DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Management and Administration

Budget Request for Fiscal Year 2018

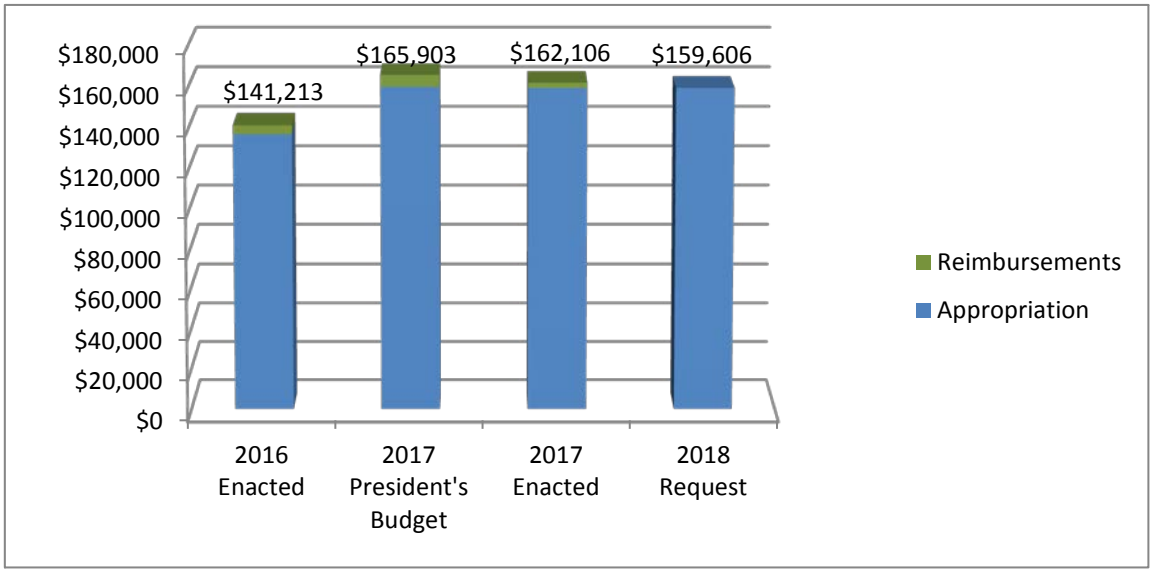
BUDGET REQUEST

APRIL 30, 2019

Budget Request Contents

Office Of Inspector General

Summary of Budgetary Resources — Inspector General
(Dollars in Thousands)



Summary of Budget Request

(Dollars in Thousands)	2017	FTE	2018	FTE
Office of Inspector General				
Budget Authority	$159,606	760	$159,606	820
Reimbursements	$2,500	13	$0	0
Total Budgetary Resources	**$162,106**	**773**	**$159,606**	**820**

For FY 2018, the Office of Inspector General (OIG) requests budget authority of $159,606,000 and 820 FTE to carry out its statutory oversight mission. The budget request includes notification to Congress of the transition from a reimbursable agreement to direct appropriations to support the Office of Contract Review in late FY 2017. This office currently includes 26 FTE who provide valuable oversight of VA procurement practices and pricing methodologies through preaward and postaward reviews of Federal Supply Service, Health Care, and Architectural/Engineer contracts.

The FY 2018 request of $159.6 million is the same level of funding that was enacted for FY 2017. In combination with carryover resources, it will support a total of 60 additional FTE above FY 2017—including 26 FTE for Contract Review. The balance of new FTE will be allocated towards operational initiatives underway to address high-risk areas

across VA. This includes the placement of additional health care inspectors, criminal investigators, and auditors at new and existing locations nationwide, especially areas in the Southern and Western tiers of the country where there is no permanent OIG presence and a growing veteran population. In broad terms, these additional staff will strengthen and enhance oversight related to patient safety, access to care, mental health care, women's health care, facility inspections, emergent criminal activity such as illicit drug activity, procurement fraud, and identity theft, and audits of construction projects and Choice Act programs. Additional information supporting this request is provided later in this chapter.

Appropriation Language

For necessary expenses of the Office of Inspector General, to include information technology, in carrying out the provisions of the Inspector General Act of 1978, $159,606,000 [$159,606,000] of which not to exceed 10 percent shall remain available until September 30, 2019 [2018].

Inspector General Mission

As authorized by the *Inspector General Act of 1978* and other enacted legislation, the Inspector General is responsible for conducting and supervising audits, investigations, and recommending policies designed to promote economy and efficiency in the administration of and to prevent and detect waste, mismanagement, and criminal activity in VA programs and operations; and for keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. OIG is also charged with oversight of VA health care programs. OIG is authorized to inquire into all VA programs and activities as well as VA-related contracts, grants, and other agreements.

OIG is dedicated to helping VA provide veterans and their families the care, services, support, and recognition that they have earned through their service to our country. Through its oversight programs, OIG works to promote positive change and to help ensure VA can meet the needs of our latest generation of veterans as well as those of our older veterans.

Strategic Plan and Goals

OIG's recently published *Strategic Plan 2016–2020* includes six strategic goal areas—health care delivery, benefits processing, financial management, procurement practices, information management, and workforce investment. These strategic goal areas encompass the major programmatic issues VA will face in the next few years, while providing OIG with the necessary flexibility to adjust to changing circumstances as they arise.

- **Strategic Goal 1 — Health Care Delivery.** Improve veterans' access to safe, effective, high-quality health care by identifying opportunities to improve the

management and efficiency of VA's health care delivery systems, and by detecting, investigating, and deterring fraud and other criminal activity.

- **Strategic Goal 2 — Benefits Processing.** Improve the delivery of benefits and services by identifying opportunities to improve the quality, timeliness, and accuracy of benefits processing, while reducing criminal activity in the delivery of benefits through proactive and targeted audit and investigative efforts.
- **Strategic Goal 3 — Financial Management.** Assist VA in achieving its financial management mission of providing all VA activities with accurate, reliable, and timely information for sound oversight and decision-making while identifying opportunities to improve the quality, management, and efficiency of VA's financial management systems.
- **Strategic Goal 4 — Procurement Practices.** Ensure that VA's acquisition programs support our Nation's veterans, other Government entities, and the taxpayer by providing customers with quality products, services, and expertise delivered in a timely fashion, at a reasonable price, and to the right place.
- **Strategic Goal 5 — Information Management.** Assess information systems and policies within VA to ensure that they protect information security and integrity, are cost-effective, meet the needs of users, and are used in a lawful and ethical manner, while investigating fraud and other computer-related crimes against VA.
- **Strategic Goal 6 — Workforce Investment.** Recruit, retain, and empower a diverse workforce. Foster a work environment that enhances productivity, innovation, excellence, and employee satisfaction by leveraging technology and tools to maximize the impact of OIG work.

