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.

GEORGE J.
OPFER Inspector
General

Major Management Challenges Identified by OIG

VA's Office of Inspector General (OIG), an independent entity, evaluates VA's programs and operations. OIG submitted the following update of the most serious management challenges facing VA.

VA reviewed OIG's report and provided responses, which are integrated within OIG's report. Our responses include the following for each challenge area:

- ***Estimated resolution timeframe (fiscal year)*** to resolve the challenge
- ***Responsible Agency Official*** for each challenge area
- ***Completed 2013 milestones*** in response to the challenges identified by OIG

VA is committed to addressing its major management challenges. Using OIG's perspective as a catalyst, we will take whatever steps are necessary to help improve services to our Nation's Veterans. We welcome and appreciate OIG's perspective on how the Department can improve its operations to better serve America's Veterans.

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OIG CHALLENGE #1: HEALTH CARE DELIVERY (VHA)
-Strategic Overview-

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

However, VHA faces particular challenges in managing its health care activities. The effectiveness of clinical care, budgeting, planning, and resource allocation are negatively affected due to the continued yearly uncertainty of the number of patients who will seek care from VA. Over the past 8 years, OIG has invested about 40 percent of its resources in overseeing the health care issues impacting our Nation's Veterans and has conducted reviews at all VA Medical Centers (VAMCs) as well as national inspections and audits, issue-specific Hotline reviews, and criminal investigations. The following sub-challenges highlight the major issues facing VHA today.

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

VHA provides Veterans with comprehensive medical and specialty care; however, VHA continues to face challenges with matching Veterans' demands for specific types of medical care with the appropriate care providers. This has been evident with VHA's difficulty in providing a proper mix of in-house mental health providers and integrating purchased care providers seamlessly in the plan of care for Veterans who receive their mental health care from non-VA providers. Matching the supply of available providers to the demand for health care is made more difficult by the absence of staffing standards for most physician specialist and mental health providers, the inaccuracies in data reported from the current appointment system with respect to appointment metrics, and the lack of oversight to force VA managers to rigorously evaluate the business case that determines how the provider workforce is utilized.

Modern health care requires that timely decisions be made and then executed with precision. VA is the largest integrated health care organization in the U.S. with a patient medical record system that was originally a model for other health care organizations. However, the system has not been upgraded as necessary to keep pace with competing medical record systems with respect to appointment scheduling and decision support. In addition, VA has not been able to provide a coherent plan forward to link Department of Defense and VA medical records after having spent considerable money and effort. There are many outstanding features to VA's medical record system, but without a clear and workable plan going forward VA will have increasing difficulty managing the data required by providers and administrators to ensure that Veteran health care retains its outstanding value to our citizens.

VA provides nationwide high quality medical care to its patients; however, in order to maintain patient confidence and this level of care, VA managers must focus on operations oversight to ensure that VA hospitals operate in accordance with VA standards and that health care is the number one priority. A

lack of oversight has resulted in quality of care lapses (lack of program oversight, poor coordination, communication, and education) that were reported by OIG this past year. These instances include the misuse of insulin pens which required notification to hundreds of Veterans that they are at risk of blood borne infectious disease, mismanagement of a mental health care contract where thousands of Veterans' mental health care needs may not have been provided, and lapses in the provision of routine colonoscopies for cancer screening. To correct these quality care lapses, VA must review the current methods used to fill internal vacancies, review quality oversight mechanisms used by Veterans Integrated Service Network (VISN) and national leaders, and make the required changes to address these errant decisions.

Veterans who have been injured during their service often suffer from physical and mental injuries. The use of narcotic medications for pain related symptoms in the United States and within VA is of staggering proportions. The use of high doses of narcotics for individual patients, where the medication has significant abuse potential, creates significant societal stresses within VA's community. VA's policy with respect to the management of the population of high narcotic users must be regularly reviewed and supported in order to affect the best possible outcomes for patients.

VA's Program Response

Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed 2013 Milestones

The VA health record, Computerized Patient Record System (CPRS), is a collection of a patient's clinical information and is an important communication tool contributing to high-quality care. With rapid changes in the standards for electronic health records, VA continues to enhance CPRS through agile development and innovation. The use of clinical information to trigger reminders and alerts continues to support improvements in clinical quality guidelines and patient outcomes, such as allergy checks, and suggesting recommended actions. With electronic data capture and storage of patient health information, we continue to work toward the seamless exchange of patient data with external authorized users, such as the Department of Defense and private sector providers, and to enhance continuity of patient care.

VHA has established Relative Value Unit (RVU)-based productivity standards for various specialties and developed a process for the review of specialty group practices. As part of this review process, VHA has established a template for consistent application of business rules for labor mapping for physicians and has developed a Quadrant tool and Practice Management Report for evaluating specialty productivity, access, staffing, and efficiency. Algorithms related to the Quadrant tool and Practice Management Report have been developed. The purpose of these algorithms is to assist facility leaders in the management of specialty care resources and ensure appropriate staffing for specialty care services across all VHA sites.

VHA's Office of Mental Health has made significant gains in developing staffing and productivity standards as well as substantial hiring to adequately staff VHA mental health programs. In June 2013, VA announced the successful hiring of 1,600 mental health clinicians and a decrease in the national vacancy rate from 12 percent to 11 percent. Concurrently, productivity standards for mental health providers were published. In August 2013, VHA began national expansion of its pilot guidance for staffing general outpatient mental health programs. In addition, VA developed improved metrics for assessing the timeliness of care delivery throughout fiscal year 2013 and began development of

outcome metrics for evaluating quality of care. Implementation of these initiatives is providing VA managers at all levels of the organization with tools to make more accurate decisions about resource needs.

VHA is developing and implementing a series of educational sessions for leaders and clinicians that reinforce organizational expectations that patients receive prompt notification of colorectal cancer (CRC) screening results and that clinicians counsel patients to proceed with diagnostic testing within 60 days of a positive CRC screening result. Communication of CRC screening, specifically Fecal Occult Blood Test (FOBT) results, will be included in national monitors.

VHA facilities will be provided with tools to assist in identifying and tracking Veterans with positive FOBT results. These tools will also assist in determining the proportion of patients who undergo desired diagnostic testing within 60 days of that positive result. VHA Patient Care Services will collaborate with Office of Informatics Analytics in the development of a quarterly report identifying those Veterans with positive FOBT results and those who have undergone diagnostic colonoscopy within 60 days of a positive screen.

In early 2013, VHA launched the Opioid Safety Initiative to monitor the frequency and dosing of opioid analgesic prescriptions across all VA facilities. This initiative identifies Veterans with high dose prescriptions and activates expert consultation to ensure appropriate pain management. The initiative institutes corrective education and training of providers in the use of opioid analgesics for pain and in risk management strategies to improve safe opioid prescribing. FY 2013 Combined Assessment Program (CAP) reviews at 30 VHA facilities included an assessment of medication management to determine whether facilities complied with selected requirements for opioid dependence treatment. OIG found high compliance (>95 percent) in its review of whether controlled substance policies in facilities were consistent with VHA requirements.

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

As mentioned in Sub-Challenge 1A, Veterans' access to VA health care is a major challenge for VHA. Here the focus is on the particular challenges of providing timely access to high-quality care and services by increasing telemedicine, medical staff productivity, fee care services, access to quality contract nursing homes, and nursing home care services.

In January 2002, Public Law (P.L.) 107-135 mandated that VA establish a nationwide policy to ensure medical facilities have adequate staff to provide appropriate, high-quality care and services. However, OIG audits and inspections, including a December 2012 report, *Audit of VHA's Physician Staffing Levels for Specialty Care Services*, continue to identify the need for VHA to improve their staffing methodology by implementing productivity standards. OIG determined that VHA had not established productivity standards for 31 of 33 specialty care services reviewed, and had not developed staffing plans that addressed the facilities' mission, structure, workforce, recruitment, and retention issues to meet current or projected patient outcomes, clinical effectiveness, and efficiency.

VHA's lack of established productivity standards for specialty care services and staffing plans limited the ability of medical facility officials to determine the appropriate number of specialty physicians for patient care needs and to measure productivity of specialty care services. Productivity standards had not been developed because of lack of agreement within VHA on how to develop a methodology to measure productivity, and current VHA policy does not provide sufficient guidance on developing

medical facility staffing plans. As a result, VHA's lack of productivity standards and staffing plans limit the ability of medical facility officials to make informed business decisions on the appropriate number of specialty physicians to meet patient care needs, such as access and quality of care. This issue will be compounded as VA begins integrating the requirements of the Affordable Care Act (ACA).

VA must have a clear understanding of how VA care will be integrated into the ACA. VA should anticipate modifying their policies to accommodate changes required by this law and notify stakeholders accordingly of their actions. Congress has held hearings and VA has engaged contractors to address aspects of this change, yet many aspects of VA's roles and implementation are unclear. The fundamental issue of how VA health care, which is intended to provide care for Veterans, will be integrated into the options selected by families through health care exchanges remains to be clarified.

OIG's *Audit of the Community Nursing Home Program* reported Veterans were placed in contract nursing homes that did not meet VHA standards for nursing home operation and quality of care. VHA renewed contracts for nursing homes that were ineligible to participate in VHA's Community Nursing Home program. Specifically, inadequate VA medical facility reviews of nursing homes' eligibility resulted in the renewal of ineligible nursing homes' contracts. VA medical facility review teams did not adequately review Centers for Medicare and Medicaid Services (CMS) profile information and State Survey Reports and apply VHA exclusionary criteria when they assessed nursing home eligibility. This allowed the continued participation of ineligible nursing homes in the program and increased the risk of patient safety and quality of care problems. OIG projected that VHA places about 6,700 patients in ineligible nursing homes at a cost of about $59.3 million annually. If program controls are not strengthened, VHA will place approximately 33,500 patients in ineligible nursing homes at a cost of about $296.5 million over the next 5 years.

VHA needs to establish one standard of care for providing selected purchased home care services to ensure that it is providing consistent and equitable access to purchased home care services to eligible Veterans across the Nation. On September 30, 2013, OIG reported in its *Audit of VHA's Selected Non-Institutional Purchased Home Care Services* that VA medical facilities used various methods and strategies to limit Veterans' access to homemaker/home aide, respite, and skilled care services. Although this report highlights gaps in providing access to services it also identified significant variation in the quality of care delivered.

