

**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 service members 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 dually meets the needs of today's and yesterday's Veterans. It is vital that VA health care and benefits delivery work in tandem with support services like financial management, procurement practices, 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 and other relevant Government reports, as well as an assessment of the Department'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 identified issues and to ensure that the Department will provide the best possible service to the Nation's Veterans and their dependents.



GEORGE J. OPFER
Inspector General

MAJOR MANAGEMENT CHALLENGES – FY 2012

OIG CHALLENGE #1: HEALTH CARE DELIVERY (VHA)

-Strategic Overview-

For many years, 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. VHA's use of the electronic medical record, its National Patient Safety Program, and its commitment to use data to improve the quality of care has sustained VHA's quality of care performance. VHA's decision to provide the public access to extensive data sets on quality outcomes and process measures is a further step forward as a national leader in the delivery of health care. Additionally, VHA's action to determine each hospital's ability to handle complex surgical cases, assign a rating classification, and then limit the procedures that can be performed at each class of facility is further evidence of its groundbreaking efforts to maintain and improve the quality of care that Veterans receive.

However, VHA faces particular challenges in managing its health care activities. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA. Over the past 7 years, OIG has invested about 40 percent of its resources in overseeing the health care issues impacting our Nation's Veterans and has conducted reviews at all VA Medical Centers (VAMCs) as well as national inspections 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)

VHA faces increased challenges in meeting the mental health needs of today's returning war Veterans. The high incidence of Post-Traumatic Stress Disorder (PTSD), depression, substance abuse, and military sexual trauma (MST) among today's Veterans challenge VHA to provide one standard of care across the country. This is especially impacted by the increase in the number of women Veterans. Although VHA has a high compliance with the goal of providing these at-risk Veterans with suicide safety plans, VHA is challenged to improve that coordination of care between VHA medical facilities, civilian and military facilities and providers for at-risk Veterans. Deficits in the coordination of care for these high-risk patients may result in patient deaths.

VHA has demonstrated the ability to deliver a high quality of patient care as determined by standard measures of population health. However, OIG continues to note excessive variation in the quality of care delivered. With the increasing number of Veterans receiving care at community-based outpatient clinics (CBOCs), VA faces challenges in delivering quality care at CBOCs that are often distant from their parent facilities.

While CBOCs expand Veterans' access to care, they require increased oversight by VHA. An OIG audit of CBOC management oversight found that VHA lacks the means to evaluate CBOC performance at the national, regional, and local levels; ensure parent facilities provide adequate CBOC oversight; and identify health care gaps at VA and contractor-operated CBOCs. In addition, VHA lacks the management controls needed to ensure CBOCs provide Veterans consistent quality care, because the CBOC Primary Care Management Module (PCMM) data, which VHA uses to make budgetary and resource management decisions, is inaccurate. Inaccurate PCMM data and problems in the completion of traumatic brain injury (TBI) and MST screenings at CBOCs demonstrate the need for VHA to establish CBOC-specific monitors to evaluate systemic problems and deviations from VHA's one standard of care. To address this challenge, VHA is in the process of taking action to improve the accuracy of PCMM data, monitor TBI and MST screenings, and establish a comprehensive CBOC performance monitoring system.

An additional ongoing challenge relates to reusable medical equipment (RME). VHA recognizes the importance of safe and consistent RME practices, but it continues to face problems despite efforts to comply fully with proper reprocessing procedures. After identifying poor compliance with RME procedures at several hospitals, OIG notes issues with maintaining compliance with RME directives. Veterans seeking care at a VA facility should have assurance that any equipment they come in contact with will be properly cleaned and, if necessary, sterilized within specifications promulgated by bodies advising on such processes. To do otherwise, at a minimum, exposes patients to unnecessary and unacceptable risk of infection.

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

As mentioned in Sub-Challenge 1A, Veterans' access to VA mental health care is a major challenge for VHA. Here the focus is on the particular challenges of providing timely access to mental health services, reducing wait times for services and ensuring the availability of providers. With the increase in the number of Veterans needing care, VA contracts care to private physicians and medical facilities where the challenge is both in ensuring the standard of care provided, and also verifying fees charged to VA by non-VA providers.

OIG reviews, including an April 2012 report, *Review of Veterans' Access to Mental Health Care*, indicate VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services. VHA did not provide first-time patients with timely mental health evaluations, and existing patients often waited more than 14 days past their desired date of care for their treatment appointment. Using the same data VHA used to calculate the 95 percent success rate shown in the FY 2011 PAR, OIG selected a statistical sample of completed evaluations to determine the starting and ending points of the elapsed day calculation. OIG calculated the number of days between initial contact in mental health and the full mental health evaluation. The analysis projected that VHA provided only 49 percent (approximately 184,000) of their evaluations within 14 days. On average, for

the remaining patients, it took VHA about 50 days to provide them with their full evaluations. As a result, performance measures used to report patients' access to mental health care do not depict the true picture of a patient's waiting time to see a mental health provider.

OIG reported concerns with VHA's calculated wait time data in the *Audit of VHA's Outpatient Scheduling Procedures* and *Audit of VHA's Outpatient Wait Times*. During both audits, OIG found that schedulers were entering an incorrect desired date. VHA needs a reliable set of performance measures and consistent scheduling practices to accurately determine whether they are providing patients timely access to mental health services. Given VHA's inability to correct the long-standing problem, VHA also needs to reassess their training, competency, and oversight methods and develop appropriate controls to collect reliable and accurate appointment data.

Furthermore, VHA needs to strengthen the management of rural health care funding to ensure that rural health projects meet VHA's Office of Rural Health's (ORH's) goals of improving access and quality of care for rural Veterans. ORH was created in February 2007 to conduct rural health research and develop policies and programs to improve health care and services for approximately 3.3 million rural Veterans. Men and women from geographically rural areas make up a disproportionate share of service members and comprise about one-third of all Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) enrolled Veterans.

In April 2011, OIG reported that VHA needed to improve the management of rural health funding, finding that ORH did not adequately manage the use of rural health funds for fee care and their rural health project selection process. Additionally, ORH did not monitor project obligations and performance measures. The cause was a lack of financial controls, the absence of policies and procedures to ensure staff followed management directives, and inadequate communication with key stakeholders. Also, ORH lacked a project monitoring system, procedures to monitor performance measures, and a process to assess rural health needs. As a result, OIG determined that VHA lacked reasonable assurance that ORH's use of \$273.3 million of the \$533 million in funding received during FYs 2009 and 2010 improved access and quality of care for Veterans residing in rural areas. To address this challenge, VHA must identify high-impact projects during the formulation of the program's annual budget requests and strengthen its future proposal selection process. Completing these actions will improve VHA's accounting of funds and measuring of the rural health program's impact on the health care of rural Veterans and their families.

As reported last year, the Veterans Benefits Administration (VBA) relies on VHA medical facilities to perform compensation and pension (C&P) medical examinations to determine the degree of disability or provide a medical opinion as to whether a disability is related to the Veteran's military service. A 2010 OIG audit found that VA medical facilities do not consistently commit sufficient resources to ensure Veterans receive timely C&P medical examinations. This occurred because VHA has not established procedures to identify and monitor resources needed to conduct C&P medical

examinations and to ensure resources are appropriately planned for, allocated, and strategically placed to meet examination demand. VHA's ability to complete C&P examinations in a timely and efficient manner is of extreme importance due to VBA's claims processing backlog. Due to the insufficient resources committed to the C&P medical examination program, many Veterans do not receive timely C&P medical examinations. VHA is taking steps to capture workload data and analyze staffing models and is also developing standards on the amount of time that should be allotted when scheduling appointments for each examination.

