



OTHER INFORMATION

INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES.....	153
SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES.....	168
PAYMENT INTEGRITY INFORMATION ACT REPORT.....	169
CIVIL MONETARY ADJUSTMENT FOR INFLATION.....	176
GRANT PROGRAMS.....	177
CLIMATE-RELATED FINANCIAL RISK.....	178

Taps and Pledge of Allegiance

Pictured in the previous page:

When 90-year-old Air Force Veteran and VA patient John Gordon offered to play Taps at the Martinsburg VAMC to honor Pearl Harbor Remembrance Day, it was an opportunity the medical center couldn't refuse.

Gordon served 28 years during the Korea and Vietnam conflict eras. When he retired from the military and returned home, he traded his high school band trumpet for a bugle.

As a member of Taps Across America, Gordon has played Taps in his community for the past 2 years. He also recites the Pledge of Allegiance.

It's important to him to remember and honor his comrades—those who came before him and those who will come after—by playing Taps daily for his housing development overlooking the Potomac River in West Virginia.

"I usually single out the youngest person in the crowd for the pledge," Gordon said. "I do that so the young people get involved, learn the importance of why I do this."

A retired schoolteacher, Gordon's mission is to teach others about Veterans, Service members and their dedication to our Nation. To him, the opportunity to play Taps is not for his own recognition but an opportunity to honor those who lost their lives at Pearl Harbor.

"It's not about me," Gordon explains. "It's about them."

With each passing year, the Nation loses more World War II Veterans. Nationwide, there are about 167,000. Martinsburg VAMC has fewer than 1,000 enrolled World War II Veterans, five of whom call the Community Living Center their home.

The next time you hear Taps played, let it hold a special reverence. Let it remind you of the people who made the ultimate sacrifice.

Martinsburg VAMC thanks Gordon for teaching us to stop and remember.

INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES

Department of Veterans Affairs
Office of Inspector General
Washington, DC 20420

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FOREWORD

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, and the public by conducting effective independent oversight of Department of Veterans Affairs (VA) programs, operations, and services. Each year, the Inspector General summarizes the top management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges.

This year's major management challenges for VA continue to align with the OIG's strategic goals for addressing five areas of concern: (1) health care, (2) benefits, (3) stewardship of taxpayer dollars, (4) information systems and innovation, and (5) leadership and governance.

The challenges in these areas that VA must navigate in the fiscal year ahead have been identified by OIG personnel, with assistance from external oversight agencies and organizations, the veteran community, Congress, and other stakeholders. The OIG remains fully committed to identifying weaknesses that affect VA operations and its work on behalf of veterans, and then making meaningful recommendations for continuous improvement.

VA leaders face monumental challenges—both in scope and scale. At this writing, VA is struggling to implement a number of information technology systems critical to safely and promptly meeting the needs of veterans while making the best use of taxpayer dollars. Some of these systems, such as the new electronic health records system, cost billions of dollars and directly affect patient care and safety. VA also faces one of the largest benefits expansions in history, with more than four million veterans having completed screenings for toxic exposure since the PACT Act's passage. The resulting benefits backlog is anticipated to grow to 730,000 claims by April 2024 and newly connected veterans are expected to increase healthcare demands on VA as well. Although VA has hired tens of thousands of staff, it still grapples with critical shortages. Other challenges include addressing issues with veteran suicide (VHA's top clinical priority), maintaining timely access to quality health care across specialties both within VA and the community, and advancing fiscal controls are just some of the major management challenges oversight staff have highlighted. In addition, OIG reports reveal recurring themes and deficiencies that center around failures in VA governance and accountability.

The OIG appreciates the work VA personnel at every level do each day on behalf of veterans even as they try to navigate these many challenges.

(/s/) MICHAEL J. MISSAL
Inspector General

OIG CHALLENGE #1: HEALTHCARE SERVICES

High-quality care demands that patients receive the necessary treatment provided by qualified clinicians in a timely manner. This is even more critical for individuals deemed to be at high risk due to their mental health and substance use conditions. The pandemic disrupted healthcare delivery in all settings, including addiction treatment, yet at the same time increased the demand for such interventions. VHA will continue to rely on community providers to deliver care when a veteran's needs cannot be met within VA's own facilities. According to internal data systems' queries that OIG has access to, VA referrals to community care have increased over 70 percent from FY 2020 to FY 2022. As of July, FY 2023 referrals have already exceeded the number of total referrals for FY 2021 and are projected to exceed FY 2022. Coordinating medical care between the VHA care system and community providers remains a challenge, particularly for managing patients with complex behavioral health needs.

Many recent OIG reports have highlighted the risks when VA personnel fail to offer care in the community as required and, even more concerning, when that care is not coordinated.

Specifically, the OIG has identified persistent administrative and communication errors or failures among VHA, its third-party administrators, and community care providers, as well as between the care providers and their patients. These deficiencies challenge the considerable efforts of VHA personnel to ensure a seamless experience for veterans. Many OIG reports have described the frustrations and, most importantly, the risks associated with patients referred to the community.

In one example of the consequences of poor care coordination for high-risk patients, an OIG review found that administrative errors and confusion in the Phoenix VA healthcare facility's community referral process delayed specialized psychological testing for a veteran. The veteran died by suicide never having received the appropriate evaluation and resulting targeted treatment.

Another oversight report focused on a patient who ultimately died by suicide after not receiving several authorized community care counseling sessions. This was due to deficiencies in the coordination of the patient's care between the Memphis VA facility's community care staff, providers in the community, and the third-party administrator.

Further, VHA faces significant challenges in meeting the needs of individuals with substance use disorders. The devastating effects on veterans, their families and caregivers, and communities cannot be overstated. Veterans with substance use disorders often have co-occurring mental health issues that can place them at higher risk for suicide. Given that VHA's top clinical priority is to reduce veteran suicide, evidence-based substance use disorder treatment programs are imperative to addressing the clinical needs of these high-risk patients. When both VHA and community care providers are engaged in managing these patients, the coordination must be seamless and collaborative.

Why This Is a Challenge

Across the community care system there is wide variability in what services are available to meet veterans' healthcare needs. This is influenced by geographic location, the disease burden of local veteran populations, medical academic institution affiliations, and other factors.

VHA has launched the Referral Coordination Initiative (RCI) at medical facilities across the country to facilitate consult scheduling for specialty care within VHA facilities and in the community, but it has struggled to implement and develop mechanisms to assess the initiative's effectiveness. The facilities have reported facing implementation challenges such as insufficient staffing and resources, unreliable wait time data, and delays in getting responses to questions. In addition, the Office of Integrated Veteran Care lacked reliable data to measure whether RCI was meeting its goal of reducing the time required to schedule appointments. The office did not assess whether staff appropriately provided patients with key information to make informed care decisions or enabled healthcare providers to spend more time with patients.

In addition, the OIG has found that VHA does not have reliable data to assess clinical and nonclinical community care staffing levels within its facilities. Many VA medical facilities reported challenges recruiting and retaining qualified medical support assistants who are responsible for processing community care referrals. Those positions require knowledge of clinical terminology and context and VA is competing with some local healthcare systems that offer higher wages and signing bonuses. The medical support assistant position was the most frequently reported Hybrid Title 38 severe shortage occupation reported by the OIG in FY 2023.

In a final example, the OIG has determined that VHA does not provide sufficient oversight for prescribing opioids to veterans despite their having a higher risk of opioid overdose than the general population. Recent OIG work shows that the Office of Integrated Veteran Care did not adequately oversee third-party administrators to ensure providers received and certified that they reviewed the Opioid Safety Initiative guidelines, nor did the office monitor third-party administrators to make certain that non-VA providers were completing prescription drug monitoring program queries as required.