VHA's non-institutional care program allows Veterans to receive VA and contractor- provided services in the least restrictive environment possible, such as in the Veteran's home. OIG projected that at least 114 VA medical facilities limited access to these services through the application of more restrictive eligibility criteria and review processes, and/or the avoidance of waiting lists. These processes also allowed many of the same VA medical facilities to avoid placing about 49,000 Veterans on waiting lists. The gap in service delivery occurred because VA medical facilities took action to fund higher priorities, such as mental health, and to reduce their fee program expenses. Additionally, VHA disseminated inaccurate eligibility information for purchased skilled care services and lacked adequate monitoring and evaluation mechanisms. VAMCs also used ineligible home care agencies to provide services. OIG estimates that VHA will pay about $893 million to ineligible agencies over the next 5 years unless it ensures these agencies are adequately reviewed and monitored.

VHA raised a number of concerns about OIG estimates and statistical projections after reviewing the draft report on non-institutional purchased home care services. The randomly selected sites provided a statistically accurate representation of purchased home care services because they were representative

of VA's universe of medical facilities, their patient populations, and the conditions under which the facilities operate.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed 2013 Milestones

VHA has established RVU-based productivity standards for the specialties of dermatology, gastroenterology, neurology, ophthalmology, orthopedics, and urology, and developed a process for the review of specialty group practices. As part of this review process, VHA has established a template for consistent application of business rules for labor mapping for physicians and has developed a Quadrant tool and Practice Management Report for evaluating specialty productivity, access, staffing, and efficiency. Algorithms have been developed to guide the interpretation and utilization of the Quadrant tool and Practice Management Report. The purpose of these algorithms is to assist facility leaders in the management of specialty care resources and ensure appropriate staffing for specialty care services across all VHA sites.

Any practice among these six specialties that falls below the 25th percentile productivity standard or above the 75th percentile for a specific specialty and medical center complexity group must undergo a local review which addresses data inputs including person class designation and physician labor mapping. If a specialty practice productivity level is more than one standard deviation below the mean for its specialty and medical center complexity group, facility clinical leaders work with the specialty to develop a remediation plan. The remediation plan undergoes facility Director and VISN Director review and concurrence.

Since the ACA enactment, VA has worked diligently to understand the impact of the health care law by examining the key provisions and identifying the implications for Veterans and VA. As a result, VA has established a collaborative enterprise-wide approach to implementing ACA. VA's efforts to implement ACA fall into four broad categories: (1) data analysis; (2) communications; (3) operations; and (4) information technology. In July 2013, VA began using various modalities to communicate with Veterans, staff and other stakeholders that Veterans health care does not change as a result of ACA. VA will continue to provide Veterans with high-quality, comprehensive health care and benefits they have earned through their service. As the key provision of ACA to have health insurance coverage takes into effect in January 2014, VA will continue to assess the impact of ACA on VA and integrate these efforts into current VA business processes and policies as needed.

VHA has plans in place to improve the provision of non-institutional purchased home care services to Veterans. VHA is working to tighten controls for ensuring only eligible home care agencies receive VHA funds. VHA has developed improved mechanisms to assure that Veterans who are enrolled with VA for health care either receive purchased home health care for their needs or are placed on a wait list which will be tracked. VHA will address the billing concerns OIG identified at one of the eight facilities they audited and will provide clear and comprehensive guidance to appropriate personnel at all other facilities on proper documentation of orders for purchased home care services.

VHA has concerns about some of the estimates and projections presented in OIG's Audit of Selected VHA Non-Institutional Purchased Home Care Services because they are based on sampling methodology that does not accurately represent the complexity of non-institutional purchased home care for

Veterans nation-wide. VHA does not agree with OIG's national estimate of the number of VA medical centers potentially limiting access to services (114), the projected potential use of ineligible agencies (1,300), or the projection that VA could pay $893 million to ineligible agencies over 5 years. VHA does not concur with OIG's national estimate that 49,000 Veterans should have been placed on wait lists for purchased home and community based services because this estimate does not take into account Veterans' rights to choose where they receive their care.

VHA appreciates that OIG correctly identified improper payments of $67,000 at one facility and did not identify any significant problems at the other seven facilities they audited. However VHA does not concur with OIG's decision to project the findings at one facility across all VHA facilities to achieve 5-year projection of $13.2 million in improper payments. VHA finds there is insufficient justification to support the projection beyond the actual finding, particularly in light of aforementioned concerns about the sampling methodology used in this report.

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

VHA maintains inventories of about 93,000 specific prosthetic items with a total value of about $70 million. Every year, VAMCs process hundreds of millions of dollars' worth of prosthetic supplies through these inventories. OIG reported to Congress in FY 2012 that VHA needs to strengthen VAMC management of prosthetic supply inventories to avoid spending funds on excess supplies and to minimize risks related to supply shortages. Further, OIG identified the need for VHA to replace the Prosthetic and Generic Inventory Packages with one automated system. OIG recommended VHA implement a modern inventory system and strengthen the management of prosthetic supply inventories. The Under Secretary for Health agreed with our FY 2012 recommendations but the recommendations remain open. A plan to replace Prosthetic and Generic Inventory systems is in development and completion is projected for 2015 pending availability of funds. OIG will continue to monitor this area and the risks imposed by reliance on the legacy inventory systems as a management challenge until a modern inventory system is put in place.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed 2013 Milestones

VHA promoted the Prosthetic Service Card (PSC) program during FY 2013. VHA provided education on the program to Veterans and VA staff. All eligible Veterans who have service-connected amputations (12,128 Veterans) were sent a PSC information letter and pre-paid response card. As of July 2013, 65.2 percent of identified Veterans possess a PSC for their qualifying prosthetic device. The second attempt to reach Veterans who have not responded was completed in August 2013. A PSC information letter and prepaid response card was sent to over 2,700 Veterans.

VHA has undertaken several initiatives to enhance oversight of management and acquisition of prosthetic limbs. In February 2013, VHA issued a memorandum to the field providing guidance on the use of Medicare L-codes and Not Otherwise Classified codes. National policy on the development of the Healthcare Common Procedural Coding System list for prosthetic limb or custom orthotic device prescription has been developed and is undergoing VHA review for concurrence. VHA finalized a

national contract template for prosthetic limbs, now under review by the Office of General Counsel and the Office of Acquisition and Logistics. A comprehensive assessment of Orthotic and Prosthetic Services solicitation was issued in March 2013 and the contract was awarded in August 2013.

VHA developed an educational course titled Principles in Inventory Management (PIM), which will be provided to prosthetics supply inventory managers and logistics staff in FY 2014. More than 100 field-based staff have already taken or will soon take the PIM course. Eight of the initially planned 10 classes have been conducted, with plans for 15 more. Prosthetics and Sensory Aids Service developed an online inventory management course that provides an overview of the Prosthetics Inventory Package (PIP); in January 2013, this course was made available to all VHA staff through the Talent Management System.

OIG CHALLENGE #2: BENEFITS PROCESSING
-Strategic Overview-

Persistent large inventories of pending claims for Compensation and Pension benefits pose a continuing challenge for VBA. As of September 2013, this inventory of claims is 722,013. This backlog is attributed to an increase in the disability claims workload, in part due to returning Iraqi 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. Complex benefits laws related to traumatic brain injury (TBI) claims, court decisions, technology issues, workload, and staffing issues also contribute to VBA's benefits processing challenges.

In efforts to address this backlog, VBA has adopted 40 transformation initiatives, including claims digitization and automated processing using the Veterans Benefits Management System (VBMS). VBA has also moved to initiatives such as claims brokering to even out workloads across VA regional offices (RO), provisional ratings for claims over 2 years old, and mandatory overtime during summer 2013 for claims raters.

In addition to falling short of goals for claims processing accuracy, OIG reported VBA continues to experience challenges in ensuring its 56 ROs comply with VA regulations and policies and deliver consistent operational performance. OIG also found that expedited rollout of Disability Benefits Questionnaires (DBQ) to reduce the claims backlog was put in place without adequate controls.

OIG continues to report the need for enhanced policies and procedures, training, oversight, quality review, and other management controls to improve the timeliness and accuracy of VBA's disability claims processing. OIG reports issued in 2013 highlight continuing VA challenges in managing the claims backlog, ensuring accuracy in disability benefits processing workload, and claims storage issues at certain ROs.

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

RO staff faced challenges providing accurate decisions on Veterans' disability claims. From October 2012 through June 2013, OIG inspected 11 ROs and reported on their performance in 3 claims areas: temporary 100 percent disability evaluations for service-connected conditions requiring surgical or

medical treatment, TBI, and Gulf War Veterans' entitlement to mental health care. RO staff did not correctly process 47 percent of the total 762 claims OIG sampled primarily due to a lack of oversight and training. Specifically, RO staff incorrectly processed:

- 60 percent of 324 temporary 100 percent disability evaluations, resulting in nearly $3 million in improper payments within this sample of national claims.
- 32 percent of 197 TBI claims reviewed. OIG found that TBI claims processing errors resulted from staff using VHA medical examination reports that did not contain sufficient information to make accurate rating determinations. Staff generally over evaluated the severity of TBI-related disabilities because they did not properly interpret the medical examination reports.
- 40 percent of 241 claims involving Gulf War Veterans' entitlement to mental health care.

VA's Program Response

Estimated Resolution Timeframe: 2015
Responsible Agency Official: Under Secretary for Benefits

Completed 2013 Milestones

VBA has aggressively pursued its Transformation Plan to implement a series of tightly integrated people, process, and technology initiatives designed to achieve the 2015 strategic goal of completing all rating-related compensation and pension claims within 125 days at 98 percent accuracy level. Significant progress has been made. As of September 30, 2013, the claims inventory totaled 722,013, down from a high of 883,930 in July 2012. As of September 30, 2013, the backlog of claims older than 125 days totaled 418,472. This was 192,601 below the peak backlog in March 2013 and its lowest point since March 2011. As of August 2013, claim-based accuracy was 89.1 percent and accuracy measured at the medical issue-based level was 95.8 percent.

VA developed a strategy for the secure electronic submission of DBQs received outside the VA examination process. Controls for verifying the identity and credentials of private physicians submitting DBQs online will occur once the DBQ automated solution is integrated with VBMS and the Stakeholder Enterprise Portal. As an interim control, VBA's Quality Assurance staff conducts DBQ validation reviews of a statistically valid sample of DBQs submitted by private physicians.

VBA continues to monitor records that contain temporary 100 percent evaluations to ensure they have the appropriate controls and indicators established and to ensure a future examination date is in the Veteran's electronic record. Throughout 2013, VBA conducted biweekly reviews of all 100 percent evaluations to identify any records without the proper controls and indicators for correction by regional offices.

