Department of Veterans Affairs
Office of Inspector General

MAJOR MANAGEMENT CHALLENGES
FISCAL YEAR 2005

Report No. 06-00480-26 **November 15, 2005**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

Foreword

The Office of Inspector General (OIG), through a program of audits, inspections, investigations, and Combined Assessment Program reviews, seeks to identify and eliminate waste, fraud, and abuse in the Department of Veterans Affairs (VA) programs and operations. OIG provides independent oversight that addresses VA's mission-critical activities and programs. Each year, as required by the *Reports Consolidation Act of 2000*, Public Law 106-531, OIG provides VA with an update summarizing the most serious management problems identified by OIG work and an assessment of VA's progress in addressing them. In turn, VA program officials provide a current status on progress in these areas.

The following OIG report contains the updated major management challenges organized by the five OIG strategic goals—health care delivery, benefits processing, financial management, procurement practices, and information management—and includes VA's progress report on implementing OIG recommendations. VA will also publish these challenges and responses as part of its annual Performance and Accountability Report (PAR).

OIG will continue to work with VA until each of these issues is resolved. Together we can ensure that VA will provide the best possible service to veterans and their dependents in an efficient and effective manner, and that OIG recommendations will assist VA in becoming the best-managed service delivery organization in Government.

Jon A. Wooditch
Acting Inspector General

FY 2005 Major Management Challenges

Identified by VA Office of Inspector General

Major Management Challenges

The Office of Inspector General (OIG) identified the major management challenges facing the Department of Veterans Affairs (VA) and provided the following descriptions of the challenges. Left uncorrected, these challenges have the potential to impede VA's ability to fulfill its program responsibilities and ensure the integrity of operations. For the most part, the challenges are not amenable to simple, near-term resolution and can only be addressed by a concerted, persistent effort, resulting in progress over a long period of time. *(In this report, years are fiscal years unless stated otherwise.)*

Challenges Identified by VA Office of Inspector General

The VA OIG's strategic planning process is designed to identify and address the key issues facing VA. The OIG focused on the key issues of health care delivery, benefits processing, procurement, financial management, and information management in the 2005–2010 OIG Strategic Plan. The following summaries present the most serious management problems facing VA in each area and assess the Department's progress in overcoming 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

Quality of care is the primary health care focus of both the Veterans Health Administration (VHA) and OIG. Veterans should receive medical care that meets the highest standards. OIG believes that improvements in the measurement and effective use of medical outcome data will provide opportunities for VHA to improve the health care provided to veterans. We will work with VHA to develop appropriate medical outcome measures consistent with industry and Government standards that demonstrate the quality of health care VA provides.

VA provides health care through fee-basis services, scarce medical sharing agreements, contract care, and other arrangements in addition to full-time and part-time VA physician employees. OIG will continue to monitor the development of VA's staffing models for hiring or purchasing physician services to ensure VA physicians provide the full tour of duty and range of services funded by taxpayer dollars.

Providing safe, accessible, high-quality, and timely medical care is just one of the fundamental service delivery issues presenting challenges to VA on a continuing basis. Meeting these challenges requires vigilant management and evaluative oversight. VHA must maintain a fully functional quality management program that ensures high-quality patient care and safety, and safeguards against the occurrence of adverse events.

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

This area continues to be a management challenge. 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. We concluded that VA medical center (VAMC) managers did not ensure that part-time physicians met employment obligations required by their VA appointments. Over 2 years later, 5 of 12 recommendations from our 2003 report to improve physician timekeeping remain unimplemented.

Additionally, our Combined Assessment Program (CAP)[1] reviews have assessed physician time and attendance issues at about 70 facilities nationwide and identified deficiencies at over 30. Our CAP reviews conducted at VHA facilities in 2004, and so far in 2005, continue to identify systemic weaknesses associated with controls over physicians' time and attendance, and the reviews show that some part-time physicians are not fully meeting their VA employment obligations.

VA's Program Response to OIG1A:

VA continues exploring and developing ways to best expand flexibility in physician scheduling to more realistically accommodate demands of patient care, education, and research. VHA Directive 2003-1, *Time and Attendance for Part-time Physicians*, reiterated existing human resources policy and suggested methods of documenting time and attendance and the proper roles for part-time physicians. Since the directive was issued, VHA has explored ways to create a time and attendance system that meets the needs of VA in providing patient care while at the same time allowing flexibility in scheduling for those part-time physicians who need such accommodations. The concept of eliminating core hours for those part-time physicians on alternative work schedules was agreed upon by all relevant organizational elements. The new policy is documented in revisions to VA Handbooks 5005 (Staffing), 5007 (Pay Administration), and 5011 (Hours of Duty and Leave). These revised policies have been submitted to the Office of Human Resources Management for national release, which is expected to occur in October 2005.

Five VA medical centers have been testing the new policies together with supporting software changes to the Enhanced Time & Attendance System. Concurrently, the Employee Education System has developed a training module to assist the field when national implementation of the new policies becomes mandated. A period of 60 to 90 days will be needed after the issuance of the policies to allow installation and debugging of the software at all facilities and completion of necessary training. Once that has been completed, the policies will be mandatory for all VHA facilities.

[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.

1B. OIG Issue–Staffing Guidelines

The absence of staffing standards for physicians and nurses continues to impair VHA's ability to adequately manage medical resources. Public Law 107-135, Department of Veterans Affairs Health Care Program Enhancement Act of 2001, enacted on January 23, 2002, requires VA 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. In July 2004, VHA issued a policy (tied to the number of veterans receiving care) that provides standards for physicians and support staff in primary care. VHA is further behind in its process of establishing staffing models for subspecialty medical physicians. After over 2 years, four of five recommendations relating to physician staffing remain unimplemented from our April 2003 part-time physician time and attendance report.

Our August 2004 report, *Healthcare Inspection, Evaluation of Nurse Staffing in VHA Facilities* (Report No. 03-00079-183), found that managers could have managed their resources better in providing patient care if VHA had developed and implemented consistent staffing methodologies, standards, and data systems. Currently, 11 of 14 recommendations for improvement remain unimplemented. The absence of nurse staffing guidelines impedes management's ability to ensure that the nursing mix on a ward is adequate to meet patient needs. Title I of Public Law 107-135, Department of Veterans Affairs Health Care Programs Enhancement Act of 2001, provides help in the recruitment and retention of nursing staff through a variety of pay and benefit enhancements, and calls for national staffing guidelines to ensure quality of care.

The OIG continues to work with VHA to review their proposed policy due to concerns over compliance with the intent of Public Law 107-135, particularly with respect to national standards for nurse staffing; the length of time VHA projects to establish a complete set of staffing standards; and questions over the need to develop new data systems versus using existing data resources such as Decision Support System in a consistent manner.

VA's Program Response to OIG1B:

Public Law 107-135 provided that the Secretary of Veterans Affairs shall, in consultation with the Under Secretary for Health, establish a nationwide policy on the staffing of Department medical facilities in order to ensure that such facilities have adequate staff to provide veterans with appropriate high-quality health care and services. The policy must take into account the staffing levels and mixture of staff skills required for the range of care and services provided veterans in Department facilities.

VA has developed a proposed policy to meet this requirement. It relates staffing levels and staff mix to patient outcomes and other performance measures. Under this proposed policy, all VHA facilities would be required to develop a written staffing plan for each distinct unit of patient care or health services. The directive's requirements are to be used in conjunction with the requirements of appropriate accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Currently, there are no information management systems available that would support nationwide standardized staffing plans for health care providers in varied care settings. However, the workload and patient outcome indicators in the staffing plans required under this directive and other related systems will be used to provide the basis for aggregate reviews at the local, network, and national levels. VA's goal is to develop information management strategies that permit analysis of the relationships between staffing numbers, mix, care delivery models, and patient outcomes for multiple points of care. Projects currently underway will be used to develop a standardized evidence-based approach to staffing plans and use such information to provide high-quality patient care in the most efficient manner possible. It is anticipated that systems for the collection and analysis of this information will be developed in phases over a 4-year period and that they will be in place by September 30, 2009.

1C. OIG Issue–Quality Management

Although VHA managers are vigorously addressing VA's Quality Management (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 2003, we conducted QM reviews at 31 VA health care facilities during CAP visits. All the facilities we reviewed had established comprehensive QM programs and performed ongoing reviews and analyses of mandatory areas. 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. Currently, of the report's six recommendations, the one to establish a national policy for disclosing adverse events to patients remains unimplemented.

In 2005, we reported QM deficiencies at six VAMCs. We continued to identify problems with disclosure of adverse events, data collection, trending and analyses, and the patient complaints program.

VA's Program Response to OIG1C:

A new national policy on communication of adverse events will be issued in the first quarter of 2006. Within 6 months of its issuance, each facility will issue its own policy based on the national directive.

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, we completed reviews in December 2002, involving VHA's Community Nursing Home (CNH) Program; in December 2003, involving Homemaker/Home Health Aide (H/HHA) Program; and in May 2004, involving

VHA's Community Residential Care (CRC) Program. We identified issues warranting VHA's attention in all three reviews.

While VHA has contracted with CNHs to provide care for aging veterans, it has taken since 1995 to implement standardized 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 delay has led to inconsistent oversight by VHA and varying quality of care for veterans residing in CNHs. We made recommendations to clarify and strengthen the VHA CNH oversight process and to reduce the risk of adverse incidents for veterans in CNHs. After almost 3 years, 3 of 11 recommendations for improvement still remain unimplemented. These include recommendations that VHA medical facility managers devote the necessary resources to adequately administer the CNH program; VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials; and VHA program officials determine how VHA CNH managers and Veterans Benefits Administration (VBA) Fiduciary and Field Examination (F&FE) employees can most effectively complement each other and share information such as medical record competency notes, online survey certification and reporting data, and F&FE reports of adverse conditions to protect the financial interests of veterans receiving health care and VA-derived benefits.

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). We inspected the program at 17 VA medical facilities and found that 14 percent of the patients receiving program services in our sample did not meet clinical eligibility requirements. After almost 2 years, two of four recommendations for improvement remain unimplemented, which include conducting thorough initial interdisciplinary patient assessments prior to placement in the program, and ensuring patients receiving H/HHA services meet clinical eligibility requirements.

In our May 2004 report, *Healthcare Inspection - VHA's Community Residential Care Program* (Report No. 03-00391-138), we found VAMC inspection teams did not consistently inspect their CRC homes. Our report found that VAMC clinicians did not always conduct interdisciplinary assessments, advise CRC caregivers about patients' conditions or special needs, conduct monthly visits as required, or ensure caregivers received appropriate training. Also, VAMC clinicians and VA regional office (VARO) fiduciary activity supervisors had not met at least once a year to discuss services to incompetent veterans. Currently, 4 of 11 recommendations for improvement remain unimplemented.

