Major Management Challenges

Identified by VA Office of Inspector General

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Identified by the Government Accountability Office

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As we strive to provide the highest quality benefits and services to our Nation's veterans, we realize we have many program and management challenges to overcome. Following are descriptions of our major challenges as identified by the VA Office of Inspector General (OIG) and the Government Accountability Office (GAO) along with the VA program's response. *(In this report, years are fiscal years unless stated otherwise.)*

Challenges Identified by VA Office of Inspector General

The VA OIG has implemented a strategic planning process designed to identify and address the key issues facing VA. These issues, which include health care delivery, benefits processing, procurement, financial management, and information management, are presented in the OIG Strategic Plan 2001-2006. The following summarizes the most serious management problems facing VA in each of these areas, and assesses the Department's progress in addressing them. While these issues guide our oversight efforts, we continually reassess our goals and objectives to ensure that our focus remains relevant, timely, and responsive to changing priorities. *(On these pages, the words "we" and "our" refer to the OIG.)*

OIG1. Health Care Delivery

VA reports that the number of veterans using the Department's health care system has risen dramatically, increasing from 2.9 million in 1995 to nearly 4.5 million in 2003. This increase has significantly challenged the Department's capacity to treat these veterans. In addition, the Veterans Health Administration (VHA) restructured health care delivery to emphasize managed care through an extended network of community-based outpatient clinics and ambulatory care settings. This transition raised new issues concerning the utilization of facilities and the allocation of resources. Opening VA health care to nonservice-connected veterans created an unprecedented increase in demand for VHA, leading to inordinately high waiting times and insufficient resources. Providing safe, high-quality medical care, reasonable waiting times, and accessibility to care are just some of the fundamental delivery of service issues that present challenges on a continuous basis.

The political leadership in both the legislative and executive branches should confront this reality and codify the long-term health care benefits that will be provided to our Nation's veterans, and fund them accordingly. VHA needs to continue the trend of increasing revenue growth from non-appropriated sources and pursue every avenue possible to maximize the economy and efficiency of its programs and activities. The following issues present major challenges and opportunities to do just that.

1A. OIG Issue - Part-Time Physician Time and Attendance

Our April 2003 report, *Audit of VHA's Part-Time Physician Time and Attendance* (Report No. 02-01339-85), identified VA physicians who were not present during their scheduled tours of duty, were not providing VA the services obligated by their employment agreement, or were "moonlighting" on VA time. Currently 11 of 12 recommendations on management controls remain unimplemented. We concluded that VA medical center (VAMC) managers did not ensure that part-time physicians met employment obligations, and that VAMCs did not perform workload analyses to determine the number of full-time equivalent employees needed or evaluate hiring alternatives (such as part-time, full-time, intermittent, or fee-basis).

Additionally, our Combined Assessment Program (CAP)[1] reviews assessed physician time and attendance issues at 54 facilities and identified deficiencies at 28.

Our February 2004 report, *Follow-up of the VHA's Part-Time Physician Time and Attendance* (Report No. 03-02520-85), found that at 15 medical facilities where we conducted unannounced follow-ups 8 percent of the part-time physicians scheduled for duty were not on duty, approved leave, or authorized absence and were potentially not meeting their VA employment obligations. All six recommendations remain unimplemented. We concluded that VHA's implementation of management controls continues to need improvement to ensure that part-time physicians meet their employment obligations. OIG CAP reviews conducted at VHA facilities in FY 2004 also continue to identify systemic weaknesses associated with controls over part-time physicians' time and attendance and show that some part-time physicians are not fully meeting their employment obligations.

VA's Program Response: VHA now conducts a monthly survey of all sites to determine whether facilities are monitoring time and attendance of part-time physicians. VHA uses a statistically generated program to select a random sample of the part-time physicians at each facility. The facilities are asked to verify the presence of these physicians either through electronic means or by direct physical verification. If any discrepancies are identified, appropriate actions are taken locally. In addition, the issue of part-time physician time and attendance is discussed at the quarterly performance reviews with the network directors. VA has also developed revised policies and procedures that will enable it to more easily meet patient care requirements and schedule physicians in a manner that is more consistent with their practice patterns. The policies and procedures are being paired with modifications to VA's electronic time and attendance (ETA) system. Anticipated completion date for the modifications to VA's ETA is May 2005.

1B. OIG Issue - Staffing Guidelines

The lack of staffing standards for physicians and nurses as required by Public Law 107-135 continues to impair VHA's ability to adequately manage personnel resources. Congress passed Public Law 107-135, *Department of Veterans Affairs Health Care Program Enhancement Act of 2001*, on January 23, 2002, which requires the Secretary, in consultation with the Under Secretary for Health, to establish a policy to ensure that staffing for physicians and nurses at VA medical facilities is adequate to provide veterans appropriate, high-quality care and services. VHA recently issued a policy that provides standards for physicians and support staff in primary care that is tied to the number of veterans receiving care. The OIG believes VHA needs to incorporate this requirement into performance plans and hold managers accountable for implementing the policy. VHA is further behind in its process of establishing staffing models for subspecialty medical physicians. Currently, all five recommendations relating to physician staffing remain unimplemented from our April 2003 report, *Audit of VHA's Part-Time Physician Time and Attendance* (Report No. 02-01339-85).

There is and will continue to be a national nursing shortage. The absence of nurse staffing guidelines impedes hospital management's ability to ensure that the nursing mix on a ward is adequate to meet the needs of the patient population. Recent legislative changes will help in recruitment and retainment of nursing staff, but staffing guidelines are still needed to ensure quality of patient care. In August 2004, we issued the report, *Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities* (Report Number 03-00079-183) that addressed this subject.

[1] Through this program, auditors, investigators, and health care inspectors collaborate to assess key operations and programs at VA health care systems and VA regional offices on a cyclical basis.

VA's Program Response: A draft directive on staffing guidelines for VHA health care providers, including nurses, is targeted for completion by the end of December 2004. On July 6, 2004, VHA Directive 2004-031, "Guidance on Primary Care Panel Size," was issued and distributed to the field for implementation. It requires VHA primary care practices to establish maximum panel sizes for all primary care providers. VA continues to work on developing a productivity model for specialty care providers. It is expected to be completed by the end of 2005.

1C. OIG Issue - Quality Management (QM)

Although VHA managers are vigorously addressing the Department's QM procedures in an effort to strengthen patients' confidence, issues remain. OIG and GAO reviews in the 1990s found that managers needed to improve efforts for collecting, trending, and analyzing clinical data. During fiscal year 2003, we conducted QM reviews at 31 VA health care facilities during CAP reviews. All of the facilities we reviewed during 2003 had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. We noted improvements in several areas compared with our 2002 review. While we found improvements in QM programs, our July 2004 summary report, *Healthcare Inspection, Evaluation of Quality Management in VHA Facilities Fiscal Year 2003* (Report No. 03-00312-169), found that facility managers need to strengthen QM programs through increased attention to: the disclosure of adverse events, the utilization management program, the patient complaints program, and medical record documentation reviews. Senior managers need to strengthen designated employees' data analysis skills, benchmarking, and corrective action identification, implementation, and evaluation across all QM monitors.

Because of continued weaknesses in QM data management, particularly the implementation and evaluation of corrective actions, facility senior managers need to clearly state their expectations to all managers, program coordinators, and committee chairpersons who are responsible for QM monitors that corrective actions must be evaluated until resolution is achieved. To provide reasonable assurance that its facilities are thoroughly addressing quality of care and patient safety issues, VHA needs a stronger system for corrective action implementation and evaluation.

VA's Program Response: VHA has convened a quality management workgroup, consisting of six subcommittees: 1) Disclosure of Adverse Events, 2) Utilization Management, 3) Patient Complaints, 4) Joint Commission on Accreditation of Healthcare Organizations Medical Record Review Requirements, 5) Data Management, and 6) Quality Improvement. The groups fielded a Web-based survey to assess current field activities in each of these areas on October 22, 2004. The survey will be used to conduct a gap analysis and prepare preliminary recommendations on gaps, addressing gaps, and monitoring implementation and progress in each of the subcommittee areas for the Deputy Undersecretaries. A report of preliminary recommendations in each of these areas will be delivered to the Deputy Undersecretaries for Health and of Operations and Management by the end of calendar year 2004. Further work of these groups will be dependent on these early findings and the recommendations of VHA leadership. Some will become ongoing committees while others may be time-limited once the recommendations are reviewed.

1D. OIG Issue - Long-Term Health Care

VHA established a number of programs to provide long-term health care to aging veterans, but the OIG found that serious challenges continue to exist. For example, in 2003 we completed reviews of VHA's Community Nursing Home (CNH) Program and Homemaker/Home Health Aide (H/HHA) Program, and in 2004 we completed a review of VHA's Community Residential Care (CRC) Program. We identified several issues warranting VHA's attention.

While VHA has contracted with CNHs to provide care for aging veterans, it has taken years to implement stan-

dardized monitoring/inspection procedures, as noted in our December 2002 report, *Healthcare Inspection - Evaluation of VHA's Contract Community Nursing Home Program* (Report No. 02-00972-44). This has caused VA facilities to be inconsistent in overseeing the care and service provided to veterans residing in community facilities. We made recommendations to further clarify and strengthen the VHA CNH oversight process and to reduce the risk of veterans in CNHs from adverse incidents. VHA issued a new CNH handbook; however, the following actions remain to be completed in order to close all the recommendations: finalize new performance indicators that show nurses and social workers are visiting veterans at the recommended frequency and gathering the recommended information, finalize the Web site and schedule audio training broadcasts, complete guidance on Web site links and special broadcasts related to new criteria to exclude CNH homes from the program when involved with neglect and abuse, and finalize efforts on how VHA and Veterans Benefits Administration (VBA) employees can complement each other and share information.

We found VHA's H/HHA program also needed improvements. We issued a summary evaluation in December 2003, *Healthcare Inspection - Evaluation of VHA Homemaker and Home Health Aide Program* (Report No. 02-00124-48). As part of the OIG's CAP reviews, we inspected the program at 17 VA medical facilities. We found that 14 percent of the patients receiving program services in our sample did not meet clinical eligibility requirements. Two OIG recommendations remain open.

We also found VHA's CRC program needed improvement. We issued a report in May 2004, *Healthcare Inspection - VHA's Community Residential Care (CRC) Program* (Report No. 03-00391-138). We found VAMC inspection teams did not consistently inspect their CRC homes; VAMC clinicians did not always conduct interdisciplinary assessments, advise CRC caregivers about patients' conditions or special needs, conduct monthly visits as required, and ensure caregivers received appropriate training. Also, VAMC clinicians and VA regional office (VARO) fiduciary activity supervisors did not meet at least once a year to discuss services to incompetent veterans. We made 11 recommendations for improvement.

VA's Program Response: The VBA Fiduciary Program has had a long-standing requirement to establish annual visits with each VAMC in the Fiduciary Activity's jurisdiction for the purpose of discussing cross-cutting program issues and cases of mutual concern. The VA Central Office (VACO) Fiduciary Program staff reminded all Fiduciary Program managers nationwide of this requirement in an e-mail message on June 20, 2002. Additionally, this was extensively discussed in the quarterly Fiduciary Program Teleconference on July 18, 2002, and was an agenda item on the Veterans Service Center Manager call on July 19, 2002.

Beginning October 2002, compliance with this requirement has been monitored during routine site visits, and VBA is satisfied that such meetings are taking place. In December 2003, VACO Fiduciary Program staff met with VHA's Director of Long-Term Care Contracts to discuss the OIG findings and any cooperative actions necessary to fully implement the recommendations. As a result of that meeting, the director undertook a project to update the VHA handbook on VHA community nursing home oversight procedures.

The revised VHA Handbook 1143.2, "Community Nursing Home (CNH) Oversight," was published on June 4, 2004. This document implemented the majority of the OIG recommendations. Work on the education Web site and associated training material is ongoing, and the Web site is scheduled for release in December 2004. VHA established a monitor for tracking efforts by VAMCs and regional offices to identify cases of neglect and abuse. Both VBA and VHA handbooks now mandate annual meetings for regional office and medical center staff. VA is in the process of identifying points of contact in both administrations. VHA is planning to highlight some best practices this coming year on the CNH Web site and in a joint audio conference. VHA's efforts focus on the quality of care delivered by CNHs, as measured by Centers

for Medicaid and Medicare Service (CMS) quality profiles. VHA has clearly stated its intention to measure CNH quality in this manner.

VHA developed a Homemaker/Home Health Aide (H/HHA) program monitor to measure improvements in meeting the target population for this program, thus ensuring better utilization of resources for those veterans most in need of H/HHA services. VHA's handbook, "Home Health and Hospice Care Reimbursement Policy," which establishes benchmark rates, was published August 16, 2004.
VHA concurred with the 11 OIG recommendations on the Community Residential Care (CRC) Program. An action plan has been developed and a process to track the implementation of the recommendations has been established.

1E. OIG Issue - Security and Safety

On March 19, 2002, the OIG issued 16 recommendations to improve overall security, inventory, and internal controls over biological, chemical, or radioactive agents at VHA facilities. We performed this review at the request of the VA Secretary in October 2001 following the September 11, 2001, terrorist attacks and the anthrax infiltration in the U.S. Postal System.

In the report, *Review of Security and Inventory Controls over Selected Biological, Chemical and Radioactive Agents Owned by or Controlled at Department of Veterans Affairs Facilities* (Report No. 02-00266-76), we identified that security and physical access controls were needed in research and clinical laboratories and other areas in which high risk or sensitive materials may be used or stored, or where those materials were actually in use (e.g., biological agents [bioagents], chemicals, gases, and certain radioactive materials). We found inventories of these types of sensitive materials were often incomplete or inadequate. While most facilities we visited had complied with requirements for disaster planning and preparedness, many had not updated these plans to include considerations for terrorist threats or actions. We also found inadequacies in background screening and assurance procedures for employees and contractors allowed to access sensitive areas.

Most of the report's recommendations were made to the Under Secretary for Health; however, several recommendations required joint efforts on the part of VHA and the Office of Security and Law Enforcement. Recently, the Office of Security and Law Enforcement completed its actions by revising two security publications cited in the OIG report. Although numerous VHA actions have been completed, such as the newly issued research handbook and clinical handbook, 15 of the 16 report recommendations remain open.

We will not close these recommendations until laboratory security upgrades have been made, training is developed and provided to all applicable employees, and VAMC directors certify implementation of directives and security requirements. The purpose of the certification requirement is to document compliance with the directives and provide assurance that the intent of our recommendations to address all the security and control vulnerabilities presented in our report have been addressed and corrected at each facility.

VA's Program Response: Significant progress has been made on all of the OIG recommendations identified in Report Number 02-00266-76. VHA Handbook 1106.2, "Pathology and Laboratory Medicine Service Bio-security and Bio-safety," was published in May 2004. This handbook provides general security and additional safety procedures for clinical laboratories in the possession, handling, and shipping of biological materials identified as potential agents of terrorism within VA facilities. The Office of Research and Development also issued VHA Handbook 1200.6, "Control of Hazardous Agents in Research Laboratories," in June 2004 that further addresses the OIG recommendations.