With the June 2013 implementation of the VBMS – rating functionality in all ROs, systemic safeguards are in place to prompt users to input controls and prevent users from completing associated actions for all 100 percent evaluations without proper controls and indicators established.

VBA developed a TBI Training and Performance Support System (TPSS) module. This training module will be mandatory in 2014 for all Rating Veterans Service Representatives (RVSR) and Decision Review Officers (DRO). The module contains guidance for properly identifying residuals of TBI, determining if evidence is sufficient to grant service connection, and assigning appropriate percentages.

VBA also added several classes in the National Training Curriculum on rating mental health conditions. VBA updated the medical TPSS module on mental disorders, specifically PTSD and the military sexual trauma training. These training modules are mandatory for all RVSRs and DROs in 2013.

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

VBA continues to experience challenges ensuring its 56 ROs comply with VA regulations and policies and deliver consistent performance of their Veterans Service Center (VSC) operations. OIG's Benefits Inspectors reported almost two-thirds of the 11 ROs inspected from October 2012 through June 2013 did not follow VBA policy to ensure Systematic Analysis of Operations (SAO) were timely and complete. SAOs provide an organized means of reviewing VSC operations annually to identify existing or potential problems in claims processing and propose corrective actions. If RO management had ensured the completion of SAOs, they would have identified weaknesses associated with their operations and could have developed plans to correct these shortcomings.

VA's Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Under Secretary for Benefits

Completed 2013 Milestones

VBA strives to find new ways to improve the performance at all ROs. VBA aggressively monitors RO performance, and if negative performance trends develop, area directors establish improvement plan requirements for RO Directors, ensuring appropriate attention to problem areas. Area directors visit each RO at least annually to conduct an in-person review of operations. Oversight is also provided through on-site review of RO operations conducted by Compensation and Pension and Fiduciary Services. RO Directors are held accountable for station performance through annual performance evaluations.

All VBA ROs are required to perform annual SAOs to provide a comprehensive overview of specific divisional functions as well as identify areas for improvement. Procedures and a schedule for completing SAOs are available for each VBA business line. Also, each RO Director can establish additional SAOs for local operational issues.

SAOs are reviewed during both Central Office and Area Office site visits. SAO compliance is tracked and monitored closely for timeliness and content at every level of management, to include local business line and executive management reviews. Reviews ensure compliance with the elements cited in M21-4, Chapter 5. Area Offices may request copies of the RO SAO schedules and specific completed SAOs for further review. SAO training is provided to management on-site during site visits if deficiencies are present.

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

According to VA's 2012 Annual Benefits Report, the benefits of more than 134,000 incompetent VA beneficiaries are being managed by fiduciaries. The total estimated amount of VA benefits under the control of fiduciaries is more than $2.3 billion. From April 1, 2008, to March 31, 2013, OIG conducted 148 investigations involving fiduciary fraud and arrested 91 fiduciaries and/or associates. OIG

investigations highlight program vulnerabilities that are exploited by unscrupulous individuals at the expense of incompetent VA beneficiaries.

Two recent examples illustrate weaknesses that allowed funds to be embezzled. In the first example, an attorney, who was the court-appointed fiduciary for 54 Veterans, and his wife, who served as his legal assistant and office manager, were each sentenced to 46 months' incarceration and 3 years' supervised release. In addition, they were ordered to jointly pay restitution of more than $2.3 million to VA and $282,112 to the Internal Revenue Service (IRS). An OIG investigation determined that from January 2003 through December 2008, the couple stole more than $2.3 million from the incompetent Veterans and submitted falsified accountings to VA to conceal the thefts. In addition, they failed to report the stolen funds to the IRS. In the second example, a former VA fiduciary was sentenced to 41 months' incarceration, 36 months' supervised probation, and ordered to pay $639,618 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant, an attorney, embezzled $460,679 of VA benefits and $176,246 of Social Security Administration benefits from an incompetent Veteran. The defendant admitted to submitting fraudulent accountings to both VA and the court by altering reports and creating fraudulent certificates of deposit.

VA's Program Response

Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Benefits

Completed 2013 Milestones

VA enhanced procedures to prevent and identify misuse of beneficiary funds. Procedural improvements previously implemented up through 2012 led to a 2012 misuse rate that was less than one-tenth of one-percent. VA required that fiduciaries provide detailed financial documents, including bank records, with their annual accountings. This additional information allows VA to verify reported expenditures and identify potential misuse of funds. VA mandated criminal background checks for proposed fiduciaries prior to appointment. These precautionary requirements serve as a deterrent for fiduciaries. VA issued procedures for instructing fiduciaries to provide a copy of VA-approved accountings to beneficiaries. This policy increases transparency of the fiduciary's management of the beneficiary's funds. VA issued guidance to limit calculation of fiduciary fees based upon monthly benefit payments only and eliminate the requirement that fiduciaries seek VA approval of certain expenditures from beneficiary funds. This guidance emphasizes the need for fiduciaries to communicate with beneficiaries and determine whether expenditures are in the beneficiary's interest. VA established telephone units in the fiduciary hubs to respond to direct inquiries from beneficiaries and fiduciaries and ensure consistent service delivery.

In 2013, VA completed a draft revision of its fiduciary regulations consistent with current law and policies and VBA's recent consolidation of its fiduciary activities at six fiduciary hubs. The proposed rules would clarify the rights of beneficiaries in the program and the roles of VA and fiduciaries in ensuring that VA benefits are managed in the best interest of our most vulnerable beneficiaries. The proposed rules are expected to be published in the Federal Register for public comment in early 2014.

In April 2013, VA implemented a standardized, national training curriculum for fiduciary personnel, which, among other things, addresses applicable fiduciary program policies and procedures, file documentation, account audits and appropriate follow ups, surety bonds, fiduciary appointments, and workload management.

In April 2013, VA deployed Centralized Field Examiner Training. This training provides consistent and standardized instruction targeted at field examiners with less than 1 year of experience. Training includes field examination techniques and customer service, as well as the responsibilities of the fiduciary. VA is developing advanced training modules for journey-level field examiners. The first training module focuses on misuse procedures and is expected to be released in early 2014.

In May 2013, VA increased the number of field examination and accounting cases selected for quality assurance review. VA conducts monthly fiduciary quality reviews on a random sample of the fiduciary workload at each fiduciary hub. The quality review results are used to increase awareness of policy and procedures and guide the development of training when needed.

In August 2013, VA tested the Beneficiary Fiduciary Field System (BFFS), which is the new information technology (IT) system for the fiduciary program. VA anticipates national deployment at the end of December 2013. BFFS will allow VA to leverage existing technology to create an interface with VBA's corporate database, improve reporting processes to enhance workload management capabilities, integrate an automated field examination report generator tool, and improve misuse monitoring. It will greatly improve VA's ability to track beneficiary visits, fiduciaries' annual accountings, and further detect potential misuse.

In August 2013, VA published a "Guidebook for VA Fiduciaries." The new guidebook is targeted to volunteer fiduciaries and will advise fiduciaries about beneficiary rights, fiduciary responsibilities, management of funds, and accounting and audit procedures. In conjunction with the guidebook, VA released an automated accounting preparation tool to assist fiduciaries in preparing their annual accountings.

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. In FYs 2012 and 2013, as a result of an OIG administrative investigation involving wasteful expenditures at two training conferences, VA is redesigning controls over conference management activities. Further, OIG identified several lapses in sound financial stewardship impacting VA's programs and operations, including its Beneficiary Travel Program (BTP).

Failure in some instances to ensure sufficient funds are available to pay for non-VA care fee services for Veterans is one way in which improper payments occur. Addressing these and other issues related to financial systems, information, and asset management would promote improved stewardship of the public resources entrusted for Departmental use.

OIG Sub-Challenge #3A: Lack of Accountability and Control over Conference Costs (Training Support Office (TSO) in the Office of the Secretary[1] – Lead, HRA, VHA, VBA, NCA)

[1] TSO moved to the Office of Management, Financial Services Center, in October 2013.

OIG conducted an administrative investigation upon receiving allegations of wasteful expenditures related to Human Resources (HR) conferences held in Orlando, Florida, in July and August 2011. The lack of accountability and controls prevented OIG from obtaining a full accounting of the expenses associated with these conferences. More than a year after the conferences, VA was unable to provide an accurate and complete accounting of costs for these conferences. VA's estimates of the conference expenditures changed multiple times during the course of the administrative investigation. While VA reported lower estimates of conference costs to Congress, OIG reconstructed the costs of the two conference events to be approximately $6.1 million.

However, OIG could not gain reasonable assurance that this figure represented a complete accounting of the conference costs. Overall, VA's processes and the oversight were too weak, ineffective, and in some instances, nonexistent to ensure that conference costs identified were accurate, appropriate, necessary, and reasonably priced. Accountability and controls were inadequate to ensure effective management and reporting of the dollars spent. OIG questioned about $762,000 as unauthorized, unnecessary, and/or wasteful expenses.

This administrative investigation was followed by OIG's audit of VA's use of interagency agreements to fund four Financial Management Training Conferences (FMTC) in 2010-2012.

VA's Program Response
Estimated Resolution Timeframe: 2015
Responsible Agency Official: Chief of Staff

Completed 2013 Milestones
VA is implementing a comprehensive action plan to revise and strengthen policies and controls on the planning and execution of training conferences and events. These actions are consistent with the recommendations in the September 30, 2012, Inspector General Report and are reflected in VA policy issued on September 26, 2012.

Stringent internal controls for conferences and training conferences are in place and the senior executives in the Department provide oversight. Further, the newly established TSO ensures consistency and adherence with all appropriate regulations and requirements as the Department balances critical training requirements to ensure we achieve stated goals and objectives while minimizing costs.

Automating data collection is essential to provide accurate and timely information for senior leaders so they can execute their responsibilities and respond to queries for training related events from Congressional and other Federal oversight bodies. VA is currently engaged in developing and delivering an automated data collection tool to increase accountability, control conference spending, and produce congressionally required reports.

OIG Sub-Challenge #3B: Strengthen Financial Controls Over the BTP (VHA)

VHA's BTP pays the actual necessary expense of travel, including mileage traveled, to and/or from a Department facility or other place in connection with vocational rehabilitation or counseling, or for the purpose of examination, treatment, or care for certain eligible Veterans. In 1978, VA set the travel mileage reimbursement rate at 11 cents per mile. The rate remained unchanged until February 2008,

when VA raised the rate to 28.5 cents per mile. In November 2008, VA raised the mileage reimbursement rate to 41.5 cents per mile. As a result, the BTP experienced a significant growth in both usage and cost. Expenditures for the program increased by approximately 285 percent from FY 2006 through FY 2010.