VA's Program Response to OIG1D:

In the past year, VHA implemented a Geriatrics and Extended Care referral instrument and reporting system to monitor appropriate placements in its Homemaker/Home Health Aide Services *(*H/HHA) and other long-term care programs. This monitoring of the appropriateness of placements helps provide assurance that resources for those most in need of H/HHA services are used efficiently.

During this past year, VHA has continued its implementation of actions outlined in the revised VHA Handbook 1143.2, *"Community Nursing Home (CNH) Oversight,"* published on June 4, 2004, which addresses the majority of OIG's recommendations concerning the community nursing home program. The release of the CNH Education and CNH Certification Report Web sites in August and September 2005 resolved most of the unimplemented recommendations. The Education Web site provides needed instruction on the process of annual review and monthly visits, while the Certification Web site allows VA to measure the quality of nursing homes under contract. VHA continues its collaborative work with VBA to share medical care information and information concerning reports of adverse conditions to protect the financial interests of veterans receiving health care and VA-derived benefits.

In regard to the remaining recommendations for improvement involving the Community Residential Care (CRC) program, VA implemented 7 of the 11 recommendations with the publication of the CRC Handbook on March 7, 2005. The remaining initiatives require regulatory changes, which are presently being drafted.

The VBA Fiduciary Program continues to require an annual visit with each VHA medical center in the Fiduciary Activity's jurisdiction. The purpose of these meetings is to discuss cross-cutting program issues, gain a better understanding of each other's program functions, and discuss issues of mutual concern.

Since October 2002, at each site visit performed by the Compensation and Pension (C&P) Service, the Fiduciary Program reviewer has confirmed that the station has conducted the required visits and has reported the findings in the site visit report. C&P Service conducts 19 site reviews yearly and will have visited all 57 VA regional offices by the end of September 2005. Site visit findings have confirmed that VHA-Fiduciary Activity visits are occurring and that field examiners are routinely contacting social workers at the VA medical centers on cases of mutual concern. The lines of communication are open between VHA and VBA.

1E. OIG Issue–Security and Safety

In March 2002, the OIG issued a series of 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 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 materials such as biological agents, chemicals, gases, and certain radioactive materials were actually in use.

VHA and the Office of Security and Law Enforcement have completed numerous actions, such as issuing research, clinical, and security publications, and constructing a biosecurity training Web site. In addition, VHA provided a certification that all VA medical facilities are in

compliance with the policies. We will close this report after VHA develops procedures to forward requests for research articles to facility Freedom of Information Act Officers.

In the March 2004 report, *Healthcare Inspection, Survey of Efforts to Safeguard VA Potable and Waste Water Systems* (Report No. 03-01743-114), we found varying degrees of effort in conducting water system assessments and security reviews. This survey was accomplished at the request of the Environmental Protection Agency (EPA) to review security over VA potable and waste water systems, and the degree of VA coordination with EPA concerning those systems. No VHA facility reported that it coordinated efforts with EPA. The Under Secretary for Health needs to standardize security requirements for protecting water infrastructures and coordinate efforts with EPA. Currently one of three recommendations to improve security of water systems on VHA properties remains unimplemented.

VA's Program Response to OIG1E:

The Office of Security and Law Enforcement in the Office of Policy, Planning, and Preparedness updated physical security standards that were published in VA Handbook 0730/1, Security and Law Enforcement, Appendix B, on August 20, 2004, that address the issues raised in the OIG recommendation. The handbook provides updated physical security standards for laboratories and handling/storage of hazardous chemicals and materials. These revised standards are being implemented throughout all VHA facilities. The Office of Security and Law Enforcement conducts periodic facility program inspections during which compliance with the updated standards is verified.

In regard to 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), VA expects to publish the revised VHA Handbook 1200.6 in the first quarter of 2006. It details procedures to forward requests for research articles to facility Freedom of Information Act (FOIA) Officers.

VHA anticipates issuing a directive that addresses the remaining recommendation concerning improving the security of water systems on VHA properties by the end of the first quarter of 2006. The directive is based upon the latest guidance from EPA and the Department of Homeland Security.

OIG2. BENEFITS PROCESSING

VBA has made progress improving benefits processing in recent years, but significant challenges remain in terms of ensuring the accuracy and timeliness of payments to veterans, reducing backlogs in claims processing, and addressing the quality and consistency of disability rating decisions and practices. VBA faces challenges to effectively address fundamental benefits processing problems, including variances in average annual compensation payments caused by factors such as participation and rating inconsistencies. A major restructuring of the rating schedule is long overdue.

Veteran participation in VA's compensation benefits needs further assessment to identify and effectively position outreach services to ensure certain veteran populations such as World War II and Korean Conflict veterans, or veterans living in specific locales, receive appropriate service. Because of the high dollar value of claims, large volume of transactions, complexity of the criteria used to compute benefits payments, and significance of the erroneous and improper payments, we consider these high-risk areas. These issues pose a major management challenge impacting benefits processing and continue to impair VA's efforts to meet its strategic goals of providing timely and responsive support to veterans.

2A. OIG Issue–State Variances in VA Disability Compensation Payments

In 2004, approximately 2.5 million veterans in the 50 states received disability compensation benefits totaling $20.9 billion. In May 2005, we issued the report, *State Variances in VA Disability Compensation Payments* (Report No. 05-00765-137). The review evaluated factors contributing to variances in average annual compensation payments by state, ranging from $6,961 for Illinois veterans to $12,004 for New Mexico veterans. Because of many factors, both within and outside VA influence, we expected some variance in compensation payments. However, our analysis of rating decisions showed that some disabilities are inherently more susceptible to variations in rating determinations. This is attributed to a combination of factors, including a disability rating schedule based on a 60-year-old model and some diagnostic conditions that lend themselves to more subjective decision-making. In fact, VA's rating schedule does not reflect modern concepts of disability.

Data showed that the variance in 100 percent post-traumatic stress disorder (PTSD) cases is a primary factor contributing to the variances in average annual compensation payments by state. We concluded that VAROs approached stressor verification requirements differently from state to state, and that 25 percent of the 2,100 PTSD claims reviewed had insufficient verification of claimed service-related stressors. VBA's quality review program did not detect the problems we found in PTSD cases. The number and percentage of PTSD cases increased significantly between 1999 and 2004. The potential associated monetary risk for questionable payments VA-wide is about $19.8 billion over the lifetime of the veterans. As a result, the consistency of rating decisions is considered a major management challenge.

We made eight recommendations to VBA including that it conduct a scientifically sound study of influences on compensation payments and develop methods and data to monitor and address variances. We also recommended VBA undertake a more detailed analysis to identify differences in claims submission patterns to determine if certain veterans have been underserved, along with outreach efforts to ensure all veterans have equal access to VA benefits. VBA is in the process of addressing the eight unimplemented recommendations identified in our report. VBA is reviewing the same 2,100 PTSD claims used in our May 2005 report. VBA has referred cases from the first stage of their review to regional offices for additional development and corrective actions.

VA's Program Response to OIG2A:

VA is committed to improving the quality and consistency of benefits decisions and is aggressively acting on the OIG's recommendations to correct noted deficiencies. The review was precipitated by the OIG's findings that VA had failed, in some cases, to obtain all required evidence to fully document decisions to award or increase disability compensation for PTSD.

VBA is reviewing the same 2,100 PTSD cases that the OIG reviewed and used to support its findings. This review was undertaken to give VBA a better understanding of the deficiencies found by the OIG so that additional training and guidance can be provided. VBA is identifying those cases lacking sufficient evidentiary development and determining what additional development is needed. VBA has completed the first stage of the review of the 2,100 cases, and cases needing additional development have been referred to the regional offices for corrective actions.

VBA will analyze the results of the additional development undertaken to correct the deficiencies found.

In 2006, VBA will begin reviewing specific cases during site visits. VBA will examine cases after extensive data analysis to identify the disability evaluations most prone to inconsistency. In addition, VBA will analyze rating and claims data on an ongoing basis to identify any unusual patterns or variance by regional office or diagnostic code for further review.

VBA will continue to work closely with the OIG to provide regular status updates containing detailed implementation plans and actions taken to address the eight recommendations.

2B. OIG Issue–Compensation and Pension Timeliness

Although VA had made some progress in addressing its claims processing backlog that once peaked at over 600,000 total outstanding claims, its efforts have been impeded by a variety of issues to include the complexity of claims, a court decision, and the war on terrorism. That court decision held that unless VA could grant a benefits claim, VA was required to wait 1 year before it could deny the claim in order to afford the claimant time to submit information to substantiate the claim. Legislation in December 2003 allowed VA to make claims decisions before the expiration of the 1-year period.

VBA reported 418,000 total claims pending in June 2003, then the backlog increased to 469,000 as of June 2004, and then to over 504,000 by the end of September 2005. When examining just the rating related claims pending, VBA reported 253,000 for September 2003, an increase to 321,000 as of September 2004, and a total of over 346,000 by the end of September 2005. VBA attributed these recent increases to the impact of claims filed by servicemembers returning from Operations Enduring Freedom and Iraqi Freedom.

VA credits improvements in reducing backlogs from the original peak to the reforms recommended by the Secretary's Claims Processing Task Force report of October 2001. The report recommended measures to increase the efficiency and productivity of VBA operations,

shrink claims backlogs, reduce claims processing time, and improve the accuracy of decisions. The VA Task Force made 34 recommendations, and VBA defined 70 actions to accomplish those recommendations. As of August 2005, VBA reported all approved task force recommendations have been implemented. VBA remains challenged to reduce the outstanding backlog and to process benefits claims in a timely, accurate, and consistent manner. In light of VBA's assertion that all VA Task Force recommendations were implemented, we will initiate a review to determine why pending claims have increased in the past 2 years and to measure the relevancy of VA Task Force recommendations to the increase in pending claims, or if new barriers to timely claims processing exist.

While the number of claims pending rating decisions has increased, Compensation and Pension (C&P) rating actions that averaged 189 days for completion in January 2004 are averaging 167 days as of September 2005, demonstrating improvement in the timeliness of claims processing. Although VA established that processing claims in a timely and accurate manner is a top priority, the performance goal of 145 days for completing rating-related actions on C&P claims has not been met.

VA's Program Response to OIG2B:

Progress in achieving rating-related decision timeliness is significantly affected by the increasing numbers of claims being received and the increased complexity of those claims. While VBA had reduced its rating-related pending claims to approximately 253,000 in September 2003, the backlog increased to over 321,000 as of September 2004, and to over 346,000 by the end of September 2005. Disability claims from returning war veterans as well as from veterans of earlier periods increased from 578,773 in 2000 to 771,115 in 2004. In 2004 this represents an increase of more than 192,000 claims or 33 percent over the 2000 base year. Receipts in 2005 continue to increase.

