DEPARTMENT OF VETERANS AFFAIRS

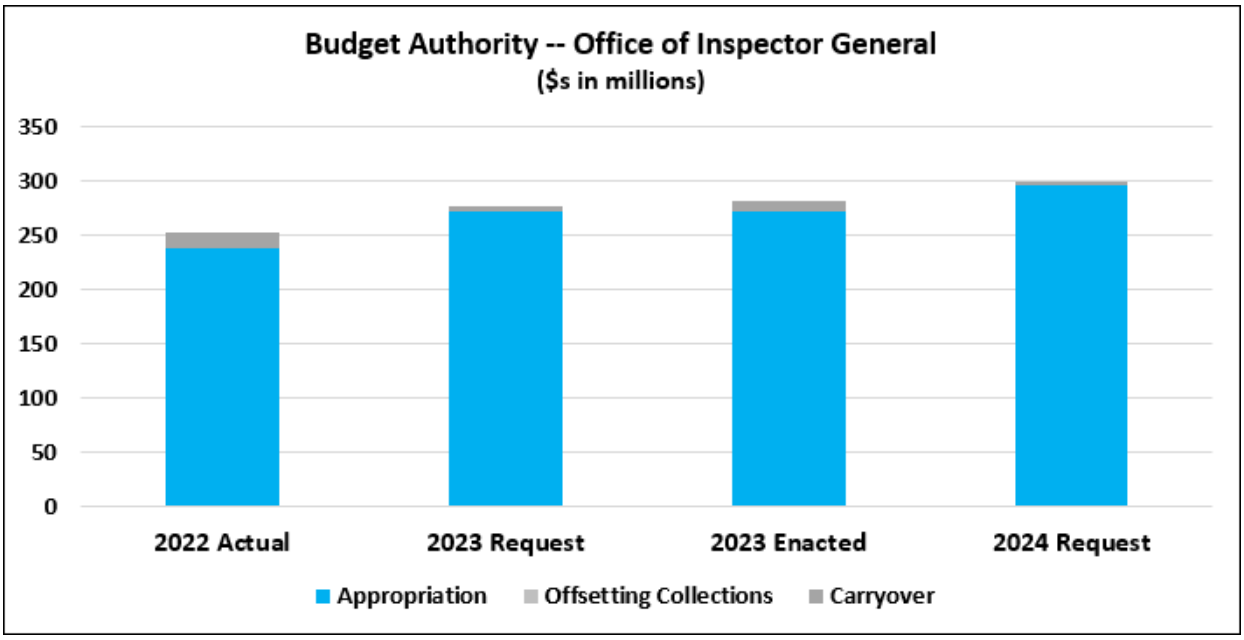
# OFFICE OF INSPECTOR GENERAL

*Office of Management and Administration*

# Budget Request for Fiscal Year 2024

**BUDGET REQUEST** **MARCH 2023**

# *Office of Inspector General*




| (Dollars in Thousands) | 2023 | FTE | 2024 | FTE |
|---|---|---|---|---|
| **Office of Inspector General** | | | | |
| Annual Appropriation | $273,000 | 1,131 | $296,000 | 1,155 |
| Net Carryover | $9,500 | - | 4,543 | - |
| Reimbursements | $100 | - | 250 | - |
| **Total Budgetary Resources** | **$282,600** | **1,131** | **$300,793** | **1,155** |

## Summary of Budget Request

The Office of Inspector General (OIG) requests $296 million for 1,155 FTE in 2024 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 2024 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.

| FY | Monetary Benefits($M) | Cost of Operations($M) |
|---|---|---|
| 2016 | $4,093.2 | $119.5 |
| 2017 | $10,024.9 | $137.9 |
| 2018 | $2,840.1 | $135.4 |
| 2019 | $5,666.0 | $154.9 |
| 2020 | $4,005.7 | $176.3 |
| 2021 | $4,868.5 | $193.3 |
| 2022 | $4,564.5 | $189.5 |
| **Total** | **$36,062.9** | **$1,106.9** |

OIG oversight activities have yielded numerous findings and recommendations that translate into direct savings to the taxpayer. Since the start of 2016 (*Semiannual Report* (*SAR)* issues 75 through 88), the OIG identified $36 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 over $33:1 during that time. During the past two reporting periods (SAR issues 87 & 88), the OIG issued 309 reports, alternative work products, and other publications, addressing themes that 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 (5 U.S.C. [App.] *401 et seq.*), [$273,000,000] *$296,000,000*, of which not to exceed 10 percent shall remain available until September 30, [2024] *2025*.

## 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 semiannual reports (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. Improve Access to Quality and Timely VA Healthcare Services** |
|---|
| • VHA Progressed in the Follow-up of Canceled Appointments during the Pandemic but Could Use Additional Oversight Metrics. Report No. 21-03777-218, November 3, 2022.<br>• Review of VA's Staffing and Vacancy Reporting under the MISSION Act of 2018. Report No. 22-01440-254, October 31, 2022.<br>• Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative, Report No. 21-03924-234, October 27, 2022.<br>• Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2021. Report No. 22-00814-230, September 1, 2022.<br>• Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement. Report No. 21-02732-153, July 21, 2022.<br>• The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm. Report No. 22-01137-204, July 14, 2022.<br>• Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia. Report No. 21-03349-186, June 28, 2022.<br>• Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight. Report No. 20-02186-78, June 6, 2022.<br>• Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6. Report No. 21-03917-123. April 7, 2022.<br>• Comprehensive Healthcare Inspection Summary Report: Evaluation of Mental Health in Veterans Health Administration Facilities, Fiscal Year 2020. Report No. 21-01506-76. February 17, 2022. |
| **Goal 2. Ensure Timely and Accurate Benefits for Eligible Veterans** |
| • VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments. Report No. 21-03063-04, December 8, 2022.<br>• Required Medical Reexaminations Canceled. Report No. 22-01503-231, September 20, 2022.<br>• Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune. Report No. 21-03061-209, September 1, 2022.<br>• The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing. Report No. 21-01361-192, August 9, 2022.<br>• Veterans Prematurely Denied Compensation for Conditions That Could Be Associated with Burn Pit Exposure. Report No. 21-02704-135, July 21, 2022. |

- Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions. Report No. 21-01237-127, June 8, 2022
- Additional Actions Can Help Prevent Benefits Payments from Being Sent to Deceased Veterans. Report No. 21-00836-124, April 21, 2022.
- Public Disability Benefits Questionnaires Reinstated but Controls Could Be Strengthened. Report No. 21-02750-63, March 9, 2022.