OIG continues to monitor VA's ability to complete C&P examinations in a timely and efficient manner. During FY 2011, VHA continued to face C&P examination backlogs. In at least one Veterans Integrated Service Network (VISN), some VHA facilities conducted C&P examination "blitzes" during the spring of 2011. These facilities dedicated up to 80 percent of their primary care appointment schedules over the course of 3 weeks to address a backlog of C&P examinations. While VHA recently reorganized responsibility for VHA's C&P examination efforts under a new Office of Disability and Medical Assessment, report recommendations made in the OIG 2010 audit report remain open. VHA needs to implement procedures to better capture data on C&P examination workload, costs, and productivity and use this data to ensure appropriate resources are dedicated to completing C&P examinations.

VHA also faces a significant challenge in ensuring Veterans obtain needed nursing home care. In March 2011, an OIG audit of VHA's State Home Per Diem Program reported that two states were denying care to eligible Veterans and none of the eight VAMCs the OIG visited had strengthened their outreach efforts to ensure Veterans denied access to State Veterans Homes (SVHs) nursing home care obtained access to care from other VA sources. The issue resulted from VAMCs not providing SVHs information on VA nursing home care options for distribution to Veterans. VHA can address this challenge by providing fact sheets on VA nursing home care options to SVHs for distribution to eligible Veterans, identifying the SVHs that have denied eligible Veterans access to care, and developing and initiating a plan to conduct specific and targeted outreach activities.

The March 2011 audit also reported that VA medical facilities need to improve their oversight of SVHs to reduce risks of Veterans receiving inappropriate nursing home care. In addition, VAMCs did not properly document or ensure timely SVH submission of 32 percent of eligibility determinations and 55 percent of medical care approval requests for the sample of Veterans the OIG reviewed. This was the result of ineffective VHA policies and procedures, insufficient oversight, and inadequate staff training. Improvements are needed to avoid an increased risk that Veterans will not receive needed nursing home care, and SVHs will not provide appropriate medical care. By revising VHA policies and procedures, ensuring VISNs establish oversight procedures, and providing training to VAMC staff responsible for SVH oversight, VHA can reduce the risks of Veterans receiving inappropriate SVH nursing home care.

VA has undertaken the mission of ending homelessness among Veterans, but VHA continues to face difficulties in serving this population of Veterans appropriately. In

many instances, VHA has provided compassionate care to a most challenging population; however, the successful provision of health care to Veterans without a fixed address and with the disease burden typical of this population will require comprehensive programs and outreach. VHA faces challenges in identifying Veteran subpopulations most susceptible to homelessness, and in placing homeless or at-risk Veterans into programs that are demonstrated to be effective. Furthermore, the diagnosis and treatment of complex cardiac disease, gastrointestinal disorders, cancer, and substance abuse are examples of medical disorders that are a challenge to provide care for in disadvantaged areas and to homeless Veterans.

The VHA Grant and Per Diem Program is successfully assisting homeless Veterans to live independently in safe and affordable permanent housing. This program supports the Secretary's goal to eliminate homelessness for Veterans by 2015. However, OIG identified serious issues impacting the housing safety, security, and privacy issues of homeless Veterans, particularly homeless female Veterans. Further, an incomplete grant application evaluation process; a lack of program safety, security, health, and welfare standards; and an inconsistent monitoring program impacted the program's effectiveness. As a result, VHA did not ensure homeless Veterans consistently received the supportive services agreed to in approved grants. In addition, funding was not effectively aligned with program goals. Program improvements are needed to ensure access to vital support services as VA prepares to serve approximately 20,000 homeless Veterans in 2012 and thousands more in subsequent years based on a 2011 Department of Housing and Urban Development report, *The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report*, estimating that 67,500 Veterans were homeless on a single night in January 2011.

VHA continues to face significant challenges in addressing the healthcare and financial vulnerabilities associated with the Non-VA Fee Care Program. The OIG issued *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program and Alleged Mismanagement of the Fee Basis Program VA Connecticut Healthcare System West Haven, Connecticut*. OIG concluded in both reports that controls over pre-authorizing fee care services needed improvement. Yet in FY 2011, OIG substantiated an allegation that the Phoenix Health Care System (HCS) experienced an \$11.4 million budget shortfall, 20 percent of the Non-VA Fee Care Program funds for that year. HCS management did not have sufficient procedural and monitoring controls to ensure that: (1) the official designated to pre-authorize fee care thoroughly reviewed requests, (2) clinical staff conducted necessary utilization and concurrent reviews, and (3) fee staff obligated sufficient funds for fee care. As a result, the Phoenix HCS had to obtain additional funds from the National Fee Program and VISN 18 and cancel equipment purchases to cover the \$11.4 million shortfall. OIG concluded that authorization procedures and the procedures to obligate sufficient funds to ensure it could pay its commitments were so weak that the Phoenix HCS processed about \$56 million of fee claims during FY 2010 without adequate review.

OIG Sub-Challenge #1C: Accountability of Prosthetic Supplies in VHA Medical Facilities (VHA)

From FY 2007 through FY 2011, VHA's prosthetic supply costs increased nearly 79 percent to about \$1.8 billion. Every year, VHA medical facilities process hundreds of millions of dollars of prosthetic supplies through inventories. In March 2012, OIG completed an audit of VHA's prosthetic supply inventory management. VHA medical facilities need to improve the management of prosthetic supply inventories. The audit estimated from April through October 2011, VHA medical facilities maintained inventories of nearly 93,000 prosthetic supply items with a total value of about \$70 million. Of the 93,000 items, VHA medical facilities inventories exceeded current needs for almost 43,500 items (47 percent) and were too low for nearly 10,000 items (11 percent), increasing the risk of supply shortages. As a result, VHA medical facilities spent about \$35.5 million to purchase unnecessary prosthetic supplies and increased the risk of supply expiration, theft, and supply shortages. Without adequate inventory management tools and controls and a more modern inventory system, it is difficult for VHA medical facilities managers and staff to ensure proper stewardship and accountability of prosthetic inventories and the continuous availability of prosthetic supplies needed for clinical staff to provide patient care. To improve prosthetic supply inventory management, VHA needs to increase inventory system capabilities, provide sufficient staff training, strengthen oversight, and revise policies and procedures.

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

The OIG has consistently reported the need for enhanced policies and procedures, training, oversight, quality review, and other management controls to improve the timeliness and accuracy of disability claims processing. OIG remains committed to keeping decision makers informed of longstanding and emerging problems identified through the audits, inspections, investigations, and reviews so that the Department can take timely corrective actions. While the Department has made much progress, there is still much to do to establish an effective and efficient organization.