In February 2013, OIG's *Audit of VHA's Beneficiary Travel Program,* reported serious issues regarding lack of controls over beneficiary travel payments. Specifically, VHA did not perform regular reconciliations of approved travel reimbursements with paid reimbursements, accurately code financial transactions, and reduce the risk of fraudulent payments. This occurred because VHA had not established policies and mechanisms that address reconciliations of BTP financial data, provided adequate training to ensure accurate coding of beneficiary travel expenses, and established procedures to mitigate the risk for making duplicate payments on approved travel reimbursements. In addition, current information system limitations present challenges to performing automated reconciliations.

OIG identified material differences in mileage reimbursements paid compared with approved mileage reimbursements. According to VHA data, VA medical facilities paid approximately $89 million more in beneficiary travel than the facilities approved during the period from January 1, 2010, through March 31, 2011. OIG determined that approximately $46.5 million of the variance was in part the result of miscoded charges, but could not determine the reason for the variance of the remaining approximately $42.5 million. This was because of a lack of an adequate financial audit trail and system limitations.

The audit also revealed that VHA does not have sufficient procedures to reduce the risk of making duplicate payments on approved travel reimbursements. Medical facility staff record only the aggregate value of batched cash reimbursements in VA's Financial Management System (FMS). Staff cannot electronically identify individual cash payments associated with approved beneficiary travel claims which increases the risk of fraudulent payments. For example, after receiving an approved travel reimbursement, a Veteran can photocopy it and provide multiple copies of the approved travel reimbursement for payment. Since no record exists in FMS that an agent cashier made a previous payment for the approved travel, the medical facility is susceptible of paying the Veteran more than once for the same approved travel reimbursement.

As a result of these program vulnerabilities, the number of OIG criminal investigations increased as VA raised beneficiary travel mileage reimbursement rates. In FY 2007, OIG conducted one beneficiary travel fraud investigation. In comparison, in FY 2010, OIG conducted 44 investigations. As of June 2013, OIG has 125 open beneficiary travel investigations. Two recent examples illustrate this type of fraud. In the first example, two Veterans were indicted for bribery, conspiracy to defraud the U.S. Government, and false claims. Previously, five other Veterans and two Seattle, Washington, VAMC travel clerks were charged in this case. An OIG investigation revealed that the seven Veterans participated in a scheme with the VAMC travel clerks to submit inflated and fictitious travel benefit vouchers. The VA employees processed the vouchers and then demanded kickbacks from the Veterans. The loss to VA is estimated to be over $150,000. In the second example, 16 Veterans were charged with theft of Government property and false statements. A VA OIG, VA Police Service, and Department of Housing and Urban Development OIG investigation revealed that the defendants filed fraudulent travel vouchers at the Cleveland, Ohio, VAMC in order to obtain travel benefits they were not entitled to receive. The loss to VA is over $242,000.

To deter this fraud, OIG has encouraged prosecutors to issue press releases when judicial action occurs, developed a data analytic tool to proactively identify this fraud in specific facilities, and worked closely

with VA to significantly enhance their own data mining efforts and design new warning posters. VHA agreed with OIG recommendations and findings. However, until VHA fully implements planned changes and strengthens authorization and payment controls, VHA will continue to lack reasonable assurance that program costs are accurate and paid only to eligible Veterans.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Under Secretary for Health

Completed 2013 Milestones

In October 2012, VHA and the Financial Services Center used VBA payment information to create Veteran records in FMS. FMS records will enable more efficient processing of Veterans' payments using direct deposit. As of October 2013, the current number of Veterans that can receive direct deposit payment is 1,180,094.

This is a decrease from the 1,213,523 cited in May 2013, and is the result of some Veterans requesting that they be removed from direct deposit. Although facilities are encouraging Veterans to enroll for direct deposit, we do not have the ability to enforce compliance with electronic funds transfer (EFT) if the Veteran declines. The current timeline for the debit card, which is an alternative payment mechanism to direct deposit, is currently estimated to be implemented late FY 2014. When that occurs, Veterans will have to choose an EFT payment method unless they have received a waiver from the Treasury.

OIG Sub-Challenge #3C: Improve Compliance with the Improper Payments Elimination and Recovery Act, Reduce Improper Payments, and Weaknesses in Non-VA Fee Care Program (VHA)

VA needs to strengthen its efforts to reduce improper payments to meet Improper Payments Elimination and Recovery Act (IPERA) requirements and report statistically valid estimates. VA reported about $2.2 billion in improper payments in its FY 2012 Performance and Accountability Report (PAR) and did not comply with four of seven requirements of IPERA in FY 2012. VHA also did not report a gross improper payment rate less than 10 percent or meet a reduction target for its Non-VA Care Fee program. While not a matter of noncompliance, VHA could also improve its estimation methodology to achieve the required statistical precision for all of its reported programs. Additionally, VBA did not use statistically valid methodologies to calculate improper payment estimates for some programs or report amounts collected through its activities to recapture improper payments. VA officials provided appropriate action plans and OIG will follow up on VA's progress during our annual review of VA's compliance with IPERA.

VA failed to ensure sufficient funds were available to pay for non-VA care for Veterans resulting in improper payments. The South Texas Veterans Health Care System (STVHCS) authorized $29 million dollars in fee care in FYs 2009 and 2010 although it did not have sufficient funds obligated and available to pay for the services Veterans received. This occurred because STVHCS did not ensure clinical and fee staff complied with required steps for authorizing the fee care, and assigned staff did not timely process fee care payments. Also, STVHCS clinical and fee staff lacked defined roles and responsibilities, sufficient training, and adequate supervision. Further, neither STVHCS nor VISN 17 management had effective oversight mechanisms in place to ensure sufficient funds were available to pay for the non-VA care received by Veterans. As a result, STVHCS lacked the necessary visibility over these unpaid claims when vendors' invoices were received until fee staff researched, summarized, and processed this information.

VHA continues to face significant challenges in addressing the health care and financial vulnerabilities associated with the Non-VA Fee Care program. OIG reported these challenges in *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program* and *Audit of Veterans Health Administration's Non-VA Inpatient Fee Care Program* in 2009 and 2010, respectively. OIG concluded in both reports that controls over pre-authorizing fee care services needed improvement.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed 2013 Milestones
VHA has completed 100 percent of the action items described in the 2012 PAR to reduce improper payments in the Non-VA Medical Care (NVC) program.

For NVC, VHA is working aggressively to ensure FY 2013 annual reduction targets are met. VHA met and exceeded the target goals in FY 2012 for reducing improper payments in all area reviews except for the NVC program. In 2013, VHA's Chief Business Office (CBO) introduced a Virtual Audit Team that will perform audits of the NVC program at all facilities and VISNs to reduce error rates and achieve reduction targets. In addition, CBO developed and deployed a Fee Basis Claims System (FBCS) patch to deliver

electronic Medicare pricing of eligible FBCS claims which will improve payment timeliness, eliminate manual entry of the payment amounts, and reduce error rates.

VHA worked to establish their 2013 sampling methodology. VHA briefed OIG and submitted the sampling methodology to the Office of Management and Budget (OMB) which approved VHA's statistical sampling methodology in June 2013.

VHA has completed the 2013 IPERA audit of the NVC program and successfully met the reduction target. The audit results were reviewed and a statistically valid analysis was performed by the national IPERA contract staff in response to a contract requirement.

VBA also worked with VA to establish VBA's 2013 sampling methodology. This sampling methodology was developed to achieve a statistical precision of 90 percent confidence interval with a 2.5 percent margin of error as required by IPERA. The sampling methodology was submitted to OMB on February 11, 2013. OMB approved VBA's statistical sampling methodology on June 28, 2013.

OIG CHALLENGE #4: PROCUREMENT PRACTICE
-Strategic Overview-

VA operations require the efficient procurement of a broad spectrum of services, supplies, and equipment at national and local levels. OIG audits and reviews continue to identify systemic deficiencies in all phases of the procurement process to include planning, solicitation, negotiation, award, and administration. OIG attributes these deficiencies to inadequate oversight and accountability.

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

OIG Sub-Challenge #4A: VA Can Achieve Significant Procurement Savings (VHA-Lead, OM, OALC)

In August 2013, OIG's *Audit of Non-Purchase Card Micro-Purchases*, reported that VA medical facilities missed opportunities to achieve significant procurement savings by maximizing the use of purchase cards for micro-purchases. OIG estimated VHA missed opportunities to decrease procurement-processing costs by about $20 million and obtain additional rebates of about $4 million. Medical facilities have two primary methods to make micro-purchases: purchase cards and purchase orders. Purchase card use helps VHA quickly procure supplies and services to ensure Veterans receive timely medical care. Typically, processing purchase card procurements may take up to 3 days, while processing purchase order procurements can take up to 30 days. Obtaining supplies and services by purchase card streamlines the procurement process, while using purchase orders is more complex and time consuming. The $20 million savings represents the difference in labor costs for processing purchase card and non-purchase card transactions. By increasing purchase card use, VA medical

facilities can increase productivity by shifting staff efforts from resource-intensive non-purchase card processing costs to other medical facility activities. In particular, eliminating the time contracting staff spend on processing micro-purchases is important due to a reported shortage of contracting specialists/officers positions throughout the Federal government.

VHA also missed opportunities to obtain estimated annual rebates of almost $4 million. VA executives have recognized rebates and other benefits related to purchase card use and have emphasized purchase card use to procure supplies and services. Over the last 5 fiscal years, VHA's reported rebates increased 51 percent from about $43 million in FY 2008 to just over $65 million in FY 2012. Although VHA has increased the amount of rebates earned through increased purchase card use, opportunities still exist for VHA to earn additional rebates. By maximizing the use of purchase cards for micro-purchases, VHA can increase purchasing efficiency and cost-effectiveness by $24 million annually and $120 million over the next 5 years. These improvements will help VHA address challenges to create a more efficient, effective, and coordinated acquisition program to ensure VHA protects taxpayers' interest when procuring supplies and services.

VA's Program Response
Estimated Resolution Timeframe: 2014
Responsible Agency Official: Under Secretary for Health

Completed 2013 Milestones
OIG published the *Audit of Non-Purchase Card Micro-Purchases* on August 9, 2013. VHA has developed an action plan in response to OIG's recommendations that will be implemented during 2014.

