



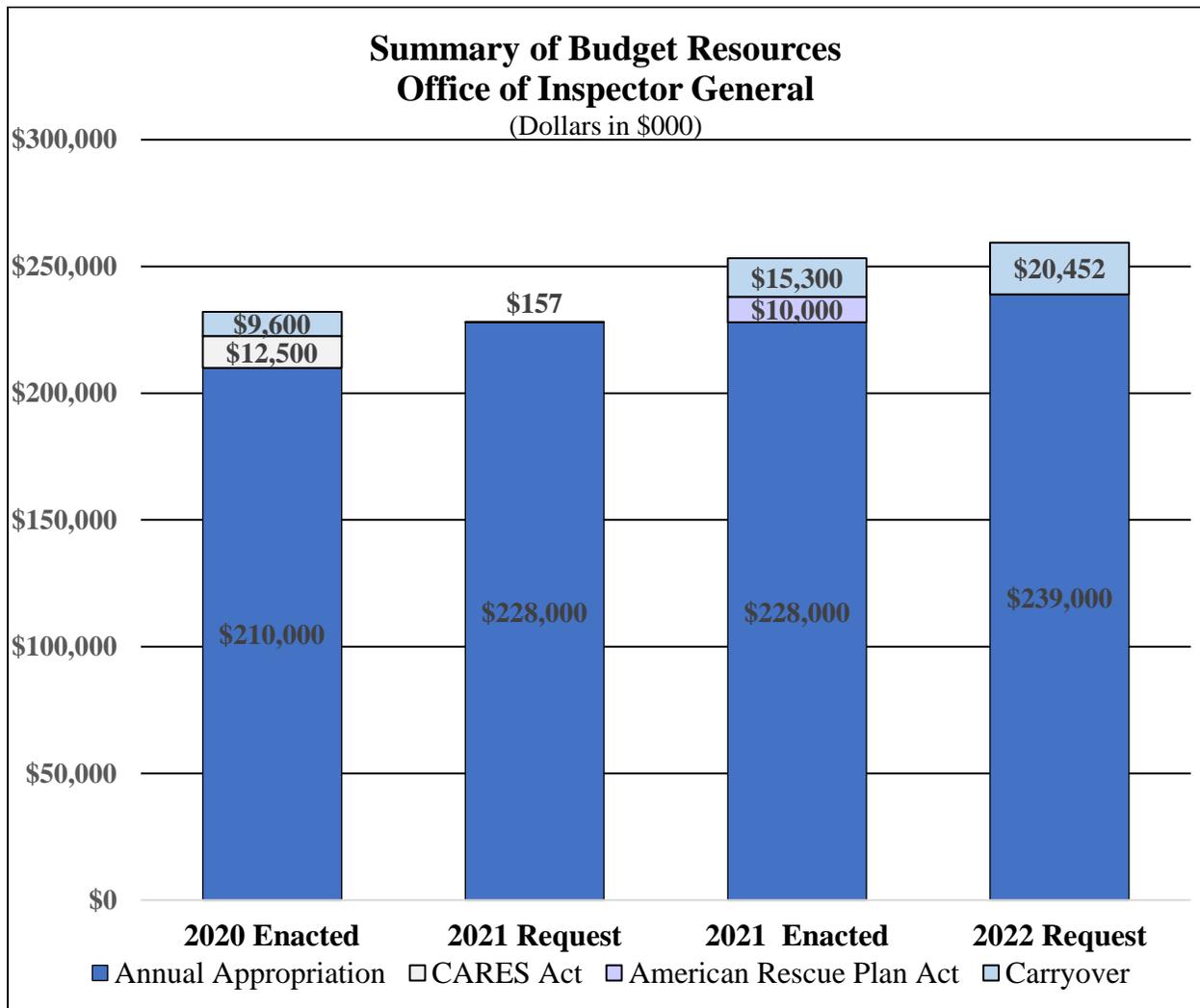
DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Management and Administration

Budget Request for
Fiscal Year 2022



Office of Inspector General



Note: 2022 SOY carryover is estimated.

(Dollars in Thousands)	2021	FTE	2022	FTE
Office of Inspector General				
Annual Appropriation	\$228,000	1,041	\$239,000	1,064
American Rescue Plan Act	\$10,000	-	-	-
Net Carryover	\$15,300	-	\$20,452 *	36
Total Budgetary Resources	\$253,300	1,041	\$259,452	1,100

*Estimate includes annual and APR balances

Summary of Budget Request

The Office of Inspector General (OIG) requests \$239 million for 1,100 FTE in 2022 to support essential oversight of VA’s programs and operations through independent audits, inspections, reviews, and investigations; and for the timely detection and deterrence of fraud, waste, and abuse. With a total dollar impact of over \$4 billion and a return on investment of \$23:1 in 2020, as well as the scores of recommendations to improve the access and quality of healthcare, the additional funding for the OIG is prudent to safeguard the taxpayers’ continued and significant investments in VA and to help improve the services and benefits for veterans and their families. Even before the current public health crisis, maintaining an effective oversight program was a significant undertaking in the context of the complexity of VA’s programs and services, and the VA’s 2021 enacted funding level of \$246 billion. The recent passage of the American Rescue Plan (ARP) Act, which provided an additional \$17.1 billion in supplemental funds to VA, will undoubtedly result in a sustained need for additional oversight, including complex investigations of possible crimes, ranging from allegations that some medical supply manufacturers are engaging in price fixing and price gouging, to claims that some VA employees have been stealing personal protective equipment (PPE) and selling the items for significant personal gain.