Performance Measures

OIG's performance measures tie directly to its oversight mission and strategic goals and demonstrate the critical linkages between work and results, and between effort and effect. The following OIG performance measures will be used to assess the impact of OIG work on VA short-term and long-term mission-related outcomes in each of the six strategic goal areas and to track OIG outcomes related to this budget request.

- Number of reports (audit, inspection, evaluation, contract review, Comprehensive Healthcare Inspection Program (CHIP) reports, and Community Based Outpatient Clinic (CBOC) reports) issued that identify opportunities for improvement and provide recommendations for corrective action.
- Number of arrests, indictments, convictions, criminal complaints, pretrial diversions, administrative sanctions, and corrective actions.
- Monetary benefits ($ in millions) from audits, investigations, contract reviews, inspections, and other evaluations.
- Return on investment (monetary benefits ÷ cost of operations in dollars).
- Percentage of: full cases that result in criminal, civil, or administrative actions; recommendations implemented within 1 year to improve efficiencies in operations

through legislative, regulatory, policy, practices, and procedural changes in VA; and recommended recoveries achieved from postaward contract reviews.

OIG's performance results for fiscal years (FY) 2012-2016 and targets through 2018 are included as part of the Department's Annual Performance Plan and Report for 2018.

Stakeholders and Partners

OIG oversight work encompasses all VA programs, services, functions, and funding. As such, stakeholders or partners in the OIG's work and results may include the Secretary, Congress, VA managers and staff, beneficiaries, taxpayers, affiliated health care and educational institutions, contractors, other Federal agencies, law enforcement organizations, and other OIGs.

Program Description

The OIG conducts operations through four Offices, each headed by an Assistant Inspector General, and the Office of Contract Review, which is directed by the Counselor to the Inspector General.

Office of Audits and Evaluations. The Office of Audits and Evaluations (OAE) conducts independent and timely performance and financial audits and other evaluations of VA health care, benefits, financial management, procurement, and information management programs. The audits and evaluations contribute to improved management of VA programs by providing useful and practical recommendations to improve the economy, efficiency, and effectiveness of VA management, programs, services, operations, and systems. OAE also conducts cyclical inspections of benefits processing activities at VA regional offices (VAROs). Additionally, OAE oversees the annual Consolidated Financial Statement audit that assesses VA's financial management systems and information under the requirements of the *Chief Financial Officers Act of 1990*, annual evaluation of VA's information security programs and controls required by the *Federal Information Security Management Act of 2002* (FISMA), and other requirements under the *Digital Accountability and Transparency Act or 2014* (DATA).

Office of Healthcare Inspections. The Office of Healthcare Inspections (OHI) conducts oversight aimed at enhancing the safety, effectiveness, and quality of VA health care programs and promoting continuous quality improvement. OHI helps safeguard the quality of Veterans Health Administration (VHA) medical care for veterans by conducting inspections, evaluations, cyclical CHIP and CBOC reviews that evaluate quality of care issues at VA medical facilities, and clinical consultations in support of criminal investigations. OHI also conducts oversight of VHA's quality assurance programs.

Office of Investigations. The Office of Investigations (OI) conducts criminal and administrative investigations of wrongdoing in VA programs and operations. Criminal investigations focus on such activities as fraud against VA committed by beneficiaries, fiduciaries, contractors, and employees; illegal pricing by pharmaceutical firms; bribery of

VA employees, embezzlement, and extortion; theft and diversion of drugs by employees and others; theft of VA resources and data; identity theft; assaults involving employees and patients; threats against employees, patients, facilities, and information systems; mortgage fraud; and workers compensation fraud. Administrative investigations focus on misuse of Government resources, abuse of authority, and travel irregularities by senior officials. Through criminal prosecutions, administrative sanctions, and monetary recoveries, these investigations promote integrity, patient safety, efficiency, security, and accountability in VA.

Office of Management and Administration. The Office of Management and Administration (OMA) provides a wide range of administrative and operational support functions to OIG offices and employees. Information technology units nationwide provide a broad array of information technology support and security services, as well as data gathering and analysis support for audits, inspections, and investigations. OMA also provides follow-up on OIG report recommendations and other administrative, human resources, reporting, logistics, budget, and fiscal services for the entire OIG organization. OMA operates the OIG Hotline, providing the means for VA employees and others to report allegations of fraud, waste, and abuse to OIG and to ensure that these referrals are resolved timely and appropriately. The Hotline also coordinates whistleblower protection services providing education and information on whistleblower protections against reprisals.

Office of Contract Review. The Office of Contract Review, which is overseen by the Counselor to the Inspector General, provides preaward, postaward, and other reviews of vendor proposals and contracts under a reimbursable intra-agency agreement with VA's Office of Acquisition, Logistics, and Construction. OIG plans to end the reimbursable intra-agency agreement and to fully absorb the responsibilities of the Office of Contract Review under direct appropriations in the second half of FY2017. This will further strengthen our independence and lead to more effective utilization of these staff resources to address a broad range of procurement issues that negatively impact VA programs and operations. The Counselor also provides independent legal advice and representation on issues arising from OIG activities and directs OIG's *Freedom of Information Act* and *Privacy Act* activities.

Inspector General Accomplishments

The surfacing of allegations in early 2014 involving veterans' access to care at the Phoenix VA Health Care System, in Phoenix, Arizona, was a watershed event for VA and OIG. The crisis seriously undermined public confidence in VA operations and ultimately led to multidisciplinary OIG investigations into allegations of gross mismanagement of VA resources, criminal misconduct by senior officials, systemic patient safety issues, and possible wrongful deaths at 100 different care sites nationwide. It ushered in a new paradigm for positioning OIG assets nationally to meet the growing demand for oversight of VA programs, and with the support of the previous Administration and Congress, led to enactment in FY 2017 of the largest budget ever for OIG of $159.6 million.