The OIG will not close the recommendation on laboratory security upgrades until all eligible VA facilities have received the equipment for which the Office of Research

and Development (ORD) grants funding. ORD initiated a program to spend more than $2 million to upgrade laboratory security in February 2002. Of the 64 research sites identified as needing upgrades, 62 sites have been funded for a total of $2.35 million. Funding for the remaining two sites is pending and will be distributed in the first quarter of FY 2005. In addition to the above initiative, ORD has conducted infrastructure site visits at 40 sites.

The OIG will not close the recommendation on training until ORD develops and implements a program of instruction for laboratory security. Each facility is currently developing training in all aspects of responding to intrusions and/or terrorist events. ORD is currently developing a Web-based educational program that outlines security training requirements that will be in operation by December 2004 and available through the Intranet in late January 2005. A VA-specific training program is being developed that will reflect requirements that are found in the new directive on control of hazardous agents in research laboratories. Since 2002, ORD has included sessions on research laboratory security in two national meetings and works with individual facilities as needed.

The OIG mandated that VAMC directors certify implementation of directives and security requirements before the OIG will close these recommendations. VHA will submit a consolidated certificate to the OIG by December 31, 2004.

1F. OIG Issue - Management of Violent Patients

While our May 2004 report, *Healthcare Inspection, Healthcare Program Evaluation VHA's Management of Violent Patients* (Report No. 02-01747-139), found opportunities for improvement in the management of violent patient events at the facilities visited, we also found that several components for successful violence prevention programs were in place. Nevertheless, employees made suggestions that would enhance security in their work area, some of which VHA managers should consider. Several recommendations were made for improvement.

VA's Program Response: VHA has implemented a network director performance indicator regarding the implementation of interdisciplinary teams at each facility. The expected revisions to existing automated reporting systems are currently with the Office of Information and are expected to be implemented in FY 2005. The establishment of interdisciplinary Disruptive Behavior Committees (DBC) has been verified at all facilities. VHA's Employee Educational System (EES) hosted two system-wide series of conference calls on patient record flagging, one on the information technology/application implementation, and the other on threat assessment and management strategies. A Patient Record Flagging summit was held in early September 2004. A data call to collect information on DBC performance was issued at the end of FY 2004.

OIG2. BENEFITS PROCESSING

VBA has made progress in veterans benefits processing in recent years, but significant challenges remain in terms of timeliness and accuracy. Because of the total dollar value of claims, the volume of transactions, the complexity of the criteria used to compute benefits payments, and the number of erroneous and improper payments already identified, we consider these issues high risk areas and major management challenges for VBA. VA must report erroneous[2] and improper[3] payments on four of its major programs[4] in its annual budget submissions and the Performance and Accountability Report beginning in 2004. We believe VA needs to be more aggressive in identifying and eliminating erroneous and improper payments to comply with this reporting requirement.

[2] The Office of Management and Budget defines erroneous payments as payments made that should not have been made or were made for incorrect amounts (including payments that do not necessarily involve cash disbursements).
[3] The Improper Payments Information Act of 2002 defines improper payments as payments made that should not have been made or that were made in incorrect amounts (including overpayments and underpayments).
[4] The four programs are Compensation, Dependency and Indemnity Compensation, Pension, and Insurance.

2A. OIG Issue - Compensation and pension (C&P) Timeliness

As of June 26, 2004, VBA reports about 469,000 total C&P claims are pending, including about 325,000 that require rating action. VA made progress in addressing its claims processing backlog that once peaked at about 601,000 outstanding claims. Although the number of claims pending rating decisions is continuing to increase, C&P rating actions that once averaged 195 days for completion are averaging 168 days as of June 2004. The backlog of claims pending increased primarily because VBA was unable to make decisions on cases as a result of a court decision invalidating a provision that permitted VA to decide a claim prior to the expiration of the 1-year notice in the Veterans Claims Assistance Act. However, correcting legislation was signed by the President in December 2003 that states that VA may make a decision on a claim before the expiration of the 1-year notice period. VBA remains challenged to reduce the outstanding backlog and to improve the timeliness in its claims processing activities.

VA credits many of its recent improvements to the reforms recommended by the Secretary's Claims Processing Task Force, which was charged with identifying ways to expedite claims and deliver more timely benefits to veterans. In October 2001, the Task Force recommended measures to increase the efficiency and productivity of VBA operations, shrink the backlog of claims, reduce the time it takes to decide a claim, and improve the accuracy of decisions. The Task Force made 34 recommendations (20 short-term and 14 medium-term), and VBA defined 70 actions to accomplish the 34 recommendations. VBA has implemented 55 of the 70 action items. The Task Force report has helped facilitate improvements in claims processing activities.

CAP reviews performed at VAROs since 2001 found that C&P claims processing failed to achieve prescribed timeliness goals at 15 of 18 facilities. VBA still needs to address recommendations made in the CAP reviews and fully implement the Task Force recommendations.

VA's Program Response: VBA has had marked success in reducing the number of pending rating claims and improving the timeliness of rating-related actions. The organization reduced the pending rating inventory from a high of 432,000 claims in January 2002 to 253,000 in September 2003. The timeliness of VBA's pending inventory improved from 203 days in January 2002 to 111 days in September 2003. The average length of time to provide veterans with a decision on their claims improved from a high of 233 days in March 2002 to 156 days in September 2003. However, as noted by the OIG, court decisions interpreting the Veterans Claims Assistance Act of 2000 (VCAA) significantly affected the gains made by VBA in claims processing.

Specifically, the September 2003 decision of the U.S. Federal Circuit Court of Appeals in *PVA v. Principi* caused VBA to stay the processing of over 62,000 claims. The *PVA* decision, issued in response to a challenge to VA's regulations implementing the VCAA, held that unless VA could grant a claim for benefits, VA was required to wait 1 year before it could deny a claim in order to afford the claimant time to submit information or evidence to substantiate the claim. This, in effect, resulted in a stay of any rating action that would, in whole or in part, contain a denial of a claimed benefit.

As a result, VBA lost nearly 3 months of full production, and the volume and age of the rating inventory continually increased until Congress clarified the language of the law in a December 16, 2003, amendment, expressly allowing VA to decide claims for benefits prior to the expiration of the 1-year time period in the law during which a claimant could submit evidence on a claim. Consequently, VBA produced 64 percent fewer rating decisions in the first 3 months of FY 2004 than in the first 3 months of FY 2003 (69,316 versus 192,669). Once VA could resume normal rating production, it was faced with the prospect of addressing the backlog of claims while keeping pace with processing incoming claims. The average processing time for claims completed in January 2004 reached 189 days as we began to process the deferred claims. Timeliness of completed actions is back down to 163 days

during the month of September 2004, and we continue to make progress toward the Secretary's goal. Two years ago, 35 percent of VBA's rating inventory was comprised of cases pending over 6 months. As of September 2004, that percentage has been reduced to 21 percent.

VBA has also experienced a significant increase in disability claim receipts. During FY 2004, VBA recorded a 5 percent increase in disability claims. The majority of the increased receipts were original disability claims. Specifically, our original claim receipts are up by 17 percent over last year, most likely attributable to the impact of claims filed by servicemembers returning from Operation Enduring Freedom and Operation Iraqi Freedom. Despite these challenges, VBA continues to make progress toward the high expectations set by the Secretary.

VBA continues to place an increasing emphasis on oversight and accountability through program reviews conducted by business lines, the Office of Resource Management, and the OIG. The results of these reviews are used to highlight best practices and address areas where an out-of-line situation may be occurring at more than one regional office. In addition, VBA's four area directors routinely review the results of OIG CAP reviews conducted for the regional offices in their jurisdiction and follow up to ensure corrective actions are implemented.

The Task Force made 34 recommendations (20 short-term and 14 medium-term), and VBA defined 70 action items to accomplish the 34 recommendations. To date, action has been taken on 65 of those 70 items. Fifty-five have been fully completed, and 10 are in various stages of implementation. The other five action items have been determined not to be feasible at this time.

2B. OIG Issue - Compensation and Pension Program's Internal Controls

In 1999, the former Under Secretary for Benefits asked the OIG for assistance to help identify internal control weaknesses that might facilitate or contribute to fraud in VBA's C&P program. In June 1999, we issued a vulnerability assessment on the management implications of employee thefts from the C&P system. We identified 18 internal control vulnerabilities.

Our July 2000 report, *Audit of the C&P Program's Internal Controls at VARO St. Petersburg, FL* (Report No. 99-00169-97), confirmed that 16 of the 18 categories of vulnerability reported in our 1999 vulnerability assessment were present at VA's largest VARO. We made 26 recommendations for improvement. Currently, 5 of the 26 recommendations are unimplemented, including controlling adjudication of employee claims, use of a third-person authorization control in the Benefits Delivery Network, and verification of continued entitlement of certain beneficiaries. Our regional office CAP reviews have identified that vulnerabilities remain in 13 of the 18 categories in the 2000 report.

VA's Program Response: As of September 2004, five C&P action items remain open.

The following two action items are pending the completion of VBA's Modern Award Processing application, the testing of which began in March 2004 at the VA Regional Office in Lincoln, Nebraska: (1) establish a positive control system edit keyed to employees to ensure employee claims are adjudicated at the assigned regional office and to prevent employees from adjudicating matters involving fellow employees and veterans service organizations at their home office and (2) establish a Benefits Delivery Network (BDN) system field for third-person authorization with a control preventing release of payments greater than $15,000 without the third-person authorization.

To address the action item on direct input and storage of rating decisions in the BDN, VBA released an updated version of Rating Board Automation (RBA 2000) in September 2004 containing fixes for defects impacting 100 percent utilization of RBA 2000. Upon conclusion of a 60-day validation period, VBA will determine the schedule for retirement of the old RBA application.

The last two action items related to use of employee social security numbers (SSN) as employee identification numbers in the BDN and the replacement VETSNET system. VBA is in the process of validating and documenting steps taken to use SSN as employee identification numbers and to tie VETSNET access to SSN. This will also ensure perpetual VETSNET transaction files are maintained and include a unique user identification number identifying employees associated with recorded transactions.

2C. OIG Issue - Fugitive Felon Program

The Veterans Education and Benefits Expansion Act of 2001 prohibits veterans who are fugitive felons, or their dependents, from receiving specified veterans benefits. The OIG has established a fugitive felon program to identify VA benefits recipients and employees who are fugitives from justice. This program is a collaborative effort involving the OIG, VBA, VHA, and VA Police Service. The program consists of conducting computerized matches between fugitive felon files of law enforcement organizations and VA benefit files. Location information is provided to the law enforcement organization responsible for serving the warrant for those veterans identified as fugitive felons. Fugitive information is subsequently provided to VA so that benefits may be suspended and recovery action for any overpayments can be initiated.

Memoranda of Understanding have been completed with the U.S. Marshals Service; Federal Bureau of Investigation National Crime Information Center (NCIC); and the States of California, New York, Tennessee, Washington, and Pennsylvania. Agreements are pending with those states that do not enter all felony warrants into the NCIC. In addition, the VA Secretary signed a directive establishing VA procedures for dealing with fugitive felons.

As of June 2004, more than 2.2 million warrant files received from law enforcement agencies have been matched to more than 11 million records contained in VA benefit system files, resulting in the identification of 32,346 matched records. The records match has resulted in 11,153 referrals to various law enforcement agencies throughout the country and has led to the apprehension of 402 fugitive felons, including the arrest of 38 VA employees. In addition, 8,299 fugitive felons identified in these matches have been referred to the Department for benefit suspension resulting in the creation of $54.5 million in overpayments and an estimated cost avoidance of over $100 million. With an estimated 1.9 million felony warrants outstanding in the United States and an estimated 2 million new felony warrants added each year, should this program be fully funded, the estimated cost avoidance is projected to reach $209.6 million per year.

Since the beginning of the program, VBA has received 3,839 referrals from the VA OIG and has used new policies and procedures to implement the benefit suspension requirements of the law. As of June 2004, VHA has received 4,465 referrals from the VA OIG. VHA used some of the initial referrals to implement a pilot program involving 10 VAMCs. VHA officials are using the results of the pilot program to help finalize a new handbook on fugitive felons. VHA plans to forward more referrals to additional VAMCs once the new handbook is finalized. Collaborative efforts must continue if we are to successfully achieve the full potential of this mandate.

VA's Program Response: VBA continues to work closely with the OIG in implementing the fugitive felon program. The Vocational Rehabilitation and Employment Service (VR&E) received a list of nine veteran fugitive felons and notified the appropriate regional offices with jurisdiction. VR&E is in the process of finalizing guidance to address handling of veteran fugitive felons participating in the VR&E program. During the past 2 years, the Education Service has processed a total of 97 fugitive felon referrals, creating slightly over $420,000 in debts. Since the beginning of the program, the C&P Service has received 3,572 referrals from the OIG. As a result of the fugitive felon program, actual overpayments of $20,426,509 have been identified. Loan Guaranty Service (LGY) staff

attended initial meetings with the OIG to discuss how to meet the requirements of the Fugitive Felon Act. Under the current arrangement, the OIG has agreed to provide LGY with the OIG's list of fugitive felons. LGY has agreed to work with the OIG to check LGY databases against the listings to determine whether any individual on the felons list has attempted to use his/her home loan benefit. Any matches will be forwarded to the OIG for action. The Insurance Service has participated in the fugitive felon process since March 2004. The OIG provided 161 referrals of fugitive names to the Insurance Service. As a result, the Insurance Service froze the insurance accounts. The Insurance Service continues to monitor fugitive lists for signs of activity and has implemented processes to alert both the veteran and the OIG of any changes affecting the fugitive felon status.

The Office of Security and Law Enforcement has been an active collaborator with the OIG since 2002 in implementing the fugitive felon program within VA. The office was a task force member charged with the development of a VHA directive on the fugitive felon program and provided guidance and coordination to the VA police units during the VHA pilot program. Cooperative efforts with the OIG continue, including a presentation by the OIG at the VA Police Chiefs' conference in August 2004.

The VHA fugitive felony program (FFP) handbook has been finalized and will be issued by the end of the first quarter of FY 2005. The handbook will address areas identified for improvement through the VHA pilot. To address the high number of warrants that have already been satisfied, VA police will be asked to validate warrants with the issuing agency prior to any veteran being notified of his/her fugitive felon status. In addition, once the warrant is validated, the veteran will have a 60-day time frame to clear or provide proof that the warrant is satisfied before his/her health care benefits are suspended. Additionally, any veteran requiring continued care will have a transition of care plan developed prior to dis-enrollment. Upon its publication, the roll-out of the FFP to all VHA facilities will begin. The roll-out is expected to be completed by January 2005.

2D. OIG Issue - Incarcerated Veterans

In February 1999, the OIG published the report, *Evaluation of Benefit Payments to Incarcerated Veterans* (Report No. 9R3-B01-031). The review found that VBA officials did not implement a systematic approach to identify incarcerated veterans and adjust their benefits as required by Public Law 96-385. The evaluation included a review of 527 veterans randomly sampled from the population of veterans incarcerated in six states. Projecting the sample results nationwide, we estimated that about 13,700 incarcerated veterans had been, or will be, overpaid a total of about $100 million.

