DEPARTMENT OF VETERANS AFFAIRS

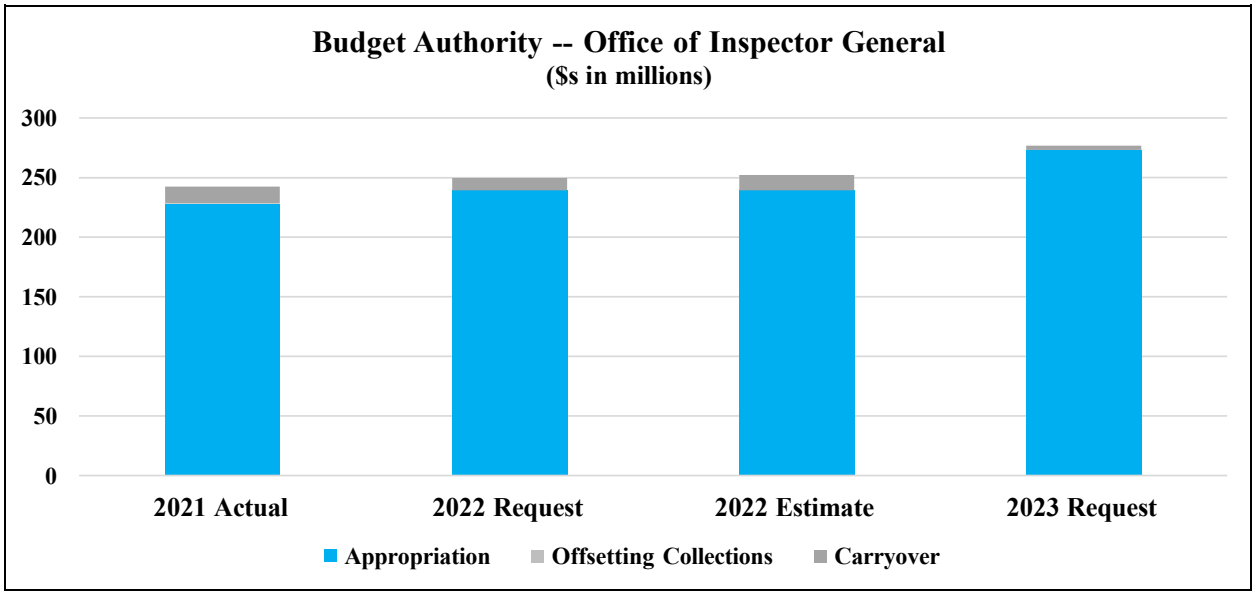
OFFICE OF INSPECTOR GENERAL

Office of Management and Administration

Budget Request for Fiscal Year 2023

BUDGET REQUEST **MARCH 2022**

Office of Inspector General



(Dollars in Thousands)	2022	FTE	2023	FTE
Office of Inspector General				
Annual Appropriation	$239,000	1,080	$273,000	1,135
Net Carryover	$13,000	-	3,716	-
Reimbursements	$50	-	-	-
Total Budgetary Resources	**$252,050**	**1,080**	**$276,716**	**1,135**

Summary of Budget Request

The Office of Inspector General (OIG) requests $273 million for 1,135 FTE in 2023 to fulfill statutory oversight requirements for all VA programs, services, and operations, including healthcare and benefits delivery, procurements and acquisitions, information technology and security, construction, leadership and governance, and financial stewardship. The budget supports a spectrum of audits, inspections, and reviews that identify potential improvements to VA program outcomes, strengthen the integrity of high-risk activities, and deter misconduct. These programs also support and enhance the OIG's capacity to detect criminal activity and conduct timely and thorough investigations when serious instances of fraud, waste, and abuse are discovered. The 2023 budget request encompasses the full cost of operational requirements anticipated for the year

and assumes that OIG will have no appreciable carryover from previous appropriations (regular or supplemental) to support staff or other business needs.

OIG oversight activities have yielded numerous findings and recommendations that translate into direct savings to the taxpayer. Since the start of fiscal year 2016 (see semiannual reports (*SARs)* issues 75 through 86), the OIG identified $31.4 billion in monetary benefits in the form of better use of funds; dollar recoveries; fines, penalties and restitution; savings and cost avoidance; and questioned costs. The OIG averaged a dollar return on investment of nearly $36:1 during that time. During the last fiscal year, the OIG issued 337 reports, alternative work products, and other publications, addressing themes which undermine the efficacy of VA programs and services. These include administrative and leadership deficiencies that present significant barriers to the timeliness and quality of healthcare veterans receive, excessive payments for contracted services and poor acquisitions practices, lack of proper internal controls for fiduciary activities, security risks in information technology and financial systems, and inconsistent payments for benefits and allowances to veterans.

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, $273,000,000 [$239,000,000] of which not to exceed 10 percent shall remain available until September 30, 2024 [2023].

Mission

As authorized by the *Inspector General Act of 1978* and other enacted legislation, the OIG is responsible for conducting and supervising audits, inspections, evaluations, reviews, and investigations, and making recommendations to promote economy, efficiency, and effectiveness of VA operations. The OIG is authorized to inquire into all VA programs and activities, including healthcare programs and VA contracts, grants, and other agreements. The OIG is required to report to Congress on activities and outcomes every six months. These SARs keep stakeholders informed about the challenges VA is experiencing and promote transparency for OIG's operations. Under the leadership of the Inspector General (IG) and Deputy IG, the OIG's work focuses on higher-risk, impactful programs and issues throughout VA. For additional information, see the OIG's *Mission, Vision, and Values*, which can be accessed from www.va.gov/oig/pubs/VA-OIG-Mission-Vision-Values.

Strategic Plan and Goals

The OIG's *Strategic Plan 2022–2026* outlines the OIG's five goals and objectives in promoting the efficiency, effectiveness, and integrity of VA's programs and operations to better serve the needs of veterans, their families, and caregivers. It also frames OIG strategies for deterring and addressing criminal activity, waste, fraud, and abuse while promoting innovation throughout VA, and builds on observed and ongoing major management challenges. Examples of recently published reports are presented in the table below.

Goal 1. Help ensure veterans receive prompt access to exemplary health care

- Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas, Report No. 20-02993-181, July 15, 2021.
- Traumatic Brain Injury Services and Leaders' Oversight at the Southeast Louisiana Veterans Health Care System in New Orleans, Report No. 21-00669-176, June 30, 2021.
- VHA Needs More Reliable Data to Better Monitor the Timeliness of Emergency Room Care, Report No. 20-01141-145, June 23, 2021.
- Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens, Report No. 20-02968-170, June 22, 2021.
- Delay in a Patient's Emergency Department Care at the Malcom Randall VA Medical Center in Gainesville, Florida, Report No. 20-03535-146, June 03, 2021.
- Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio, Report No. 20-01523-102, May 06, 2021.