**Goal 3. Help Facilitate Strong Stewardship of Taxpayer Dollars**

- Improvements Needed to Reduce Duplicate Payments by VHA and Medicare and Ensure VHA Has Authorized Community Medical Services. Report No. 21-03630-250, December 8, 2022.
- Audit of VA's Financial Statements for Fiscal Years 2022 and 2021. Report No. 22-01155-14, November 15, 2022.
- Buy American Act Compliance Deficiencies at Regional Procurement Office Central. Report No. 21-02641-229, September 28, 2022.
- Financial Efficiency Review of the VA Cincinnati Healthcare System. Report No. 22-00208-221, September 1, 2022.
- Financial Efficiency Review of the VA Boston Healthcare System in Massachusetts. Reports No. 21-03853-174, July 7, 2022.
- VA Medical Facilities Took Steps to Safeguard Refrigerated Pharmaceuticals but Could Further Reduce the Risk of Loss. Report No. 21-01898-152. June 30, 2022.
- Review of VA's Compliance with the Payment Integrity Information Act for Fiscal Year 2021. Report No. 22-00576-178, June 28, 2022.
- VHA Continues to Face Challenges with Billing Private Insurers for Community Care. Report No. 21-00846-104, May 24, 2022.
- Purchases of Smartphones and Tablets for Veterans' Use during the COVID-19 Pandemic. Report No. 21-02125-132, May 4, 2022.

**Goal 4. Identify Weaknesses in Leadership and Governance**

- New York/New Jersey VA Health Care Network (VISN 2) Should Improve Boiler Maintenance to Reduce Safety Risks and Prevent Care Disruptions. Report No. 21-00887-211, September 19, 2022.
- OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2022. Report No. 22-00722-187, July 7, 2022.
- Failure of Leaders to Address Safety, Staffing, and Environment of Care Concerns at the Tuscaloosa VA Medical Center in Alabama. Report No. 2103201-185, June 29, 2022.
- Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care Systemin Danville, Illinois. Report No. 19-08364-140, May 3, 2022.
- Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims. Report No. 21-03916-103, April 27, 2022.
- Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities. Report No. 20-00827-126, April 07, 2022.
- Improved Governance Would Help Patient Advocates Better Manage Veterans' Healthcare Complaints. Report No. 21-00510-105, March 24, 2022.

**Goal 5. Identify Ways to Enhance Information Systems and Innovation**

- Inspection of Information Technology Security at the Harlingen VA Health Care Center in Texas. Report No. 22-00973-215. Report No.22-00973-215, September 27, 2022.
- Mission Accountability Support Tracker Lacked Sufficient Security Controls. Report No. 21-03080-142, June 8, 2022.
- Veterans Data Integration and Federation Enterprise Platform Lacks Sufficient Security Controls. Report No. 21-01123-97, June 01, 2022.
- Inspection of Information Technology Security at the Consolidated Mail Outpatient Pharmacy in Tucson, Arizona. Report No. 21-02453-99. June 1, 2022.
- Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann Grandstaff VA Medical Center in Spokane. Washington, Report No. 21-03020-168, June1, 2022.

- The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule. Report No. 21-02889-134, April 25, 2022.
- Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane. Washington. Report No. 21-00781-108, March 17, 2022.

## 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 evaluates diverse areas such as healthcare inventory and financial systems, the administration of benefits, resource utilization, acquisitions, construction, contracts, 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;
- 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 the deliverance of timely and high-quality healthcare. Staff conduct inspections prompted by OIG Hotline complaints, congressional requests, proactive initiatives, 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, space and facilities, training, and procurement. 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, proactive initiatives, 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 | 34 |
| Data Modeling Group | 38 |
| Investigations | 262 |
| Audits and Evaluations | 352 |
| Management and Administration | 112 |
| Healthcare Inspections | 262 |
| Special Reviews | 21 |
| **Grand Total** | **1,103** |
| Note: Onboard staffing levels reflected above are as of February 10, 2023, 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 87 and 88 which cover the period of October 1, 2021, to September 30, 2022. 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 42 pandemic-related reports through December 1, 2022, which include a total of 158 recommendations, and supported several high-profile criminal investigations specific to pandemic-related fraud. The examples below highlight work where the OIG

- Initiated unannounced inspections and performed evaluations at 34 facilities to determine whether senior VHA managers complied with selected medication management requirements related to the use of remdesivir. [32] The OIG found that many facilities exceeded elements of expected performance, including staff's ability to receive remdesivir shipments. However, the OIG found deficiencies with patient/caregiver education and timely reporting of adverse events to the Food and Drug Administration.
- Evaluated COVID -19 readiness and response for facilities in Veterans Integrated Service Networks (VISNs) 2, 5, and 6.[33] The OIG's review covered emergency preparedness; supplies, equipment, and infrastructure; staffing; access to care; community living center patient care and operations; and vaccine administration. Although the pandemic placed tremendous strain on VA facilities and presented many unique challenges, OIG survey and interview findings identified favorable, recurrent themes across facilities including the importance of communication, teamwork, and for most facilities, sufficient clinical and support staff.
- Conducted a review to assess how VHA addressed the emotional well-being of employees during the novel coronavirus disease (COVID-19) pandemic.[34] The OIG also conducted an overview of VHA programs, including what specialized programs, if any, were developed and deployed in response to the unique psychological challenges created by the COVID-19 pandemic for VHA's staff. The OIG identified areas of concern related to employee emotional well-being: mainly a generally diminishing awareness of support in relation to organizational hierarchy, low utilization of support resources by leadership and frontline employees, as well as employee perception of inadequate support and responsiveness from leadership. The OIG issued one recommendation to the Under Secretary for Health to review the processes by which COVID-19 emotional well-being resources were developed and disseminated and improve both leadership and staff's awareness of these resources and potential signs of burnout.

[32] VAOIG *Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2021.* Report No. 22-00814-230, September 1, 2022. https://www.va.gov/oig/pubs/VAOIG-22-00814-230.pdf

[33] VAOIG *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, and 6.* Report No. 21-03917-123, April 07, 2022. https://www.va.gov/oig/pubs/VAOIG-21-03917-123.pdf

[34] VAOIG *The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic.* Report No. 21-00533-157, May 22, 2022. https://www.va.gov/oig/pubs/VAOIG-21-00533-157.pdf

- Reviewed VHA Office of Connected Care purchases of iPads and iPhones that were intended to support telehealth care during the pandemic through a new digital divide consult process.[35] Between July 2020 and January 2021, Connected Care officials used CARES Act funds to purchase 10,000 iPhones and nearly 81,000 iPads which cost approximately $71 million in total. Because the demand for iPhones was much lower than expected and data plans for both iPhones and iPads were activated while these devices were in storage, the OIG determined that a significant waste of program resources had occurred. The OIG issued two recommendations to VA. The first included establishing realistic goals with a monitoring process for the number of days devices are stored; the second advised using cost benefits analysis to strengthen estimated data plan requirements.
- Investigated allegations that over a period of 5 months, a registered nurse stole COVID-19 vaccination cards from a VA facility, added lot numbers to the cards, and sold them for up to $200 each to individuals in the Detroit area.[36] The investigation, which was conducted jointly with support from the HHS OIG and VA Police Service, led to an indictment on COVID-19 Vaccination Record Cards fraud. The former employee pleaded guilty to the charges in June 2022 and is awaiting sentencing.