Claims have also become increasingly more complex, particularly because of evolving legal interpretations of requirements issued by the Court of Appeals for Veterans Claims such as a ruling that required decisions on issues not claimed by the veteran but which are "reasonably raised by the medical evidence of record" ("inferred issues"). The Veterans Claims Assistance Act (VCAA), passed in November 2000, increased VA's notification and development duties considerably, adding more steps to the claims process and lengthening the time it takes to develop and decide a claim and also requiring that VA review the claims at more points in the decision process. When processing "inferred issues" claims, VCAA requires additional notice and development requirements.

In addition to the increased volume and complexity of claims, the number of conditions for which veterans claim entitlement to disability compensation continues to increase. In 2004, VBA received 194,706 original compensation claims. Of that number, 36,401, or 18.7 percent, were claims in which the veteran claimed eight or more disabling conditions. Under the VCAA, each condition must be addressed within a VA medical examination and often multiple specialty examinations. In addition, medical opinions are generally required. These evidence requirements complicate the claims process considerably.

As a result of the factors cited above, VA changed its strategic target for processing disability compensation and pension rating-related actions from 90 days to 125 days and changed the performance goal for 2005 to 145 days. VBA continues to focus its efforts on improving both the timeliness and quality of claims processing. Timeliness of processing for 2005 through September averaged 167 days. At the end of September, there were approximately 346,000 pending rating claims.

As of August 2005 VBA considers action on the Task Force recommendations completed. Action has been taken to implement 68 of the 70 action items. The remaining two action items were not approved by the Secretary.

2C. OIG Issue–C&P Program's Internal Controls

In 1999, the Under Secretary for Benefits asked the OIG for assistance to help identify internal control weaknesses that might facilitate, or result in, fraud in VBA's C&P program. In response, we conducted a vulnerability assessment of the management implications of employee thefts from the C&P system and identified 18 internal control vulnerabilities. In our July 2000 follow-up report, *Audit of the C&P Program's Internal Controls at VARO St. Petersburg, FL* (Report No. 99-00169-97), we identified that 16 of the 18 previously reported categories of vulnerability remained present at VA's largest VARO. We made 26 recommendations for improvement. After over 5 years, 2 of 26 recommendations remain unimplemented, including controlling adjudication of employee claims and use of a third-person authorization control to monitor large payments.

In 2005, C&P internal controls continue to be identified as a weakness during CAP reviews at VAROs. Specifically, physical security controls over sensitive records needed improvement at 10 of 16 facilities. Semiannual reviews of hardcopy and electronic file security were not performed as required, access to file cabinets containing employee-veteran claims folders and other sensitive records were not properly controlled, sensitive files were not secured in locked files, claims folders were not maintained at the designated regional offices of jurisdiction, and sensitive electronic records were not secured through the common security user manager application. Since VBA points to VETSNET as an important step in strengthening internal controls, the OIG Office of Audit will be evaluating VETSNET design, development, and project management to determine if the application met design specifications, achieved project milestones, and improved accuracy of benefit payments.

VA's Program Response to OIG2C:

VBA has made major strides in eliminating internal control weaknesses and remains committed to final resolution of the recommendations for improvement. The two recommendations not fully implemented are tied to implementation of the VETSNET Award application. VETSNET is a combination of applications being deployed to replace the current Benefits Delivery Network.

The first recommendation is related to systemic controls over adjudication of employee claims at the employing VA regional office (VARO). VETSNET Award has security features to prevent

processing of both employee-veteran and Veteran Service Officer claims at the station where the individual is employed. While this will provide the needed internal control, further system testing is required. At the present time, VETSNET Award is being tested in two facilities that do not share employee-veteran jurisdiction. The projected completion date for testing is December 2005.

The second recommendation requires the use of an automated third-person authorization control to monitor payments greater than $25,000. In June 2005 VBA demonstrated the completed systemic controls in VETSNET Award for third-person authorization of large payments. VBA provided further support for closing the recommendation based on the interim C&P large-payment review process instituted in 2001. This process continues to be reviewed during C&P Service site visits and is also validated through the OIG CAP review process. In July 2005 the OIG reported that it will close the recommendation after the system is implemented and used by all VAROs. The OIG will verify that it is operating accurately. VETSNET Award implementation is slated for December 2006.

Regarding weaknesses identified by OIG CAP reviews, the C&P Service reviews OIG findings prior to all site visits and follows up to determine if the CAP review findings have been corrected. C&P Service findings from site visits are forwarded to the VAROs via site visit reports. VAROs are required to provide C&P Service with an implementation plan for the noted action items within 60 days from the date of the report. VARO implementation plans include steps taken to address the action items or a description of how and when they will be implemented.

In February 2004 VA created the Office of Business Oversight (OBO) in the Office of Management to conduct oversight and monitoring of financial, capital asset management, acquisition, and logistics activities across the Department. During 2005 OBO initiated research on physical security controls over hardcopy and electronic files related to the C&P program. This research included:

- Reviewing VA and VBA security guidelines and VARO documentation such as Privacy Act compliance procedures, security badge procedures, and work-at-home agreements.
- Observing VARO facility access vulnerabilities as well as control and accountability over claims folders.
- Interviewing VARO management, employees, and security personnel such as Information Security Officers.
- Learning about the Control of Veterans Records System and associated bar coding of claims folders.
- Expanding understanding of Benefits Delivery Network controls and security exception reporting.

Further, OBO has explored other C&P physical security control issues such as record control at veterans service organizations; VARO assessment of veteran, employee, and other threats; and the removal of electronic information from VAROs with portable flash drives.

OBO is planning to include physical security controls as a formal objective of C&P reviews during 2006. OBO will formally report any findings to VARO directors with recommendations for corrective action and will also issue an annual report with recommendations.

2D. OIG Issue–Fugitive Felon Program

Public Law 107-103, The Veterans Education and Benefits Expansion Act of 2001, enacted December 27, 2001, prohibits veterans who are fugitive felons, or their dependents, from receiving specified veterans benefits. At the direction of the Secretary, the OIG 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. We provide location information to the law enforcement organization responsible for serving the warrant for those veterans identified as fugitive felons. Subsequently, we provide fugitive information to VA to suspend benefits and to recover erroneous payments.

OIG completed agreements to match records with the U.S. Marshals Service; Federal Bureau of Investigation National Crime Information Center (NCIC); and the States of Alabama, Arizona, California, Massachusetts, New York, Ohio, Pennsylvania, Tennessee, Delaware, and Washington. OIG is seeking additional agreements with 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 May 2005, more than 6.9 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 45,136 matched records. The records match resulted in 17,469 referrals to various law enforcement agencies throughout the country and led to the apprehension of 872 fugitive felons, including the arrest of 58 VA employees. In addition, 13,509 fugitive felons identified in these matches have been referred to VA for benefit suspension resulting in the creation of $79 million identified for recovery and an estimated cost avoidance of $174.5 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, we project full implementation cost avoidance reaching $209.6 million per year.

Since the beginning of the program, VBA has received over 5,700 referrals from the VA OIG and has used new policies and procedures to implement the benefit suspension requirements of the law. While VA OIG has identified an overpayment recovery of $79 million from the referrals, VA's program response indicating VBA has established about $48 million in overpayments seems to indicate a time lag in processing actions as a result of the referrals. As of June 2005, VHA received over 7,800 referrals from the VA OIG. VHA's handbook outlining procedures for the Fugitive Felon Program was approved in December 2004, and we now expect full implementation by VHA. We view the Fugitive Felon Program as fully implemented in VBA and agree it is no longer a major management challenge there, but our assessment of implementation in VHA continues.

VA's Program Response to OIG2D:

VHA provided copies of the VHA Fugitive Felon Program Handbook published in January 2005 to network directors and also provided copies of fugitive felon listings at the end of June 2005. Networks are now validating warrants. Sixty-day due process notification letters will be mailed to the veterans identified with active warrants. Both the validation process and the mailing of notification letters are expected to begin in the first quarter of 2006 and will be ongoing. After the 60-day due process period, benefits will be terminated, and collection letters will be forwarded to veterans who received VHA services while in a fugitive felon status.

VBA continues to work closely with the OIG in implementing the Fugitive Felon Program. The Vocational Rehabilitation and Employment Service (VR&E) received 13 veteran fugitive felon referrals from the OIG and notified the appropriate regional offices with jurisdiction. VR&E published guidance in October 2004 on handling veteran fugitive felons participating in the VR&E program. As of July 2005 C&P Service received 5,403 referrals from the OIG and forwarded them to field stations. C&P Service monitors regional office action on these referrals and has reported $47,482,358 in overpayments since the beginning of the program. To date, Education regional processing offices have processed a total of 97 fugitive felon referrals, creating slightly over $420,000 in debts. Loan Guaranty Service (LGY) staff worked with the OIG to determine how LGY can meet the requirements of the Fugitive Felon Act. Under the current arrangement, the OIG has agreed to provide LGY with the OIG list of fugitive felons. LGY 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 OIG referred 262 fugitive felon names to the Insurance Service, of which 207 cases remain in a "no release of funds" status. The Insurance Service will continue to monitor fugitive felon lists for signs of activity, and will continue cooperation with the OIG. VBA has established procedures to effectively manage the Fugitive Felon Program and does not consider this a major management challenge.

OIG3. PROCUREMENT

VA faces major challenges in implementing and maintaining a more efficient, effective, and coordinated acquisition program. VA spends over $6 billion annually for pharmaceuticals, medical and surgical supplies, prosthetic devices, information technology, construction, and services.

In response to an OIG report issued in May 2001, the VA Secretary established a Procurement Reform Task Force. In May 2002, the Task Force made 65 recommendations to better leverage VA's substantial purchasing power and to improve the overall effectiveness of procurement actions. VA has been implementing the Task Force recommendations since June 2002. As of May 2005, there are 5 of the 65 Task Force recommendations that remain open. However, we continue to identify significant problems with VA acquisitions involving Federal Supply Schedule (FSS) contracts, procurements of health care services, VHA construction, Vocational Rehabilitation and Employment contracts, and acquisition support weaknesses associated with VA's recent effort to acquire an E-Travel service. We also continue to identify weaknesses in management of purchase cards and problems with inventory management as shown below.

3A. OIG Issue–FSS Contracts

Preaward and postaward reviews of FSS proposals and contracts continue to show that VA is at risk of paying excessive prices for goods and services unless VA strengthens contract development and administration. During the first half of 2005, preaward reviews of 15 FSS and cost-per-test offers resulted in recommendations that VA contracting officers negotiate reduced prices totaling over $1 billion. Vendors were not offering VA and other FSS customers most favored customer prices, when those same prices were offered to commercial customers purchasing under similar terms and conditions. As a result, VA and other FSS customers inappropriately paid higher prices than similarly situated commercial customers.