Although the Phoenix crisis has abated, OIG continues to receive a significant number of Congressional inquiries and an above average volume of Hotlines regarding care at VA

facilities across the country. Our inspections and audits subsequent to the Phoenix crisis continue to identify significant barriers to timely health care, including inappropriate scheduling practices, inaccurate wait time data, mismanagement of specialty care consults, and poor execution of Choice Act programs, and indicate that a significant amount of change must occur before the Department can achieve a level of service delivery that is consistent and on par with demand.

OIG oversight activities continue to yield meaningful and quantifiable outcomes for veterans and taxpayers. During the 12 months covered by the two most recent OIG Semiannual Reports to Congress, OIG identified $4.1 billion in actual and potential monetary benefits; issued 304 audit, healthcare inspection, contract review, evaluation, benefits inspection, and administrative investigation reports on VA programs and operations; and achieved 2,425 investigative outcomes, including 349 arrests, 39 fugitive felon arrests, 290 indictments, 78 criminal complaints, 263 convictions, 38 pretrial diversions and deferred prosecutions, and 1,368 administrative sanctions and corrective actions. OIG operations provided a return on investment of $34 in monetary benefits for each $1 of OIG resources expended. OIG representatives provided testimony on the results of their oversight work at 11 Congressional hearings. Other recent and noteworthy accomplishments by OIG oversight programs are summarized below.

Hotline Reviews

- The OIG Hotline continues to play an important role in bringing new issues to the attention of OIG and VA management. Hotline workload is expected to continue growing for the foreseeable future and reflects an expectation that a larger number of allegations will be completed internally based upon increases in budget authority rather than being referred to the Department for action. In FY16, OIG Hotline logged 38,076 contacts—a sustained level of receipts on par with the record number of contacts received in FY14. Hotline opened 1,177 cases and closed 1,263 cases with a substantiation rate of 39 percent. Resolution of Hotline cases referred to VA management for review and action resulted in 870 administrative sanctions and other corrective actions including the identification of $4.23 million in monetary benefits.

Healthcare Inspections

- OIG conducted a healthcare inspection of the Veterans Crisis Line (VCL) with four primary objectives. The first two objectives included evaluating an allegation that VCL staff did not respond adequately to a veteran's urgent needs and performing a detailed review of VCL's governance structure, operations, and quality assurance functions. The second two objectives included evaluating whether VHA completed planned actions in response to VA OIG recommendations from a previously published OIG report and addressing complaints received from the U.S. Office of Special Counsel (OSC).

  The essential concept of a crisis line is that competent and compassionate individuals are available to provide around-the-clock resources to any veterans in distress, to include help, support, and referrals, and even arrange for immediate evaluation if necessary. We determined that VCL staff did not respond adequately to a veteran's

urgent needs, and found deficiencies in the VCL's processes for managing incoming telephone calls and in governance and oversight of VCL operations. We found substantial disagreement about key decisions in operations of the VCL between the VHA Suicide Prevention Office and VHA Member Services and determined that VHA contracting staff and leadership lacked sufficient understanding of the backup center contractual requirements and could not effectively monitor contractor performance. We also found some backup call centers used a queuing process that may lead callers to perceive they were on hold, and that VCL leadership had not established expectations, targets, or thresholds for taking action on queue times. We discovered deficiencies in the VCL Quality Management (QM) program and found several challenges in VCL QM staff's ability to collect, analyze, and effectively review relevant QM data. VCL policies were not consistent with existing VHA policies for veteran safety or risk management and did not incorporate techniques for evaluating available data to improve quality, safety, or value for veterans. We found that the VCL had not completed actions to fully implement the seven recommendations from our prior report. Lastly, we substantiated the OSC complainant's allegations that Social Service Assistants (SSA) were allowed to coordinate emergency rescue responses independently after the end of a 2-week training period, without supervision and regardless of performance or final evaluation; that a newly trained SSA contacted a caller in crisis by telephone to solicit the veteran's location; and an SSA did not document when closing out a veteran's case. We made 16 recommendations. OIG expects to provide additional oversight of VA's actions addressing these recommendations in the future and to help ensure the effectiveness of these mission-critical services.

- In FY 2016, OIG healthcare inspections published several hotline reports addressing various aspects of VA opioid prescribing practices. The use of opioids to treat chronic pain and other conditions continues to be a serious concern in VA and the Nation, and OIG work focuses on ensuring both safe prescribing practices and availability of alternatives. In a hotline inspection at a large tertiary care Veterans Affairs Medical Center (VAMC), OIG determined that the quality of care provided for a patient's chronic pain did not follow recommendations of the VA/Department of Defense clinical guidelines, which were developed to promote evidence-based management of patients' chronic pain. The inspection found that VAMC providers did not order urine drug testing, complete a suicide risk assessment, or obtain an opioid pain care agreement as part of the patient's chronic pain therapy. The patient continued to receive refills of an opioid without a face-to-face assessment with a provider for 22 months. During another hotline inspection, OIG identified challenges with the clinical environment in which CBOC providers prescribe opioids and manage the pain-related needs of their patients. The inspection noted a lack of non-opioid pain management options for outpatients and, despite the opening of the Veterans' Integrated Pain Management Clinic at the parent VAMC, the high demand for non-opioid pain management options continued. Further, the inspection found that VAMC leadership needed to develop proactive organizational solutions to ensure that consistent monitoring and timely patient reassessments and prescription refills could occur. OIG made seven recommendations for the two inspections to improve opioid safety and monitoring practices.