The VHA Procurement and Logistics Office (P&LO) will generate a report that identifies all purchases below the micro-purchase threshold level for FY 2012. P&LO will identify the number and amount of micro-purchases that have been obligated through VHA procurement. P&LO will establish monthly monitors of the total universe of micro-purchase thresholds and the number of micro-purchases effected through the procurement organization P&LO, and in conjunction with the VHA Chief Financial Officer, will establish performance targets to increase the percent of micro-purchases made with government purchase cards. Performance of VISNs will be reviewed regularly with VISN leadership throughout the year. VHA Deputy Under Secretary for Health for Operations and Management will develop recommended policies for VISNs to perform periodic reviews of micro-purchases utilizing the government purchase card. Periodic reviews will be performed by VISN Financial Quality Assurance Managers.

OIG Sub-Challenge #4B: Improve Oversight of Interagency Agreements (OALC- Lead, HRA)

VA has funded several of its training academies and workforce training under ADVANCE. OIG has reported the lack of VA oversight of ADVANCE's use of interagency agreements (IA), which represent a significant portion of ADVANCE spending. VA incurred almost $2.8 million in costs under IAs with the Office of Personnel Management (OPM) to hold two HR conferences in Orlando, Florida. VA relied upon its ADVANCE program to manage the funding needed to provide many of the conference support services. The issues associated with the HR conference expenditures magnify the process failures reported in an earlier OIG report, *Audit of VA's ADVANCE and the Corporate Senior Executive Management Office Human Capital Programs*. During this prior audit, OIG reported that VA needed to strengthen its management of IAs with OPM and improve its measures to more accurately assess

program impact. VA did not establish adequate controls over IA costs and terms, lacked reasonable assurance it effectively spent program funds during FYs 2010 and 2011, and did not evaluate the reasonableness of IA service fees.

In June 2013, OIG reported that VA expanded the terms of their Veteran Employment Services Office's (VESO) IA with OPM to provide VESO with two Veteran employment call centers operating 24 hours a day, 7 days a week. These call centers had call volumes so low during a 13-month period that call center employees each handled an average of 2.4 calls per day.

VA also funded the IA to develop and maintain a Veteran employment Web site for VESO, which duplicated key components of two existing VA Veteran employment Web sites. VESO awarded a $4.4 million 1-year contract to acquire HR support services that duplicated VESO's own internal HR capabilities and contracted for certain inherently Governmental functions. These costly and excessive acquisitions occurred because VESO did not conduct a thorough analysis to justify the need for the acquired support services. As a result, OIG estimated VESO will spend at least $13.1 million during FYs 2013 through 2015 on excess call center capacity unless action is taken to align call center capacity with Veteran use and demand.

These funds, along with the estimated $4.4 million that will be spent on the HR support services contract in FY 2013, could be better used to provide Veteran employment services with greater efficiency and accountability. By strengthening its management controls and improving its program impact measures, VA could improve its accountability over ADVANCE program funds. Implementation of these controls will be critical for VA to effectively manage the risks associated with future program initiatives, especially the oversight of conference management and management of active IAs.

In September 2013, OIG also reported that VA inappropriately paid about $5.3 million of a total $6.7 million spent for separately priced item (SPI) purchases and related service fees for three financial management conferences held in 2010 and 2011. SPIs can be purchased as incidental items to support tasks developed under IAs. VA and OPM lacked documentation of required approvals for approximately $3.4 million of the $6.7 million spent. In addition, VA paid the vendor about $697,000 in inappropriate service fees and paid OPM about $132,000 in service fees associated with inappropriate SPI purchases. Among the recommendations OIG made to VA in September 2013 were to consider discontinuing the use of assisted acquisition IAs with OPM, provide visibility and oversight over SPI purchases by approving proposed purchases in advance, and improve the transparency over SPI costs by reviewing detailed invoices before approving payments. SPI purchases under IAs had not been a focus in our prior conference management reviews. However, strong oversight controls are needed over these purchases and better assurance that these expenditures are economical and in the best interest of VA.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Principal Executive Director

Completed 2013 Milestones

OALC has revised and issued VA policy on IAs to implement changes to the FAR Subpart 17.5, Interagency Acquisitions, which broadens the scope to include any IA including Federal Supply Schedule orders exceeding $500,000; requires formal determination of an IA as the "best procurement approach," development of a business case for multi-agency contracts, and written agreements

stipulating VA and servicing agency roles and responsibilities; and submission of an annual agency IA report to OMB.

OALC coordinated with VA's Office of Human Resources and Administration (HRA), as well as OPM to strengthen oversight of appropriate costs and deliverables. Specific activities include the following:

OALC amended all of the IAs to increase the oversight controls when receiving financial data. Additionally all IA management plans at OPM have been reviewed to specifically address the separately priced items required in P.L. 112-154.

OALC and OHRA are actively implementing a plan to transition the OHRA/Human Capital Investment Plan (HCIP) requirements away from IAs. OALC and OHRA, in conjunction with OPM, are revisiting VA's required submissions on Department of Treasury FMS Forms 7600 A and B for the HCIP Initiatives to ensure alignment of the management plans to tasks identified in the FMS Form 7600B. Further, revisions to the information required for completion of FMS Form 7600A, which address general terms and conditions, will include language that will require the delivery of all OPM invoices correlating with OPM vendor deliverable receipt forms. The revisions are scheduled to be completed in 1st quarter FY 2014. OHRA's 2014 acquisition strategy is to work all contract award efforts, other than interagency agreements, through the Strategic Acquisition Center-Frederick (SAC-F).

To address the findings from the OIG audit of the *VA for Vets* call centers, the Acting Assistant Secretary for HRA and representatives from VESO met with OPM to discuss the IAA for the call centers. OPM conducted an analysis and concluded that the vendor delivered products to the standards of the requirements specified by VA. The IA with OPM ended on September 29, 2013. Subsequently, VA reviewed the needs of the VESO program and eliminated the call centers. Although a new solicitation was made public, the solicitation was withdrawn. Had a contract been awarded, it would not have been an IA. After a thorough analysis is conducted, decisions will be made in 2014 to determine if any scope of work is required. Any such decision will be based on the best value to VA, U.S. taxpayers, and America's Veterans.

OIG Sub-Challenge #4C: Sound Information Technology Procurement Practices (OIT)

A data breach in May 2006 evoked heightened and immediate concern regarding the protection of VA personally identifiable information (PII). In August 2006, the VA Secretary mandated that all VA computers would be upgraded with enhanced data security encryption software. However, in October 2012, OIG substantiated a Hotline allegation that OIT had not installed and activated an additional 100,000 licenses purchased in 2011. As of July 2012, OIT officials stated that due to inadequate planning and management, they had installed and activated only a small portion, about 65,000 (16 percent), of the total 400,000 licenses procured. Specifically, OIT did not allow time to test the software to ensure compatibility with VA computers, ensure sufficient human resources were available to install the encryption software on VA computers, and adequately monitor the project to ensure encryption of all VA laptop and desktop computers.

As such, 335,000 (84 percent) of the total 400,000 licenses procured, totaling about $5.1 million in questioned costs, remained unused as of 2012. Given changes in VA technology since 2006, VA lacked assurance that the remaining software licenses were compatible to meet encryption needs in the current computer environment. Further, because OIT did not install all 400,000 encryption software

licenses on VA laptop and desktop computers, Veterans' PII remained at risk of inadvertent or fraudulent access or use.

In 2013, OIT performed an assessment and decided to move forward with the deployment of the encryption software. However, as of April 2013, OIT has only managed to deploy approximately 47,000 of the 335,000 remaining encryption software licenses and may face challenges to meet its projected goal of complete implementation of the remaining software encryption licenses by the end of FY 2013. Further, OIT has not provided assurances that adequate IT resources are available to better ensure the implementation, as recommended.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Deputy Assistant Secretary for Information Security and Deputy Assistant Secretary for Service Delivery and Engineering

Completed 2013 Milestones

Throughout 2013, OIT worked to improve its IT procurement practices to ensure that it made sound decisions in regards to IT procurements and to continue to be a good steward of its funding. To do this, a Strategic Investment Tool was created to conduct analyses that are used to determine the most impactful and cost-effective IT solutions.

Initially, when the contract was executed to purchase the licenses, laptops were targeted first and we made significant progress encrypting all laptops. Desktops were targeted as well, but there were numerous issues due to the diversity of the devices in the field. The technology, at the time, was relatively new to the Federal Government and to an enterprise the size of VA. In addition, VA's planned rollout of the Windows 7 Operating System on desktop computers introduced unforeseen testing and compatibility issues with the encryption software. That issue has been resolved and VA is now rolling out encryption alongside Windows 7 with a targeted completion date of December 2013.

As of the end of September 2013, 293,640 Windows 7 desktops and 34,237 laptops were equipped with Symantec Endpoint Encryption encryption capabilities. OIT has proactively implemented a top-level policy to automatically encrypt laptops as they are introduced to the network.

OIG CHALLENGE #5: INFORMATION MANAGEMENT

-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 counterproductive. 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 Chief Information Officer, 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 our FY 2012 Consolidated Financial Statements Audit, our 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 consolidated financial statements, for the 12th year in a row the independent auditor has identified 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. VA could not readily account for the various systems linkages and sharing arrangements with affiliate organizations, leaving sensitive Veterans' data at unnecessary risk of unauthorized access and disclosure. OIT also has not fully implemented competency models, identified competency gaps, or created strategies for closing the gaps to ensure its IT human capital resources will support VA in accomplishing IT initiatives and mission goals well into the future. Despite implementation of the Program Management and Accountability System (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: Development of 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, 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.

Recent work on the Consolidated Financial Statements Audit supports our annual Federal Information Security Management Act (FISMA) assessment. During FY 2012, while our annual FISMA assessment was ongoing, VA instituted the Continuous Readiness in Information Security Program (CRISP) to ensure continuous monitoring year-round and establish a team responsible for resolving the IT material weakness. As our FISMA work progressed, OIG noted more focused VA efforts to implement standardized information security controls across the enterprise. OIG also saw improvements in role-based and security awareness training, contingency plan testing, reduction to the number of outstanding Plans of Action and Milestones (POA&M), development of initial baseline configurations, reduction in the number of IT individuals with outdated background investigations, and improvement in data center Web application security. However, the CRISP initiative was not launched until March 2012 and the improved processes have not been implemented for an entire FY with the opportunity to demonstrate sustained improvements in information security.