In recognition of the value of OIG oversight, Congress, the Office of Management and Budget, and VA have provided strong support to expand operational capacity for several years. This funding translated into an increase of more than 400 onboard staff, from the start of 2014 to the end of 2020, and supported important, new initiatives. Examples of these recent initiatives include the creation of the Veterans Affairs Health Care Fraud Task Force with the Department of Justice to investigate and prosecute complex/significant fraud impacting VA health care programs,³³ rapidly establishing a portfolio of pandemic-related oversight, expanding recurring inspections of regional offices that oversee VA medical facilities to emphasize the quality and stability of leadership, as well as launching a series of program reviews of the quality of compensation claims. Significant achievements in 2020 included

- Completion of an investigation that led to a former nursing assistant pleading guilty to seven counts of second-degree murder and one count of assault to commit murder;
- Publication of two healthcare inspection reports of VHA’s early pandemic response that identified best practices, lessons learned, and opportunities for improvement;

³³ Department of Justice. “The Department of Veterans Affairs - Office of Inspector General and Department of Justice Announce Veterans Affairs Health Care Fraud Task Force.” October 1, 2019. <https://www.justice.gov/opa/pr/department-veterans-affairs-office-inspector-general-and-department-justice-announce-veterans>.

- Arrest of an individual investigated by the OIG for attempting to sell hundreds of millions of dollars of fraudulent PPE to VA and other government entities; and
- Publication of two reports outlining concerns associated with VA's electronic health record modernization efforts which is projected to cost over \$16 billion.

The 2022 budget request and anticipated carryover from 2021 (including ARP funds) will support salaries, pay adjustments, and benefits increases for agency retirement contributions, law enforcement availability pay, and health insurance, for up to 1,100 FTE. This is 59 FTE above the 2021 baseline of 1,041 FTE. The additional investment in the OIG will support continued oversight of the aftermath of the pandemic without diminishing ongoing work. The request will also fund the expansion of multidisciplinary oversight (e.g., joint staff efforts that include auditors, benefits and healthcare inspectors, criminal investigators, attorneys, project managers, and information technology specialists) to detect and deter healthcare fraud, waste, and abuse, the establishment of a special investigations unit to support and coordinate complex and significant healthcare fraud-related initiatives, and additional oversight of other vital issues such as VA governance and leadership and emergency preparedness. For more information regarding the OIG's 2022 request, refer to the Budget Highlights section below.

Appropriation Language

For necessary expenses of the Office of Inspector General, to include information technology, in carrying out the provisions of the Inspector General Act of 1978, \$239,000,000 [\$228,000,000] of which not to exceed 10 percent shall remain available until September 30, 2023 [2022].

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. 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.

Strategic Plan and Goals

The OIG's *Strategic Plan 2018–2022*, enhanced by the *Strategic Plan: Implementation Update, February 28, 2021*, 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.

<p>Goal 1. Improve Access to Quality and Timely VA Healthcare Services</p> <ul style="list-style-type: none"> • Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center, Report No. 20-00563-68, February 25, 2021. • Thoracic Surgery Quality of Care Issues and Facility Leaders’ Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida, Report No. 18-01321-56, January 13, 2021. • Review of Veterans Health Administration’s COVID-19 Response and Continued Pandemic Readiness, Report No. 20-03076-217, July 16, 2020. • Deficiencies in Virtual Pharmacy Services in the Care of a Patient, Report No. 19-07827-182, June 18, 2020. • OIG Inspection of Veterans Health Administration’s COVID-19 Screening Processes and Pandemic Readiness, Report No. 20-02221-120, March 26, 2020.
<p>Goal 2. Ensure Timely and Accurate Benefits for Eligible Veterans</p> <ul style="list-style-type: none"> • 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. • Posttraumatic Stress Disorder Claims Processing Training and Guidance Need Improvement, Report No. 20-00608-29, December 9, 2020. • Telehealth Public-Use Questionnaires Were Used Improperly to Determine Disability Benefits, Report No. 19-07119-80, February 18, 2020. • Veterans Received Inaccurate Disability Benefit Payments After Reserve or National guard Drill Pay Adjustments, Report No. 18-05738-56, February 11, 2020.
<p>Goal 3. Help Facilitate Strong Stewardship of Taxpayer Dollars</p> <ul style="list-style-type: none"> • Insufficient Oversight for Issuing Prosthetic Supplies and Devices, Report No. 18-00972-38, February 11, 2021. • Audit of VA’s Financial Statements for Fiscal Years 2020 and 2019, Report No. 20-01408-19, December 14, 2020. • VA Should Examine Options to Expand Retail Pharmacy Drug Discounts, Report No. 19-07281-105, June 30, 2020. • A Synopsis of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2019, Report No. 20-00010-151, June 30, 2020. • Summary of Fiscal Year 2019 Preaward Reviews of Healthcare Resources Proposals from Affiliates, Report No. 20-00184-153, June 25, 2020.
<p>Goal 4. Identify Weaknesses in Leadership and Governance</p> <ul style="list-style-type: none"> • Senior VA Officials’ Response to a Veteran’s Sexual Assault Allegations, Report No. 20-01766-36, December 10, 2020. • Veterans Crisis Line Challenges, Contingency Plans, and Successes During the COVID-19 Pandemic, Report No. 20-02830-05, October 28, 2020. • Waste and Abuse by the Former Assistant Secretary for Human Resources and Administration, Report No. 19-00230-190, July 8, 2020. • Attorney Misconduct, Inadequate Supervision, and Mismanagement in the Office of General Counsel, Report No. 18-06501-158, June 24, 2020. • Manipulation of Radiology Reports and Leadership Failures in the Medical Imaging Service at Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin, Report No. 18-06074-123, April 29, 2020.