Goal 2. Make recommendations to facilitate the swift delivery of benefits and superior services

to eligible veterans, their families, and caregivers

- Improper Processing of Automated Pension Reductions Based on Social Security Cost of Living Adjustments, Report No. 20-03898-236, October 28, 2021.
- Improvements Still Needed in Processing Military Sexual Trauma Claims, Report No.20-0041-163, August 5, 2021.
- VBA's Fiduciary Program Needs to Improve the Timeliness of Determinations and Reimbursements of Misused Funds, Report No. 20-00433-168, July 21, 2021.
- VBA Overpaid Veterans Due to Delays in Reducing Compensation Benefits, Report No. 20-03229-155, July 08, 2021.
- VBA Did Not Consistently Comply with Skills Certification Mandates for Compensation and Pension Claims Processors, Report No. 20-00421-63, March 3, 2021.
- VA Needs Better Internal Communication and Data Sharing to Strengthen the Administration of Spina Bifida Benefits, Report No. 20-00295-61, February 23, 2021.

Goal 3. Identify and implement procedures and strategies for making the most responsible use of

VA's appropriated funds

- Financial Efficiency Review of the Southeast Louisiana Veterans Health Care System in New Orleans, Report No. 20-00971-235, September 20, 2021.
- Inadequate Financial Controls and Payments Related to VA-Affiliated Nonprofit Corporations, Report No. 20-03704-165, July 08, 2021.
- VHA Made Inaccurate Payments to Part-Time Physicians on Adjustable Work Schedules, Report No. 20-01646-139, July 01, 2021.
- Veterans Cemetery Grants Program Did Not Always Award Grants to Cemeteries Correctly and Hold States to Standards, Report No. 20-00176-125, June 24, 2021.

- Entitled Veterans Generally Received Clothing Allowance but Stronger Controls Could Decrease Costs, Report No. 20-01487-142, June 15, 2021.
- Review of VHA's Financial Oversight of COVID-19 Supplemental Funds, Report No. 20-02967-121, June 10, 2021.

Goal 4. Address failures in governance and leadership

- Improvements Needed to Ensure Final Disposition of Unclaimed Veterans' Remains, Report No. 19-09592-262, December 15, 2021.
- Inadequate Oversight of Contractors' Personal Identity Verification Cards Puts Veterans' Sensitive Information and Facility Security at Risk, Report No. 20-00345-77, June 29, 2021.
- Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, Report No. 18-02496-157, June 02, 2021.
- Inadequate Resident Supervision and Documentation of an Ophthalmology Procedure at the Oklahoma City VA Health Care System in Oklahoma, Report No. 20-03886-141, May 18, 2021.
- Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, Report No. 20-03593-140, May 11, 2021.
- Deficiencies in Leaders' Responses to Lapses in Reusable Medical Equipment Reprocessing at the Chillicothe VA Medical Center in Ohio, Report No. 20-02265-100, May 06, 2021.

Goal 5. Encourage innovation and recommend enhancements to VA's infrastructure and systems

- VA Applications Lacked Federal Authorizations, and Interfaces Did Not Meet Security Requirements, Report No. 20-00426-02, December 2, 2021.
- New Patient Scheduling System Needs Improvement as VA Expands Its Implementation, Report No. 21-00434-233, November 10, 2021.
- Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program, Report No. 20-03185-151, July 07, 2021.
- Improvements Needed in Adding Non-VA Medical Records to Veterans' Electronic Health Records, Report No. 19-08658-153, June 17, 2021.
- Program of Comprehensive Assistance for Family Caregivers: IT System Development Challenges Affect Expansion, Report No. 20-00178-24, June 08, 2021.
- Deficiencies in Reporting Reliable Physical Infrastructure Cost Estimates for the Electronic Health Record Modernization Program, Report No. 20-03178-116, May 25, 2021.

Program Description

The OIG is headquartered in Washington, DC, has staff in over 60 locations throughout the country, and is organized into the seven offices described below.

Immediate Office of the Inspector General. The IG and Deputy IG provide leadership and set strategic direction. The office includes congressional relations and public affairs staff who ensure that information is accurately and promptly released and that requests from legislators and reporters are appropriately addressed, staff responsible for electronic report distribution and

recommendation follow up, as well as a data modeling group that specializes in advanced analytics, information integration, and data visualization to inform oversight on emerging issues.

Office of Counselor to the Inspector General. The Office of the Counselor provides legal support for investigations, audits, reviews, and inspections; works with OIG investigators in developing qui tam and False Claims Act matters; provides counsel to OIG managers on legal and administrative matters, including contracting actions; represents OIG in employment litigation and personnel matters; and informs legislative proposals and congressional briefings. The Counselor's office also oversees the Release of Information Office and the employee relations and reasonable accommodation functions.

Office of Audits and Evaluations. The Office of Audits and Evaluations evaluate diverse areas such as healthcare inventory and financial systems, the administration of benefits, resource utilization, acquisitions, construction, and information security. Additionally, this office oversees the following congressionally mandated reviews:

- Consolidated financial statement audit, required by the Chief Financial Officers Act of 1990, to assess whether VA's financial statements are free of material error;
- Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2020 (PIIA);
- Evaluation of VA's information security programs and controls required by the Federal Information Security Modernization Act of 2014 (FISMA);
- Evaluation of VA's compliance under the Digital Accountability and Transparency Act of 2014 (DATA Act);
- 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 specialized treatment and rehabilitative needs of disabled veterans as required under 38 U.S.C. § 1706;
- Report on VA employees who violated agency policies regarding purchase cards or convenience checks and actions taken based on each violation under the requirements of the Government Charge Card Abuse Prevention Act of 2012;
- Audit of VA's collection, production, acquisition, maintenance, distribution, use, and preservation of geospatial data by the covered agency as required under the Geospatial Data Act of 2018;
- Review of VA's detailed accounting submission and performance summary report to the Office of National Drug Control Policy as outlined in 21 U.S.C. § 1703 and 1704; and
- Review of VA's Publication and Acceptance of Disability Benefit Questionnaire Forms pursuant to the Veterans Health Care and Benefits Improvement Act of 2020.

Office of Healthcare Inspections. The Office of Healthcare Inspections assesses VA's efforts to maintain a fully functional and high-quality healthcare program. Staff conduct inspections prompted by OIG Hotline complaints, congressional requests, and other leads; recurring inspections of VA facilities, healthcare systems, networks, and Vet Centers; and national reviews. Staff also provide consultations to criminal investigators and audit staff and conduct an annual determination of occupational staffing shortages across the VA, as required by the *Veterans Access, Choice, and Accountability Act*.

Office of Investigations. The Office of Investigations investigates possible crimes and civil violations of law involving VA programs and operations. Staff focus on a wide range of matters including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offences; violent crimes; and threats against VA employees, patients, facilities, and computer systems.

Office of Management and Administration. The Office of Management and Administration provides comprehensive support to the OIG, including financial, personnel, budget, information technology, procurement, space and facilities, and data services. The office also oversees the OIG Hotline, which receives, screens, and refers all allegations and complaints for additional action.