VBA has implemented the recommendations in the report. VBA reached an agreement with the Social Security Administration (SSA) to use the State Verification and Exchange System to identify claimants incarcerated in state and local facilities. VBA is now processing both a Bureau of Prisons match and SSA prison match on a monthly basis. By September 2002, over 18,500 veterans were identified who received VA benefits and were potentially incarcerated. Additional potentially incarcerated veterans are being identified at the rate of 600-700 monthly. VBA has indicated it is tracking the disposition of a 20 percent sample of the monthly SSA prison match cases. The OIG believes this case disposition sampling should continue, and we will monitor whether this sampling is adequate. VBA should set up a database for tracking the total dollar value of incarcerated overpayments, which VA is required to report annually with other erroneous payments.

VA's Program Response: During FY 2004, over 41,000 veterans were identified who received VA benefits and were potentially incarcerated. VBA is tracking the disposition of a 20 percent sample of the monthly SSA prison match cases. Actual FY 2003 overpayments identified from the 20 percent sample total $5,721,640. The 20 percent sample is not a random sample. They are cases with the largest potential overpayments. It is VBA's opinion that tracking 100 percent of these cases would not be cost beneficial.

In regard to the reporting requirements for erroneous payments, VBA continues to work with OMB and the Department to comply with the Improper Payments Information Act of 2002. C&P currently uses the Statistical Technical Accuracy Review (STAR) database to identify and project erroneous payments for the compensation and pension programs.

OIG3. PROCUREMENT

VA faces major challenges in implementing a more efficient, effective, and coordinated acquisition program. The Department spends about $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction, and services. High-level management support and oversight are needed to ensure VA leverages its full buying power, maximizes the benefits of competition, and improves contract administration.

In response to an IG report issued in May 2001, the VA Secretary established a Procurement Reform Task Force. In May 2002, the Task Force recommended improvements to better leverage VA's substantial purchasing power and to improve the overall effectiveness of procurement operations. By June 2002, VA began implementing Task Force recommendations. For example, to leverage its purchasing power, VA established a contract hierarchy which mandates use of VA Federal Supply Schedule (FSS)[5] Groups 65 and 66 for procurement of health care supplies.

OIG reviews continue to identify problems with FSS contracts and blanket purchase agreements (BPAs)[6], along with procurements for health care items, scarce medical services, and construction. We also continue to identify weaknesses in the management of purchase cards and problems with inventory management, as discussed below.

3A. OIG Issue - Federal Supply Schedule (FSS) Contracts

In March 2004, the OIG issued the report, *Audit of VAMC Procurement of Medical, Prosthetic, and Miscellaneous Operating Supplies* (Report No. 02-01481-118). The audit found that VAMCs needed to make more effective use of the best purchasing sources. Large proportions of VAMC supply purchases were not made from the best contract/BPA source, and VAMCs paid higher prices than necessary. In addition, some networks and VAMCs established contracts that were not beneficial because they covered supply products that were available from other sources (primarily FSS contracts) at equal or lower prices. To help ensure that VAMCs purchase supplies from the best sources, the audit recommended that VHA fully implement and monitor compliance with its purchasing hierarchy.

The audit also found that significant portions of the supplies purchased by VAMCs were not covered by VA national and FSS contracts and were only available on the open market. For these open market supply purchases, VAMCs paid a wide range of prices for the same products. The audit estimated that improving VAMC purchasing practices and increasing efforts to award more national contracts for supplies would result in cost reductions of about $214 million a year. Over 5 years (the typical life of national contracts and BPAs), the potential savings would be about $1.4 billion taking into account inflation and projected increases in supply usage.

To help minimize the amount of open market purchases and better leverage VA's purchasing power, the audit recommended that VHA and the Office of Acquisition and Materiel Management increase efforts to award new national contracts and BPAs for supply products.

[5] The General Services Administration (GSA) provides Federal agencies with a simplified process for obtaining commonly used commercial supplies and services at prices associated with volume buying. GSA issues Federal Supply Schedules containing the information necessary for placing delivery orders with schedule contractors. GSA has delegated authority to VA to award and administer schedules for pharmaceuticals and medical/surgical supplies and equipment.

[6] BPAs are a simplified method of filling anticipated repetitive needs for services and supplies. Contractual terms and conditions are contained in a GSA Schedule contract and do not need to be re-negotiated for each use.

VA's Program Response: Each VISN chief logistics officer conducted training of all VISN contracting officers and purchase card holders to ensure full understanding of the requirements of the purchasing hierarchy. The VISNs are providing advance notice of all BPAs to VA's National Acquisition Center (NAC) and the Clinical Logistics Office (CLO) for a review to determine if a multi-VISN or national BPA is available or should be awarded. This is in accordance with VHA Directive 2003-018, "Review of Blanket Purchase Agreements (BPAs) for Multi-VISN or VISN Groups." A CLO workgroup has been formed to develop a list of performance measures and best practices for field contracts and logistics personnel. The list was made available on October 30, 2004.

The Prosthetic and Sensory Aid Strategic Health Care Group (PSAS SHG) has been monitoring a total of 20 national Prosthetic Clinical Management Program (PCMP) contracts for network compliance since the end of the third quarter, FY 2004. The target is 95 percent compliance with the contracts. Of the 20 national contracts, the networks as a whole are achieving a 95 percent compliance rate on 9 of the 20 contracts. These nine national contracts were implemented in FY 2002 or FY 2003. The 11 remaining contracts where a 95 percent compliance rate was not met were implemented in the fourth quarter of FY 2003 and FY 2004. This trend indicates that facilities' transition to procuring devices off the new national PCMP contracts is a work in progress and improvement is noted quarterly. PSAS SHG continues to track and monitor network compliance with national PCMP contracts.

All VISNs have had their staff complete the Simplified Acquisition Procurement training. There is at least one individual within each VISN who has a high warrant level to procure high-ticket items such as the computerized leg.

In coordination with the VHA Chief Logistics Officer, the Office of Acquisition and Materiel Management (OA&MM) has issued a list of priorities for use of government supply sources. In light of this direction, VHA mandated purchasing hierarchy training for all field staff employees responsible for the purchase of supplies and equipment. The field chief logistics officers certified this training in April 2004.

OA&MM sales generated from medical/surgical BPAs, basic order agreements, and other national contracts increased 336 percent for the third quarter of FY 2004, as compared with the third quarter of FY 2003, minimizing the amount of local purchases. OA&MM will continue to be proactive in supporting contract hierarchy as outlined in published guidance. OA&MM will continue to work with the VHA Chief Logistics Officer to increase the use of the mandatory sources of supply.

3B. OIG Issue - Contracting for Health Care Services

OIG reviews have identified conflicts of interest in the request for approval of contracts, preparation of solicitations, contract negotiations, and contract administration efforts. The most frequent violations are where VA physicians, who also receive compensation from the affiliate and/or the affiliate's practice group, are involved in the contracting process as VA employees, in violation of Federal ethics laws and regulations. Violations carry both civil and criminal penalties. In several cases, in addition to being involved in multiple aspects of the procurement process, the VA physician was expected to perform services at VA for compensation under the contract. We have received opinions from the VA Designated Agency Ethics Official (DAEO) in the Office of General Counsel, as well as from regional counsel, which have determined that certain participation in the contract process by such "affiliated" physicians violated Federal law. We believe VA needs to increase awareness among physician staff of, and enforce compliance with, the requirements of VHA Handbook 1660.3, *Conflict of Interest Aspects of Contracting for Scarce Medical Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis and Intergovernmental Personnel Art Agreements (IPAs).* Toward this end, the DAEO has added to its ethics training video a section on this issue.

Also, we continue to see that legal, technical, and pre-award price reasonableness reviews are not always

performed on non-competitive contract awards. Some contracts and solicitations do not contain terms and conditions that adequately protect the Department's interests. Lastly, we have found instances where VA has allowed the affiliated medical schools to dictate the terms and conditions of contracts, including the services to be provided. For example, the services of an individual in training do not qualify as a "commercial service" under the sole-source authority of title 38, United States Code, Section 8153. In another instance, because the physician expected to provide services to VA under the contract was not an employee of the affiliate, the affiliate could not meet certain contract requirements.

VA's Program Response: The Resources Sharing Office staff hosted 2 conferences for over 100 contracting officers and other VHA facility staff. Topics included contracting with affiliated institutions and conflict-of-interest issues. A draft directive on procuring services under sharing authority, including guidelines for price with affiliated institutions, is in the concurrence process with expected publication this fall.

The Deputy Under Secretary for Health for Operations and Management (O&M) notified network directors that O&M monitors are being modified to require certification that VHA facilities are in compliance with VHA Handbook 1660.3. This policy requires that facility directors ensure that each chief of staff and physician, clinician or allied health supervisor, or manager receive a copy of Handbook 1660.3 and the Acknowledgement Form (VA Form 10-21009 {NR}). A copy of the signed acknowledgement must be placed in the clinician's personnel folder. A workgroup has been formed to address "national clinical contract strategy" issues that have emerged from the VA Capital Asset Realignment for Enhanced Services (CARES) report. This workgroup will support the Secretary's national health care strategy. To promote the development of sound contracts, the Clinical Logistics Office is preparing guidance (to be issued in January 2005) for the field on the development of service contracts, with an emphasis on statements of work.

OA&MM has conducted acquisition business reviews and made recommendations for appropriate corrective actions, which are often the same as the OIG recommendations. OA&MM acquisition business reviews will continue to look for the problems identified by the OIG and make recommendations to correct deficiencies. In addition to the required ethics training offered by the Department, acquisition professionals have participated in OA&MM-sponsored training in conflict-of-interest issues.

The DAEO video is the principal training vehicle for the VHA managers and executives who are mandated by an ethics program regulation to have ethics training each year. These employees, including many physicians, viewed the video in calendar years 2003 and 2004. In late 2003, the Deputy Under Secretary for Health went beyond the ethics program mandate and required annual ethics training for all VHA physicians, including researchers. The video focuses on conflicts of interest affecting contracts for scarce medical services.

The DAEO has been featuring the subject matter of the handbook in each of the annual ethics videos since 2001. The DAEO staff has also emphasized the handbook guidance in training sessions at various national and regional conferences for VHA procurement and contracting officers, for staff of the sharing program, and for VHA executive candidates.

3C. OIG Issue - Government Purchase Card Activities

The OIG identified systemic management weaknesses in VA's oversight and use of government purchase cards. We found instances of wasteful spending (buying without regard to need or price), purchases that exceeded the cardholder's authority, and purchases that were inappropriately split to avoid competition requirements. Some cardholders did not use existing contracts, which has resulted in paying higher prices for the same items.

VA management controls over purchase card transactions need to be strengthened so that VA buying power

is leveraged to the maximum extent possible and discounts are not lost. Increased visibility and oversight over procurements are needed to ensure price reasonableness so that VA procurement needs are met effectively and economically. In our April 2004 report, *Evaluation of the Department of Veterans Affairs Purchase Card Program* (Report No. 02-01481-135), we identified additional opportunities for VBA, VHA, and the Office of Management to provide greater assurance that purchase cards are used properly.

VA's Program Response: To rectify the systemic management weaknesses in the oversight and use of government purchase cards, VBA has finalized a new handbook that sets forth sound policy, procedures, and guidance for all participants of the purchase card program. Major emphasis in the re-write of the handbook was placed on increased management oversight, internal controls, a procedural checklist, span of control, purchasing from GSA/VA-required vendors, best pricing, and commercial vendor rebates. Additionally, the Director, Vocational Rehabilitation & Employment Service (VR&E) is addressing the "buying power" issue. Contract options are being pursued, in particular, the use of the agency Procurement of Computer Hardware and Software (PCHS) contract, using VA-negotiated pricing. Currently, VR&E has an exemption from use of the PCHS contract.

During the past 12 months, VBA has administered three VBA-wide hands-on training courses to over 150 individuals. This training addressed some of the purchase weaknesses identified by the OIG in its April 2004 purchase card program evaluation report. Additionally, VBA's Office of Resource Management Financial Operations staff performs field station on-site financial surveys, which include review of the purchase card program. VBA will continue to provide the necessary resources and oversight to ensure efficient and effective use of purchasing authorities.

The documented occurrence of fraud and misuse in VHA's purchase card program is remarkably low. A recent GAO report summarized 83 OIG reports from March 1999 through September 2003. GAO identified a total of $435,900 in fraudulent activity in this period. This represents less than 0.01 percent of VA purchase card activity over this period. VHA will continue working toward eliminating vulnerabilities to fraud and misuse.

The VHA Clinical Logistics Office has required that VISN chief logistics officers conduct training of all VISN contracting officers and purchase card holders to ensure full understanding of the requirements of the purchasing hierarchy. Each VISN has certified the completion of this training. Given the issues currently surrounding the CoreFLS roll-out, VHA is in the process of hiring a contractor to work on development of programming changes to the Integrated Funds Distribution, Control Point Activity, Accounting & Procurement Package (IFCAP) program to allow VHA to pull compliance information from its current procurement history file. The anticipated date for the expected IFCAP program changes to be developed is December 31, 2004. In the meantime, interim measures for determining compliance rely on management reviews at the field level. VHA is updating its purchase card guidance, to be issued this coming year, to address internal control weaknesses.

Among the OIG recommendations were that VA management should strengthen internal controls and provide greater oversight to ensure that VA policies and the Federal Acquisition Regulation are effectively implemented in order to prevent and detect fraudulent, improper, and questionable uses of purchase cards. Based on the OIG recommendations, the Office of Management issued Office of Finance (OF) Bulletin 04GC1.03 to include span of control criteria for approving officials, limiting the number of cardholders for which an approving official can be responsible — from a minimum of 10 to a maximum of 20. Exceeding that limit would require approval from the facility director.

The GAO conducted an audit (report number GAO-04-737, dated May 2004) entitled, *Veterans Health Administration (VHA) Purchase Cards – Internal Controls over the Purchase Card Program Need Improvement*. In

response to the GAO recommendation to substitute convenience checks in lieu of the use of purchase cards, the Treasury Financial Manual reference on other small purchase methods was incorporated into OF Bulletin 04GC1.04.

3D. OIG Issue - Inventory Management

Since 1999, we have issued six national audits of inventory management practices for various supply categories, identifying potential cost savings of about $388.5 million. We noted potential savings ($ in millions) could be achieved in the management of the following:

• Medical Supply Inventories	$ 75.6
• Prosthetic Supply Inventories	$ 31.4
• Pharmaceutical Inventories	$ 30.6
• Engineering Supply Inventories	$168.4
• Miscellaneous Supply Inventories	$ 53.7
• Consolidated Mail Outpatient Pharmacy Inventories	$ 28.8
Total	$388.5

In March 2004, we issued an *Interim Report on Patient Care and Administration Issues at VA Medical Center in Bay Pines, Florida* (Report No. 04-01371-108). Reported problems involving the unavailability of medical-surgical supplies was only one of a number of long-standing problems identified at the Medical Center that went uncorrected. Other deficiencies included inadequate inventory practices.

In August 2004, our report, *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)* (Report Number 04-01371-177), concluded that in spite of repeated notices by VHA of the need for an efficient inventory management program, the medical center did not fully or adequately implement VA's Generic Inventory Program (GIP) to manage inventories. Consequently, conversion of inventory data to CoreFLS failed. VA should ensure all facilities have certified the accuracy and reliability of GIP data so problems encountered at Bay Pines do not occur at other sites.