During the 6-year period from FY 2007 through 2011, VBA's national accuracy rates for rating claims decisions remained the same or declined every year, dropping from 88 percent in FY 2006 to 83 percent in FY 2011. In FY 2012, VBA realigned its rating accuracy goal from 90 percent to 87 percent, to make a more stair-step achievable approach to reaching 98 percent accuracy in 2015. With the significant expansion of its claims workforce through current recruitment efforts and increasing receipt of claims from Veterans, VA will face additional significant challenges in meeting its goals for accuracy and consistency of benefit decisions. VBA is moving forward with plans to implement about 40 transformational initiatives to improve the accuracy and timeliness of claims processing. However, at this time, sufficient information to assess how each of these individual initiatives will contribute to meeting the Secretary's goals is unobtainable due to early implementation efforts.

OIG Sub-Challenge #2A: Effectively Managing Disability Benefits Claims Workload (VBA)

In FY 2011, VBA completed 1.8 million rating and non-rating claims, resulting in an end-of-year claims inventory of 1.1 million claims, up 54 percent from FY 2010's ending inventory of almost 726,000 claims. As of May 31, 2012, VBA's rating and non-rating inventory had climbed to an unprecedented 1.28 million claims. The May 2012 inventory represents dramatic increases of 15 percent from the end of FY 2011 and 76 percent from the end of FY 2010. OIG has completed several audits and reviews to assist VBA in addressing the demands of a rapidly increasing workload. VBA introduced several initiatives to attempt to reduce disability benefits claims processing times.

In a May 2012 audit, the OIG reported that opportunities exist for VBA to improve appeals processing at VA Regional Offices (VAROs). The nationwide inventory of appeals increased over 30 percent from about 160,000 appeals in FY 2008 to about 209,000 in FY 2010. During this time, the inventory of compensation rating claims increased by 40 percent from 380,000 to 532,000 claims. OIG found VBA contributed to the growing inventory and time delays. Regional office managers did not assign enough staff to process appeals, diverted staff from appeals processing, and did not ensure appeals staff acted on appeals promptly because compensation claims processing was their highest priority. OIG reported that *de novo* reviews will result in quicker decisions on the Veterans' appeals because decision review officers can render decisions without waiting for new evidence as required with traditional reviews. The audit showed that VARO staff did not properly record 145 appeals in Veterans Appeal Control and Locator System (VACOLS) that delayed processing for an average of 444 days. VBA had launched a pilot program, the Appeals Design Team, to try several different process changes to the appeals workflow. The pilot began in March 2012 at the Houston VARO, and VBA anticipates pilot completion in January 2013.

Processing the increased number of Veterans' compensation benefit claims has been a major challenge for VBA, as was discussed previously in Sub-Challenge 1B. Here the focus is directed specifically at process. VBA utilizes a claims brokering system with the goal to reduce claims backlogs by expediting processing and helping VAROs meet their processing timeliness targets. In 2010, OIG conducted an audit to evaluate the effectiveness of VBA's Compensation Program claims brokering. OIG reported VBA could improve the effectiveness of claims brokering by ensuring area offices consider additional factors affecting timeliness and accuracy. Nearly 171,000 brokered claims were completed during FY 2009, with an average processing time of 201 days. OIG projected the average processing time could have been reduced by 49 days if VBA had avoided the claims processing delays identified in this report. Rating Centers and Veterans Service Centers (VSC) with reported claims-processing accuracy rates completed almost 117,000 of the 171,000 brokered claims. Of the nearly 117,000 claims VBA brokered for ratings, OIG projected area offices brokered about 54,000 (46.2 percent) to facilities with lower rating accuracy rates than original offices. To

address these issues, VBA needs to revise brokering policies and procedures and include timeliness and accuracy measurements in performance plans for directors of VAROs that process brokered claims. In June 2010, VBA interrupted most claims brokering to address the additional challenge of processing Nehmer claims. VBA officials have stated they plan to resume full-scale brokering in July 2012.

OIG Sub-Challenge #2B: Improving the Quality of Claims Decisions (VBA)

VARO management teams face multiple challenges in providing benefits and services to Veterans. Unlike last year's summary report, VARO staff was generally effective in processing PTSD claims. However, from the FY 2011 inspection reports, OIG identified systemic issues in providing oversight and training to staff in three areas: temporary 100 percent disability evaluations for service-connected conditions requiring surgical or specific medical treatment, TBI, and herbicide exposure-related claims. Based on these results, OIG projected VARO staff did not correctly process 30 percent of approximately 48,000 claims. These results do not represent the overall accuracy of disability claims processing at these VAROs as OIG sampled claims we considered at higher risk of processing errors.

During the period from October 2011 through June 2012, OIG inspected 14 VAROs and assessed their performance in the three areas identified above. Staff at these 14 VAROs incorrectly processed 40 percent of 1,026 disability compensation claims in these categories, resulting in nearly \$5 million in overpayments. In addition, these 14 VAROs incorrectly processed 35 percent of 232 TBI claims because VHA medical examination reports did not contain sufficient information to make an accurate determination. Further, inaccuracies resulted from staff not properly evaluating the severity of TBI-related disabilities. OIG found that VARO staff generally over-evaluated the severity of TBI-related disabilities because they did not properly interpret the medical examination reports.

OIG found that VBA needs to ensure the quality of 100 percent disability evaluations. In January 2011, OIG reported that VARO staff inconsistently processed temporary 100 percent disability evaluations. OIG projected that VARO staff did not correctly process evaluations for approximately 27,500 Veterans and that, since January 1993, VBA has paid Veterans a net \$943 million without adequate medical evidence. The review showed that VARO staff did not enter the required future medical exam date into VBA's electronic records. Entering the future medical exam date generates an automatic notification that alerts VARO staff to request a medical exam to evaluate whether the Veteran's temporary 100 percent disability evaluation should continue. Without this notification, improper payments could potentially continue for the Veteran's lifetime. OIG estimated that if VBA does not take timely corrective action, it could overpay Veterans a projected \$1.1 billion over the next 5 years. VBA generally classifies these overpayments as administrative errors and does not establish a receivable or expect the Veteran to repay the overpayment.

In response to a recommendation in the January 2011 report, the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations

and ensure each had a future medical examination date entered in VBA's electronic record with a target completion date of September 30, 2011. However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until early September 2011. VBA subsequently extended the deadline several times to December 31, 2011, then to March 31, 2012, and then again to September 2012. At one VARO, management erroneously reported to the Western Area office that staff had requested VA medical reexaminations to determine whether the Veterans' disabilities warranted the continued temporary 100 percent evaluations, when in fact this had not occurred. Given the financial risks associated with continuing to pay benefits in the absence of adequate medical documentation, OIG considers this a major challenge. VBA must ensure controls are in place and working to ensure staff input suspense diaries, which alert staff when a medical re-examination is needed, into VBA's electronic system as required.

OIG Sub-Challenge #2C: VA Regional Office Operations (VBA)

VBA continues to experience challenges with ensuring its 56 VAROs comply with VA regulations and policies and deliver consistent performance of their VSC operations. OIG's Benefits Inspection Division has reported problems in ensuring VARO personnel complete thorough and timely Systematic Analysis of Operations (SAO) and accurately process claims-related mail. Half of the VAROs inspected during 2011 did not follow VBA policy to ensure SAOs were timely and complete. SAOs provide an organized means of reviewing VSC operations annually to identify existing or potential problems in claims processing and propose corrective actions. OIG reported that if VARO management had ensured staff completed thorough SAOs, they would have identified weaknesses associated with their operations and could have developed plans to correct these shortcomings. In addition, many VAROs did not always control and process mail according to VBA policy. Delays in processing claims-related mail might affect the accuracy and overall timeliness of claims processing.

