DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Management and Administration

Budget Request for Fiscal Year 2020

BUDGET REQUEST

APRIL 30, 2019

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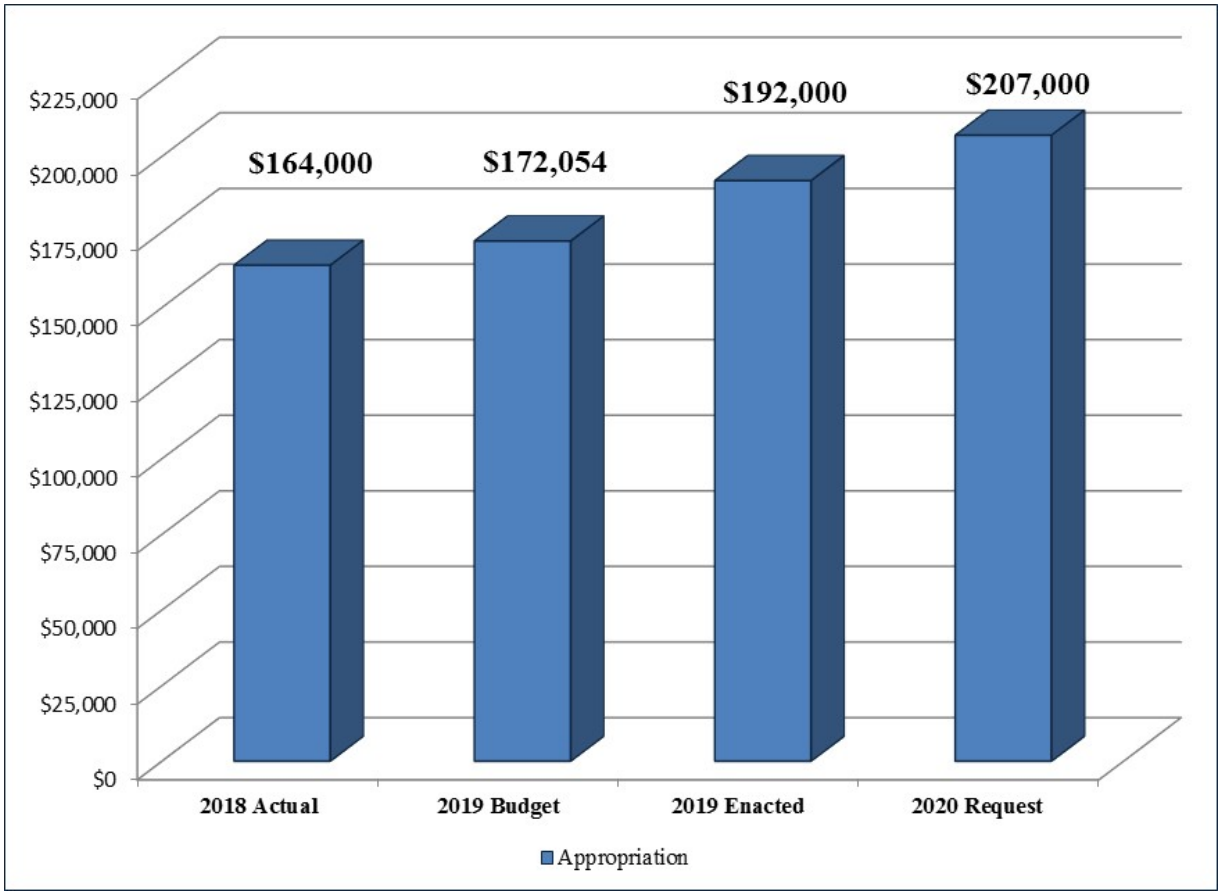
Summary of Budgetary Resources — Inspector General
(Dollars in Thousands)



Summary of Budget Request

(Dollars in Thousands)	2019	FTE	2020	FTE
Office of Inspector General				
Budget Authority	$192,000	975	$207,000	1,000
Total Budgetary Resources	**$192,000**	**975**	**$207,000**	**1,000**

The Office of Inspector General (OIG) requests $207 million and 1,000 FTE in 2020 to fulfill statutory oversight requirements and sustain the investments made in people, facilities, and technology during the last three years. The 2020 budget supports FTE targets envisioned under a

multi-year effort to grow the OIG to a size that is more appropriate for overseeing the approximately 380,000 VA personnel and the Department's steadily rising spending on new complex systems and initiatives. These include a new electronic health record system, which is expected to cost more than $16 billion over the next ten years, and VA's expanding care in the community programs. The 2020 budget request will also provide sufficient resources for the OIG to continue to timely and effectively address the increased number of reviews and reports mandated through statute.

The VA OIG has one of the smallest ratios of oversight staff to agency staff among larger Inspectors General offices and is funded at a level of less than 0.1 percent of the total VA budget. The 2020 budget request normalizes OIG fiscal requirements to an annualized basis and provides the OIG with the resources to conduct proactive and impactful reviews of critical VA programs necessary to improve access and quality of services for veterans and their dependents. The OIG's average return on investment over the last three fiscal years is $43 for every dollar appropriated. That return includes more than $389 million in recoveries, fines, penalties, restitutions, and civil judgements, which substantially counterbalanced the OIG's operational cost. The increase in the OIG budget will serve to strengthen the OIG's abilities and allow for an even greater impact.