Goal 5. Identify Ways to Enhance Information Systems and Innovation

- VA Needs to Comply Fully with the Geospatial Data Act of 2018, Report No. 20-02339-35, January 26, 2021.
- VA's Implementation of the FITARA Chief Information Officer Authority Enhancements, Report No. 18-04800-122, June 9, 2020.
- Review of Access to Care and Capabilities during VA's Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington, Report No. 19-09447 136, April 27, 2020.
- Deficiencies in Infrastructure Readiness for Deploying VA's New Electronic Health Record System, Report No. 19-08980-95, April 27, 2020.
- Federal Information Security Modernization Act Audit Fiscal Year 2019, Report No. 19-06935-96, March 31, 2020.

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 Inspector General (IG) and Deputy IG provide leadership and set strategic direction. The office includes congressional and communications staff, who ensure that requests from legislators and the media are appropriately addressed, staff responsible for electronic report distribution and recommendation follow up, as well as a team of data modeling experts who use data visualizations to inform oversight on emerging issues.

Office of Counselor to the Inspector General. OIG attorneys provide legal support for investigations, audits, reviews, and inspections; work with OIG investigators in developing qui tam and False Claims Act matters; represent OIG in employment litigation and personnel matters; and inform 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. Staff are involved in evaluating 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 *Improper Payments Elimination and Recovery Act (IPERA)*;
- 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;

- Risk assessment of VA’s grant closeout process as required by the *Grants Oversight and New Efficiency Act of 2016* (GONE);
- 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*;
- Review of leases and VA’s management of land use at the West LA campus as required under the *West Los Angeles Leasing Act of 2016*;
- 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*.

Beginning in 2021, the Office of Contract Review was realigned under the Office of Audits and Evaluations, consolidating all the OIG’s audit work within a single directorate. Previously, this office was overseen by the Office of the Counselor. The Office of Contract Review continues to provide preaward, postaward, and other pricing reviews of Federal Supply Schedule, construction, and healthcare provider contracts. Preaward reviews provide VA contracting officers with assistance and information needed to negotiate fair and reasonable prices. Postaward reviews assess compliance with contract terms and conditions and help recover identified overcharges.

Office of Healthcare Inspections. The Office of Healthcare Inspections assesses VA’s efforts to maintain a high-quality healthcare program. Staff conduct inspections prompted by OIG Hotline complaints, congressional requests, and other sources; recurring inspections of VA facilities and Veterans Integrated Service Networks (VISNs); 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 other violations of law involving VA programs and operations. Staff focus on issues that include benefits and procurement fraud, Service-Disabled-Veteran-Owned Small Business fraud, health care fraud, contract fraud, embezzlement, extortion, bribery, drug diversion, identity theft, cyber-crimes, homicide, sexual assault, and threats against VA employees, patients, facilities and computer systems.

Office of Management and Administration. With a multidisciplinary team, this office provides comprehensive support to the OIG, including personnel, financial, budgetary, procurement, space and facilities, information technology, and data analysis and predictive analytics services. The office also oversees the OIG Hotline, which receives, screens, and refers contacts for additional action.

Office of Special Reviews. This office conducts reviews of significant events and emergent issues not squarely within the focus of existing OIG offices. Staff undertake projects assigned by the IG and work collaboratively with other offices to review topics and issues of interest that span multiple offices, such as community care for veterans.

Office / Directorate	FTEs Onboard
Inspector General	18
Counselor	23
Data Modeling Group	15
Investigations	238
Audits and Evaluations	336
Management and Administration	134
Healthcare Inspections	232
Special Reviews	22
Grand Total	1,018

Note: Onboard staffing levels reflected above are as of September 27, 2020, the beginning of pay period 20.

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 with 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 83 and 84 which cover the period of October 1, 2019, to September 30, 2020. Current performance measures include

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

Examples of recent OIG oversight 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. In mid-2020, the OIG rapidly established a portfolio of oversight of the pandemic response, including audits, inspections, investigations, and other reviews. For example, the OIG

- Conducted unannounced site visits to 237 VA medical facilities in mid-March 2020, approximately one week after infection screening was initiated VHA-wide. The OIG subsequently provided just-in-time information to VA senior leadership, members of Congress, and the public regarding the OIG's assessment of screenings, including the

strong processes in place at most facilities as well as opportunities to improve screenings at others.³⁴

- Published a second healthcare inspection in July 2020 regarding VHA's pandemic response that highlights a multitude of actions taken by VHA, VISN, and facility leaders to maintain operations during the national emergency.³⁵ This report discusses operational challenges associated with delivering care in the inpatient and outpatient setting, coordination of care with community providers, and strategies to protect high risk patients. With the uncertainty of timing and magnitude of possible recurrent outbreaks, this review presented strategies that various facilities put into place over the past several months to promote discussion and consideration of lessons learned and best practices.
- Served as the lead law enforcement agency in an investigation with Homeland Security Investigations that led to the arrest of a Georgia resident for making a series of fraudulent misrepresentations in an attempt to secure orders from VA for 125 million face masks and other PPE that would have totaled over **\$750 million**. This investigation resulted in the largest COVID-19-related fraud prosecution brought by the Department of Justice.³⁶
- Published 15 pandemic-related reports through mid-March 2021 and initiated additional COVID-19-related oversight work, including audits, healthcare inspections, and criminal investigations, which are ongoing.

Monetary Benefits. During the past two SAR reporting periods, the OIG identified a monetary benefit of more than **\$4 billion** in 296 reports issued. For example, the OIG

- Recommended that VA conduct a formal analysis of VHA's Office of Community Care prescription drug programs to determine the steps that would need to be taken to require drug manufacturers to provide discounted prices for covered prescription drugs purchased for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and other VA programs that use retail pharmacies.³⁷ This could lead to **\$345.1 million** in cost savings over the next five years for CHAMPVA alone.