**Electronic Health Records Modernization Oversight**. In May 2018, VA awarded a multibillion-dollar contract to procure a new patient electronic health record (EHR) system developed by the Cerner Corporation. The EHR system is critical to VA providing prompt and continuous quality health care to veterans. The VA Office of Inspector General (OIG) has been conducting oversight of multiple aspects of this extensive and challenging implementation effort, which has drawn intense public scrutiny and congressional oversight since the project's inception. Since April 2020, the OIG has published 14 reports and issued 67 recommendations on VA's electronic health records modernization (EHRM) program. These reviews have identified a variety of barriers to successful program implementation that include inadequate cost estimates, planning schedules, reporting, training, and decision making. 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 EHR system nationwide. In its reports the OIG

- Initiated an administrative investigation of the Office of Electronic Health Records Management (OEHRM) [37] Change Management group (Change Management) after an OIG health inspection team raised concerns about the accuracy of information they had received as part of a broader EHRM implementation review at the Mann-Grandstaff VA Medical Center in Spokane, WA. [38] The administrative investigation revealed that the Change Management group's lack of care and due diligence resulted in misinformation being provided to OIG healthcare staff including inaccurate training data and proficiency

[35] VAOIG *Purchases of Smartphones and Tablets for Veterans' use during the COVID-19 Pandemic.* Report No. 21-02125-22, May 4, 2022. https://www.va.gov/oig/pubs/VAOIG-21-02125-132.pdf
[36] Department of Justice. *Registered Nurse Pleads Guilty in Vaccination Record Card Fraud.* https://www.justice.gov/usao-edmi/pr/registered-nurse-pleads-guilty-covid-19-vaccination-record-card-fraud
[37] OEHRM was effectively dissolved on December 20, 2021, with its functions transferred to the newly formed Electronic Health Record Modernization Integration Office (EHRM IO). However, many reports in this section refer to the office as OEHRM because it was the name of the entity at the time the review was initiated.
[38] VAOIG. *Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training.* Report No. 21-02201-200, July 14, 2022. https://www.va.gov/oig/pubs/VAOIG-21-02201-200.pdf

check scores. The Change Management group also failed to recognize red flags and verify accuracy of data before providing it to the inspection team. The OIG issued four recommendations to which the Department concurred.

- Conducted a focused healthcare inspection to assess a VHA identified high-risk patient safety concern due to an Oracle Cerner-designed element of the new EHR that resulted in patient harm.[39] The OIG determined that the EHR sent thousands of orders to an unknown queue instead of the intended care or service location (e.g., specialty care, laboratory, diagnostic imaging). The VHA initiated a clinical review of facilities identified in this queue and determined that there were 149 adverse events for patients, that were categorized according to minor, moderate, or major harm. VHA defined major harm as permanent decrease in the body's functioning or disfigurement, requires surgery or inpatient care; moderate as increased length of hospital stay or required increase in level of care; and minor as no injury, no increased length of stay, no increased level of care. The OIG made two recommendations to the Deputy Secretary related to Oracle Cerner's failure to inform VA of the unknown queue and evaluation of the unknown queue technology and mitigation process.
- Evaluated the availability and utilization of metrics more than a year after the Mann-Grandstaff VA Medical Center became the first VHA medical center to implement the new EHR system.[40] With VA's transition to the new EHR, metrics were created by adding new EHR data to the existing VA data repository and by using the new EHR's functionality. The OIG found that gaps in available metrics due to the new EHR transition impaired the facility's ability to measure and act on issues of organizational performance, quality of care and patient safety, and access to healthcare services. The OIG is concerned that further deployment of the new EHR without addressing these issues may impede the ability of the facility and future sites to provide timely, effective, safe, and veteran-centered care. The OIG made two recommendations to the Deputy Secretary related to evaluating gaps in new EHR metrics and the factors affecting the availability of metrics and taking appropriate actions.
- Examined whether VA and its contractors developed and managed a high-quality, reliable EHRM program Integrated Master Schedule (IMS), which is imperative for the successful deployment of the new records system to facilities nationwide.[41] The OIG found that the current IMS did not fully capture all the work required for the duration of the program, lacked a risk analysis and valid critical path as defined by Government Accountability Office standards, and needed a controlled baseline schedule that allowed for performance management or trend analysis.

**Monetary Benefits.** In 2022 (SAR Issues 87 & 88), the OIG identified monetary benefits of almost **$4.6 billion** in 250 published reports and issued 894 recommendations to VA. For example, the OIG

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[39] VAOIG. *The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm.* Report No. 22-001137-204, July 14, 2022. https://www.va.gov/oig/pubs/VAOIG-22-01137-204.pdf

[40] VAOIG. *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann Grandstaff VA Medical Center in Spokane, Washington.* Report No. 21-03020-168, June 1, 2022. https://www.va.gov/oig/pubs/VAOIG-21-03020-168.pdf

[41] VAOIG. *The Electronic Health Record Modernization Program Did Not Fully Meet the Standards for a High-Quality, Reliable Schedule.* Report No. 21-02889-134, April 25, 2022. https://www.va.gov/oig/pubs/VAOIG-21-02889-134.pdf

- Conducted 96 contract reviews (preaward & postaward) to help VA obtain fair and reasonable pricing on products and services which identified **$3.3 billion** in monetary benefits.[42]
- Estimated that 1.3 million of 2.4 million billable community care claims (54 percent) paid between April 20, 2017, and October 31, 2020, were not submitted to private health insurers before filing deadlines expired which resulted in potential collections losses of **$805 million**.[43]
- Determined that poor internal controls led VA to issue improper payments of almost $137 million for non-VA acupuncture and chiropractic services between 2018 and 2019 and estimated improper payments through 2022 of nearly **$342 million**.[44]
- Identified nearly **$157 million** in improper benefits overpayments to fugitive felons.[45]
- Completed a follow up review of Special Monthly Compensation housebound benefits claims processes and found that because the Veterans Benefits Administration had failed to implement earlier recommendations, the VA likely issued an estimated **$136 million** in net improper payments.[46]
- Found that VHA lacked necessary internal controls for evaluation and management services procured through Community Care providers and conservatively issued nearly **$60 million** in improper payments between 2020-2022.[47]