- In FY 2016, OIG healthcare inspections published two hotline reports detailing how the lack of staffing contingency plans contributed to significant patient care delays and patients being lost to follow-up. During a hotline inspection at a large VAMC, OIG determined that the VAMC suffered a significant staffing shortage in Urology Service, yet leaders did not have plans to provide urological services to Veterans during the shortage. VAMC leaders' failure to promptly respond to this staffing crisis may have contributed to thousands of patients being "lost to follow-up" and staff frustration due to lack of direction. In response to OIG recommendations, VAMC leaders hired additional urology staff and conducted reviews (and disclosures, as appropriate) of cases where patients may have been harmed by delays. Another hotline inspection found that a CBOC experienced inadequate primary care provider staffing when a provider abruptly resigned, leaving a panel of 1,100 patients without a provider. Patients were reportedly called about their clinic appointment cancellations during the first two days after the provider resigned. However, the facility had no contingency plan that would ensure continuity of, and access to, appropriate primary care. OIG made two recommendations.

- In FY 2016, OIG published a roll-up report addressing the extent to which VAMCs complied with selected requirements for the assessment and treatment of patients who had acute ischemic stroke symptoms. Stroke is the fifth leading cause of death in the United States, accounting for about one of every 20 deaths. OIG conducted this review at 50 VAMCs during Combined Assessment Program reviews performed across the country. Although OIG observed many positive practices, several opportunities for improvement were identified and numerous recommendations were made. OIG recommended that the Under Secretary for Health improve the availability of expertise in stroke treatment across the system and ensure compliance with stroke care requirements, including prompt and thorough assessment, treatment, and patient education, and ensure the gathering and reporting of required stroke data elements. In response to the review, the VA Under Secretary for Health reported that VA would implement a "telestroke program" to link stroke specialists with VA Emergency Departments and intensive care unit staff. VA leaders also provided additional guidance to VAMCs regarding stroke care and treatment expectations and data collection and reporting requirements. These changes in policy should decrease the morbidity associated with large vessel strokes for veterans across the United States. By addressing the recommendations, VA officials will strengthen VA's efforts to provide quality and timely assessments and treatments to patients who present to VAMCs with stroke symptoms.

- OIG healthcare inspections conducted an inspection at the request of the Committee on Veterans' Affairs, U.S. House of Representatives, and the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives, to assess allegations that a VAMC lacked adequate patient safety policies and procedures to safeguard patients when they "come and go" from the Community Living Center (CLC) and whether additional safety measures could have prevented a patient's suicide. OIG did not substantiate the allegation that the CLC lacked adequate safety policies and procedures regarding patients' "comings and goings" in the CLC. However, OIG found that VAMC staff did not consistently enforce certain policies and procedures when the patient did not comply with them.

Although OIG could not substantiate the allegation that the VAMC should have instituted additional safety precautions given the patient's past medical and mental health history, OIG did identify additional potential suicide risk factors known to at least one staff member that were not documented or discussed in the CLC Interdisciplinary Team meetings. OIG also found that staff did not initiate an Integrated Ethics consult, which could have been done to assist them and the patient in making informed decisions and applying appropriate healthcare ethics standards regarding medical care, treatment, and patient autonomy. By failing to consistently enforce certain policies and procedures and initiate an Integrated Ethics consult, VAMC staff missed opportunities to intervene with this patient. OIG made four recommendations to strengthen patient safety.

- A Congressionally requested healthcare inspection found that non-VA medical records, resulting from VA provider referrals, were not available in a patient's VA electronic health record (EHR). Non-VA medical records are vital in understanding a patient's overall health status and care. Gaps in non-VA documentation, such as those found in this case, put a patient at risk and make continuity of care between various providers and specialties more difficult to achieve. Copies of clinical documentation submitted by non-VA medical care providers and other reports (such as laboratory and radiology records) should be available in the EHR. OIG discovered several examples of non-VA care reports that had not been scanned and made available in the EHR. OIG identified this issue during another hotline inspection at the same VAMC and made a recommendation.

Audits, Evaluations, and Benefits Inspections

- OIG reviewed whether VHA Veterans Integrated Service Network (VISN) 6 provided new veterans timely access to health care within its medical facilities and through Choice, as well as to determine whether VISN 6 appropriately managed consults. OIG found that new VISN 6 patients consistently lacked timely access to health care and that wait times were significantly higher than the wait time data reflected through VHA's electronic scheduling system. This occurred because VISN 6 and medical facility management did not ensure staff consistently implemented VHA's scheduling requirements. Inaccurate wait time data resulted in a significant number of veterans not being eligible for treatment through Choice— we estimated that 82 percent of the appointments during the relevant time period had wait times longer than 30 days. This occurred primarily because medical facilities did not ensure they had sufficient staffing resources to provide timely access to Choice care. VISN 6 also did not consistently manage the timeliness of specialty care consults. We concluded that VHA and VISN 6 leadership relied on wait time data that did not accurately represent how long veterans were waiting for care. Access to health care has been a recurring issue in VHA. This audit demonstrates that many of the same access to care conditions reported over the last decade continued to exist within VISN 6 medical facilities in 2016. OIG made 10 recommendations regarding monitoring controls over scheduling requirements, wait time data, Choice, and consult management.

- At the request of several members of Congress, OIG reviewed the plans and costs associated with the Denver Medical Center replacement project (Denver project),

which is arguably the most expensive VA medical center built to date. OIG evaluated the events that led to major delays in the construction and to the increases in costs from the budgeted amount of $800 million to the current estimated costs of $1.7 billion. The concept for the Denver project dates back to the late 1990s and was in response to the region's growth in the veteran population and the need to replace an aging and inadequate facility built in 1951. The new facility will be approximately 600,000 square feet larger than the current one and will provide additional functional capability such as more examination, treatment, and dental procedure rooms. It will also afford 30 beds designed for Spinal Cord Injury patients, which the current facility lacks. The project took years to start due to changes implemented under five former VA Secretaries and incurred significant and unnecessary cost overruns due to poor business decisions which followed. OIG's review identified several major points of failure that encompass a series of questionable business decisions by VA senior officials concerning planning, design, construction, and consultant services. The project is estimated to be completed in mid-to-late late 2018, nearly 20 years after VA identified the need to replace its aging facility.