OIG Sub-Challenge #2D: Improving Disability Benefits Questionnaires (DBQs) (VBA)

In October 2010, VA introduced Disability Benefits Questionnaires (DBQs) to reduce the claims backlog by speeding up the collection of medical evidence. DBQs replaced the C&P examination worksheets previously used and can also be filled out and submitted by a Veteran's private physician. DBQs have changed the way VA collects medical evidence to support Veterans' disability compensation claims. The volume of disability compensation claims processed using this new method will increase significantly as VA has deployed about 80 DBQs for use.

The OIG conducted an audit in February 2012 to provide an early assessment of VA's internal controls over the use of DBQs. OIG found that the expedited rollout of the DBQ process did not provide VA sufficient time to design, evaluate, and implement adequate internal controls to prevent potential fraud. VA does not verify the authenticity of medical information submitted by Veterans and private physicians prior to awarding

disability benefits, track disability-rating decisions where VARO staff used a DBQ as medical evidence, or electronically capture information contained on completed DBQs.

Further, while VBA has a quality assurance review process to verify a limited number of DBQs completed by private physicians, it is OIG's opinion that the quality assurance reviews do not provide reasonable assurance that fraudulent DBQs will be detected. Developing and implementing additional controls—as conveyed in the report—should reduce the risk of fraud, allow for greater fraud detection, and help VA identify disability compensation claims that carry an increased risk of fraud. VBA implemented new measures to review about 1,200 DBQs a year and agreed to promptly refer DBQs with questionable information or inconsistencies to OIG for further investigation.

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

VBA beneficiary funding managed by the Fiduciary Program are at risk for fraud based on program weaknesses. From April 1, 2007, to March 31, 2012, OIG conducted 142 investigations involving fiduciary fraud and arrested 84 fiduciaries and/or their associates. Two recent examples illustrate weaknesses that allowed funds to be embezzled. In the first example, a former VA fiduciary, who was also a disbarred attorney, was sentenced in September 2011 to 18 months in prison and ordered to pay \$318,899 restitution after having previously pled guilty to embezzling money over a 10-year period from the accounts of 11 incompetent Veterans. In the second example, a former VA Field Examiner and a court-appointed fiduciary were each sentenced in December 2011 to 36 months' incarceration and ordered to pay \$889,626 for conspiring to embezzle funds from 12 Veterans over a 10-year period to support gambling at area casinos. Of particular concern in both of these cases is that the fraud continued undetected for 10 years.

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

Sound financial management not only represents 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 oversight assists VA in identifying opportunities to improve the quality and management of VA's financial information, systems, and other assets.

OIG Sub-Challenge #3A: Strengthen Financial Management and Fiscal Controls for VISN Offices (VHA)

In 1995, VHA restructured its field operations from 4 medical regions to 22 VISN offices to redistribute VHA health care resources to better meet Veterans' needs, improve Veterans' access to health care, and decentralize decision-making and operations. At that time, VHA expected the VISN offices to have about 220 full-time equivalent staff and estimated that VISN operating costs would be about \$26.7 million. However, by

FY 2011, the VISN offices had grown significantly in size to over 1,000 staff with expenses totaling at least \$164.9 million, a 500 percent increase above the estimated costs (\$26.7 million) at inception.

OIG's audit of the VISNs' management and fiscal operations disclosed that VHA lacked budgetary controls and reliable data to monitor VISN offices, evaluate their performance relative to operational costs, justify their organizational structures and staffing levels, and ensure the effective and efficient use of funds. The OIG determined that VHA had allowed the VISN offices to operate independently and that VHA had not established required fiscal controls because it considered the VISN offices small. However, the growth in the offices' costs and the fiscal issues identified in the VISN offices' travel, leased office space, and performance awards demonstrated that VHA needed to strengthen VISN office fiscal controls to ensure transparency and accountability in their operations and the effective and efficient use of funds. To address this challenge, VHA initiated actions to standardize and build accountability in the VISNs' organizational and management structures and to establish fiscal controls and a comprehensive financial management system. However, full implementation of these actions is expected to require a more long-term plan.

OIG Sub-Challenge #3B: Strengthen Oversight of Human Capital Management and Development Programs (LEAD--OHRA, CSEMO, VHA)

In FY 2010, VA paid nearly \$111 million in retention incentives to 16,487 employees. OIG found VHA and VA Central Office (VACO) approving officials did not adequately justify and document retention incentive awards in accordance with VA policy. VA lacked clear guidance, oversight, and training to effectively support the program. Officials did not effectively use the Personnel and Accounting Integrated Data system to generate timely review notices and did not always stop retention incentives at the end of set payment periods. Based on these findings, OIG questioned the appropriateness of 96 (80 percent) of 120 VHA incentives and 30 (79 percent) of 38 VACO incentives reviewed. These incentives totaled about \$1.06 million in FY 2010. Furthermore, OIG identified 6 of 99 statistically sampled cases where VA assigned incorrect duty stations due to inadequately trained human resources personnel and lack of supervisor verification of employee duty assignments. Consequently, VA overpaid a total of about \$106,000 in locality pay from the time the errors first occurred. If problems assigning incorrect duty stations are not fixed, OIG projected a total of \$1,355,355 in potential monetary overpayments over the next 5 years.

In addition, VA's ADVANCE program aligns with Federal human capital reforms by centralizing workforce training and senior executive recruitment and development. VA started its ADVANCE human capital program, including its Corporate Senior Executive Management Office (CSEMO), in FY 2010 as part of the Secretary's initiative to transform VA into a 21st century organization. ADVANCE operated on an estimated budget of about \$864 million from FY 2010 through FY 2012, including about \$32 million for CSEMO. VA achieved many of its ADVANCE program goals. However, VA needs to strengthen its management of interagency agreements with the Office of Personnel

Management (OPM) and improve its program measures to more accurately assess program impact. These management weaknesses occurred because VA deployed ADVANCE rapidly and did not establish adequate controls over interagency agreement costs and terms. Further, VA proceeded without fully assessing its implementation options and concluded that only OPM could provide the needed resources and expertise. As a result, VA lacks reasonable assurance that it effectively spent program funds during FYs 2010 and 2011, and that its spending plans for FY 2012 will achieve the intended impact on VA's workforce.

OIG Sub-Challenge #3C: Strengthen Oversight to Better Leverage Capital Assets (OM)

An OIG audit of VA's use of the Enhanced-Use Lease (EUL) program revealed that program policies and procedures, oversight, and performance measures were not in place to ensure adequate project documentation, timely project development and execution, effective monitoring, and accurate cost accounting. VA had little assurance of EUL effectiveness due to inaccurate reporting on program benefits and expenses. Personnel did not always document major project decisions, resulting in a lack of transparency to ensure program integrity. Further, VA often paid to maintain capital assets longer than necessary due to delays in executing EUL arrangements. The program lacked the policies and procedures, oversight, and performance measures needed for effective EUL project management. As a result of these deficiencies, VA may not have fully realized the potential benefits of the EUL program.