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

[42] VAOIG. *Semiannual Report to Congress,* Issue 87, October 1, 2021- March 31, 2022. https://www.va.gov/oig/pubs/sars/VAOIG-SAR-2022-1.pdf and VAOIG. *Semiannual Report to Congress,* Issue 88, April 1, 2022-September 30, 2022. https://www.va.gov/oig/pubs/sars/VAOIG-SAR-2022-2.pdf
[43] VAOIG. *VHA Continues to Face Challenges with Billing Private Insurers for Community Care.* Report No. 21-00846-104, May 24, 2022. https://www.va.gov/oig/pubs/VAOIG-21-00846-104.pdf
[44] VAOIG. *VHA Improperly Paid and Reauthorized Non-VA Acupuncture and Chiropractic Services.* Report No. 20-10199-249, December 8, 2021. https://www.va.gov/oig/pubs/VAOIG-20-01099-249.pdf
[45] VAOIG. *Semiannual Report to Congress,* Issue 87, October 1, 2021- March 31, 2022. https://www.va.gov/oig/pubs/sars/VAOIG-SAR-2022-1.pdf and VAOIG. *Semiannual Report to Congress,* Issue 88, April 1, 2022-September 30, 2022. https://www.va.gov/oig/pubs/sars/VAOIG-SAR-2022-2.pdf.
[46] VAOIG. Follow-Up Review of the Accuracy of Special Monthly Compensation Housebound Benefits. Report No. 20-02149-07, December 15, 2021. https://www.va.gov/oig/pubs/VAOIG-20-04219-07.pdf
[47] VAOIG. *VHA Risks Overpaying Community Care Providers for Evaluation and Management Services.* Report No. 21-01807-251. December 8, 2021. https://www.va.gov/oig/pubs/VAOIG-21-01807-251.pdf

| Measure | Semiannual Report (SAR) Summary | | |
|---|---|---|---|
| | Issue 87 | Issue 88 | Combined |
| **Monetary Benefits (in millions)** | **$3,134.1** | **$1,430.4** | **$4,564.6** |
| Better Use of Funds | $2,157.8 | $959.9 | $3,117.7 |
| Dollar Recoveries | $2.8 | $2.3 | $5.1 |
| Fines, Penalties, Restitutions and Judgments | $285.5 | $278.1 | $563.6 |
| Fugitive Felon Program | $86.6 | $70.2 | $156.8 |
| Savings and Costs Avoidances | $7.8 | $74.7 | $82.4 |
| Questioned Costs | $593.7 | $45.2 | $638.9 |
| **Cost of Operations** | **$98.3** | **$91.2** | **$189.5** |
| **Return on Investment** | **32:1** | **16:1** | **24:1** |
| **Contract Review Only - Monetary Benefits** | **$3,149.2** | **$131.1** | **$3,280.3** |
| Preaward Reviews | $3,097.0 | $123.6 | $3,220.6 |
| Postaward Reviews | $52.3 | $7.4 | $59.7 |
| Claim Reviews | $0.0 | $0.0 | $0.0 |

**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:

- Recommended that VA provide Suicide Prevention Coordinators with additional training, guidance, and oversight to ensure that at-risk veterans are reached. This includes measures to improve call center data integrity, train coordinators on how to use patient outcome codes, ensure managers regularly review crisis line referrals and document follow-ups in electronic health records, and consider guidance to coordinators' training tools to improve follow-ups for veterans who are hospitalized in a non-VA facility, admitted to an emergency department, or provided a welfare check.[48]
- Identified instances where multiple care providers failed to communicate, act on, and document abnormal test results that led to a patient's diagnosis of prostate cancer at a VA medical facility. The OIG issued seven recommendations to the VA medical facility director which included ensuring that test results are reviewed in a manner consistent with VHA policies and communicated in a timely manner to patient providers and surrogates, procedures are in place to identify and reduce errors when staff submit nuclear orders, and quality management staff initiate timely quality reviews when deficiencies in patient care are identified.[49]
- Conducted a healthcare inspection at a VA medical facility to evaluate leaders' responses to inappropriate relationships between mental health providers and mental health patients, which are prohibited by federal regulation, state law, and VA policy and considered a form of professional misconduct. While facility directors did act in response to these inappropriate relationships, the OIG identified multiple factors that undermined their efficacy. The OIG issued three recommendations to facility directors which included evaluating processes that help identify and address inappropriate relationships, reviewing

[48] VAOIG. *Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight.* Report No. 20-02186-78, June 6, 2022. https://www.va.gov/oig/pubs/VAOIG-20-02186-78.pdf

[49] VAOIG. *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia.* Report No. 21-03349-186, June 28, 2022. https://www.va.gov/oig/pubs/VAOIG-21-03349-186.pdf

processes for reporting violations to state licensing and state certification boards, and determining whether the patient's care involved any adverse events and, if so, whether institutional disclosure is warranted.[50]

- Evaluated VHA's Airborne Hazards and Open Burn Pit Registry Exam Process and found that improvements would ensure that more eligible and interested veterans would receive exams. The OIG issued seven recommendations which included revising the questionnaire to be more veteran-centric, maintaining accurate contact information for environmental health coordinators, and identifying whether veterans with unscheduled exams are still interested in one. The OIG also recommended implementing processes and metrics to ensure exams are completed, to include a procedure to transfer veterans to closer facilities to receive exams. Further, the OIG recommended developing guidance to ensure responsible parties review and discuss performance data and the enhancement of registry information systems.[51]
- Found deficiencies in VBA's governance and accountability of the contract medical disability exam program. These exams help establish service connection and determine the severity of each veteran's disabilities related to military service. The OIG made four recommendations to the Acting Under Secretary for Benefits, including assessing and modifying contracts and any renewals to ensure that vendors can be held accountable for unsatisfactory performance and establishing procedures for vendors to correct errors that VBA's Medical Disability Exam Office (MDEO) identifies. The OIG also recommended implementing procedures requiring MDEO to communicate vendor exam errors to the Office of Field Operations and the regional offices and demonstrate progress in correcting the identified errors, as well as analyzing all available error data to identify and inform vendors of systemic errors and trends.[52]

**Investigative Actions.** The OIG's criminal, civil, and administrative investigations led to 195 indictments, 181 convictions, and 149 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.

- Bethann Kierczak, a former registered nurse at a VA Hospital in Detroit, Michigan, pled guilty to stealing or **embezzling** authentic Covid-19 Vaccination Record Cards from the VA hospital—along with vaccine lot numbers necessary to make the cards appear legitimate—and then reselling those cards and information to individuals within the metro Detroit community.[53] Kierczak's theft of Covid-19 Vaccination Record Cards began at

[50] VAOIG. *Facility Leaders' Response to Inappropriate Mental Health Provider-Patient Relationships at the VA Illiana Health Care System in Danville, Illinois.* Report No. 19-08364-140, May 3, 2022. https://www.va.gov/oig/pubs/VAOIG-19-08364-140.pdf

[51] VAOIG. *Airborne Hazards and Open Burn Pit Registry Exam Process Needs Improvement.* Report No. 21-02732-153, July 21, 2022. https://www.va.gov/oig/pubs/VAOIG-21-02732-153.pdf

[52] VAOIG. *Contract Medical Exam Program Limitations Put Veterans at Risk for Inaccurate Claims Decisions.* Report No. 21-01237-127, June 8, 2022. https://www.va.gov/oig/pubs/VAOIG-21-01237-127.pdf

53 Department of Justice. Registered Nurse Pleads Guilty in Covid-19 Vaccination Record Card Fraud. https://www.justice.gov/usao-edmi/pr/registered-nurse-pleads- guilty-covid-19-vaccination-record-card-fraud

least as early as May 2021 and continued through September 2021. Kierczak sold the cards for $150-$200 each and communicated with buyers primarily via Facebook Messenger. The investigation was conducted by the U.S. Department of Veterans Affairs- Office of Inspector General (VA-OIG), VA Police Detroit and the Medicare Fraud Strike Force (MFSF) partners, a partnership among the Criminal Division, U.S. Attorney's Offices, and U.S. Health and Human Services-Office of Inspector General (HHS-OIG).