The 2020 request is based on consideration of onboard staff hired to date with enacted funds and the level of stakeholder support to include recent 2019 appropriation action. With respect to staffing, expansion efforts continue to progress favorably, though an unobligated balance from 2018 was carried forward due to delays in recruiting specialized positions and activating field offices. The OIG averaged 848 FTE in 2018, an increase of 172 FTE since 2015 (676) and can support up to 975 FTE in 2019 with enacted funding of $192 million. For 2020, the OIG requests an additional 25 FTE to support new oversight requirements and plans to plateau staffing at approximately 1,000 FTE for the near term, absent a significant expansion of VA programs; legislative mandates; or new, high-impact oversight initiatives. Regarding the trend for enacted funding, as outlined in the table below, the OIG's budget in recent years was at or above the Senate Appropriation Committee mark-up. This underscores Congressional support to strengthen the OIG's oversight capacity.

Budget Progression - Multiyear Comparison				
Fiscal Year	**President's Budget**	**House Mark**	**Senate Mark**	**Enacted**
2014	$116M	$116M	$121M	$121M
2015	$121M	$122M	$126M	$126M
2016	$127M	$131M	$127M	$137M
2017	$160M	$160M	$160M	$160M
2018	$160M	$158M	$164M	$164M
2019	$172M	$172M	$192M	$192M

The OIG's current operational profile is approximately $199 million (sum of the 2019 enacted budget of $192 million and $7 million in carryover from 2018). Although carryover is well below statutory limits, OIG will continue efforts to minimize unobligated balances moving forward and align operational costs to an annual appropriations profile.

The majority of OIG employees are field staff located outside of the Washington DC metropolitan area who conduct audits, inspections, reviews, and investigations. They are either co-located on VA campuses or stationed proximate to the VA facilities they oversee. Additionally, the OIG

includes several teams in the DC metropolitan area who have similar responsibilities. These include the OIG Hotline Division, Contract Review Division, Office of Healthcare Inspections' Office of Medical Consultation and Review, and field offices in Washington, DC; Arlington, VA; and Baltimore, MD. Because payroll comprises over 80 percent of operational costs, funds provided in 2020 must cover salaries and benefits for all OIG employees, including law enforcement officers who receive law enforcement availability pay and physicians who receive physician comparability allowances (PCA). The OIG will continue to manage inflationary costs associated with payroll and fixed requirements for space, contracts, and mission-essential travel, as necessary.

The 2020 budget request ensures the OIG has the necessary resources to address many serious challenges that undermine the quality and efficiency of VA programs and services and pose unacceptable risks to veterans and the taxpayer. These challenges include leadership and workforce investment shortcomings, systemic barriers to the delivery of health care, inconsistent benefits determinations, weak financial management and procurement practices, and vulnerable information security protocols. The OIG plans to continue to deploy and maintain a cadre of objective, responsive, highly trained, and dedicated employees at locations nationwide, especially near facilities where a more significant presence is required or there is an increased demand for oversight work. The OIG is also establishing two new inspections teams to address long-standing challenges faced by the VA: one team will conduct in-depth financial inspections of VA facilities and another will focus on the provision of outpatient and community care, particularly in rural areas. These professionals will strengthen the OIG's capacity to meet emergent threats, fulfill its statutory mission and achieve organizational and strategic goals. Additional information on the 2020 request and planned staffing efforts appears in the Budget Highlights section below.

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, $207,000,000 [$192,000,000] of which not to exceed 10 percent shall remain available until September 30, 2021 [2020].

Inspector General Mission, Vision, and Values

As authorized by the *Inspector General Act of 1978* and other enacted legislation, the Inspector General is responsible for conducting and supervising audits and investigations, and making recommendations to promote economy, efficiency, and effectiveness. The OIG is authorized to inquire into all VA programs and activities, including healthcare programs as well as VA-related contracts, grants, and other agreements. The OIG is required to report to Congress on activities and outcomes every six months. These semiannual reports (SARs) keep stakeholders informed about the challenges VA is experiencing and promote transparency for OIG's operations.

The Inspector General made a number of relatively recent enhancements to the office's practices, policies, and operations. These initiatives represent concerted OIG efforts to focus on higher-risk and impactful areas throughout VA in order to provide more proactive and effective oversight. OIG's Mission, Vision, and Values inform these efforts.

Mission. To serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

Vision. To be recognized as an independent and fair voice for veterans and their families that makes meaningful improvements to VA programs and services, while being responsive to the concerns of veterans' service organizations, Congress, VA employees, and the public. To achieve this vision, the OIG will

- Make meaningful recommendations that enhance VA programs and operations, as well as prevent and address fraud, waste, and abuse;
- Identify opportunities to promote economy, efficiency, and effectiveness throughout VA and help ensure taxpayer dollars are appropriately spent;
- Safeguard the OIG's independence, consistent with governing laws and policy;
- Identify impactful issues proactively and strategically;
- Produce reports that meet quality standards, including being
  - Accurate,
  - Timely,
  - Proportionate,
  - Objective, and
  - Thorough;
- Act with transparency by promptly releasing reports that are not otherwise prohibited from disclosure;
- Promote accountability of VA employees; and
- Treat whistleblowers and others who provide information to the OIG with respect and dignity, including protecting the identities of individuals who wish to remain anonymous.