Department's Corrective Actions

In a positive step forward, VA has gathered best practices on RCI implementation and posted them to an RCI SharePoint site. The Office of Integrated Veteran Care also developed and released revised RCI reference materials for VA medical facilities, including an updated guidebook, a scheduling learners' guide, scripts for discussing options with veterans, and training courses to standardize RCI execution.

However, as recommended in a recent OIG report, the Department needs to develop and implement a process that ensures timely clinical information sharing between VHA and community providers. Doing so will help ensure high-quality and safe care, coordinated support for veterans with complex and high-risk mental health diagnoses requiring multidisciplinary services, and provide support staff with clear guidance on offering every veteran all options of care.

VHA needs to improve RCI implementation by better assigning responsibilities and roles, improving training, establishing local procedures for sharing community care data for informing patients, sharing best practices among all facilities, ensuring accurate tracking of RCI consults, and developing ways to measure how well facilities meet the initiative's requirements. VHA also needs to improve the reliability of community care staffing data. It should also develop staffing reports that can be searched by service departments and assess incentives to determine whether they are effective in recruiting and retaining administrative staff.

OIG CHALLENGE #2: BENEFITS FOR VETERANS

VBA's responsibility for processing claims is at the core of providing veterans an extensive range of benefits, including military service-connected disability compensation, pension benefits, and education and vocational training, as well as compensation for eligible family members and caregivers. Claims processing often involves tremendously complicated processes, evaluations, and decision-making. Yet it is subject to challenging timelines in order to promptly provide eligible recipients with the accurate amount or level of benefits.

Challenges with benefits processing rise exponentially when eligibility is expanded or systems and processes are modernized. For example, VA has reported that since the PACT Act was passed in one of the largest benefits expansions in VA history, more than 100,000 veterans presumed to have toxic exposure for benefits consideration have enrolled in VA health care. In addition, more than four million veterans have completed toxic exposure screenings. Further, the PACT Act benefits backlog is expected to grow to 730,000 claims in April 2024. VBA's non-PACT Act claims inventory has risen to nearly 1.4 million with a backlog of more than 230,000 as of June 2023. In response, VA has expanded hiring for over 21,000 healthcare staff and 4,300 benefits personnel as it addresses the challenge of staffing shortages in multiple disciplines across the enterprise.

The PACT Act implementation has prompted a hiring surge and strategies such as automation to address the processing of claims backlogs. These actions have created many novel challenges for VA. Notably, the OIG has identified 25 high-risk areas associated with PACT Act implementation. There is also an expectation that the OIG will receive an increased number of allegations and complaints related to VA's provision of healthcare screening and care required by the PACT Act. All of this work will be conducted as key information technology systems are being modernized that have historically created additional obstacles for staff deploying them.

Why This Is a Challenge

VBA processes claims that can be exceedingly complex. VBA must process claims consistent with complicated and often unclear laws, policies, regulations, and VA procedures. Processing these claims accurately and within the mandated timelines requires continuous monitoring and oversight by VBA leaders and personnel. They must incorporate constant updates, standardize decisions for consistency, and identify errors that could affect the accuracy of the monetary benefits veterans receive.

These challenges can also be exacerbated by conditions beyond VBA's control. In FY 2023, for example, VBA was still handling a backlog of claims that flowed from the COVID-19 pandemic and anticipates an additional increase from the implementation of the PACT Act. While they are resolving claims year at a record rate—about 15 percent higher than last year on average as of June 2023—those gains were eclipsed by a record 30 percent more claims filed in the same time period, according to VA.

In addition to managing its backlog, VBA continues to struggle to interpret and implement laws and policy for managing claims and appeals—from knowing when to request medical reexaminations for veterans with claimed disabilities to ensuring complex appeals are reviewed by qualified staff. For example, VBA employees erroneously required veterans to be reexamined, even when their disabilities were permanent and not likely to improve. This subjected some veterans to unnecessary exams and travel. The employees made this error in

part because VBA had not required claims examiners to cite objective evidence for why reexaminations were needed. Additionally, VBA's Compensation Service failed to contact visually impaired veterans by telephone to discuss the contents of decision notices, despite knowing since 2011 that its written products were not in compliance with section 504 of the Rehabilitation Act. Consequently, some veterans may not have been made aware of the evidence VBA required to process their claims. In addition, complex appeals were decided by VBA staff who were not designated to do so or had not completed all mandatory training because VBA's Office of Administrative Review did not monitor completed appeals to ensure they were decided by qualified staff.

With respect to personnel shortages, both VBA and VHA are struggling to hire and retain qualified personnel, despite VA having one of its best hiring years, according to VA. The OIG is required by law to conduct an annual review to identify clinical and nonclinical VHA occupations with the largest staffing shortages within each VHA medical center. In the FY 2023 review, the OIG found that all 139 VHA medical facilities that were surveyed reported at least one severe occupational staffing shortage. The total number of their reported severe shortages was 3,118, up from 2,622 the previous year. In FY 2023, even more severe occupational staffing shortages were reported by more facilities than in recent years.

Department's Corrective Actions

VBA is taking steps to better process its tremendously high volume of claims. To improve its claims processing quality, VBA is planning to use information technology system modernization and automation tools that reduce the errors inherent in manual processing. VBA anticipates automation tools will also improve claims processing efficiency by increasing the number of claims processed, shortening the time to make decisions, improving quality, and reducing the number of unnecessary examinations. In addition, VBA has updated its procedures manual to clarify which raters meet the requirements to issue decisions on complex appeals.

VBA needs to continue to implement the OIG's recommendations for improvement and better instruct VBA claims examiners. VBA should make sure that its personnel are equipped and prepared to do their jobs. VBA is responding to the OIG's recent findings that claims processors did not consistently identify relevant medical evidence for the examiner's review, did not always use clear and accurate language, did not regularly request all warranted medical opinions, and sometimes requested unnecessary medical opinions. One contributing factor was inadequate training. These failings can lead to inaccurate medical opinions, incorrect decisions on veterans' claims, delayed decisions for veterans, and an inefficient use of resources.

To address its staffing shortages, VA has engaged in surge hiring and other recruitment strategies under their expanded authority. While expedient hiring is critical, VA cannot lower its standards for suitability and expertise. VA is also responding to a recent OIG report on suitability (background) checks. In the course of auditing the personnel suitability process across all VA medical facilities, the OIG detected problems with how this process was being conducted at the VA medical center in Beckley, West Virginia. VA must be diligent in employing proper protocols to ensure staff are both qualified and suited to their positions even as they expedite hiring.

OIG CHALLENGE #3: STEWARDSHIP OF TAXPAYER DOLLARS

The OIG has repeatedly found that VA's failure to effectively modernize its financial management systems has led to significant challenges in assuring accountability and transparency in how it obligates and expends funds. These failures in maintaining effective systems for financial management (as well as inventory tracking, patients' electronic health records management, and others discussed in the following section) have made it difficult for VA staff to effectively conduct their duties, making inefficient and ineffective use of their time and taxpayer dollars. For example, financial management system problems have significantly hampered planning of activities; ordering and tracking supplies and equipment, some of which have been found damaged or expired in storage areas; and providing oversight of the expenditure of billions of taxpayer dollars on emergent and expanded programs.

The recurring deficiencies identified by the OIG and other oversight agencies related to VA's inability to effectively implement major systems modernization have been the subject of intense congressional and media scrutiny. Although the OIG recognizes that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, their efforts are being undermined by aging legacy systems that create significant hurdles to performing their jobs and in monitoring the use of funds for personnel, purchases, and services.