As such, the FY 2012 FISMA audit report discussed control deficiencies in four key areas: configuration management controls, access controls, change management, and service continuity controls.

Improvements are needed in these key controls to prevent unauthorized access, alteration, or destruction of major application and general support systems. VA had over 4,000 system security risks and corresponding POA&Ms that still need to be remediated to improve its overall information security posture. More importantly, OIG continued to identify significant technical weaknesses in databases, servers, and network devices that support transmitting sensitive information among VA facilities. Many of these weaknesses may be attributed to inconsistent enforcement of an agency-wide information security program across the enterprise and ineffective communication between VA management and the individual field offices.

OIG's FY 2012 FISMA report provided 27 current recommendations to the Assistant Secretary for Information and Technology for improving VA's information security program. The report also highlighted 5 unresolved recommendations from prior years' assessments for a total of 32 outstanding recommendations. Overall, we 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 2012 Consolidated Financial Statements 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.

OIG continues to evaluate VA's progress during the ongoing FY 2013 FISMA audit and acknowledges increased VA efforts to improve information security, but OIG is still identifying repeat deficiencies, albeit to a lesser extent. Upon completion of the FY 2013 FISMA testing and related work, OIG will make a determination as to whether VA's improvement efforts are successful in overcoming the IT material weakness.

A range of additional OIG audits and reviews over the past 2 years have exemplified VA's information security controls deficiencies. For example, in March 2013, the OIG reported that VA was transmitting sensitive data, including PII and internal network routing information, over an unencrypted telecommunications carrier network. VA OIT personnel disclosed that VA typically transferred unencrypted sensitive data, such as electronic health records and internal Internet protocol addresses, among certain VAMCs and Community-Based Outpatient Clinics using an unencrypted telecommunications carrier network. OIT management acknowledged this practice and formally accepted the security risk of potentially losing or misusing the sensitive information exchanged. VA has not implemented technical configuration controls to ensure encryption of sensitive data despite VA and Federal information security requirements. Without controls to encrypt the sensitive VA data transmitted, Veterans' information may be vulnerable to interception and misuse by malicious users as it traverses unencrypted telecommunications carrier networks. Further, malicious users could obtain VA router information to identify and disrupt mission-critical systems essential to providing health care services to Veterans.

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

as security violations. As a result, VA lacked assurance of adequate control and protection of sensitive STDP data. VA OIT concurred with OIG's recommendation and plans to implement a VA-wide encryption solution to mitigate these security risks.

In July 2011, OIG reported that certain contractors did not comply with VA information security policies for accessing mission critical systems and networks. For instance, contractor personnel improperly shared user accounts when accessing VA networks and systems; did not readily initiate actions to terminate accounts of separated employees; and did not obtain appropriate security clearances or complete security training for access to VA systems and networks. OIG concluded that VA has not implemented effective oversight to ensure that contractor practices comply with its information security policies and procedures. Contractor personnel also stated they were not well aware of VA's information security requirements. As a result of these deficiencies, VA sensitive data is at risk of inappropriate disclosure or misuse.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Deputy Assistant Secretary for Information Security

Completed 2013 Milestones

OIT continued efforts to improve its information security program and system security controls throughout 2013 by addressing findings in the 2012 FISMA Report regarding configuration management, access controls, change management, and service continuity controls. We continue to improve our security posture through existing initiatives such as the agency-wide CRISP, and the closing out of POA&Ms. Since October 2012, the number of open POA&Ms has almost halved and the trend continues to decline. High-severity POA&Ms have also decreased by one-third. We have also implemented new initiatives, such as the Governance, Risk, and Compliance (GRC) tool, Agiliance RiskVision OpenGRC (RiskVision), which establishes effective processes for evaluating information security controls by further instituting continuous monitoring throughout VA's network.

Regarding the March 2013 OIG report that VA has not implemented technical configuration controls to ensure encryption of sensitive data, OIT non-concurred with this finding. VA Directive 6609 provides policy that can be used for mailing personally identifiable and sensitive information when encrypted email is not available. Furthermore, when employees sign the VA Rules of Behavior, they agree to use VA approved encryption to encrypt any e-mail, including attachments to the email that contains VA sensitive information before sending the e-mail. Employees agree that they will not send any email that contains VA sensitive information in an unencrypted form.

Regarding the February 2012 OIG report that VA did not adequately protect sensitive data hosted within its STDP application, OIT has taken the following actions: OIT ensures that its employees on the STDP project receive the necessary role-based security training to address the issues highlighted in the February 2012 report. In addition, Information Security Officers (ISO) are assigned to oversee STDP development activities, ensure proper approval of requests for user access to the system at the appropriate levels, perform checks locally before system access is granted, and report information security events in accordance with VA policy.

Regarding the July 2011 OIG conclusion that VA has not implemented effective oversight to ensure that contractor practices comply with our information security policies and procedures, OIT has taken the following actions: First, VA holds a mandatory annual training stand down where every VA facility must

certify 100 percent training compliance for *VA Privacy and Information Security Awareness Training and Rules of Behavior* for all VA employees, contractors, resident-trainees, and volunteers/Veterans Service Organization representatives within their area of responsibility in the set timeframe. Contractors that are not compliant with VA's Privacy and Information Security Awareness Training and Rules of Behavior requirement will have their VA network access removed. Also, new contractors may not be given access to any VA information or information systems until they have completed this training requirement. Action items are being issued approximately every 6 months for ISO and service delivery and engineering IT operations personnel to conduct reviews of separated user accounts; this includes review of contractor accounts.

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

In October 2012, OIG reported that VA has not consistently managed its systems interconnections and data exchanges with its external research and university affiliates. Despite Federal requirements, VA could not readily account for the various systems linkages and sharing arrangements. VA also could not provide an accurate inventory of the research data exchanged, where data was hosted, or the sensitivity levels. In numerous instances, OIG identified unsecured electronic and hardcopy research data at VAMCs and co-located research facilities.

OIG determined that VA's decentralized data governance approach has been ineffective to ensure that research data exchanged is adequately controlled and protected throughout the data life cycle. VA and its research partners have not consistently instituted formal agreements requiring that hosting facilities implement controls commensurate with VA standards for protecting the sensitive data. The responsible VHA program office's decentralized approach to research data collection and oversight at a local level has not been effective to safeguard sensitive VA information. For several years, leading Federal and industry sources have proposed a more centralized model for improving governance of sensitive data throughout the data life cycle. Federal and industry sources also emphasize that effective data governance should provide centralized policies, procedures, and resources to effectively identify important data and securely manage them. Because of these issues, VA data exchanged with its research partners was considered to be at risk of unauthorized access, loss, or disclosure.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Under Secretary for Health and Assistant Secretary for Information and Technology

<u>Completed 2013 Milestones</u>

All Memoranda of Understanding (MOU) and Interconnection Security Agreements (ISA) are currently under review by the OIT and will be established or updated to reflect operational environments. The review of all MOU/ISAs is currently 79.5 percent complete. A total of 162 air gapped connections have been identified and documented as part of this process.

OIT has established a review group to examine the current templates in use and the process for updating and reviewing MOU/ISAs. Target date for completion of this review, and the revisions to the current MOU/ISA templates and process, is August 30, 2013.

OIT and VHA continue to develop a set of guidelines for conducting oversight of research labs. A workgroup consisting of OIT Field Security Service and VHA Office of Research and Development subject matter experts has been convened to draft guidelines and once matured, will be sent to OIT and VHA leadership for review. Target date for completion of these guidelines is 1st quarter of 2014. An action plan for conducting oversight reviews of research labs will be completed after the guidelines are developed.

VHA appreciates the importance of an accurate inventory of collected research data, compliance with research protocol requirements on data collection, and secure management of research information over the data life cycle. However, modalities for ensuring these elements of data management do not currently exist in government or private research settings. VHA continues to consider whether the simple solution of a centralized data governance and storage model would achieve the needs of complex research data management and whether such a model would be feasible or appropriate. Such a governance and management model would take considerable human and monetary resources. A cost-benefit analysis has yet to be performed to determine whether the benefit to be gained by such a system is appropriate to the level of resourcing required to develop, implement, and manage it over time. VHA has been working with OIT to develop questions that need to be answered with respect to a centralized repository. Issues associated with centralization are intimately related to issues associated with data sharing.

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

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

OIT has not fully implemented competency models, identified competency gaps, or created strategies for closing the gaps. OIT also has not captured the data needed to assess how well contractor support supplements OIT staffing and fills competency gaps. Moreover, OIT lacks assurance that it has made cost-effective decisions regarding how it spent money on contractors. Finally, OIT has not established a mechanism to evaluate the success of its human capital initiatives. As a result, OIT has no assurance it has effectively managed its human capital resources to support VA in accomplishing its mission. Once the strategy and competencies are in place, OIG will revisit this issue to determine the overall effectiveness of OIT's human capital management.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Director, Human Capital Management

Completed 2013 Milestones

OIT developed and implemented the OIT Human Capital Strategic Plan (HCSP), FY 2014 - 2020, and released it as scheduled on October 1, 2013. The plan was developed by OIT's Human Capital Strategic Working Group, with guidance from VA's Office of Human Resources Management Office of Workforce Planning. The HCSP is aligned with VA's missions, goals and objectives, and the performance measures and milestones outlined in the Human Capital Assessment and Accountability Framework. The HCSP is also linked to the following VA Plans:

- VA Strategic Plan Draft 2014-2020
- VA Strategic Plan Refresh FY 2011-2015
- VA Information Resource Management Strategic Plan Draft, May 15, 2013
- Office of Human Resources and Administration (HRA) Strategic Plan Draft 2014-2020
- IT Strategic Plan Draft FY 2012-2015
- Diversity and Inclusion Strategic Plan FY 2012-2016

OIT's HCSP identifies goals to remove the "ad hoc" nature of managing human resources while establishing linkage with HRA and servicing human resource stations. While we are making progress in identifying competency gaps we still have progress to make in first identifying the competency level of each employee. As of October 31, 2013, OIT has completed individual competency assessments on 93% of the 7,579 OIT employees in the Talent Management System and will continue working towards 100% completion. The number will continually change as organizational gains and losses occur.