Further, CAP reviews continue to identify systemic problems with the Department's inventory management caused by inaccurate information, lack of expertise needed to use the electronic inventory management system, and non-use of the system at some supply points in medical centers. Since January 1999, we have examined supply inventory management practices during CAP reviews at 82 facilities and reported inventory management deficiencies to VHA management at 68 facilities. VA continues to face significant challenges in deploying an accurate inventory management information system, nationwide.

VA's Program Response: The VHA Clinical Logistics Office has created an inventory management workgroup with representatives from the field and VHA Central Office. This workgroup developed an action plan that is being used by VHA for improving inventory management practices throughout all medical centers. An initiative to fully implement VA's Generic Inventory Program (GIP) for all supply inventories excluding prosthetics, pharmaceuticals, and subsistence is nearing completion. At completion, a listing of all inventories found at VHA medical centers will be established. A monitoring system using the inventory listing will track key indices of medical center inventories. Improvements to the monitoring system are being planned to more effectively trend data, provide management reports, and provide accurate information. Implementing the GIP and monitoring key indices are two of the three factors to improve inventory management practices. The third is a renewal of a national training program. As of September 17, 2004, 78 percent of the facilities had GIP fully implemented. GIP is expected to be fully implemented VHA-wide by the end of the second quarter of FY 2005. VHA has implemented all the recommendations from the six national audits of inventory management.

Inventory management at medical centers is a local operation under the auspices of VHA management. OA&MM is responsible for overall Departmental guidance on the processes and procedures for managing inventories. The deficiencies continually cited by the OIG are largely a

result of local operations failing to follow prescribed policy and practices issued by both OA&MM and VHA. Use of IFCAP/GIP was mandated several years ago by VHA Directive and Handbook 1761.2, but many facilities did not comply. A memorandum was issued by the Deputy Under Secretary for Operations and Management over a year ago reaffirming this mandate.

OA&MM assists the field in better inventory management by conducting a business review program that performs site visits to medical center logistics activities, reviewing materiel management operations and providing findings to VHA and medical center management, and conducting on-site training when possible. OA&MM is also working with the VHA Clinical Logistics Office to implement improved reporting to follow up on previously described actions.

The Office of Management reorganization re-established the position of accountable officer at each medical center. The director delegates the responsibility of the accountable officer position to an appropriate person, who is responsible for inventory management compliance and performance. This is the first time in many years that one VA official is responsible for inventory management.

OIG4. FINANCIAL MANAGEMENT

Since 1999, VA has achieved unqualified audit opinions on its consolidated financial statements. Material weaknesses related to information technology security controls and implementing an integrated financial management system continue, and corrective actions to address these weaknesses are expected to take several years to complete.

Over the last few years, the OIG reported that VHA needs to: (i) strengthen procedures and controls for means testing, billings, and collections; (ii) reduce the rate of coding and billing errors; (iii) decrease the time it takes to bill for services; (iv) improve medical record documentation for billing purposes; and (v) perform reconciliations. In addition, VA reported in the past that VHA's Revenue Office believes that significant amounts of revenue have yet to be collected. While VA has addressed many of the concerns we reported over the last few years, our most recent audits continue to identify major challenges where VHA could improve debt management, financial reporting, and data validity. In addition, VA needs to correct problems we have identified in the employees workers' compensation program.

4A. OIG Issue - Financial Management and Reporting

VA program, financial management, and audit staffs perform certain manual compilations and labor-intensive processes in order to attain auditable consolidated financial statements. These manual compilations and processes should be automated and performed by VA's financial management system. In the meantime, we consider the risk of materially misstating financial information as high.

For the past few years, VA has responded that its new integrated financial management systems under development, CoreFLS, would resolve many OIG concerns. VA implemented CoreFLS at three test sites in October 2003, with implementation at further sites to be phased in, and full implementation scheduled for March 2006. However, problems occurred with data conversion, training, testing, segregation of duties, and access controls at the VHA test site, causing further deployment to be delayed. These issues are included in our March 2004 interim report on patient care and administrative issues at VAMC Bay Pines, and in our August 2004 report on issues at VAMC Bay Pines and procurement and deployment of CoreFLS.

VA's Program Response: In 1997, the financial statement auditors identified the lack of integrated financial management systems as a noncompliance under the Federal Financial Management Improvement Act (FFMIA). In 2000, the auditors elevated this noncompliance to a material weakness. The Department continues to face challenges in building and maintaining financial manage-

ment systems that comply with Federal requirements. Until recently, the Department intended to replace the current financial system with CoreFLS. During the testing phase of the CoreFLS project, problems occurred with data conversion, training, testing, segregation of duties, and access controls. As a result, VA is reevaluating the current plans for CoreFLS. To address the material weakness, task groups will investigate the feasibility of developing tools to support the effective and efficient preparation of financial statements to eliminate significant manual workarounds, improve interfaces between legacy systems and VA's core accounting system (Financial Management System), enhance data consistency between the core accounting and subsidiary systems, and automate reconciliation processes.

VHA concurs with the finding that the Department lacks adequate automation in its financial reporting and that current processes require excessive manual intervention. This is labor intensive and therefore inefficient, and it increases the potential for error. Recognizing the unanticipated challenges in developing and implementing CoreFLS, VHA cannot confidently forecast when these reporting concerns will be effectively addressed.

4B. OIG Issue - Data Validity

The Government Performance and Results Act (GPRA) requires agencies to develop measurable performance goals and report results against those goals. Successful implementation requires that information be accurate and complete. VA has made progress in implementing GPRA, but additional improvement is needed to ensure that stakeholders have useful and accurate performance data. In 1997, we initiated a series of audits assessing the quality of data used to compute the Department's key performance measures. The eight audits completed to date validated the underlying data in only two of the nine key measures reviewed. While VA has corrected the deficiencies cited in our reports involving the 7 measures that had validity problems, we are concerned that the remaining 17 key performance measures identified in the 2003 Performance and Accountability Report that have not been reviewed may have similar problems. Until the remaining 17 measures are reviewed, this issue will remain a major management challenge. VA staff should do a thorough review of the remaining measures and provide the OIG assurance that data validity problems do not exist or have been corrected.

VA's Program Response: Data validity can be viewed in a larger context than the reporting of performance goals. Valid data on the number of veterans and their characteristics are important for placing VA performance goals into a larger context. Such data are critical to making forecasts of future utilization of VA resources as well as evaluating the propriety of current resource allocations. The forecasts in turn are important for budgeting, decision-making, strategic planning, and liability calculations. Because of the nature of the veteran population, VA cannot ascertain exact historical values. Thus, historical data must be estimated.

The Office of the Actuary (OACT) is charged with making the official estimates and forecasts of the number of veterans and their characteristics. OACT regularly updates its estimate of the past and forecast of the future with new data and improved modeling, while providing expanded information. The latest revision, "VetPop2001Adj," was adjusted to match public summary data from Census 2000 and was distributed in the second quarter of FY 2003. OACT is currently finalizing a new revision, "Veterans Actuarial Model 3 (VAM3)." It should be available by the end of CY 2004. An independent validation of the OACT model is being initiated.

The Office of Policy, Planning, and Preparedness' Data Management and Analysis Service provides veteran data to members of the general public as well as various organizations within VA. These data are obtained through an array of both internal sources (Office of the Actuary, VHA, VBA, and NCA) and external sources, such as the U.S. Census Bureau and the Department of Defense. In order to ensure that the data are accurate and consistent with previously released figures, the Data Management and Analysis Service validates the data through various methods.

VHA recognizes that additional progress needs to be made in this area and continues to take steps to improve data quality. Regional "data management and analysis" training programs were completed in the fourth quarter of FY 2004. These programs focused on: data collection, data management, data analysis for decision-making, data display, benchmarking, and national VA data access. There were approximately two quality managers from each VA facility who participated in the 2-day program and who are now available to support data quality issues at their respective medical centers.

VBA's Office of Performance Analysis and Integrity conducts data validation studies to ensure the integrity of VBA's performance data and improve the value and quality of such data. This office also maintains a corporate Data Warehouse and an Operational Data Store that facilitate the ability to have reliable, timely, and accurate data.

During FY 2004, VBA conducted validation reviews on two of its nine key measures contained in the Performance and Accountability Report. These included the review of Loan Guaranty's Foreclosure Avoidance Through Servicing ratio and VR&E's Rehabilitation Rate measure. The Office of Performance Analysis and Integrity plans to continue validation reviews in 2005.

NCA continues efforts to ensure that stakeholders have useful and accurate performance data. NCA has initiated the Organizational Assessment and Improvement Program to identify and prioritize improvement opportunities and to enhance program accountability by providing managers and staff at all levels with one NCA "scorecard." In 2004, assessment teams drawn from national cemeteries, Memorial Service Network offices, and NCA Central Office began conducting site visits to all national cemeteries on a rotating basis to validate performance reporting.

For further information on the Department's efforts to improve its data quality, see the Assessment of Data Quality section on page 120.

4C. OIG Issue - Workers' Compensation Program (WCP)

VA continues to be at risk for significant WCP abuse, fraud, and unnecessary costs because of inadequate case management and fraud detection. Prior OIG audit[7] recommendations to enhance the Department's case management and fraud detection efforts and to avoid inappropriate dual benefit payments have not been fully implemented.

Reducing the risk of abuse, fraud, and unnecessary costs is important due to the significance of the Department's WCP costs. Since 1998, Department costs have totaled $876 million. In 2003, costs totaled $157 million. Our audit findings show that WCP costs could be significantly lower if prior OIG audit recommended case management improvements were fully implemented.

Our August 2004 report, *Follow-Up Audit of Department of Veterans Affairs Workers' Compensation Program Cost* (Report No. 02-03056-182), found that ineffective case management and program fraud results in potential unnecessary/inappropriate costs to the Department totaling $43 million annually. These costs represent significant potential lifetime[8] compensation payments to claimants totaling $696 million. Additionally, an estimated $113 million in avoidable past compensation payments were made that are not recoverable.

Given the continued risk of program abuse, fraud, and unnecessary costs, we recommend that the Assistant Secretary for Management continue to designate the WCP as an internal high priority area with increased program monitoring and oversight. This should include

[7] Report No. 8D2-G01-67, "Audit of VA's Worker's Compensation Program Costs," dated 7/1/98 and Report No. 99-00046-16, "Audit of High Risk Areas in VHA Workers' Compensation Program," dated 12/21/98.

[8] Lifetime estimates were calculated using the VBA life expectancy table for net worth determinations contained in VBA Manual M21-1, Part IV, Chapter 16, Addendum B. The annual dollar impact was multiplied by the number of years of life expectancy. The estimates did not include future increases in WCP benefits.

preparation of an action plan and timeline to correct this program weakness. The WCP requires priority attention to address significant case management deficiencies, program fraud, and future program costs. The Department faces a significant liability for future compensation payments that is estimated at $1.9 billion. The Department's decentralized approach to administration is not effective. There is a lack of effective case management and fraud detection Department-wide and VA needs to establish a more coordinated approach to administration and implement necessary case management improvements. We recommend that this effort be directed by the Office of Human Resources and Administration, which has overall Department responsibility for the program.

VA's Program Response: VA generally concurs with the OIG findings and recommendations presented in the OIG report. In response to the report, VA workers' compensation management is now being monitored by the Deputy Secretary at his monthly performance review meetings. The Deputy Secretary has also directed the Acting Assistant Secretary for Human Resources and Administration and the Acting Under Secretary for Health to work together to develop a plan for addressing the OIG recommendations. The Office of Management (OM) will continue to designate WCP as an internal high priority area with increased program monitoring and oversight. OM will monitor the detailed corrective action plan addressing the 10 actions identified in recommendation 2 of the OIG audit report.

OIG5. INFORMATION MANAGEMENT

VA faces significant challenges addressing Federal information security program requirements and establishing a comprehensive, integrated VA security program. Information security is critical to the confidentiality, integrity, and availability of VA data, and to protect the assets required to support health care and benefits delivery. Lack of management oversight contributes to inefficient practices and weaknesses in electronic information and physical security. We continue to identify serious Department-wide vulnerabilities.

5A. OIG Issue - Information Security

In our December 2003 report, *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 02–03210–43), we concluded that VA has made insufficient progress in improving its information security posture. VA is not in compliance with the requirements of the Federal Information Security Management Act. VA's information security vulnerabilities have not been adequately addressed because the Department did not complete necessary corrective actions in response to our audit findings. Serious security vulnerabilities have continued to exist over a multi-year period that place VA systems, data, and delivery of services to the Nation's veterans at risk. In our 2004 work, we found that many information system security vulnerabilities reported in our 2001 through 2003 national audits are unresolved, and we have identified additional vulnerabilities. VA needs to devote sufficient resources to implement the 16 OIG recommendations. The OIG has reviewed the June 2004 status update from the Associate Deputy Assistant Secretary for Cyber and Information Security, and while VA has made progress in addressing the issues raised in our report, all recommendations remain open pending receipt of satisfactory implementation documentation.

In our January 2004 report, *Evaluation of the Department of Veterans Affairs' Installation of the Microsoft Blaster Worm Patch* (Report No. 03-02970-55), we found that the security patch was not effectively installed leaving VA systems vulnerable to a denial of service attack. Oversight of the installation of the patch was unsystematic and VA's Central Incident Response Capability Service (VA-CIRC) did not provide effective assistance to solve installation problems. VA systems were not protected because VA has not established a patch management program meeting guidance established by the National Institute of Standards and Technology (NIST), and the responsibility and accountability for VA-wide

patch management is not specifically assigned. The Associate Deputy Assistant Secretary for Cyber and Information Security is responsible for issuing guidance on installing security patches through VA-CIRC. However, VA-CIRC does not have direct line authority to ensure the implementation of patches by facility level information technology officials. All three recommendations remain open.

OIG CAP reviews for FY 2003 and the first 6 months of FY 2004 found security weaknesses at 32 of 34 VAMCs and 12 of 14 VAROs where we reviewed information security management. We made recommendations to improve contingency planning, background checks, systems certification, and other internal controls. VA has not implemented all planned security measures and has not ensured compliance with established security policies, procedures, and controls requirements.

VA's Program Response: VA is actively working to implement recommendations in the OIG report, *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 02-03210-43), consistent with available funding and personnel. As of this date, the Office of Cyber and Information Security (OCIS) has completed actions on 6 of the 16 audit issues, with progress being made on all the remaining recommendations. VA recognizes that although it has provided its completed actions to the OIG, the OIG will determine whether those actions will close the recommendations. The planned completion date for the majority of the remaining recommendations is the end of calendar year 2004, and full implementation of all the recommendations is at the end of calendar year 2005. The need to devote resources to additional high-priority projects and the extensive periods for initiating, developing, and implementing some of the proposed solutions have resulted in remediation progress constituting a multi-year effort for many of the remaining issues.

Progress has been made in implementing the recommendations that a patch management program be established that (1) follows the guidance contained in NIST Special Publication (SP) 800-40, Procedures for Handling Security Patches, (2) identifies authorities and responsibilities for implementation of the patch management program, and (3) establishes accountability for compliance.