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 continue to identify systemic deficiencies in all phases of the procurement process to include 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 (FAR) and VA Acquisition Regulation (VAAR), and the lack of effective oversight increase the risk that VA may award contracts that are not in the best interests 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: Compliance with Laws, Regulations, and Policies (OALC—LEAD, VHA, OIT)

For several years, OIG audits and reviews have identified VA challenges in complying with Federal and VA acquisition laws and regulations that protect the Government's

interests and promote transparency in procurements. In 2009, VA made two major changes intended to strengthen its procurement process. VHA created Service Area Offices to oversee VISN contracting activities. VA also established an Integrated Oversight Process (IOP) that replaced traditional technical and legal contract reviews. OIG's audit of VHA's VISN contracts disclosed that these changes, which were made to strengthen acquisition operations, were not effective because the new review processes were not followed consistently, and VA and VHA acquisition management did not provide adequate guidance and oversight on how to implement the IOP.

A 2011 OIG audit report on VISN contracts identified recurring systemic deficiencies associated with acquisition planning, contract award, and contract administration. A review of 89 noncompetitive VISN contracts identified deficiencies associated with the acquisition planning and award phases for 81 of the 89. A review of 83 competitive contracts identified deficiencies in these phases for 61 of the 83. Eighty-five of the 89 noncompetitive contracts reviewed, valued at \$56 million, had 1 or more contract deficiencies. VISN contracting officers could also not provide evidence that they made a determination of responsibility of prospective contractors by checking the Excluded Parties List System prior to award, as required. OIG estimated that a determination of responsibility was not made for nearly 1,290 contracts, valued at \$674 million. OIG estimated that VISN contracting staff did not perform required IOP contract reviews for about 3,000 contracts, valued at about \$1.58 billion, awarded between June 2009 and May 2010.

The Office of Information and Technology (OIT) contracted for in-depth technical reviews of VA's major information technology (IT) initiatives to ensure IT systems met VA's Enterprise Architecture standards. However, OIG determined the work the contractor performed did not meet the primary intent of the task order, which called for in-depth technical reviews of VA's major IT initiatives. OIT's decision to continue using the contractor to perform work that did not meet the primary intent of the task order resulted in ineffective and inefficient use of contract resources. As a result, OIT incurred contract costs of approximately \$1.7 million for an underutilized task order during the first and second option years. The amount could have also grown to approximately \$2.4 million if OIT had chosen to exercise the third option year of the task order—OIT did not, based on the OIG recommendations. In addition, no other organization within OIT was performing technical reviews of VA's major IT initiatives. As a result, VA's IT programs and projects may be at an increased risk of noncompliance with VA's Enterprise Architecture standards. As a result of the OIG evaluation of the secure VA-Chief Information Security Officer support services acquisition process, it was determined that VA's proposal evaluation and contract award procedures demonstrated a potential bias toward the incumbent contractor and did not promote full and open competition in accordance with the FAR.

OIG Sub-Challenge #4B: Improve Oversight for VA's VOSB and SDVOSB Programs (OSDBU-LEAD, OALC, VHA)

VA continues to experience challenges with contract awards to Veteran-owned small businesses (VOSBs) and service-disabled Veteran-owned small businesses (SDVOSBs). Forty of the 42 noncompetitive VOSB and SDVOSB contracts reviewed during the audit of VISN contracts, valued at about \$17.9 million, had one or more contract deficiencies. Price negotiation memoranda were not prepared, or were determined to be inadequate, for 22 of 42 contracts awarded to SDVOSBs, valued at \$10.5 million. OIG also disclosed that VISN contracting officers from each SAO used Public Law 109–461, “Veterans Benefits, Health Care, and Information Technology Act of 2006,” as justification to award noncompetitive contracts to VOSBs and SDVOSBs without considering competition restricted to these businesses.

These results are consistent with the findings reported in a 2011 OIG audit of VOSB and of SDVOSB programs. Sixty-eight percent of 79 VOSB and SDVOSB contracts valued at \$21.9 million had 1 or more contracting deficiencies. Contracting officers did not complete a justification for other than full and open competition prior to the award or perform and document a price reasonableness determination in a document such as the price negotiation memorandum for 30 VOSB and SDVOSB contracts, valued at \$12 million, awarded to 20 businesses.

These contracting deficiencies prompted criminal investigations of SDVOSB contract participants. To date, the investigations have resulted in the issuance of 407 subpoenas and the execution of 25 search warrants. OIG’s investigative efforts have resulted in 14 indictments, 6 convictions, and nearly 100 open investigations ongoing.

The following three examples demonstrate the types of fraud frequently committed among participants misusing the program. The first example was a referral received from the Government Accountability Office alleging that an SDVOSB was a shell company. The OIG conducted an investigation which substantiated that the owner of a non-SDVOSB approached a bedridden Vietnam War Veteran and proposed the idea of starting a joint venture using the Veteran’s service-disabled status. The OIG determined that the Veteran performed no work for either company, had no ownership stake in the SDVOSB, and did not control the management of the company. The SDVOSB contract simply served as a pass-through for the larger company. In November 2011, a Federal grand jury indicted the company owner on charges of wire fraud and major fraud against the United States. Both the company and the owner have been debarred from doing business with the Government.

In a second example, the OIG received allegations that a company was engaging in SDVOSB fraud and that a VA employee was accepting bribes and/or gifts from the company. OIG initiated a joint investigation with the Small Business Administration (SBA) OIG and General Services Administration (GSA) OIG. The OIG investigation determined that two individuals approached a service-disabled Veteran about setting up a construction company to compete for Government contracts under the SDVOSB Program. They gave a VA employee luxury box tickets at sporting events, as well as lunches and interest-free loans, to ensure that the company would continue to receive VA contracts. In February 2012, two individuals pled guilty to conspiracy involving the

illegal payment of gratuities. In May 2012, one was sentenced to serve 2 years in prison and ordered to pay a \$50,000 fine; the second was sentenced to serve 3 years of probation and ordered to pay \$1,550,000 in restitution and fined \$60,000. In March 2012, the former VA employee pled guilty to accepting an illegal gratuity and was subsequently sentenced to 15 months in prison. The three defendants and two companies have been referred for debarment from future Government contracts.

Finally, two individuals were charged in February 2012 with conspiracy, major fraud, and false statements after an OIG investigation determined that a company owner and his son-in-law conspired to defraud VA by falsely claiming that the company was an SDVOSB. A third individual, who was a service-disabled Veteran and received payment for allowing the use of his service-disabled Veteran status, had previously pled guilty to conspiracy and major fraud. Between March 2009 and February 2012, the company was awarded five SDVOSB set-aside contracts totaling \$10.9 million. In March 2012, the three individuals and the company were suspended from doing business with the Federal government.

OIG Sub-Challenge 4C: Effective Contract Administration (LEAD--OALC, VHA)

OIG continues to identify poor contract administration as a systemic deficiency resulting in overpayments to vendors. A 2012 review of VA's Fast Pay system concluded that inadequate segregation of supply ordering and receiving duties makes VA facility pharmacies vulnerable to fraudulent activity. OIG determined three of four VA medical facility pharmacies reviewed needed to strengthen controls to ensure an adequate segregation of duties existed. The three VA medical facility pharmacies did not segregate duties among different staff to prevent any one individual from having the ability to both order and receive non-controlled pharmacy supplies. These findings related to contract administration are consistent with other recently issued OIG reports.