Office of Special Reviews. The Office of Special Reviews conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of other OIG offices. This office undertakes projects in response to referrals from VA employees, the OIG Hotline, Congress, the Office of Special Counsel, veterans service organizations, and other sources. Staff work collaboratively with other OIG directorates to review topics of interest that span multiple disciplines.

Office / Directorate	Onboard Staff
Inspector General	22
Counselor to the Inspector General	35
Data and Analytics Group	35
Investigations	251
Audits and Evaluations	360
Management and Administration	124
Healthcare Inspections	253
Special Reviews	24
Grand Total	**1,104**
Note: The staffing levels reflected above are as of February 2, 2022, the beginning of pay period 04.	

Stakeholders and Partners

The OIG's oversight work encompasses all VA programs and operations, services, functions, and funding. Consequently, its stakeholders include the Secretary, VA senior leaders, managers and staff, members of Congress and its staff, veterans service organizations (VSOs), 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. Therefore, the IG and Deputy IG continue to organize recurring listening sessions with stakeholders, including other OIG senior leaders, senior Department executives, Members of Congress and their staff, and VSOs.

Inspector General Performance Measures and Accomplishments

The OIG's sustained, high level of performance is reflected in VA's *Annual Performance Plan and Report* and the OIG's SARs, including issues 85 and 86 which cover the period of October 1, 2020, to September 30, 2021. Current performance measures include

- Percentage of reports—audit, inspection, evaluation, contract review, and Comprehensive Healthcare Inspection Program reports—issued that identify opportunities for improvement;
- Percentage of recommendations implemented within one year that 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 evaluations;
- 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 investigations that result in criminal, civil, or administrative actions.

Examples of recent OIG oversight projects are presented below to demonstrate the significant impact of the OIG's efforts for veterans and taxpayers. Internal improvements are also discussed to highlight initiatives to better engage and develop highly skilled employees who fulfill the OIG's mission.

Pandemic-Related Oversight. Beginning in mid-2020, the OIG rapidly established a portfolio of oversight projects focused on the pandemic response, including audits, inspections, investigations, and other reviews. The OIG has published 33 pandemic-related reports through mid-February 2022. The examples below highlight work where the OIG

- Conducted a healthcare inspection at a VA Medical Center and substantiated that a Care in the Community (CITC) COVID Priority 1 cardiology consult was not scheduled in accordance with Veterans Health Administration (VHA) time requirements.[15] The OIG made 8 recommendations related to CITC Improvement Action Plans, monitoring progress, clinical review processes, backlog management strategies, appointment scheduling, CITC staffing levels, and other clinical practices.
- Evaluated COVID-19 pandemic readiness and response at two VA Integrated Service Networks (VISNs) during the second quarter of fiscal year 2021 (January 1 through March 31, 2021).[16] The evaluation covered emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; and community living center patient care and operations. The OIG also surveyed facility staff to solicit their feedback and potentially identify any problematic trends or issues that may require follow-up. The report provides data that illustrates the tremendous COVID-19-related demands on VA healthcare services.

[15] VA OIG *Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia.* Report No. 21-01724-84, February 16, 2022. https://www.va.gov/oig/pubs/VAOIG-21-01724-84.pdf

[16] VA OIG *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8.* Report No. 21-002969-20, November 18, 2021. https://www.va.gov/oig/pubs/VAOIG-21-02969-20.pdf

- Examined the reporting and monitoring of personal protective equipment (PPE) inventory. Specifically, in a February 2021 report, OAE assessed how VA reported and monitored PPE and swiftly developed processes and tools to gather data that would help VA navigate facilities' surging demand for PPE. [17] As demand for PPE such as masks, gloves, and gowns drastically increased during the pandemic, VHA had to compete for PPE for its personnel and patients and then store and distribute it. OIG made recommendations to help VHA improve the accuracy and consistency of PPE inventory data. OIG's lessons learned in assessing PPE inventory were recognized by the Pandemic Relief Accountability Committee.
- Collaborated on an investigation with US Immigration and Customs Enforcement's Homeland Security Investigations and FBI on the owner of a wholesale pharmaceutical company who participated in a scheme to defraud healthcare providers, including VA, of more than **$1.8 million** by acquiring and hoarding personal protective equipment during the pandemic.[18] The total amount of designated scarce material billed to VA by the vendor was approximately **$334,300**. The owner was indicted on charges of conspiracy to commit wire fraud and mail fraud, conspiracy to defraud the United States, conspiracy to commit hoarding of designated scarce materials, and hoarding of designated scarce materials.
- Collaborated on an investigation with Department of Homeland Security OIG and FBI on a chief executive officer of a government service provider who pleaded guilty to false statements, wire fraud, and theft of government funds. The defendant made false statements to VA and the Federal Emergency Management Agency to obtain contracts, which were valued at approximately **$38 million**, to provide personal protective equipment during the pandemic. [19] The defendant electronically submitted applications containing false information for Paycheck Protection Program funding and an Economic Injury Disaster Loan, which resulted in his receipt of approximately **$1 million** in loans. He also submitted fraudulent DD Form 214 (certifying release or discharge from active military duty) to VA, and as a result, fraudulently received VA compensation benefits. The loss to the Small Business Administration is approximately **$261,000** and the loss to VA is approximately **$74,000**.
- Revealed that a terminated employee of the VA Puget Sound Healthcare System in Seattle, Washington, stole several pieces of medical equipment, to include ventilators and bronchoscopes, and then sold the stolen items online during the pandemic.[20] The defendant was sentenced to three months' incarcerations, nine months' home confinement with electronic monitoring, and three years' supervised release after pleading guilty to theft of government property. The defendant was ordered to pay **over $132,000** in restitution to the VA.

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[17] VA OIG. *Reporting and Monitoring Personal Protective Equipment Inventory during the Pandemic*. Report No. 20-02959-62, February 24, 2021. https://www.va.gov/oig/pubs/VAOIG-20-02959-62.pdf

[18] Department of Justice. *Businessman Charged in Scheme to Hoard Personal Protective Equipment and Price Gouge Health Care Providers*. https://www.justice.gov/opa/pr/businessman-charged-scheme-hoard-personal-protective-equipment-and-price-gouge-health-care

[19] Department of Justice. *Former CEO Sentenced for Defrauding Multiple Federal Agencies*. https://www.justice.gov/usao-edva/pr/former-ceo-sentenced-defrauding-multiple-federal-agencies

[20] Department of Justice. V*eterans Affairs Respiratory Therapist sentenced to prison for stealing and selling medical supplies*. https://www.justice.gov/usao-wdwa/pr/veterans-affairs-respiratory-therapist-sentenced-prison-stealing-and-selling-medical

Electronic Health Records Modernization Oversight. Since April 2020, the OIG has published four reports and issued 27 recommendations on VA's electronic health records modernization (EHRM) program. OIG repeatedly found unreliable and incomplete estimates for upgrades and costs, inadequate reporting affecting transparency to Congress, and stove-piped governance with decision making that does not appropriately engage VHA personnel who are the end users of the new electronic health record system. OIG's recommendations are meant to help VA make modifications to its roadmap for future implementation efforts and address the risk for cascading failures, breakdowns, delays, and poor health care when deploying the new electronic health record (EHR) system nationwide. In these reports the OIG