In December 2003, through funding commitments from the Administrations and staff offices, the VA Enterprise Information Board approved implementation of the Security Configuration and Management Program (SCAMP). Over the past several months, SCAMP has established and implemented several components of a patch management program/security configuration management program in accordance with NIST (SP) 800-40. As of September 2004, 9 of the 16 milestones established for the SCAMP program have been achieved including development of patch management (still in draft) and cyber incident "rules of engagement" policies and implementation of several point patch systems, an enterprise Hercules/Stat solution, and an enhanced VA-CIRC reporting capability. Additional SCAMP activities will include creating an organizational hardware and software inventory, prioritizing patch applications, creating an organization-specific patch database, testing patches for functionality and security, and training system administrators in the use of vulnerability databases. Implementation of the remaining seven milestones is currently scheduled for December 2005; however, SCAMP is in the process of formally requesting an extension until December 2006 to allow for proper and effective implementation of an enterprise level, network structured, configuration management framework capability to centrally manage all desktops, servers, communications, and security devices in the VA environment. This additional time is being requested based on input received from private industry, lessons learned from the SCAMP pilot, and evaluations of several framework technologies. The additional time will allow for discovery, planning, and training to take place in FY 2005 with implementation in FY 2006.

The responsibility and accountability for the management of desktop functions has always resided at the facility level within the Administrations. The "Cyber

Incident Rules of Engagement" policy mentioned above defines organizational responsibilities for future incidents. The SCAMP program provides the opportunity for that responsibility and accountability to be centralized under the VA Chief Information Officer (CIO). When the SCAMP program becomes fully functional, the VA CIO will have the opportunity to assign accountability when functions are not carried out.

The OIG CAP reviews and the annual information technology (IT) security audit, independent reviews conducted by OCIS, and VA IT security self-assessments conducted by facility information security personnel for each VA system and major application have determined that VA has not implemented all planned security measures, nor are all facilities in compliance with established security policies, procedures, and control requirements. The Department has developed a centralized process to assist facilities in documenting these deficiencies and in managing associated remediation activities. To place emphasis on CAP issues, OCIS, in coordination with VHA, provides the Deputy Secretary with a quarterly report on progress to remediate identified deficiencies.

Although a significant number of deficiencies still exist, the Department is making measured progress to correct identified security weaknesses, with the average number being identified for each system/major application steadily decreasing each year. These deficiencies averaged approximately 23 per system/major application for FY 2001, 16 per system/major application for FY 2002, and 10 per system/major application for FY 2003. OCIS will continue to assist the Administrations and staff offices with their remediation planning and management activities in order to ensure that appropriate emphasis is placed on bringing VA into compliance with security legislation, executive branch guidance, and Department policies and procedures.

Major Management Challenges Identified by the Government Accountability Office (GAO)

In January 2003, GAO issued its special series of reports entitled the *Performance and Accountability Series: Major Management Challenges and Program Risks*. One of the reports described major management challenges and high-risk areas facing the Department of Veterans Affairs (GAO-03-110). The following is excerpted from the report in which GAO discusses the actions VA has taken to address the challenges identified and major events that have significantly influenced the environment in which the Department carries out its mission. The report can be viewed in its entirety at the GAO Web site: http://www.gao.gov/cgi-bin/getrpt?GAO-03-110.

GAO1. Ensure Access to Quality Health Care

1A. Access

Although VA has opened hundreds of outpatient clinics, waiting times are still a significant problem. To help address this, VA has taken several actions including the introduction of an automated system to schedule appointments. Over the past several years, VA has done much to ensure that veterans have greater access to care and that the care they receive is appropriate and of high quality. Yet VA remains challenged to ensure that veterans receive the care they need, when they need it — a challenge that has become even greater with the recent expansion of benefits.

VA's Program Response: VHA has been working on an initiative called Advanced Clinic Access (ACA) since 1999. The ACA initiative provides principles for office practice efficiencies that are not resource intensive. Adoption of these key principles in VA clinics gives a better idea of the status of waiting times and the capacity and demand on the system. The goal is to meet the demand of the patient population for care at the time the demand occurs.

In addition to working on ACA, VHA has made a concerted effort to improve waiting times in a variety of ways. The measuring system has been enhanced so that waiting times for nearly every patient are being measured. In conjunction with the Office of the Chief Information Officer, we developed a National Waiting Times Web site that hosts a variety of documents and information on ACA. VA has developed a monitor for the Primary Care Management Module (PCMM) that will identify the percent of active patients assigned to an active primary care provider and the percent of primary care provider capacity utilized by active patients assigned in PCMM. VA has developed both a guide for schedulers in how to properly use the scheduling package and an electronic waiting list in *VistA* to obtain a better assessment of the demand on the system. We are revising the scheduling package so that it will provide flexibility to accurately schedule patients. This is expected to be completed in 2005. VHA has established a workgroup on Provider Productivity and Staffing Standards as well as a core group of national Access Coaches to promote the ACA initiative. VHA issued three directives that define the business processes for waiting times: Directive 2003-068, "Process for Managing Patients When Patient Demand Exceeds Current Clinical Capacity;" Directive 2003-062, "Priority Scheduling for Outpatient Medical Services and Inpatient Hospital Care for Service Connected Veterans;" and Directive 2002-059, "Priority for Outpatient Medical Services and Inpatient Hospital Care."

1B. Long-Term Care

VA must also better position itself to meet the changing needs of an aging veteran population by improving nursing home inspections and increasing access to non-institutional long-term care services. In FY 2001, VA spent 92 percent of its long-term care dollars in institutional settings, such as nursing homes — the costliest long-term care setting. However, VA's oversight of community nursing homes — where about 4,000 veterans received care each day in FY 2001 — has not been adequate to ensure acceptable quality of care. While VA has begun to implement certain policies to improve oversight of these homes, as GAO recommended in July 2001, VA has yet to develop a uniform oversight policy for all community nursing homes under VA contract. Further, VA plans to rely increasingly on the results of state inspections of community nursing homes rather than conducting its own inspections, but VA has not developed plans for systematically reviewing the quality of state inspections.

VA's Program Response: VA has implemented this recommendation. The Department now has a single, structured, comprehensive oversight policy for community nursing homes, outlined in VHA Handbook 1143.2, "VA Community Nursing Home Oversight Procedures," dated June 4, 2004. Further, VA has a system for identifying states that may be unreliable in their surveys of nursing homes, also found in VHA Handbook 1143.2.

1C. Hepatitis C

Since 1999, VA's budgets submitted to the Congress have included a total of $700 million to screen, test, and provide veterans who test positive for hepatitis C with a recommended course of treatment. In June 2001, GAO testified that VA missed opportunities to screen as many as 3 million veterans who visited medical facilities during FY 1999 and 2000, potentially leaving as many as 200,000 veterans unaware that they have hepatitis C. In response to GAO testimony, VA has begun to improve screening and testing procedures. In 2002, VA established a process to monitor screening and testing performance. In addition to monitoring VA's progress in screening and testing veterans for hepatitis C, GAO is assessing VA's efforts to notify veterans who test positive and to evaluate veterans' medical conditions regarding potential treatment options.

VA's Program Response: VA has instituted a number of steps to improve screening, testing, medical treatment, data-based quality improvement, communication, and education in the care of veterans at risk for and infected with hepatitis C. VA instituted network performance measures for universal hepatitis C risk assessment

(screening) and testing of those at risk in 2002. Performance is measured by independent chart reviews conducted through the External Peer Review Program (EPRP). In FY 2003, in a review of over 52,000 medical records, 95 percent contained evidence of risk factor screening and over 85 percent of those at risk had been tested for or diagnosed with hepatitis C. An enhanced electronic clinical reminder is being developed and piloted to prompt testing based not only on patient-reported risk behavior but also on information from the electronic medical record indicating increased risk. VA is monitoring timeliness of test notification and disease management decisions through the EPRP program. A telephone reminder system and other electronic means of ensuring notification of test results are being developed. Comprehensive recommendations regarding antiviral therapy and management of cirrhosis and portal hypertension have been published and are now available on VA's hepatitis C Web site (http://www.hepatitis.va.gov). The number of hepatitis C patients receiving antiviral therapy increased by over 30 percent from FY 2002 to FY 2003, with over 9,000 patients receiving treatment in FY 2003. VA has developed and implemented a system-wide electronic case registry of hepatitis C patients for administrative oversight, quality improvement, and patient safety monitoring. As of March 2004, over 250,000 patients had been added to the registry, and over 180,000 of those had at least one VA admission or outpatient encounter in FY 2003. VA has developed a broad-based approach to provider and patient education and communication. Lead clinicians have been identified at each VA facility, and regular contact is maintained through e-mail groups and an electronic news service. Patient education materials have been distributed to all VA facilities.

GAO2. Manage Resources and Workload to Enhance Health Care Delivery

2A. Veterans' Equitable Resource Allocation (VERA) System

In FY 1997, VA began allocating most of its medical care appropriations under the VERA system, which aims to provide VA networks comparable resources for comparable workloads. In response to recommendations GAO made in February 2002 regarding VERA's case-mix categories and Priority 7 workload, VA said that further study was needed to determine how and whether to change VERA. In November 2002, VA announced its intention to make changes to VERA for FY 2003 when VA's appropriation was finalized. Some of the planned changes, if implemented, could address recommendations GAO made. Delaying these improvements to VERA means that VA will continue to allocate funds in a manner that does not align workload and resources as well as it could.

VA's Program Response: In FY 2003, the Secretary approved expanding VERA from a 3-price case-mix to a 10-price case-mix model, including six (1 through 6) Basic Care price groups and four (7 through 10) Complex Care price groups. This change follows the recommendation provided in the GAO and RAND Corporation reports and recognizes a differentiation in VA's "core mission" patients (veterans with service-connected disabilities, those with incomes below the current threshold, or those with special needs, for example, the homeless) not present in the previous three VERA price groups. The change also improved allocation equity among the 21 health care networks and modified the funding allocation split between Basic Care and Complex Care to reflect the current cost experience between these groups rather than using a fixed ratio that reflects their FY 1995 relative costs.

For FY 2004, the Secretary approved including all Priority Group 7 Basic Care veterans in the VERA model.

Previously, only Priority Group 7 Complex Care veterans were included. Because FY 2002 is the base year for the FY 2004 VERA model, VERA includes only veterans in Priority Groups 1 through 7 (Priority Group 8 was established on October 1, 2002; it will not have an impact until the FY 2005 VERA model, which will use FY 2003 as the base year). This change is consistent with GAO's recommendation to include all Priority 7 veterans in VERA. Including all Priority Group 7 Basic Care patients in VERA is more consistent with VA's current enrollment policy and better aligns the VERA workload with actual workload served. In conjunction with this change, the VERA price groups were modified, and there is now a separate price for Priority Group 7 veterans in each of the 10 price groups based on their relative cost to Priority Group 1 through 6 veterans. As a result, VERA now has 20 prices, 2 in each price group.

2B. CARES

VA has begun to make more efficient use of its health care resources to serve its growing patient base. However, to meet the growing demand for care, VA must carry out its plan to realign its capital assets and acquire support services more efficiently. At the same time, VA needs to improve its process for allocating resources to its 21 health care networks to ensure more equitable funding. VA must also seek additional efficiencies with the Department of Defense (DoD), including more joint purchasing of drugs and medical supplies.

VA is one of many Federal agencies facing challenges in managing problems with excess and underutilized real property, deteriorating facilities, and unreliable property data. In 1998, GAO reported that in the Chicago area alone, as much as $20 million could be freed up annually if VA served area veterans with three instead of four hospitals. In response, in October 2000, VA established the Capital Asset Realignment for Enhanced Services (CARES) program, which called for assessments of veterans' health care needs and available service delivery options to meet those needs in each health care market — a geographic area with a high concentration of enrolled veterans. VA needs to build and sustain the momentum necessary to achieve efficiencies and effectively meet veterans' current and future needs. The challenge is to do this while mitigating the impact on staffing, communities, and other VA missions. Successfully completing this capital asset realignment will depend on VA's ability to strategically and expeditiously complete the implementation of CARES.

VA's Program Response: CARES is the most comprehensive analysis of VA's health care infrastructure that has ever been conducted, and it provides a 20-year blueprint for the critical modernization and realignment of VA's health care system. The CARES process provided a data-driven assessment of veterans' health care needs within each market, the condition of the infrastructure, and the strategic realignment of capital assets and related resources to better serve the needs of veterans. This process identified the necessary infrastructure to provide high-quality health care to veterans where it is most needed now and in the future. Through CARES, VA based its plan for enhanced health care services on objective criteria and analysis as well as cost-effectiveness, and in some cases, significant capital asset restructuring. In designing the CARES process, VA explicitly followed GAO recommendations, such as working to eliminate subjective judgments, developing methods to quantify the benefits of locations and facilities, and seeking the best defined measurement standards. CARES became a comprehensive, data-driven, objective capital investment planning process with extensive stakeholder involvement.

The "roll-out" of CARES began on June 5, 2002, when the Secretary of Veterans Affairs announced the initiation of the CARES process. Fourteen months later, on August 1, 2003, the draft National CARES Plan was presented to the CARES Commission for its review and to provide recommendations to the Secretary. The CARES Commission developed and applied six factors in the review of each proposal in the draft plan: 1) impact on veterans' access to health care; 2) impact on health care quality; 3) veteran and stakeholder views; 4) economic impact on the

community; 5) impact on VA missions and goals; and 6) cost to the government. Commission members visited 81 VA and DoD medical facilities and state veterans homes, conducted 38 public hearings, and analyzed more than 212,000 comments from stakeholders. The CARES Commission submitted its report to the Secretary in February 2004.

In May 2004, the Secretary announced his CARES decisions. He accepted the majority of the recommendations of the Commission report including:

- Construction of new medical centers in Orlando, Florida and Las Vegas, Nevada and a replacement hospital in Denver, Colorado.
- Replacement and major expansion of the Columbus, Ohio, VA Outpatient Clinic.
- New bed towers in Tampa, Florida and San Juan, Puerto Rico.
- 156 new community-based outpatient clinics by 2012, about 55 to 60 of which will open in the next 2 years.
- Consolidations of medical center divisions in Pittsburgh, Pennsylvania; Cleveland, Ohio; and Biloxi, Mississippi.
- Creation of four new and expansion of five existing spinal cord injury centers.
- Two new blind rehabilitation centers.

The Secretary's CARES decisions call for additional studies to refine the analyses developed in the CARES planning and decision-making process, which VA is already formulating. Master plans as referenced in the Secretary's decision document have been redefined to be more specific regarding the work to be done at each site and have been divided into two categories - capital plans and reuse plans. A statement of work is being developed for contractor(s) to conduct site-specific studies and capital and reuse planning for sites for which the Secretary requested further study. Local site task forces that will include VA staff and stakeholder representatives are in the process of being formulated to interact with the national contractor.

The objective of a capital plan is to provide the best configuration of capital assets for modern health care delivery. Capital plans will be developed in conjunction with the reuse plans and health care delivery studies (if appropriate) to assist in development of overall options to determine the best method, location, and cost-effective physical configuration of VA capital assets to deliver health care services while improving or maintaining the level of access and the quality of VA health care. The reuse plans will include highest and best use determination for the property and a cost-effectiveness analysis. VA will pursue enhanced use (EU) opportunities for vacant and underutilized space.

