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## I trust my doctors at VA

*Pictured in the previous page: Navy Petty Officer Michael Monsoor.*

As president of the American Medical Association, Dr. Jesse Ehrenfeld is the face and voice of the nation's largest association of doctors and medical students. He's also a Navy Veteran who relies on Milwaukee VA for his health care. He just turned 45 and he recently did what we should all do at that age: get a colonoscopy. "I don't know if looking forward to it is the right phrase, but I know it's the right thing for me to do. I trust in my doctors at VA to get me the care I need and I encourage other Veterans to do the same. I have a lot of faith in my doctors and my team, and I know it will go smoothly," he says.

Ehrenfeld says it is important for everyone to get screened. "A lot of people put this off for lots of reasons, but frankly that could be deadly," he says, noting that colorectal cancer screenings are recommended starting at age 45.

As an anesthesiologist, he has cared for "too many patients who had this disease, which is preventable. If caught early, colon cancer can be treated." "Colorectal cancer is one of the leading cancer killers, and it often has no symptoms," says Dr. Juan Trivella, Ehrenfeld's gastroenterologist at Milwaukee VA. "Someone could have polyps or colorectal cancer and not know it. That is why getting screened regularly for colorectal cancer is so important. It doesn't matter who you are, what your job is, or what you look like. You need to get it done because it really prevents and decreases mortality."

While a colonoscopy is considered the gold standard for screening, many people are leery of the procedure, mostly because of the preparation. Before a colonoscopy, patients must alter their diet for a few days. The day before they start a regimen of medications and a liquid that helps clear the bowels. That means frequent trips to the bathroom. "There have been plenty of potty jokes in my house," says Ehrenfeld, father of two boys, ages 1 and 5. Colonoscopy is not the only way to screen. There are also at-home tests, which require collecting a stool sample and sending it to a lab for testing. "Each test has advantages and disadvantages. The patient should talk with their doctor about the pros and cons of each test and how often to be tested," Trivella says.

That is exactly what Ehrenfeld did. He's been a VA patient since returning from service in Afghanistan in 2015, first at Nashville VA and since 2019 at Milwaukee. 'I feel fortunate to get my health care through VA'. Ehrenfeld has commercial insurance and could get his health care anywhere, but he chooses to go with VA. "It's not your granddad's VA. I believe in the VA system. It's been a great experience for me. They're extraordinary clinicians. I feel privileged and fortunate to get all my health care through VA."

"The VA as a system has really pivoted in some important ways. It's not perfect. There's always work to do, but I don't know any health system in the country that I wouldn't say the same thing about."

Ehrenfeld hopes other Veterans heed his experience to get screened. "If one Veteran gets their colonoscopy because of this, then it's worth it. And if 10 get their colonoscopy, that will probably save a life," he says.

**INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES**

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

**September 30, 2024**

**FOREWORD**

The Office of Inspector General's (OIG) mission is to serve veterans, their families, caregivers, survivors, and the public by conducting effective independent oversight of VA programs, operations, and services. Each year, the Inspector General summarizes the top management and performance challenges identified by OIG work and assesses 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 have been identified by OIG personnel, with assistance from external oversight agencies and organizations, VA leaders, 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.

The OIG recognizes the monumental challenges VA faces. VA is implementing a number of new systems critical to safely and promptly meeting the needs of veterans, while making the best use of taxpayer dollars. This includes attempting to continue the deployment of VA's multibillion dollar electronic health record system, while also fielding a new financial management system intended to improve how the department handles taxpayer funds.

The implementation of the historic passage of the PACT Act has resulted in millions more veterans applying for related benefits and health care, even as VA struggles to manage the impacts of increased numbers of veterans seeking eligible care within their communities. Several OIG reports illustrate VA's continued inability to hold third-party providers to contract requirements, and a lack of private-sector providers has left some veterans without the critical care they need.

Despite a hiring "surge," VA still suffers from critical staffing shortages. Other challenges such as ensuring patient safety, maintaining timely access to quality health care, and addressing deficiencies that center around failures in VA governance and accountability are just some of the major management challenges that OIG reports have identified.

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

(/s/) MICHAEL J. MISSAL  
Inspector General

### OIG CHALLENGE #1: HEALTHCARE SERVICES

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A series of legislative changes have allowed VA to outsource more healthcare services for veterans to private-sector community providers. According to internal VA data, between FYs 2021 and 2023, referrals to community care have increased over 37 percent, with FY 2024 (as of May) outpacing FY 2023 by more than 16 percent.

As veterans obtain more services from the community care program, VHA has struggled to oversee the performance of their third-party administrators—the contracted entities that manage the network of community providers—and ensure they meet their contractual requirements. Recent VA OIG reports have found that VA medical facilities have failed at times to get these administrators to make certain that local area providers are accessible to eligible veterans who seek or require care outside the facility.

Apart from community care, the VA OIG has also found that staffing shortages at VA medical facilities have not only degraded veterans' access to care—particularly mental health care—but also the quality of care provided. In the VA OIG's most recent occupational staffing report, VHA facilities self-reported for FY 2024 a total of 2,959 severe occupational staffing shortages. Eighty-six percent of facilities reported severe occupational staffing shortages for medical officers, and 82 percent of facilities reported severe shortages for nurses. Psychology was the most frequently reported severe clinical occupational staffing shortage, and this shortage is particularly meaningful in the delivery of mental health care.

However, while new demands and challenges increase the urgency for VA to address long-standing staffing shortages, it must balance the need to conduct proper background investigations with the quick onboarding of staff. Having the right people in the right positions committed to doing the right thing is essential to building and maintaining a culture of accountability. The OIG has published reports on deficiencies in the personnel suitability program since 2017. Recent oversight reports have continued to identify such problems. One report identified weaknesses in governing background checks for contracted employees, which increases the risks to the health and well-being of veterans and VA employees, as well as the efficiency and integrity of VA services.

#### **Why This Is a Challenge**

Coordinating medical care between the VHA healthcare system, third-party administrators, and private-sector community providers continues to be a challenge, especially as the demand for community care continues to grow. In recent reports, the OIG found third-party administrators generally used providers from their existing healthcare portfolios to build VHA's provider networks without verifying the providers' contact information or whether the providers would accept VA patients. The lack of verification by the third-party administrators left inaccuracies in VHA's master database of community care providers. The Office of Integrated Veteran Care—the VHA office responsible for overseeing access to care in the community—is required by VHA directive to ensure provider availability and that third-party administrators meet contract requirements. OIG reporting found they failed to do both; therefore, facilities were left without enough providers and veterans were not receiving timely care in the community. Finally, because the Office of Integrated Veteran Care did not have a process in place to analyze provider network adequacy, they couldn't help the facilities justify the need to add more third-party administrators.

Other recent OIG work highlighted coordination failures between VHA, the third-party administrators, and community providers. Specifically, community providers rarely submitted initial prescriptions for special-authorization drugs with required justifications and VHA did not hold the administrators accountable for making certain that community providers followed formulary procedures for special-authorization drugs. This occurred partly because the electronic prescription system lacked the means to include justifications.

With respect to staffing, in the past year, VHA leaders have reported that shortages led to closure of medical surgical beds, as well as the inability to process sterilization of medical instruments, leading to more than 1,500 procedures being canceled, rescheduled, or referred to the community. Some VHA officials expressed concerns about the inability to maximize community living center bed capacity due to the length of time it takes to onboard new staff, and others expressed that the difficulties with hiring could put medical centers at risk for additional staffing shortages.

### **Department's Corrective Actions**

As part of VA's efforts to ensure VA medical facilities have enough community care providers to provide timely care for veterans, the Office of Integrated Veteran Care launched the Advanced Medical Cost Management Solution suite in October 2022, which allows users to assess the adequacy of community providers networks by locality. VHA will need to leverage its Advanced Medical Cost Management Solution suite to conduct routine assessment of facility-level network adequacy and provide training for relevant facility staff. In addition, VHA needs to hold future third-party administrators accountable for operational readiness and provider network adequacy, as well as develop processes to update and maintain community care network data.