- Determined that VA failed to resolve significant system and process limitations before or after implementing the new scheduling system at facilities which reduced effectiveness and risked delays in patient care. [21] OIG recommendations included improvements to training, scheduler engagement, testing guidance on measuring patient wait times, and development of strategies to resolve identified issues.
- Identified weaknesses in how VA developed and reported cost estimates for IT infrastructure upgrades needed to support the new EHR system.[22] OIG recommendations included the use of independent cost estimates, improved cost-estimating standards and guidance, and that VA ensure requirements for all IT infrastructure upgrades are disclosed in program life-cycle cost estimates presented to Congress.
- Found that critical physical and IT infrastructure upgrades had not been completed at VA facilities, which jeopardized the ability to properly deploy the new EHR system and increased risks of delays to the overall schedule. [23] OIG recommendations included establishment of an infrastructure-readiness schedule that incorporates lessons learned from DoD, revising the enterprise-wide deployment schedule to include realistic and achievable milestones, implementation of tools to monitor the status and progress of medical devices at the enterprise level, standardized infrastructure requirements in conjunction with VHA and the OIT, and ensuring physical security assessments are completed.

Monetary Benefits. During the past two SAR reporting periods, the OIG identified a monetary benefit of almost **$4.9 billion** in 277 reports issued. For example, the OIG

- Conducted 109 contract reviews (preaward, postaward, & claim reviews) to help VA obtain fair and reasonable pricing on products and services. The OIG issued 250 recommendations, identified potential cost savings of almost $616 million, and recovered nearly $27 million in overcharges. [24]

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[21] VAOIG. *New Patient Scheduling System Needs Improvement as VA Expands Its Implementation.* Report No. 21-00434-233, November 10, 2021. https://www.va.gov/oig/pubs/VAOIG-21-00434-233.pdf

[22] VAOIG. *Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program.* Report No. 20-03185-151. https://www.va.gov/oig/pubs/VAOIG-20-03185-151.pdf

[23] VAOIG. *Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System,* Report No. 19-08980-95, April 27, 2020. https://www.va.gov/oig/pubs/VAOIG-19-08980-95.pdf

[24] VA OIG. *Semiannual Report to Congress,* Issue 86, April 1, 2021-September 30, 2021. https://www.va.gov/oig/pubs/sars/VAOIG-SAR-2021-2.pdf and VA OIG. *Semiannual Report to Congress,* Issue 85, October 1, 2020-March 31, 2021. https://www.va.gov/oig/pubs/sars/vaoig-sar-2021-1.pdf

- Identified nearly **$794 million** in estimated overpayments of VA benefits improperly paid to fugitive felons.[25]
- Determined that a contractor responsible for administering VA's Patient-Centered Community Care and Veterans Choice programs retained overpayments received from VA.[26] The contractor agreed to pay **$179.7 million** to the government to settle the case. Of this amount, VA will receive approximately **$158 million**.
- Examined whether veterans received intended VHA Homemaker and Home Health Aide program services and whether VHA accurately processed program claims.[27] VHA lacked assurance that veterans received services and, as a result, may have made up to **$145.4 million** in improper payments. In the sample of claims reviewed during the audit, the OIG found that VHA improperly paid an estimated **$8.5 million** with at least **$5.5 million** of this amount potentially recoverable. OIG made eight recommendations to VHA to address these issues, such as updating program policies and ensuring sufficient monitoring of claim payments.
- Found VHA has oversight weaknesses that led to Prosthetic and Sensory Aids Service staff improperly cloning consults. [28] VHA improperly issued an estimated **$15.8 million** in prosthetic supplies during calendar year 2017.
- Determined that the VA did not report **$2.5 billion** in IT upgrade costs to Congress because the Office of Electronic Health Records Management failed to consider costs that other VA program offices would need to incur in order to upgrade their IT systems to support the records management system.[29]
- Reviewed Veterans Benefits Administration disability compensation claim management practices and found that delays in adjudicating benefits reductions or removals could lead to excessive payments of **$232 million** over the next two years.[30]

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

[25] Ibid.

[26] VA OIG. *Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System.* Report No. 19-00226-245, September 30, 2020. https://www.va.gov/oig/pubs/VAOIG-19-00226-245.pdf

[27] VA OIG. *Homemaker and Home Health Aide Program: Most Claims Paid Correctly, but Opportunities Exist to Improve Services to Veterans*. Report No. 19-07316-262, November 23, 2020. https://www.va.gov/oig/pubs/VAOIG-19-07316-262.pdf

[28] VA OIG. *Insufficient Oversight for Issuing Prosthetic Supplies and Devices.* Report No. 18-00972-38, February 11, 2021. https://www.va.gov/oig/pubs/VAOIG-18-00972-38.pdf

[29] VAOIG. *Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program.* Report No. 20-03185-151. https://www.va.gov/oig/pubs/VAOIG-20-03185-151.pdf

[30] *VBA Overpaid Veterans Due to Delays in Reducing Compensation Benefits,* Report No. 20-03229-155, July 08, 2021. https://www.va.gov/oig/pubs/VAOIG-20-03229-155.pdf

Measure	Semiannual Report (SAR) Summary		
	Issue 85	Issue 86	Combined
Monetary Benefits (in millions)	**$1,923.4**	**$2,945.1**	**$4,868.5**
Better Use of Funds	$290.7	$502.2	$793.0
Fines, Penalties, Restitutions and Judgments	$755.2	$386.6	$1,141.8
Fugitive Felon Program	$251.3	$542.2	$793.5
Savings and Costs Avoidances	$15.1	$1,028.0	$1,043.1
Questioned Costs	$607.6	$482.0	$1,089.6
Recoveries	$3.5	$4.0	$7.5
Cost of Operations	**$92.3**	**$101.0**	**$193.3**
Return on Investment	**21.1**	**29.1**	**25.1**
Contract Review Only - Monetary Benefits	**$298.9**	**$348.5**	**$647.5**
Preaward Potential Savings	$286.4	$329.4	$615.8
Postaward Recoveries	$8.2	$18.6	$26.8
Claim Reviews	$4.3	$0.6	$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, the OIG recommended that VA take the following steps:

- Establish a group of VHA staff comprised of core user roles with expertise in VHA operations and Cerner electronic health record use with data architect level knowledge to lead the effort of generating optimized VHA clinical and administrative workflows, establish an electronic health record training domain that is readily available to all end users during and following training, ensure end users receive sufficient training time to impart the skills necessary, and ensure user role assignment process addresses facility leaders and staff concerns.[31]
- Ensure an independent cost estimate is performed for program life-cycle cost estimates related to information technology infrastructure costs, reassess the cost estimate for Electronic Health Record Modernization program-related information technology infrastructure and refine as needed to comply with VA's cost-estimating standards, and develop procedures for cost-estimating staff that align with VA cost-estimating guidance.[32]
- Enhance training for providers and chaperones who conduct or provide support to patients during sensitive exams, improve the tracking of patient complaints, and expand staff education on policies and procedures related to administrative investigations to ensure that allegations of staff misconduct are appropriately addressed.[33]
- Determine (1) the actions needed to ensure staff understand requirements for gathering evidence and verifying stressors for posttraumatic stress disorder claims (PTSD) claims and