Overall, the CARES plan identified more than 100 major construction projects in 37 states, the District of Columbia, and Puerto Rico. When implemented, CARES will dramatically improve access to primary care, especially for veterans living in rural areas. In 2001, VA met inpatient care access guidelines in only 28 of our 77 health care market areas. When the CARES process is complete, VA will meet that standard in 73 of its health care market areas. Implementation of the CARES plan will decrease vacant space within VHA from 8.57 million square feet to 4.93 million square feet, a reduction of 42.5 percent.

In addition, VHA has created the Office of Strategic Initiatives to oversee and coordinate CARES implementation across the country. CARES' actions will also be incorporated in the VISN FY 2005 strategic plans. A CARES implementation board has been established and is composed of senior level VA officials, chaired by the Secretary, to ensure Department-level oversight of CARES implementation plans.

In June 2004, the Department produced its first 5-year capital plan, a systematic and comprehensive framework for managing VA's portfolio of more than 5,500 buildings and approximately 32,000 acres of land. This plan is a sound blueprint for managing the Department's capital investments and will lead to improved use of resources and more effective delivery of health care and benefits. This plan outlines CARES implementation by identifying priority

projects that will improve the environment of care at VA medical facilities and ensure more effective operations by redirecting resources from maintenance of vacant and underused buildings and reinvesting the resources in veterans' health care. The plan is being reviewed by Congress and serves as a budget request for 30 major construction projects that would be funded using FY 2004 available dollars and the FY 2005 requested amount. The plan reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care. Through CARES and improved asset management strategies, VA is meeting the challenge identified by GAO for Federal agencies in managing problems with excess and underutilized real property.

2C. Alternative Methods for Patient Care Support Services

VA's transformation from an inpatient to an outpatient-based health care system has significantly reduced the need for certain patient care support services such as food and laundry. In November 2000, GAO recommended that VA conduct studies at all of its food and laundry service locations to identify and implement the most cost-effective way to provide these services at each location. In August 2002, the Department issued a directive establishing policy and responsibilities for VA networks to follow in implementing a competitive sourcing analysis to compare the cost of contracting versus in-house performance to determine the appropriate entity to do the work. VA needs to follow through on its commitment to ensure that the most cost-effective, quality service options are applied throughout its health care system and to conduct system-wide feasibility assessments for consolidation and competitive sourcing.

VA's Program Response: VA has stopped developing studies that examine competitive sourcing of consolidated laundry services because VA's General Counsel has determined that VHA is not authorized to use appropriated funds to conduct competitive sourcing studies under current law. VA has been authorized to conduct such studies in the past and is now requesting this authority. The Nutrition and Food Service (NFS) in VHA Central Office continues to assess the efficiency and cost effectiveness of its VA food service operations in order to identify potential alternative service delivery options. The NFS Product Standardization User Group is in the process of developing a national cook/chill equipment model to realize cost savings on high-cost equipment items. Effective July 2004, the Veterans Canteen Service (VCS) now shares the efficiencies and cost savings of the NFS/VHA subsistence prime vendor (SPV) contract as the VCS purchases its food products from the SPV contract. The estimated food purchases by VCS are approximately $18-20 million annually. A national benchmarking program was established in partnership with a private sector organization to compare VA operations with private non-contract health care facilities.

2D. VA/DoD Sharing

In an effort to save Federal health care dollars, VA and DoD have sought ways to work together to gain efficiencies. To ensure sharing occurs to the fullest extent possible, VA needs to continue to work with DoD to address remaining barriers, as GAO recommended in its 2000 report. It is particularly critical that VA take a long-term approach to improving the VA/DoD sharing database, which VA administers. Currently, VA and DoD do not collect data on the volume of services provided, the amount of reimbursements collected, or the costs avoided through the use of sharing agreements. Without a baseline of activity or complete and accurate data, neither VA, DoD, nor the Congress can assess the progress of VA and DoD sharing.

VA's Program Response: Upon further review, VA believes that the investment of dollars and effort spent to modify the database to include utilization data would not result in improved management of VA/DoD sharing agreements. Several local factors (for example, not having excess capacity to provide services to active military personnel without impacting care for veterans) can influence the level of VA/DoD sharing. VA/DoD reimburse-

ment amounts are currently tracked but have not yet been integrated within the VA/DoD database. VA plans to continue efforts to integrate utilization and reimbursement data into the database in the future.

Over the past 3 years, VA and DoD have undertaken unprecedented efforts to remove barriers impeding interagency collaboration in order to improve access to quality health care and increase efficiency. Using the President's Management Agenda and the Final Report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, the Departments have developed a strategy to institutionalize VA/DoD partnering and focus collaboration in areas that will ensure enhanced services to veterans and military beneficiaries.

VA's commitment to this effort is demonstrated through the Joint Executive Council structure, which has brought the senior leadership of both Departments into collaborative discussions at an earlier stage, thus increasing both oversight and accountability. When the Under Secretary of Defense for Personnel and Readiness and the Deputy Secretary of Veterans Affairs signed the VA/DoD Joint Strategic Plan in April 2003, it was a significant step forward in the partnership between the two Departments. The first document of its kind, the Joint Strategic Plan articulates a vision for collaboration, establishes priorities for partnering, launches processes to develop and implement interagency policy decisions, develops joint operations guidelines, and institutes performance monitors to track progress. While some of the target dates included in the initial joint strategic plan were overly ambitious, much has been accomplished.

Through the Health Executive Council, VA and DoD have adopted a schedule to develop interoperable electronic medical records by the end of FY 2005. This agreement (the VA/DoD Joint Electronic Health Records Plan – Health*e*People strategy) is outlined in the VA/DoD Joint Strategic Plan and calls for joint development of a virtual health record that will be accessible by authorized users throughout DoD and VA.

Significant progress has also been made to improve the transition of separating servicemembers, with particular emphasis on those who have sustained injuries, illnesses, and disabilities in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Examples of this include placement of full-time VA social workers and veterans' service representatives at military medical centers receiving large numbers of OEF/OIF casualties, while part-time VA staff liaisons were assigned to other military treatment facilities. We also established specific points of contact and case managers at all VHA and VBA sites. These individuals work closely with active duty health care teams to ensure the optimal seamless transition from DoD to VA for servicemembers who will require VA care upon separation from active service.

Through the Benefits Executive Council, we have simplified the transition from active military to veteran status by developing a single physical examination that meets both the military services' separation requirements and VA's disability compensation examination criteria. A national memorandum of agreement to codify this policy is scheduled for implementation in the second quarter of FY 2005.

The VA/DoD Joint Executive Council also established a Joint Capital Asset Planning Committee. The Committee provides a formalized structure to facilitate collaboration in achieving an integrated approach to capital coordination that considers both short-term and long-term strategic capital issues mutually beneficial to both Departments. The Committee provides the final review of all joint capital asset initiatives recommended by the executive council structure or Department-specific body, including the VA CARES and DoD Base Realignment and Closure (BRAC) programs, and provides the oversight necessary to ensure that collaborative opportunities for joint capital asset planning are maximized.

Many other joint projects in the areas of procurement, provider credentialing, health care and business operations, data exchange, and information management are also underway. Although proud of these successes, VA

recognizes there is still much work to be done. Therefore, at the April 2004 meeting of the Joint Executive Council, the co-chairs of the Health and Benefit Executive Councils and Capital Asset Planning Committee were charged with updating the VA/DoD Joint Strategic Plan. That process is currently underway. The updated plan will build on the successes that have been achieved over the last year, include medium- and long-range objectives, refine the performance measures, and continue to emphasize the issues raised by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans as well as our efforts to enhance the transition from active duty to veteran status. The revised plan is expected to be completed in the first quarter of 2005.

The accomplishments of the first joint strategic plan will be outlined in the first annual report of the VA/DoD Joint Executive Council to be submitted to the Secretaries and the Congress in the first quarter of FY 2005.

2E. Third-Party Collections

VA's third-party collections increased in FY 2001 — reversing a trend of declining collections — and again in FY 2002. However, over the past several years, GAO has reported on persistent collections process weaknesses — such as lack of information on patient insurance, inadequate documentation of care, a shortage of qualified billing coders, and insufficient automation — that have diminished VA's collections. VA has taken several steps to improve its collections performance, including developing the Veterans Health Administration Revenue Cycle Improvement Plan in 2001, which aims to address VA's long-standing collections problems. More recently, in May 2002, VA created a Chief Business Office that planned additional initiatives to improve collections. However, by the end of FY 2002, VA was still working to implement proposed initiatives for resolving its long-standing collection problems. To ensure it maximizes its third-party collections, VA will need to be vigilant in implementing its plan and initiatives.

VA's Program Response: Collections through August 2004 totaled $1.5 billion, which is $175 million above last fiscal year's record collection rate as of the same date. Estimated collections for this fiscal year are approximately $1.7 billion, representing the largest amount collected in the history of the revenue program. In addition, and consistent with industry measurement approaches, VHA continues to reduce gross days revenue outstanding, accounts receivable greater than 90 days, and days to bill.

VHA has made considerable improvement in operating processes and systems, migrating from a labor-intensive manual process to automated billing and collection activities. Upon creation of the Chief Business Office, VHA initiated a comprehensive assessment of ongoing activities within the revenue program. The 2001 revenue improvement plan was integrated into the 2003 revenue action plan. This assessment focused on "industry best" practices and resulted in the identification of a series of objectives in addition to those originally included in the 2001 revenue improvement plan. The revenue action plan is a living document. As we continue to develop additional initiatives and projects intended to improve revenue business processes, we will add to the plan.

The immediate improvement strategies include development of the Medical Care Collections Fund (MCCF) performance metrics, an expanded focus on contracting for collection of accounts receivable over 60 days, and utilization of available contract support encompassing collections, insurance identification and verification, and coding. Currently, over 70 outsourcing contracts are being used throughout VHA. Many of these are structured to allow contractors to retain a percentage of collections, which minimizes operational costs. Another significant accomplishment is the development and implementation of electronic data interchange for third-party claims to meet Health Insurance Portability and Accountability Act (HIPAA) deadlines. The initial e-Claims software is operational at all VA facilities, and as of July 2004, more than 11.4 million claims have been generated.

An important improvement in the revenue action plan, targeted for completion this fall, will be the completion of the Medicare Remittance Advice project. This project is

designed to improve the quality of the many Medicare supplemental claims and accurately identify deductible and coinsurance amounts that Medicare supplemental insurers calculate to determine reimbursement to VA. This effort will also allow VA to more accurately identify accounts receivable. Numerous other improvement strategies are underway to improve data quality, expand data sharing capabilities, and allow the receipt of electronic payments from insurers. Additionally, a major tactical initiative currently underway is the phased piloting of Consolidated Patient Account Centers. Modeled after private industry as an effort to enhance revenue consolidation efforts throughout VA, the initiative is targeted for deployment in September 2005 and is designed to gain economies of scale by regionally consolidating key business functions.

A major focus of VHA's long-term strategy is the implementation of an industry-proven patient financial services system (PFSS) that will yield dramatic improvements in both the timeliness and quality of claims and collections. VA's Chief Information Officer will provide additional oversight and monitoring to ensure the project stays on schedule. The PFSS project is targeted for rollout at the first test site in VISN 10 (Cleveland) in October 2005, with subsequent rollout to the remaining four test sites in this network.

In order to alleviate weaknesses in the collection process caused by a shortage of qualified coders and to improve the documentation of care, VHA has taken several steps. Coding Blanket Purchase Agreements were signed and issued to the field for use in September 2003. These allow the field to implement coding contracts quickly without conducting an entire bid solicitation. Hybrid Title 38 status was given for medical record coding positions. While this will not solve the scarcity issue, it will shorten the hiring delay, allowing VHA to compete for the best coders in the marketplace. The Health Data and Informatics, Health Information Management program, in conjunction with the Employee Education System, will continue to offer educational coding satellite sessions in FY 2005 to assist coding staff in improving and retaining coding skills.

GAO3. Prepare for Biological and Chemical Acts of Terrorism

Following the attacks of September 11, 2001, VA determined that it needed to stockpile pharmaceuticals and improve its decontamination and security capabilities. VA also has new responsibilities to establish four medical emergency preparedness centers and carry out other activities to prepare for potential terrorist attacks.

VA's Program Response: The Department has completed its procurement of 143 pharmaceutical caches located at VA medical centers. Decontamination/hazmat training and equipment were initially provided to the 78 medical centers determined to be the highest priority. VA completed training and equipment for a second group of 53 facilities in September 2004. The week-long course is provided to trainees from about six medical centers at a time, four students per facility. Recurring training will continue at a reduced but still significant level due to staff turnover.

Although Congress directed VA to establish four medical emergency preparedness centers, previous appropriations language prohibited VA from using funds on these centers.

The full assessment of 18 and preliminary assessment of 100 of VA's critical facilities was completed in July 2004. The 18 facilities receiving full assessments represent unique facilities, facilities with national responsibilities, and facilities where CARES major construction projects are funded or planned. In July 2004, VA obtained an electronic database to capture vulnerability assessment data. The data will be linked with existing VA space and building databases as well as law enforcement databases.

The study to assess the Department's ability to reconstitute its essential business papers was completed and the Office of Information and Technology has presented VA leadership with an implementation plan.

Recommendations emerging from the study of preparedness of VA personnel are currently under review, and a major revision of the Department's Continuity of Operations plan is in final coordination.

Under a new contract with a major consulting firm, VA is also conducting an independent evaluation of VA medical centers to assess their emergency preparedness posture and capability in the event of a chemical, biological, or weapons of mass destruction event. The focus of the study is to provide a comprehensive, independent, and current assessment of the capabilities of our hospital system and to focus VA management efforts on improvement of related policies, resource allocation, and training.

GAO4. Improve Veterans' Disability Program: A High-Risk Area

VA acted to improve its timeliness and quality of claims processing, but is far from achieving its goals. Of greater concern are VA's outmoded criteria for determining disability and its capacity to handle the increasing number and complexity of claims. VA will need to seek solutions to provide meaningful and timely support to veterans with disabilities. While the Department is taking actions to address these problems in the short term, longer-term solutions may require more fundamental changes to the program including those that require legislative action. For these reasons, GAO has added VA's disability benefits program, along with other federal disability programs, to the 2003 "high-risk" list.

The Secretary made improving claims processing performance one of VA's top management priorities, setting a 100-day goal for VA to make accurate decisions on rating-related compensation and pension claims, and a reduction in the rating-related inventory to about 250,000 claims by the end of FY 2003.

4A. Challenges to Improving Timeliness

While VA has made some progress in improving production and reducing inventory, the Department is far from achieving the Secretary's goals. Improving timeliness, both in the short and long term, requires more than just increasing production and reducing inventory. VA must also continue addressing delays in obtaining evidence to support claims, ensuring that VA has experienced staff for the long term, and implementing information systems to help improve productivity.