Postaward reviews conducted in the first half of 2005 resulted in cost recoveries associated with contractor overcharges of about $2.3 million. These included four OIG reviews of vendors' contractual compliance with the specific pricing provisions of their FSS contracts (recoveries of $1.7 million) and three drug pricing compliance reviews at pharmaceutical vendors (recoveries of $632,000) under Public Law 102-585.

VA's Program Response to OIG3A:

VA contracting officers are actively pursuing the OIG preaward audit recommendations and seeking better discounts, terms, and conditions than originally offered. Additional training has been provided to the contracting staff to reinforce the intent of the FSS program to seek "equal to or better than" most favored (non-federal, comparable) customer pricing during the negotiating process. In regards to postaward reviews conducted within the first 6 months of 2005, contracting staff has pursued the overcharges identified by the OIG. The contracting staff will continue to review active contracts to identify possible price violations and, when identified, will seek the OIG's services.

3B. OIG Issue–Contracting for Health Care Services

OIG reviews have continued to show a need for improvement in health care resource contracts awarded under 38 U.S.C. § 8153. Reviews in recent years have identified numerous problems with these contracts, including a lack of acquisition planning, conflict of interest violations, poorly written solicitations, inadequate contract negotiations, and poor contract administration. We also found that required legal, technical, and preaward reviews for price reasonableness determinations were not obtained and, when they were, the recommendations were not implemented. As a result, contracts were awarded that did not adequately protect the interests of VA or our veteran patients.

Our February 2005 summary report, *Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions* (Report No. 05-01318-85), discussed issues that we identified during preaward reviews of proposals, postaward reviews, and reviews conducted as part of the OIG's Combined Assessment Program. This summary report focused our collective findings and recommendations since 2000 for improvement in the procurement of health care resources. The report addressed general contracting issues including poor acquisition planning, contracting practices that interfered with the contracting officers' ability to fulfill their

responsibilities, and contract terms and conditions that did not protect VA's interest; contract pricing issues that resulted in VA overpaying for services; and legal issues, including conflict of interest violations, improper personal services contracts, terms and conditions that were inherently governmental, and contracts that were outside the scope of § 8153 authority. For example, in 2003 the VHA Resource Sharing Office reported that 99 contracts valued at $500,000 or more were awarded. Only 3 of the 99 were referred for a preaward review.

The Under Secretary for Health concurred with the report's findings and recommendations to improve VHA's award and administration of these contracts. The Under Secretary convened a workgroup who were tasked with the development of a VA directive to implement the recommendations. The draft directive has been approved by all VA entities and is awaiting the Secretary's signature. Currently, 32 of 35 recommendations remain open.

VA's Program Response to OIG3B:

VA Directive 1663, Health Care Resources Contracting Buying, is expected to be published and released no later than during the first quarter of 2006.

3C. OIG Issue–Management of VHA Major Construction Contracts

Our February 2005 report, *Audit of VHA Major Construction Contract Award and Administration Process* (Report No. 02-02181-79), identified that VHA needed to improve the construction contract award and administration process to ensure price reasonableness, prevent excessive prices, and deter or avoid fraud, waste, abuse, and mismanagement. We reviewed over 30 major construction contracts and identified a risk for excessive prices involving projects valued at $133.6 million. We also identified about $960,000 in unused funds that should be returned to the construction reserve fund if no longer needed. Additionally, we made a series of recommendations to strengthen the construction contract process. Currently 3 of 17 recommendations remain open.

VA's Program Response to OIG3C:

Fourteen of the OIG's 17 recommendations were closed by the OIG as of August 2005, a result of actions VHA has taken to strengthen the construction contract process. The OIG final report was forwarded to all Office of Facilities Management (FM) staff, and it, along with the recommendations, were discussed in a mandatory national conference call in May 2005. The report and its recommendations have been the subject of subsequent calls and meetings. Several FM directives and manuals as well as the Project Managers Handbook have been revised with expected publication and issue in the first quarter of 2006. With these actions, VHA expects all remaining recommendations will be closed. FM's Quality Assurance Service, officially established in July 2004, has been implementing systematic reviews of and providing guidance to the FM staff concerning the quality of project management and contract administration. Project manager performance plans now include an item in the work plan indicating project managers will develop, monitor, and proactively control project schedules throughout the project. FM's quality assurance staff monitors this.

3D. OIG Issue–Vocational Rehabilitation and Employment Contracts

In February 2005, we issued the report *Evaluation of VBA Vocational Rehabilitation and Employment Contracts* (Report No. 04-01271-74). VA had awarded over 240 contracts to support veterans' access to evaluations, rehabilitation, training, and employment services. Based on contracting vulnerabilities identified, we concluded that VA was at risk of paying excessive prices for services on these contracts. Prices for similar services from the same contractors on prior contracts varied significantly. Base year price increases ranged from 23 to 314 percent. There was no evidence that VA conducted price reasonableness determinations to ensure the best prices were obtained, while information contained in contract specifications and the statement of work were vague and, in our opinion, subject to multiple interpretations. Voluntary price reductions received from 25 contractors showed that contracting costs could be reduced by as much as 15 percent, which would reduce VA's $45 million in expenditures by $6.8 million over the 5-year term of existing contracts. We made recommendations to replace the existing contracts and to strengthen management and oversight. Currently five of seven recommendations remain open.

VA's Program Response to OIG3D:

As of July 2005, five VR&E action items remain open. The following two items are pending issuance of a directive requiring: (1) files that are maintained by contracting staff include copies of contracts being used and (2) documentation supporting the selection of one contractor over another when higher prices are paid for services received. A draft directive was provided to the OIG on June 14, 2005, for review prior to finalization.

To address the OIG action item on determining price reasonableness, VR&E staff is conducting market research prior to making option renewal determinations. This information will be used to establish base-year prices and annual increases of VR&E contracts. The remaining two action items relate to internal and management controls. Contractors' performance and quality assurance reviews are performed quarterly to validate that corrective actions have been taken on identified deficiencies. All auditing functions of VR&E contracts will be reassigned to VBA's Finance Staff. The projected completion date for these three action items is October 2006.

3E. OIG Issue–Contracting and Acquisition Support for Major System Development Initiatives

OIG completed reviews of two major VA system development initiatives in late 2004 and in 2005. These reviews involved procurement and deployment of the Core Financial and Logistics System (CoreFLS), and the implementation of VA's E-Travel service. During these reviews, OIG identified significant deficiencies, demonstrating that acquisition support activities and contract actions continue to remain high risk. Both reports indicate VA faces significant management challenges to ensure that these system development initiatives meet program goals, user expectations, and budget targets.

Our August 2004 report, *Issues at VAMC Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)* (Report Number 04-01371-177),

concluded that VA did not adequately contract for or monitor the CoreFLS project or protect the Government's interests. VA did not allow sufficient time to conduct full and open competition to fulfill the requirements of the CoreFLS project, which was budgeted to cost VA over $300 million. VA's actions effectively made the CoreFLS project a sole-source award, with the award determination based solely on a very small portion of expected costs and services needed to implement and deploy a CoreFLS solution.

We identified systemic inadequacies in the contracting processes and serious weaknesses in contract development. These included statements of work that were nonexistent or not prepared independently, technical evaluations that were also inadequate or nonexistent, independent Government cost estimates that were missing, and multiple contract task orders that contained deficiencies. In fact, we concluded the type of task orders issued to the CoreFLS contractor were inappropriate for acquiring integrator services. We made 66 recommendations in the report. Twenty-nine of them relate directly to issues identified as major management challenges. Fourteen of these 29 recommendations remain open. We discuss three recommendations addressing contracting issues in the Financial Management section (4A), three recommendations on CoreFLS security issues in the Information Security and Systems section (5A), and the remaining eight recommendations in the same section (5B).

In our March 2005 report, *Review of VA Implementation of the Zegato E-Travel Service* (Report No. 04-00904-124), we identified that VA's E-Travel initiative duplicates the General Services Administration's (GSA) efforts to provide E-Travel service options that all Federal agencies must use. The project was not meeting VA's requirements and user needs effectively, and we identified contracting actions that did not adequately protect VA's interests. Also, we concluded that aspects of this project were fast-tracked and the initial award determination was based solely on a very small portion of expected costs and services. We made recommendations to the Assistant Secretary for Management to initiate timely actions to migrate to one of GSA's approved E-Travel options, which could save $7.4 million over the next 10 years. The Department's Chief Management Officer concurred with the report recommendations and VA initiated actions needed to strengthen the current contract, reduce contract costs, and effect a timely migration to one of GSA's E-Travel services. VA also initiated technical and legal reviews of the existing contracts to better protect its financial, performance, and contractual interests. These actions helped ensure the price reasonableness of current service levels until migration can be completed and position the Department to save the funds we identified once migration to a GSA-approved E-Travel service is complete. Although all 10 report recommendations remain open, we expect to close the report recommendations in the near future since the Department has taken most of the actions needed to meet the intent of our recommendations or is making significant progress toward implementing the open recommendations. However, we will continue to follow up on the corrective actions until they are completed.

Our findings showed that both of these projects lacked adequate control, risk management, and senior management oversight because acquisition activities were expedited, while key management and system development controls were omitted or weakened by actions associated with the accelerated pace. VA needs to use a more strategic and disciplined approach to improve acquisition and contract support activities for complex, expensive system development efforts.

VA's Program Response to OIG3E:

In April 2005 the Chief Information Officer sent a memorandum to the OIG requesting that the remaining recommendations regarding previous plans for implementation of a new integrated financial management system be closed since the Department was still evaluating what course of action would be most prudent for development and implementation of this type of system. VA has now initiated a 4-year remediation program to eliminate the existing material weakness—Lack of an Integrated Financial Management System. This new program will be referred to as VA's Financial and Logistics Integrated Technology Enterprise (FLITE)—the goal of which is to correct financial and logistics deficiencies throughout the Department. For FY 2006 and 2007, the work associated with FLITE will be primarily "functional" in nature, that is, oriented on planning and the standardization of financial and logistics processes and data. This effort will be led by the Assistant Secretary for Management and will be very labor intensive involving both contractors and Government personnel. During those fiscal years, a detailed review and analysis of software options will also occur and will include "pilot programs" as needed.

In 2004 implementation of the Zegato Travel System was halted and VA proceeded to initiate migration to one of the GSA-approved e-Travel Service (eTS) options in accordance with the President's Management Agenda. After a thorough evaluation by a VA-wide team of technical experts, including vendor demonstrations, hands-on testing of functionality, system performance, and comparative pricing, VA awarded a task order to Electronic Data Systems (EDS) from GSA's master contract in January 2005.

Shortly after awarding the task order, VA conducted "sandbox" testing to review the functionality of FedTraveler.com to ensure all items in the "request for quotes" were met. A gap analysis document was provided to EDS, listing all items found deficient by VA. All items are required to be completed before VA will implement FedTraveler.com.