[31] VA OIG. *Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*. Report No. 20-01930-183, July 8, 2021. https://www.va.gov/oig/pubs/VAOIG-20-01930-183.pdf

[32] VA OIG. *Unreliable Information Technology Infrastructure Cost Estimates for the Electronic Health Record Modernization Program*. Report No. 20-03185-151, July 7, 2021. https://www.va.gov/oig/pubs/VAOIG-20-03185-151.pdf

[33] VA OIG. *Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, MS.* Report No. 20-01036-70, February 10, 2021. Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi (va.gov)

(2) whether the adjudication procedures manual needs to be reorganized and amended to help staff process PTSD claims more accurately.[34]

- Provide clarifying guidance and controls to clinic staff and purchasing agents, monitor facility compliance, perform inventory reviews of biologic implants, establish a structure for oversight responsibility, create policies and procedures for facilities to follow, and establish standardized systems and requirements for facility staff.[35]
- Grant direct-hire authority, expediting the hiring process for Hybrid Title 38 occupations, to address severe shortages identified by the OIG Office of Healthcare Inspections' annual determination of VHA's occupational staffing shortages.[36]

Investigative Actions. The OIG's criminal, civil, and administrative investigations led to 187 indictments, 195 convictions, and 314 administrative sanctions during the past two SAR reporting periods. The OIG's work, alone and in collaboration with other law enforcement agencies, led to significant judicial actions, as highlighted by these examples.

- Reta Mays, a former nursing assistant at the VA medical facility in Clarksburg, West Virginia, was sentenced to **seven consecutive life sentences for murdering seven veterans**.[37] She was also sentenced to an **additional 240 months** for **assault with intent to commit murder** for administering insulin to an eighth veteran with the intent to cause his death. Mays was employed as a nursing assistant at the medical center, working the night shift during the same period of time that the veterans in her care died of hypoglycemia while being treated at the hospital. Mays would sit one-on-one with patients and admitted to administering insulin to several patients with the intent to cause their deaths.
- Jonathan Dean Davis, the owner of Retail Ready Career Center, was sentenced to nearly 20 years in federal prison after being found guilty of seven counts of **wire fraud** and four counts of **money laundering** in the Northern District of Texas.[38] Davis was convicted of defrauding VA of **$72 million** and misleading student veterans who attended the center's heating, ventilation, and air conditioning training course. Using the proceeds of his fraud, Mr. Davis purchased a $2.2 million home in Dallas, a $428,000 Lamborghini, a $280,000 Ferrari, and a $260,000 Bentley, among other things.
- A compound pharmacy owner in Texas, three marketers, a referring physician, and two clinic employees were charged with **health care fraud**, **conspiracy to pay and receive illegal kickbacks**, and **conspiracy to commit money laundering** in connection with a

[34] VA OIG. *Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement.* Report No. 20-00608-29, December 9, 2020. https://www.va.gov/oig/pubs/VAOIG-20-00608-29.pdf

[35] VA OIG. *Biologic Implant Purchasing, Inventory Management, and Tracking Need Improvement*. Report No. 19-07053-51, February 25, 2021. https://www.va.gov/oig/pubs/VAOIG-19-07053-51.pdf

[36] VA OIG. *Determination of VHA's Occupational Staffing Shortages, FY 2020.* Report No. 20-01249-259, September 23, 2020. https://www.va.gov/oig/pubs/VAOIG-20-01249-259.pdf

[37] Department of Justice. *Former VA Hospital Nursing Assistant Sentenced to Seven Consecutive Life Sentences for Murdering Seven Veterans and Assault with Intent to Commit Murder of an Eighth.* https://www.justice.gov/usao-ndwv/pr/former-va-hospital-nursing-assistant-sentenced-seven-consecutive-life-sentences

[38] Department of Justice. *For-Profit Trade School Sentenced to Nearly 20 Years for Defrauding VA, Student Veterans*. https://www.justice.gov/usao-ndtx/pr/profit-trade-school-sentenced-nearly-20-years-defrauding-va-student-veterans

multi-million dollar scheme. [39] From May 2014 to September 2016, Pharr Family Pharmacy allegedly billed federal health care programs more than **$110 million**, including claims that were false, fraudulent, and the result of illegal kickbacks.

- Susan K. Harris, 74, and William S. Harris, 60, were sentenced to **47 years** and **15 years in prison**, respectively, for **conspiracy to defraud** the United States and other financial crimes committed in connection with the operation of Ayudando Guardians, Inc.[40] This was a non-profit corporation that previously provided guardianship, conservatorship, and financial management to hundreds of people with special needs, including veterans. As president of the organization, Susan Harris unlawfully transferred money from client accounts to a comingled account without any client-based justification. The stolen funds were used to fund an extravagant lifestyle, including the purchases of homes, vehicles, luxury RVs, and cruises.
- A husband and wife were sentenced for their roles in a large-scale **kickback and bribery** scheme involving VA employees and vendors located in West Palm Beach and Miami.[41] Earron and Carlicha Starks were vendors who sold supplies to the VA and paid kickbacks to VA employees in exchange for getting the VA's business. Earron Starks was sentenced to 30 months imprisonment (followed by three years of supervised release) and Carlicha Starks was sentenced to three years of supervised release. Eleven VA employees involved in the scheme were sentenced to incarceration, supervised release, or home confinement and were either terminated or resigned.
- A Louisiana doctor was indicted or his role in **distributing** over 1,200,000 doses of Schedule II controlled substances, including **oxycodone and morphine**, outside the scope of professional practice and not for a legitimate medical purpose, and for maintaining his clinic for the purpose of illegally distributing controlled substances.[42] The indictment also charges the physician with **defrauding** health care benefit programs, including Medicare, Medicaid, and Blue Cross and Blue Shield of Louisiana, of more than **$5.1 million**.

The table below summarizes the OIG's investigative actions.