³⁴ VA OIG. *OIG Inspection of Veterans Health Administration's COVID-19 Screening Processes and Pandemic Readiness*. Report No. 20-02221-120, March 26, 2020. <https://www.va.gov/oig/pubs/VAOIG-20-02221-120.pdf>.

³⁵ VA OIG. *Review of Veterans Health Administration's COVID-19 Response and Continued Pandemic Readiness*. Report No. 20-03076-217, July 16, 2020. <https://www.va.gov/oig/pubs/VAOIG-20-03076-217.pdf>.

³⁶ Department of Justice. "Georgia Man Arrested for Attempting to Defraud the Department of Veterans Affairs in a Multimillion-Dollar COVID-19 Scam." April 10, 2020. <https://www.justice.gov/opa/pr/georgia-man-arrested-attempting-defraud-department-veterans-affairs-multimillion-dollar-covid>.

³⁷ VA OIG. *VA Should Examine Options to Expand Retail Pharmacy Drug Discounts*. Report No. 19-07281-105, June 30, 2020. <https://www.va.gov/oig/pubs/VAOIG-19-07281-105.pdf>.

- Made recommendations to VA contracting officers that yielded **\$203 million** in savings for VA based on 19 preaward reviews of pharmaceutical proposals, many of which were not accurate, complete, or current.³⁸
- Issued recommendations to improve VA’s oversight of the issuance of prosthetic supplies and devices to veterans after an audit of 2017 patient data determined that improperly cloned consults and duplicative orders resulted in questioned costs of **\$79.2 million** over a five-year period.³⁹
- Reviewed Veterans Choice Program reimbursements to third-party administrators for community provided healthcare and determined that VA could have saved more than **\$132 million** had effective payment controls and customary rate schedules been in place.⁴⁰

³⁸ VA OIG. *A Synopsis of Preaward Reviews of VA Federal Supply Schedule Pharmaceutical Proposals Issued in Fiscal Year 2019*. Report No. 20-00010-151, June 30, 2020. <https://www.va.gov/oig/pubs/VAOIG-20-00010-151.pdf>.

³⁹ VA OIG. *Insufficient Oversight for Issuing Prosthetic Supplies and Devices*. Report No.18-00972-38, May 11, 2021. <https://www.va.gov/oig/pubs/VAOIG-18-00972-38.pdf>

⁴⁰ 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>

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

Measure	Semiannual Report (SAR) Summary		
	Issue 83	Issue 84	Combined
Monetary Benefits (in millions)	\$868.8	\$3,136.9	\$4,005.7
Better Use of Funds	\$484.7	\$507.2	\$991.9
Fines, Penalties, Restitutions and Judgments	\$87.7	\$54.2	\$141.9
Fugitive Felon Program	\$83.5	\$200.0	\$283.5
Savings and Costs Avoidances	\$92.9	\$2,022.6	\$2,115.5
Questioned Costs	\$106.9	\$329.8	\$436.7
Dollar Recoveries	\$13.0	\$23.1	\$36.1
Cost of Operations	\$83.2	\$93.1	\$176.3
Return on Investment	10:1	34.1	23.1
Contract Review Only - Monetary Benefits	\$462.0	\$205.4	\$667.4
Preaward Potential Savings	\$59.0	\$183.4	\$242.4
Postaward Recoveries	\$8.0	\$18.6	\$26.6
Claims Reviews	\$0.4	\$3.4	\$3.8

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 prompted VA to take the following steps:

- Ensure that Virtual Pharmacy Services Meds by Mail clinical pharmacists are practicing within an appropriate scope of practice, particularly as relates to modifications to treatment plans for veterans with complex mental health needs.⁴¹
- Evaluate existing leadership and governance structures as they related to the thoracic surgery program to include consideration of designating a thoracic specialty leader with authority to review all aspects of the personnel and management actions and who can provide unbiased, authoritative, and timely guidance to facilities on the most clinically sound course of action when a thoracic surgeon’s practice or outcomes are under review, in order to ensure that VA provides high quality care.⁴²
- Develop comprehensive standard operating and compliance procedures for mammography programs that ensures facilities appropriately document breast imaging data in electronic health records, communicate test results to patients and providers in a timely manner, and formalize critical training for technical and administrative staff.⁴³

⁴¹ VA OIG. *Deficiencies in Virtual Pharmacy Services in the Care of a Patient*. Report No. 19-07827-182, June 18, 2020. <https://www.va.gov/oig/pubs/VAOIG-19-07827-182.pdf>.

⁴² VA OIG. *Thoracic Surgery Quality of Care Issues and Facility Leaders’ Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida*. Report No. 18-01321-56, January 13, 2021. <https://www.va.gov/oig/pubs/VAOIG-18-01321-56.pdf>

⁴³ VA OIG. *Mammography Program Deficiencies and Patient Results Communication at the Washington DC VA Medical Center*, Report No. 20-00563-68, February 25, 2021. <https://www.va.gov/oig/pubs/VAOIG-20-00563-68.pdf>.