VA faces the ongoing challenge of overseeing its vast spending across its enterprise. OIG reports have detailed inadequate oversight in areas such as pharmaceuticals and medical supply purchases, recovered overpayments, and purchase card use. These oversight problems have been attributed to and compounded by the Department's outdated financial management system. Although VA has initiated deployment of iFAMS (see management challenge 4), VA continues to rely on legacy financial systems, manual reconciliations, and adjustments, which has caused VA to be noncompliant with major financial management regulations. Due to VA's outdated financial management system, VA has struggled to ensure accountability and transparency in how it obligates and expends funds, particularly the supplemental funds VA received to prevent, prepare for, and respond to the COVID-19 pandemic. As the OIG reported, VA ultimately lacked assurance that funds allocated specifically for COVID-19-related purposes were being spent as intended.

Other core system failures also have significant financial consequences. For example, the Electronic Health Record Modernization program discussed in the following section was initially projected to cost \$10 billion but has been revised upward of \$16 billion, although based on OIG reports that amount is likely to increase. Failures in system planning, contracting, remediation, and other factors have led to long pauses, and the OIG has estimated that delays in the program's completion beyond the projected end date would cost about an additional \$1.95 billion a year.

Beyond information technology systems, OIG reports have focused on significant waste that can be attributed in large part to the lack of controls, systems, and VA oversight needed to ensure products and services purchased with taxpayer funds are used efficiently and effectively.

Also, given the billions of dollars allocated for PACT Act implementation and other program expansions—including the increased payment of disability benefits and healthcare expenditures by VA—the OIG expects VA will need to be even more vigilant for identifying potential criminal activity. This creates a challenge for VA to develop greater controls for prevention of theft, misuse of funds, and fraud, and to report indicators of such activity to the OIG.

A recent example of benefits fraud was an investigation in early 2023 by the VA OIG and Social Security Administration OIG that revealed multiple individuals conspired to submit fraudulent documents and misrepresent the severity of their disabilities to obtain VA compensation benefits. The loss to VA for this single case is approximately \$964,000 and the individuals involved received sentences of probation or prison time as well as an order for restitution.

Why This Is a Challenge

VA has faced significant challenges with improving its financial processes and systems—some of which result from deficiencies in information technology and lack of controls, while others are due to weaknesses in governance or the clarity of roles and responsibilities. More effective financial management is key to VA’s ability to better plan, direct, monitor, and control its resources. Advances could also enhance efforts to safeguard VA assets and the timely payment of its obligations. Reliable and accurate financial information would help VA and Congress identify links between resources and results, and to understand and improve the value gained from appropriated funds.

Persistent issues require extensive efforts to change business processes, research legacy differences, and implement workarounds or more lasting solutions. Other contributing factors include questionable controls over significant program accounting estimates, decentralized and disjointed financial systems and reporting, and serious control weaknesses throughout the organization with respect to financial reporting. Attributable to a decentralized and fragmented organizational structure for financial management, these weaknesses include challenges with risk assessment and monitoring; the lack of an effective, comprehensive, and integrated financial management system; a challenging IT environment; and the reliance VA places on manual processes to identify or correct errors with financial information.

Without the deliberate and universal implementation of a centralized and testable financial management application, VA’s history of noncompliance with major financial management regulations will continue.

Department’s Corrective Actions

By implementing iFAMS, the Financial Management Business Transformation office reports it will increase the transparency, accuracy, timeliness, and reliability of financial information across VA. iFAMS is meant to result in improved fiscal accountability to taxpayers and strengthen the department’s ability to provide care and services to veterans. Additionally, VA proposes that iFAMS will help to resolve a material weakness on its annual financial statements and increase its operational efficiency, productivity, agility, and flexibility.

The transition is exceptionally complicated—requiring intensive and continuous attention from VA—and demands strong organizational leadership and coordination. The OIG urges VA to dedicate the time and resources to resolving the early opportunities for improvement in the iFAMS transition, being vigilant in identifying challenges that will arise in the forthcoming deployments, and developing processes for timely and effective responses.

OIG CHALLENGE #4: INFORMATION SYSTEMS AND INNOVATION

VA is responsible for storing, managing, and providing secure access to enormous amounts of sensitive data, such as veterans' medical records, benefits determinations, financial disclosures, and education records. Safeguarding systems and networks that contain this sensitive data is essential, especially with the wide availability and effectiveness of internet-based hacking tools. Without proper measures, these systems and networks are vulnerable to groups seeking to obtain sensitive information, commit fraud, disrupt operations, or launch attacks against other VA systems.

VA is in the process of modernizing a number of vital systems that are critical to its operations. VA's wide-ranging IT systems and networks are essential to providing medical care, benefits, and services to millions of veterans and their families. The OIG has been proactively overseeing VA's implementation of these crucial systems. However, as the OIG has detailed in multiple reports, VA has had significant troubles with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. Major plans to modernize electronic health records, supply chain management, claims processing, and financial management systems have been marked by serious missteps. These have typically included weaknesses in planning, lack of stability in leadership positions, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies.

The OIG recognizes the tremendous complexity and cost of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working tirelessly to ensure patient safety and to deliver benefits and services to eligible veterans.

Why This Is a Challenge

VA has made progress developing, documenting, and distributing policies and procedures as part of its agency-wide information security and risk management program. VA has also initiated several high-level action plans to address previously identified security weaknesses and the information technology material weakness reported as part of the Consolidated Financial Statement Audit. Still, OIG reports indicate there is much more to be done.

Information technology modernization projects have historically been very challenging for VA. The update of its patient record system has proven to be especially troubling. Perhaps the largest contract in VA history, and one that affects patient care, is VA's contract for its Electronic Health Record Modernization program. Key objectives of the new system include achieving interoperability of VA and DoD systems to provide complete health records for veterans and enhancing VA's ability to exchange records with external healthcare providers. Essential to implementing and budgeting this multibillion-dollar effort, VA needs a high-quality, reliable, and integrated master schedule to ensure all tasks are properly and fully completed and reported. An OIG audit found, however, that this foundational master schedule had significant reliability weaknesses, including missing tasks, no baseline schedule, and no risk analyses.

Although VA paused its Electronic Health Record Modernization rollout in June 2022, users of the new system continue to raise troubling complaints that the system hinders the delivery of prompt, high-quality patient care. The effects on staff, workload, and the risks for errors continue to be concerning.

Similarly, there are other key systems for maintaining effective and efficient VA operations in other areas that are also in critical need of updates or replacement. To modernize its financial and acquisition management systems, VA established the Financial Management Business Transformation program to replace legacy systems with the new iFAMS described above. VA maintains that iFAMS should be a streamlined, federally compliant, and cloud-hosted financial and acquisition solution with business processes and capabilities, which will help VA better comply with major financial management regulations. iFAMS implementation is intended to occur in a series of 18 waves, starting with the NCA. However, when deploying iFAMS at the NCA, the FMBT Service failed to establish comprehensive controls to reduce data reliability risks posed by a manual acquisition process and comprehensively test converted contracts. As a result, NCA contracting staff had to manually enter data in both iFAMS and the legacy system for deobligations. Additionally, iFAMS made paying some contract invoices more cumbersome. Improving risk management and system testing could help the FMBT Service prevent issues from affecting a significantly greater number of staff at VA's larger administrations and allow the FMBT Service to achieve the overall program goals.

Department's Corrective Actions

To help secure the information systems in place, VA needs to continue to address identified deficiencies within access and configuration management controls across all systems and applications. Because of the issues with the consistent application of the security program and practices across VA's portfolio of systems, VA should have adequate control and risk management procedures applied to all their systems and applications consistent with OIG recommendations.