- OIG evaluated VBA's oversight of Post-9/11 G.I. Bill tuition and fee payments to determine if payments were appropriate and accurate. Of the $5.2 billion in Post-9/11 G.I. Bill tuition and fee payments made for nearly 796,000 students during academic year 2013-2014, OIG reviewed more than $1.7 million in payments made to 50 statistically-selected schools for 225 students. OIG found VBA staff at the Regional Processing Offices (RPO) made 46 improper payments totaling just under $90,900 and 39 overpayments totaling just under $96,400 where the RPOs had not initiated recoupment actions. In total, 32 of the reviewed schools had improper payments and missed recoupments; furthermore, 20 of these schools lacked compliance surveys. Of the $5.2 billion in tuition and fee payments made for academic year 2013-2014, OIG projected that VBA made about $247.6 million in improper payments and more than $205.5 million in missed recoupments annually. As a result, VBA may have an estimated $2.3 billion in improper tuition and fee payments and missed recoupments ($1.2 billion in improper payments and $1 billion in missed recoupments) over the next 5 academic school years if it does not strengthen program controls. OIG recommended VBA improve school outreach to ensure accurate and complete certifications are submitted, develop risk profiles for schools to periodically review and verify their certifications, and incorporate risk factors into the prioritization and completion of compliance surveys. OIG also recommended VBA strengthen policies and controls related to the discontinuance and recoupment of payments, repeated classes, and satisfactory academic progress and that it take action, where appropriate, to recover identified improper payments and initiate recoupments.

- OIG reviewed whether the VBA properly granted entitlement to all statutory housebound special monthly compensation (SMC) benefits for living veterans with a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent. This review focused on whether VBA failed to pay or delayed paying any of these benefits. OIG also assessed the accuracy of SMC evaluations for veterans receiving compensation at the housebound rate, including statutory housebound, and housebound in fact, as well as SMC that had been incorrectly coded as housebound benefits. The first review objective focused on a population of about 186,000 living

veterans' cases nationwide that at some point were entitled to statutory housebound SMC benefits based on a single disability rated as 100 percent and one or more disabilities independently rated at 60 percent as of March 10, 2015. To address the second objective, OIG reviewed a population of about 98,400 veterans' cases nationwide receiving compensation at the housebound rate for any reason as of March 10, 2015. OIG estimated errors in 33,400 of 186,000 cases. OIG estimated that these errors resulted in veterans being underpaid $110.1 million through February 2015, and receiving recurring underpayments of $1.8 million per month as of March 2015. In addition, OIG estimated that VBA staff delayed paying veterans $54.3 million. Errors for veterans receiving compensation at the housebound rate also resulted in incorrect benefits decisions. OIG made a number of recommendations including that VBA establish plans to update the electronic system, conduct reviews of cases in which housebound benefits are being paid, and provide updated training to staff. VBA concurred with OIG recommendations.

- After receiving an anonymous allegation that staff at a VA Regional Office (VARO) were inappropriately shredding mail regarding veterans' disability compensation claims, OIG conducted an unannounced inspection at the facility in February 2015. Although we could not quantify or identify claims-related documents that the VARO may have shredded prior to our review, we did find nine claims-related documents inappropriately placed in shred bins and substantiated that the VARO staff were not following current Veterans Benefits Administration's (VBA) policy on management of veterans' and other Governmental paper records. Eight of the nine documents had the potential to affect veterans' benefits and one had no effect on the veterans' benefits. We did not substantiate that VARO supervisors were instructing their staff to shred claims-related documents. OIG recommended that the VARO Director implement a plan and provide training to ensure that all VARO staff comply with VBA's policy for handling, processing, and protection of claims related documents and other Government paper records. OIG also recommended that the VARO director take proper action on the eight cases that had the potential to affect veterans' benefits. We then conducted unannounced inspections at 10 other VAROs to determine if this was a systemic issue. OIG found that VBA's controls were not effective to prevent VARO staff from potentially destroying claims-related documents.

- OIG conducted an audit to determine whether VBA was adjusting compensation and pension (C&P) benefits payments in a timely manner for veterans incarcerated for more than 60 days in Federal, state, or local penal institutions. OIG found that VARO and Pension Management Center staff did not consistently take action to adjust C&P benefits for veterans incarcerated in Federal penal institutions. Specifically, based on Federal incarceration data from May 2008 through June 2015, employees did not adjust veterans' C&P benefits, as required, for an estimated 1,300 of 2,500 cases (53 percent), which resulted in improper payments totaling approximately $59.9 million. Although VBA had a computer matching agreement (CMA) in place with the U.S. Department of Justice, Federal Bureau of Prisons (BOP) to obtain monthly data on individuals confined in Federal penal institutions, VBA did not receive this data because it could not ensure a secure method for receiving it. VBA also failed to effectively monitor the terms of the CMA, which lapsed in

2012. Although VBA later renewed the CMA and started receiving the incarceration information from BOP in May 2015, VBA Central Office and VARO leadership did not make the work a priority due to the scope of the disability claims backlog. OIG recommended and the Acting Under Secretary for Benefits (USB) concurred that VBA needs to increase the priority of its incarceration adjustment workload.

- OIG conducted a review to determine whether VA complied with the requirements of the Improper Payments Elimination and Recovery Act (IPERA) for FY 2015. The Office of Management and Budget (OMB) Circular A-123 specifies that each agency's IG annually review improper payment reporting in the agency's Performance and Accountability Report (PAR) or the Agency Financial Report (AFR). OIG's review found VA did not fully comply with IPERA. VA met four of six IPERA requirements for FY 2015 by publishing the AFR; performing risk assessments; publishing improper payment estimates; and providing information on corrective action plans. VA did not comply with two of six IPERA requirements by not maintaining a gross improper payment rate of less than 10 percent and meeting reduction targets for all programs published in the AFR. Two programs exceeded the 10 percent threshold: VA Community Care and Purchased Long Term Care Support and Services. Eight programs did not meet reduction targets: Compensation; Education Chapter 1606; Education Chapter 1607; VA Community Care; Purchased Long Term Services and Support; Beneficiary Travel; Supplies and Materials; and Disaster Relief Act (Hurricane Sandy) activities under P.L. 113-2. In addition, VHA underestimated improper payments for one program and did not achieve the expected level of accuracy for two others. Likewise, VBA expended considerable effort to collect improper payments because of a program design issue with drill pay, and it needs to develop a plan and seek the assistance of OMB to coordinate future resolution.