Values. OIG conduct will be guided and informed by adherence to the following

- Meet the highest standards of professionalism, character, ethics, and integrity and accept responsibility for actions.
- Maintain a collaborative and engaging work environment that attracts, develops, and retains the highest quality staff.
- Promote diversity, individual perspectives and expertise, and equal opportunity throughout the OIG.
- Honor veterans and the individuals who serve them by continually striving for excellence.

Strategic Plan and Goals

The OIG's *Strategic Plan 2018–2022* includes five strategic goals that are responsive to areas of need identified by VA, Congress, external agencies and organizations, the veteran community, other stakeholders, and OIG Hotline personnel and staff in the field. They reflect the OIG's unwavering commitment to veterans, their families, and the public, while providing needed support to the VA leaders and staff who serve them.

- **Goal 1: Healthcare Services**. Improve veterans' access to exemplary health care by identifying opportunities to improve the quality, management, efficiency, and delivery of patient-centered care in VA facilities and in the community.
- **Goal 2: Benefits for Veterans.** Help ensure that veterans and their families receive benefits in a timely manner and superior services for which they are eligible and make recommendations to advance expeditious and accurate VA decision-making and processes for delivering benefits.
- **Goal 3: Stewardship of Taxpayer Dollars**. Identify procedures and strategies for making the most responsible use of VA appropriated funds, including sound and closely monitored procurement practices and financial systems that reduce the risk of fraud, waste, and misuse of resources.
- **Goal 4: Leadership and Governance**. Address emergent, pervasive, and persistent problems within VA that have arisen or gone unaddressed because of failures in leadership, including lack of accountability, poor governance, staffing deficits, and misconduct by individuals in positions of trust.
- **Goal 5: Information Systems and Innovation**. Assess and recommend enhancements to VA's infrastructure systems, including information technology, data security, and financial management that support VA operations. Through findings and report recommendations, highlight practices that promote quality standards that can be implemented throughout VA, particularly those that effectively use program planning, budget forecasting, and other predictive tools.

These goals will be advanced through VA OIG audits, inspections, reviews, and investigations that have the greatest impact on veterans' lives, investments of taxpayer dollars, and the public interest. Examples of recently published reports that align with each goal are presented in the table below.

Goal 1: Healthcare Services.

- *Review of Two Mental Health Patients Who Died by Suicide, William S. Middleton Memorial Veterans Hospital Madison, Wisconsin,* Report No. 17-02643-239, August 1, 2018.
- *Healthcare Inspection – Testosterone Replacement Therapy Initiation and Follow-Up Evaluation in VA Male Patients,* Report No. 15-03215-154, April 11, 2018.
- *Healthcare Inspection – Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility, Report No. 16-03576-53, January 4, 2018.*
- *Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System,* Report No. 17-00414-376, November 16, 2017.
- *Healthcare Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line*, Report No. 16-03985-181, March 20, 2017.

Goal 2: Benefits for Veterans.

- *VA's Oversight of State Approving Agency Program Monitoring for Post-9/11 GI Bill Students,* Report No. 16-00862-179, December 3, 2018.
- *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma,* Report No. 17-05248-241, August 21, 2018.
- *Program of Comprehensive Assistance for Family Caregivers: Management Improvements Needed,* Report No. 17-04003-222, August 16, 2018.
- *Review of Timeliness of the Appeals Process*, Report No. 16-01750-79, March 28, 2018.
- *Healthcare Inspection – Review of Montana Board of Psychologists Complaint and Assessment of VA Protocols for Traumatic Brain Injury Compensation and Pension Examinations,* Report No. 15-01580-108, February 27, 2018.

Goal 3: Stewardship of Taxpayer Dollars.

- *Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment, and Economic Impact*, Report No. 16-04555-138, May 2, 2018.
- *Review of Alleged Split Purchases at the VA St. Louis Health Care System*, Report No. 16-02863-199, July 17, 2018.
- *Review of Research Service Equipment and Facility Management, Eastern Colorado Health Care System,* Report No. 16-02742-77, March 29, 2018.
- *Critical Deficiencies at the Washington DC VA Medical Center,* Report No. 17-02644-130, March 7, 2018.

Goal 4: Leadership and Governance.

- *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages FY 2018*, Report No. 18-01693-196, June 14, 2018.
- *Administrative Investigation - VA Secretary and Delegation Travel to Europe,* Report No. 17-05909-106, February 14, 2018.
- *Healthcare Inspection – Primary Care Provider's Clinical Practice Deficiencies and Security Concerns, Fort Benning VA Clinic, Fort Benning, Georgia,* Report No. 16-03405-80, January 30, 2018.
- *Healthcare Inspection – Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma*, Report No. 16-02676-13, November 2, 2017.

Goal 5: Information Systems and Innovation.

- *Review of Alleged Funding Security Issues of the Veterans Services Adaptable Network at VA Medical Center Orlando, Florida,* Report No. 15-03059-384, January 31, 2018.
- *Review of Alleged Unsecured Patient Database at the VA Long Beach Healthcare System*, Report No. 15-04745-48, March 28, 2018.
- *VA's Federal Information Security Modernization Act Audit for Fiscal Year 2017*, Report No. 17-01257-136, April 11, 2018.