VA's Program Response: VBA has had marked success in reducing the number of pending rating claims and improving the timeliness of rating-related actions. The organization reduced the pending rating inventory from a high of 432,000 claims in January 2002 to 253,000 in September 2003. The timeliness of our pending inventory improved from 203 days in January 2002 to 111 days in September 2003. The average length of time to provide veterans with a decision on their claims improved from a high of 233 days in March 2002 to 156 days in September 2003. However, as noted by the Office of the Inspector General, court decisions interpreting the Veterans Claims Assistance Act of 2000 (VCAA) significantly adversely affected the gains made by VBA in claims processing.

Specifically, the September 2003 decision of the U.S. Federal Circuit Court of Appeals in *PVA v. Principi* caused VBA to stay the processing of over 62,000 claims. The *PVA* decision, issued in response to a challenge to VA's regulations implementing the VCAA, held that unless VA could grant a claim for benefits, VA was required to wait 1 year before it could deny a claim in order to afford the claimant time to submit information or evidence to substantiate the claim. This, in effect, resulted in a stay of any rating action that would, in whole or in part, contain a denial of a claimed benefit.

As a result, VBA lost nearly 3 months of full production, and the volume and age of the rating inventory continually increased until Congress clarified the language of the law in a December 16, 2003, amendment, expressly allowing VA to decide claims for benefits prior to the expiration of the 1-year time period in the law during which a claimant could submit evidence on a claim. Consequently, VBA produced 64 percent fewer rating

decisions in the first 3 months of FY 2004 than in the first 3 months of FY 2003 (69,316 versus 192,669). Once VA could resume normal rating production, it was faced with the prospect of addressing the backlog of claims while keeping pace with processing incoming claims. The average processing time for claims completed in January 2004 reached 189 days as we began to process the deferred claims. Timeliness of completed actions is back down to 163 days during the month of September 2004, and we continue to make progress toward the Secretary's goal. Two years ago, 35 percent of VBA's rating inventory was comprised of cases pending over 6 months. As of September 2004, that percentage has been reduced to 21 percent.

VBA has also experienced a significant increase in disability claim receipts. During FY 2004, VBA recorded a 5 percent increase in disability claims. The majority of the increased receipts were original disability claims. Specifically, our original claim receipts are up by 17 percent over last year, most likely attributable to the impact of claims filing by servicemembers returning from Operation Enduring Freedom and Operation Iraqi Freedom. Despite these challenges, VBA continues to make progress toward the high expectations set by the Secretary.

VBA is working to ensure that it has a well-trained workforce for the long term with efforts underway to facilitate the necessary knowledge transfer due to expected retirements. The organization is implementing a workforce and succession planning strategy to ensure current and future capability to provide a comprehensive program of benefits to veterans. This strategy includes workforce development, innovative technology, recruitment, retention, and succession planning. VBA will continue these efforts and pursue innovations and adjustments to enable the organization to compete for talent and foster a high-performing workforce.

The organization remains committed to the transition from our older technology base for claims processing to the Modern Award Processing applications as part of the Veterans Services Network (VETSNET). Rating Board Automation (RBA) 2000, Modern Award Processing – Development (MAP-D), SHARE (a computer application used by regional office employees to establish pending issue claim data), and other VETSNET applications have been deployed and are in use at all VA regional offices. Currently, testing of the award processing component of VETSNET is ongoing at the Lincoln Regional Office. The development and deployment of a modern information technology infrastructure continues to be a priority for VBA.

4B. Decision Accuracy and Consistency

To help improve decision accuracy and consistency across regional offices, VA established the Training and Performance Support System (TPSS), a computer-assisted system designed to provide standardized training for staff at all regional offices. However, many of the modules were not available to help train the new claims processing staff VA hired during FY 2001 and 2002, and, in May 2001, GAO reported that VA had pushed back its completion of all TPSS modules until sometime in 2004. Until VA completes TPSS implementation, the Department will not be able to evaluate the program's impact on claims processing accuracy and consistency. More recently, GAO recommended in August 2002 that VA establish a system to regularly assess and measure the degree of consistency across all levels of VA claims adjudication and to improve the quality of decisions made by VA's Board of Veterans' Appeals.

VA's Program Response: Developing and sustaining a knowledgeable workforce is a significant challenge for VBA, and the Training and Performance Support System (TPSS) is just one initiative to address this critical issue. We recognize that we must have a properly trained workforce to analyze the complex details of veterans' medical conditions and to adjudicate claims for other benefits. This workforce has to be able to assess veterans' benefits claims in the context of a dynamic environ-

ment of ever-changing statutes, regulations, and veterans' needs.

TPSS is a dynamic training system that will constantly evolve as requirements change. Since the GAO Report on Training for Claims Processors was published in May 2001, for example, the claims processing improvement (CPI) initiative, recommended by the Secretary's Claims Processing Task Force, necessitated significant change in the design of TPSS. The CPI changed the basic foundations of how the work is performed, and therefore training must adapt accordingly. There remain numerous advanced level modules to be developed, not only for Veterans Service Representatives (VSRs) and Rating VSRs, but also for other key decision-making positions within a service center, such as Decision Review Officer.

Evaluating the direct impact of TPSS on claims processing accuracy and consistency may be difficult to achieve. TPSS is effective in providing employees the knowledge they need to accurately and consistently process claims. In applying that knowledge, a number of factors may intervene, making it difficult to isolate the effects of TPSS training from other factors that might influence those same results. This remains a critical issue and a great challenge for all organizations.

VBA believes that consistency of the adjudication process is an important goal that is best achieved by comprehensive training and communication throughout all steps of the process. Significant individual and joint training efforts are underway to improve the quality and consistency of the adjudication process. VBA continues to use the national Statistical Technical Accuracy Review (STAR) process to ensure quality and consistency. The CPI model's creation of specialized teams focusing on discrete steps in the claims adjudication process, thereby building considerable expertise in the skill set required for that step, leads to more consistent decision-making. In addition, VA is in the process of revising 38 CFR Part 4, Part B, Schedule for Rating Disabilities, to remove criteria for evaluating disabilities that are inherently subjective (for example, "slight" limitation of motion) and replacing these criteria with objective measures (for example, limitation of motion to 20 degrees), thereby ensuring consistent application of the evaluation criteria.

In response to the GAO finding that the Board of Veterans' Appeals (BVA) understated the quality of its decisions by affording nonsubstantive errors the same weight as substantive errors, BVA modified its system to capture only substantive errors. BVA also modified its decision sampling method to ensure review of a statistically valid sampling of work products. Finally, BVA amplified its training efforts, using information gathered in the quality review process to target specific problem areas. As a result of these efforts, decisional quality has improved significantly. For example, in April 2003, the error-free decision rate was 84.5 percent; for FY 2004, the rate was up to 93 percent.

The Secretary concurred in principle with GAO's recommendation that VA develop a system to regularly assess consistency through all levels of the adjudication system. However, the Secretary stated that this could best be done by "comprehensive communication and training" by all involved in the process. To this end, BVA has been deeply involved in training efforts for its own personnel as well as in continuing intra-Departmental training and improvement programs. These programs include the Compensation and Pension Examination Project (CPEP) program to improve Compensation and Pension medical examinations; joint VBA, OGC, and BVA bimonthly satellite training broadcasts to all VA regional offices; participation in VBA's quarterly Judicial Review Hotline; training sessions for BVA, VBA, and OGC personnel at the Adjudication Academy; and training provided to VHA adjudication personnel.

4C. Disability Criteria

Of greater concern is VA's use of outmoded criteria for determining disability. In 1997, GAO reported that VA's disability rating schedule is still primarily based on physicians' and lawyers' judgments made in 1945 about the effect service-connected conditions had on the average

individual's ability to perform jobs requiring manual or physical labor.

More recently, GAO reported that the criteria used by VA and other Federal programs to determine disability have not been fully updated to reflect medical and technological advances and have not incorporated labor market changes. GAO recommended that VA use its annual performance plan to delineate strategies for and progress in periodically updating its disability criteria. GAO also recommended that VA study and report to the Congress the effect that a comprehensive consideration of medical treatment and assistive technologies would have on VA disability programs' eligibility criteria and benefit package. VA did not concur with the recommendations. The Secretary of Veterans Affairs stated that the current medically-based criteria are an equitable method for determining disability and that VA is in the process of updating its criteria to account for advances in medicine. However, GAO believes that until VA aligns its disability criteria with medical and technological advances and holds itself accountable for ensuring that disability ratings are based on current information, future decisions affecting its disability program will not be adequately informed. This fundamental problem and sustained challenges in processing disability claims put the VA disability program at high risk of poor performance.

VA's Program Response: VA disagrees with the assessment of GAO that VA's rating schedule is "…still primarily based on physicians' and lawyers' judgments made in 1945 about the effect service-connected conditions had on the average individual's ability to perform jobs requiring manual or physical labor."

38 U.S.C. § 1110 provides (in part) that veterans be compensated for disability resulting from personal injury suffered or disease contracted in the line of duty. 38 U.S.C. §1114 provides the dollar amount for each level of disability.

38 CFR 4.1 states that "the percentage (disability) ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries . . ." The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (AMA 2001) are a well-known and authoritative treatise on disability. The guides provide percentages or ratings for impairment based on the severity of the medical condition (using specific and objective criteria) and the degree to which the impairment decreases an individual's ability to perform common activities of daily living, excluding work (AMA Guide, page 4). As far as VA can practicably determine, the rating schedule represents the average impairment in earning capacity as a consequence of service-connected disease and injury.

When considering the effect of a disability on the ability to earn a living, VA is cognizant of the potential interrelationship between a physical disability and the veteran's ability to earn a living. VA recognizes that its rating schedule may not accurately compensate veterans in every specific case. To accord justice, 38 CFR 3.321 provides that VA can go outside the schedule when determining compensation ratings.

VA has reviewed and revised, or reviewed and proposed revisions, for the major body systems in VA's rating schedule. The revisions in the rating schedule reflect advances in medicine. To ensure that similarly disabled veterans are similarly evaluated, VA has adopted and continues to adopt objective rating criteria.

VA withdrew a proposal for the musculoskeletal system because of the nature of the comments VA received. Adopting some of the suggestions (with which we concurred) would have produced a rule that would not have been seen as a "logical outgrowth" of the proposed rule. VA is working on a new proposal. VA believes that its rating schedule equitably determines the level of disability, across disabilities, because the evaluation criteria reflect advances in medicine and are objective.

The Americans with Disabilities Act (ADA) mandates that employers make reasonable accommodations for those

with disabilities. Labor markets have changed over the past several decades, and the labor market varies across the Nation. VA continues to believe that its rating schedule is the fairest way to compensate veterans who have suffered a disease or an injury while serving in the military.

GAO5. Develop Sound Departmentwide Management Strategies to Build a High-Performing Organization

Since 1997, VA has spent about $1 billion annually on its information technology. VA has established executive support and is making strides in developing an integrated Departmentwide enterprise architecture. To safeguard financial, health care, and benefits payment information and produce reliable performance and workload data, VA must sustain its commitment.

5A. Link Health Care Budget Formulation and Planning Processes

Establishing a close link between budgeting and planning is essential to instilling a greater focus on results. While VA's health care budget formulation and planning processes are centrally managed, they are not closely linked. VA's annual performance plan describes the Department's goals, strategies, and performance measures. However, the relationship between its performance plan and its health care budget formulation is unclear.

VA officials noted that steps are being taken to better integrate the health care budget formulation and planning processes. However, VA continues to face challenges in further integrating these processes and in defining areas for improvement.

VA's Program Response: VA continues to make a number of advancements toward integrating budget planning, operational execution, and performance monitoring. As part of the budget formulation process, VHA sometimes develops budget scenarios. Associated with each funding option are performance goals that are tied to the varying resource levels. This approach gives senior leadership the information needed to help make funding decisions based, at least in part, on the expected performance to be achieved with these resources. These scenarios are based on prior years' outcomes and budget allocations. This process is used to predict costs, number and mix of veterans served, and types of employees required to provide services to veterans. The budget scenario process is a key component in VHA's budget formulation and future services plans.

Managers throughout the VA health care system have strongly embraced linking performance with resource and operations management responsibilities. Prior to the start of each year, VA central management enters into written performance plan agreements with each network director. In turn, each network director has written performance plan agreements with their medical facility directors. These agreements contain detailed standards for VA's key measures that must be achieved and establish expected levels of performance in a wide range of administrative, financial, and clinical areas. The types of measures that are tracked include waiting time standards, financial indices, quality of care, clinical intervention standards, and work force planning.

Monthly performance reviews involving VA senior leadership have created the forum for a continual review of financial and program performance, workload, and major construction and information technology projects at and below the national program level. The purpose of these regularly scheduled reviews, chaired by the Deputy Secretary, is to monitor operations and to inform while identifying issues through a detailed review of Department operations. Because all programs are represented at this meeting, the resulting management decisions are immediately communicated and plans are put in place to implement actions needed to help ensure that the Department makes the most efficient and effective use of resources and makes progress toward achievement of performance goals.

5B. Information Technology Challenges: A High-Risk Area

GAO has designated protecting information systems supporting the Federal government and the Nation's critical infrastructures as a governmentwide high-risk area. Over the past 2 years, VA's commitment to addressing critical weaknesses in the Department's IT management has been evident. Nonetheless, challenges to improve key areas of IT performance remain. Specifically, VA's success in developing, implementing, and using a complete and enforceable enterprise architecture hinges upon continued attention to putting in place a sound program management structure. In addition, VA's computer security management program requires further actions to ensure that the Department can protect its computer systems, networks, and sensitive health and benefits data from vulnerabilities and risks.

VA is also challenged to develop an effective IT strategy for sharing information on patients who are both VA and DoD beneficiaries or who seek care from DoD under a VA/DoD sharing agreement. The lack of complete, accurate, and accessible data is particularly problematic for veterans who are prescribed drugs under both systems. While each department has established safeguards to mitigate the risk of medication errors, these safeguards are not necessarily effective in a shared environment — in part because VA's and DoD's IT systems are separate. Consequently, DoD providers and pharmacists cannot electronically access health information captured in VA's system to aid in making medication decisions for veterans, nor can they take advantage of electronic safeguards such as computerized checks for drug allergies and interactions.

VA's Program Response: In order to maximize limited resources to make the most significant improvement in the Department's overall security posture in the near term, the VA Chief Information Officer (CIO) sponsors an annual program review to prioritize Federal Information Security Management Act (FISMA) remediation activities. To establish FY 2004 remediation priorities, the VA CIO, in conjunction with program managers and VA Deputy CIOs, reviewed the summary results of the recently completed 2003 FISMA self-assessment survey as well as the results of OIG and GAO audits conducted during the past year. With advice from the program managers and Deputy CIOs, and in consultation with the OIG, the VA CIO identified 11 key weakness areas for priority remediation during FY 2004.

Two new "priority remediation areas" were identified for FY 2004: (1) establishing policies and controls related to the use of wireless devices and (2) Departmentwide deployment of authentication and authorization technologies. These priorities were identified by the OIG and included in its draft *2003 Audit of the Department of Veterans Affairs Information Security Program* report. The OIG has reported that wireless security assessments identified vulnerabilities that would allow a potential hacker to gain unauthorized access to VA systems and data, including circumventing security measures VA has established as part of its firewall protection. Additionally, the OIG has reported vulnerabilities associated with the transmission of patient data in clear text, as VA's legacy medical and benefit systems do not have a viable encryption application that can adequately protect the electronic transfer of sensitive data. The Department, following the OIG's recommendations, made these additional activities a priority for FY 2004 in order to enhance protection of its computer systems, networks, and sensitive health and benefits data from identified vulnerabilities and risks.

