memorial Service Network

MSO
Military Service Organization

MTF
Military Treatment Facility

NAC
National Acquisition Center

NAGE
National Association of Government Employees

NCA
National Cemetery Administration

NCCHV
National Call Center for Homeless Veterans

NDAA
National Defense Authorization Act

NDMS
National Disaster Medical System

NIST
National Institute of Standards and Technology

NOD
Notice of Disagreement

NOFA
Notice of Funding Availability

NRP
National Response Plan

NSOC
Network and Security Operations Center

NTGB
National Telehealth Governance Board

NVC
Non-VA Medical Care

NWQ
National Work Queue

OAEM
Office of Asset Enterprise Management

OAI
Organizational Assessment and Improvement

OALC
Office of Acquisition, Logistics, and Coordination

OBC
Office of Business Continuity

OBO
Office of Business Oversight

OBPI
Office of Business Process Integration

OC
Operations Center

OCR
Office of Contract Review

OEF/OIF/OND
Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn

OGC
Office of General Counsel

OIG
Office of Inspector General

OIT
Office of Information and Technology

OLCS
On Line Certification System

OM
Office of Management

OMB
Office of Management and Budget

OMS
Overutilization Safety Initiative

OPIA
Office of Public and Intergovernmental Affairs

OPM
Office of Personnel Management

OSI
Opioid Safety Initiative

OWCP
Office of Workers' Compensation Program

P&LO
Procurement & Logistics Office

PACT
Patient Aligned Care Team

PAID
Personnel and Accounting Integrated Data

PAR
Performance and Accountability Report

PBO
PMAS Business Office

PC3
Patient Centered Community Care

PCP
Primary Care Provider

PII
Personally Identifiable Information

PIP
Prosthetics Inventory Package

PIT
Point in Time

PIV
Personal Identity Verification

P.L.
Public Law

PMAS
Program Management Accountability System

PMC
Pension Maintenance Center

PMP
Project Management Plan

PMR
Private Medical Record

POA&M
Plans of Actions & Milestones

PPBE
Planning, Programming, Budgeting and Execution

PP&E
Property, Plant & Equipment

PPA
Prompt Payment Act

PPO
Program Planning and Oversight

PSC
Prosthetic Service Card

PTSD
Post-Traumatic Stress Disorder

QA
Quality Assurance

QRT
Quality Review Team

RBPS
Rules Based Processing System

RIN
Regulation Identification Number

RO
Regional Office

RPO
Regional Processing Office

RVSR
Rating Veterans Service Representative

RVU
Relative Value Unit

SAC-F
Strategic Acquisition Center - Frederick

SAH
Specially Adapted Housing

SAM
Strategic Asset Management

SAO
Systematic Analysis of Operations

SBA
Small Business Administration

SCA
Security Control Assessment

SCAN-ECHO
Specialty Care Access Network-Extension for Community Healthcare Outcomes