To improve community provider compliance with VHA's standards for special-authorization prescriptions, VHA should add electronic system capabilities allowing users to attach medical justifications. The Office of Integrated Veteran Care should also train community providers on the VA formulary process.

Finally, to better meet its hiring goals, VHA needs to coordinate and clearly define roles and responsibilities at each organizational level. It also needs to ensure regional and facility staff monitor progress and address challenges in filling positions. VA removed some of the conflicting guidance from its website and is working to update existing personnel suitability policy. VA needs to develop a plan to ensure that future systems support the functionality needed to effectively oversee and manage the background investigation process, including addressing limitations identified in the current system.

### **OIG CHALLENGE #2: BENEFITS FOR VETERANS**

VBA processes millions of claims that provide veterans, eligible family members, and caregivers a wide array of benefits, including disability compensation, pension benefits, education, and vocational training. VBA must balance the need to accurately process complicated claims and benefit requests while still meeting challenging deadlines. In addition, it must protect VA beneficiaries who are unable to manage their VA benefits due to injury, disease, or age.

VBA's responsibilities have increased significantly with the passage of The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, which expands VA health care and benefits for veterans exposed to burn pits and other toxic



substances. The PACT Act is perhaps the largest healthcare and benefit expansion in VA history. According to VA, as of July 14, 2024, more than 325,000 veterans presumed to have toxic exposure during military service for the purposes of benefit payment consideration have newly enrolled in VA health care since the act's passage in 2022. Further, more than 5.5 million veterans have completed toxic exposure screenings and over 1 million claims have been approved. In addition to VBA's other claims backlog, the PACT Act benefit claims backlog was around 390,000 in June 2024. To address the swell in workload demands, VA has expanded hiring to fill thousands of healthcare and benefits personnel positions.

In a July 2024 congressional testimony, the OIG highlighted persistent concerns with VBA quality assurance and training—identifying oversight reports that document continued issues with (1) processing errors VBA personnel made on veterans' individual unemployability claims, (2) inconsistencies implementing changes to the disability rating schedule, (3) issues with claims automation, and (4) unwarranted medical reexaminations for veterans.

### **Why This Is a Challenge**

VBA processes claims that can be extremely complex, especially when the agency must interpret VA policies and guidance that may be unclear. When regulations add new presumptive diseases of service connection, VA must search its records to find eligible claimants and award benefits. A recent report found VBA failed to identify and notify veterans who were potentially eligible for prior disability claim readjudication and retroactive benefits under the National Defense Authorization Act. A VA senior management advisor stated VHA records were not involved in these readjudication determinations because they were part of a VHA data set, and not part of VBA's records. Because VBA did not send these veterans notification letters, some 87,000 veterans or their survivors were not made aware of their potential entitlement to retroactive compensation benefits. The OIG believes VHA's records were available and should have been included in the initial readjudication determinations.

Other OIG oversight reports on VA's compensation and pension programs have found that overpayments, underpayments, or other improper payments (such as those that lack support or documentation) are often caused by a lack of effective internal controls and inadequate technology.

For example, when veterans request a waiver to participate in vocational training that is not covered under their GI Bill benefits, VBA's weak internal controls resulted in improper authorizations because Veteran Readiness and Employment staff misinterpreted the application of the applicable law. The basic case of this issue was that VBA staff were not trained on how certain programs could be used by veteran program participants. Veteran Readiness and Employment controls also did not prevent participants from being authorized and enrolled in unapproved courses.

In another example, VBA established the Fiduciary Program to protect VA beneficiaries who are unable to competently manage their own VA benefits. Questionnaires are used to help medical professionals assess a veterans' mental competency for managing their benefits, but a recent report discovered inconsistencies in these questionnaires, which can lead to inconsistent medical assessments. Such inconsistencies can lead to discrepancies in how rating veterans service representatives assess a veteran's mental competency—a matter of the greatest importance.

Other oversight reports have found weaknesses in the Fiduciary Program governance. The reports identified delays in determining whether a fiduciary is warranted, in reimbursing veterans when their benefits have been misused by a fiduciary, and in distributing of deceased veterans' fiduciary-controlled funds to their heirs. The delays often created—at difficult life moments when VA's assistance was critical—unnecessary risks to veterans' welfare and exposed beneficiaries and their families to potential hardships.

### **Department's Corrective Actions**

The OIG acknowledges that VBA personnel face significant difficulties in processing often complex claims. These challenges are exacerbated by constantly changing policies and processes, increasing workloads, as well as tight timelines. This state of constant change reinforces the OIG's calls for VBA to provide its employees with accurate, timely, and effective training.

The OIG also acknowledges that VBA has improved its quality assurance review process by implementing action plans associated with OIG report recommendations. VBA officials have initiated plans to establish a work group to better identify veterans potentially eligible for prior disability claim readjudication. To improve mental competency determinations, VBA updated the post-traumatic stress disorder questionnaire in August 2023 to include VA's regulatory definition in the initial questionnaire.

However, one of the critical foundations of accountability for any program is effective quality assurance to detect and resolve issues. The OIG has found that VBA needs to improve the execution of its quality assurance review program so that eligible veterans receive the disability compensation benefits they are due.

To improve compensation and pension claim accuracy, VBA needs to ensure it continuously monitors internal controls to prevent procedural, technology, or process failures that result in improper payments. This monitoring can make certain that VBA is acting as an effective steward of taxpayer funds and to protect veterans and their families from related hardships. Similarly, improper entitlement payments could be prevented if VBA develops and implements policies and system controls to verify that programs meet requirements and there is effective training for all appropriate Veteran Readiness and Employment regional office staff.

Also, VBA staff should use improved methodologies to identify eligible veterans and update the standard operating procedures accordingly to identify and notify veterans potentially eligible for prior disability claim readjudication and retroactive benefits under the National Defense Authorization Act.

### **OIG CHALLENGE #3: STEWARDSHIP OF TAXPAYER DOLLARS**

Congress and the media have consistently questioned VA budget requests and financial management deficiencies. In August 2024, VA reported a gap in funding for FY 2025 of approximately \$12 billion, drawing increased scrutiny of the department's ability to forecast and manage its finances. VA has attributed some of the funding gap to recent surges in its workforce, unanticipated spending, and the broader scope of services to record-high numbers of veterans associated with passage of the PACT Act and other measures—the effects of which will continue to be felt for some time. These statutory measures qualify millions of additional

veterans for healthcare enrollment and benefits that can affect the department's capacity to provide quality and timely care and services.

VA continues to face significant challenges concerning how it oversees its spending. Many OIG reports have shown instances of inadequate oversight and weak internal controls over community care spending, inventory management, purchase card usage, contract management, and open obligations. These issues have been compounded by VA's outdated financial management system and outdated or incomplete data. Although VA has started deploying iFAMS—a new financial management system intended to improve how the department handles taxpayer funds—VA continues, in many areas, to rely on legacy financial systems, manual reconciliations, and adjustments, which has caused VA to be noncompliant with major financial management regulations.

The OIG recognizes that claims processing can be tremendously complex. As stated above, the lack of internal controls—in addition to inadequate technology and unclear policies and guidance—is the primary cause of overpayments and underpayments. Internal controls are therefore vital to quality assurance and help ensure the integrity of systems and processes. Minimizing improper payments will also require strong leadership, effective supervision, clear procedures, and adequate staff training. Many of the weaknesses identified in OIG oversight reports have also been the result of poor planning and implementation of information technology that is meant to support the work of VBA personnel. The OIG recognizes that VBA staff face these and other challenges daily to keep pace with tremendous workloads while attempting to ensure eligible beneficiaries are given the compensation and pensions they are due while preventing waste.

VA also continues to experience issues in monitoring community care program claims and payments, which impacts their ability to detect duplicate claims and payments across different claims processing systems as well as in seeking reimbursement from third-party insurance companies for services rendered to veterans who are ineligible for VA payment. This is due to the Program Integrity Tool database being offline as of February 2023 following the discovery of various data integrity and quality issues in the database. In addition to being the source of comprehensive community care data from multiple source systems, the tool was also the sole source of Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) data as well as historical community care program data (e.g., Veterans Choice Program, Patient-Centered Community Care or PC3).