- Address deficiencies in infrastructure readiness⁴⁴ and the potential deleterious impact on access to care and other capabilities⁴⁵ associated with the go-live date for the new electronic health record system.
- Revise the current VBA peer review process to ensure that all errors are identified during quality reviews of the processing of disability compensation claims, revise performance review processes to assess competency in identifying errors, revise the error reconsideration process to adhere to VBA procedures and promote objectivity, and improve oversight of the error correction process.⁴⁶
- Meet requirements of the Federal Information Technology Acquisition Reform Act (FITARA) by ensuring that the chief information officer reviews and approves all IT acquisitions and initiating an agency wide IT acquisition awareness and training program covering FITARA requirements; providing clear and consistent acquisition processes to ensure FITARA compliance; ensuring all VA administration and staff offices work with the chief information officer for planning, programming, budgeting, and execution of all IT resources; and implementing department-level oversight processes to ensure the chief information officer is a member of governance boards that make informed decisions on all IT resources across the agency.⁴⁷

Investigative Actions. The OIG’s criminal, civil, and administrative investigations led to 177 indictments, 183 convictions, and 496 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.

- A former nursing assistant pleaded guilty to **seven counts of second-degree murder and one count of assault with intent to commit murder** for administering insulin to eight veterans with the intent to cause their deaths at the VA medical facility in Clarksburg, West Virginia.⁴⁸ The OIG learned of suspicious deaths at the facility in late June 2018 and a team of investigators was on site within 24 hours. In a matter of days, the defendant was identified as a person of interest and the OIG had her removed from further patient care, likely saving additional lives while the OIG and its law enforcement partners built a case

⁴⁴ VA OIG. *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>.

⁴⁵ VA OIG. *Review of Access to Care and Capabilities during VA’s Transition to a New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*. Report No. 19-09447 136, April 27, 2020. <https://www.va.gov/oig/pubs/VAOIG-19-09447-136.pdf>.

⁴⁶ VA OIG. *Deficiencies in the Quality Review Team Program*. Report No. 19-07054-174, July 22, 2020. <https://www.va.gov/oig/pubs/VAOIG-19-07054-174.pdf>.

⁴⁷ VA OIG. *VA’s Implementation of the FITARA Chief Information Officer Authority Enhancements*. Report No. 18-04800-122, June 9, 2020. <https://www.va.gov/oig/pubs/VAOIG-18-04800-122.pdf>.

⁴⁸ Department of Justice. *Former VA Hospital Nursing Assistant Admits to 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-admits-murdering-seven-veterans-and-assault-intent>.

that ultimately resulted in court adjudications holding her accountable for her unconscionable crimes.

- A former Chief of Pathology at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, was sentenced to 20 years in prison and ordered to pay **\$487 thousand** in restitution for one count each of **involuntary manslaughter** and **mail fraud**.⁴⁹ A VA OIG investigation revealed the defendant misdiagnosed over 6,500 VA patients while under the influence of a potent substance that is undetectable using routine drug and alcohol testing methods. The defendant also circumvented contractually obligated drug and alcohol testing to conceal his chemical dependency.
- A former VA Doctor of Osteopathic Medicine was sentenced to 25 years in federal prison for **sexually abusing veterans** under the guise of legitimate medicine. The abuse occurred while the doctor was acting under color of law in his capacity as a VA physician and a federal employee and **deprived the veterans of their constitutional right** to bodily integrity and caused them pain.⁵⁰
- The owner of a technical training school and his wife admitted to falsifying student enrollment documents and employer verification information dating back to 2015, which caused VA to pay over **\$29 million** in tuition, books, fees, and monthly student housing allowances.⁵¹ As a result of the investigation, both the owner and his wife pleaded guilty in the Southern District of California to **wire fraud** and **making false statements**, respectively.
- A former case management liaison for the VA Spina Bifida Health Care Benefits Program was found guilty at a jury trial and sentenced in the District of Colorado to **16 years** in prison for **health care fraud, conspiracy, payment of illegal kickbacks and gratuities, money laundering, and conflict of interest**.⁵² The defendant was also ordered to pay **\$18.7 million** in restitution to VA.
- A health care services company headquartered in King of Prussia, Pennsylvania, and related entities settled **allegations under the False Claims Act** relating to medically unnecessary inpatient behavioral health services and **illegal kickbacks**.⁵³ The company

⁴⁹ Department of Justice. *Fayetteville Doctor Sentenced To 20 Years In Federal Prison For Mail Fraud And Involuntary Manslaughter*. <https://www.justice.gov/usao-wdar/pr/fayetteville-doctor-sentenced-20-years-federal-prison-mail-fraud-and-involuntary>.

⁵⁰ Department of Justice. *Former Veterans Affairs Doctor Sentenced to Prison for Sexual Abuse of Veterans*. <https://www.justice.gov/opa/pr/former-veterans-affairs-doctor-sentenced-prison-sexual-abuse-veterans>.

⁵¹ Department of Justice. *Owner of Local Technical Training School Pleads Guilty to Defrauding Department of Veterans Affairs of \$29 Million in Education Benefits*. <https://www.justice.gov/opa/pr/departement-veterans-affairs-office-inspector-general-and-department-justice-announce-veterans>.

⁵² Department of Justice. *VA Employee Sentenced For Orchestrating \$19 Million Corruption Scheme*. <https://www.justice.gov/usao-co/pr/va-employee-sentenced-orchestrating-19-million-corruption-scheme>.

⁵³ Department of Justice. *Universal Health Services, Inc. and related entities to pay \$122 million to settle False Claims Act allegations relating to medically unnecessary inpatient behavioral health services and illegal kickbacks*. <https://www.justice.gov/usao-ndga/pr/universal-health-services-inc-and-related-entities-pay-122-million-settle-false-claims>.

agreed to pay **\$122 million** to the federal government, of which **\$2.6 million** was returned to VA.

The table below summarizes the OIG’s investigative actions.