Work is ongoing on additional implementation activities. Migration of the first site is scheduled for the first quarter of 2006. Senior management officials and the eTS Steering Committee are overseeing eTS project management and migration activities.

3F. OIG Issue–Government Purchase Card Activities

VA management controls over purchase card transactions need improvements so that VA leverages buying power to the maximum extent possible and captures available discounts. In our April 2004 report, *Evaluation of the Department of Veterans Affairs Purchase Card Program* (Report No. 02-01481-135), we identified additional opportunities to ensure that purchase cards are used properly. Of the eight recommendations, the one to develop and implement procedures and checklists for approving officials to use in monitoring cardholders' use of cards remains unimplemented.

During 2005, OIG CAP reviews continue to show that VA needs to improve controls for the effective administration of the Government purchase card program. We identified program deficiencies at VBA and VHA facilities during CAP reviews. Deficiencies included insufficient supporting documentation, problems with reconciliations and certifications, single purchase

limits that were not enforced, expensive or unusual procurements made on behalf of veterans, use by unauthorized individuals, split purchases, failure to use national contracts, a lack of training, and inadequate separation of duties between billing officers and purchase card coordinators.

VA's Program Response to OIG3F:

To address the OIG's concerns, VA's Office of Business Oversight (OBO) began using data mining techniques to identify potentially questionable purchase card transactions. Beginning in 2005, transactions identified as questionable have been provided to station Agency/Organization Program Coordinators for research and validation. If transactions are verified as being improper, such as splitting purchases, OBO notifies facility directors to take appropriate administrative and personnel action and provide a response on corrective measures taken to prevent reoccurrence. OBO provides status updates to the VA Chief Financial Officer (CFO) as well as Administration CFOs on a quarterly and annual basis, with overall program recommendations provided at the end of the fiscal year.

OBO also performs site reviews at VHA and VBA facilities and examines purchase card processes and procedures, such as reconciliations and certifications. A sample of purchase card transactions is tested for validity of supporting documentation and purchase limits. Any findings are formally reported to facility directors with recommendations for corrective action. Findings are also summarized in an annual report, with program-wide recommendations directed to appropriate VA officials.

The following desk guides for the purchase card program have been signed and placed on the VHA CFO Web site at http://vaww.cfo.med.va.gov/173/accnt_deskguides.asp:

Purchase Card Approving Official -- Issued April 12, 2005.
Purchase Card Cardholder -- Issued April 12, 2005.
Purchase Card Program Coordinator -- Issued June 14, 2005.
Purchase Card Dispute and Fraud -- Issued July 20, 2005.

The last desk guide to be issued is entitled Purchase Card Accruals and Audits. This will be distributed to the field in the first quarter of 2006. The desk guides provide guidance to those who use the Government purchase card.

VHA Handbook 1730.1, *Use and Management of the Government Purchase Card*, was signed on June 17, 2005, by the Under Secretary for Health. The handbook updates and clarifies procedures for the use of the Government purchase card for VHA facilities and program offices; defines the establishment of local facility quarterly monitors of purchases made with the purchase card; indicates discrepancies should be corrected immediately; and requires certification of the report by the facility CFO, Agency/Organization Program Coordinator, Logistics Officer, or equivalent.

In addition, during the past year the VHA Chief Logistics Officer Purchase Card Workgroup developed a white paper with recommendations for improving the procedures and controls and to

decrease risk in the purchase card program. As a result of this initiative, a number of software system upgrade requests were submitted to the VHA Data Validation workgroup for implementation to improve the automated record of purchase card transactions. Other recommendations of this workgroup are in process, such as the identification of best practices and the evaluation of training needs.

During 2005 VBA continued to emphasize to regional office staff the importance of following the guidance set forth in VBA Handbook 4080. The handbook, which incorporated prior OIG recommendations and suggestions, was released to the field in June 2004. The handbook includes a purchase card checklist as well as an approving official's review guide to aid in monitoring cardholders' purchase card use. VBA teams used a purchase card checklist in 2005 during regional office reviews.

With the changing requirements and new initiatives associated with the purchase card program, VBA management has been proactive in communicating information to all purchase card coordinators and will continue to provide the necessary tools to support the oversight of this program.

3G. OIG Issue–Inventory Management

OIG reviews of inventory management practices have identified significant management challenges involving various supply categories and excessive expenditures of hundreds of millions of dollars. Our August 2004 Bay Pines/CoreFLS report concluded that in spite of repeated notices by VHA of the need for an efficient inventory management program, the VAMC did not fully or adequately implement VA's Generic Inventory Program (GIP) to manage inventories, which contributed to the failed conversion of inventory data to CoreFLS. This review highlighted problems with VA's inventory management and showed VA needs to ensure that all facilities have certified the accuracy and reliability of GIP data to prevent the problems encountered at Bay Pines from occurring at other sites.

In 2005, CAP reviews continue to identify systemic problems with inventory management caused by inaccurate information, lack of expertise needed to use GIP, and failure to use the system at some supply points in medical centers. The 30-day maximum supply level used in our audits and CAPs was originally developed with the participation and agreement of OA&MM and VHA, and remains a reasonable standard for most recurring medical, prosthetic, engineering, and operating supply requirements. Current OIG reviews provide for exceptions to the standard, such as items that have long ordering lead times, infrequent but necessary use, order quantities larger than a 30-day supply, and earmarked emergency stockpiles. CAP reviews conducted in 2005 found management of supply inventories was deficient at 36 of 38 facilities tested. VA continues to face significant challenges in deploying an accurate inventory management information system nationwide, along with ensuring the accuracy of inventory management information needed for decision-making. By improving inventory management practices nationwide, VA can potentially reduce excess inventories and reduce funds tied up in maintaining excess inventories.

VA's Program Response to OIG3G:

The Office of Acquisition and Materiel Management (OA&MM) has taken the following actions to address inventory management issues in VA:

- Developed a national item file that will force standardized identification for supplies and ensure that all items are accounted for in perpetual inventory accounts. Further development and maintenance of the file was recently transferred to VHA.

- Sponsored materiel management seminars that promote the use of and include technical training for GIP.

- Transferred the supply, processing, and distribution (SPD) program to VHA for more authority in its management. SPD manages the largest amount of medical supplies in VHA facilities and has been repeatedly cited in CAP reviews for deficient inventory management practices.

OA&MM agrees that much improvement is needed regarding inventory management. However, the office questions the 30-day stock standard used by the OIG in conducting CAP reviews. For most items, a 30-day stock is a good limit for proper inventory management; however, many items cannot be held to this standard including stand-by supplies available for rare occurrences, items that require long lead times for replenishment, and supplies that are packaged in quantities greater than 30-day supply. VA recommends that the OIG not apply the standard to every item.

In February 2004 VA created the Office of Business Oversight (OBO) to conduct oversight and monitoring of financial, capital asset management, acquisition, and logistics activities across the Department. In 2005 OBO conducted logistics business reviews at 10 VA medical centers not reviewed by the OIG in 2005. OBO determined GIP was not fully implemented at 5 of the 10 facilities reviewed. The remaining five had implemented GIP but were not effectively using it to manage supply inventories.

OBO conducts physical inventories and reviews supply management practices in clinical areas. OBO also provides training, including best practices, to inventory management personnel to ensure familiarity and compliance with VA and VHA directives.

In 2006 OBO will double the number of logistics business review site visits. OBO anticipates the increased reviews will provide greater oversight, monitoring, and improvement of the inventory management practices in VA.

The VHA Chief Logistics Officer (CLO) continues to monitor inventory issues through the use of internal/external reviews and an online database where medical centers enter inventory information. Inventory information is collected and analyzed to determine compliance with VHA Handbook 1761.2, *Inventory Management.*

Continued progress is being made in areas of inventory management and the maintenance of GIP. To date, all inventories have been certified as implemented. Inventories are being

monitored to ensure continued use of GIP, lower levels of inactive and long supply stock, and overall lower dollar value of inventory.

Problems identified by CAP reviews require stations to address their specific issues with corrective action plans, which are followed up by the CLO. The CLO is also writing a new directive that addresses various inventory problems. The directive, which will be completed by the first quarter of 2006, identifies opportunities for more focused training, targeting critical areas identified in the reviews.

Actions currently underway to address the recommendations include:

- Creation of standardized business processes for inventory management.
- Creation of a national report server.
- IFCAP (VA field station procurement ordering, accounting and distribution system)/GIP programming changes.
- Separate performance measures for recurring stock vs. just-in-case stock.
- Rewrite of VHA Handbook 1761.2, Inventory Management.
- GIP continuing education.

OIG4. FINANCIAL MANAGEMENT

Since 1999, VA has achieved unqualified audit opinions on its consolidated financial statements (CFS). However, material weaknesses related to information technology controls and the lack of an integrated financial management system continue. VA expects to take several years to complete the corrective actions to address these weaknesses.

While VA has addressed many of our concerns over the last few years, OIG audits and reviews continue to identify major challenges where VA could improve financial management controls, data validity, and debt management. VA also needs to correct problems identified in the Federal employees Workers' Compensation Program (WCP) operations.

4A. OIG Issue–Financial Management Control

Annual CFS audit work continues to report the lack of an integrated financial management system at VA as a material weakness, as well as a noncompliance issue with the Federal financial management systems requirements under the Federal Financial Management Improvement Act (FFMIA). VA continues to experience difficulties related to the preparation, processing, and analysis of financial information to support the efficient and effective preparation of VA's CFS. While significant efforts are made at the component and consolidated levels to assemble, compile, and review the necessary financial information for annual reporting requirements, in many cases, components of certain feeder systems and financial applications are not integrated with VA's core financial management system. As a result, CFS work in VA requires significant manual compilations and labor-intensive processes for the preparation of auditable reports. The lack of an integrated financial management system also increases the risk of materially misstating financial information.

To address the lack of an integrated financial management system, VA deployed a new computerized financial management and logistics system, CoreFLS. VA believed that CoreFLS would resolve OIG concerns. Operational testing of CoreFLS began in October 2003 at three VA facilities, with implementation at further sites to be phased in, and full implementation scheduled for March 2006. However, after our August 2004 report titled *Issues at VA Medical Center Bay Pines, Florida and Procurement and Deployment of the Core Financial and Logistics System (CoreFLS)* (Report No. 04-1371-177) was issued, VA responded by discontinuing implementation of CoreFLS and the test sites resumed operation within VA's existing financial management system in early 2005. Three financial management and control recommendations remain unimplemented.

VA is now evaluating how it will proceed with the deployment of a functioning financial management system. Currently an executive project committee, chaired by VA's Assistant Secretary for Information and Technology and comprised of other senior leaders, is examining the results of the operational testing of CoreFLS and will make recommendations to the VA Secretary concerning the future of the program. In looking at VA's program response and based on OIG experience with the CoreFLS review, we view the Office of Finance's plan to develop a Web-based single system that will improve the accessibility of financial data, provide ad-hoc reports, and secure access within an integrated computer environment in 2006 as a positive interim step towards correcting the material weakness; but this interim step also represents a formidable major management challenge.