SCI
Spinal Cord Injury

SCIP
Strategic Capital Investment Plan

SCIP SAT
Strategic Capital Investment Plan Automated Tool

SCS
Specialty Care Services

SDR
Service Delivery and Engineering

SDVOSB
Service Disabled Veteran Owned Small Business

SECVA
Secretary, Veterans Affairs

SEP
Stakeholder Enterprise Portal

SES
Senior Executive Service

SFFAS
Statement of Federal Financial Accounting Standards

SGLI
Servicemembers' Group Life Insurance

SHEP
Surveys of the Health Experiences of Patients

SMC
Strategic Management Council

SMC
Special Monthly Compensation

SOARD
Service-Oriented Architecture Research and Development

SOP
Standard Operating Procedures

SPAWAR
Space and Naval Warfare Systems Center

SPI
Separately Priced Item

SSA
Social Security Administration

STAR
Systematic Technical Accuracy Review

STDP
System-to-Drive-Performance

STR
Service Treatment Record

STVHCS
South Texas Veterans Health Care System

SUD
Substance Use Disorder

TA
Traditional Aggregate

TBI
Traumatic Brain Injury

TDIU
Total Disability Individual Unemployablity

THP
Tribal Health Program

TOP
Treasury Offset Program

TPSS
Training and Performance Support System

TSA
Telehealth Service Agreement

TSO
Training Support Office

TSS
Telehealth Scheduling System

USB
Under Secretary for Benefits

USH
Under Secretary for Health

U.S.C.
United States Code

US-CERT
United States Computer Emergency Readiness Team

USICH
US Interagency Council on Homelessness

VA
Veterans Affairs

VAAR
VA Acquisition Regulation

VACAA
Veteran Access, Choice and Accountability Act of 2014

VAMC
VA Medical Center

VARO
VA Regional Office

VASH
VA Supportive Housing

VASRD
VA Schedule for Rating Disabilities

VATAS
VA Time and Attendance System

VBA
Veterans Benefits Administration

VBMS
Veterans Benefits Management System

VCAA
Veterans Claims Assistance Act

VCGP
Veterans' Cemetery Grant Program

VCM
Virtual Care Measure

VE
Vista Evolution

VESO
Veteran Employment Services Office

VETSNET
Veterans Services Network

VGLI
Veteran's Group Life Insurance

VHA
Veterans Health Administration

VIP
Vendor Information Pages

VISN
Veterans Integrated Service Network

VistA
Veterans Information System and Technology Architecture

VLER
Virtual Lifetime Electronic Record

VOSB
Veterans Owned Small Business

VRM
Veterans Relationship Management

VR&E
Vocational Rehabilitation and Employment

VSC
Veterans Service Center

VSCM
Veterans Service Center Manager

VSO
Veterans Service Organization

VSR
Veterans Service Representative

VSSC
VHA Support Service Center

VT
Video Telehealth

WMS
Work Measurement Study

VA Online: Fast and Easy Access to Information

The table below provides links to several Web sites that provide information for and about Veterans.

What Information Do You Need?	Web Site
Veterans' Home Page*	www.vets.gov
VA's Home Page	www.va.gov
VA's AFR Submission and Strategic Plans	www.va.gov/performance
VA's Budget Submission	www.va.gov/budget/products.asp
Health Care in VA	www1.va.gov/health/index.asp
VA Health Quality and Safety Performance	www.hospitalcompare.va.gov
Managing My Health as a Veteran	www.myhealth.va.gov
Medical Research in VA	www.research.va.gov
Clinical Training Opportunities and Education Affiliates	www.va.gov/oaa
Office of Rural Health	www.ruralhealth.va.gov
Public Health	www.publichealth.va.gov
Health Promotion and Disease Prevention	www.prevention.va.gov/
Employment	www.vaforvets.va.gov
VA Benefits	www.benefits.va.gov
Education Benefits for Veterans	www.gibill.va.gov
Insurance for Servicemembers and Veterans	www.benefits.va.gov/insurance
Vocational Rehabilitation and Employment	www.benefits.va.gov/vocrehab

What Information Do You Need?	Web Site
Disability Compensation for Veterans	www.benefits.va.gov/compensation/
Pension Information for Veterans and Survivors	www.benefits.va.gov/pension
Educational and Vocational Counseling	www.benefits.va.gov/vocrehab/edu_voc_counseling.asp
Dependent and Survivor Benefits	www.va.gov/opa/persona/dependent_survivor.asp
Dependency and Indemnity Compensation	www.benefits.va.gov/COMPENSATION/types-dependency_and_indemnity.asp
Home Loans	www.benefits.va.gov/homeloans/index.asp
eBenefits	www.ebenefits.va.gov
Vow to Hire Heroes	www.benefits.va.gov/vow
Burial and Memorial Benefits for Veterans	www.cem.va.gov
Opportunities for Veteran-Owned Small Businesses	www.vetbiz.gov
Minority Veterans	www.va.gov/centerforminorityVeterans/
Women Veterans	www.va.gov/womenvet
Survivors Assistance	www.va.gov/survivors
Operations, Security and Preparedness	www.osp.va.gov
Recently Published VA Regulations	www.va.gov/ORPM/
VA's Social Media Sites	www.va.gov/opa/SocialMedia.asp
Human Resources and Administration	www.vacareers.va.gov/veterans
Reports, Surveys, or Statistics Regarding the Veteran Population	www.va.gov/vetdata/
Freedom of Information Act	www.foia.va.gov/

What Information Do You Need?	Web Site
Privacy Policy Information	www.va.gov/privacy/
VA Directives and Handbooks	www.va.gov/vapubs/
Green VA	www.green.va.gov
Center for Faith-based and Neighborhood Partnerships	www.va.gov/cfbnpartnerships/
Homelessness Info	www.va.gov/homeless/

* Part of the Department of Veterans Affairs MyVA vision is to provide our Veterans with a seamless, unified Veteran Experience across the entire organization and throughout the country. In support of this goal VA is creating a website solely dedicated to helping Veterans learn about the benefits they've earned and providing a clear path for applying for them. MyVA's Veterans Experience office along with our Digital Service team are building a new Veteran-centric experience that will consolidate our services and benefit application process into one portfolio for an organized and distinct destination for Veterans.

Vets.gov initial release is planned for November 2015 and will provide clear instructions and steps for some of VA's most popular services and transactions. Vets.gov will evolve over the upcoming year as we include existing and build new self-service functionality and tools. The ultimate goal for Vets.gov is to become the single, one-stop shop for information and self-service for Veterans and those that care for them. Our initial launch will be your first look into how we are modernizing the Veteran experience. New content and functionality will be added week by week, with improvements based on user feedback and usage data, incrementally evolving to become a valued Veteran-focused digital experience.