Measure	Semiannual Report (SAR) Summary		
	Issue 83	Issue 84	Combined
Investigative Actions			
Arrests	142	73	215
Fugitive Felon Arrests (OIG assisted)	12	2	14
Indictments	111	66	177
Criminal Complaints	28	27	55
Convictions	118	65	183
Pretrial Diversions and Deferred Prosecutions	14	5	19
Case Referrals to the Department of Justice	158	144	302
Administrative Sanctions and Corrective Actions (excl. Hotline)	303	193	496

Hotline Actions. The OIG’s Hotline continued to serve as the key conduit for allegations of fraud, waste, and abuse. Hotline staff received and processed 29,352 contacts—toll-free phone calls, web submissions, letters, and faxes—concerning problems related to VA programs and operations during the most recent SAR reporting periods, as summarized in the table below. All contacts received by the Hotline are triaged. Further, the OIG opened 1,613 cases in response to Hotline contacts, substantiated 36 percent of related allegations, and prompted 1,079 administrative sanctions. The Hotline also issued more than 6,633 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 83	Issue 84	Combined
Contacts	14,747	14,605	29,352
Cases Opened	895	718	1,613
Cases Closed	686	706	1,392
Substantiation Percentage Rate	36%	35%	36%
Administrative Sanctions (Hotline)	531	548	1,079

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. As of today, the OIG grew its LinkedIn base to 40,000 followers, a 196% percent increase from 2019, and published 411 updates to highlight reports, hiring activities, and other news that resulted in about 780,000 impressions (delivery to unique LinkedIn streams). In addition, the OIG had over 5,600 followers on Twitter, posted 200 tweets largely focused on reports and other OIG work that resulted in over 805,000 impressions. The OIG also published 26 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 100 inquiries and requests for quotes and interviews on the OIG's oversight work to major news outlets, including *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 VHA's COVID-19 preparedness, critical staffing shortages, major management challenges, and missteps in the initial implementation efforts involving electronic health record modernization.

Internal Improvements. The OIG took numerous steps in 2020 to increase operational efficiency and to maintain a highly engaged and productive workforce despite the transition to 100 percent telework for the vast majority of employees due to the pandemic. To address feedback from the *All Employee Survey* and gaps identified through an organizational needs analysis, a multidisciplinary team took noteworthy steps to empower OIG supervisors with the knowledge and skills to effectively lead teams, and to support their staff and ensure accomplishment of the OIG mission during a public health crisis. Examples of these steps include developing tip sheets for managers on common employee relations issues, offering more frequent training seminars for managers, developing a toolkit on managing a virtual workforce, and restructuring the OIG's new employee and new supervisor orientation to be conducive to a virtual format. The OIG also made several operational changes during the year to accommodate increased telework. These changes included distributing enhanced telework kits with external monitors, headsets, and other IT equipment; launching a virtual onboarding and offboarding process to limit person-to-person contact; and initiating expanded internal communications strategies including frequent emails to all staff with coronavirus updates and recurring virtual town halls.

VA OIG entered into an agreement with the General Services Administration and an integrated architecture, design, planning, and consulting firm to evaluate our current space portfolio. Based on the evaluation and in consultation with the consulting firm, VA OIG will develop a strategic path forward for our space portfolio that takes into consideration our mission, our ability to co-locate at VA facilities, and the impact the 2020 global health pandemic has had on how our employees work.

Budget Highlights

The OIG requests \$239 million for 1,100 FTE in 2022 to support essential oversight of VA's programs and operations through independent audits, inspections, reviews, and investigations; and timely detection and deterrence of fraud, waste, and abuse. The OIG will also utilize carryover from 2021 (both annual and APR supplemental funds) to support staffing and business requirements. The OIG's vast oversight responsibilities are complicated by the scope of VA's budget portfolio—over \$246 billion in enacted funding for 2021, plus \$17.1 billion in ARP funds—and the complexity of VA's major initiatives, including Mission Act implementation, electronic health record modernization, implementation of a new electronic medical logistics system, and financial management transformation. Despite its significant responsibilities, annualized funding for the OIG is consistently around 0.1 percent of the aggregate VA budget and the current VA to OIG staffing ratio is approximately 400:1. The VA OIG also has proportionally lower funding and staffing levels when compared with other OIGs for large executive branch agencies (see table below).

2021 Staff and Resource Comparisons for Selected Inspectors General*						
OIG	Funding (\$M)			FTE		
	Agency	OIG	OIG % of total	Agency	OIG	OIG % of total
Commerce	\$8,190	\$48	0.58%	43,206	200	0.46%
Treasury	\$17,692	\$39	0.22%	98,964	180	0.18%
Interior	\$21,554	\$59	0.27%	60,939	274	0.45%
Justice	\$38,845	\$107	0.28%	116,989	491	0.42%
Housing and Urban Development	\$47,942	\$133	0.28%	7,282	502	6.89%
Homeland Security	\$75,884	\$178	0.23%	232,326	747	0.32%
Transportation	\$88,725	\$98	0.11%	55,029	403	0.73%
Agriculture	\$151,411	\$100	0.07%	91,714	482	0.53%
VA	\$243,257	\$228	0.09%	404,835	1,048	0.26%
Health and Human Services	\$1,427,609	\$419	0.03%	77,845	1,676	2.15%

* Resource comparison references 2021 President's Budget requests (not enacted appropriations or supplementals). The VAOIG ranked 8th in funding ratios among surveyed agencies.

The OIG achieved significant financial and programmatic accomplishments that translate into direct savings to the taxpayer. During the past 5 years (SAR issues 75 through 84), the OIG identified more than \$26 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 and averaged a dollar return on investment of nearly \$38:1. Additionally, as described earlier in this chapter, the OIG performed at a high level with respect to the scope of published reports, recommendations issued and other significant work products, including alternative work products, congressional testimony, press releases, and podcasts.