Finally, benefit payments paid by VBA to deceased veterans and beneficiaries increased from \$4.2 billion in 2019 to \$7.6 billion in 2023. These payments included various benefit awards, such as pensions, disability compensation, and educational benefits. When VBA's death match process fails to accurately identify deceased veterans and beneficiaries, these payments can continue erroneously, placing unnecessary financial and emotional burden on surviving family members, creating additional workload for VBA personnel to rectify these errors, and resulting in improper use of taxpayer funds.

### **Why This Is a Challenge**

From FY 2022 to FY 2023, community care expenditures grew by 22 percent, from \$25.9 billion to \$31.6 billion. Given the size of the program, it is critical that VA pay only for authorized care. A recent OIG report found, however, that VA has paid for unauthorized dental care through the



community care program. For community care network invoices, the contracted third-party administrators' adjudication systems process did not identify unauthorized procedures because community care network contract language contradicted VHA referral guidance for community dental claims.

Also, the OIG has repeatedly found that, when VA acquires day-to-day medical goods, it does not always use the required strategically sourced contracts that can help VA save taxpayer funds. For example, VHA requires its medical facilities to use the Medical/Surgical Prime Vendor program's distribution contracts for cost-effective ordering and distribution of day-to-day healthcare supplies. However, medical facilities did not always purchase through the program because items were often unavailable, and staff often did not check the program before ordering from the open market. Additionally, the OIG found that VHA did not ensure dialysis services were purchased through the community care network contracts; instead, dialysis was purchased through nationwide dialysis services contracts, which charged higher per treatment rates.

Unreliable data has frequently prevented the department from making informed decisions on how to best manage program and medical funds. Several reports have identified discrepancies between what was reported in medical facilities' inventory systems and what was physically present. Errors could diminish the healthcare system's ability to effectively budget for the purchase of supplies to meet patient care needs.

### **Department's Corrective Actions**

VHA needs to strengthen its prepayment and postpayment review processes for community care authorizations. To facilitate the use of strategically sourced contracts, VHA needs to improve staff training and clarify contract usage guidance. Additionally, to improve facility inventory management, VHA needs to ensure inventory values are recorded correctly in its inventory system and establish processes and procedures for monitoring inventory reports.

To improve the usage and increase transparency of the Medical/Surgical Prime Vendor program, VHA plans to simplify the system to better enable facilities to use the required contracts for day-to-day medical expenses.

VBA's internal controls should be continuously monitored to prevent procedural, technology, or process failures that result in improper payments—not only as stewards of taxpayer funds but also to protect veterans and their families from related hardships. The problems the OIG identified with VBA's compensation and pension programs are, in many cases, the result of established and new mechanisms that are insufficient in preventing and detecting errors caused by information management systems and compliance with processes. Recognizing that VBA personnel work in a fast-paced environment on often complex processes, the OIG will continue to make recommendations for improvement that support their efforts to serve veterans, their families, and other survivors.

### **OIG CHALLENGE #4: INFORMATION SYSTEMS AND INNOVATION**

VA is undertaking massive modernization efforts for systems that are estimated to cost tens of billions of dollars and are interdependent—making implementation both costly and complex.

The OIG encourages innovation and recommends enhancements to VA's infrastructure and systems through findings and recommendations that address information technology, data security, predictive tools, and financial management systems. VA relies on countless systems to

meet the needs of patients safely and promptly, to provide benefits and services to eligible recipients, and to support the strong stewardship of taxpayer dollars.

Information system failures have repeatedly contributed to breakdowns in a number of critical VA functions, including financial reporting, supply chain management, claims processing, appointment management, community care prescription requests, and personnel suitability adjudications. Weak information technology security controls can put sensitive personal information belonging to veterans at risk.

VA has long recognized the need to modernize its electronic health record information system to ensure greater interoperability with the Department of Defense and exchange information with community care providers, yet it has struggled to deploy the multiyear effort initially estimated to cost \$16 billion. In several reports, the OIG has identified a variety of barriers to implementation, including patient harm and safety concerns; pharmacy and medication management issues; inadequate cost estimates; an unreliable implementation schedule; difficulties with the patient appointment scheduling system; and reporting, training, and decision-making deficiencies. The failures have been a tremendous burden on healthcare providers where the system has been deployed and it has potentially contributed to veterans' deaths and poor outcomes because of delays, inaccuracies, and poor functionality.

Furthermore, the OIG has 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. It also makes it difficult for VA staff to plan, order, and track expenditures for supplies and services, and hampers oversight of VA's use of these funds. Limited functionality contributed, for example, to obstacles in ensuring COVID-19 supplemental funds were properly spent.

After failed attempts to replace its systems in 2004 and 2010, VA established a program to oversee the multiyear deployment of its new iFAMS, an enterprise-wide modernization to replace legacy systems that facilitated the department's financial and contracting activities. As of June 2024, this system has been deployed at several offices across VA; however, VHA, which represents the most significant user base, had yet to start using the system. The OIG has reported issues with the new system's first deployment at the National Cemetery Administration and end-user concerns with training. In FY 2025, VA expects to roll out the new system for VBA's loan guaranty program. However, the life-cycle costs for iFAMS have grown to over \$7 billion.

### **Why This Is a Challenge**

VA has historically struggled to effectively deploy new information technology projects. These efforts have often been hampered by poor planning, shifting leadership priorities, and unclear communication. While VA paused nationwide deployment of the electronic health record system in 2022 due to a troubled initial rollout, an exception to that pause was the electronic health record deployment at the Captain James A. Lovell Federal Health Care Center, a joint facility shared between VA and the Department of Defense, in March 2024. Nevertheless, a recent OIG report identified shortcomings in the appointment scheduling package of the new electronic health record that can affect veteran engagement and appointment wait times. These shortcomings included a displaced appointment queue that could result in missed appointments not being rescheduled and cause difficulty for providers and schedulers seeking to share

information. At this point, the VA has yet to make public its plan or schedule to emerge from the reset.

Poor planning has also affected successful deployment of the acquisition module of iFAMS. Leaders did not adequately include acquisition stakeholders in decision-making roles to ensure the new acquisition model addressed concerns related to functionality, lack of automation, and length of time the system took to perform various functions. In addition, users had concerns with the training provided for some tasks and day-to-day activities, leaving VA with opportunities to enhance the training program. Addressing training weaknesses now is important because over 100,000 employees have yet to be trained on the system.

### **Department's Corrective Actions**

From April 2020 through August 2024, the OIG has published 19 oversight reports and issued 83 recommendations for corrective action focused on varied aspects of VA's electronic health record modernization program. Each oversight report is meant to help VA improve the new system's implementation and support prompt, quality health care for veterans. Failure to satisfactorily complete the corrective actions associated with these recommendations can increase risks to patient safety and the ability to provide high-caliber care at the new electronic health record sites. Fully addressing oversight recommendations can also help minimize considerable cost escalations and delays in potential future deployments.

As VA moves to implement the new electronic health record at other facilities, it will need to consider assessing staffing levels and overtime usage prior to deployment. It will also need to prepare staff with approved workflow best practices that may help to reduce employee resistance and facilitate successful adoption of the system.

VA has made progress toward implementing VA iFAMS, with VA's Financial Management Business Transformation Service leading and managing the implementation of the systems in 10 "waves" across VA until full implementation is achieved in 2029. As of December 2023, five waves have "gone live" across VA. VA has indicated it will use the information weaknesses OIG identified within its iFAMS training and adjust its future training before additional iFAMS deployments.

### **OIG CHALLENGE #5: LEADERSHIP AND GOVERNANCE**

The OIG's work has demonstrated a persistence of failings in VA leadership and governance that contribute to identified problems. Errors, lapses, and missteps are often attributed to the lack of clear roles and responsibilities among department officials and personnel that impedes VA's internal monitoring of the quality, efficiency, and effectiveness of its efforts.