Performance Measures

The OIG's performance measures tie directly to the oversight mission and five strategic goals, and ensure that critical linkages are made between staff work and its impact on the VA and veteran community. Because the OIG's oversight activities encompass all aspects of VA programs and operations, the performance measures and accomplishments are necessarily broad in scope and cross-cutting in nature. Current performance measures include

- Percentage of reports (audit, inspections, investigations, and other reviews) issued that identified opportunities for improvement and provided recommendations for corrective action;
- Percentage of recommendations implemented within one year to improve efficiencies in operations through legislative, regulatory, policy, practices, and procedural changes in VA;
- Monetary benefits (dollar amounts in millions) from audits, inspections, investigations, and other reviews;
- Percentage of recommended recoveries achieved from postaward contract reviews;
- Return on investment (monetary benefits divided by cost of operations in dollars);
- Number of arrests, indictments, convictions, criminal complaints, pretrial diversions, administrative sanctions, and corrective actions; and
- Percentage of investigative cases that result in criminal, civil, or administrative actions.

Stakeholders and Partners

The OIG's oversight work encompasses all VA programs and operations, services, functions, and funding. As such, its stakeholders include the Secretary, VA managers and staff, Congress, Veterans Service Organizations, beneficiaries, taxpayers, affiliated healthcare and educational institutions, contractors, other federal agencies, law enforcement organizations, and other OIGs. Much of the OIG's work depends on the cooperation and coordination of these stakeholders, making them partners in some capacity for important improvement and oversight efforts.

Program Description

The Inspector General (IG), in collaboration with the Deputy IG, provides executive leadership and sets strategic direction for a nationwide staff of auditors, investigators, inspectors, and support personnel who conduct independent oversight of the second largest Department in the federal government, the VA. OIG oversight is designed to improve the economy, effectiveness and efficiency of VA programs, and to prevent and to detect criminal activity, waste, abuse, and fraud. The OIG is headquartered in Washington, DC and has more than 40 field offices throughout the country.

Immediate Office of the Inspector General. The Immediate Office of the IG is the focal point for all contacts with the Office of the VA Secretary, congressional staff, the media, and other federal IG organizations. The office serves as the central coordination point for all executive correspondence, congressional testimony, and external reporting requirements.

The Office of Counselor to the Inspector General. The Counselor's office provides independent legal advice to OIG leaders and is involved in all aspects of OIG operations. OIG attorneys provide legal support for investigations, audits, and inspections; work with OIG investigators in developing qui tam and False Claims Act matters; represent the OIG in employment litigation and personnel matters; and inform legislative proposals and congressional briefings. The Counselor's office also oversees the work of the Release of Information Office and the Office of Contract Review.

Office of Contract Review. Under the supervision of the Counselor, the office provides preaward, postaward, and other pricing reviews of Federal Supply Schedule, construction, and healthcare provider contracts. Preaward reviews provide VA contracting officers with assistance and information needed to negotiate fair and reasonable prices, and to protect the interest of the veteran and the taxpayer. Postaward reviews assess compliance with contract terms and conditions and recover identified overcharges.

Office of Investigations. The Office of Investigations (OI) conducts criminal investigations of wrongdoing within VA programs and operations. Criminal investigations focus on activities such as fraud against VA committed by beneficiaries, fiduciaries, contractors, and employees, and theft and diversion of drugs by employees and others. Through criminal prosecutions, administrative sanctions, and monetary recoveries, OIG's investigations promote integrity, patient safety, efficiency, security, and accountability in VA.

Office of Audits and Evaluations. The Office of Audits and Evaluations (OAE) conducts performance and financial audits and other evaluations of VA health care, benefits, financial management, procurement, and information management programs. These audits and evaluations provide useful and practical recommendations to improve the economy, efficiency, and effectiveness of VA management, programs, services, operations, and systems. OAE also conducts inspections of benefits processing activities at VA regional offices. Additionally, OAE oversees the following congressionally mandated recurring reviews

- Review of VA's publication of staffing and vacancies under the requirements of the VA Mission Act of 2018;
- Audit of VHA's capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord dysfunction, blindness, amputations, and mental illness, as required under 38 U.S.C. § 1706;
- Consolidated financial statement audit that assesses VA's financial management systems and information under the requirements of the *Chief Financial Officers Act of 1990*;
- Evaluation of VA's information security programs and controls required by the *Federal Information Security Management Act of 2002* (FISMA);
- Evaluation of requirements under the *Digital Accountability and Transparency Act of 2014* (DATA);
- Review of VA's compliance with the *Improper Payments Elimination and Recovery Act* (IPERA);
- Report on VA employees who violated agency policies regarding purchase cards or convenience checks and summarize all adverse personnel action, punishment, or other action taken based on each violation under the requirements of the *Government Charge Card Abuse Prevention Act of 2012*; *and*

- Detailed accounting submission review and performance summary review of the Office of National Drug Control Policy as outlined in 21 U.S.C. § 1703 and 1704.

Office of Management and Administration. The Office of Management and Administration provides comprehensive support services to the OIG. This office promotes organizational effectiveness and efficiency by providing reliable and timely personnel, training, financial, budgetary, and IT services to the organization. This office also operates OIG's own internal controls and records management programs. In addition, through the OIG Hotline and follow-up reporting, the office ensures all allegations communicated to the OIG are effectively monitored and resolved in a timely, efficient, and impartial manner.