As of September 1, 2023, of the 68 recommendations issued on VA's rollout of the new electronic health record system, 21 have not yet been implemented. Some of these have necessarily been put on hold during the follow-up contract execution and the site deployment pause that VA instituted to remediate identified problems. The open recommendations include VA minimizing the number of required mitigation strategies healthcare providers must use when the system goes live, determining whether veterans' appointments are being scheduled correctly, and addressing unresolved issues related to medication management and care coordination. VA must more effectively engage and coordinate with all affected offices and contractors to effect needed IT and governance solutions and develop an accurate master schedule that takes into account additional anticipated delays and related costs.

VA will also need to consider how its massive information technology system modernization efforts affect one another. These system deployments are inextricably linked. For example, the iFAMS deployment will affect the inventory system upgrades, and the benefits processing system must account for the need to access the new electronic health record system. This will require VA to not only take into account the individual users of each new system, but how they will affect other deployments.

OIG CHALLENGE #5: LEADERSHIP AND GOVERNANCE

The OIG's oversight reports often reveal recurring themes and deficiencies that center on the key elements of accountability. For example, healthcare facilities committed to patient safety should follow protocols that prioritize high-quality care and have a structured and proactive quality and safety management oversight team. OIG reports, however, routinely identify

instances in which staff fail to adhere to policy or to take actions that ensure a culture of patient safety. In recent years, the OIG has also found failures of leadership and governance across VA, to include VBA and the NCA. This included OIG findings of deficiencies with the physical security of medical facilities, faulty claims processing for military sexual trauma claims, and the inadequate and ineffective administration and oversight of the final disposition of veterans' unclaimed remains, the latter of which responsibility spanned all three agencies.

A recent OIG healthcare oversight report found that the Tuscaloosa VA Medical Center and VISN 7 had insufficient oversight of the facility's Patient Safety Program. The OIG received a VHA Issue Brief identifying concerns with the program's management personnel not completing the required patient safety root cause analyses and risk assessments, and the former patient safety manager not attending meetings with facility and VISN committees. These concerns followed the extended leave and abrupt retirement of the former patient safety manager. The OIG substantiated the concerns and identified other issues with program oversight and the facility's culture of safety. Facility leaders failed to fully engage with Patient Safety Program staff and did not sufficiently use available tools to assess and evaluate reported concerns that put patients at unnecessary risk.

Other OIG reports have identified when leaders' delays in responding to concerns related to the competency of healthcare providers put patients at risk. A report on the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana, highlights this issue. The cardiology nursing staff had expressed multiple concerns to facility leaders regarding the skills of a newly trained interventional cardiologist. As a result, the cardiologist's cardiac catheterization laboratory privileges were suspended and a fact-finding investigation was initiated. However, these actions were not completed in a timely manner. The fact-finding investigation was finalized more than three months after the cardiologist's suspension, and it took almost another three months for the cardiologist's privileges to be reinstated so that leaders could initiate a second observed evaluation of the cardiologist's performance in the catheterization laboratory. After six months out of practice, the cardiologist refused to participate in a practice review and resigned. Ultimately, the OIG did not substantiate that the interventional cardiologist provided poor quality of care to patients at the facility.

Why This Is a Challenge

VA leaders at every level often do not consistently get the information they need to make effective decisions and, in some cases, fail to take necessary and prompt action when they do. Leaders and managers often struggle to create a culture and environment in which every employee feels empowered to report problems. Frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

The OIG's recent report on the mistreatment of a patient admitted to the Miles City Community Living Center, part of the VA Montana Healthcare System in Fort Harrison, describes failures in leadership that led to several incidents of patient abuse. The OIG learned that nurses and a physical therapist forced a critically ill patient to walk. The patient first verbally refused to walk and then went down to the floor to further refuse participation. Staff reported that the physical therapist and a nurse forcefully lifted the patient by the arm to stand and then pulled the patient's walker forward and out of reach, compelling the patient to walk. A VA police report documented bruises to the patient's arms, and staff told the OIG that the patient sustained skin tears during this session. The OIG concluded that the physical therapist and nurses violated

VHA policy by failing to respect the patient's right to refuse treatment and subjecting the patient to mistreatment during two physical therapy sessions while critically ill. The OIG also determined that there were three previous investigations with confirmed findings of mistreatment or abuse in the community living center. Two nurses involved in the mistreatment of this patient were also involved in two of the other incidents, one in a 2018 incident and both in an August 2020 incident. The OIG determined that facility leaders did not complete oversight processes for the community living center, including intervening in prior findings of community living center patient mistreatment in 2018 and 2020. Facility leaders also failed to oversee the sole physician responsible for the community living center patients. The lack of oversight repeatedly placed patients at risk.

This case reflects the kind of conditions the OIG has found in other VA medical facilities that did not foster the prompt and candid reporting of concerns. Leaders' failures to create a culture in which personnel feel safe in reporting clinical personnel's incompetency or errors can lead to tragic outcomes.

Department's Corrective Actions

There is no question that the overwhelming number of VA leaders and personnel are committed to serving veterans, their families, and caregivers, as well as answering the call for assistance from their local communities in times of crisis. They often have to navigate obstacles and overcome challenges to make certain that patients receive prompt high-quality care and that veterans and other eligible beneficiaries receive the compensation and services they have earned. Unfortunately, the OIG has found that despite VA efforts to protect whistleblowers and encourage continuous improvement and accountability, some leaders and personnel continue to struggle with implementing the key components of accountability. This is a theme demonstrated throughout these major management challenges as causes for deficiencies.

Leadership within an organization the size of VA is complex, and there is not a single solution that covers all circumstances. However, OIG testimony and related report recommendations include creating a strong governance and clarity of roles and responsibilities; ensuring adequate and qualified staffing; employing updated IT systems and effectual business processes; requiring effective quality assurance and monitoring; and providing stable leadership that fosters responsibility for actions and continuous improvement. OIG reports often provide specific recommendations related to governance and leadership as part of its examination of the causes for identified problems. Even if they only apply to a single facility, office, or program area, they should be considered across the enterprise.

OTHER INFORMATION

INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES

Related Reports:

Selected related reports (with a comprehensive list of publications available at www.va.gov/oig/):

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Additional Actions Needed to Fully Implement and Assess the Impact of the Patient Referral Coordination Initiative	10/27/2022	X				
Audit of VA's Financial Statements for Fiscal Years 2022 and 2021	12/7/2022			X	X	
VBA's Compensation Service Did Not Fully Accommodate Veterans with Visual Impairments	12/8/2022		X			
Deficiencies in Credentialing, Privileging, and Evaluating a Cardiologist at the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana	1/17/2023	X				X
Inspection of Information Security at the Southern Oregon Rehabilitation Center and Clinics	1/18/2023				X	
Inspection of Information Security at the Tuscaloosa VA Medical Center in Alabama	1/18/2023				X	
Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System	1/31/2023	X				X
Mistreatment and Care Concerns for a Patient at the VA Montana Healthcare System in Miles City and Fort Harrison	1/26/2023	X				X
Financial Efficiency Inspection of the Palo Alto Health Care System in California	2/2/2023			X		
Financial Efficiency Inspection of the Northern Arizona VA Health Care System	2/8/2023			X		