Criminal and Administrative Investigations

- A non-veteran owner of a Service-Disabled Veteran-Owned Small Business (SDVOSB) was found guilty at trial of conspiracy and wire fraud. A VA OIG, Small Business Administration OIG, General Services Administration OIG, Army Criminal Investigation Command, and Naval Criminal Investigative Service investigation revealed that the defendant established a Massachusetts-based SDVOSB company in 2006 and recruited two disabled veterans as the company's straw owners for the sole purpose of obtaining Federal construction contracts set aside under the SDVOSB program. As a result of the defendant's false representations to Federal contracting officers that the company was owned and operated by those service disabled veterans, the company was awarded more than $112 million in Federal contracts between 2006 and November 2010, of which $110 million were VA contracts. The case involved over 200 VA construction contracts in seven states. The non-veteran owner was sentenced to 30 months' incarceration, 12 months' supervised release, and was ordered to pay a $1 million dollar fine. Criminal asset forfeiture proceedings are still pending.

- A husband and wife were convicted at trial of major fraud against the Government, wire fraud, and conspiracy to commit wire fraud. A VA OIG, Department of the Interior OIG, and SBA OIG investigation revealed that the defendants used a "pass-through" scheme to create a SDVOSB in order to qualify for and obtain VA SDVOSB set-aside construction contracts in Kentucky, Tennessee, North Carolina, and other states. The defendants used a service-disabled veteran who was a full-time truck driver and had no construction experience or equipment to establish a construction business, and provided fraudulent references to VA and other Government agencies in order to obtain the work. The defendants also created another business to obtain SBA 8(a) set-aside contracts with the two businesses sharing employees, financial assets, and then subcontracting out the work on most projects. The loss to VA is $4 million, including American Recovery and Reinvestment Act (ARRA) funds enacted under P.L. 111-5. The total loss to the Government is approximately $14 million.

- A former VAMC Chief was found guilty at trial of making false statements in relation to health care and making a false statement to a Federal agent. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 non-VA care coordination consults at the VAMC. Specifically, the defendant directed his subordinates to falsely document, "Services provided or patient refused services" in the patients' VA electronic medical records even though employees had not reviewed the records or contacted the patients. OIG's OHI conducted a review of approximately 2,700 patient records and determined that over 450 patients never received care and/or refused services. This case was the first OIG "Wait Time" investigation that resulted in criminal charges and a subsequent conviction.

- A former VAMC employee and a non-veteran co-conspirator were each sentenced to 30 months' incarceration, 3 years' supervised release, and were ordered to pay restitution of $1,137,694 after pleading guilty to conspiracy, theft of Government funds, wire fraud, and engaging in monetary transactions in property derived from specified unlawful activity. An OIG, Department of Justice (DOJ), and VA Police Service investigation revealed that the defendants created a fictitious medical supply company and then the former VAMC employee had the company approved as a vendor to provide medical supplies to VA. From 2007 to 2013, the defendants created fraudulent purchase orders for medical supplies that were never delivered to VA. Fraudulent invoices were then paid using the former VAMC employee's Government-issued purchase card. The fraudulently obtained payments that were then divided between the defendants.

- A veteran's widow was sentenced to 50 years' incarceration after being found guilty at trial of attempted first degree murder and conspiracy to commit first degree murder. A VA OIG, Social Security Administration (SSA) OIG, Tennessee Bureau of Investigation, and State District Attorney's Office investigation resulted in the defendant and her previous boyfriend/current spouse being charged with conspiracy to murder her previous husband, a combat veteran and VA beneficiary, by forcing him to overdose on his VA prescribed drugs and then staging a crime scene to make it appear

that he had committed suicide. The defendant later applied for Dependency and Indemnity Compensation benefits and falsely claimed that her husband's drug overdose was related to his service connected post-traumatic stress disorder. The homicide investigation was initiated pursuant to information that was developed during the compensation benefits fraud investigation. The widow and her current spouse were subsequently convicted of defrauding VA and SSA of over $457,000 in disability compensation. The widow was sentenced to 20 months' incarceration and her current spouse to 30 months' incarceration for the compensation fraud. The defendant's current spouse previously pled guilty to conspiracy to commit first degree murder and testified against her at trial in exchange for a reduced sentence of 25 years' incarceration. The loss to VA is approximately $107,000.

- The president of a private business was arrested for conspiracy to commit wire fraud while attempting to fly to Guatemala. A VA OIG, FBI, and Department of Education OIG investigation revealed that the defendant engaged in a conspiracy to defraud the VA by fraudulently obtaining tuition assistance and other education related benefits under the Post-9/11 G.I. Bill. Over the course of the conspiracy, the defendant partnered with a New Jersey university to obtain approval from VA to receive tuition and other education benefits for several online non-credit training and certification courses. These courses were purportedly developed, taught, and administered by the faculty of the university, but were actually developed, taught, and administered by undisclosed and unapproved subcontractors of the private business. The defendant and others developed marketing materials and a script to be used by the private business' salespersons at various military bases around the United States, in order to market to and enroll thousands of veterans in the courses. While most courses at the correspondence school cost between approximately $600 and $1,000 in tuition, the university charged between approximately $5,000 and $26,000 per course. Over the course of the conspiracy, the defendant and others caused VA to pay out over $35 million.

- Three defendants were sentenced to a combined total of 48 months' probation, 250 hours' community service, and a $2,700 fine. The defendants also agreed to pay $30,000 in civil monetary penalties to VA as part of the related civil case. A VA OIG and SBA OIG investigation revealed that the defendants used a "pass-through" scheme to create a SDVOSB in order to qualify for and obtain VA SDVOSB set-aside construction contracts at the San Juan, PR, VAMC. The defendants created the fraud scheme by using a service-disabled sibling who was a full time United States Postal Service employee and had no construction experience or equipment to establish a new construction business. The defendants created the SDVOSB after learning that construction contracts would only be awarded to SDVOSBs as a result of a Government stimulus package. The VA contracts included ARRA funds and were worth approximately $8.4 million.