Office of Healthcare Inspections. The Office of Healthcare Inspections (OHI) conducts oversight aimed at enhancing the safety, effectiveness, and quality of VA healthcare programs and promotes continuous quality improvement. In performing its assigned functions, OHI inspects individual cases, completes cyclical reviews of medical facility operations, evaluates nationwide healthcare programs, and provides clinical consultations to support criminal investigations. OHI ensures consistency and timeliness of responses to allegations that involve the highest risk of adverse clinical outcomes to veterans and impediments to proper patient care. OHI's oversight efforts advance national mandates for creating a more efficient, less costly government. OHI also conducts an annual determination of occupational staffing shortages across the VA, as required by the *Veterans Access, Choice, and Accountability Act*. Inherent in every OHI effort are the principles of continuous quality improvement, a focus on helping VHA to strengthen day-to-day operations, and an emphasis on caring customer service and positive patient outcomes.

Office of Special Reviews. The Office of Special Reviews was created in January 2018 to increase the OIG's flexibility and capacity to quickly conduct reviews of significant events and emergent issues not squarely within the focus of a single existing OIG directorate or office. It is led by an executive director and a deputy director, who are staffing the office with professionals with a broad array of expertise, including attorneys and administrative investigations personnel formerly organized under OI. This office undertakes projects assigned to it by the Inspector General and works collaboratively with the other directorates to review topics and issues of interest that span multiple offices, such as community care for veterans, Congressional requests, emergent events, administrative investigations and allegations of misconduct by senior-level officials.

Office / Directorate	FTE (2018)
Inspector General	10
Counselor	20
Investigations	222
Audits and Evaluations	290
Management and Administration	109
Healthcare Inspections	168
Contract Review	28
Special Reviews	2
Grand Total	**849**

Inspector General Accomplishments

The OIG is proud to serve veterans and the public through a variety of independent, proactive, and principled investigation, audit, review, and inspection programs. Its work is designed to promote efficiency and quality in the administration of VA programs, operations, and services. In order to demonstrate the positive impact that the OIG's efforts yield to both veterans and taxpayers, recent performance metrics and work examples follow. Internal improvements are also discussed to highlight initiatives that address management challenges and better engage and develop highly skilled employees who can fulfill the OIG's mission.

Key Statistics and Related Performance Measures. OIG investigations, audits, reviews, and inspections focus on impactful, higher-risk programs and operations across VA. OIG's reports include recommendations that, if implemented, would yield measurable financial benefits as well as program and operational improvements. The OIG's sustained, high level of performance is reflected in VA's *Annual Performance Plan and Report*. The OIG's *SAR,* including issues 79 and 80 which cover the period of October 1, 2017, to September 30, 2018, further support that the OIG worked efficiently and effectively and published a volume of noteworthy and impactful reports.

Monetary Benefits. During the past two SAR reporting periods, the OIG identified a monetary benefit of more than $2.8 billion in 309 reports issued. **This was a return of about $21 for every dollar invested in the OIG**. For example, the OIG

- Reviewed reexamination requests by VBA and estimated that, from March through August 2017, VBA spent **$10.1 million** on unwarranted reexaminations. The OIG estimated that VBA would waste an additional **$100.6 million** over the next five years unless it ensures that employees only request reexaminations when necessary;
- Determined that six of seven medical facilities assigned 13–30 percent fewer veterans than recommended to primary care providers, equating to an estimated **$169 million** in underutilized provider salaries in FY 2015;
- Sampled 2 million Choice claims and determined that because of weak internal controls over the payment process about 224,000 of the claims were paid in error, with **$39 million** in overpayments by VA to Third Party Administrators;
- Substantiated that VA officials provided inadequate assurance of contractor compliance with OSHA requirements at an Oklahoma medical center excavation site and terminated the contract after paying nearly $5 million, with an estimated additional **$17.5 million** needed to fix identified problems;
- Found delays and inaccuracies in 1,900 of 2,800 Medicaid benefits-reduction cases completed in 2015, resulting in an estimated **$6.9 million** in improper benefits payments (and without proper corrective action would face **$34.5 million** in improper benefit payments from calendar years 2016 through 2020).

In addition, OIG recently completed an audit of VA and State Approving Agencies (SAAs) oversight practices and estimated that up to 86 percent of SAAs fail to effectively monitor or review the eligibility requirements of education and training programs. The OIG estimated that,

without correction, VA could issue an estimated $2.3 billion in improper payments to ineligible programs over the next five years.

The table below summarizes additional information about monetary benefits of the OIG's work.

Measure	Semiannual Report (SAR) Summary		
	Issue 79	Issue 80	Combined
Monetary Benefits (in millions)	**$1,687.4**	**$1,152.7**	**$2,840.1**
Better Use of Funds	$865.8	$164.2	$1,030.0
Fines, Penalties, Restitutions and Judgments	$15.4	$100.4	$115.8
Fugitive Felon Program	$144.2	$94.3	$238.5
Savings and Costs Avoidances	$557.9	$342.7	$900.6
Questioned Costs	$91.2	$397.4	$488.6
Dollar Recoveries	$12.9	$53.7	$66.6
Cost of Operations	**$68.2**	**$67.2**	**$135.4**
Return on Investment	**25:1**	**17:1**	**21:1**
Contract Review Only - Monetary Benefits	**$544.1**	**$268.8**	**$812.9**
Preaward Potential Savings	$532.9	$258.7	$791.6
Postaward Recoveries	$9.1	$7.5	$16.6
Claims Reviews	$2.2	$2.6	$4.8

Program Benefits. In addition to monetary benefits, OIG audits, inspections, investigations, and other reviews identified valuable opportunities to improve VA programs and services. For example, staff's work prompted VA to take the following steps