VA's Program Response to OIG4A:

VA has contracted with an independent consulting firm to provide an "As is" and "To be" analysis of VA's finance and logistics system and processes, including a plan to address the material weakness "Lack of an Integrated Financial Management System."

The Office of Finance has developed and is implementing a remediation plan that creates a dual path to substantially reduce the material audit weaknesses associated with the lack of an integrated financial management system. The first path focuses on improving the quality and timeliness of VA's financial data by developing a single and centralized Web-based data repository of information that is currently maintained in several different legacy systems. We will provide the user with a commercial off-the-shelf financial statement reporting system tool that will improve the accessibility of financial data, provide ad-hoc reports, and secure access to our customers within an integrated computer environment. The second path will reduce the significant manual compilation and labor-intensive processes for the preparation of VA's consolidated financial statements and other standardized automated accounting reports. Under the new system, VA's consolidated financial statements, Treasury's Governmentwide Financial Reporting System and Federal Agency's Centralized Trial-Balance System II budgetary reports, and intra-governmental reporting will be produced from a single database using standardized formats. The new system decreases the risk of materially misstating financial information, strengthens reporting controls, automates the collection and consolidation of accounting data, and reduces the reporting lead time required to produce reports. Scheduled for implementation in 2006, the remediation plan should reduce the material weaknesses and make VA's financial

management system substantially compliant with the Federal Financial Management Improvement Act.

The current status of the three open management and control recommendations is as follows:

Recommendation: Initiate a review of all payments to BearingPoint to determine whether there were any improper or erroneous payments for collections.

Status of Implementation: The Office of Business Oversight (OBO) continues to review expenditures made to the CoreFLS vendors. In August 2005 OBO issued a report of findings and recommendations regarding BearingPoint. The report is currently under review by the VA Chief Management Officer. OBO is drafting a report of findings and related recommendations regarding Oracle. The estimated report issuance date is October 2005. OBO will begin drafting a report of findings and related recommendations regarding Information Control in September 2005.

Recommendation: If the discounts offered for Phase IV work and/or the award fee cannot be recovered, take appropriate administrative action against the responsible VA personnel.

Status of Implementation: The certified letter to BearingPoint has been rescinded; the issue of discounts for Phase IV work and/or the award fee will be considered within the context of the OIG's continuing investigation of this matter.

Recommendation: Conduct a complete review of all travel vouchers submitted by BearingPoint since commencing work in January 2000 to:

- Determine if the claimed costs are allowable in accordance with the provisions of the Joint Travel Regulations.
- Coordinate findings with the Office of Inspector General.
- Collect any amounts found to be in excess of those allowable under regulations.
- Clarify return home allowable expenses.
- Check rebates.

Status of Implementation: OBO continues to review all travel expenditures submitted by BearingPoint. In June 2005 OBO received a large volume of critical supporting documentation for BearingPoint travel claims. As of September 2005 OBO has fully audited over 4,100 claims. OBO's findings include potentially recoverable amounts by VA due to some inconsistencies with the Federal Travel Regulation and the lack of supporting documentation from the traveler. In addition, OBO has identified several key management issues. OBO anticipates a completion date for the report issuance by the first quarter of 2006.

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. While VA has made progress in implementing GPRA, OIG audits have identified a need to improve data validity so that stakeholders have accurate and reliable performance data. Starting in 1997, we conducted a series of audits assessing the quality of data used to compute VA's key performance measures. While VA has corrected the deficiencies cited in our first eight reports, involving seven of nine key measures where we identified data validity problems, we are concerned that the remaining key performance measures that have not been reviewed may have similar problems.

Our July 2005 report, *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures* (Report No. 04-02887-169), indicated outpatient scheduling procedures need to be improved to ensure accurate reporting of veterans' waiting times and facility waiting lists. VHA strives to schedule at least 90 percent of all next available appointments for veterans within 30 days. Of the 1,104 appointments reviewed, schedulers created 315 (28 percent) as next available appointments. We determined that 505 of the 1,104 appointments should have been created as a next available appointment. Of the 505 appointments, only 330 appointments (65 percent) were scheduled with 30 days of the desired date—well below the VHA goal of 90 percent and the medical facilities directors' reported accomplishment of 81 percent. Although the recalculated average waiting time of 30.1 days was consistent with VHA's goal of scheduling appointments within 30 days, it was 44 percent more that the reported average waiting time of 20.9 days. Even though the report was just issued in July 2005, VHA has already completed action on one of eight recommendations.

Until the remaining key measures are reviewed, this issue will remain a major management challenge. While we plan to review a key performance reporting measure annually, and will work with VA program officials to identify these critical measures, VA staff should do a thorough review of the remaining issues and provide the OIG assurance that data validity problems do not exist or have been corrected.

VA's Program Response to OIG4B:

The Office of Policy (OP) in the Office of Policy, Planning, and Preparedness is responsible for making the official estimates and forecasts of the veteran population and their characteristics. The estimates of the size and composition of the veteran population are based on data updates from DoD, the Bureau of Census, internal VA sources, and other sources. To further improve the quality of the veteran statistical estimating process, OP completed an independent review in 2005 of the methods used to make these estimates. OP also administers the National Survey of Veterans program to collect extensive data on the characteristics of the veteran population and selected cohorts. These data are supplemented with data from other federal agencies.

OP is the official source for the public, Congress, and other agencies for a variety of data on the veteran population and their use of benefits, services, and resources. OP continually reviews the methods of analysis and data to ensure that the data are accurate and consistent with previously

released information. To further improve the quality of veteran data, VA will create the National Center for Veteran Statistics, which is envisioned to be a federal statistical data center.

VHA recognizes that since scheduling involves interactions by human beings, there will always be issues with data validity. However, VHA continues to work at ensuring accurate data entry. Facilities are providing training for schedulers who are instructed that new patients are to be scheduled to be seen within 30 days of request unless the patient or provider specifically requests a later appointment date. In addition, VHA revised its process for measuring wait times for new patients that effectively tracks wait times for these patients, regardless of whether these patients are given a next available or non-next available appointment, so that facilities can now clearly identify where there are real problems with wait times in excess of 30 days for new patients (rather than merely the appearance of wait time problems created by appointment labeling errors) and take actions to correct any such problems.

VBA continues to review the validity, not only of key performance measures, but of all workload and performance data. Program services conduct data system reviews and on-site visits throughout the year at the regional offices. The Office of Performance Analysis and Integrity (PA&I) conducts specific data validation studies. PA&I also maintains the corporate Data Warehouse and Operational Data Store that enables VBA to have realistic, timely, and accurate data.

The issue of data validity is also stressed in national training programs. PA&I is routinely asked to participate in a number of such programs, with the primary focus being the use of the Data Warehouse to support data/performance analysis. Data validity and its importance are discussed during each of the sessions, with an emphasis on understanding that managing workload or directing improvement efforts will fall short unless data are reliable and accurate.

NCA determines the percent of veterans served by existing national and state veterans' cemeteries within a reasonable distance of their residence by analyzing census data on the veteran population. In 1999, the OIG performed an audit assessing the accuracy of the data used for this measure. Audit results showed that NCA personnel generally made sound decisions and accurate calculations in determining the percent of veterans served. Data were revalidated in the 2002 report entitled Volume 1: Future Burial Needs, prepared by an independent contractor as required by the Veterans Millennium Health Care and Benefits Act, P.L. 106-117.

NCA has established an 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." As part of the program, assessment teams conduct site visits to all national cemeteries on a rotating basis to validate performance reporting.

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

VA continues to suffer significant risk for WCP abuse, fraud, and unnecessary costs from inadequate case management and fraud detection. VA did not fully implement prior OIG audit recommendations[2] to enhance VA's case management and fraud detection efforts and to avoid inappropriate dual benefit payments. Reducing the risk of abuse, fraud, and unnecessary costs is important because of the significance of VA's WCP costs. Since 1998, VA costs have totaled more than $1 billion. Our work demonstrates that WCP costs could be significantly lower if VA had fully implemented our prior audit recommendations for case management improvements.

Our August 2004 report, *Follow-Up Audit of Department of Veterans Affairs WCP Cost* (Report No. 02-03056-182), found that ineffective case management and program fraud resulted in potential unnecessary/inappropriate costs to VA totaling $43 million annually. These costs represent potential lifetime 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 VA continue to designate the WCP as an internal high priority area with increased program monitoring and oversight.

VA faces a significant liability for future compensation payments estimated at more than $2 billion. VA's decentralized approach to WCP 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 program administration. While the Department has begun to take action, only 1 of 15 recommendations is fully implemented by the Office of Human Resources and Administration.

VA's Program Response to OIG4C:

Since the last report, VA has implemented significant initiatives to address the findings and recommendations presented in OIG Report No. 02-03056-182. VA formed a Workers' Compensation (WC) Strategic Planning Committee in October 2004. The Strategic Management Council approved the WC strategic plan on February 8, 2005. The WC Strategic Planning Committee, chaired by the Principal Deputy Assistant Secretary for Human Resources and Administration, is comprised of representatives from throughout VA. WC programs are currently being developed to promote professional development, case file review, WC education, and quality assurance programs. The strategic plan is comprised of the following goals and objectives:

Strategic Goal 1 – Case Management

- Recruit, develop, and retain a cadre of world class case managers.
- Document accidents and illnesses in a timely, accurate, and consistent manner.
- Ensure that access to clinical treatment is appropriately received with a focus on rehabilitation, recovery, and return to work.

[2] *Audit of VA's Workers' Compensation Program Cost* (Report No. 8D2-G01-67), July 1, 1998, and *Audit of High Risk Areas in the Veterans Health Administration's Workers' Compensation Program* (Report No. 99-00046-16), December 21, 1999.

- Ensure that case managers coordinate with the employees, the Department of Labor (DOL), medical professionals, and supervisors during the entire claims process.
- Ensure that case managers monitor and oversee the status/progress of all employees on WC.
- Ensure that the quarterly Office of Workers' Compensation Programs (OWCP) Chargeback Report is utilized so that VA can better manage WC by reemploying injured employees in appropriate positions.

Strategic Goal 2 – Return to Work
- Conduct a one-time review of legacy cases.
- Ensure that case documentation with functional capacity is received in a timely manner.
- Ensure that a job offer is made or the OWCP Form 5 is completed by the provider and requested by VA.

Strategic Goal 3 – Education
- Develop WC training programs that address education needs for all beneficiaries and stewards of the program.
- Deploy an effective curriculum of training programs to increase awareness of OWCP policies and procedures.
- Provide relevant training that continually meets the needs of the VA WC program.