For example, the OIG's audit of prosthetic limb acquisition and management practices found that VHA needs to strengthen payment controls for prosthetic limbs to minimize the risk of overpayment. OIG identified overpayments in 23 percent of all the transactions paid in FY 2010. Specifically, VHA needs to establish appropriate separation of controls within its prosthetic management practices and ensure staff follows these practices before authorizing payment. The acquisition practices reviewed at the four VISNs visited did not stress Contracting Officer's Technical Representative (COTR) responsibilities, which resulted in internal control weaknesses. VHA overpaid about \$2.2 million for prosthetic limbs in FY 2010. VA can recover the overpayments from vendors because the invoices paid exceeded the agreed upon prices per the terms in the contracts.

OIG's national audit of VISN contracts also disclosed that multiple issues are negatively impacting the quality of VISNs' efforts to administer contracts. VISN contracting officers are not consistently initiating background checks for contractors having access to VA computer systems. OIG also determined that contracting officers are not consistently designating COTRs to help oversee contract administration. In addition, contracting

officers and/or COTRs are not consistently monitoring contractors' performance. Lapses in monitoring a contractor's performance or taking actions to ensure that goods and services have been received increases the risk that VA may not be getting what it paid for and increases the risk of contract failure. The FAR requires that contracting officers ensure contractors comply with the terms and conditions of the contract and safeguard the interests of the Government in its contractual relationships.

OIG Sub-Challenge #4D: Improve Oversight of Procurement Activities (OALC—LEAD, VHA)

Effective oversight is difficult to achieve because there is no central database that captures all VA contracting and purchasing information. Although VA established the Electronic Contract Management System (eCMS) in 2007 as the required contract management tool for the Department, OIG has found that it does not capture all VA procurement information. A 2009 OIG audit revealed that eCMS is not used effectively and procurement information in eCMS is incomplete. Recent audits indicate that these deficiencies still exist.

For example, the OIG audit of VISN contracts concluded that VISN acquisition personnel were not properly and consistently using eCMS. OIG found that documentation of COTR training and invoices were most frequently missing from the system for competitive and noncompetitive contracts. OIG also identified inaccurate data in eCMS for 44 of the 172 contracts reviewed, including inaccurate classifications of goods and services purchased, obligation amounts, estimated values, and award dates.

During the OIG's nationwide audit of VHA's acquisition and management of prosthetic limbs, eCMS data reliability and system problems were identified that impacted VISN contracting personnel's ability to effectively oversee VA procurements. None of the VISNs reviewed included vendors' invoices in eCMS. As a result, OIG could not readily verify whether a COTR had reviewed vendors' invoices prior to certification to ensure they accurately reflected that goods received were in accordance with the requirements of the contract. The lack of official contract documentation in eCMS adversely affects VISN management's ability to assess the quality and administration of prosthetic limb procurements.

A 2011 OIG audit also concluded managers at VA's NAC did not ensure that staff fully utilized VA's mandatory eCMS to develop and award national contracts. This occurred because VA's Office of Acquisition, Logistics, and Construction (OALC) provided limited oversight to monitor eCMS compliance and ensure eCMS capabilities adequately supported NAC operations. In addition, OALC and NAC officials impaired visibility of VA procurement actions by not ensuring compliance with the mandatory use of eCMS.

OIG Sub-Challenge #4E: Sound IT Procurement Practices (OALC—LEAD, OIT)

OIG evaluated the Secure VA-Chief Information Security Officer Support Services acquisition process to determine whether the solicitation, proposal evaluation, and contract award processes were conducted in line with full and open competition requirements. In December 2011, OIG found that VA's acquisition process demonstrated a potential bias by using knowledge of VA procedures and practices as a significant selection factor without clear disclosure of its relative importance when asking for bids. As such, the technical evaluation process favored awarding the contract to the incumbent, Booz-Allen Hamilton. This was the same contractor that had provided VA's Information Assurance and Information Technology Security Services for the previous 2 years. VA awarded the contract for \$133 million, at a premium of 16 percent (\$18 million) and 22 percent (\$24 million) over two other offers.

OIG reported that the Department's failure to disclose all significant evaluation factors prevented vendors from submitting comparable proposals, placing potential contractors at a disadvantage in the bidding process. The Executive Director, OALC, neither concurred nor non-concurred with OIG recommendations and provided no statement on his intent for future acquisitions. Therefore, OIG will evaluate VA's contract award decisions in future audits to determine if evaluation panels assess vendor proposals based solely on evaluation factors stated in the solicitations.

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

Information Management should enable government to better serve its citizens. The Federal government, however, has experienced difficulty in achieving productivity improvements from IT advances similar to those realized by private industry. In large part, this has been caused by poor management of large-scale IT projects. All too often, Federal IT projects run over budget, behind schedule, or fail to deliver promised functionality.

VA has consolidated the vast majority of its IT resources under the Chief Information Officer (CIO) by reorganizing the IT functions of VA's Administrations under OIT. Through the stewardship of the CIO, OIT has positioned itself to facilitate VA's transformation into a 21st century organization by focusing on five key management areas. In 2012, OIT strived to: (1) achieve customer service in all aspects of IT; (2) develop a next generation IT Security Plan; (3) manage its IT organizations with metrics that are tracked; (4) focus on product delivery using the Project Management Accountability System (PMAS); and (5) perform better financial reporting to more effectively track spending on IT projects.

However, OIG's annual Consolidated Financial Statement (CFS) and information security program audits continue to report IT security control deficiencies that place sensitive information at risk of unauthorized use and disclosure. Furthermore, OIG oversight work indicates that additional actions are needed to safeguard and effectively manage VA's information resources and data, and that VA has only made marginal

progress toward eliminating the information management material weakness reported in the CFS audit and remediating major deficiencies in IT security.

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

OIG continues to identify major IT security deficiencies in the annual information security program audits. While VA has made progress defining policies and procedures supporting its agency-wide information security program in accordance with the Federal Information Security Management Act (FISMA), they face significant challenges in meeting the requirements of FISMA.

OIG's 2011 FISMA audit identified significant deficiencies related to access, configuration management, change management, and service continuity controls. Improvements are needed in these key controls to prevent unauthorized access, alteration, or destruction of major application and general support systems. CFS auditors also concluded that a material weakness exists related to the implementation of VA's agency-wide information security program. Finally, VA has also identified over 15,000 system security risks and corresponding Plans of Action & Milestones (POA&Ms) that need to be remediated to improve its overall information security posture.

To improve its IT security posture, VA needs to focus its efforts to: (1) dedicate resources to aggressively remediate the significant number of unresolved POA&Ms, while addressing high risk system security deficiencies and vulnerabilities; (2) implement mechanisms to identify and remediate system security weaknesses on the Department's network infrastructure, database platforms, and web application servers across the enterprise; (3) develop and establish a system development and change control framework that will integrate information security throughout each system's life cycle; (4) implement technological solutions to actively monitor all network segments for unauthorized system access to Department programs and operations; and (5) implement mechanisms to ensure that system contingency plans are fully tested in accordance with FISMA.

In February 2012, OIG reported that VA did not adequately protect sensitive data hosted within its STDP application. Specifically, OIG determined that more than 20 system users had inappropriate access to sensitive STDP information. Further, OIG reported that project managers did not report unauthorized access as a security event as required by VA policy. STDP project managers were not fully aware of VA's security requirements for system development and had not formalized user account management procedures. Inadequate Information Security Officer oversight contributed to weaknesses in user account management and failure to report excessive user privileges as security violations. As a result, VA lacked assurance of adequate control and protection of sensitive STDP data.