- Improve the rigor of traumatic brain injury (TBI) compensation and pension assessments by developing a plan to
  - ensure personnel performing those examinations have comprehensive training on the evaluation of TBI, including the assessment and evaluation of cognitive disorders;
  - develop requirements for documenting the TBI examinations process, including the basis for determinations; and
  - consider whether disability ratings should be provided to veterans with claims arising from cognitive issues based on their clinical signs and symptoms, rather than primarily on the diagnoses or causes of their cognitive deficits.
- Strengthen supervision of psychiatric clinical pharmacists to effectively leverage those providers to support high-quality mental health care and ensure that they do not practice outside the scope of their practice.
- Enhance services and address longstanding deficiencies at a large VA medical center, including appointing new leadership, addressing a backlog of prosthetics consults, as well as implementing plans to resolve supply shortages, sterile processing of instrument delays, and unsecured storage areas.
- Reduce the volume of future improper payments recover identified overpayments under the Veterans Choice Program.
- Review approximately 5,500 military sexual trauma (MST)-related claims denied from October 2016 through September 2017, take corrective action on those claims in which VBA staff did not follow all required steps, assign MST-related claims to a specialized

group of claims processors, and improve oversight and training on addressing MST-related claims.

Investigative Actions. The OIG's criminal and administrative investigations led to 247 indictments, 231 convictions, and 465 administrative sanctions during the past two SAR reporting periods. The OIG's work, alone and in collaboration with other federal agencies, led to significant actions, as highlighted by these examples

- *Identification of errors in the billing practices of a contractor that acted as a third-party payer for the VA Choice Program (one of the community healthcare programs).* The contractor reimbursed VA more than **$40 million** for overpayments that it received as a result of improperly submitting duplicate invoices.
- *Arrests of 24 individuals and recoveries of **$2.5 million**, with a projected 5-year savings of **$14.6 million** during the first 6 months of FY 2018, resulting from the OIG's proactive Death Match project.* This project identifies deceased beneficiaries whose benefits continue because VA was not notified of the veteran's death. During FY 2018, the OIG's Death Match project was streamlined to improve accountability and efficiency.
- *Sentencing of a healthcare executive who was found guilty at trial of conspiracy, fraud, wire fraud, and money laundering relating to his and his co-defendants' ownership and operation of multiple Office of Workers' Compensation Program (OWCP) clinics throughout the United States*. The defendant was sentenced to 19 years and five months' incarceration, three years' probation, and was ordered to pay restitution of approximately **$14.5 million**.

The table below summarizes additional information about the OIG's investigative actions.

Measure	Semiannual Report (SAR) Summary		
	Issue 79	Issue 80	Combined
Investigative Actions			
Arrests	150	211	361
Fugitive Felon Arrests (OIG only)	7	3	10
Indictments	106	141	247
Criminal Complaints	45	84	129
Convictions	115	116	231
Pretrial Diversions and Deferred Prosecutions	11	12	23
Case Referrals to the Department of Justice	224	249	473
Administrative Sanctions and Corrective Actions (excludes Hotline)	142	323	465

Hotline Actions. The OIG's Hotline has continued to serve as the key conduit for allegations and information about potential wrongdoing such as fraud, waste, and abuse by operating a toll-free telephone service. Staff also reviews web submissions, letters, and faxes. Hotline staff received and processed over 35,000 contacts from sources concerning problems related to VA programs and operations during the most recent SAR reporting periods, as summarized in the table below. The OIG opened nearly 2,500 cases in response to Hotline contacts, substantiated 40 percent of related allegations, and prompted almost 1,500 administrative sanctions.

Measure	Semiannual Report (SAR) Summary		
	Issue 79	Issue 80	Combined
Contacts	16,320	18,772	35,092
Cases Opened	1,368	1,093	2,461
Cases Closed	1,295	1,323	2,618
Substantiation Percentage Rate	41%	40%	40%
Administrative Sanctions and Corrective Actions (Hotline)	711	737	1,448
Individuals Claiming Retaliation/Seeking Whistleblower Protection	52	62	114

Dissemination. In addition to publishing reports to a public website, the OIG engaged key stakeholders through social and digital media, hearings, roundtable discussions, and briefings to disseminate further the report findings. For example, in 2018, the OIG posted 210 tweets largely focused on reports and other OIG work that resulted in nearly a quarter million impressions (delivery to unique Twitter streams). During the same period, followers of the OIG's Twitter feed increased by more than ten percent to nearly 4,500 followers. In addition, the OIG recently launched a new podcasting program and has published over 20 podcasts that serve as companions to reports, monthly highlights, and other features of the OIG's work. The OIG hosted a roundtable meeting with representatives from veterans service organizations to solicit useful feedback on VA programs and OIG oversight of those programs. With respect to congressional outreach, the Inspector General and OIG senior staff testified at five hearings and participated in two roundtable discussions in 2018 that dealt with issues that were addressed in the OIG's reports and ongoing work, or drew on staff expertise and experience. Topics included opioid use, VA regional office leadership and governance, and occupational staffing shortages. The Inspector General and OIG senior staff also delivered nearly 90 congressional briefings.