Safe, quality health care is jeopardized when leaders and staff fail to execute their responsibilities. Inconsistent and ambiguous policies create role confusion and hinder staff's ability to perform effectively. Recent OIG reports highlight unacceptable oversight practices related to a variety of reasons, most notably staffing shortages and inconsistent or ambiguous policies. The impacts of these failures range from delays in identifying and responding to unprofessional conduct to delays in, or barriers to, coordinating patient care.

VA has struggled to consistently implement and oversee programs when multiple VA leaders across the department share responsibility. In addition, VA continues to fall short when overseeing contractors and holding them accountable.

Last year, officials at multiple levels across VA failed to ensure the requirements and intent of the PACT Act were satisfied when VA awarded about \$10.8 million in critical skill incentives to 182 senior executives in the VA Central Office. The incentives were authorized by the PACT Act as a new tool for VA to use to improve recruiting and retention in anticipation of a substantial increase in healthcare enrollments and benefits claims from individuals exposed to toxic substances, which would require significant additional staffing to handle the workload. The incentives are available to an employee who “possesses a high-demand skill or skill that is at a shortage.” Nearly all eligible senior executives in VHA and VBA at the central office were awarded the incentive pay for critical skill retention, with VHA providing only the most cursory justification and neither administration conducting an objective assessment of what was needed, if anything, to retain them. The senior executives were awarded the maximum percentage allowed under the PACT Act, which is 25 percent of their basic pay—resulting in awards that ranged from nearly \$39,000 to over \$100,000. Concerns expressed by some VA officials were not escalated to the Secretary, and some key leaders who were positioned to understand the reputational and financial risks to the department were not included in the incentive vetting process or were not provided all the facts needed to make an informed decision.

### **Why This Is a Challenge**

Leadership and cultural development are essential for maintaining a safe, quality healthcare environment. Through strong leadership and a high-reliability organizational culture, leaders can identify, resolve, and prevent risks to patient safety. When leaders fail to establish a culture that proactively manages actual and potential risk, mistakes happen and keep happening.

Several OIG reports highlight the ongoing challenges leaders face in demonstrating leadership and cultural development and advancement. Failures to plan for low volume and high-risk complex care and activities; review and remediate personnel dysfunction in patient care areas; and comply with medical staff privileging processes represent a few vulnerabilities that have negatively affected patients, disrupted operations, and stifled efforts to ensure VA delivers the best care anywhere. Some OIG reports have identified ineffective communication systems, which do not ensure the exchange of critical patient safety information between leaders and staff, contributing to an incomplete understanding of problems and advancing a cycle of continued risks.

The VA OIG routinely reviews and publicly reports on the quality of health care VHA provides, as well as any risks to patient safety, across the nation. In many of these reviews, lack of oversight by VISN leaders and staff is a key contributor to identified deficiencies or adverse patient outcomes. Given its importance, the OIG has increased its focus on VISN leaders' roles and actions in supporting facility leaders and staff to deliver high-quality care. Through this effort, the OIG has repeatedly discovered inconsistent practices and inefficiencies that run counter to VHA's initiative to transform into a high-reliability organization.

VHA is this country's largest integrated healthcare system, and the volume and complexity of patient encounters require deliberate and clear lines of communication and information sharing. Dotted reporting lines, optional participation in sharing critical metrics, and confusion over authority undermine the essential functions of medical facilities and further highlight the failure of the current VISN structure to ensure consistent delivery of safe care to patients.

### **Department's Corrective Actions**

The OIG has repeatedly published healthcare reports that find there are effective and comprehensive VHA policies and skilled and dedicated staff aggressively working to carry them out to provide high-quality and timely care to veterans. Yet, OIG oversight teams also continue to find the inconsistent application or misinterpretation of policy, insufficient VA personnel training, and other issues that could be mitigated by a clear and consistent structure of authority and accountability. Such a structure would clarify roles and responsibilities for those who could track and identify trends in noncompliance in real time and intervene proactively.

VHA care has evolved and expanded dramatically since the creation of the VISN structure. The size of VHA, the increasing demands of meeting complex healthcare needs, the escalating cost of health care, and the simultaneous implementation of massive initiatives—such as community care, the PACT Act, and electronic healthcare record modernization—require a standardized internal oversight structure that can assume accountability for the efficient and effective implementation of these high-cost but necessary efforts. The OIG strongly encourages VA leaders at every level to use oversight reports as risk assessment tools to proactively address identified vulnerabilities in their own offices, networks, and facilities. The findings should also stimulate discussions about the VISN structure and its role in ensuring and supporting consistent high-quality care to veterans.

Lastly, to avoid another costly loss of public confidence, VA should revise its critical skill incentives policy to be responsive to the findings in the OIG's published report, undertake two reviews of other awarded critical skill incentives (senior field executives and nonexecutive high-demand skill incentives) to ensure compliance with the statute and policy, and examine and address the potential conflict of interest issues identified in the report. The OIG made additional specific recommendations that VA should avoid such a catastrophic lapse in senior leadership judgement and oversight in the future.



**OTHER INFORMATION**

**INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES**

**RELATED REPORTS:**

Selected related reports (with a comprehensive list of publications available at [www.vaotig.gov](http://www.vaotig.gov)):

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
<a href="#">A Hiring Initiative to Expand Substance Use Disorder Treatment Needed Stronger Coordination, Planning, and Oversight</a>	9/4/2024	X				X
<a href="#">Deficiencies in Facility Leaders' Summary Suspension of a Provider and Patient Safety Reporting Concerns at the VA Black Hills Health Care System in Fort Meade, South Dakota</a>	8/29/2024					X
<a href="#">VBA Needs to Improve Oversight of the Digital GI Bill Platform</a>	8/28/2024		X	X	X	
<a href="#">Incorrect Use of the Baker Act at the North Florida/South Georgia Veterans Health System in Gainesville, Florida</a>	8/28/2024	X				X
<a href="#">Ineffective Oversight of Community Care Providers' Special-Authorization Drug Prescribing Increased Pharmacy Workload and Veteran Wait Times</a>	8/15/2024	X				X
<a href="#">Unauthorized Community Care Dental Procedures Risked Improper Payments</a>	8/8/2024	X	X			
<a href="#">OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024</a>	8/7/2024	X				
<a href="#">Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas</a>	7/31/2024	X				X
<a href="#">Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10</a>	7/31/2024	X				X

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
<a href="#">Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming</a>	7/25/2024	X				X
<a href="#">Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia</a>	7/23/2024	X				X
<a href="#">The Pause of the Program Integrity Tool Is Impeding Community Care Revenue Collections and Related Oversight Operations</a>	7/16/2024	X				
<a href="#">Lessons Learned for Improving the Integrated Financial and Acquisition Management System's Acquisition Module Deployment</a>	7/10/2024				X	X
<a href="#">VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits</a>	6/27/2024		X	X		
<a href="#">Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora</a>	6/24/2024	X				X
<a href="#">Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety</a>	6/24/2024					X
<a href="#">Potential Weaknesses Identified in the VISN 20 Personnel Suitability Program</a>	6/20/2024					X
<a href="#">Ineffective Use and Oversight of Medical/Surgical Prime Vendor Program Led to Increased Spending</a>	6/11/2024	X		X		
<a href="#">VA Improperly Awarded \$10.8 Million in Incentives to Central Office Senior Executives</a>	5/9/2024					X

**OTHER INFORMATION**

**INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES**

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
<a href="#">Improved Oversight Needed to Evaluate Network Adequacy and Contractor Performance</a>	4/9/2024	X				X
<a href="#">Scheduling Challenges Within the New Electronic Health Record May Affect Future Sites</a>	3/21/2024	X			X	
<a href="#">Electronic Health Record Modernization Caused Pharmacy-Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus</a>	3/21/2024	X			X	
<a href="#">Inadequacies in Patient Safety Reporting Processes and Alleged Deficient Quality of Care Prior to a Patient's Foot Amputation at the Edward Hines, Jr. VA Hospital in Hines, Illinois</a>	3/20/2024	X				
<a href="#">Care Concerns and Failure to Coordinate Community Care for a Patient at the VA Southern Nevada Healthcare System in Las Vegas</a>	2/15/2024	X				
<a href="#">Noncompliance with Contractor Employee Vetting Requirements Exposes VA to Risk</a>	2/8/2024					X
<a href="#">Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena</a>	2/6/2024	X				X
<a href="#">Discontinued Consults Led to Patient Care Delays at the Oklahoma City VA Medical Center in Oklahoma</a>	2/1/2024	X				
<a href="#">VA's Allocation of Initial PACT Act Funding for the Toxic Exposures Fund</a>	1/11/2024			X		
<a href="#">Deficiencies in the Community Care Network Credentialing Process of a Former VA Surgeon and Veterans</a>	1/4/2024					X