OIG Sub-Challenge #5D: Effective Oversight of Active IT Investment Programs and Projects (OIT-Lead, VBA, VHA)

VA is challenged to ensure appropriate investment decisions are made and that annual funding decisions for VA's IT capital investment portfolio will make the best use of VA's available resources. In 2011, OIT instituted PMAS, constituting a major shift from the way VA historically has planned and managed IT development projects. PMAS was designed as a performance-based management discipline that provides incremental delivery of IT system functionality—tested and accepted by customers—within established schedule and cost criteria. As of May 2012, OIT was managing all 134 active development programs and projects using PMAS. An additional 46 projects were in the planning stage, while 30 projects were classified as new starts.

However, our 2011 audit showed the current PMAS framework did not provide a sound basis for future success. OIG reported that a lot more work remained to be done before PMAS could be considered completely established and fully operational. OIT had instituted the PMAS concept without a roadmap identifying the tasks necessary to accomplish it or adequate leadership and staff to effectively implement and manage the new methodology. OIT did not establish key management controls to ensure PMAS data reliability, verify project compliance, and track project costs. OIT also did not put in place guidance on how such controls should be used within the framework of PMAS to manage and oversee IT projects. Lacking such foundational elements, OIT has not instilled the discipline and accountability needed for effective management and oversight of IT development projects. Until these deficiencies are addressed, VA's portfolio of IT development projects will remain susceptible to cost overruns, schedule slippages, and poor performance.

VA has a longstanding history of challenges in effectively managing IT development projects. For example, the Veterans Service Network (VETSNET) program, VA's effort to consolidate Compensation and Pension (C&P) benefits processing into a single replacement system, has faced a number of cost,

schedule, and performance goal challenges. In May 2009, VBA estimated the total cost of VETSNET to be more than $308 million—more than three times the initial cost estimate. After more than 15 years of VBA development, including management and process improvements, VETSNET has the core functionality needed to process and pay the majority of C&P claims. However, work remains to meet the original goals for VETSNET. Major releases of the system were also developed with unstable functional requirements, resulting in inadequate time to fully test software changes. Consequently, major releases of VETSNET contained functions that did not operate as intended and many system defects were deferred or corrected in subsequent software releases. Further complicating matters, VBA has recently launched several high profile IT initiatives that will leverage VETSNET to make benefit payments. These overlapping IT initiatives increase the risks that VBA will experience further delays in achieving the original VETSNET goals.

As of September 2012, VA had not fully tested VBMS. Due to the incremental software development approach VA chose, the system had not been fully developed to the extent that its capability to process claims from initial application through review, rating, award, to benefits delivery could be sufficiently evaluated. As VA expected, the partial VBMS capability deployed to date had experienced system performance issues. Further, scanning and digitization of Veterans' claims lacked a detailed plan and an analysis of requirements. OIG identified issues hindering VBA's efforts to convert hard copy claims to electronic format for processing within VBMS, including disorganized electronic claims folders and improper management of hard copy claims.

VA senior officials have taken recent actions to improve. However, given the incremental system development approach used and the complexity of the automation initiative, VA will continue to face challenges in meeting its goal of eliminating the backlog of disability claims processing by 2015. Because the system was in an early stage of development at the time of OIG's review, OIG could not examine whether VBMS was improving VBA's ability to process claims with 98 percent accuracy. However, OIG continues to examine VBMS implementation, functionality, and security as part of an ongoing audit in 2013.

VA's Program Response

Estimated Resolution Timeframe: 2014

Responsible Agency Official: Deputy Chief Information Officer

Completed 2013 Milestones

The characterization by OIG does not reflect that for the third year in a row OIT has delivered on greater than 80 percent of all increments for scheduled commitments and 98 percent of all increments in under 6 months. Examples of OIT effective oversight include the International Classification of Diseases, 10th edition (ICD-10) Conversion of Class 1 Clinical Remaining Products, Revenue Improvement and Systems Enhancements (RISE) – National Insurance File, and VBMS Phase 4. The accountability at the core of the PMAS framework drives greater customer engagement and expectation for smaller, more incremental deliveries. As a result, rather than delivery of large code sets months after business requirements are known, project managers are incentivized to deliver early and often to ensure customer acceptance and satisfaction. Providing on-time delivery coupled with necessary solutions is indicative of how PMAS engages leadership at all levels and focuses project manager delivery efforts.

As Pharmacy Rengineering (PRE) and PMAS have evolved, project teams have improved their ability to determine an achievable increment-sized scope. Reviews now include function-point counts as well as an assessment of risks and dependencies. OIT requires Milestone Reviews and pre-briefs for each increment; a project will not be approved if the milestone dates, budget and technical approach are not achievable. Milestone Reviews require senior management representation from each of the primary organizations under the CIO. Each of these Milestone Reviews also involves not less than three levels of review before full approval: Level 1 IPT Approval, Level 2 Pre-brief Approval, and Level 3 Formal Milestone Brief Approval.

OIT established and implemented the recommended controls to ensure IT projects have sufficient leadership and staff assigned throughout the project life cycle prior to the release of the draft OIG report. OIT leaders are engaged in the Integrated Project Team(IPT), Milestone Review, and competency Resource Management Council (RMC) processes. OIT has implemented the red flag and Techstat processes to gain senior management assistance when a project manager has resource requirements for an Active PMAS project that cannot be met through the RMC. Red Flags serve to escalate the priority level of a resource request that goes to the competency model for staffing. OIT now uses the competency model to prioritize and allocate staffing for each project increment. Under this model, the project manager requests resources through the Project Management Council (PMC) and RMC based on the resource requirements identified in their project plans. Once the PMC approves and prioritizes a resource request, the RMC will work within the competency organization to match resources to the highest priority needs.

OIT has already addressed funding, until a decision is made regarding transferring the PRE effort to the Integrated Electronic Health Record (iEHR) project, prioritization through the IT Planning, Prioritization, Budget, and Execution (IT PPBE), IT Leadership Board (ITLB), and the Budget Operating Plan (BOP) process. These processes ensure adequate plans for resources and funding based on the transformation priorities of the department, and the prioritization input of the VA Staff Offices. OIT merely executes development funds in accordance with the prioritization guidance it receives from the IT PPBE, ITLB, and BOP. Current plans do not call for PRE to be absorbed into iEHR in FY 2014. Instead, under current plans, PRE will move forward as an independent project. The FY 2014 funding request for PRE was submitted to the BOP. Depending on the priority of the PRE project among other OIT projects, it may or may not be funded in FY 2014. Finally, it is also likely that the FY 2014 continuing resolution, which provides significantly reduced funding than was requested in the President's FY 2014 budget, may cause funding constraints that undermine VA's planning efforts.

PRE's record on deployment/implementation increments shows PRE has been very effective at completing them in less than 6 months. The schedule challenges are occurring in the period of Initial Operating Capabilities (IOC), before deployment increments. Because current policies and procedures do not include reporting for the IOC period, this data is not tracked on the PMAS Dashboard. OIG has misunderstood the difference between the IOC period (IOC entry to IOC exit) and the PMAS Deployment/Implement increment period which starts after IOC exit. OIG is focusing on the increment segment, which is not the true problem. The IOC segment is the true problem.

PMAS is the disciplined approach VA employs to ensure on-time delivery of IT capabilities. PMAS establishes the framework that ensures the customer, IT project team, vendors and all stakeholders engaged in a project focus on a single compelling mission – achieving on-time project delivery. From the very inception of PMAS, VA leadership planned to systematically expand the scope and function of PMAS over time. PMAS continues to evolve and now includes a variety of accountability structures to ensure not only that IT development projects are effectively managed, but also to ensure that the IT products that are delivered meet strict, well-defined quality, functionality and customer requirements.

The current version of PMAS (4.0) already uses the PMAS Dashboard to track the total time needed to deploy an increment. This change was implemented under PMAS 4.0 as "implementation" increments which begin after IOC exit and after Milestone 2. All current and past versions of PMAS and the PMAS Dashboard also track "development" increments. These increments end either at IOC entry or when the customer signs off and does not want to proceed to IOC entry without first working on a subsequent development increment. For some PMAS projects, this period of time consists of recursive testing and defect repair cycles until production testing reveals that the functionality is ready for additional production sites. This IOC period is not tracked on the dashboard, except in rare exceptions to the current PMAS 4.0 practices. The PMAS Dashboard has been enhanced to track all periods of time within a project, including testing, and this functionality will be available after the February 2014 implementation.

PMAS is an evolving set of policies, practices, and methodologies which have progressed through lessons learned and best practices over the past 4 years. Many findings reflect lapses in data collection and reporting, which were present in the previous iterations of PMAS, but PMAS has since matured to provide tailored workflows and guidance for the software development lifecycle.

PMAS Dashboard has already developed requirements to track IOC, testing, and deployment, which will ensure monitoring within the PMAS Dashboard of the time needed to develop and deploy IT software. OIT implemented all but the IOC period tracking in FY 2013.

A reliable methodology and guidance for capturing and reporting project costs at the increment level was established by OIT's Product Development (PD) organization in FY 2013, with 86 percent of eligible PD contracts executing at the increment level. PRE will adapt to this methodology and guidance in FY 2014.

OIT established guidance on planning well thought-out and achievable software development project increments as part of the PMAS Milestone Review process. OIT published this guidance in PMAS Guide 4.0 in November of 2012.

Controls to ensure IT projects have sufficient leadership and staff assigned throughout the lifecycle has already been established through leadership engagement in the IPT, Milestone, and competency RMC process. In the event that insufficient resources are available, the Flag and Techstat processes allow for rapid leadership awareness and engagement to resolve resource requirements.

Increment-based development: It is important to recognize the difference between the time period covered by a PMAS increment and the time period covered by a full software development cycle. A full

software development cycle includes the entire period from planning to full deployment at all sites; a PMAS increment covers a shorter period.

Health deployment variances: Due to the highly customized business processes within VHA, a project team declares IOC once it releases software into the production environment. The PMAS definition of success is customer facing functionality delivered into the production environment. OIG documents PMAS failure when the PRE project national deployment was not achieved within 6 months or less. The 6 month software development increments intentionally do not account for the IOC time, as it varies significantly amongst increments, depending on the clinical environment.

Presently, costs are often only known reliably at a project or program level. OIT is transitioning to framework which will execute development contracts at the increment level. In FY13, 86 percent of eligible PD contracts were executed at the increment level. However, it will take time before legacy contracts with only program level costs information expire and can be replaced with new contracts that require costs to be tracked at the increment level. PRE will have contracts that are all increment-based by FY 2014. PRE now meets monthly to reconcile and report actual costs to the PMAS Dashboard.

