



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.

A handwritten signature in cursive script, reading "Linda A. Halliday".

LINDA A. HALLIDAY
Deputy Inspector General



Major Management Priorities and Challenges

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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.

Completed VHA FY 2015 Milestones:

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 13,731,15,172 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."¹

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.

Completed VHA FY 2015 Milestones:

¹ 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>.



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 93.1 days (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 accidentally 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.

FY 2015 – FY 2016 OM Action Plan:

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, a 100% 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
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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](#)

Congressional Testimony 7/30/2015

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
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Congressional Testimony 7/1/2015

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"
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Congressional Testimony 4/30/2015

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](#)

Congressional Testimony 3/30/2015

Statement of John D. Daigh, Jr., M.D., CPA, Assistant Inspector General For Healthcare Inspections Office of Inspector General Department of Veterans Affairs Before 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](#)

Congressional Testimony 3/30/2015

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 Tridex 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](#)

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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](#)

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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](#)