Internal Improvements. Performance during the most recent SAR periods indicated that OIG staff produces high-quality work. To build on that strong foundation, and in keeping with continuous improvement efforts, the Inspector General enhanced efforts in 2018 to conduct impactful work by initiating a one-year predictive analytics pilot program. This pilot, which is in collaboration with the Department of Commerce, National Technical Information Service, and joint venture partners, will assist the OIG to leverage big data to inform oversight plans and determine the staffing and other resources needed to support a permanent predictive analytics program.

Also in 2018, the IG expanded training and workforce investment efforts. To that end, the OIG recently launched an updated strategic plan to ensure that all staff are focused on high-impact projects that make the most effective use of taxpayer dollars and promotes leveraging diverse perspectives and expertise. The OIG also implemented several internal training initiatives that seek to promote the values and vision necessary to help VA provide veterans the care they deserve. This included an OIG-wide shadowing program for mid-level employees, further development of the OIG mentoring program, including leader-as-coach training for volunteer mentors, and an interactive training on setting virtual teams up for success. OIG also began conducting an organizational needs analysis to identify key skills and activities required for excellent performance at all levels of the OIG, to identify learning opportunities that will best support all employees.

Budget Highlights

The OIG is requesting $207 million in budget authority in 2020 to support approximately 1,000 FTE, nationwide. These resources will sustain staff and investments in facilities that began in late 2015 as part of our multiyear effort to optimize OIG operations and meet an increasing demand for oversight in a variety of VA program areas. Although this expansion effort will plateau in 2020, OIG will continue to adjust oversight priorities to identify and eliminate the most concerning root causes of issues that prevent the delivery of timely and appropriate health care and benefits services to veterans, their families, and caregivers.

The 2020 request supports the OIG's mission to identify waste, fraud, and abuse and issue recommendations that improve the delivery of services to veterans, many of whom have complex needs. Appropriated resources will support a variety of critical oversight responsibilities including conducting cyclical healthcare inspections, facility reviews, and benefits and procurement audits; responding to potential criminal activity; and evaluating risks and threats to VA infrastructure, such as investments in technology and procurement projects. The budget will also support a number of special focus activities established this year or that will become active in 2019. These include

- Strengthening fiscal practices and operational readiness at VHA medical facilities through structured audits by a new Financial Inspection Team;
- Establishing a Community Care Team to provide comprehensive reviews of care provided to vulnerable veteran populations through non-VA community providers, particularly those in rural areas;
- Improving VA's leadership and governance capacity through reviews of workforce practices, training and credentialing requirements, and staffing shortfalls;
- Expanding the OIG's newest office -- the Office of Special Reviews -- which reports directly to the IG and increases the agency's capacity and flexibility to respond to exigent issues that span multiple OIG mission areas;
- Implementing a permanent predictive analytics program and investigative development division to identify potential threats to VA operations and forecast program elements that are vulnerable to fraud, waste, or abuse.

OIG developed a plan to increase its oversight capacity in response to a review of alleged patient deaths, patient wait times, and scheduling practices at the Phoenix VA Health Care System (PVAHCS) in 2014. This crisis revealed weaknesses in our operational posture that included insufficient numbers of skilled healthcare inspectors, investigators, and other specialized professionals. With congressional support, OIG has utilized budgetary increases over the past three years to increase its staff strength and activate new facilities across the country including Salt Lake City, UT; Denver, CO; Kansas City, MO; Buffalo, NY; Minneapolis, MN; and Trenton, NJ. In 2015, the budget supported about 676 FTE nationwide. In 2018, OIG averaged approximately 849 FTE, an increase of 173 FTE. By the close of 2019, with enacted 2019 funding of $192 million, the OIG can support up to 975 FTE, a gain of almost 300 FTE since the advent of the PVAHCS scandal. OIG is requesting a modest increase of 25 FTE for 2020 to supplement inspection and review teams in the field and recruit critical healthcare professionals.

The 2020 personnel compensation and benefits estimate for 1,000 FTE includes funds to cover the costs of anticipated career ladder advancements and scheduled within-grade increases, agency contributions for retirement, health insurance, transit benefits, Social Security and Medicare, and translocation. The budget request also includes funding for special pay components such as Law Enforcement Availability Pay and Physician's Comparability Allowances. Note however, that consistent with the Administration's budget proposals, the 2019 and 2020 personnel cost estimates do not include a pay raise. The non-personnel services estimate reflects requirements and inflation adjustments for travel, transportation, rent, contractual services, training, communications, supplies, and equipment. OIG funds its own information technology requirements and does not receive any resource allocations from the VA centralized IT account. Additionally, OIG pays for all space requirements that cannot be fulfilled at VA campuses or facilities in the field.

The 2020 budget realigns fiscal operations and more accurately reflects annualized costs. Because the OIG has experienced some delays hiring staff and activating space projects, the level of carryover over the last two cycles has been somewhat higher than anticipated. While OIG is operating within statutory limitations, changes to the current business model and the stabilization of staffing levels will yield smaller carryover moving forward.

Budget Submission Requirements of the *Inspector General Act*

This budget request was prepared in accordance with Section 6(g)(1) of the *Inspector General Act of 1978* as amended.

The OIG's 2020 budget request to VA was for $207,000,000 and 1,000 FTE. This includes $538,200 as OIG's estimated allocation to support the Council of Inspectors General on Integrity and Efficiency (CIGIE), and up to $2,000,000 for OIG employee training. The Inspector General certifies that the requested amounts will meet OIG's known 2020 requirements for CIGIE support and employee training. In addition, OIG requests that $1,500,000 be set aside in the 2020 VA Minor Construction appropriation request to support projects to improve the efficiency and effectiveness of OIG's space utilization.