[39] Department of Justice. *Seven charged for roles in a $110 million compound drug scheme.* https://www.justice.gov/usao-sdtx/pr/seven-charged-roles-110-million-compound-drug-scheme

[40] Department of Justice. *Albuquerque couple sentenced to federal prison in Ayudando Guardians case.* https://www.justice.gov/usao-nm/pr/albuquerque-couple-sentenced-federal-prison-ayudando-guardians-case

[41] Department of Justice. *Husband and Wife Sentenced in Large-Scale Fraud and Bribery Scheme Involving Two South Florida VA Hospitals.* https://www.justice.gov/usao-sdfl/pr/husband-and-wife-sentenced-large-scale-fraud-and-bribery-scheme-involving-two-south

[42] Department of Justice. *Louisiana Doctor Indicted for Illegally Dispensing Over One Million Doses of Opioids and for $5.1 Million Health Care Fraud Scheme.* https://www.justice.gov/opa/pr/louisiana-doctor-indicted-illegally-dispensing-over-one-million-doses-opioids-and-51-million

Measure	Semiannual Report (SAR) Summary		
	Issue 85	Issue 86	Combined
Investigative Actions			
Arrests	109	113	222
Fugitive Felon Arrests (OIG assisted)	5	19	24
Indictments	94	93	187
Criminal Complaints	21	24	45
Convictions	71	124	195
Pretrial Diversions and Deferred Prosecutions	6	13	19
Case Referrals to the Department of Justice	137	139	276
Administrative Sanctions and Corrective Actions (excl. Hotline)	81	233	314

Hotline Actions. The OIG's Hotline continued to serve as the key conduit for allegations of fraud, waste, abuse, and mismanagement, prioritizing those having the most potential risk to veterans, VA programs and operations, or for which the OIG may be the only avenue for redress. During the two most recent SAR reporting periods, Hotline staff received and triaged 29,233 contacts—toll-free phone calls, web submissions, letters, and faxes—to help identify wrongdoing and concerns with VA programs and services (see table below). Further, the OIG opened 1,210 cases in response to Hotline contacts, substantiated 40 percent of related allegations, and prompted 1,067 administrative sanctions. The Hotline also issued more than 8,921 semi-custom responses to provide other options for redress to individuals who contacted the hotline with concerns that were outside the OIG's scope.

Measure	Semiannual Report (SAR) Summary		
	Issue 85	Issue 86	Combined
Contacts	14,129	15,104	29,233
Cases Opened	527	683	1,210
Cases Closed	636	521	1,157
Substantiation Percentage Rate	39%	41%	40%
Administrative Sanctions (Hotline)	571	496	1,067

Dissemination. In addition to publishing reports, the OIG engaged stakeholders through social and digital media, hearings, roundtable discussions, briefings, and responses to media inquiries to further disseminate the report findings. The OIG has an active presence on two social media platforms – LinkedIn and Twitter. The OIG grew its LinkedIn base to 48,500 followers, a 15% percent increase from the prior year, and published 456 updates to highlight reports, hiring activities, and other news that resulted in about 650,000 impressions (delivery to unique LinkedIn streams). In addition, the OIG had over 6,300 followers on Twitter, posted 371 tweets largely focused on reports and other OIG work that resulted in over 160,000 impressions. The OIG also published 23 podcasts covering reports, monthly highlights, and other features. For Congress, the IG and OIG senior staff testified at 8 hearings and delivered 131 congressional briefings regarding issues that were addressed in the OIG's reports and ongoing work or drew on staff expertise and experience. For the media, the OIG responded to more than 128 inquiries and requests for quotes and interviews on the OIG's oversight work to major news outlets, including *Dateline: NBC*, *New York Times, USA Today*, *Washington Post*, *Wall Street Journal*, and the Associated Press. The work by the OIG routinely makes local and national headlines. Highly cited oversight included

topics such as the murders of several veterans by a nursing assistant at the Clarksburg, West Virginia, VA Medical Center, the conviction of a former VA doctor for sexual assault and another for involuntary manslaughter, alleged VA senior leader retaliation against a veteran who claimed sexual assault at a VA medical center, ongoing COVID-19-related issues, and missteps in the initial implementation efforts involving electronic health record modernization.

Internal Improvements. During the last 18 months, the OIG has focused significant resources on modernizing its IT infrastructure to help improve operational efficiencies. The first step in this process was to elevate the Chief Information Officer (CIO) position to an executive level position and to hire an individual as the CIO who has extensive experience working in the OIG community and who understands the unique requirements associated with protecting an OIG's independence while using its parent agency's IT infrastructure. The next step was to restructure and increase the size of the OIG IT support organizations by creating distinct IT Divisions with specialized expertise in the areas of Enterprise Systems Management, IT Security, Applications Development, and Customer Service.

These changes are enabling the OIG to move to a cloud-based environment and bring online new tools that enhance the organization's eDiscovery program which increases the organization's oversight capabilities by increasing the OIG's ability to use the content of emails and other electronic communications to inform investigations and other oversight projects. These changes are also assisting the OIG in implementing a more sophisticated case management tool that will increase efficiencies associated with processing correspondence and complaints and conducting investigations. The OIG has also been able to implement an even more robust IT security posture that works in concert with the Department's security program.

In addition to the OIG's focus on IT efficiencies, the OIG has enhanced its efforts around Diversity, Equity, Inclusion, and Accessibility (DEIA). Over 150 VA OIG employees volunteered to participate on five DEIA subcommittees that identified recommendations associated with cultural events; hiring and recruiting; mentorship; executive performance; and training. The subcommittee recommendations resulted in 22 specific actions to be implemented by VA OIG in 2021 and in 2022. At the forefront of these action items was the appointment of a Chief DEIA Officer, which was accomplished in April 2021. To support the Chief DEIA Officer and to address several additional action items, VA OIG hired four employees to focus on issues designed to ensure that all VA OIG employees believe that they are a valued and integral part of the organization.

Budget Highlights

The 2023 budget request can support 1,135 FTE under current inflation assumptions and pay trends. The budget includes funding for a 4.6 percent pay raise and commensurate locality adjustments, career ladder promotions, within-grade increases, and historical increases in agency benefits contributions, such as health insurance, social security, and retirement. The request annualizes the scope of appropriated funding with fiscal year operations and reflects a $17.9 million increase in total operational costs over the current estimate. Since the OIG will have executed all prior year carryover ($13 million) and supplemental resources ($10 million) at the close of 2022, there is a considerable resource gap that must be replaced with annual appropriations in 2023 to sustain recent hires and investments, including work to oversee pandemic-related

programs. Accordingly, the 2023 appropriation request is $34 million above the anticipated budget for 2022. Historically, the OIG has been able to quickly scale its operations to execute additional funds provided through the appropriations process. For example, in 2021, the OIG hired more than 150 new employees to match increases in its appropriations, to include supplemental funding.

The OIG budget supports highly trained and experienced staff who understand the complexity of VA programs and services. Despite these significant responsibilities, the OIG's annual appropriation request has consistently averaged less than 0.1 percent of the total VA budget. Similarly, in terms of FTE, the VA to OIG staffing ratio (based on the 2022 Budget projections) is approximately 387:1. The VA OIG also has proportionally lower funding and staffing levels when compared with other OIGs for large executive branch agencies (see table below). In addition, the OIG's budget addresses space and technology requirements that cannot be leveraged though VA or other federal partners.