- An architect, formerly employed by a VA contractor, was sentenced to 33 months' incarceration, a $12,500 fine, and was ordered to forfeit $70,801 after being convicted at trial of conspiracy, wire fraud, mail fraud, theft of Government property, and

violating the Hobbs Act. An OIG and FBI investigation revealed that the defendant bribed the former Directors of two VAMCs in order to receive nonpublic information concerning VA contracts. As a result, the defendant was able to obtain an advantage over other companies in the awarding of VA contracts. The former VAMC Director pled guilty to corruption-related charges in 2014. In addition, the company the architect worked for entered into a Criminal Enforcement Agreement (CEA) with the Government to resolve criminal liability for its employee(s) criminal conduct. Per the CEA, the contractor accepted legal responsibility for the criminal conduct and agreed to pay a $12,000,000 penalty. Attached to the CEA are a Criminal Information, signed Waiver of Indictment, and Statement of Facts that will be filed in U.S. District Court if the contractor fails to comply with the terms of the CEA.

Contract Reviews

- OIG completed 127 contract reviews—78 pre-award, 39 post-award, and 10 claim reviews—related to VA contracts, identifying $548.2 million in potential savings and other monetary benefits including $12.3 million in recoveries returned to the Government. A highlight from one of these reviews follows below.

- OIG reviewed three separate contracts awarded by a VA HCS to a private medical practice. OIG found that the VA HCS lacked adequate internal controls and systems to effectively monitor contract performance which contributed to erroneous invoices, improper reimbursement rates, and inadequate documentation of administrative and overhead expenses. OIG made several recommendations including a requirement to implement a process to adequately administer the performance of all physician contracts and a requirement to consult with Regional Counsel when contracts involve dual appointed physicians. VA concurred with these findings.

Budget Highlights

A common theme across OIG reporting during the past three years is that the breakdown in effective stewardship of VA programs and services is often related to failures in recognizing increased demand and allocating resources appropriately. The 2018 budget will be used to continue our effort to “right size” the OIG to an appropriate ratio to VA given its size, scope, and program complexity. As we have mentioned in previous budgets and in recent testimony before Congress, OIG funding lags that of comparably situated Federal OIGs; the current budget request of $159.6 million is less than 0.1 percent of the total enacted VA budget of $180.4 billion in FY 2017.

The 2018 budget request (with carryover) will support modest growth of 60 FTE. Staff increases beyond those related to the assumption of Contract Review operations (26 FTE) will be deployed at new and existing locations nationwide to help OIG fulfill its statutory mission to identify waste, fraud, or abuse and make recommendations that help VA provide care and benefits to a growing cohort of veterans with increasingly complex needs. Special focus areas and activities supported by this budget request are listed below.

- Improving the quality and scope of VHA patient care through:
    - A newly established Access to Care Division that will focus on mitigating wait times and eliminating barriers to care;
    - A newly established Rapid Response Team that will respond to emergent high risk clinical allegations at VHA facilities;
    - Enhanced healthcare inspections under the risk-based CHIP assessments formerly known as the Combined Assessment Program (CAP);
    - Increased numbers of site visits and inspections and compliance reviews of hospitals and clinics;
    - Greater emphasis and focus on women's health, military sexual trauma, substance use disorders, suicide prevention and crisis outreach, and mental health; and,
    - Increased support for combat wounded veterans with traumatic brain injuries, who often lack adequate treatment options in their local communities.
- Ensuring adequate staff are in place and can be responsive to review the increased number of Hotline contacts and complaints.
- Increasing the number of Hotline cases completed by OIG staff to decrease the referral of external case referrals to VA, thus yielding greater numbers of OIG investigative cases and published reports of inspections, reviews, and audits.
- Detecting and deterring criminal activity related to identity theft, procurement fraud, fiduciary and workers compensation fraud, drug diversion, and other instances of emergent criminal activity.
- Strengthening the integrity of VA benefit programs and support services through a concomitant increase in audits and reviews of Patient Centered Care and Non-VA Fee Care contracts, construction projects, medical care collections, information technology projects, prosthetics, and research activities.

The 2018 personal services estimate reflects salary and benefits for 820 FTE including the costs for proposed pay raises, career ladder advancements, scheduled within-grade increases, changes in staff composition, and retirement benefits. The non-personnel services estimates reflect requirements for inflation, travel, transportation, rents for office space, contractual services, training, communications, OIG technology upgrades, other equipment replacement, and operating supplies to support OIG operations and staffing at the requested level.

OIG is ending its intra-agency reimbursement agreement with VA in the second half of FY 2017 and will support the Office of Contract Review with direct budget authority moving forward. OIG will continue to perform contract support services including pre and postaward and contract pricing reviews.

Budget Submission Requirements of the *Inspector General Act*

This budget request was prepared in accordance with Section 6(f)(1) of the Inspector General Act of 1978. OIG's FY 2018 budget request to VA was $170,000,000 and, in consideration of the Administration's efforts to scale back the size of the Federal government and the impact of the hiring freeze, already reflected a significant reduction from our original expansion plan. Although funding at $159,606,000 will not adversely impact current operations, it will delay expansion towards an optimal level of strength necessary to fully meet requirements tied to the growth of VA programs in recent years. This request includes $319,212 as OIG's estimated allocation to support the Council of Inspectors General on Integrity and Efficiency (CIGIE), and up to $2,100,000 for OIG employee training. The Inspector General certifies that the requested amounts will meet OIG's known 2018 requirements for CIGIE support and employee training. In addition, OIG requests that $2,500,000 be set aside in the 2018 VA Minor Construction appropriation request to support OIG expansion needs.

OIG continues to identify efficiencies and opportunities to reduce and control costs for employee travel, conferences, training, Government vehicles, technology, and other areas as required by Executive Order 13589, *Promoting Efficient Spending*. However, as the Executive Order recognized, OIG employees must travel extensively to VA facilities across the country to perform its statutory oversight of VA programs. This means that opportunities to further reduce travel costs are limited. OIG has reprogrammed identified efficiencies back into operations to sustain the level of oversight to the extent possible.