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 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)					
		2019			
	2018 Actual	Budget Estimate	Current Estimate	2020 Request	Increase (+) Decrease (-) from 2019
Average employment:					
Headquarters functions	176	179	202	207	5
Operations functions	673	648	773	793	20
Total employment	**849**	**827**	**975**	**1,000**	**25**
Obligations:					
Personnel compensation and benefits	$139,840	$142,287	$163,682	$170,546	$6,864
Travel	$6,272	$6,028	$6,667	$6,925	$258
Transportation of things	$37	$337	$40	$41	$1
Rents, communications, and utilities	$4,503	$9,235	$9,673	$9,836	$163
Printing and reproduction	$27	$27	$27	$28	$1
Other services	$14,721	$11,548	$13,227	$13,458	$231
Supplies and materials	$399	$432	$431	$442	$11
Equipment	$5,307	$2,577	$5,128	$5,215	$87
Insurance	$125	$120	$125	$127	$2
Total obligations	**$171,231**	**$172,591**	**$199,000**	**$206,618**	**$7,618**
Reimbursements	$0	$0	$0	$0	$0
SOY Unobligated Balance (-)	($15,961)	($537)	($7,000)	$0	$7,000
EOY Unobligated Balance (+)	$8,730	$0	$0	$382	$382
Total Budget Authority	**$164,000**	**$172,054**	**$192,000**	**$207,000**	**$15,000**

Note: Totals subject to rounding.

Net Change and Employment Tables

The following table summarizes the changes in resource requirements between the 2019 enacted budget and the 2020 request.

Net Change *Office of Inspector General* *2020 Summary of Resource Requirements* *(dollars in thousands)*		
		BA
2019 Enacted Budget		**$192,000**
Adjustments		$0
Adjusted 2019 Budget Estimate		**$192,000**
2020 Current Services Increases:		
Payraise Assumption Increases (0%)		$0
Non Payroll Inflation (1.7%)		$600
Required Personnel Compensation and Benefits Increases (1.2%)		$1,964
One Additional Compensable Day (0.38%)		$635
	Subtotal	**$3,199**
Execution of carryover (GSA rents and interagency agreements)		$7,382
Tiered Staff Expansion (25 FTE)		$4,419
	Subtotal	**$11,801**
2020 Total Current Services		**$207,000**
2020 Total Budget Authority Request		**$207,000**

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

Employment Summary—FTE by Grade				
Grade	2018 Actual	2019 Estimate	2020 Request	Incr./Decr. from 2019
IG/Senior Executive Service (SES)	18	19	20	1
Senior-Level (SL)	7	7	9	2
GS-15	81	93	95	2
GS-14	161	185	188	3
GS-13	455	525	538	13
GS-12	46	54	57	3
GS-11	26	31	29	-2
GS-10	1	1	1	0
GS-9	26	30	31	1
GS-8	14	15	16	1
GS-7	8	9	9	0
GS-6	2	2	2	0
GS-5	4	4	5	1
GS-1 thru GS-4	0	0	0	0
Grand Total FTE	**849**	**975**	**1,000**	**25**

Analysis of 2018 Actual FTE Distribution – Headquarters/Operations			
Grade	Headquarters	Operations	Total
IG/Senior Executive Service (SES)	18	0	18
Senior-Level (SL)	3	4	7
GS-15	25	56	81
GS-14	33	128	161
GS-13	80	375	455
GS-12	10	36	46
GS-11	3	23	26
GS-10	0	1	1
GS-9	2	24	26
GS-8	2	12	14
GS-7	0	8	8
GS-6	0	2	2
GS-5	0	4	4
GS-1 thru GS-4	0	0	0
Grand Total FTE	**176**	**673**	**849**

Other Requirements

The Office of Management and Budget directed that following information on the OIG's use of PCA be included in this budget submission.

Physicians' Comparability Allowance (PCA) Worksheet

1) Department and component:

VA Office of Inspector General

2) Explain the recruitment and retention problem(s) justifying the need for the PCA pay authority.

(*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.)*

The 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.

3-4) Please complete the table below with details of the PCA agreement for the following years:

	PY 2018 (Actual)	**CY 2019 (Estimates)**	**BY 2020 (Estimates)**
3a) Number of Physicians Receiving PCAs	17	17	17
3b) Number of Physicians with One-Year PCA Agreements	--	--	--
3c) Number of Physicians with Multi-Year PCA Agreements	17	17	17
4a) Average Annual PCA Physician Pay (without PCA payment)	$169,734	$170,752	$171,777
4b) Average Annual PCA Payment	$28,500	$28,500	$28,500

5) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

PCA has proven to be a valuable incentive mechanism for recruiting and retaining Board-certified physicians, who often take a pay cut when entering government service. OIG hired five physicians in FY 2016, three physicians in FY 2017, and has three active recruitment actions for FY 2018.

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

With just over 170 employees in late 2018, the Office of Healthcare Inspections is a relatively small OIG operational office tasked with significant oversight responsibilities. 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 21 million veterans at hundreds of medical facilities with more than 379,000 employees. For 2017, VA operated under a $180.5 billion budget, which maintains 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 healthcare mandates, such as improving veteran mental health care, designing a veteran-centric healthcare model, and expanding health care access. In addition to these initiatives, the expansion of VHA healthcare 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.