- Sarah J. Cavanaugh, a former VA Social Worker at the Department of Veteran Affairs at the Rhode Island Veterans Affairs Medical Center, will plead guilty to charges of **fraud, aggravated identity theft, forgery, and fraudulent use of medals**.[54] It is alleged that she used her position as a licensed social worker, employed by the Department of Veteran Affairs at the Rhode Island Veterans Affairs Medical Center, to gain access to documents, personal information, and medical records belonging to a Marine and an actual cancer-stricken Navy veteran. She allegedly used the information to create fraudulent documents and medical records in her name, claiming that she was an honorably discharged Marine stricken with cancer. It is further alleged that Cavanaugh used the fraudulent documents in various schemes to obtain more than $250,000 in cash, charitable donations, and services reserved for injured veterans. A defendant's sentence is determined by a federal district judge after consideration of the U.S. Sentencing Guidelines and other statutory factors.
- Universal Helicopters Inc. (UHI), a private helicopter flight instructor training company, and Dodge City Community College (DC3), which operates campuses in Dodge City, Kansas, and Chandler, Arizona, have agreed to pay **$7.5 million** to resolve allegations that they **violated the False Claims Act** by making false statements to the U.S. Department of Veterans Affairs (VA) in connection with the helicopter flight instructor training program jointly run by UHI and DC3.[55] The VA provided financial assistance as part of the Post-9/11 GI Bill to veterans taking classes at the UHI-DC3 helicopter flight instructor program. The United States alleged that from 2013 to 2018, UHI and DC3 made or caused to be made false statements to the VA regarding enrollment in the UHI-DC3 helicopter flight instructor program in order to obtain VA funding.
- Novo Nordisk Inc., a global healthcare company, agreed to pay **$6.3 million** to resolve allegations that it **violated the False Claims Act** by selling items to the United States that were manufactured in non-designated countries in violation of the Trade Agreements Act of 1979.[56] The settlement resolves claims that from July 2012 through November 2020, Novo Nordisk sold to United States government agencies its NovoFine 30G 8 mm needles, and that from May 2016 through November 2020, Novo Nordisk sold to United States

[54] Department of Justice. *Rhode Island Woman to Admit to Falsifying Military Service; False Use of Military Medals; Identity Theft; and Fraudulently Collecting More Than $250,000 in Veteran Benefits and Charitable Contributions.* https://www.justice.gov/usao-ri/pr/rhode-island-woman-admit-falsifying-military-service-false-use-military-medals-identity

[55] Department of Justice. *Universal Helicopters Inc. and Dodge City Community College Agree to Pay $7.5 Million to Settle False Claims Act Allegations Related to Post-9/11 GI Bill Funding.* https://www.justice.gov/opa/pr/universal-helicopters-inc-and-dodge-city-community-college-agree-pay-75-million-settle-false

[56] Department of Justice. *Global Healthcare Company to Pay $6.3 Million to Resolve False Claims Act Allegations*. https://www.justice.gov/usao-nj/pr/global-healthcare-company-pay-63-million-resolve-false-claims-act-allegations

government agencies its NovoFine 32G 6 mm needles, all of which were manufactured in non-designated countries. The claims settled by this agreement are allegations only, and there has been no determination of liability.

- TriMark USA, LLC of Mansfield, Massachusetts, has agreed to pay **$48.5 million** to resolve allegations that its subsidiaries, TriMark Gill Marketing and Gill Group, Inc. (collectively, TriMark), **improperly manipulated federal small business set-aside contracts** around the country.[57] A former TriMark executive in charge of the company's government business agreed to pay an additional $100,000 as an individual civil penalty for her conduct in connection with the scheme. The settlement constitutes the largest-ever False Claims Act recovery based on allegations of small business contracting fraud.
- 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.[58] 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.
- Christopher A. Parris of Lawrenceville, Georgia, pleaded guilty to **conspiracy to commit mail fraud** related to a Ponzi scheme, as well as to **wire fraud** involving the fraudulent sale of purported N95 masks during the pandemic.[59] Parris offered to sell the VA 125 million 3M N95 masks at a cost of $6.45 per mask. In this process, the defendant attempted to obtain an upfront payment of $3.075 million from the VA, even though he knew at the time that he had no access to the promised masks or present ability to deliver the promised masks.
- Rita Copeland was **sentenced to 9.5 years in prison** for **wire fraud** and aggravated **identity theft** in connection with a scheme to defraud veterans. [60] Copeland caused a number of victims to apply for Home Improvements and Structural Alterations (HISA) grants through the U.S. Department of Veterans Affairs. Such grant payments are to be used for certain designated improvements to the residences of veterans. She failed to perform all of the promised work and used a portion of these payments for her own benefit, contrary to the designated purposes of the funds. Copeland also diverted the income and retirement fund payments of another veteran to a bank account that she had opened. In addition, she fraudulently obtained and diverted loan funds and used the credit and debit

[57] Department of Justice. *Government Contractor Agrees to Pay Record $48.5 Million to Resolve Claims Related to Fraudulent Procurement of Small Business Contracts Intended for Service-Disabled Veterans* https://www.justice.gov/usao-ndny/pr/government-contractor-agrees-pay-record-485-million-resolve-claims-related-fraudulent

[58] 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

[59] Department of Justice. *Georgia Man Pleads Guilty in New York Federal Court on Charges Related to Ponzi and COVID-19 Fraud Schemes*. https://www.justice.gov/opa/pr/georgia-man-pleads-guilty-new-york-federal-court-charges-related-ponzi-and-covid-19-fraud

[60] Department of Justice. *Portsmouth Woman Sentenced for Fraud Crimes Targeting Veterans.* https://www.justice.gov/usao-edva/pr/portsmouth-woman-sentenced-fraud-schemes-targeting-veterans

cards of this elderly victim. Finally, Copeland engaged in a rental fraud scheme, purporting to link veterans and others with landlords, but then diverted rental and security deposit payments to her own benefit. In total, from at least 2017-2020, Copeland's fraud schemes impacted at least 29 victims, resulting in a combined loss of approximately $430,000.