APPENDIX

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

OIG MAJOR MANAGEMENT CHALLENGE #1: HEALTH CARE DELIVERY

Healthcare Inspection–Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington
9/25/2012 | *12-01731-284* | *Summary*|

Healthcare Inspection–Delay in Treatment, Louis Stokes VA Medical Center, Cleveland, Ohio
10/12/2012 | *12-01487-08* | *Summary* |

Healthcare Inspection–Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas
10/23/2012 | *12-03594-10* | *Summary* |

Healthcare Inspection–Alleged Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California
11/19/2012 | *12-01758-40* | *Summary* |

Healthcare Inspection–Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma
12/5/2012 | *12-03399-54* | *Summary* |

Audit of VHA's Physician Staffing Levels for Specialty Care Services
12/27/2012 | *11-01827-36* | *Summary* |

Healthcare Inspection–Appointment Scheduling and Access Patient Call Center, VA San Diego Healthcare System, San Diego, California
1/28/2013 | *12-04108-96* | *Summary* |

Healthcare Inspection–Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia
4/17/2013 | *12-03869-179* | *Summary* |

Healthcare Inspection–Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia
4/17/2013 | *12-02955-178* | *Summary* |

Healthcare Inspection–Inappropriate Use of Insulin Pens, VA Western New York Healthcare System, Buffalo, New York
5/9/2013 | *13-01320-200* | *Summary* |

Healthcare Inspection–Nursing Care in the Community Living Center for Spinal Cord Injury, Louis Stokes VA Medical Center, Cleveland, Ohio
6/27/2013 | *12-02186-227* | *Summary* |

Healthcare Inspection–Provider Availability, VA Roseburg Healthcare System, Roseburg, Oregon
7/18/2013 | *13-01241-250* | *Summary* |

Healthcare Inspection–Alleged Inadequate Oversight at a Contracted Homeless Program, VA New Jersey Health Care System, East Orange, New Jersey
7/16/2013 | *12-01344-243* | *Summary* |

Healthcare Inspection–Quality and Patient Safety Concerns in the CLC, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

Healthcare Inspection–Quality and Patient Safety Concerns in the CLC, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
7/22/2013 | *13-01123-249* | *Summary* |
Healthcare Inspection–Review of a Patient with Medication-Induced Acute Renal Failure, Amarillo VA Health Care System, Amarillo, Texas
7/29/2013 | *13-01988-253* | *Summary* |
Healthcare Inspection–Follow-Up Assessment of Radiation Therapy, VA Long Beach Healthcare System, Long Beach, California
7/31/2013 | *13-00696-254* | *Summary* |
Healthcare Inspection–Review of VHA Follow-Up on Inappropriate Use of Insulin Pens at Medical Facilities
8/1/2013 | *13-01987-263* | *Summary* |
Healthcare Inspection–Prevention of Legionnaires' Disease in VHA Facilities
8/1/2013 | *13-01189-267* | *Summary* |
Healthcare Inspection–Review of Circumstances Leading to a Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana
8/2/2013 | *13-00670-265* | *Summary* |
Healthcare Inspection–Alleged Patient Rights, Quality of Care, and Other Issues, VA Puget Sound Health Care System, Seattle, Washington
8/13/2013 | *13-02235-277* | *Summary* |
Vet Center Contracted Care Program Review
8/16/2013 | *12-00040-268* | *Summary* |
Healthcare Inspection–Alleged Sterile Processing Service Deficiencies, VA Puget Sound Health Care System, Seattle, Washington
9/3/2013 | *13-01351-296* | *Summary* |
Healthcare Inspection–Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina
9/6/2013 | *12-04631-313* | *Summary* |
Healthcare Inspection–Laboratory Delays and Alleged Staff Training Issues, Memphis VA Medical Center, Memphis, Tennessee
9/16/2013 | *13-02599-311* | *Summary* |
Healthcare Inspection–An Unexpected Death in a Mental Health Treatment Program, VA New Jersey Health Care System, Lyons, New Jersey
9/17/2013 | *13-01498-318* | *Summary* |
Healthcare Inspection–Inadequate Staffing and Poor Patient Flow in the Emergency Department, VA Maryland Health Care System, Baltimore, Maryland
9/18/2013 | *12-03887-319* | *Summary* |
Healthcare Inspection–Quality of Care Issues, Erie VA Medical Center, Erie, Pennsylvania, and VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania
9/25/2013 | *13-01855-336* | *Summary* |
Audit of Selected VHA Non-Institutional Purchased Home Care Services
9/30/2013 | *11-00330-338* | *Summary* |

Congressional Testimony 2/13/13
Statement of Office of Inspector General Department of Veterans Affairs to the Committee on Veterans' Affairs U.S. House of Representatives Hearing: "Honoring The Commitment: Overcoming Barriers To Quality Mental Health Care For Veterans," February 13, 2013 More

Congressional Testimony 3/13/2013
Statement of Linda A. Halliday Assistant Inspector General For Audits and Evaluations Office of Inspector General Department of Veterans Affairs Before The Subcommittee on Health Committee on Veterans' Affairs U.S. House of Representatives Hearing: "Meeting Patient Care Needs: Measuring the Value of VA Physician Staffing Standards," March 13, 2013 More

Congressional Testimony 7/19/2013
Statement of Michael L. Shepherd, M.D., Before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives Hearing: "Care and Treatment Available To Survivors of Military Sexual Trauma," July 19, 2013 More

Congressional Testimony 8/7/2013
Statement of Michael L. Shepherd, M.D., Before the Committee on Veterans' Affairs, U.S. Senate Hearing: "Ensuring Veterans Receive the Care They Deserve: Addressing VA Mental Health Program Management," August 7, 2013 More

OIG CHALLENGE #2: BENEFITS PROCESSING

Audit of Vocational Rehabilitation and Employment Program's Self-Employment Services at Eastern and Central Area Offices
12/11/2012 | *11-00317-37* | *Summary* |

Audit of NCA's Internal Gravesite Review of Headstone and Marker Placement
2/7/2013 | *12-02223-98* | *Summary* |

Interim Report–Participation in VBA's Veterans Retraining Assistance Program
4/15/2013 | *12-04524-171* | *Summary* |

Audit of VBA's Foreclosed Property Management Contractor Oversight
8/27/2013 | *12-01899-238* | *Summary* |

Audit of VBA's Pension Payments
9/4/2013 | *12-00181-299* | *Summary* |

Audit of VBA's Veterans' Retraining Assistance Program Participation
9/17/2013 | *12-04524-321* | *Summary* |

Congressional Testimony 2/5/2013
Statement of Linda A. Halliday 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 U.S. House of Representatives Hearing: "The 100 Percent Temporary Disability Rating: An Examination of its Effective Use," February 5, 2013 More

Congressional Testimony 4/10/2013
Statement of Linda A. Halliday 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 U.S. House of Representatives Hearing: "Sustaining the Sacred Trust: An Update on Our National Cemeteries," April 10, 2013 More

Congressional Testimony 4/18/2013
Statement of Richard J. Griffin 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 U.S. Senate Hearing: "VA Challenges in Fiscal Year 2014," April 18, 2013 More

OIG CHALLENGE #3: FINANCIAL MANAGEMENT

Audit of VBA's Liquidation Appraisal Oversight in the Cleveland and Phoenix Regional Loan Centers
10/4/2012 | *10-04045-124* | *Summary* |

Review of Allegations at VA Medical Center, Providence, Rhode Island
12/17/2012 | *10-01937-63* | *Summary* |

Review of VHA's South Texas Veterans Health Care System's Management of Fee Care Funds
1/10/2013 | *11-04359-80* | *Summary* |

Audit of VA's Consolidated Financial Statements for Fiscal Years 2012 and 2011
1/18/2013 | *12-01284-13* | *Summary* |

Audit of VHA's Beneficiary Travel Program
2/6/2013 | *11-00336-292* | *Summary* |

Review of VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2012
3/15/2013 | *12-04241-138* | *Summary* |

Audit of the Community Nursing Home Program
3/29/2013 | *11-00331-160* | *Summary* |

Independent Review of VA's FY 2012 Performance Summary Report to the Office of National Drug Control Policy
3/31/2013 | *13-00680-142* | *Summary* |

Independent Review of VA's FY 2012 Detailed Accounting Submission to the Office of National Drug Control Policy
3/31/2013 | *13-00682-143* | *Summary* |

Review of VA's Programs for Addressing Climate Change
6/28/2013 | *13-01846-235* | *Summary* |

Audit of Non-Purchase Card Micro-Purchases
8/9/2013 | *12-01860-237* | *Summary* |

Review of VHA's Management of Travel, Duty Stations, Salaries and Funds in the Procurement and Logistics Office
9/30/2013 | *11-01653-300* | *Summary* |

OIG CHALLENGE #4: PROCUREMENT PRACTICE

Review of VHA's Minor Construction Program
12/17/2012 | *12-03346-69* | *Summary* |

Review of VA's Acquisitions Supporting the Veteran Employment Services Office
6/25/2013|*13-00644-231* | *Summary*|

Audit of NCA's Contracting Practices
9/26/2013 | *12-00366-339* | *Summary* |

Audit of VA's Technology Acquisition Center Contract Operations
9/27/2013 | *12-02387-343* | *Summary* |

Review of VA's Separately Priced Item Purchases for Training Conferences
9/30/2013 | *13-00455-345* | *Summary* |

OIG CHALLENGE #5: INFORMATION MANAGEMENT

Review of VA's Alleged Incomplete Installation of Encryption Software Licenses
10/11/2012 | *12-01903-04* | *Summary* |

Audit of VA's Systems Interconnections with Research and University Affiliates
10/23/2012 | *11-01823-294* | *Summary* |

Audit of VA's Office of Information Technology Strategic Human Capital Management
10/29/2012 | *11-00324-20* | *Summary* |

Review of VBA's Transition to a Paperless Claims Processing Environment
2/4/2013 | *11-04376-81* | *Summary* |

Review of Alleged Transmission of Sensitive VA Data Over Internet Connections
3/6/2013 | *12-02802-111* | *Summary* |

Federal Information Security Management Act Audit for Fiscal Year 2012
6/27/2013 | *13-01712-229* | *Summary* |

Review of Alleged System Duplication in VA's Virtual Office of Acquisition Software Development Project
9/18/2013 | *12-02708-301* | *Summary* |

Congressional Testimony 6/4/2013
Statement of Linda A. Halliday Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, Hearing: "How Secure is Veterans' Private Information?" June 4, 2013 More

Congressional Testimony 5/21/2013
Statement of the Office of Inspector General before the Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives Hearing, May 21, 2013 More