In July 2011, OIG reported that certain contractors did not comply with VA information security policies for accessing mission critical systems and networks. For instance, contractor personnel: improperly shared user accounts when accessing VA networks and systems; did not readily initiate actions to terminate accounts of separated

employees; and did not obtain appropriate security clearances or complete security training for access to VA systems and networks. OIG concluded that VA has not implemented effective oversight to ensure that contractor practices comply with its information security policies and procedures. Contractor personnel also stated they were not well aware of VA's information security requirements. As a result of these deficiencies, VA sensitive data is at risk of inappropriate disclosure or misuse.

OIG Sub-Challenge #5B: Interconnections with University Affiliates (OIT—LEAD, VHA)

VAMCs have numerous systems interconnections with external organizations to exchange the data needed to support a range of health care services and collaborative research studies. VA has not effectively managed its network interconnections and data exchanges with its external research and university affiliates. Despite Federal requirements, VA could not readily account for the various systems linkages and sharing arrangements. VA also could not provide an accurate inventory of the research data exchanged, where they were hosted, or their sensitivity levels. In numerous instances, the OIG identified unsecured electronic and hardcopy research data at VAMCs and co-located research facilities.

VA's data governance approach has been ineffective to ensure that research data exchanged with research partners are adequately controlled and protected throughout the data life cycle. VA and its research partners have not consistently instituted formal agreements requiring that hosting facilities implement controls commensurate with VA standards for protecting sensitive data. The responsible VHA program office's decentralized approach to research data collection and oversight at a local level has not been effective to safeguard sensitive information. Because of these issues, VA data exchanged with research partners were at risk of unauthorized access, loss, and disclosure.

OIG Sub-Challenge #5C: Successful Deployment of Encryption Software (OIT)

A data breach in May 2006 initiated a heightened and an immediate concern in the protection of VA Personally Identifiable Information. In August 2006, the VA Secretary mandated that all VA computers would be upgraded with enhanced data security encryption software. As a result, VA awarded a contract to Systems Made Simple for Guardian Edge encryption software. The contract—at a cost of \$2.8 million—was for 300,000 encryption licenses and 1 year of maintenance, training, and services. VA also exercised 4 option years to extend the maintenance for the entire 300,000 encryption licenses for an additional \$1.2 million for a total award of \$4 million. Finally, in April 2011, VA procured an additional 100,000 licenses for \$2.3 million, which included a 2-year extended maintenance on the original 300,000 licenses procured in 2006.

However, to date, OIT has only managed to encrypt approximately 65,000 computers, 48,000 laptops, and 17,000 desktops, resulting in some 335,000 encryption licenses and related maintenance agreements going unused. Initially, OIT's inability to

successfully encrypt was due to inadequate planning of the original and subsequent encryption acquisitions. Subsequently, OIT encountered compatibility issues between IT equipment and encryption software. Delays also occurred due to OIT's transition from Windows XP to Windows 7. Currently, OIT lacks adequate IT resources to support full deployment of encryption software. OIT's inability to successfully manage the deployment of the encryption software has resulted in approximately \$5.1 million dollars in funds that OIT could have put to better use.

OIG Sub-Challenge #5D: Strategic Management of Office of Information Technology Human Capital (OIT)

OIT provides IT systems support in the provision of benefits and health care services to our Nation's Veterans. However, within the next 5 years, OIT may face a loss of over 40 percent of its leadership and technical employees, which could threaten institutional knowledge and mission-critical IT capabilities as VA moves forward in the 21st century. Given the potential loss of critical staff, OIT has not established a strategic approach to mitigate and manage its human capital. Instead, OIT has been managing its human resources in an ad hoc manner with no clear vision. Although OIT recognizes the importance of strategic human capital management, it has not made it a priority and does not have the leadership and staff in place to support implementation of an OIT human capital strategy.

OIT has not developed a strategic human capital plan, fully implemented competency models, identified competency gaps, or created strategies for closing the gaps. OIT also has not captured the data needed to assess how well contractor support supplements OIT staffing and fills competency gaps. Moreover, OIT lacks assurance that it has made cost-effective decisions regarding how it spent money on contractors. Finally, OIT has not established a mechanism to evaluate the success of its human capital initiatives. As a result, OIT has no assurance it has effectively managed its human capital resources to support VA in accomplishing its mission.

OIG Sub-Challenge #5E: Strengthening Information Technology Governance (OIT)

A 2009 OIG audit determined that the ad hoc manner in which VA managed the realignment of its IT program from a decentralized to a centralized management structure inadvertently resulted in an environment with inconsistent management controls and inadequate oversight. Although OIG conducted this audit more than 2 years after VA centralized its IT program, senior OIT officials were still working to develop policies and procedures needed to manage IT investments effectively in a centralized environment. For example, OIT had not clearly defined the roles of IT governance boards responsible for facilitating budget oversight and IT project management.

Further, in September 2009, OIG reported that VA needed to better manage its major IT development projects, valued at that time at over \$3.4 billion, in a more disciplined and

consistent manner. In general, OIG found that VA's System Development Life Cycle (SDLC) processes were adequate and comparable to Federal standards. However, OIT did not communicate, comply with, or enforce its mandatory software development requirements. OIT did not ensure that required independent milestone reviews of VA's IT projects were conducted to identify and address system development and implementation issues. OIG attributed these management lapses to OIT centralizing IT operations in an ad hoc manner, leaving little assurance that VA was making appropriate investment decisions and best use of available resources. Moreover, VA increased the risk that its IT projects would not meet cost, schedule, and performance goals, adversely affecting VA's ability to timely and adequately provide Veterans health services and benefits.

These audits demonstrated that OIT needed to implement effective centralized management controls over VA's IT investments. Specifically, OIG recommended that OIT develop and issue a directive that communicated the mandatory requirements of VA's SDLC process across the Department. OIG also recommended that OIT implement controls to conduct continuous monitoring and enforce disciplined performance and quality reviews of the major programs and projects in VA's IT investment portfolio. Although OIT concurred with recommendations and provided acceptable plans of actions, OIT's implementation of the corrective actions is still ongoing.

As of May 2012, OIT was managing all 134 active development programs and projects using PMAS. PMAS represents a major shift from the way VA historically has planned and managed IT development projects. An additional 46 projects were in the planning stage, while 30 projects were classified as new starts. However, OIT lacks the program management skills and the financial management system capabilities to fully track program costs and to implement an effective earned value management system to assist with achieving cost and performance goals. VA is challenged to ensure appropriate investment decisions are made and that annual funding decisions for VA's IT capital investment portfolio will make the best use of VA's available resources.

OIG Sub-Challenge #5F: Effective Oversight of Active IT Investment Programs and Projects (OIT—LEAD, VBA)

VA has a longstanding history of challenges in effectively managing IT development projects. For example, the Veterans Service Network (VETSNET) program, which is VA's effort to consolidate C&P benefits processing into a single replacement system, has faced a number of cost, schedule, and performance goal challenges. In May 2009, VBA estimated the total cost of VETSNET to be more than \$308 million—more than 3 times the initial cost estimate. After more than 15 years of VBA development, including management and process improvements, VETSNET has the core functionality needed to process and pay the majority of C&P claims; however, work remains to meet the original goals for VETSNET. VETSNET's major releases were also developed with unstable functional requirements resulting in inadequate time to fully test software changes. Consequently, major releases of VETSNET contained functions that did not

operate as intended and many system defects were deferred or corrected in subsequent software releases. Further complicating matters, VBA has recently launched several high profile IT initiatives that will leverage VETSNET to make benefit payments. These overlapping IT initiatives increase the risks that VBA will experience further delays in achieving the original VETSNET goals.