The table below summarizes the OIG's investigative actions.

| Measure | Semiannual Report (SAR) Summary | | |
|---|---|---|---|
| | Issue 87 | Issue 88 | Combined |
| **Selected Investigative Actions** | | | |
| Arrests | 104 | 135 | 239 |
| Fugitive Felon Arrests (OIG assisted) | 37 | 39 | 76 |
| Indictments | 82 | 113 | 195 |
| Indictments and Informations Resulting from Prior Referrals | 36 | 40 | 76 |
| Criminal Complaints | 22 | 32 | 54 |
| Convictions | 94 | 87 | 181 |
| Pretrial Diversions and Deferred Prosecutions | 8 | 12 | 20 |
| Case Referrals to the Department of Justice | 136 | 191 | 327 |
| Case Referrals to State and Local Authorities | 15 | 33 | 48 |
| Administrative Sanctions and Corrective Actions (excl. Hotline) | 59 | 90 | 149 |
| Cases Opened | 173 | 178 | 351 |
| Cases Closed | 224 | 213 | 437 |

**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 36,042 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 1,304 cases in response to Hotline contacts, substantiated 41 percent of related allegations, and prompted 1,007 administrative sanctions. The Hotline also issued more than 10,219 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 87 | Issue 88 | Combined |
| Contacts | 17,646 | 18,396 | 36,042 |
| Cases Opened | 752 | 552 | 1,304 |
| Cases Closed | 523 | 568 | 1,091 |
| Administrative Sanctions & Corrective Actions (Hotline) | 498 | 509 | 1,007 |
| Substantiation Percentage Rate | 43% | 39% | 41% |

**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 grew its electronic delivery subscribership by about 12 percent to 115,080. On social media, the OIG grew its LinkedIn base to 60,184 followers,

a 58 percent increase from the prior year, and published 409 updates to highlight reports, hiring activities, and other news that resulted in more than 666,000 impressions. In addition, the OIG had over 6,900 followers on Twitter, posted about 330 tweets largely focused on reports and other OIG work that resulted in over 75,000 impressions. For Congress, the IG and OIG senior staff testified at 14 hearings and delivered 142 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 110 inquiries and requests for quotes and interviews on the OIG's oversight work to major news outlets, including the New York Times, Washington Post, Los Angeles Times, Military.com, Newsday, U.S. News and World Report, Military Times, and Stars and Stripes as well as coordinated the appearance of OIG special agents discussing their work to solve the murders at the VA medical center in Clarksburg, West Virginia, on episodes of Forensic Files II, "The Telltale Marks," and the A&E Network's Interrogation Raw, "Serial Killer at the VA Hospital." Highly cited oversight included topics such as the troubled implementation of the Electronic Health Record Modernization Program, creating a culture of patient safety, and ensuring veterans exposed to toxic burn pits have adequate access to benefits.

**Internal Improvements.** The OIG continues to invest significant resources in IT systems and infrastructure, which are critical to supporting VA oversight activities and fulfilling internal business requirements. During 2022, the OIG Chief Information Officer (CIO) initiated a formalized framework for assessing OIG's unique IT requirements, incorporating best practices, developing strategic goals, improving budget planning, and fulfilling federal cybersecurity requirements. Plan elements include efforts to

- **Modernize Infrastructure**
  Refresh or decommission existing software and hardware infrastructure, leverage VA strategic sourcing capabilities and streamline processes to the maximum extent possible. Actively pursue opportunities to migrate infrastructure to the cloud to promote fiscal efficiencies and a more seamless user experience for the OIG's increasingly remote workforce.
- **Innovate Applications**
  Procure, configure, and implement customizable commercially available off-the-shelf products to support highly reliable, flexible, and comprehensive systems that will be scalable and adaptable to support existing and future mission requirements.
- **Enhance Continuous Monitoring**
  Leverage both existing and new tools to mature the OIG's enterprise-wide continuous monitoring program by transitioning from a reactive to proactive cybersecurity risk management framework.
- **Strengthen IT Program Management and Governance**
  Establish an overarching governance structure for ensuring that all our information technology (IT) investments align with our technology roadmap and support our business objectives. Invest in the development of current IT employees and, as possible, recruit additional talent to ensure that we have a top-tier workforce contributing to and managing our critical projects.
- **Improve Customer Experience**

Deliver exceptional customer service by reinvigorating close partnerships with cross-directorate stakeholders to understand and anticipate business needs and deliver just-in-time IT solutions that are versatile and flexible.

In addition to improvements in IT operations, the OIG has established a robust and comprehensive program to support Diversity, Equity, Inclusion, and Accessibility (DEIA), which includes the appointment of a Chief DEIA Officer within the organization. DEIA program outcomes and strategic goals are memorialized in a 22-element action plan that was developed through voluntarily employee committees and approved by the IG in 2021. The plan addresses cultural event guidelines, hiring and recruitment recommendations, Senior Executive performance metrics, training recommendations, and mentoring programs. Over the past year, the DEIA program has offered OIG staff a variety of activities that promote DEIA awareness and opportunities. These include guest speaker forums, cultural awareness activities, employee affinity engagements, and other activities consistent with Office of Personnel Management guidance and Executive Orders.

## Budget Highlights

The 2024 budget request supports at least 1,155 FTE under current pay and inflation assumptions. This is 24 FTE over the 2023 current estimate. The 2024 budget includes funding for a 5.2 percent annualized pay raise (effective January 2024), locality adjustments, career ladder promotions, within-grade increases, and a proportionate share of agency benefits contributions including health insurance, social security, Medicaid, and retirement. Unlike most other VA administrative programs, the OIG incurs significant payroll and training costs for law enforcement officers and physicians, which far outpace those for other staff positions. The 2024 budget reflects an $21.7 million increase in total operational costs (obligations) over the 2023 current estimate. Because the 2024 budget assumes no significant carryover from 2023 or supplemental funding, there is a significant increase in the annual appropriation request compared to the 2023 budget. Accordingly, the 2024 appropriation request is $23 million higher than the budget requested for 2023.