Related Reports	Date	Challenge				
		#1	#2	#3	#4	#5
<a href="#">Health Administration Oversight Failures</a>						
<a href="#">Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA</a>	1/4/2024		X	X		
<a href="#">Veterans Health Administration Needs More Written Guidance to Better Manage Inpatient Management of Alcohol Withdrawal</a>	1/4/2024	X				
<a href="#">Care in the Community Summary Report for Fiscal Year 2022</a>	11/29/2023	X				
<a href="#">Improvements Needed for VBA's Claims Automation Project</a>	9/25/2023		X			
<a href="#">Nonadherence to Requirements for Processing Gulf War Illness Claims Led to Premature Decisions</a>	9/7/2023		X	X		

Related Congressional Testimony	Date	Challenge				
		#1	#2	#3	#4	#5
<a href="#">Is The Veterans Benefits Administration Properly Processing and Deciding Veterans' Claims?</a>	7/23/2024		X	X		X
<a href="#">The Continuity of Care: Assessing the Structure of VA's Healthcare Network</a>	6/26/2024	X				X
<a href="#">Bonus Blunder: Examining VA's Improper Decision to Award Senior Executives Millions in Incentives</a>	6/4/2024			X		X
<a href="#">Caring for All Who Have Borne the Battle: Ensuring Equity for Women Veterans at VA</a>	4/10/2024	X				
<a href="#">Hearing on EHR Modernization Deep Dive: Can the Oracle Pharmacy Software be Made Safe and Effective?</a>	2/15/2024	X		X		X

**OTHER INFORMATION**

**INSPECTOR GENERAL'S MANAGEMENT AND PERFORMANCE CHALLENGES**

Related Congressional Testimony	Date	Challenge				
		#1	#2	#3	#4	#5
<a href="#">Hearing on "Is VA Illegally Spending Taxpayer Dollars in its Compensation and Pension Programs?"</a>	2/14/2024		X	X		X
<a href="#">Hearing on Vet Centers: Supporting the Mental Health Needs of Servicemembers, Veterans, and Their Families</a>	1/31/2024	X				
<a href="#">Hearing on Background Checks: Are VA's HR Failures Risking Drug Abuse and Harm?</a>	12/6/23	X	X			X
<a href="#">Hearing on VA's Fiduciary Program: Ensuring Veterans' Benefits are Properly Managed</a>	9/28/2023		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.



**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 2024 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)***

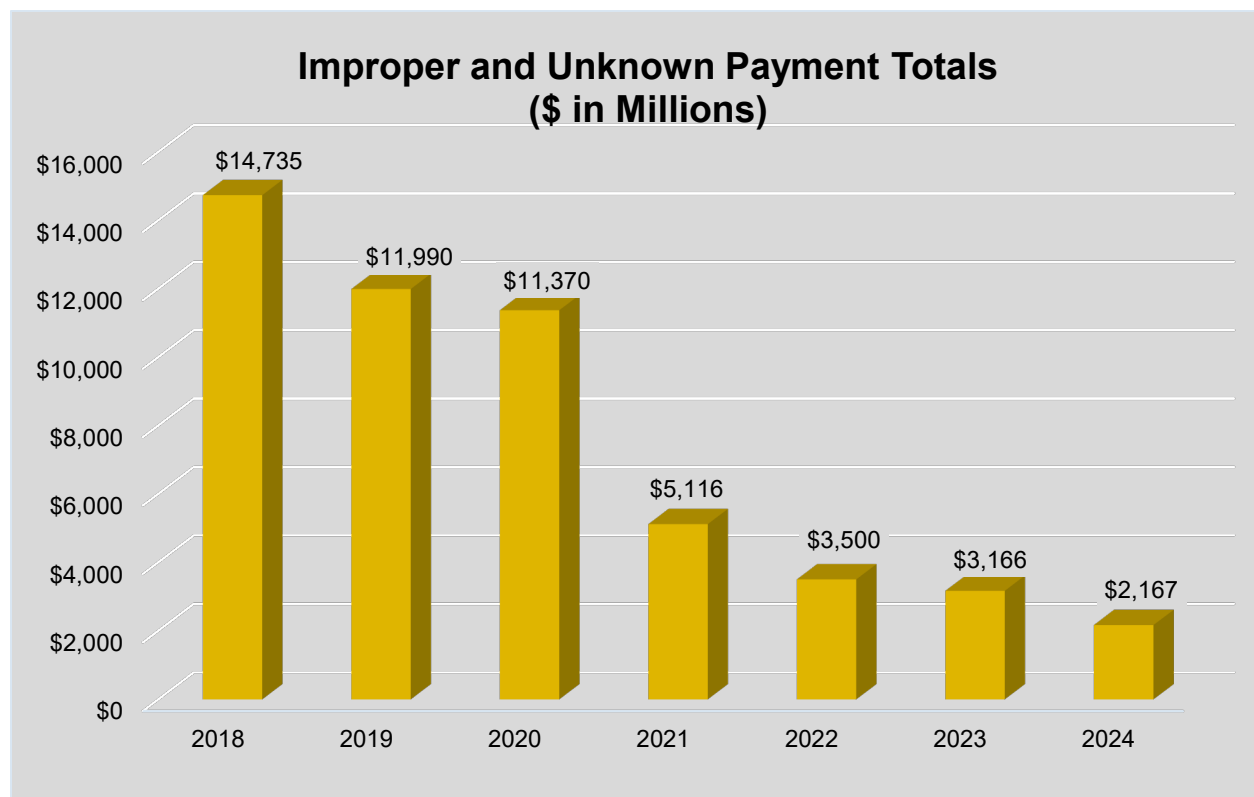
Statement of Assurance	Unmodified					
<b><i>Conformance with Federal Financial Management System Requirements (FMFIA § 4)</i></b>						
Statement of Assurance	Systems conform, except for the below nonconformance					
Nonconformances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
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 2024, VA reported a reduction of about \$1 billion in improper and unknown payments, a reduction of 31.55% from FY 2023 results, despite increases in outlays of \$4.43 billion, or 12.30%. In addition, VA is reporting improper and unknown payments under 1.5% and \$100 million for Communications, Utilities, and Other Rents (CUOR) in FY 2024; therefore, this program will revert to fulfilling legislative requirements for risk assessments no less than every 3 years in FY 2025. Since FY 2018, VA has reduced improper and unknown payments by \$12.57 billion, or 85.29%, and removed seven programs from reporting requirements by prioritizing corrective actions on the largest proportion of errors and noncompliance with laws and regulations. VA continues to strengthen its risk assessment, test plans, and collection of error data to ensure accurate projections and inform effective remediation strategies.



**PROGRAMS REPORTING IMPROPER AND UNKNOWN PAYMENTS**

During FY 2024, VA tested and developed projections for seven programs: Beneficiary Travel (BT), CUOR, Medical Care Contracts and Agreements (MCCA), Supplies and Materials (SM), Pension, Purchased Long-Term Services and Supports (PLTSS), and VA Community Care (VACC). In addition, VA reported on three high-priority programs (Pension, PLTSS, and VACC) based on payment integrity testing completed in FY 2023. Per OMB Circular A-123, Appendix C, dated March 5, 2021, programs with estimates of monetary loss 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 2024, VA will continue to report Pension, PLTSS, and VACC as high-priority programs during FY 2025.