Recently, VA has also had trouble establishing an effective IT project management system. A 2011 OIG audit found a great deal of work remains before VA's PMAS can be considered completely established and fully operational. PMAS was designed as a performance-based management discipline that provides incremental delivery of IT system functionality—tested and accepted by customers—within established schedule and cost criteria. However, the audit concluded that OIT instituted the PMAS concept without a roadmap identifying the tasks necessary to accomplish PMAS or adequate leadership and staff to effectively implement and manage the new methodology. Lacking such foundational elements, OIT has not instilled the discipline and accountability needed for effective management and oversight of IT development projects.

Specifically, OIT did not establish key management controls to ensure PMAS data reliability, verify project compliance, and track project costs. Also, OIT did not put in place detailed guidance on how such controls will be used within the framework of PMAS to manage and oversee IT projects. Consequently, the current PMAS framework does not provide a sound basis for future success. Until these deficiencies are addressed, VA's portfolio of IT development projects will remain susceptible to cost overruns, schedule slippages, and poor performance. To improve PMAS, VA must develop an implementation plan and assign adequate leadership and staff needed to fully execute the IT project management system. In addition, VA needs to establish controls for ensuring data reliability, verifying project compliance, and tracking costs to strengthen PMAS oversight. Finally, VA must prepare and provide users detailed guidance on using PMAS to ensure IT project success.

APPENDIX

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

Review of Veterans' Access to Mental Health Care

4/23/2012 | 12-00900-168 | [Summary](#) |

Audit of VHA's Homeless Providers Grant and Per Diem Program

3/12/2012 | 11-00334-115 | [Summary](#) |

Audit of VHA's Prosthetics Supply Inventory Management

3/30/2012 | 11-00312-127 | [Summary](#) |

Audit of the VHA's Office of Rural Health

4/29/2011 | 10-02461-154 | [Summary](#) |

Audit of the Veterans Health Administration's Outpatient Scheduling Procedures

7/8/2005 | 04-02887-169 | [Summary](#) |

Audit of the Veterans Health Administration's Outpatient Waiting Times

9/10/2007 | 07-00616-199 | [Summary](#) |

Healthcare Inspection Alleged Mismanagement of the Fee Basis Program VA Connecticut Healthcare System, West Haven, Connecticut

6/3/2009 | 09-01219-141 | [Summary](#) |

Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program

8/3/2009 | 08-02901-185 | [Summary](#) |

Audit of the VHA's Office of Rural Health

4/29/2011 | 10-02461-154 | [Summary](#) |

Audit of VA's Efforts To Provide Timely Compensation and Pension Medical Examinations

3/17/2010 | 09-02135-107 | [Summary](#) |

OIG CHALLENGE #2: BENEFITS PROCESSING

Audit of VA Regional Offices' Appeals Management Processes

5/30/2012 | 10-03166-75 | [Summary](#) |

Audit of VA's Internal Controls Over the Use of Disability Benefits Questionnaires

2/23/2012 | 11-00733-95 | [Summary](#) |

Audit of VBA's 100 Percent Disability Evaluations

1/24/2011 | 09-03359-71 | [Summary](#) |

Audit of the Fiduciary Program's Effectiveness in Addressing Potential Misuse of Beneficiary Funds

3/31/2010 | 09-01999-120 | [Summary](#) |

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

Independent Review of VA's FY11 Detailed Accounting Summary Report to the ONDCP

3/22/2012 | 12-01071-122 | [Summary](#) |

Independent Review of VA's FY 2011 Performance Summary Report to ONDCP

3/22/2012 | 12-01072-121 | [Summary](#) |

Audit of the VA's Enhanced-Use Lease Program

2/29/2012 | 11-00002-74 | [Summary](#) |

Audit of VA's Duty Station Assignments

4/19/2012 | 11-04081-142 | [Summary](#) |

Audit of VHA's Financial Management and Fiscal Controls for Veterans Integrated Service Network Offices

3/27/2012 | 10-02888-128 | [Summary](#) |

Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices

3/27/2012 | 10-02888-129 | [Summary](#) |

Review of VA's Compliance with the Improper Payments Elimination and Recovery Act

3/14/2012 | 12-00849-120 | [Summary](#) |

Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System

11/8/2011 | 11-02280-23 | [Summary](#) |

Audit of Retention Incentives for Veterans Health Administration and VA Central Office Employees

11/14/2011 | 10-02887-30 | [Summary](#) |

Audit of VA's Consolidated Financial Statements for Fiscal Years 2011 and 2010

11/10/2011 | 11-00343-26 | [Summary](#) |

Audit of NCA's Appropriated Operations and Maintenance Funds Oversight

6/20/2012 | 11-003060-193 | [Summary](#) |

Audit of VA's Duty Station Assignments

4/19/2012 | 11-04081-142 | [Summary](#) |

Audit of VA's ADVANCE and the Corporate Senior Executive Management Office Human Capital Development Programs

8/2/2012 | 11-02433-220 | [Summary](#) |

Audit of VBA's Liquidation Appraisal Oversight at the Cleveland and Phoenix Regional Loan Centers

9/28/2012 | 10-04045-124 | [Summary](#) |

Audit of VHA's Medical Care Collections Fund Billing of VA-Provided Care

8/30/2012 | 11-00333-254 | [Summary](#) |

Audit of VA's Savings Reported Under OMB's Acquisition Savings Initiative

9/30/2012 | 11-03217-293 | [Summary](#) |

Administrative Investigation of VA's FY 2011 HR Conferences in Orlando, FL

9/30/2012 | 12-02525-291 | [Summary](#) |

OIG CHALLENGE #4: PROCUREMENT PRACTICE

Review of VA's Controls for the Pharmaceutical Prime Vendor Fast Pay System

5/17/2012 | 12-01008-185 | [Summary](#) |

Audit of VHA Acquisition and Management of Prosthetic Limbs

3/8/2012 | 11-02254-102 | [Summary](#) |

Review of Alleged Mismanagement of Systems to Drive Performance Project

2/13/2012 | 11-02467-87 | [Summary](#) |

Review of VA's Secure VA-Chief Information Security Officer Support Services Acquisition Process

12/20/2011 | 11-01508-24 | [Summary](#) |

Audit of VHA's Veterans Integrated System Network Contracts

12/1/2011 | 10-01767-27 | [Summary](#) |

Review of Alleged Contract Irregularities in VA's Office of Information and Technology

10/13/2011 | 11-01708-02 | [Summary](#) |

OIG CHALLENGE #5: INFORMATION MANAGEMENT

VA's Federal Information Security Management Act Assessment for FY 2011

4/6/2012 | 11-00320-138 | [Summary](#) |

Review of VA's Alleged Circumvention of Security Requirements for System Certifications and Apple Mobile Devices

5/23/2012 | 12-00089-182 | [Summary](#) |