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 2023 Budget projections) is approximately 384:1. 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 includes a significant portfolio of space and technology needs that cannot be leveraged through VA or other federal partners.

| 2023 Staff and Resource Comparisons for Selected Inspectors General* | | | | | | |
|---|---|---|---|---|---|---|
| | Funding ($M) | | | FTE | | |
| OIG | Agency | OIG | OIG % of total | Agency | OIG | FTE Ratio |
| Commerce | $12,943 | $52 | 0.40% | 44,430 | 209 | 213:1 |
| Treasury | $20,532 | $44 | 0.21% | 101,658 | 190 | 535:1 |
| Interior | $31,665 | $80 | 0.25% | 68,092 | 334 | 204:1 |
| Justice | $48,088 | $146 | 0.30% | 119,023 | 575 | 207:1 |
| Housing and Urban Development | $71,900 | $149 | 0.21% | 8,712 | 535 | 16:1 |
| Homeland Security | $97,291 | $215 | 0.22% | 247,618 | 778 | 318:1 |
| Transportation | $142,111 | $108 | 0.08% | 56,054 | 425 | 132:1 |
| Agriculture | $195,900 | $112 | 0.06% | 107,796 | 450 | 240:1 |
| VA | $300,428 | $273 | 0.09% | 435,926 | 1,135 | 384:1 |
| Health and Human Services | $1,765,121 | $454 | 0.03% | 84,212 | 1,638 | 51:1 |

* Resource comparison references 2023 President's Budget requests (discretionary and mandatory programs). The VAOIG ranked 7th in funding ratios among surveyed agencies.

The funding requested for 2024 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, $296 million for 2024 would fund an additional 24 FTE (over the 2023 current estimate) to support recent reporting requirements, such as the PACT Act, and enhanced oversight of high-risk programs such as EHRM. Anticipated areas for increased attention in 2024 include

- Toxic exposures (including recent enhancements authorized under the PACT Act),
- Mental health and women's health,
- IT modernization projects, including EHRM, Defense Medical Logistics Standard Support, and Integrated Financial and Acquisition Management Systems implementation,
- Financial benchmarking at VHA facilities,
- Community care/Mission Act activities,
- Vet Centers,
- 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 2024 budget request to VA is $296 million to support 1,155 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 ($1,206,176) and OIG employee training ($2,800,000), including training to address continuing education requirements and mandatory training for law enforcement officers. In addition, OIG requests that $20,800,000 be set aside in the 2024 VA Minor Construction appropriation request to support OIG-specific renovation projects which includes a potential relocation for headquarters space in Washington, DC due to a lease termination.

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)**

| | 2022 Actual | 2023 Request | 2023 Enacted | 2024 Request | 2024 Request vs 2023 Enacted | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| **Average employment:** | | | | | | |
| Headquarters functions | **255** | **261** | **260** | **266** | **6** | |
| Operations functions | **852** | **874** | **871** | **889** | **18** | |
| **Total employment** | **1,107** | **1,135** | **1,131** | **1,155** | **24** | 2.1% |
| **Obligations** | | | | | | |
| Personnel compensation and benefits | $211,987 | $228,940 | $226,394 | $246,011 | $19,617 | 8.7% |
| Travel/vehicles | $4,597 | $7,100 | $6,978 | $7,946 | $968 | 13.9% |
| Transportation of things | $19 | $60 | $60 | $65 | $5 | 8.3% |
| Rents, communications, and utilities | $12,524 | $13,500 | $13,203 | $15,869 | $2,666 | 20.2% |
| Printing and reproduction | $35 | $26 | $38 | $38 | $0 | 0.0% |
| Other services | $23,572 | $21,030 | $26,203 | $26,548 | $345 | 1.3% |
| Supplies and materials | $1,502 | $380 | $554 | $737 | $183 | 33.0% |
| Equipment | $1,804 | $5,175 | $4,842 | $3,074 | ($1,768) | -36.5% |
| Insurance | $0 | $5 | $290 | $5 | ($285) | -98.3% |
| **Total obligations** | **$256,039** | **$276,216** | **$278,562** | **$300,293** | **$21,731** | 7.8% |
| **Budgetary resources** | | | | | | |
| Unobligated balance: | | | | | | |
| Unobligated balance brought forward, Oct 1 | $10,000 | $0 | $505 | $0 | $0 | 0.0% |
| Unobligated balance transfers between expired and unexpired accounts | $14,000 | $3,716 | $9,500 | $4,543 | ($4,957) | -52.2% |
| **Subtotal, unobligated balance** | **$24,000** | **$3,716** | **$10,005** | **$4,543** | **($4,957)** | **-49.5%** |
| Budget authority: | | | | | | |
| Appropriations, discretionary | | | | | | |
| Appropriation | $239,000 | $273,000 | $273,000 | $296,000 | $23,000 | 8.4% |
| Unobligated balance of appropriations permanently reduced | | | | | | |
| **Subtotal, appropriation** | **$239,000** | **$273,000** | **$273,000** | **$296,000** | **$23,000** | **8.4%** |
| Offsetting collections | $296 | - | $100 | $250 | $150 | |
| **Subtotal, budget authority** | **$239,296** | **$273,000** | **$273,100** | **$296,250** | **$23,150** | **8.5%** |
| **Total, budgetary resources** | **$263,296** | **$276,716** | **$283,105** | **$300,793** | **$18,193** | |
| Unobligated balance expiring | ($6,751) | ($500) | ($4,543) | ($500) | $4,043 | -89.0% |
| Unexpired unobligated balance | ($505) | $0 | ($0) | $0 | $0 | |

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

| | 2022 Actual | 2023 Request | 2023 Enacted | 2024 Request | 2024 Request vs 2023 Enacted | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| **Average employment:** | | | | | | |
| Headquarters functions | **247** | **261** | **260** | **266** | **6** | |
| Operations functions | **826** | **874** | **868** | **889** | **21** | |
| **Total employment** | **1,073** | **1,135** | **1,128** | **1,155** | **27** | **2%** |
| **Obligations** | | | | | | |
| Personnel compensation and benefits | $205,619 | $228,940 | $225,889 | $246,011 | $20,122 | 8.9% |
| Travel/vehicles | $4,597 | $7,100 | $6,978 | $7,946 | $968 | 13.9% |
| Transportation of things | $19 | $60 | $60 | $65 | $5 | 8.3% |
| Rents, communications, and utilities | $11,618 | $13,500 | $13,203 | $15,869 | $2,666 | 20.2% |
| Printing and reproduction | $35 | $26 | $38 | $38 | $0 | 0.0% |
| Other services | $21,350 | $21,030 | $26,203 | $26,548 | $345 | 1.3% |
| Supplies and materials | $1,502 | $380 | $554 | $737 | $183 | 33.0% |
| Equipment | $1,804 | $5,175 | $4,842 | $3,074 | ($1,768) | -36.5% |
| Insurance | $0 | $5 | $290 | $5 | ($285) | -98.3% |
| **Total obligations** | **$246,544** | **$276,216** | **$278,057** | **$300,293** | **$22,236** | 8.0% |
| **Budgetary resources** | | | | | | |
| Unobligated balance: | | | | | | |
| Unobligated balance brought forward, Oct 1 | | | | | | |
| Unobligated balance transfers between expired and unexpired accounts | $14,000 | $3,716 | $9,500 | $4,543 | ($4,957) | -52.2% |
| **Subtotal, unobligated balance** | **$14,000** | **$3,716** | **$9,500** | **$4,543** | **($4,957)** | **-52.2%** |
| Budget authority: | | | | | | |
| Appropriations, discretionary | | | | | | |
| Appropriation | $239,000 | $273,000 | $273,000 | $296,000 | $23,000 | 8.4% |
| Unobligated balance of appropriations permanently reduced | | | | | | |
| **Subtotal, appropriation** | **$239,000** | **$273,000** | **$273,000** | **$296,000** | **$23,000** | **8.4%** |
| Offsetting collections | $296 | | $100 | $250 | $150 | |
| **Subtotal, budget authority** | **$239,296** | **$273,000** | **$273,100** | **$296,250** | **$23,150** | **8.5%** |
| **Total, budgetary resources** | **$253,296** | **$276,716** | **$282,600** | **$300,793** | **$18,193** | **6.0%** |
| Unobligated balance expiring | ($6,751) | ($500) | ($4,543) | ($500) | $4,043 | |
| Unexpired unobligated balance | | | | | | |