Summary of Employment and Obligations (Dollars in Thousands)					
		2017			
	2016 Actual	Budget Estimate	Current Estimate	2018 Request	Increase (+) Decrease (-) from 2017
Average employment:					
Headquarters functions	224	263	248	262	14
Operations functions	482	558	525	558	33
Total employment	**706**	**821**	**773**	**820**	**47**
Obligations:					
Personal services	$112,893	$133,978	$126,650	$137,035	$10,385
Travel	$5,392	$6,523	$6,011	$6,445	$434
Transportation of things	$107	$291	$339	$345	$6
Rents, communications, and utilities	$1,941	$9,231	$8,441	$9,025	$584
Printing and reproduction	$30	$43	$30	$33	$3
Other services	$9,071	$13,501	$15,136	$12,707	($2,429)
Supplies and materials	$410	$481	$544	$575	$31
Equipment	$2,202	$1,855	$3,561	$3,835	$274
Insurance	$0	$0	$0	$0	$0
Total obligations	**$132,046**	**$165,903**	**$160,712**	**$170,000**	**$9,288**
Reimbursements	($4,447)	($5,797)	($2,500)	$0	$2,500
SOY Unobligated Balance (-)	($1,183)		($9,000)	($10,394)	($1,394)
EOY Unobligated Balance (+)	$10,350		$10,394		($10,394)
Total Budget Authority	**$136,766**	**$160,106**	**$159,606**	**$159,606**	**$0**

Note: Total subject to rounding.

Net Change and Employment Tables

The following table summarizes the changes in resource requirements between the 2017 President's Request and this 2018 request.

Net Change – 2018 Summary of Resource Requirements (Dollars in Thousands)	
	Budget Authority
2017 Budget Authority (President's Request)	**$160,106**
Enacted Rescission	($500)
2017 Budget Authority (Current Estimate)	**$159,606**
2018 Increases/Decreases:	
Pay raise (1.9%), career ladder promotions and within-grade increases, and other staff composition adjustments	$1,716
Required personnel benefits increases	$652
Tiered Staff Expansion (60 FTE)	$8,849
Non-payroll inflation (1.7%)	$571
Net carryover change (SOY/EOY)	($11,788)
Subtotal	**$0**
Subtotal 2018 Current Request	**$159,606**
2018 Total Budget Authority Request	**$159,606**

The following tables present analyses of OIG employment levels by grade and by headquarters and operations functions.

Employment Summary—FTE by Grade				
Grade	2016 Actual	2017 Estimate	2018 Request	Incr./Decr. from 2017
IG/Senior Executive Service (SES)	14	18	20	2
Senior-Level (SL)	6	7	9	2
GS-15	69	70	73	3
GS-14	130	137	148	11
GS-13	370	400	424	24
GS-12	51	52	53	1
GS-11	25	33	33	0
GS-10	0	3	3	0
GS-9	25	30	30	0
GS-8	11	14	15	1
GS-7	4	7	9	2
GS-6	0	0	0	0
GS-5	1	2	3	1
GS-1—4	0	0	0	0
Grand Total FTE	**706**	**773**	**820**	**47**

Analysis of 2016 Actual FTE Distribution – Headquarters/Operations		
Grade	Headquarters	Operations
IG/SES	14	0
Senior-Level (SL)	5	1
GS-15	35	34
GS-14	50	80
GS-13	77	293
GS-12	20	31
GS-11	10	15
GS-10	0	0
GS-9	7	18
GS-8	1	10
GS-7	4	0
GS-6	0	0
GS-5	1	0
GS-1—4	0	0
Grand Total FTE	**224**	**482**

Other Requirements

Physicians' Comparability Allowance Worksheet

The Office of Management and Budget directed that following information on OIG's use of Physician Comparability Allowance (PCA) be included in this budget submission.

VA Office of Inspector General

		PY 2016 Actual	CY 2017 Estimates	BY 2018* Estimates
1) Number of Physicians Receiving PCAs		13	16	17
2) Number of Physicians with One-Year PCA Agreements		–	–	–
3) Number of Physicians with Multi-Year PCA Agreements		13	16	17
4) Average Annual PCA Physician Pay (without PCA payment)		$167,250	$165,549	$165,949
5) Average Annual PCA Payment		$29,384	$28,338	$29,400
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	–	–	–
	Category II Research Position	–	–	–
	Category III Occupational Health	–	–	–
	Category IV-A Disability Evaluation	–	–	–
	Category IV-B Health and Medical Admin.	13	16	17

*FY 2018 data will be approved during the FY 2018 budget cycle.

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Not applicable.

1) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

Physicians with 48 months or more of Government service at the GS-15, SL, or SES levels may receive a maximum of $30,000 annually. OIG will pay the minimum PCA amount required to overcome recruitment and retention problems. Accordingly, OIG will base the amount on such considerations as relative earnings, responsibilities, expenses, workload, working conditions, and benefits for comparable physician positions inside and outside the Federal Government.

2) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist). (*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

VA OIG utilizes PCA because its physician-employees are covered by Title 5, U.S. Code. This is different from the rest of VA, which employs physicians under Title 38. The difference in pay rates between Title 5 and Title 38 physicians can be substantial. Title 38 physicians receive significantly higher salaries than Title 5 physicians, even when PCA and performance bonuses are considered.

3) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year. (*Please include any staffing data to support your explanation, such as number and duration of unfilled positions and number of accessions and separations per fiscal year.)*

Prior to OIG receiving approval to offer PCA, it was very difficult to recruit physicians and indicates why PCA is critical to OIG for recruiting and retaining Board-certified physicians. As a result of utilizing the PCA function, we have been able to recruit four highly qualified physicians in fiscal year (FY) 2016.

4) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

With a ceiling of just over 140 employees, the Office of Healthcare Inspections is the smallest of OIG line organizations. The retention of physicians is appropriate based upon OHI's mission of providing independent oversight of VHA, which is responsible for providing health care to more than 22 million veterans at hundreds of medical facilities with more than 369,000 employees. For fiscal year (FY) 2017, VA operated under a $180.4 billion budget, which allows for facilities in every state, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Republic of the Philippines, and the U.S. Virgin Islands.

Further, the Secretary of Veterans Affairs continues to support health care mandates, such as improving Veteran mental health care, designing a veteran-centric health care model, and expanding health care access. In addition to these initiatives, the expansion of VHA health care services to accommodate the increasing numbers of veterans receiving care following service in Operations Enduring Freedom/Iraqi Freedom/New Dawn underscores the need and importance of OIG retaining the number of Board-certified physicians to ensure effective oversight of the quality of VA health care.