2022 Staff and Resource Comparisons for Selected Inspectors General*

	Funding ($M)			FTE		
OIG	**Agency**	**OIG**	**OIG % of total**	**Agency**	**OIG**	**FTE Ratio**
Commerce	$11,552	$47	0.40%	43,608	187	233:1
Treasury	$18,693	$42	0.23%	95,804	190	504:1
Interior	$27,455	$66	0.24%	67,026	283	237:1
Justice	$42,983	$137	0.32%	117,954	539	219:1
Housing and Urban Development	$68,700	$147	0.21%	7,971	535	15:1
Homeland Security	$90,811	$205	0.23%	240,370	760	316:1
Transportation	$88,085	$103	0.12%	54,684	414	132:1
Agriculture	$198,100	$110	0.06%	99,365	450	221:1
VA	$269,862	$239	0.09%	425,428	1,100	387:1
Health and Human Services	$1,631,000	$430	0.03%	81,461	1,649	49:1

* Resource comparison references 2022 President's Budget requests (not enacted appropriations or supplementals). The VAOIG ranked 8th in funding ratios among surveyed agencies.

The funding requested for 2023 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. To that end, $273 million for 2023 would fund an additional 19 FTE to support recent mandates and enhanced oversight of high-risk programs. Anticipated areas for increased attention in 2023 include

- Toxic exposures,
- Mental health and women's health,
- Major IT modernization, including EHRM, Defense Medical Logistics Standard Support, and Integrated Financial and Acquisition Management Systems implementation,
- Financial benchmarking at VHA facilities,
- Community care/Mission Act,
- Vet Centers, and
- Leadership and governance.

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 2023 budget request to VA is $273 million to support 1,135 FTE and other initiatives. This includes the amounts that the Inspector General certifies to fulfill known requirements to support the Council of Inspectors General on Integrity and Efficiency ($982,800) and OIG employee training ($1,900,000), including training to address continuing education requirements and mandatory training for law enforcement officers. In addition, OIG requests that $4,700,000 be set aside in the 2023 VA Minor Construction appropriation request to support OIG-specific projects. In addition to supporting OIG's regularly scheduled renovation requirements and ongoing efforts to improve the efficiency and effectiveness of OIG's space utilization, these funds will be used to renovate office space to accommodate increased staffing levels in Bay Pines, FL; Dallas, TX; and San Diego, CA.

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 No. 13589, Promoting Efficient Spending*. However, as the executive order recognized, OIG employees must travel extensively to VA facilities across the country to perform statutory oversight. This means that opportunities to reduce travel costs will be increasingly limited as pandemic-related restrictions are lifted. To the extent possible, the OIG has reprogrammed identified efficiencies back into operations to sustain the level of oversight.

Office of Inspector General
Summary of Employment & Obligations - Total Budgetary Resources
($s in thousands, FTE)

	2021 Actual	2022 Request	2022 Estimate	2023 Request	2023 Request vs 2022 Estimate	
					$	%
Average employment:						
Headquarters functions	**237**	**253**	**256**	**261**	**5**	
Operations functions	**795**	**847**	**860**	**874**	**14**	
Total employment	**1,032**	**1,100**	**1,116**	**1,135**	**19**	1.7%
Obligations						
Personnel compensation and benefits	$192,551	$211,835	$215,286	$228,940	$13,654	6.3%
Travel/vehicles	$1,695	$6,790	$2,900	$7,100	$4,200	144.8%
Transportation of things	$57	$75	$75	$60	($15)	-20.0%
Rents, communications, and utilities	$11,982	$13,605	$12,266	$13,500	$1,234	10.1%
Printing and reproduction	$25	$26	$25	$26	$1	4.0%
Other services	$18,417	$20,824	$24,670	$21,030	($3,640)	-14.8%
Supplies and materials	$1,512	$800	$452	$380	($72)	-15.9%
Equipment	$2,603	$5,193	$2,655	$5,175	$2,520	94.9%
Insurance	$0	$5	$5	$5	$0	0.0%
Total obligations	**$228,842**	**$259,152**	**$258,334**	**$276,216**	**$17,882**	6.9%
Budgetary resources						
Unobligated balance:						
Unobligated balance brought forward, Oct 1	$2,302	$10,000	$10,000	$0	($10,000)	-100.0%
Unobligated balance transfers between expired and unexpired accounts	$14,200	$10,452	$13,000	$3,716	($9,284)	-71.4%
Subtotal, unobligated balance	**$16,502**	**$20,452**	**$23,000**	**$3,716**	**($19,284)**	**-83.8%**
Budget authority:						
Appropriations, discretionary						
Appropriation	$238,000	$239,000	$239,000	$273,000	$34,000	14.2%
Unobligated balance of appropriations permanently reduced*	($1)					
Subtotal, appropriation	**$237,999**	**$239,000**	**$239,000**	**$273,000**	**$34,000**	**14.2%**
Offsetting collections	$97	-	$50	-	($50)	
Subtotal, budget authority	**$238,096**	**$239,000**	**$239,050**	**$273,000**	**$33,950**	**14.2%**
Total, budgetary resources	**$254,598**	**$259,452**	**$262,050**	**$276,716**	**$14,666**	
Unobligated balance expiring	($2,757)	($300)	($3,716)	($500)	$3,216	-86.5%
Unexpired unobligated balance	($3,000)	$0	$0	$0	$0	

* Spectrum Relocation Fund

Office of Inspector General
Summary of Employment & Obligations - Regular Appropriations
($s in thousands, FTE)

	2021 Actual	2022 Request	2022 Estimate	2023 Request	2023 Request vs 2022 Estimate	
					$	%
Average employment:						
Headquarters functions	**234**	**245**	**248**	**261**	**13**	
Operations functions	**785**	**819**	**832**	**874**	**42**	
Total employment	**1,019**	**1,064**	**1,080**	**1,135**	**55**	**5%**
Obligations						
Personnel compensation and benefits	$190,250	$204,657	$208,108	$228,940	$20,832	10.0%
Travel/vehicles	$1,695	$6,790	$2,900	$7,100	$4,200	144.8%
Transportation of things	$57	$75	$75	$60	($15)	-20.0%
Rents, communications, and utilities	$11,982	$13,605	$12,266	$13,500	$1,234	10.1%
Printing and reproduction	$25	$26	$25	$26	$1	4.0%
Other services	$18,417	$18,002	$21,848	$21,030	($818)	-3.7%
Supplies and materials	$1,512	$800	$452	$380	($72)	-15.9%
Equipment	$2,603	$5,193	$2,655	$5,175	$2,520	94.9%
Insurance	$0	$5	$5	$5	$0	0.0%
Total obligations	**$226,542**	**$249,152**	**$248,334**	**$276,216**	**$27,882**	11.2%
Budgetary resources						
Unobligated balance:						
Unobligated balance brought forward, Oct 1	$1					
Unobligated balance transfers between expired and unexpired accounts	$14,200	$10,452	$13,000	$3,716	($9,284)	-71.4%
Subtotal, unobligated balance	**$14,201**	**$10,452**	**$13,000**	**$3,716**	**($9,284)**	**-71.4%**
Budget authority:						
Appropriations, discretionary						
Appropriation	$228,000	$239,000	$239,000	$273,000	$34,000	14.2%
Unobligated balance of appropriations permanently reduced*	($1)					
Subtotal, appropriation	**$227,999**	**$239,000**	**$239,000**	**$273,000**	**$34,000**	**14.2%**
Offsetting collections	$97		$50		($50)	
Subtotal, budget authority	**$228,096**	**$239,000**	**$239,050**	**$273,000**	**$33,950**	**14.2%**
Total, budgetary resources	**$242,297**	**$249,452**	**$252,050**	**$276,716**	**$24,666**	**8.9%**
Unobligated balance expiring	($2,757)	($300)	($3,716)	($500)	$3,216	
Unexpired unobligated balance	($13,000)					