Strategic Goal 4 – Partnerships
- Improve relations with DOL at the national and district levels.
- Improve partnerships with other federal agencies.
- Enhance relations with unions to address WC issues.
- Improve internal collaboration and performance in WC.

Strategic Goal 5 – Identify and Reduce Fraud, Waste, and Abuse
- VA and the OIG will develop and deploy a communication plan.
- Develop a comprehensive strategy between the OIG and VA's three administrations for identifying, reporting, investigating, and prosecuting fraud.
- Explore establishing an independent WC fraud investigation group in the OIG.
- Upon development of probable cause to suspect fraud, the OIG will partner with the Department of Justice to take appropriate action.

The WC Strategic Planning Committee meets monthly to review progress toward these goals. Four of the 15 identified items have already been completed, and substantial progress has been achieved on the remaining items. A number of the recommendations involve complex organizational issues that are currently under development by WC subcommittees.

4D. OIG Issue–Federal Energy Management Cost

Our March 2005 report, *Evaluation of VA Compliance with Federal Energy Management Policies* (Report No. 04-00986-101), found that VA needed to strengthen compliance with Federal energy management policies and improve the reliability of data. OIG concluded VA did

not comply with Federal energy management policies or give sufficient priority to its energy management program. We recommended the Assistant Secretary for Management require each administration appoint an energy supervisor for each of its facilities, ensure facility energy supervisors received specialized training, perform energy audits for 10 percent of VA's facilities each year, and train acquisition staff on requirements to purchase energy-efficient products. We estimated VA could better use $12.9 million annually if it achieved the 2000 goal of reducing energy consumption 20 percent compared to 1985 energy consumption.

VA's Program Response to OIG4D:

The Office of Asset Enterprise Management (OAEM) in the Office of Management assumed leadership of VA's energy conservation program in March 2003 and issued a new energy policy directive and handbook in July 2003. The directive and handbook direct each VA administration to audit 10 percent of its facilities each year, train acquisition and energy management staff, and designate energy managers for each region. Accomplishments to date are as follows:

Energy Audits

- Through its energy conservation pilot program, VA exceeded the energy audit goal in fiscal years 2003 and 2004.

Training

- More than 500 VA employees have completed the online training for "green purchasing," which covers energy-efficient products that the Office of Personnel Management offers on its Go Learn Web site. In addition, VA's Office of Acquisition and Materiel Management provides information about energy-efficient product purchasing at quarterly materiel management seminars.

Energy Managers

- Energy managers are in place in 19 out of the 21 VHA networks.

OAEM will revise the 2003 VA Energy Conservation Program policy directive and handbook by the first quarter of 2006 to reflect the new requirements for federal agencies regarding an annual reduction in energy consumption.

NCA has designated an office to serve as the energy liaison with the Department and coordinate NCA's energy program in conjunction with NCA subject matter experts.

NCA is currently modifying the Management and Decision Support System database to improve and enhance data collection on energy use and consumption. Changes to the system include collection of energy cost data and a requirement to report both energy cost and usage information on a monthly rather than quarterly basis. During site visits under the Organizational Assessment and Improvement Program, teams validate the energy data as reported by the cemeteries.

NCA completed an energy audit of its largest national cemetery, Riverside, in 2004 as part of a larger VA pilot energy study. Study findings identified several measures that are applicable not only to Riverside but to other cemeteries as well. Funds are requested in the President's FY 2006 budget to perform additional energy and water audits at national cemeteries. Through these audits, NCA will identify new techniques to reduce energy and water consumption, implement

environmentally sound landscaping practices, and minimize the impact of national cemeteries on the environment.

VHA has an energy coordinator responsible for the implementation of energy initiatives throughout the Administration. VHA has been working with OAEM to develop a comprehensive energy policy.

To improve the reliability of data, the VISN Service Support Center (VSSC) has added data validation to identify any errors during data entry. Quarterly reports are sent to facilities with the errors identified for correction. Because of these improvements, the accuracy of data entry has drastically improved.

VBA designated an energy management official and energy liaisons to serve on VA's Energy Team. The team serves as the point of contact for data collection, analysis, and reporting of VBA energy conservation efforts. Energy liaisons have been designated for each of the five VBA-owned or direct-leased facilities that are not under the purview of VHA. VBA has retained a professional engineering firm to assess the training needs of energy liaisons and develop an appropriate training plan to comply with federal energy management policies. VBA contracted with a professional engineering firm to perform facility condition assessments and energy audits at the five VBA-owned facilities. The Montgomery VA Regional Office audit was completed in June 2005, four additional audits are planned in 2005, and three audits are planned for 2006. By the end of 2006, 60 percent of VBA-owned facilities will have completed energy audits.

VBA offices do not have local contracting authority. The regional offices will continue to work with the Office of Acquisition and Materiel Management and servicing medical center staffs to ensure requirements pertaining to ENERGY STAR and other energy-efficient products are procured.

4E. OIG Issue–Medical Care Collections Fund

In our December 2004 report, *Evaluation of Selected Medical Care Collections Fund (MCCF) First Party Billings and Collections* (Report No. 03-00940-38), we evaluated the appropriateness of MCCF first party billings and collections for certain veterans receiving C&P benefits. Veterans receiving compensation for service-connected disabilities rated 50 percent or higher, or VA pensions based on being totally disabled with low income, are generally exempt from copayments and should not be billed. We found that 89 percent of the veteran cases reviewed had debts referred inappropriately to VA's Debt Management Center (DMC) because of inaccurate eligibility information regarding the veteran's C&P status in the Veterans Health Information Systems and Technology Architecture system. We made recommendations to prevent inappropriate billings and collections of inappropriately established debts. Currently, two of four recommendations remain unimplemented. They require medical facilities to access veterans' benefits information through VBA to obtain the effective dates for veterans awarded service-connection, verify that debts are appropriate before issuing bills or referring debts to the DMC for collection, and ensure that Health Eligibility Center management follows up timely on rejected award information and uploads the correct information into its database so that veterans' status changes can be updated in medical facility systems.

In 2005, CAP reviews examining Medical Care Collections Fund activities found deficiencies at 19 of 21 facilities tested. We found staff did not obtain insurance information from veterans at the time of treatment; also, staff recorded inadequate and untimely documentation relating to services provided, had episodes of billable care not identified, and did not forward fee-basis care documentation to veterans' health insurers for payment. In addition, we continue to find billing backlogs being processed in alphabetical order instead of by date of treatment. Facility management needs to strengthen billing procedures to avoid missed billing opportunities, improve timeliness of billings, improve accuracy of diagnostic and procedure coding, and aggressively pursue accounts receivable.

VA's Program Response to OIG4E:

During the October 2004 Chief Business Office (CBO) nationwide conference call, guidance was provided instructing field staff to follow up with VBA when new awards are made to determine the effective date of the award. Additionally, during its February 16, 2005, nationwide conference call, the CBO provided specific guidance to field facilities recommending that the Diagnostic Measures First Party Follow-up report be run monthly. This report enables medical centers to identify cases for which eligibility may have changed and helps prevent billings and collections of inappropriately established debts.

The Health Eligibility Center (HEC) staff continues to place a priority on resolving the C&P status changes that require manual resolution. In reviewing the cases requiring manual processing, the HEC identified a problem with how its information system processes VBA updates when VBA fails to include the entitlement codes. Although the data sharing specification requires an entitlement code, we have identified a number of records received without this data element. Because the HEC is able to ascertain the VBA benefit without these codes, the current review file filter, which routes such updates into the manual review file, has been determined inappropriate. A new software enhancement will include the change necessary to fix this problem and will allow automatic update of the veteran's eligibility status. This enhancement is expected to be released concurrent with VBA/VHA data sharing improvements no later than the end of the first quarter of 2006. VHA believes that the combination of continued priority processing of the review file cases and this new enhancement to improve automated processing of VBA updates will effectively address the OIG recommendation.

In support of the need to strengthen billing procedures to avoid missed billing opportunities, improve timeliness of billings, improve accuracy of diagnostic and procedure coding, and aggressively pursue accounts receivable, VHA has initiated a comprehensive assessment of ongoing activities within the revenue program in an effort to develop "industry best practices" and identify project initiatives designed to improve and standardize business processes. The goal is to ensure that to the maximum extent practical, VHA is properly compensated for the services provided to those veterans with private health insurance coverage. Included in this body of work is a series of electronic data interchange initiatives that include, and in some instances exceed, the Health Insurance Portability and Accountability Act (HIPAA) requirements.

With regards to fee billing, the VHA CBO has established a field committee comprised of both field and Central Office staff to identify best practices associated with capturing potentially billable cases and the development of automation to support that process.

VBA will continue working cooperatively with VHA to improve and enhance data and information exchange.

During 2005 the Office of Business Oversight (OBO) increased reviews of revenue operations, performing reviews of nine VA medical facilities. As part of these reviews, OBO assessed insurance identification, insurance verification, billing, and accounts receivable processes. OBO provided suggestions for improvement to each facility director and will issue a summary report to VHA officials at the end of the fiscal year.

OBO also assisted VHA in reducing outstanding third party accounts receivable by performing an analysis of the outstanding receivable balances. As part of this analysis, receivables were categorized and recommendations made to medical facility, VHA, and Office of General Counsel officials for eliminating receivables that were not collectible.

OIG5. INFORMATION MANAGEMENT SECURITY AND SYSTEMS

VA information technology (IT) security and systems continue to be a high-risk area and a significant management challenge. In recent years, VA has not made adequate progress improving its information security posture. System development initiatives have experienced cost overruns, technical difficulties, and schedule delays. VA has not been able to effectively address its significant information security vulnerabilities and reverse the impact of its historically decentralized management approach. While VA has accelerated efforts to improve Federal information security, more needs to be done to put security improvements in place that effectively eliminate the risks and vulnerabilities of unauthorized access and misuse of sensitive information.

Recent OIG reviews addressing information security and system development underscore the need for continued improvements in addressing security weaknesses. The OIG has reported VA information security controls as a material weakness and as an instance of noncompliance with the Federal financial management systems requirements under FFMIA in its annual CFS audits since 1997. VA has also disclosed information security controls as a material weakness as part of its Federal Managers' Financial Integrity Act submission since 1998. Further, a computer network vulnerability assessment performed as part of the 2004 CFS audit found that, because of problems in interconnectivity of the Veterans Integrated Service Network's (VISN) architecture, weaknesses occurred that placed an entire VISN at risk to unauthorized access and misuse.

5A. OIG Issue–Information Security

In our March 2005 report, *Audit of the Department of Veterans Affairs Information Security Program* (Report No. 04–00772–122), we identified significant information security vulnerabilities that place VA at considerable risk of denial of service attacks, disruption of mission-critical systems, fraudulent benefits payments, fraudulent receipt of health care benefits,

unauthorized access to sensitive data, and improper disclosure of sensitive data. The magnitude of these risks is impeding VA from carrying out its mission of providing health care and delivering benefits to our Nation's veterans. All 16 recommendations for improvement remain unimplemented.