**FY 2024 Improper Payments by Program**

FY 2024 Payments Overview	Beneficiary Travel (BT)		Communications Utilities and Other Rents (CUOR)		Medical Care Contracts and Agreements (MCCA)		Supplies and Materials (SM)		Pension		Purchased Long-Term Services and Supports (PLTSS)		VA Community Care (VACC)	
	\$ (in Millions)	% of Outlays	\$ (in Millions)	% of Outlays	\$ (in Millions)	% of Outlays	\$ (in Millions)	% of Outlays	\$ (in Millions)	% of Outlays	\$ (in Millions)	% of Outlays	\$ (in Millions)	% of Outlays
<b>Outlays</b>	<b>\$1,849.10</b>		<b>\$2,326.80</b>		<b>\$1,236.77</b>		<b>\$3,705.91</b>		<b>\$3,742.93</b>		<b>\$5,620.66</b>		<b>\$21,981.87</b>	
<b>Proper Payments</b>	<b>\$1,699.54</b>	<b>91.91%</b>	<b>\$2,313.53</b>	<b>99.43%</b>	<b>1,208.53</b>	<b>97.72%</b>	<b>\$3,425.24</b>	<b>92.43%</b>	<b>\$3,224.36</b>	<b>86.15%</b>	<b>\$4,860.57</b>	<b>86.48%</b>	<b>\$21,565.24</b>	<b>98.10%</b>
<b>Improper Payments</b>	<b>\$132.04</b>	<b>7.14%</b>	<b>\$12.54</b>	<b>0.54%</b>	<b>\$1.13</b>	<b>0.09%</b>	<b>\$215.51</b>	<b>5.82%</b>	<b>\$404.01</b>	<b>10.79%</b>	<b>\$657.17</b>	<b>11.69%</b>	<b>\$416.63</b>	<b>1.90%</b>
<b>Overpayments</b>	<b>\$86.22</b>	<b>4.66%</b>	<b>\$3.55</b>	<b>0.15%</b>	<b>\$0.65</b>	<b>0.05%</b>	<b>\$0.31</b>	<b>0.01%</b>	<b>\$381.78</b>	<b>10.20%</b>	<b>\$218.30</b>	<b>3.88%</b>	<b>\$416.63</b>	<b>1.90%</b>
<b>Within Agency Control</b>	<b>\$86.22</b>	<b>4.66%</b>	<b>\$3.55</b>	<b>0.15%</b>	<b>\$0.65</b>	<b>0.05%</b>	<b>\$0.31</b>	<b>0.01%</b>	<b>\$381.78</b>	<b>10.20%</b>	<b>\$218.30</b>	<b>3.88%</b>	<b>\$416.63</b>	<b>1.90%</b>
Data Does Not Exist	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
Failure to Access Data	\$86.22	4.66%	\$3.55	0.15%	\$0.65	0.05%	\$0.31	0.01%	\$381.78	10.20%	\$218.30	3.88%	\$416.63	1.90%
<b>Outside Agency Control</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>
Data Does Not Exist	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
Failure to Access Data	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
<b>Non-Monetary Loss</b>	<b>\$45.82</b>	<b>2.48%</b>	<b>\$8.99</b>	<b>0.39%</b>	<b>\$0.48</b>	<b>0.04%</b>	<b>\$215.20</b>	<b>5.81%</b>	<b>\$22.23</b>	<b>0.59%</b>	<b>\$438.86</b>	<b>7.81%</b>	<b>\$0.00</b>	<b>0.00%</b>
<b>Underpayments</b>	<b>\$3.59</b>	<b>0.19%</b>	<b>\$0.42</b>	<b>0.02%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$22.23</b>	<b>0.59%</b>	<b>\$6.41</b>	<b>0.11%</b>	<b>\$0.00</b>	<b>0.00%</b>
Data Does Not Exist	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
Inability to Access Data	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%	\$0.00	0.00%
Failure to Access Data	\$3.59	0.19%	\$0.42	0.02%	\$0.00	0.00%	\$0.00	0.00%	\$22.23	0.59%	\$6.41	0.11%	\$0.00	0.00%
<b>Technically Improper</b>	<b>\$42.23</b>	<b>2.28%</b>	<b>\$8.57</b>	<b>0.37%</b>	<b>\$0.48</b>	<b>0.04%</b>	<b>\$215.20</b>	<b>5.81%</b>	<b>\$0.00</b>	<b>0.00%</b>	<b>\$432.46</b>	<b>7.69%</b>	<b>\$0.00</b>	<b>0.00%</b>
<b>Unknown Payments</b>	<b>\$17.53</b>	<b>0.95%</b>	<b>\$0.73</b>	<b>0.03%</b>	<b>\$27.11</b>	<b>2.19%</b>	<b>\$65.16</b>	<b>1.76%</b>	<b>\$114.57</b>	<b>3.06%</b>	<b>\$102.93</b>	<b>1.83%</b>	<b>\$0.00</b>	<b>0.00%</b>
<b>Improper Payments + Unknown Payments</b>	<b>\$149.56</b>	<b>8.09%</b>	<b>\$13.27</b>	<b>0.57%</b>	<b>\$28.25</b>	<b>2.28%</b>	<b>\$280.67</b>	<b>7.57%</b>	<b>\$518.58</b>	<b>13.85%</b>	<b>\$760.09</b>	<b>13.52%</b>	<b>\$416.63</b>	<b>1.90%</b>

Note: In FY 2024, VA tested and reported on payments made in FY 2023. A detailed description of each program's errors and corrective actions can be found on <https://paymentaccuracy.gov/>. The improper and unknown payment total amounts may not sum due to rounding. In addition, there may be slight variances in the dollar amounts and percentages reported on PaymentAccuracy.gov due to rounding.

**Technical Terms to Know**

**Data Does Not Exist:** A situation in which there is no known database, dataset, or location currently in existence that contains the data/information needed to validate the payment accuracy prior to making the payment.

**Inability to Access Data:** A situation in which the data or information needed to validate payment accuracy exists, but VA does not have access to it.

**Failure to Access Data:** Improper payments are attributed to human errors to access the appropriate data/information to determine whether a beneficiary or recipient should be receiving a payment, even though such data/information exists and is accessible to VA.

**BT IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS**

The BT program is organizationally aligned under Veterans Health Administration (VHA) Member Services. The program consists of mileage reimbursement, common carrier, and special mode transportation (ambulance, wheelchair van, etc.) to eligible Veterans and other beneficiaries. In addition, VA can provide or reimburse for the actual cost of bridge tolls, road tolls, and tunnel tolls. Expenses related to meals and/or lodging may also be provided in limited circumstances. In FY 2024, the program reported an estimated 91.91%, or \$1.70 billion, in proper payments and 8.09%, or \$149.56 million, in improper and unknown payments.

From 2023, the total estimated improper and unknown payment error rate increased by 1.26%, and the total estimated improper and unknown payment amount increased by \$29.61 million in FY 2024. The increase is attributed to the rise in delinquent authorizations in special mode transportation claims where manual processes exist. Most improper payments resulted from incorrect claim calculation and delinquent authorizations. 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 2024, or are planned for FY 2025, to correct and mitigate the BT program’s improper and unknown payments:

<b>Mitigation Strategy or Corrective Action</b>	<b>Description</b>
Automation	<p>Actions taken included continuing to implement new software that will provide a customized and enhanced tool to streamline claims; automate eligibility determinations, payment processing, and detection and prevention of improper payments; and enhance reporting and auditing capabilities. In addition, VA continued with the post-implementation modernization of BT claims processing software and other systems. Further, VA continued planning for invoice payment processing nationwide, which is expected to improve the timeliness and accuracy of ambulance claims processing. Finally, VA transitioned from a legacy system to a new BT claims processing system.</p> <p>Actions planned include continuing with the post-implementation modernization of beneficiary travel claims processing systems. VA enhanced automation action plans to expand use of transportation modalities that will streamline third-party preauthorized claims processing, integrate medical qualifications, and automate contract execution.</p>
Change Process	<p>Actions taken included establishing and deploying enterprise-wide infrastructure solutions, to include quality assurance monitoring processes for mileage reimbursement and special mode transportation.</p>
Training	<p>Actions planned include developing new and enhanced claims processing training and deploying training resources across various stakeholder groups to ensure more effective communication across target audiences. Additionally, VA will continue establishing and deploying enterprise-wide infrastructure solutions, including reviewing the effectiveness of quality assurance and monitoring</p>

Mitigation Strategy or Corrective Action	Description
	reporting processes and developing and implementing effective standardized processes.