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Security and Incident Preparedness at VA Medical Facilities	2/22/2023					X
Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia	2/23/2023					X
Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama	2/27/2023	X				X
VBA Did Not Ensure Complex Appeals Were Decided by Appropriate Staff	3/9/2023		X			
Veterans Are Still Being Required to Attend Unwarranted Medical Reexaminations for Disability Benefits	3/16/2023		X			
Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona	3/23/2021	X				X
Improvements Needed in Integrated Financial and Acquisition Management System Deployment to Help Ensure Program Objectives Can Be Met	3/28/2023				X	
Audie L. Murphy Memorial Veterans' Hospital Missed Opportunities to Distribute Excess Ventilators during the COVID-19 Pandemic	4/11/2023			X		
VHA Can Improve Controls Over Its Use of Supplemental Funds	5/9/2023			X	X	
Federal Information Security Modernization Act Audit for Fiscal Year 2022	5/17/2023				X	
Goals Not Met for Implementation of the Beneficiary Travel Self-Service System	5/31/2023		X		X	

OTHER INFORMATION

INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
Inspection of Information Security at the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania	6/7/2023				X	
Compensation and Pension Benefits Claims Backlog Issue Statement	6/8/2023		X			
Inspection of Information Security at the St. Cloud VA Medical Center in Minnesota	6/8/2023				X	
Financial Efficiency Inspection of the NY Harbor VA Health Care System	6/14/2023			X		
Community Care Departments Need Reliable Staffing Data to Help Address Challenges in Recruiting and Retaining Staff	7/19/2023	X				
OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023	8/22/2023	X				X
Deficiencies in Care, Care Coordination, and Facility Response to a Patient Who Died by Suicide, Memphis VA Medical Center in Tennessee	9/3/2020	X				X
Surgical Adverse Clinical Outcomes and Leaders' Responses at the Columbia VA Health Care System in South Carolina	9/27/2022	X				X

Related Congressional Testimony	Challenge				
	#1	#2	#3	#4	#5
VA's Electronic Health Record Modernization: An Update on Rollout, Cost, And Schedule, September 21, 2022				X	X
Statement of Inspector General Michael Missal – Hearing on “How the OIG Enhances Accountability at VA” – February 28, 2023					X

Related Congressional Testimony	Challenge				
	#1	#2	#3	#4	#5
Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on “Combatting a Crisis: Providing Veterans Access to Life-Saving Substance Abuse Disorder Treatment” – April 18, 2023	X				X
Statement of Inspector General Michael Missal – Hearing on “COVID-19 Supplemental Funding: Did it Protect and Improve Veteran Care” – May 23, 2023	X		X		X
Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on “Care Coordination: Assessing Veteran Needs and Improving Outcomes” – June 13, 2023	X				X
Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections – Hearing on “Connections to Care: Improving Substance Use Disorder Care for Veterans in Rural America and Beyond” – June 14, 2023	X				X
Statement of Nicholas Dahl, Deputy Assistant Inspector General, Office of Audits and Evaluations – Hearing on “The Status of VA’s Financial Management Business Transformation” – June 20, 2023				X	X
Statement of Deputy Inspector General David Case – Hearing on “Pending Legislation” – July 12, 2023					X
Statement of Stephen Bracci, Director, Claims and Medical Exams, Office of Audits and Evaluations – Hearing on “VA Disability Exams: Are Veterans Receiving Quality Service?” – July 27, 2023		X			X

VA Management’s Response

VA acknowledges the challenges presented in the OIG report and appreciates the IG’s dedication to identifying opportunities for improvement in VA programs and operations. For additional information on management’s response and the measures VA is implementing to address each challenge, refer to the individual IG reports related to each challenge as provided in the previous table.

OTHER INFORMATION

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

SUMMARY OF FINANCIAL STATEMENT AUDIT AND MANAGEMENT ASSURANCES

The following tables provide a summary of audit-related or management-identified material weaknesses and the noncompliance with FFMA and Federal financial management system requirements outlined in the 2023 AFR.

Audit Opinion	Unmodified				
Restatement	No				
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Ending Balance
Controls Over Significant Accounting Estimates	1	-	-	-	1
Financial Systems and Reporting	1	-	-	-	1
IT Security Controls	1	-	-	-	1
<i>Total Material Weaknesses</i>	3	-	-	-	3

Summary of Management Assurances

Effectiveness of Internal Control over Financial Reporting (FMFIA § 2)

Statement of Assurance	Modified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Controls Over Significant Accounting Estimates	1	-	-	-	-	1
Financial Systems and Reporting	1	-	-	-	-	1
<i>Total Material Weaknesses</i>	2	-	-	-	-	2

Effectiveness of Internal Control over Operations (FMFIA § 2)

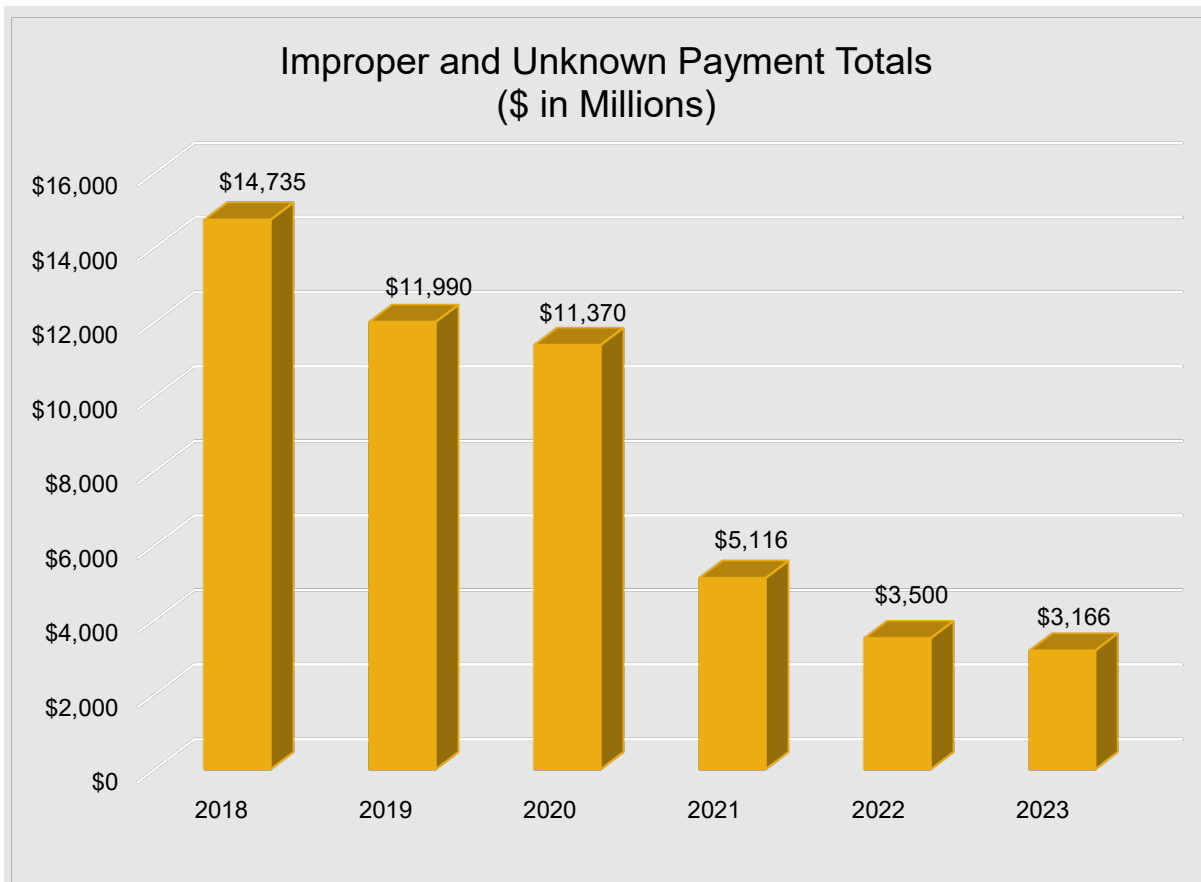
Statement of Assurance	Unmodified					
<i>Conformance with Federal Financial Management System Requirements (FMFIA § 4)</i>						
Statement of Assurance	Systems conform, except for the below nonconformance					
Nonconformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
IT Security Controls	1	-	-	-	-	1
<i>Total Nonconformances</i>	1	-	-	-	-	1