The 11 priority remediation goals for FY 2004 are depicted in priority order as follows: (1) certification and accreditation of key financial and human resource systems; (2) a Departmentwide critical infrastructure protection plan; (3) data center contingency planning; (4) configuration management; (5) enterprise-wide intrusion detection system capability; (6) upgrade of external connections; (7) relocation of the VACO server farm from a sub-ground location to preclude flooding; (8) application program/operating system change controls; (9) physical access controls at data centers; (10) deployment of

authorization and authentication technologies; and (11) a standardized Department-level wireless device policy.

During 2004, VA began a very effective collaboration with the DoD Joint Requirements and Integration Office, concerning the introduction and integration of DoD Defense Integrated Military Human Resource System (DIMHRS) veteran service history data. VA is developing consolidated data requirements across all business lines for submission to DoD. VA expects DoD to provide a draft data specification and dictionary by December 2004 and to provide live DIMHRS data for the Army, as a pilot, by September 2005. The Office of Enterprise Architecture Management in VA's Office of Information and Technology is working directly with VHA, VBA, and NCA to achieve DIMHRS data integration and to further numerous short-term initiatives for improved data sharing in support of returning Operation Iraqi Freedom and Operation Enduring Freedom servicemembers.

An example of the improvement in the collaboration between VA and DoD is the VA Seamless Transition Task Force formed to better serve our newest veterans from Operation Iraqi Freedom and Operation Enduring Freedom. By sharing early information about servicemembers who are injured but still in the military, VA can provide a seamless transition to civilian life. VA medical and benefits personnel can visit these veterans while they are still in the military medical facility. VA personnel interview the veteran and enter the data in a centralized database. This will not only improve service to the veteran, but he or she will also have a better entry experience into the VA system.

5C. Financial Management Material Weaknesses

In December 2002, VA's independent auditor issued an unqualified audit opinion on VA's consolidated financial statements for fiscal years 2002 and 2001. However, the unqualified opinion was achieved, for the most part, through extensive efforts of both program and financial management staff and the auditors to overcome material internal control weaknesses to produce auditable information after year-end. The auditor reported two long-standing systems and control problems that remain unresolved. In addition, VA's accounting systems — similar to those of most major agencies — did not comply substantially with Federal Financial Management Improvement Act requirements. These weaknesses continue to make VA's program and financial data vulnerable to error and fraud and limit the Department's ability to monitor programs through timely internal financial reports throughout the fiscal year.

VA has demonstrated management commitment to addressing material internal control weaknesses previously reported and has made significant improvements in financial management. For example, in February 2001, the auditor reported that VA had improved on its reporting and reconciling of fund balances with Treasury — removing this as a material weakness. VA also continued to make progress in implementing recommendations from the GAO March 1999 report, which resulted in improved control and accountability over VA's direct loan and loan sale activities and compliance with credit reform requirements.

However, during its audit of VA's FY 2002 financial statements, the auditor reported that two previously reported material weaknesses still exist in the areas of information systems security and financial management system integration.

Departmentwide weaknesses in security controls over automated data processing continue to make VA's sensitive financial and veteran medical and benefit information at risk of inadvertent or deliberate misuse or fraudulent use.

Material weaknesses continue to hamper timely completion of financial statements. Specifically, VA continues to have difficulty related to the preparation, processing, and analysis of financial information to support the efficient and effective preparation of its financial statements.

VA's Program Response: VA's Office of Information and Technology (OIT) has developed and monitors the implementation of a Departmentwide information security controls plan that details corrective actions through March 2005. Currently, OIT is in the process of refining the Departmentwide plan to include specific information recently received from the auditors. In the meantime, OIT continues to ensure the Department moves forward in eliminating the risk of inadvertent or deliberate misuse or fraudulent use of VA's sensitive financial and veteran medical and benefits information.

The Department continues to face challenges in building and maintaining financial management systems that comply with federal requirements. Until recently, the Department intended to replace the current financial system with the Core Financial and Logistics System (CoreFLS). During the testing phase of the CoreFLS project, problems occurred with data conversion, training, testing, segregation of duties, and access controls. As a result, VA is reevaluating the current plans for CoreFLS. To address the material weakness, Lack of Integrated Financial Management System, task groups will investigate the feasibility of developing tools to support the effective and efficient preparation of financial statements to eliminate significant manual workarounds, improve interfaces between legacy systems and VA's core accounting system (Financial Management System), enhance data consistency between the core accounting and subsidiary systems, and automate reconciliation processes.

GAO6. Federal Real Property: A High-Risk Area

GAO has designated "federal real property" as a governmentwide high-risk area. There is a need for a comprehensive and integrated real property transformation strategy that could identify how best to realign and rationalize federal real property and dispose of unneeded assets; address significant real property repair and restoration needs; develop reliable, useful real property data; resolve the problem of heavy reliance on costly leasing; and minimize the impact of terrorism on real property.

VA has struggled to respond to asset realignment challenges due to its mission shift to outpatient, community-based services. GAO reported in 1999 that VA had 5 million square feet of vacant space and that utilization will continue to decline. VA has recognized that it has excess capacity and has an effort underway known as the Capital Asset Realignment for Enhanced Services (CARES) that is intended to address this issue. VA's environment contains a diverse group of competing stakeholders who could oppose realignment plans that they feel are not in their best interests, even when such changes would benefit veterans.

Improvements in capital planning are needed. For example, GAO reported in 1999 that VA's capital asset decision-making process appeared to be driven more by the availability of resources within VA's different appropriations than by the overall soundness of investments. This resulted in VA's spending millions more on leasing property instead of ownership because funds were more readily available in the appropriation that funds leases than in the construction appropriation.

In recent years, VA has also developed legislative proposals to establish a capital asset fund, which would, among other things, be aimed at improving VA's capability to dispose of unneeded real property by helping to fund related costs such as demolition, environmental cleanup, and repairs.

VA's Program Response: VA concurs with GAO's recommendation. VA is committed to a comprehensive, corporate-level approach to capital asset management. This approach helps VA closely align asset decisions with its strategic goals, elevate awareness of its assets, and employ performance management techniques to monitor asset performance on a regular basis through the entire lifecycle of an asset. Each significant capital investment is tracked through its lifecycle from formulation to execution, steady-state, and disposal. At the core of VA's

capital asset business strategy is value management – striving to return value to VA's business and managing existing value for greater return.

VA began its pursuit of a comprehensive capital asset planning process and management strategies in 1997. VA developed a structure that facilitated a comprehensive system-wide integrated capital investment planning process. The fundamental goal of the new process was to ensure that all major capital investment proposals, including high-risk and/or mission-critical projects, were based upon sound business and economic principles; promoted the *One-VA* vision by linking diverse but complementary objectives; were aligned with VA's overall strategic goals and objectives; addressed the Secretary's priorities by emphasizing program objectives in support of internal goals; and supported the President's Management Agenda. Each year, VA re-evaluates its capital investment decision models to ensure alignment with the administration's management agenda and the strategic plan, goals, and objectives.

In June 2004, the Department produced its first 5-year capital plan, a systematic and comprehensive framework for managing the Department's portfolio of more than 5,500 buildings and approximately 32,000 acres of land. This plan is a sound blueprint for managing the Department's capital investments and will lead to improved use of resources and more effective delivery of health care and benefits. This plan outlines CARES implementation by identifying priority projects that will improve the environment of care at VA medical facilities and ensure more effective operations by redirecting resources from maintenance of vacant and underused buildings and reinvesting them in veterans' health care. The plan reflects a need for additional investments of approximately $1 billion per year for the next 5 years to modernize VA's medical infrastructure and enhance veterans' access to care. The plan is being reviewed by Congress and serves as a budget request for 30 major construction projects that would be funded using FY 2004 available dollars and the FY 2005 requested amount.

In February 2004, the President signed Executive Order 13327, Federal Real Property Asset Management. This order was created to promote the efficient and economical use of federal real property assets and to ensure management accountability for implementing federal real property management reforms. The order also encourages federal departments and agencies to recognize the importance of effective real property management and the establishment of clear goals and objectives, as well as improved policies and levels of accountability. One central component of the order was the establishment of the Federal Real Property Council (FRPC), whose membership consists of the Real Property Officers from each designated agency or department. This council has a broad range of responsibilities including creating government-wide principles for effective asset management. The FRPC is in the process of finalizing first-tier performance measures, which are measures that all federal agencies are expected to calculate, track, and monitor on an agency-wide basis. The primary first-tier performance measures address significant real property issues of quality, quantity, and cost. These measures include such things as facility condition index, facility sustainment rate, facility recapitalization rate, facility utilization index, and mission dependency investment. In addition, the FRPC encourages agencies to implement second-tier performance measures, which are measures that are tracked by an agency and are either not rolled up for agency-wide use or may not be directly applicable as a real property management measure. VA is transitioning to implementing both first and second-tier performance measures. Another important requirement found in the order was that all federal departments and agencies must develop an asset management plan (AMP). VA is in the process of completing its AMP. The VA AMP reflects the initiatives VA has implemented and is developing in order to meet and/or exceed its own requirements as well as those found in both the executive order and the guiding principles developed by the FRPC. The AMP serves as a companion document to the recently published VA 5-year capital plan. The long-term plan provides detailed descriptions of current and future capital investments, including the

investments needed to implement the recent decisions made by the Secretary regarding the CARES process. The AMP provides information, descriptions, and examples of the following:

- The Department's capital budget for FY 2005, which identifies and categorizes an inventory of assets owned, leased, or managed by VA.
- The VA capital asset management philosophy, which is grounded in the life-cycle approach and details the guiding principles used at each phase. This includes tracking the performance and making necessary adjustments for all capital assets in our portfolio during all stages of an investment lifecycle (formulation through disposal).
- A description of VA's capital portfolio goals and illustration of how they serve as both our short-term and long-term objectives.
- A description of the important elements found in the "building block" business case (OMB Exhibit 300), including strategic alignment, alternatives considered, risk analysis, and cost effectiveness analysis.
- Illustration of the actions being taken by VA to improve the formulation and operational management of our portfolio, including the development of our capital portfolio system known as the Capital Asset Management System (CAMS).
- A description of VA's sustainment model, which was recently created to assist in developing facility maintenance needs and measures.
- A description of the valuation mechanism used at VA, including fair market value, replacement value, book value, and land value.
- A description of the human capital strategies employed, including the policies developed to govern asset management at VA.

Over the past several years, VA has undertaken some major initiatives in order to improve and strengthen the capital asset management program. VA has integrated best practices into the fabric of the capital investment process, learning from the best planning and performance measurement found in government and private industry. Initiatives include: 1) creation of the VA Office of Asset Enterprise Management (OAEM); 2) reorganization of the Office of Management; 3) establishing Capital Asset Managers at the local level; 4) initiation of the CARES process; 5) creation and deployment of CAMS; and 6) introduction of pertinent legislation. Details of each initiative are as follows.

1) Creation of OAEM: The Secretary has taken steps to significantly improve the Department's management of capital assets, including the establishment of OAEM in 2001. OAEM promotes capital programming strategies including the development of integrated approaches to transform underutilized or unneeded capital assets from liabilities to potential capital resources through the use of existing authorities (enhanced-use leasing and enhanced sharing) and legislative and policy changes when necessary.

2) Office of Management Reorganization: In November 2002, the Secretary approved the Office of Management's plan to implement a major reorganization of finance, acquisition, and capital asset functions throughout VA into regional centers with delegations of authority and increased responsibility and accountability. By combining multiple functions into a single office of business oversight and streamlining field operations to a manageable size via regional business offices, VA can realize both efficiencies and improvements in its business activities.

3) Establishing Capital Asset Managers at the local level: In November 2002, the Secretary approved implementation of a major reorganization of finance, acquisition, and capital asset functions throughout VA into regional centers with clearer delegations of authority and increased responsibility and accountability. The VISN Capital Asset Manager (CAM) will provide corporate (VISN) leadership, directing activities relating to the planning, acquisition, management, and disposal of capital assets. This includes management of all capital programs including major and minor construction, non-recurring maintenance, enhanced-use leasing, sharing agreements, leasing, real property, major medical and non-medical equipment, and energy conservation/savings initiatives and associated resources. It also involves developing and monitoring VISN capital program goals and performance as well as

any corrective action plans to bring capital assets into compliance and adherence with VISN and national benchmarks and portfolio performance standards. As of October 2004, all the capital asset managers have been selected and are in place at their respective VISN.

4) CARES Process: VA's CARES process was launched to align capital assets to meet veterans' future needs for accessible, quality health care. VA's enhanced-use lease authority will play a major role in the realignment of VHA's capital assets by transforming underutilized space from a liability to an important component of VA's overall capital portfolio.

5) CAMS: VA is in the final stages of developing and deploying CAMS, which is a portfolio management tool for all significant VA capital assets. Investment protocols and capital asset management policies were developed to provide guidelines for each major phase or milestone in the life cycle of a capital asset decision. These assets are monitored and evaluated against a set of performance measures (including capital assets that are underutilized and/or vacant) and capital goals to maximize highest return on the dollar to support veteran needs. VA established the following Department-level portfolio goals:

- Decrease operational costs.
- Reduce energy utilization.
- Decrease underutilized capacity.
- Increase intra/inter-agency and community-based sharing.
- Increase revenue opportunities.
- Maximize highest and best use.
- Safeguard assets.

As mentioned previously, VA is transitioning to the above goals to be consistent with the FRPC "Tier 1" measures where appropriate.

CAMS represents the first successful attempt to link asset managers in the field with corporate and oversight branches of VA so that current data are electronically shared and vetted according to a set schedule. In FY 2004, CAMS was deployed with portfolios for leased assets, owned buildings and land, major equipment, and asset-related agreements. In FY 2005, CAMS will add an inter-portfolio capacity, which will allow for better integration of data. The information harnessed via CAMS will lead to improved asset performance measurement, which ultimately will provide VA decisionmakers with the information needed to either repair and restore assets or to divest assets that are no longer needed.

6) Legislation: For FY 2004, VA again introduced legislation that would allow the Department to dispose of, sell, transfer and/or exchange excess properties and retain the proceeds by establishing a capital asset fund. This incentive would allow VA to better manage its underutilized or excess real property by improving its capability to dispose of unneeded property. Funds may also be used to pay for related significant costs such as environmental clean-up and demolition. A majority of the proceeds received would be used to fund CARES capital needs. The improvements to VA's infrastructure would also allow dollars currently being spent on maintenance and operations to be diverted to enhance veterans' health care delivery.

VA has also performed security studies that assess the vulnerabilities (including terrorist attacks) of its infrastructure. As of July 2004, the Department completed full assessments of 18 facilities and preliminary assessments of 100 of VA's critical facilities. VA is working to appropriately address any issues or deficiencies identified by these assessments.

GAO7. Strategic Human Capital Management: A High-Risk Area

GAO has designated "strategic human capital management" as a governmentwide high-risk area. It was also placed at the top of the President's Management Agenda (PMA). Please see the discussion on pages 50-51 in the PMA section regarding VA's progress on strategic human capital management.