In recognition of the value of OIG oversight, Congress, the Office of Management and Budget, and VA have provided strong support to expand operational capacity since 2014. As shown in the table below, OIG staffing has increased progressively with annual funding increases. Since hiring often bridges fiscal years and is subject to some degree of seasonality with respect to recruitments and retirements, annualized FTE generally lags onboard strength at the end a given year. The pandemic has challenged hiring efforts over the last 12 months, but its impact is expected to diminish over the near-term as OIG adjusts its recruitment strategy and various components of the public health response—including the distribution of vaccines—progress.

Budget Progression - Multiyear Comparison				
Fiscal Year	Enacted Budget (\$M)	Onboard Staff - Start	Onboard Staff- End	Annualized FTE
2014	\$121	615	634	613
2015	\$126	635	667	651
2016	\$137	666	692	680
2017	\$160	689	805	734
2018	\$164	809	872	849
2019	\$192	880	1,000	908
2020	\$210	988	1,018	1,000
2021	\$228	1,018	1,098	1,041
2022*	\$239	1,098	1,100	1,100

* President's Budget request; all other years reflect annual appropriations only (no supplementals or carryover).

Congress provided the OIG with \$12.5 million in supplemental funding through the CARES Act in 2020. These resources supported oversight and focused reviews of VA's internal capacity and

ability to respond to the public health crisis. It allowed the OIG to procure protective equipment for infection control and prevention and enhanced custodial services for employees. Lastly, the funds supported critical IT modernization requirements to sustain uninterrupted operations while vital staff worked remotely. The OIG fully executed all CARES Act funding at the end of calendar 2020.

The OIG received an additional \$10 million in no-year funds in 2021 under the ARP. The OIG intends to use these resources in 2022 to support pandemic-related oversight, strengthen programmatic capacity, modernize investigative infrastructure, and fulfill mission requirements pursuant to the *Inspector General Act*. The OIG is developing a formal operating plan in accordance with OMB guidance and Congressional requirements.

The 2022 budget request, in conjunction with a modest carryover (less than 5 percent) of annual 2021 appropriated funds, can support up to 1,064 FTE. This includes projected costs of salary (2.7 percent pay raise) and locality adjustments, career ladder promotions, within-grades, and nominal increases in agency benefits contributions. The additional carryover of \$10 million in ARP no-year funds will support an additional 36 FTE in 2022, for a total 1,100 FTE in the budget year. Although the use of supplemental funds to support staff is not ideal in a fiscal context, the OIG believes the unique circumstances of the pandemic and exigencies for responsive oversight and support of VA operations make a strong business case for pursuing an aggressive hiring plan with all available resources over the near term. The OIG regularly evaluates its budget execution plan and the status of funds and will manage staffing and operational needs within existing resources as required.

The OIG plans to continue to deploy and maintain a cadre of objective, responsive, highly trained, and dedicated employees at locations nationwide, especially near facilities where a more significant presence is required or the demand for oversight work has increased. About 80 percent of OIG's budget is for payroll, which must cover salaries and benefits for all OIG employees, including law enforcement officers who receive law enforcement availability pay and physicians who receive physician comparability allowances. Most OIG employees will continue to be directly involved in conducting audits, inspections, investigations, and other reviews of higher risk VA programs and services. Although the OIG regularly reviews operational requirements to identify efficiencies, most of the OIG's non-payroll expenses are fixed requirements for space, contracts, mandatory training, and mission-essential travel.

The funding requested for 2022 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. The additional investment in the OIG will support

- Continued oversight of the aftermath of the pandemic, without diminishing ongoing work,
- Expansion of multidisciplinary oversight to detect and deter healthcare fraud, waste, and abuse and the establishment of a special investigations unit to focus on complex and significant healthcare fraud-related issues,
- Additional oversight of other vital issues including
 - The impact of VHA's efforts to improve patients' access to timely and quality care at VA facilities despite chronic healthcare professional shortages,

- *Mission Act* implementation-related successes, lessons learned, and opportunities for improvement,
- The extent that VBA rectified previously identified and recurring deficiencies that impact benefits claims and appeals processing, including inadequate planning, controls, and information technology functionality that contribute to inefficiencies and inaccuracies in these processes,
- Early oversight of VA's initiative to replace its legacy electronic health record system, VistA, which has served the department for more than 40 years,
- The efficiency and operational impact of VHA's ongoing work to implement Defense Medical Logistics Standard Support, which would replace the current, legacy system, and
- Procurement and contract integrity as well as VA's ongoing efforts to replace its financial management system, which is over 25 years old and has functional limitations well documented in OIG reports.

The OIG will continue to expand the use of data to inform its work, leveraging OIG's data experts and subject matter experts, joint venture partners, and robust software that was recently procured to facilitate advanced data analytics and visualization. Such steps enhanced the OIG's ability to detect and prevent fraud, waste, and abuse in VA programs and services by supporting interdisciplinary work to simultaneously investigate individual wrongdoers and publish reports on programmatic vulnerabilities that, if addressed, could prevent or deter further crimes.

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 2022 budget request to VA is \$239,000,000 and 1,100 FTE. This includes the amounts that the Inspector General certifies to fulfill known requirements to support the Council of Inspectors General on Integrity and Efficiency (\$860,000) and OIG employee training (\$2,000,000), including training to address continuing education requirements and mandatory training for law enforcement officers. In addition, OIG requests that \$4,150,000 be set aside in the 2022 VA Minor Construction appropriation request to support projects. In addition to supporting VA 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 newly acquired office space in Bedford, MA, as the VA medical center indicated that it will no longer be able to provide space to the OIG due to limited available space on the medical center campus and the need to convert existing spaces to expand services for veterans. These funds will also be used to address new lease renovations at two of the OIG's largest field offices in San Diego and Dallas.