Compliance with Section 803(a) of the Federal Financial Management Improvement Act (FFMIA)

	Agency	Auditor
System Requirements	Lack of compliance noted	Lack of compliance noted
Accounting Standards	No lack of compliance noted	No lack of compliance noted
USSGL at Transaction Level	Lack of compliance noted	Lack of compliance noted

PAYMENT INTEGRITY INFORMATION ACT REPORTING

In FY 2023, VA reported a reduction of \$333.87 million in improper and unknown payments, a reduction of 9.54% from FY 2022 results. VA’s implementation of mitigation strategies and corrective actions reduced improper and unknown payments despite increases in outlays of \$4.32 billion, or 13.61%. Since FY 2018, VA has reduced improper and unknown payments by \$11.57 billion, or 78.51%, and removed seven programs from reporting requirements, by prioritizing corrective actions on the largest proportion of errors and noncompliance with laws and regulations. No significant changes in payment integrity methodologies or activities occurred during the FY 2023 reporting period. However, VA continues to strengthen test plans and collection of error data to ensure accurate projections and inform effective remediation strategies.



HIGH-PRIORITY PROGRAMS

During FY 2023, VA reported on two High-Priority programs, Pension and VA Community Care, based on payment integrity testing completed in FY 2022 to paymentaccuracy.gov. Programs with estimates of monetary losses exceeding \$100 million for the year are considered high priority and require additional reporting the following fiscal year. Based on payment integrity testing completed in FY 2023, VA will report on three High-Priority programs, Pension, Purchased Long-Term Services and Supports and VA Community Care, during FY 2024.

OTHER INFORMATION

PAYMENT INTEGRITY INFORMATION ACT REPORTING

PENSION IMPROPER PAYMENTS AND CORRECTIVE ACTIONS

The Pension program helps Veterans and their families cope with financial challenges by providing supplemental income through Veterans’ and Survivors’ Pension benefits. The program provides monthly payments to wartime Veterans who meet age or disability requirements and whose income and net worth are within the yearly limits set by law. Income limits require adjustments when beneficiaries have changes to eligibility factors (for example, income or medical expenses, dependency and so on), and these changes are the primary cause of improper payments. In FY 2023, improper payments were estimated at \$419.27 million, or 10.86% of outlays, with overpayment projection estimates at \$418.06 million. The following table provides a summary of the program’s estimated improper and unknown payments for FY 2023.

FY 2023 Payments Overview	Dollars (\$ in Millions)	Percent of Outlays
Outlays	\$3,862.25	
Proper Payments	\$3,442.98	89.14%
Improper Payments	\$419.27	10.86%
Overpayments	\$418.06	10.82%
 Within Agency Control	\$362.34	9.38%
Data Does Not Exist	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$362.34	9.38%
 Outside Agency Control	\$55.72	1.44%
Data Does Not Exist	\$23.26	0.60%
Inability to Access Data	\$32.46	0.84%
Failure to Access Data	\$0.00	0.00%
Non-Monetary Loss	\$1.21	0.03%
Underpayments	\$1.21	0.03%
Data Does Not Exist	\$1.21	0.03%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$0.00	0.00%
Technically Improper	\$0.00	0.00%
Unknown Payments	\$0.00	0.00%
Improper Payments + Unknown Payments	\$419.27	10.86%

Notes:

1. In FY 2023, VA tested and reported on payments made in FY 2022.
2. There may be slight variances in the dollar amounts and percentages reported on PaymentAccuracy.gov due to rounding.
3. [OMB Circular A-123, Appendix C, Requirements for Payment Integrity Improvement](#) (pages 9-12), provides detailed descriptions of the improper payment and unknown payment categories.

From FY 2022, the program is reporting a reduction of \$73.16 million in improper payments in FY 2023, a reduction of 14.86%. A known barrier to further reductions is relying on beneficiaries to notify the program when they experience a change in income, as this is an important factor in determining eligibility for benefits. Over 71.35% of the total improper payments resulted from beneficiaries not notifying VA of changes in Social Security income. The program’s corrective actions are focused on remediating this and other errors.

STRATEGIES TO REDUCE IMPROPER PAYMENTS

The following actions were taken in FY 2023, or are planned for FY 2024, to correct and mitigate the Pension program’s improper payments:

Mitigation Strategy or Corrective Action	Description
Automation	Actions taken and planned regarding automation include conducting quarterly matches with the SSA to identify variances between SSA income a beneficiary is receiving versus the amounts reported by a beneficiary to VA. Differences indicate potential overpayments, so correcting the differences ensures VA is making correct payments and prevents future improper payments. In addition, VA uses the SSA’s Death Master File to match against active beneficiaries and their dependents, which allows VA to stop payment timely for deceased beneficiaries. These actions are fully implemented and are ongoing from year to year versus completed once.
Audit	Actions taken and planned regarding audit include randomly reviewing claim processors’ work to ensure policies and procedures are properly applied in making accurate pension rate decisions to prevent future improper payments. These actions are fully implemented and are ongoing from year to year versus completed once.

A detailed description of the program’s errors and corrective actions can be found on <https://paymentaccuracy.gov/>.

PURCHASED LONG TERM SERVICES AND SUPPORT (PLTSS) IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS

The PLTSS program is organizationally aligned under the VHA Geriatrics and Extended Care (GEC) Office, which strives to empower Veterans and the Nation to rise above the challenges of aging, disability or serious illness. GEC programs serve Veterans of all ages, including older, frail and chronically ill patients, their families and their caregivers. In FY 2023, the program reported improper and unknown payments estimated at \$1.42 billion, or 38.72% of the outlays, and \$318.46 million in overpayments. The following table provides a summary of the program’s estimated improper and unknown payments for FY 2023.

FY 2023 Payments Overview	Dollars (\$ in Millions)	Percent of Outlays
Outlays	\$3,662.27	
Proper Payments	\$2,244.27	61.28%
Improper Payments	\$1,363.69	37.24%
Overpayments	\$318.46	8.70%
Within Agency Control	\$318.46	8.70%
Data Does Not Exist	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$318.46	8.70%
Outside Agency Control	\$0.00	0.00%
Data Does Not Exist	\$0.00	0.00%

OTHER INFORMATION

PAYMENT INTEGRITY INFORMATION ACT REPORTING

FY 2023 Payments Overview	Dollars (\$ in Millions)	Percent of Outlays
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$0.00	0.00%
Non-Monetary Loss	\$1,045.23	28.54%
Underpayments	\$0.57	0.02%
Data Does Not Exist	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$0.57	0.02%
Technically Improper	\$1,044.65	28.52%
Unknown Payments	\$54.31	1.48%
Improper Payments + Unknown Payments	\$1,417.99	38.72%

Notes:

1. In FY 2023, VA tested and reported on payments made in FY 2022.
2. There may be slight variances in the dollar amounts and percentages reported on PaymentAccuracy.gov due to rounding.
3. [OMB Circular A-123, Appendix C, Requirements for Payment Integrity Improvement](#) (pages 9-12), provides detailed descriptions of the improper payment and unknown payment categories.