### CUOR IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS

The CUOR program is organizationally aligned under the VHA Procurement Logistics Office. The program funds payments for use of communications and utility services and charges for possession and use of land, structures, or equipment owned by others. In FY 2024, the program reported an estimated 99.43%, or \$2.31 billion, in proper payments and 0.57%, or \$13.27 million, in improper and unknown payments. This program is under the statutory threshold for significant improper payments and will revert to fulfilling legislative requirements for risk assessments no less than every 3 years. Management will continue its responsibilities for internal control outlined in the Government Accountability Office Green Book.

From 2023, the improper and unknown payment error rate decreased by 1.92%, and the total estimated improper and unknown payment amount decreased by \$39.82 million in FY 2024. The decrease in reported dollars and the overall rate occurred despite program outlays increasing by 9.35%. Most improper payments resulted from lack of requests for procurement action and claims not being paid according to the contract. 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 2024 to correct and mitigate the CUOR program's improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Change Process	Actions taken included restructuring existing local and national contracts and rejecting invoices that do not comply with contract requirements. Additionally, VA ensured ordering processes were compliant with statute and regulation, thus reducing technically improper payments caused by unauthorized commitments.

### MCCA IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS

The MCCA program is organizationally aligned under the VHA Procurement Logistics Office. The program includes contracts for research, medical and educational data or services, reimbursements at contract per diem rates for hospitalization, dialysis treatment furnished by a non-VA facility, indirect charges added for research and demonstration projects, and contracted Emergency Medical Services. In FY 2024, the program reported an estimated 97.72%, or \$1.21 billion, in proper payments and 2.28%, or \$28.25 million, in improper and unknown payments.

From 2023, the improper and unknown payment error rate decreased by 1.67%, and the total estimated improper and unknown payment amount decreased by \$17.47 million in FY 2024. The decrease in reported dollars and the overall rate occurred despite program outlays increasing by 6.74%. Most improper and unknown payments resulted from invoice pricing not reconciling to the contract and an inability to validate pricing. 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 2024, or are planned for FY 2025, to correct and mitigate the MCCA program’s improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Change Process	Actions taken included restructuring existing local and national contracts and rejecting invoices that do not comply with contract requirements. Additionally, VA ensured ordering processes were compliant with statute and regulation. VA also continued conducting an annual concurrence process to meet with field offices, which ensures accuracy of testing results and improves understanding of requirements for future purchases, as well as obtaining additional documentation required to determine payment accuracy.
	Actions planned include notifying contracting personnel of incorrect procurement procedures for resolution and updating contract language or rejecting vendor invoices that do not have the required information to validate payment accuracy.
Training	Actions planned include providing training to individuals who are incorrectly certifying invoices for payment.

**PENSION IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS**

The Pension program is organizationally aligned under the Veterans Benefits Administration Pension and Fiduciary Office. The program helps eligible Veterans and their survivors cope with financial challenges by providing supplemental income through Veterans and Survivors Pension benefits. Specifically, the Veterans Pension program provides monthly payments to wartime Veterans who meet certain age or disability requirements; the Survivors Pension offers monthly payments to qualified surviving spouses and unmarried dependent children of wartime Veterans. Pension program recipients must meet income and net worth limits set by Congress. Income limits require adjustments when beneficiaries have changes to eligibility factors (e.g., income or medical expenses, dependency, etc.), and these changes are the primary cause of improper payments. In FY 2024, the program reported an estimated 86.15%, or \$3.22 billion, in proper payments and 13.85%, or \$518.58 million, in improper and unknown payments.

A known barrier to reductions is the reliance upon beneficiaries to report when they experience a change in receiving benefits from other sources, as this is an important factor in determining continued eligibility for benefits. When VA identifies a potential change for the beneficiary that could impact their Pension benefit, VA must provide the beneficiary advance notice, known as due process, to provide additional documentation. The due process period protects the beneficiary from reduction adjustments being made to their pension payments without validation of the data. Therefore, VA must continue to make the pension payment at the higher rate and does not know if the payment at the lower rate is accurate or not until due process is complete.

From FY 2023, the improper and unknown payment error rate increased by 2.99%, and the total improper and unknown payment amount increased by \$99.31 million in FY 2024. Over 86.81% of the total improper and unknown 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 2024, or are planned for FY 2025, to correct and mitigate the Pension program’s improper payments:

Mitigation Strategy or Corrective Action	Description
Audit	Actions taken and planned include randomly reviewing claims 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 being completed once.
Automation	Actions taken included using the Social Security Administration’s (SSA) Death Master File to match against active beneficiaries or their dependents. Actions also taken and planned include conducting quarterly matches with SSA to identify variances between SSA income a beneficiary is receiving versus the amounts reported by a beneficiary to VA.
Training	Actions planned include training staff to ensure policies and procedures are properly applied in making accurate pension rate decisions to prevent future improper payments.

**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 as well as their families and caregivers. In FY 2024, the program reported an estimated 86.48%, or \$4.86 billion, in proper payments and 13.52%, or \$760.09 million, in improper and unknown payments.

From 2023, the improper and unknown payment error rate decreased by 25.20%, and the total estimated improper and unknown payment amount decreased by \$657.90 million in FY 2024. The decrease in reported dollars and the overall rate occurred despite program outlays increasing by 53.47%. Most of the improper and unknown payments resulted from purchases being made without a contract using a Basic Ordering Agreement, which is not a contract, or 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 2024, or are planned for FY 2025, to correct and mitigate the PLTSS program’s improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Automation	Actions taken included updating the claims processing system to pay or deny Homemaker/Home Health Aid Service, Community Nursing Home, and Veteran Directed Care claims appropriately.

**OTHER INFORMATION**  
**PAYMENT INTEGRITY INFORMATION ACT REPORTING**

Mitigation Strategy or Corrective Action	Description
	Actions planned include updating the claims processing system to pay Bowel and Bladder and Community Nursing Home claims appropriately.
Change Process	<p>Actions taken included working to ensure invoices are being validated per the contract pricing prior to payment. Additionally, VA worked to implement short- and long-term contracting options for Community Nursing Home payments to improve compliance with procurement requirements. Finally, VA clarified the payment methodology with third-party administrators (TPA) to bill at the correct rates.</p> <p>Actions planned include moving to a standardized rate schedule for Community Nursing Home payments to transition payments from a legacy system to an automated claims processing system. Additionally, VA will continue clarifying the payment methodology with TPAs to bill at the correct rates and will implement short- and long-term contracting options for Community Nursing Home payments to improve compliance with procurement requirements. Further, VA will resolve contracting errors involving missing signatures and the inability to reconcile procurement vendor to invoice vendor, and VA will establish Veterans Care Agreements when appropriate.</p>
Training	Actions planned include working with VA facilities to provide education and training to resolve missing documentation errors related to authorization, payment, or Veteran level of care to support the payment process.

**SM IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS**

The SM program is organizationally aligned under The VHA Procurement Logistics Office. Payments for this program include those supplies and materials acquired by formal contract or other form of purchase that are ordinarily consumed or expended within 1 year after they are put into use, converted in the process of construction or manufacturing, or used to form a minor part of equipment or fixed property or other property not separately identified in the asset accounts. In FY 2024, the program reported an estimated 92.43%, or \$3.43 billion, in proper payments and 7.57%, or \$280.67 million, in improper and unknown payments.