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 are limited once pandemic-

related restrictions abate. To the extent possible, the OIG has reprogrammed identified efficiencies back into operations to sustain the level of oversight.

Summary of Employment and Obligations (Dollars in Thousands)					
	2020 Enacted	2021 Request	2021 Enacted	2022 Request	Increase (+) Decrease (-) from 2021
Average employment:					
Headquarters functions	216	215	239	253	14
Operations functions	784	833	802	847	45
Total employment	1,000	1,048	1,041	1,100	59
Obligations:					
Personnel compensation and benefits	\$180,578	\$187,872	\$193,880	\$211,835	\$17,955
Travel/vehicles	\$3,488	\$8,272	\$1,500	\$6,790	\$5,290
Transportation of things	\$32	\$24	\$50	\$75	\$25
Rents, communications, and utilities	\$10,640	\$10,296	\$12,140	\$13,605	\$1,465
Printing and reproduction	\$25	\$21	\$25	\$26	\$1
Other services	\$18,196	\$18,039	\$20,416	\$20,824	\$408
Supplies and materials	\$707	\$636	\$427	\$800	\$373
Equipment	\$4,003	\$2,850	\$4,405	\$5,193	\$788
Insurance	\$0	\$12	\$5	\$5	\$0
Total obligations	\$217,669	\$228,022	\$232,848	\$259,152	\$26,304
Reimbursements	\$0	\$0	\$0	\$0	\$0
SOY Unobligated Balance (-)	(\$9,600)	(\$157)	(\$15,300)	(\$20,452)	(\$5,152)
EOY Unobligated Balance (+)	\$14,431	\$135	\$20,452	\$300	(\$20,152)
CARES Act	(\$12,500)	\$0	\$0	\$0	\$0
American Rescue Plan Act	\$0	\$0	(\$10,000)	\$0	\$10,000
Total Budget Authority	\$210,000	\$228,000	\$228,000	\$239,000	\$11,000

Note: Totals subject to rounding.

Net Change and Employment Tables

The following table summarizes the changes in resource requirements between the 2021 enacted budget and the 2022 request.

<i>Net Change</i> <i>Office of Inspector General</i> <i>2022 Summary of Resource Requirements</i> <i>(dollars in thousands)</i>		
	<u>BA</u>	<u>FTE</u>
2021 Enacted Budget	\$228,000	1,041
American Rescue Plan Act	\$10,000	
Net Carryover Execution	-\$5,152	
2021 Obligations Baseline	\$232,848	1,041
2021 Current Services Increases:		
Payraise (2.7%)	\$5,235	
Change in Staff Composition / Benefits Increases	\$1,357	
Nonpay Inflation (2.0%)	\$779	
Travel Normalization (Inspections, Training)	\$5,190	
Information Technology, Space, and Other Services Increases	\$2,380	
Subtotal	\$14,941	0
	\$247,789	1,041
% Change over 2021 Obligations Base	9%	0%
OIG Staffing Plan	\$11,363	59
2022 Obligations Baseline	\$259,152	1,100
Net Carryover Execution	-\$20,152	
Net BA Requirements	\$239,000	1,100
Efficiencies / Offsets*	\$0	0
Subtotal	\$0	0
2022 Total Request:	\$239,000	1,100
% Change over PB	5%	6%

* 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.

Employment Summary—FTE by Grade				
Grade	2020 Enacted	2021 Enacted	2022 Request	Incr./Decr. from 2021
IG/SES	19	19	19	0
Senior-Level (SL)	10	10	10	0
GS-15	117	123	129	6
GS-14	246	257	266	9
GS-13	510	533	570	37
GS-12	31	32	34	2
GS-11	29	29	32	3
GS-10	1	1	1	0
GS-9	26	26	28	2
GS-8	3	3	3	0
GS-7	5	5	5	0
GS-5	2	2	2	0
GS-1—4	1	1	1	0
Grand Total FTE	1,000	1,041	1,100	59

Analysis of 2020 FTE Distribution		
Grade	Headquarters	Operations
IG/SES	19	0
Senior-Level (SL)	2	8
GS-15	27	90
GS-14	57	189
GS-13	117	393
GS-12	7	24
GS-11	7	22
GS-10	0	1
GS-9	6	20
GS-8	1	2
GS-7	1	4
GS-5	0	2
GS-1—4	0	1
Grand Total FTE	244	756

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 2020 (Actual)	CY 2021 (Estimates)	BY* 2022 (Estimates)
3a) Number of Physicians Receiving PCAs	19	20	20
3b) Number of Physicians with One-Year PCA Agreements			
3c) Number of Physicians with Multi-Year PCA Agreements	19	20	20
4a) Average Annual PCA Physician Pay (without PCA payment)	175,000	177,500	179,000
4b) Average Annual PCA Payment	29,100	30,000	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. However, the OIG continues to face challenges to recruit and retain physicians. In FY 2020, VA OIG posted two Medical Officer positions. VA OIG hired one external Medical Officer and promoted two internal Medical Officers to SL positions. VA OIG currently has a cadre of 19 Medical Officers. In the last 5 years, VA OIG has lost 26 percent of its cadre of Medical Officers. Given the difficulty in recruiting Medical Officers, this level of turn over impacts the VA OIG's ability to perform its mission.

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

One of VA OIG's major 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 FY 2020, OIG conducted 54 comprehensive healthcare inspections, 46 hotline healthcare inspections, and 7 national healthcare reviews, in addition to reviewing 4,655 hotline referrals. This work illustrates a need to retain medical officers, as OIG has a need for their specific skill set in reviewing the work of our inspectors.