From 2022, the projected improper and unknown payment error rate decreased by 8.73% in FY 2023. However, the total estimated improper and unknown payment amount increased by \$132.50 million in FY 2023. The increase in reported dollars while reduction in the overall rate occurred because the program’s outlays increased 35.18%. Most improper payments resulted from orders being placed by unauthorized individuals for Basic Ordering Agreements, lack of ordering officer delegation documentation for local contracts and claims not being paid according to the contracted rates. There are no known financial, contractor or provider status related barriers prohibiting the program from improving its prevention of improper payments.

STRATEGIES TO REDUCE IMPROPER PAYMENTS

The following actions were taken in FY 2023, or are planned for FY 2024, to correct and mitigate the PLTSS program’s improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Automation	Actions taken regarding automation included moving all future purchased care to be processed through the Electronic Claims Adjudication Management System or by third-party administrators, which will ensure correct authorization, amount of care and correct rate.
	Actions planned regarding automation include working to determine if a system update in the Electronic Claims Adjudication Management System is needed to ensure Homemaker/Home Health Aid Service, Community Nursing Home and Veteran Directed Care claims are paid appropriately. VA then will develop an effective corrective action for implementation.
Change Process	Actions planned regarding change process include working to ensure invoices are being validated per the contract pricing prior to payment. VA also will implement short and long-term contracting options for Community Nursing Home payments to improve

Mitigation Strategy or Corrective Action	Description
	compliance with procurement requirements. In addition, VA will enforce contract requirements for third-party administrators to bill at the correct allowable rates.

A detailed description of the program’s errors and corrective actions can be found on <https://paymentaccuracy.gov/>.

VA COMMUNITY CARE IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS

The VA Community Care program provides timely and specialized care to eligible Veterans. This program allows VA to authorize Veteran care at non-VA health care facilities when the needed services are not available through VA or when the Veteran is unable to travel to a VA facility. In FY 2023, the program reported improper and unknown payments estimated at \$992.38 million, or 4.92% of outlays, and \$954.17 million in overpayments. The following table provides a summary of the program’s estimated improper and unknown payments for FY 2023.

FY 2023 Payments Overview	Dollars (\$ in Millions)	Percent of Outlays
Outlays	\$20,152.58	
Proper Payments	\$19,160.20	95.08%
Improper Payments	\$959.53	4.76%
Overpayments	\$954.17	4.73%
Within Agency Control	\$954.17	4.73%
Data Does Not Exist	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$954.17	4.73%
Outside Agency Control	\$0.00	0.00%
Data Does Not Exist	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$0.00	0.00%
Non-Monetary Loss	\$5.36	0.03%
Underpayments	\$5.36	0.03%
Data Does Not Exist	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%
Failure to Access Data	\$5.36	0.03%
Technically Improper	\$0.00	0.00%
Unknown Payments	\$32.85	0.16%
Improper Payments + Unknown Payments	\$992.38	4.92%

Notes:

1. In FY 2023, VA tested and reported on payments made in FY 2022.
2. There may be slight variances in the dollar amounts and percentages reported on PaymentAccuracy.gov due to rounding.
3. [OMB Circular A-123, Appendix C, Requirements for Payment Integrity Improvement](#) (pages 9-12), provides detailed descriptions of the improper payment and unknown payment categories.

OTHER INFORMATION

PAYMENT INTEGRITY INFORMATION ACT REPORTING

From FY 2022, the program is reporting a reduction of \$370.75 million in improper and unknown payments in FY 2023, a reduction of 27.20%, despite an increase in outlays of 15.94%. Most improper payments resulted from paying an amount not aligning with a contracted rate, an excluded service due to noncompliance with regulatory or contractual exclusion/requirements or paying an ineligible provider. There are no known financial, contractor or provider status related barriers prohibiting this program from improving its prevention of improper payments.

STRATEGIES TO REDUCE IMPROPER PAYMENTS

The following actions were taken in FY 2023, or are planned for FY 2024, to correct and mitigate the VA Community Care program’s improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Automation	Actions taken regarding automation include verifying that the Electronic Claims Adjudication Management System is auto denying payments appropriately based on authorization logic. VA also worked with appropriate offices to correct system logic so the Electronic Claims Adjudication Management System auto-calculates the accurate allowable amounts. In addition, VA migrated National Dialysis Contract claims processing to the Electronic Claims Adjudication Management System to auto-process correct rates.
	Actions planned regarding automation include VA will update the claims processing system, Electronic Claims Adjudication Management System, to identify and auto-deny Community Care Network claims that should be processed by a third-party administrator. VA contracting will instruct third-party administrators to deny out of network facility provider claims for emergent episodes of care. In addition, VA will update system logic in the claims processing system to suspend or deny dental claims when provider criteria does not reconcile to the Veterans Care Agreement.
Change Process	Actions taken regarding change process include updated internal policies, ensuring the correct rates are being paid and timely filing requirements are accurately enforced in the Electronic Claims Adjudication Management System. In addition, VA improved pre-payment checks in the authorization system to improve claims processing accuracy. In addition, VA researched why Veteran's other health insurance information was not present in the payment system to correct and prevent future deficiencies. VA also continued with the post-implementation of the MISSION Act, which included moving previous non-contract claims into compliant purchasing vehicles such as agreements and contracts. Finally, VA documented the decision of whether or not to apply the Centers for Medicare and Medicaid Services End-Stage Renal Disease network reduction to VA dialysis claims.
	Actions planned regarding change process include clarifying payment methodology with VA and third-party administrators to bill at the correct allowable rates. VA also will implement system

OTHER INFORMATION
PAYMENT INTEGRITY INFORMATION ACT REPORTING

	checks for non-contract payments to suspend institutional inpatient and ambulance claims for manual review prior to payment. In addition, VA will instruct third-party administrators to follow standard billing practices as defined in the contract. VA will communicate to claims processing agents to not process claims when timely filing requirements are not met.
Training	Actions planned regarding training include VA will provide training on claims processing requirements when required other health insurance documentation is missing.

A detailed description of the program's errors and corrective actions can be found on <https://paymentaccuracy.gov/>.

VA's Payment Integrity Information Act (PIIA) and High-Priority program reporting can be found, once published by OMB, at <https://paymentaccuracy.gov/>.

OTHER INFORMATION**CIVIL MONETARY ADJUSTMENT FOR INFLATION****CIVIL MONETARY ADJUSTMENT FOR INFLATION**

The Federal Civil Penalties Inflation Adjustment Act of 1990 (the Inflation Adjustment Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. The following table depicts the covered civil monetary penalties that are under VA's purview.

Statutory Authority	Penalty (Name or Description)	Year Enacted	Latest Year of Adjustment (via Statute or Regulation)	Current Penalty Level (\$ Amount or Range)	Sub-Agency/Bureau/Unit	Location for Penalty Update Details
Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, as amended	False Loan Guarantee Certifications	1986	2023 (via regulation)	The greater of (a) two times the amount of Secretary's loss on the loan, or (b) another appropriate amount not to exceed \$27,018	VBA/Loan Guarantee	Federal Register 88 (01/17/2023) : 7811-7813
Program Fraud Civil Remedies Act of 1986, as amended	Fraudulent Claims or Statements	1986	2023	\$13,508	All VA Programs	Federal Register 88 (01/06/2023) : 7811-7813

In January 2023, VA published a regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2023. VA also will publish an updated regulation in the Federal Register, reflecting the Federal Civil Penalties annual inflation adjustment for FY 2024. Per the Inflation Adjustment Act, VA will update their penalty rates in the Federal Register annually by January 15.