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

| | 2022 Actual | 2023 Request | 2023 Enacted | 2024 Request | 2024 Request vs 2023 Enacted | |
|---|---|---|---|---|---|---|
| | | | | | $ | % |
| **Average employment:** | | | | | | |
| Headquarters functions | **8** | **0** | **0** | **0** | **0** | |
| Operations functions | **26** | **0** | **3** | **0** | **-3** | |
| **Total employment** | **34** | **0** | **3** | **0** | **-3** | |
| **Obligations** | | | | | | |
| Personnel compensation and benefits | $6,368 | | $505 | | | 0.0% |
| Travel/vehicles | | | | | | |
| Transportation of things | | | | | | |
| Rents, communications, and utilities | $906 | | | | | |
| Printing and reproduction | | | | | | |
| Other services | $2,221 | | | | | 0.0% |
| Supplies and materials | | | | | | |
| Equipment | | | | | | |
| Insurance | | | | | | |
| **Total obligations** | **$9,495** | **-** | **$505** | **$0** | **($505)** | 0.0% |
| **Budgetary resources** | | | | | | |
| Unobligated balance: | | | | | | |
| Unobligated balance brought forward, Oct 1 | $10,000 | | $505 | | | 0.0% |
| Unobligated balance transfers between expired and unexpired accounts | | | | | | |
| **Subtotal, unobligated balance** | **$10,000** | **$0** | **$505** | **$0** | **($505)** | **0.0%** |
| Budget authority: | | | | | | |
| Appropriations, discretionary | | | | | | |
| Appropriation | | | | | | |
| Unobligated balance of appropriations permanently reduced | | | | | | |
| **Subtotal, appropriation** | **$0** | **$0** | **$0** | **$0** | **$0** | |
| Offsetting collections | | | | | | |
| **Subtotal, budget authority** | **-** | **$0** | **$0** | **$0** | **$0** | |
| **Total, budgetary resources** | **$ 10,000** | **$ -** | **$ 505** | **$ -** | **$ (505)** | |
| Unobligated balance expiring | | | | | | |
| Unexpired unobligated balance | ($505) | | ($0) | | | |

## Net Change and Employment Tables

The following table summarizes the changes in resource requirements between the 2023 enacted budget and the 2024 request.

| *Net Change*<br>*Office of Inspector General*<br>*2024 Summary of Resource Requirements*<br>*(dollars in thousands)* | | |
|---|---|---|
| | **BA** | **FTE** |
| **2023 Enacted** | **$273,000** | **1,131** |
| Net Carryover Executed (soy-eoy) | *$5,462* | |
| Reimbursements | *$100* | |
| **2023 Obligations Baseline** | **$278,562** | **1,131** |
| **2024 Current Services Increases:** | | |
| Pay raise (5.2% annualized) | *$8,829* | |
| Change in Staff Composition / Benefits Increases | *$3,101* | |
| Compensable days (260 vs 261 days) | *$871* | |
| Nonpay Inflation (2.0%) | *$1,043* | |
| Net nonpay baseline adjustments | *$1,071* | |
| **Subtotal (Increases)** | **$14,915** | **0** |
| **Subtotal (Obligations)** | **$293,477** | **1,131** |
| % Change over 2023 Obligations Base | **5%** | **0%** |
| OIG Staffing Plan | $6,816 | 24 |
| **2024 Obligations Baseline** | **$300,293** | **1,155** |
| Net Carryover Executed (eoy-soy) | *-$4,043* | |
| Offsetting Collections | *-$250* | |
| **Net Budget Authority** | **$296,000** | **1,155** |
| Efficiencies / Offsets* | *$0* | *0* |
| **Subtotal** | **$0** | **0** |
| **2024 Total Budget Request:** | **$296,000** | **1,155** |
| % Change over FY23 obligations baseline | 8% | 2% |
| % Change over FY23 Request | 8% | 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<br>Employment Summary<br>Full Time Equivalent (FTE) by Grade | | | | |
|---|---|---|---|---|
| Grade | 2022<br>Act. | 2023<br>Enacted | 2024<br>Request | Increase (+)<br>Decrease (-) |
| IG/SES | 19 | 21 | 21 | 0 |
| Senior-Level (SL) | 10 | 15 | 16 | 1 |
| GS-15 | 135 | 135 | 138 | 3 |
| GS-14 | 280 | 288 | 294 | 6 |
| GS-13 | 548 | 575 | 588 | 13 |
| GS-12 | 66 | 59 | 61 | 2 |
| GS-11 | 26 | 22 | 22 | 0 |
| GS-9 | 16 | 8 | 8 | 0 |
| GS-8 | 1 | 1 | 1 | 0 |
| GS-7 | 6 | 6 | 6 | 0 |
| **Grand Total FTE** | **1,107** | **1,131** | **1,155** | **24** |

| Office of Inspector General<br>Analysis of 2022 FTE Distribution | | |
|---|---|---|
| Grade | Headquarters | Operations |
| IG/SES | 17 | 2 |
| Senior-Level (SL) | 8 | 2 |
| GS-15 | 31 | 104 |
| GS-14 | 64 | 216 |
| GS-13 | 126 | 422 |
| GS-12 | 15 | 51 |
| GS-11 | 6 | 20 |
| GS-9 | 4 | 12 |
| GS-8 | 0 | 1 |
| GS-7 | 1 | 5 |
| **Grand Total FTE** | **272** | **835** |

## 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 2022 (Actual) | CY 2023 (Estimates) | BY* 2024 (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) | 173,000 | 186,000 | 191,000 |
| 4b) Average Annual PCA Payment | 26,700 | 29,600 | 30,000 |

*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 2022, OIG recruited two new Me dical 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 was one resignation in 2020, none in 2021, and one in 2022.

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. Over the last two SAR periods (Issues 87 & 88), the OIG published 41 comprehensive healthcare inspections, 32 hotline healthcare inspections, and 5 national healthcare reviews, in addition to reviewing over 4,761 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.