From 2023, the improper and unknown payment error rate increased by 4.02%, and the total estimated improper and unknown payment amount increased by \$163.21 million in FY 2024. The increase is attributed to a rise in Medical Surgical Prime Vendor and Nutrition and Food Services claims where written ordering officer delegations were not consistently documented and retained. Most improper and unknown payments resulted from lack of ordering officer delegation documentation or invoice pricing that did not reconcile to the contract. 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 2024, or are planned for FY 2025, to correct and mitigate the SM program’s improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Change Process	Actions taken included restructuring existing local and national contracts and rejecting invoices that do not comply with contract requirements, including no receipt for goods or services. Additionally, VA ensured ordering processes were compliant with statute and regulation.
	Actions planned include improving contract processes for the Medical Supplies Prime Vendor payments and the Nutrition and Food Services payments to ensure payment accuracy. In addition, VA will provide education and training to the contracting officer and/or ordering officials to ensure contracts contain required signatures and proper approvals are obtained prior to placing orders. Finally, VA will restructure existing contracts and provide education and training to certifying officials for rejecting invoices that do not comply with contract requirements.

### VACC IMPROPER AND UNKNOWN PAYMENTS AND CORRECTIVE ACTIONS

The VACC 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 2024, the program reported an estimated 98.10%, or \$21.57 billion, in proper payments and 1.90%, or \$416.63 million, in improper payments.

From 2023, the improper and unknown payment error rate decreased by 3.02%, and the total estimated improper and unknown payment amount decreased by \$575.75 million in FY 2024. The decrease in reported dollars and reduction in the overall rate occurred despite the program's outlays increasing by 9.08%. Most improper payments resulted from the program's failure to deny untimely submitted claims. 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 2024, or are planned for FY 2025, to correct and mitigate the VACC program's improper and unknown payments:

Mitigation Strategy or Corrective Action	Description
Automation	Actions taken included updating the claims processing system to identify and auto-deny Community Care Network claims that should be processed by a TPA to deny out-of-network facility provider claims for emergent episodes of care. Additionally, VA transitioned National Dialysis Contract claims from a legacy system to an automated claims processing system to ensure claims are paid at the correct rates. Finally, VA updated system logic in the claims processing system to suspend or deny dental claims when provider criteria does not reconcile to the Veterans Care Agreement.
Audit	Actions planned include conducting post-payment reviews and establishing bills of collection for claims that were overpaid.

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**OTHER INFORMATION****PAYMENT INTEGRITY INFORMATION ACT REPORTING**

<b>Mitigation Strategy or Corrective Action</b>	<b>Description</b>
Change Process	Actions taken included clarified payment methodology with VA and TPAs to bill at the correct allowable rates. Additionally, for non-network payments, VA implemented system checks to suspend institutional inpatient and ambulance claims for manual review prior to payment. In addition, VA instructed TPAs to follow standard billing practices as defined in the contract and communicated to claims processing agents to not process claims when timely filing requirements are not met.
	Actions planned include ensuring contract language is clear and clarify any inconsistent payment methodology instances with TPAs regarding payment discrepancies. Additionally, VA will engage in a contract modification to further elaborate on standard episode of care claims processing. In addition, VA will ensure timely filing criteria is clear and proper monitoring is in place.
Training	Actions taken included providing training on claims processing requirements when required other health insurance documentation is missing.

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**PROGRAMS SUBJECT TO RISK ASSESSMENTS**

In FY 2024, of VA's 65 programs spending over \$10 million annually, 24 programs were subject to risk assessments to determine if they were likely susceptible to improper and unknown payments. These programs either underwent significant changes that could increase their risk, such as increased spending over 20% or changes in legislation or had not completed a risk assessment in 3 years. One program, Compensation, was determined likely susceptible and will report statistically valid improper and unknown payments in FY 2025.

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VA's PIIA and high-priority program reporting can be found, once published by OMB, at <https://paymentaccuracy.gov/>.

**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.

<b>Statutory Authority</b>	<b>Penalty (Name or Description)</b>	<b>Year Enacted</b>	<b>Latest Year of Adjustment (via Statute or Regulation)</b>	<b>Current Penalty Level (\$ Amount or Range)</b>	<b>Sub-Agency/Bureau/Unit</b>	<b>Location for Penalty Update Details</b>
Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, as amended	False Loan Guarantee Certifications	1986	2024 (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 \$27,894	VBA/Loan Guarantee	Federal Register 89 <a href="#">(01/10/2024)</a> : 1458-1460
Program Fraud Civil Remedies Act of 1986, as amended	Fraudulent Claims or Statements	1986	2024	\$13,946	All VA Programs	Federal Register 89 <a href="#">(01/10/2024)</a> : 1458-1460

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



**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, 2024. The summary of this information is disclosed in the following table.

<b>CATEGORY</b>	<b>2-3 Years</b>	<b>&gt;3-5 Years</b>	<b>&gt;5 Years</b>
<b>Number of Grants/Cooperative Agreements with Zero Dollar Balances</b>	10	-	-
<b>Number of Grants/Cooperative Agreements with Undisbursed Balances</b>	60	4	1
<b>Total Amount of Undisbursed Balances</b>	\$2,128,916	\$192,432	\$103,957

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

In FY 2024, the State Home Construction grant office closed out 70 grants during September 2024; however, the office was not able to meet its goal to close out all grants by September 30, 2024. The 10 remaining State Home Construction grants will be closed in FY 2025. State Home Construction comprises of 10 grants with undisbursed balances totaling \$278,281.

The Adaptive Sports grant office has made significant progress reducing the closeout backlog. The grant office has closed 14 grants in the month of September 2024 and is on track to close the remaining grants in FY 2025. Adaptive Sports is comprised of 65 grants, which include those with both zero-dollar balances and undisbursed balances, with undisbursed balances totaling \$2,147,023.

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## CLIMATE-RELATED FINANCIAL RISK

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### CLIMATE ADAPTATION PLAN

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VA's Climate Adaptation Plan provides valuable information relevant to VA services, operations, programs, and assets. VA's latest 2024-2027 Climate Adaptation Plan is available at: [Department of Veterans Affairs 2024-2027 Climate Adaptation Plan \(sustainability.gov\)](https://www.va.gov/sustainability/2024-2027-climate-adaptation-plan).

### GOVERNANCE, STRATEGY, RISK MANAGEMENT, AND METRICS

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#### 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 ensure that adaptation efforts include the full scope of its operations, while continuing to deploy its climate adaptation strategy.

#### 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. For the 2024-2027 Climate Adaptation Plan, VA built on prior adaptation actions and climate vulnerability analysis to update its key actions for increasing VA's climate resilience. This includes actions to protect VA facilities, such as assessing the resilience of facilities and updating building standards. Actions will also include building public health surveillance systems to address short- and long-term impacts of climate on Veteran and employee health and the VA health care system, as well as projected climate-related health and health care vulnerabilities and expenditures. In addition, education and public health mitigation strategies will address adverse climate-related health impacts to employees' and Veterans' resources.

## OTHER INFORMATION

### CLIMATE-RELATED FINANCIAL RISK

In 2023, VA completed a nationwide assessment of climate vulnerabilities of its most 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 included 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 for the 2021 Climate Action Plan. This tool has been updated for the 2024-2027 Climate Adaptation Plan to provide further granularity on progress and challenges. Progress is updated and shared with VA's Sustainability Task Force quarterly. In accordance with E.O. 14057, VA will continue to update 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, as well as grants aimed at assisting eligible Veterans with service-connected disabilities in constructing or modifying their homes 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.

**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.

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**OTHER INFORMATION****FINANCIAL REPORTING-RELATED LEGISLATION**

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**FINANCIAL REPORTING-RELATED LEGISLATION**

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Legislative provisions enacted in the prior fiscal year and/or current fiscal year that impact VA's financial accounting, reporting, or auditing issues are reported below.

**FY 2023**

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- **Fiscal Responsibility Act of 2023 (P.L. 118-5)**: The legislation provided funding for VA's Cost of War Toxic Exposure Fund. For more information, refer to page 27.

**FY 2024**

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- **Veterans Benefits Continuity and Accountability Supplemental Appropriations Act of 2024 (P.L. 118-82)**: The legislation provided supplemental appropriations to VBA for Compensation, Pensions, and Readjustment benefits. Additionally, VA must report to Congress on improvements to budgetary forecasting and data quality, and the status of funds provided.