GRANT PROGRAMS

Pursuant to the OMB Uniform Guidance in 2 C.F.R. § 200.343(b), recipients of grants and cooperative agreements must liquidate all obligations incurred under their awards within 90 days after the end of the period of performance, unless the awarding agency authorizes an extension or program-specific statutes specify a different liquidation period.

VA is required to disclose the number of awards and balances for which closeout has not yet occurred, but for which the period of performance has elapsed by 2 years or more prior to September 30, 2023. The summary of this information is disclosed in the following table.

CATEGORY	2-3 Years	>3-5 Years	>5 Years
Number of Grants/Cooperative Agreements with Zero Dollar Balances	8	32	22
Number of Grants/Cooperative Agreements with Undisbursed Balances	27	14	6
Total Amount of Undisbursed Balances	\$3,107,291	\$448,066	\$198,609

VA manages multiple grant programs; however, two major programs with grants awaiting closeout include State Home Construction and Adaptive Sports.

In FY 2023, the State Home Construction grant office closed out 52 grants during September 2023; however, the office was not able to meet its goal to close out all grants by September 30. Of the 41 remaining State Home Construction grants, which include those with both zero dollar balances and undisbursed balances, 33 will be closed in October 2023 and 8 will have the expiration date extended. State Home Construction comprises 10 of the grants with undisbursed balances, totaling \$2,495,951.

The Adaptive Sports grant office has made significant progress reducing the closeout backlog. The grant office has closed 60 grants to date and is on track to close an additional 32 grants in October 2023. Adaptive Sports comprises 37 of the grants with undisbursed balances, totaling \$1,258,015.

CLIMATE-RELATED FINANCIAL RISK

CLIMATE ACTION PLAN AND OTHER REPORTS

VA's climate-related reports provide valuable information relevant to VA services, operations, programs and assets. Hyperlinks to VA's latest Climate Action Plan and other climate-related reports are below:

- **2021 Climate Action Plan:** [Department of Veterans Affairs 2021 Climate Action Plan \(sustainability.gov\)](https://www.sustainability.gov/department-of-veterans-affairs-2021-climate-action-plan)
- **2022 Climate Action Plan Progress Report:** [Department of Veterans Affairs Climate Action Plan 2022 Progress Report \(sustainability.gov\)](https://www.sustainability.gov/department-of-veterans-affairs-climate-action-plan-2022-progress-report)
- **2022 Sustainability Plan:** [Department of Veterans Affairs 2022 Sustainability Plan \(sustainability.gov\)](https://www.sustainability.gov/department-of-veterans-affairs-2022-sustainability-plan)

GOVERNANCE, STRATEGY, RISK MANAGEMENT AND METRICS

GOVERNANCE

E.O. 14008, *Tackling the Climate Crisis at Home and Abroad* (2021), established requirements for agencies to revitalize and prioritize responding to the climate crisis. E.O. 14057, *Catalyzing Clean Energy Industries and Jobs Through Federal Sustainability* (2022), expanded on those requirements. In response to E.O. 14057, VA adapted its Climate Change Task Force into a Sustainability Task Force, led by VA's Chief Sustainability Officer, to make senior-level decisions on policy and programs to implement the goals of E.O. 14057, including climate adaptation plans. The Task Force will engage two of VA's existing governing bodies, the Evidence-Based Policy Council and Investment Review Council, where needed to establish and roll out agency-wide solutions.

STRATEGY

VA's strategy balances the need for climate adaptation and resilience with other needs crucial to VA's mission of providing quality care and benefits to Veterans. VA understands the importance of anticipating and planning for future changes in the climate and is working to expand its adaptation efforts to include the full scope of its operations while continuing to deploy its climate adaptation strategy. The adaptation strategy falls into two primary categories, infrastructure resilience and health care resilience.

RISK MANAGEMENT

VA will continue its effort to identify mission critical functions at risk from the impacts of a changing climate. As impacts are further identified by the best available science, VA will incorporate climate change adaptation and resilience across agency programs and the management of Federal procurement, real property, public lands and waters and financial programs. Mitigation of known risks are incorporated into the agency's normal business operations to the extent practicable.

VA incorporates climate resilience into long-term planning, investments, construction and training, in conjunction with other policy and practical imperatives. In 2011, VA conducted an agency-wide high-level study focusing on the risks that climate change poses to critical agency

operations, facilities and systems. For the 2021 Climate Action Plan, VA built on prior adaptation actions and climate vulnerability analysis to update its assessment of climate vulnerabilities. VA also used its Department-level risk register and guidance from the Fourth National Climate Assessment and identified five vulnerabilities tied to management functions and decision points. For more information on the five vulnerabilities, refer to the Forward-Looking Information section on page 40 in the Management's Discussion and Analysis Section.

In FY 2023, VA completed a nationwide assessment of climate vulnerabilities of its mission critical facilities. The assessment rated the risk to facilities from a wide array of natural hazards, as well as incorporating feedback from staff about their facility's ability to withstand and adapt to climate impacts. The assessment also includes social vulnerability data, which gives insight into the potential impact of these hazards on the community. Further studies will be required to identify site-specific risk mitigation needs, but this assessment provides a starting point for VA to understand climate risk at the facility level.

METRICS

VA developed an internal tool to track implementation of its climate adaptation commitments from the 2021 Climate Action Plan. Progress is updated and shared with VA stakeholders monthly. In accordance with E.O. 14057, VA is also generating annual plans or progress reports on climate adaptation activities.

HOME LOAN PROGRAMS

Impact: VA's Home Loan Program within the Loan Guaranty Service involves loans made, insured or guaranteed by VA to assist Veterans in obtaining, retaining and adapting homes. The program includes direct home loans for Native American Veterans to purchase homes on trust lands and grants to assist eligible Veterans with certain service-connected disabilities to construct or adapt their home to accommodate their needs. The program also manages and sells properties acquired by VA from foreclosures and manages direct loans for purchase of real estate owned properties. The primary concerns for VA are the potential indirect impacts resulting from newly constructed or existing homes in and around the U.S. coastline where sea level rise can pose a threat or areas where wildfires are common due to drought conditions.

Adaptation: VA will continue to consider approaches to better integrate climate-related financial risk into underwriting standards, loan terms and conditions and asset management and servicing procedures, as related to housing policies and programs. The local government and planning authorities are ultimately responsible for infrastructure and development of the Veteran housing supported by VA home loans. The Energy Efficient Mortgage program allows for a loan to be increased by up to \$6,000 over and above the established reasonable value of a property and provides a valuable incentive for borrowers to adopt sustainable best practices, improve the value of their property and mitigate climate risk. In addition, VA recognizes that an energy-efficient home will have lower operating costs, making homeownership more affordable for Veteran borrowers. VA is evaluating whether changes to the program are warranted and if increases to the \$6,000 cap will require statutory amendments.

OTHER INFORMATION

CLIMATE-RELATED FINANCIAL RISK

Timeline: VA has begun collecting and analyzing data to comprehensively assess climate risk exposures to the VA Home Loan Program. VA also will use the assessment to inform programmatic changes to policies or procedures, such as underwriting standards, loan terms and conditions and asset management and servicing procedures. VA continues to build and enhance their dashboard as they strive to incorporate more climate and social governance related data elements.

Resources: VA will use existing resources to begin necessary assessments to determine costs associated with increased climate threats. If additional resources are required, VA will request funding through the budget process.

Disclosure: Once VA identifies potential costs associated with increased threats to homes financed through the VA Home Loan Program, it will disclose them in the AFR.