Our August 2004 report on Bay Pines/CoreFLS indicated that the CoreFLS project team did not initiate security background investigations for contract employees until 4 years into the project. When they did initiate the investigations, they established sensitivity levels that were lower than required by VA directives. We made three recommendations to the Office of Security and Law Enforcement to strengthen internal controls over the process of determining sensitivity designations for non-VA employees. We are currently evaluating a response to our recommendations, which remain open.

We determined that many information system security vulnerabilities reported in national audits from 2001 through 2004 remain unresolved. VA's action to implement OIG recommendations in previous audits is helping to address some vulnerabilities and security weaknesses. However, OIG CAP reviews conducted from October 2003 through August 2005 continue to identify information security weaknesses. We have reported security weaknesses and vulnerabilities at 45 of 60 VA health care facilities and 11 of 21 VA regional offices where security issues were reviewed. We continue to make recommendations to improve security and contingency plans, control access to information systems, conduct background investigations, conduct annual security awareness training, and improve IT physical security.

VA's Program Response to OIG5A:

VA is recommending closure of two recommendations contained in the OIG's March 2005 audit report and several issues contained in other recommendations for which corrective action has been implemented. Actions which have been taken or are planned include the following:

- **Certification and Accreditation (C&A).** As of August 31, 2005, the Department reported completing C&A activities for 585 systems and major applications, representing all VA systems currently in operation. The Administrations, staff offices, and the VA Office of Cyber and Information Security will continue to work collaboratively on continuous monitoring efforts, which occur between tri-annual certification activities, to ensure that facilities are in compliance with VA and federal policies and standards and that security controls are implemented and tested for effectiveness to ensure the confidentiality, integrity, and availability of data and adequate protection of VA systems.

- **Patch Management and Vulnerability Assessment**. With the deployment of an enterprise vulnerability assessment tool and an automated patch deployment system, VA has taken a major leap forward by addressing the need for an enterprise patch management program. The long-term solution for VA's patch management will include the implementation of an enterprise security framework, which will be piloted in 2006.

- **Technology to Protect the VA Wired Network from Wireless Devices**. VA has selected and installed Fortress Technologies AirFortress Wireless Security Gateway as the solution to

protect the VA wired network from wireless devices. All wireless data traffic is routed through the Gateway before it is transmitted on the VA network. The Gateway not only provides FIPS 140-1 certified encryption of data between the wireless client and the Gateway (thereby eliminating the need for activation/use of Wired Equivalent Privacy encryption), it also provides firewall functionality, which limits access to the VA network to only authorized devices and users.

- **Intrusion Detection.** Intrusion detection system installation has been completed. The Critical Infrastructure Protection Service is in the final stages of obtaining contractor support (award of this contract is anticipated to occur before the end of the current fiscal year) that will provide management and monitoring of security devices (intrusion detection systems) VA-wide. The services provided will include both host and network intrusion protection.

- **External Connections**. Completion of the necessary actions regarding external connections is scheduled for early 2006.

- **Configuration Management.** Progress has been made regarding configuration management of VA systems. The VHA Office of Information has developed a detailed configuration management plan, change control process, and maintenance procedures that support the system development life cycle for its VistA application and local area networks. In addition, configuration guidelines have been published on the VA Intranet to help protect the confidentiality, integrity, and availability of sensitive VA data.

- **Physical Security.** VA's centralized approach to C&A of systems also includes a section in the site documentation addressing physical security controls as required by National Institute of Standards and Technology Special Publication 800-53. Specifically, facilities and staff offices must control all physical access points (including designated entry/exit points) to facilities containing information systems and verify individual access authorizations before granting access to the facilities.

- **Electronic Transmission of Sensitive Data.** VA's Office of Information and Technology has established a working group to identify a practical, cost-effective solution. The working group will develop the strategy and action plan to implement the identified solution to protect the Department's sensitive data until the networks are fully secured against unauthorized access. In the interim, the VHA Office of Information has directed field facilities to continue to exchange data in the most secure methods available so that delivery of benefits to the veteran population is not halted or unnecessarily delayed as a result of changes to current data exchange processes and operations.

- **Critical Infrastructure Protection.** The Critical Infrastructure Protection Program has implemented a project plan to identify critical infrastructure and assets that focus on the availability of assets in time of crisis for VA. Infrastructure protection is considered for three areas: human, physical, and cyber security. The critical infrastructure systems and assets have been identified. Threat profiles and the strategic plan are in progress.

In April 2005 the Chief Information Officer sent a memorandum to the OIG requesting that the remaining recommendations regarding previous plans for implementation of a new integrated financial management system be closed since the Department was still evaluating what course of action would be most prudent for development and implementation of this type of system. VA has now initiated a 4-year remediation program to eliminate the existing material weakness—Lack of an Integrated Financial Management System. This new program will be referred to as VA's Financial and Logistics Integrated Technology Enterprise (FLITE)—the goal of which is to correct financial and logistics deficiencies throughout the Department. For FY 2006 and 2007, the work associated with FLITE will be primarily "functional" in nature, that is, oriented on planning and the standardization of financial and logistics processes and data. This effort will be led by the Assistant Secretary for Management and will be very labor intensive involving both contractors and Government personnel. During those fiscal years, a detailed review and analysis of software options will also occur and will include "pilot programs" as needed.

VA's Chief Information Officer advises and assists Department personnel in understanding and implementing security requirements and in monitoring their compliance with these requirements. This monitoring is accomplished through the Office of Cyber and Information Security (OCIS) Review and Inspection Division, the certification and accreditation program, Federal Information Security Management Act reporting, Security Configuration and Management Program, and VA Computer Incident Response Capability. VHA works closely with the Department to implement VA security requirements and assists with compliance monitoring and reporting as requested. VHA and OCIS are directing resources to address VA's goal to have all VA systems certified and accredited by August 31, 2005.

VBA regional offices continue to develop contingency plans in accordance with VBA policy and the National Institute of Standards and Technology guidance. By March 2006, these plans will fully address the seven areas outlined in the draft 2005 VBA Certification and Accreditation Plan of Action and Milestone documents.

In addressing access to information systems, a VBA letter will be distributed in November 2005 providing policy on restricting access to the LAN during non-duty hours. To reduce the likelihood of compromising weak passwords, VBA has installed Password Policy Enforcer software on servers and workstations.

VBA's Office of Human Resources issues the appropriate position sensitivity designation for all positions in compliance with VA Directive and VA Handbook 0710. VBA continues to process background investigation requests in accordance with VBA policy. VBA requires annual certification of security awareness training by all VBA employees, contractors, veterans service organizations, students, and volunteers.

Federal Information Processing Standards Publication 201 (FIPS 201) was issued in February 2005. It mandates that all federal agencies and departments be able to implement identity proofing and issuance process by October 2005 and begin issuing Personal Identification Verification (PIV) cards by October 2006. Furthermore, OMB has requested that a national rollout be completed by September 30, 2008.

It is anticipated that VA's implementation of FIPS 201 requirements will correct concerns about background checks and contract employees as presented in the OIG report. However, this issue has not been finalized by OMB. OMB is requesting comments to a proposed background check requirement by October 11, 2005. VA's Office of Human Resources and Administration (HR&A), which is responsible for development and implementation of FIPS 201 compliant architecture and processes, is working closely with the Office of Security and Law Enforcement, Office of Cyber and Information Security, and other VA offices to respond to OMB's proposal.

In addition, HR&A is planning to launch a process deployment phase in January 2006 that will lead to accreditation of the processes for the successful implementation of FIPS 201 requirements. Initiation of the deployment phase will thus depend upon OMB's finalizing the requirements for background investigations and VA's issuing related policies. HR&A will continue to inform senior VA managers on the project's progress.

5B. OIG Issue–Information Systems Development

From April 2004 through March 2005, we issued 42 reports and management letters that cited the need to improve information security, application controls in financial systems, and general controls over access to the VA data centers and operations. Our reports and management letters also cited major issues with VA's information systems development and deployment processes.

Our August 2004 report on Bay Pines/CoreFLS indicated that the deployment of CoreFLS encountered multiple system development problems. In fact, CoreFLS was deployed at the Bay Pines facility without resolving numerous OIG-reported risks, including inadequate training and concerns about not using a parallel processing system during deployment. Failure to run a parallel system resulted in unnecessary risk to patient care and contributed to the inability to monitor fiscal and acquisition operations. Also, the effect of transferring inaccurate data (some legacy systems that CoreFLS was designed to interface with did not contain accurate data) interrupted patient care and the medical center operations. In response to our report, the VA Secretary tasked a contractor to review and determine the validity of the CoreFLS software package to accomplish expected goals. Currently, there are eight recommendations under the responsibility of the Assistant Secretary for Information and Technology that remain unimplemented.

In March 2005, we also reported on VA's implementation of the Zegato Electronic E- Travel Service, disclosing that VA's initial efforts to test and implement the service failed to meet VA's requirements and user needs, and project managers were not effectively managing its implementation. Early in the project initiative, VA had to grant about 60 facilities waivers from using the E-Travel service before it could proceed with nationwide implementation plans. We reported that lapses in project management contributed to a failed implementation, schedule delays, cost escalation, and substantial user frustration. As reported under issue 3E, while VA has completed many actions, all 10 recommendations remain open.

VA's management challenge with regard to IT systems development and deployment is to develop and implement future information systems that meet expected requirements and are

secure, fully functional, and compatible with existing systems while following a sound systems development methodology.

VA's Program Response to OIG5B:

In April 2005 the Chief Information Officer sent a memorandum to the OIG requesting that the remaining recommendations regarding previous plans for implementation of a new integrated financial management system be closed since the Department was still evaluating what course of action would be most prudent for development and implementation of this type of system. VA has now initiated a 4-year remediation program to eliminate the existing material weakness—Lack of an Integrated Financial Management System. This new program will be referred to as VA's Financial and Logistics Integrated Technology Enterprise (FLITE)—the goal of which is to correct financial and logistics deficiencies throughout the Department. For FY 2006 and 2007, the work associated with FLITE will be primarily "functional" in nature, that is, oriented on planning and the standardization of financial and logistics processes and data. This effort will be led by the Assistant Secretary for Management and will be very labor intensive involving both contractors and Government personnel. During those fiscal years, a detailed review and analysis of software options will also occur and will include "pilot programs" as needed.

In January 2005 VA selected Electronic Data Systems (EDS) from GSA's e-Travel Service (eTS) master contract to provide eTS to VA. Shortly after awarding the task order, VA conducted "sandbox testing" to review the functionality of FedTraveler.com to ensure all items in the "request for quotes" were met. A gap analysis document was provided to EDS, listing all items found deficient by VA. All items are required to be completed before VA will implement FedTraveler.com.

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This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.