* Spectrum Relocation Fund

Office of Inspector General
Summary of Employment & Obligations - Supplemental Appropriations
($s in thousands, FTE)

	2021 Actual	2022 Request	2022 Estimate	2023 Request	2023 Request vs 2022 Estimate	
					$	%
Average employment:						
Headquarters functions	**3**	**8**	**8**	**0**	**-8**	
Operations functions	**10**	**28**	**28**	**0**	**-28**	
Total employment	**13**	**36**	**36**	**0**	**-36**	
Obligations						
Personnel compensation and benefits	$2,301	$7,178	$7,178		($7,178)	-100.0%
Travel/vehicles						
Transportation of things						
Rents, communications, and utilities						
Printing and reproduction						
Other services		$2,822	$2,822		($2,822)	-100.0%
Supplies and materials						
Equipment						
Insurance						
Total obligations	**$2,301**	**$10,000**	**$10,000**	**$0**	**($10,000)**	-100.0%
Budgetary resources						
Unobligated balance:						
Unobligated balance brought forward, Oct 1	$2,301	$10,000	$10,000		($10,000)	-100.0%
Unobligated balance transfers between expired and unexpired accounts						
Subtotal, unobligated balance	**$2,301**	**$10,000**	**$10,000**	**$0**	**($10,000)**	**-100.0%**
Budget authority:						
Appropriations, discretionary						
Appropriation	$10,000					
Unobligated balance of appropriations permanently reduced						
Subtotal, appropriation	**$10,000**	**$0**	**$0**	**$0**	**$0**	
Offsetting collections						
Subtotal, budget authority	**$10,000**	**$0**	**$0**	**$0**	**$0**	
Total, budgetary resources	**$ 12,301**	**$ 10,000**	**$ 10,000**	**$0**	**$ (10,000)**	
Unobligated balance expiring						
Unexpired unobligated balance	$10,000					

Net Change and Employment Tables

The following table summarizes the changes in resource requirements between the 2022 enacted budget and the 2023 request.

Net Change *Office of Inspector General* *2023 Summary of Resource Requirements* *(dollars in thousands)*		
	BA	**FTE**
2022 President's Budget	**$239,000**	**1,116**
Net Carryover Execution/ Normalization of annual appropriation baseline	*$19,284*	
Reimbursements	*$50*	
2022 Obligations Baseline	**$258,334**	**1,116**
2023 Current Services Increases:		
Pay raise (4.6%, annualized)	*$7,427*	
Change in Staff Composition / Benefits Increases	*$3,219*	
Compensable day change (261 to 260 days)	*-$825*	
Nonpay Inflation (2.0%)	*$861*	
Information Technology, Space, Travel, and Other Services Increases	*$3,367*	
Subtotal	**$14,050**	**0**
	$272,384	**1,116**
% Change over 2022 Obligations Base	**5%**	**0%**
OIG Staffing Plan	$3,832	19
2023 Obligations Baseline	**$276,216**	**1,135**
Net Carryover Execution	*-$3,216*	
Net BA Requirements	**$273,000**	**1,135**
Efficiencies / Offsets*	*$0*	*0*
Subtotal	**$0**	**0**
2023 Total Request:	**$273,000**	**1,135**
% Change over FY22 obligations baseline	6%	2%
% Change over FY22 Request	14%	2%

* The current services analysis includes baseline offsets and adjustments.

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

Office of Inspector General Employement Summary Full Time Equivalent (FTE) by Grade				
Grade	**2021 Actual**	**2022 Request**	**2023 Request**	**Increase (+) Decrease (-)**
IG/SES	17	20	24	4
Senior-Level (SL)	10	10	20	10
GS-15	123	133	134	1
GS-14	258	279	280	1
GS-13	518	560	563	3
GS-12	54	58	58	0
GS-11	28	30	30	0
GS-10	0	0	0	0
GS-9	19	21	21	0
GS-8	1	1	1	0
GS-7	4	4	4	0
GS-6	0	0	0	0
GS-5	0	0	0	0
GS-1 to GS-4	0	0	0	0
Total, FTE	**1,032**	**1,116**	**1,135**	**19**

Office of Inspector General Analysis of 2021 Actual FTE Distribution		
Grade	**Headquarters**	**Operations**
IG/SES	17	0
Senior-Level (SL)	2	8
GS-15	28	95
GS-14	59	199
GS-13	119	399
GS-12	12	42
GS-11	6	22
GS-10	0	0
GS-9	4	15
GS-8	0	1
GS-7	1	3
GS-6	0	0
GS-5	0	0
GS-1 to GS-4	0	0
Grand Total FTE	**248**	**784**

Other Requirements

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

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 and 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 2021 (Actual)	CY 2022 (Estimates)	BY* 2023 (Estimates)
3a) Number of Physicians Receiving PCAs	20	21	21
3b) Number of Physicians with One-Year PCA Agreements			
3c) Number of Physicians with Multi-Year PCA Agreements	20	21	21
4a) Average Annual PCA Physician Pay (without PCA payment)	177,589	183,000	189,000
4b) Average Annual PCA Payment	24,800	26,190	27,333

*BY data will be approved during the BY Budget cycle. Please ensure each column is completed.

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 incur a significant reduction in pay when entering government service or transferring from a Title 38 position at VA to a Title 5 position at the OIG. However, the OIG continues to face challenges to recruit and retain physicians. In 2021, OIG recruited two new Medical Officers. OIG currently has a cadre of 20 Medical Officers and is working to hire one additional Medical Officer. The OIG has increased retention of its Medical Officers, as there were two resignations in 2019, one in 2020, and none in 2021.

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

One of OIG's major, statutorily-required functions is providing oversight of the VA's healthcare system to ensure high-quality patient care and safety. This function requires physicians to review hotline complaints, conduct inspections of VA healthcare facilities, and evaluate the quality of care provided to veterans. In 2021, OIG published 41 comprehensive healthcare inspections, 44 hotline healthcare inspections, and 14 national healthcare reviews, in addition to reviewing 4,455 clinically focused hotline referrals. This work illustrates a need to retain medical officers, as OIG has a need for their specific skill set in evaluating VA's provision of healthcare and reviewing the work of our inspectors.